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OVERSIGHT ON FINANCIALLY DISTRESSED HOSPITALS

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HEARING

BEFORE THE

SUBCOMMITTEE ON

HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON

LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

TO EXAMINE THE PLIGHT OF FINANCIALLY DISTRESSED
HOSPITALS

JUNE 25, 1980



Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

68-227 O

WASHINGTON : 1980

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OVERSIGHT ON FINANCIALLY DISTRESSED HOSPITALS

WEDNESDAY, JUNE 25, 1980

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 4232, Dirksen Senate Office Building, Senator Howard Metzenbaum presiding pro tempore.

Present: Senators Metzenbaum and Javits.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. The subcommittee will come to order, please.

In the past, this subcommittee has heard extensive testimony about the problems faced by the millions of Americans whose health insurance coverage is either inadequate or wholly nonexistent.

We have learned that 50 million Americans—nearly a quarter of our population, have inferior health insurance coverage that does not cover their needs.

Another 20 million Americans have no health insurance whatsoever and do not qualify for medicaid.

And, in addition, we have among us millions of undocumented aliens and refugees who require health services, but have no means to pay for them.

I believe that these figures constitute a powerful argument for a national health insurance program. But that is not the topic of our hearing. Rather, we will focus today on the growing financial crisis that our medically underinsured society has forced upon hospitals in every corner of this country that serve the medically indigent.

The Chair feels particularly interested in this hearing because for a number of years I served as treasurer for Mt. Sinai Hospital in Cleveland. That hospital was in the Huff area and served primarily the medically indigent.

In the past, many hospitals have been medical "Robin Hoods" of a sort, recovering a portion of costs of serving the indigent by charging higher fees to those able to pay. But today, the number of patients covered by programs that reimburse on a strict cost basis is rapidly increasing. And it is manifestly unfair to continue to shift this crushing burden to the decreasing number of Americans who pay full, established hospital costs.

Clearly, Federal and State policies have played an important role in pushing hospitals that serve the poor to the edge of bankruptcy.

Under medicare and medicaid, no provisions exist for reimbursement of free care or legitimate bad debts. Inadequacies in medicare and medicaid coverage of outpatient services also unfairly penalize those hospitals whose emergency rooms serve as family doctors for Americans who live in underserved parts of the country.

In Pennsylvania, for example, payment on behalf of medicaid recipients for outpatient visits is limited to a fixed amount—\$12—which is hardly sufficient to meet the costs of any such service.

Preliminary data from the American Hospital Association show that these problems are not confined to the inner cities. The fact is that hospitals in every part of this country—in large cities, small cities and in many parts of rural America—are in deep financial trouble.

The problem is severe for the nonprofit hospitals. But for the public general hospitals—the only ones that guarantee care to everyone regardless of ability to pay—for these hospitals of last resort for the poor, the situation is truly critical.

Public general hospitals are vital providers of primary care. With only 24 percent of the Nation's community hospital beds, they account for almost 50 percent of the outpatient visits. Similarly, public hospitals provide a disproportionate amount of emergency care and they are an invaluable resource in training the Nation's health professionals.

Furthermore, the public hospitals, as well as private hospitals in poor communities are major employers—particularly of semiskilled and unskilled workers, women, and minorities.

In some inner cities, a hospital may be the only significant employer—and so when one of them closes, the effect on the community is doubly devastating—devastating to health and to employees. It is a very tragic fact that between 1974 and 1977, 85 public hospitals closed.

In the last 6 years, 21 county hospitals in California have been closed or sold. And because of severe cutbacks, the surviving institutions must inevitably offer a lower quality of care. And if nothing is done, they, too, may close.

California has no monopoly on these problems. We hear the same in Detroit, Chicago, the District of Columbia, South Carolina—the list goes on and on and on.

The provisions contained in the legislative package before us today provide only short-term solutions. Once again, I believe that only a national health insurance program can respond realistically to problems of this magnitude.

The financial distress grant program is specifically targeted for hospitals that provide needed health services and that are in imminent danger of closing—but such a program can provide only temporary assistance. A hospital that is in financial distress because it provides substantial services to the poor will continue to experience distress after the rescue period unless uncompensated care is somehow covered. Thus, a longer term solution to the problem facing these hospitals must include some improvements in the current health care financing system.

The changes suggested in S. 2841, The Hospital Ambulatory Services Reimbursement Reform Act, would modify medicare and medicaid and require that they assume their proportional responsibility for the uncollectable outpatient costs of these financially distressed hospitals. It would also insure that hospitals could be paid adjusted fees for outpatient services.

The fiscal crisis of these hospitals clearly involves Federal as well as State and local responsibilities. The legislation that we will be discussing today is a first step toward assisting hospitals that are often the only source of health care for millions of Americans. And I believe that unless we act now to assist them, many of these hospitals will be forced to close their doors in the faces of the neediest of our people.

I look forward to hearing the views of today's witnesses.

I should point out the fact that holding this hearing today is, in and of itself, helpful, because it has prompted the administration to hold a press conference yesterday to talk about its proposed program to help some distressed hospitals in the city of New York.

I will look forward to more specific answers from administration witnesses. What was said yesterday seems to be more talk than action.

There are hundreds of hospitals in trouble, and the administration is talking about trial programs, and about helping six to eight hospitals. I am glad to see the administration is concerned. It has taken a bit of time to get there. But I am happy to see at least there is some movement in that direction.

At this point we will insert Senator Javits' statement in the record.

**STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM
THE STATE OF NEW YORK**

Senator Javits. Mr. Chairman, I am pleased to participate in these hearings relating to legislation which I introduced last week, S. 2840 and S. 2841, which were cosponsored by several of my colleagues on this committee and in the Senate. This legislation seeks to avert a serious crisis in our Nation's hospitals—a crisis generated by the failure of public policy to provide adequate health insurance coverage and alternative sources of health care for all of our citizens.

Today there are approximately 20 million medically indigent Americans who do not qualify for medicaid and have no private health insurance. In recent years, the burden of providing essential health services, particularly ambulatory care services to persons who cannot pay for such services, has fallen increasingly on hospitals. While about 90 percent of all inpatient hospital days nationwide are covered by insurance, only 30 to 40 percent of outpatient visits are insured. Thus the hospitals most heavily involved in direct community service to the medically indigent are most heavily penalized by the current reimbursement system. In certain hospitals, both voluntary and public, the level of nonreimbursed services far exceeds available resources thereby jeopardizing the continued operation of the hospital.

I became acutely aware of this critical problem several months ago as a consequence of our experience in New York with the

Jewish Hospital and Medical Center of Brooklyn. This vitally important institution was on the brink of closure when city, State, and Federal officials intervened—after considered delay due to inadequate statutory authority and financial resources—to assure the hospital's continued operation while a plan was developed to restructure the health care delivery system in the surrounding communities. Brooklyn Jewish is not unique, however. To the contrary, Brooklyn Jewish represents only the beginning of what promises to evolve into a full scale national crisis in our hospital sector if immediate corrective steps are not taken.

Without appropriate relief measures, an increasing number of hospitals will be forced to close, millions of our citizens will be left without vital health care services, and, in some cases, the loss of jobs, increased welfare, and unemployment, and social instability will cripple the economic welfare of the community.

A variety of factors contribute to these hospitals' ever-worsening financial condition. I have discussed these in some detail in my statement accompanying the introduction of these bills; I request unanimous consent that this statement be included in the hearing record.

[The information referred to follows:]

[From the Congressional Record—Senate, June 17, 1980]

THE FINANCIALLY DISTRESSED HOSPITALS ASSISTANCE ACT AND THE HOSPITAL AMBULATORY SERVICES REIMBURSEMENT REFORM ACT

Mr. JAVITS. Two related bills—the Financially Distressed Hospitals Assistance Act (cosponsored by Senators Kennedy, Randolph, Pell, Metzenbaum, Moynihan, and Bradley) and the Hospital Ambulatory Services Reimbursement Reform Act (cosponsored by Senators Kennedy, Randolph, Pell, Hatch, Metzenbaum, Moynihan, and Bradley). These measures are designed to avert a serious crisis in our Nation's hospitals—a crisis generated by the failure of public policy to provide adequate health insurance coverage and alternative sources of health care for all our citizens.

In recent years, the burden of providing essential health services, particularly ambulatory care services, to persons who cannot pay for such services has fallen increasingly on hospitals. Today, there are approximately 20 million Americans who do not qualify for medicaid and have no private health insurance. At the very time that hospitals are under increasing pressure to function as comprehensive care centers, especially for those individuals with no other source of care, the resources to develop new free-standing ambulatory care centers have become more limited. While about 90 percent of all inpatient hospital days nationwide are covered by insurance, only 30-40 percent of outpatient visits are insured. Thus, the hospitals most heavily involved in direct community service to the medically indigent are most heavily penalized by the current reimbursement system.

This tremendous community service, however, is seriously threatened in those institutions where the level of nonreimbursed services, outweighs available resources, thereby jeopardizing the continued operation of the facility.

I became acutely aware of this critical problem several months ago as a consequence of our experience in New York with the Jewish Hospital and Medical Center of Brooklyn. This vitally important institution was on the brink of closing when city, State, and Federal officials intervened to assure the hospital's continued operation while a plan was developed to restructure the health care delivery system in the Bedford-Stuyvesant and Crown Heights communities of Brooklyn. Brooklyn Jewish is not unique, however. I believe that it represents only the beginning of what could soon evolve into a full-scale national crisis in our hospital sector if immediate corrective steps are not taken.

Brooklyn Jewish dramatically illustrated to all of us who became involved in this crisis the full implications of the loss of such a critical facility—that is, the devastating impact on the availability of health care services to persons who have no alternative source of care, and the crippling economic consequences to a community associated with the closure of such a facility including loss of jobs, increased welfare and unemployment, and social instability.

A variety of factors contribute to these hospitals' ever-worsening financial condition. Public hospitals, for example, which historically have been the source of care for individuals who generally have no where else to go, now face severe pressures to scale down their level of services.

Because of limits of the local tax bases, especially in our older urban areas, and the effect of inflation on the ability of municipalities to support services, there has been a sharp decline in the share of funds available to these institutions. More than 85 public hospitals in this country were closed between 1974-77. Much of the patient load of these institutions moved to voluntary hospitals. But the movement of uninsured patients from one facility to another only shifts that financial burden, it does not eliminate it.

In addition, as inflation continues to rise, cost containment efforts have increased. Such efforts, while having many positive effects on health care services delivery and costs, make it increasingly difficult for private institutions to absorb the cost of care for the medically indigent through such traditional methods as increasing the charges to paying patients. Moreover, current Federal reimbursement policies often worsen the situation. Medicare and medicaid, as currently structured, do not share the costs of care provided to the medically indigent as other insurers in some States presently do. In many States, income eligibility levels have not been raised to keep pace with inflation, thus increasing the number of persons who cannot afford health care but who cannot qualify for government assistance. This burden has resulted in staggering losses by hospitals throughout the country committed to providing this important community service.

A final problem confronting many of these institutions is the need to recognize their health care delivery system to meet the demand for ambulatory and emergency services in a more efficient and cost effective manner. Most hospital outpatient departments as traditionally structured cannot assure the provision of comprehensive, continuous primary care services. If we rely on these traditional practice patterns, we will inevitably see increased hospital admissions in order to receive adequate reimbursement for services that are more appropriately provided in the ambulatory setting. Institutions must be helped to improve operations and management, accent ambulatory services, and reduce unnecessary reliance on costly inpatient services.

I cannot emphasize enough the seriousness of this issue or the urgency with which it must be addressed. We face an imminent threat to our continued ability to provide medical services to medically indigent persons. As we discovered during the episode with Brooklyn Jewish and are learning continually as new institutions reach out for assistance, current legislative authorities are not adequate to solve the problems of these facilities. New authorities are needed to provide appropriate short- and long-term assistance.

The bills I am introducing today, I believe, represent responsible solutions to this very serious problem. These proposals are carefully formulated to provide assistance only to those institutions which serve the underserved and which can document significant deficits due to the provision of ambulatory and emergency services to medically indigent persons.

In designing this legislation, I have included provisions that deal with three critical issues: The increasing demand on hospitals to serve as providers of ambulatory care services to the medically indigent, the need to provide adequate reimbursement for the services rendered so that these critical institutions can survive and prosper, and, finally, the need appropriately to reorganize and restructure these institutions to help them meet this demand for ambulatory services in an efficient and effective manner.

The first bill, the Financially Distressed Hospitals Assistance Act, provides emergency grants to prevent the closure of hospitals which are the principal source of essential health services in their communities and which are experiencing severe financial distress due to the high volume of ambulatory health services provided to medically indigent persons. Grants would provide for payment of accrued debts for private nonprofit hospitals to allow them to regain a stable financial position for future operations.

In addition, in order to permit and encourage improved management practices and necessary health services delivery reorganization, the bill provides grant support and technical assistance to eligible institutions to make appropriate changes in health care delivery toward these ends while assuring that there will be maintenance and improvement of the quality of health care and protection of any employees affected by hospital reorganization plans.

The Hospital Ambulatory Services Reimbursement Reform Act is designed to keep acute financial crises from recurring once stability has been achieved and to prevent such crises from occurring in other hospitals serving similar populations.

The proposed reimbursement reform program presumes that the provision of care to those who cannot pay for it is part of the legitimate cost of operation in certain hospitals serving large indigent populations and should be accommodated within the reimbursement system.

In my judgment, until broader reforms in health care and hospital reimbursement are enacted, the only practical and fair solution to this problem is to require third party payers to share their proportionate burden of the cost of serving the medically indigent.

My proposal is limited to what I believe is the most critical source of deficit—unreimbursed ambulatory and emergency services. Under my bill, medicare and medicaid would be required to assume their share of “community service costs”—the costs to the hospitals of providing ambulatory services to those unable to pay. Maintenance of effort in financial support of eligible institutions by States and municipalities is required as a condition of assistance.

Both bills call for the establishment of a National Advisory Council on Hospital Financing and Stabilization and Reorganization composed of representatives of insurers, hospitals, consumers, labor, and experts on hospital organization and financing and health care delivery to develop regulations for the implementation of the proposed programs, to review applications for assistance, and to work with the Secretary in the development of a broad data base and long-term policy for the management of the hospital crisis addressed by these bills. It is hoped that the expertise of the Council will assure development and approval of high quality plans by the institutions in greatest need.

Finally, both bills require the Governor of the State in which the hospital is located to certify that the continued operation of the hospital is vital to the provision of essential health services to the community it serves.

Until now, we have lacked a comprehensive program to address these critical problems. Members of Congress whose constituents are affected by such crises have tried to be of assistance on a case-by-case basis by working within existing statutory guidelines or by acting as an advocate for special plans to address the gravest of the crises. But it is neither fiscally responsible nor acceptable health care policy to continue with case-by-case crisis management. The care of those persons who rely on hospitals for ambulatory health services is an enormous problem that must be addressed in a comprehensive fashion if these communities health needs are to be met.

In this time of severe economic restraints, whatever solutions we offer must be fiscally responsible. Major reforms in medicare and medicaid law would perhaps solve the crisis in the hospital sector; certainly enactment of a comprehensive national health plan—which I have long favored—would accomplish this goal. But these are not presently viable options due to current budgetary constraints. Consequently, I consider my bills which provide very targeted assistance to the most needy hospitals to be responsible alternatives.

I am pleased to announce that Chairman Rangel of the Ways and Means Committee will be introducing companion legislation shortly to address the needs of these institutions. I am optimistic that a solution can be found. Under any circumstances, I firmly believe it to be unconscionable to abandon those health facilities—and the people they serve—which bravely endeavor to shoulder the burden largely ignored by so many. For my own part, I pledge to do whatever possible to assure that institutions such as these can continue to fulfill their health—and social—responsibilities.

Senator JAVITS. In short, we face an imminent threat to our continued ability to provide medical services to medically indigent persons.

As we discovered with Brooklyn Jewish, and see continually as other hospitals all around the country reach out for assistance, the Federal Government currently lacks the statutory tools necessary to address the problems presented by these institutions and the communities they serve. New legislation is necessary to permit us to address comprehensively these problems in both the short and the long term.

In this time of severe economic constraints, whatever solutions we adopt must be fiscally responsible. Major reforms in Medicare and Medicaid would perhaps solve the crisis in the hospital sector; certainly enactment of a comprehensive national health plan—

which I have long favored—would accomplish this goal. But these are not immediately foreseeable options due to budgetary constraints and significant startup costs. Consequently, I have developed a legislative package which provides targeted assistance to the most needy communities. While not a replacement for national health insurance, I believe my bills are a responsible answer to the need to preserve vital components of our health care system pending the enactment of broader reforms.

My goal in introducing this legislative package has been to offer a comprehensive program that can serve as a basis for the dialogue and debate needed to develop concrete steps which address this matter as soon as possible. It is neither fiscally responsible nor acceptable health care policy to continue with case-by-case crisis management. The care of those persons who rely on hospitals for ambulatory health services is an enormous problem that must be addressed in a comprehensive fashion if the health needs of these communities are to be met. It is my hope that this hearing will mark the beginning of the development of an effective solution to this crisis in our health care system.

Today we will hear from witnesses representing a wide spectrum of interests and concerns related to this critical problem. I look forward to learning more about the impact of financially distressed hospitals on the individuals and communities they serve, and to receiving specific suggestions for improving the legislation. Furthermore, in developing this legislative package, I found that we lack important data necessary to make final determinations regarding the precise formulation of the legislative solution. I am hopeful that the testimony we receive today will constructively address these and other critical questions which are necessary to further action on the proposals.

Senator METZENBAUM. We are happy to have with us today Mr. Nathan Stark, Under Secretary of Health and Human Services.

I will ask, Mr. Stark, that your entire statement be entered in the record, and not read. It is rather lengthy. I would ask you to address yourself to some of the questions and concerns I have just raised vis-a-vis the program announced yesterday.

Senator Javits is expected to be with us, and when he arrives, if he has a statement he wishes to make, I will interrupt for the purpose of giving him an opportunity to do so. It is nice to have you with us.

STATEMENT OF HON. NATHAN STARK, UNDER SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY EARL COLLIER, JR., DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; DR. KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR HEALTH PLANNING AND EVALUATION; AND SUSANNE STOIBER, DEPUTY ASSISTANT SECRETARY FOR HEALTH

Mr. STARK. I appreciate the opportunity to be here today to discuss an issue of major concern to the administration, the members of this subcommittee and to me personally. I will be accompanied this morning by Earl Collier, Jr., Deputy Administrator of the Health Care Financing Administration; Dr. Karen Davis, Deputy

Assistant Secretary for Health Planning and Evaluation; and Susanne Stoiber, Deputy Assistant Secretary for Health.

I have a rather lengthy prepared statement this morning, Mr. Chairman. With the committee's indulgence, I will submit my full statement for the record, and read a brief summary instead.

Senator METZENBAUM. Excellent. The entire statement will be included in the record.

Mr. STARK. I applaud this committee's interest and initiative in this vitally important area. I have grappled with the problem of financially troubled hospitals for the past 10 years both inside and outside of Government.

Today, I would like to affirm this administration's commitment to providing access to care to our Nation's poor. We have dramatically expanded the funding of primary care programs such as the Community Health Centers and National Health Service Corps programs.

In just 2 years, the number of federally funded community health centers has increased from 432 to 872 (fiscal year 1980). The National Health Service Corps, a major source of primary medical care in underserved areas, more than doubled during the same period.

We have also proposed new programs which could go even further toward assuring access to care for the poor—programs such as NHP and CHAP—and we would strongly urge the members of this subcommittee to join with us in enacting these programs in this Congress.

In some cases, special assistance to certain financially troubled hospitals may also be necessary. However, it is also important to recognize that hospitals are community institutions and that primary responsibility for their viability must rest with States and localities.

Senator METZENBAUM. Let me interrupt. Where do the communities get the money? How do they do it?

Mr. STARK. They have a tax base, for one.

Senator METZENBAUM. How does a city like Cleveland or a city like New York, fighting to keep their heads above water find a tax base. In many cities across the country people have left the city and moved to suburbs. All that is left in inner city is the hospital, maybe some service industries, and the poor.

Now realistically speaking, can these cities do it?

Mr. STARK. Yes, I think they can do it realistically. There are several factors which contribute to the financial distress of these various public hospitals. But I think primarily the responsibility is theirs, and one way they have of trying to meet that responsibility is through their tax base.

One other way of meeting that responsibility is through the aggressive pursuit of third party reimbursement. Another might be a good hard look at why the hospitals are in such a desperate plight. I recognize one factor, one very important factor, that they are taking care of the majority of poor people who do not qualify or are not eligible under any of our rules.

This is one of the things which we hope to address through our demonstration projects, and particularly the demonstrations in New York City.

Senator METZENBAUM. Are you not concerned that while the demonstration programs are taking place, a number of inner city hospitals are going to be forced to close? As a matter of fact, a number of inner city hospitals, are very seriously considering leaving the inner city, and going to the suburbs in order to eliminate that responsibility. There is no question that Mt. Sinai in Cleveland, which is one of the biggest, has seriously considered leaving the inner city.

Isn't there some kind of Federal responsibility to prevent limited access to care? Actually, didn't your action yesterday somewhat contradict your statement that there is no Federal responsibility?

Mr. STARK. I am sorry, if I left that impression, Senator. I think there is very definitely a Federal responsibility. I think we have to establish the criteria by which we are going to meet that responsibility and not just throw dollars out into the field and hope that some hospital which considers itself financially distressed, for one reason or another—it may not even be a legitimate reason—picks those dollars up.

We want to spend our money in the most meaningful way and get the most for our dollars.

Senator METZENBAUM. All right.

Mr. STARK. Many of the problems faced by financially troubled hospitals relate not only to coverage issues but also to structural problems in the health care delivery system, poor management, and diminished support from State and local governments.

Therefore, we cannot assume that more Federal dollars alone are the answer. Nor is it necessarily appropriate for the Federal Government to assure that all hospitals in financial trouble are assisted. We should not simply provide long-term assistance to inefficient or unnecessary institutions.

In this summary of my prepared testimony, I would like to describe our best estimate of the magnitude of the problem and discuss some of the underlying reasons for financial distress; discuss the HHS strategy for addressing the problems of financially troubled hospitals; and discuss the legislation recently introduced by several members of this subcommittee.

In December 1979, Secretary Harris asked me to chair a Task Force to develop an appropriate HHS response to the problems faced by financially troubled hospitals.

One of the first and most important things we discovered is that determining the number and characteristics of financially distressed hospitals is difficult for a number of reasons:

First, there is no basic, objective definition of financial distress;

Second, there is a paucity of reliable information on an individual hospital basis that can be brought together nationally in a consistent and comparable manner;

Third, without detailed studies, it is difficult to attribute financial distress to a hospital's particular operating characteristics; and

Fourth, it is difficult to define deficits for public and nonprofit institutions which often receive large supplemental payments from local governments or philanthropic gifts.

Senator METZENBAUM. Did your task force come up with any targeting criteria that might be used in order to determine financial distress?

Mr. STARK. That is one of our biggest problems, Senator.

We are currently pursuing two sources of data, our medicare cost data and data from the American Hospital Association. The American Hospital Association has been most cooperative with us. We have some concerns, however, about the adequacy of the data.

The medicare data are adequate for medicare reimbursement purposes, but information on overall costs and revenue, which are not used for establishing our reimbursement formula are often not accurate, or at least we have no way of knowing their accuracy.

Senator METZENBAUM. Hasn't HHS been working for a period of about 5 years to develop a cost reporting system? What has happened to that?

Mr. STARK. Yes, sir; we have. We have put that out as an annual hospital report, and we expect this to give us some uniform information which would be comparable on a hospital-to-hospital basis.

We do not have that now. It is out, and will be in effect shortly. I am glad you asked the question, because it gives me a chance to plug something which I think will be very beneficial, not only to the hospitals in getting their costs together and on a more understandable basis, but it will also give us the kinds of information that we need in order to construct programs and to determine what financial need really is.

Senator METZENBAUM. When will you have that cost accounting procedure worked out?

Mr. STARK. It is worked out now. It has been sent to all of the hospitals.

Mr. COLLIER. Senator, that hospital report was issued as notice of proposed rulemaking, with a comment period that closed at the end of May. We have received a substantial amount of comment. It has been a matter of some controversy, as you know.

We are looking at these comments and hope to have our response to them and the proposed final hospital report regulation sometime this fall.

Senator METZENBAUM. Proceed, Mr. Stark.

Mr. STARK. As a result, we have very little hard information on the causes of financial distress. However, studies from individual States and of individual institutions indicate that hospitals in financial distress are generally faced with some combination of the following problems:

Significant amounts of uncollected revenues resulting from care provided to individuals with inadequate or no health insurance coverage;

Rapidly rising operating expenses due to inflation, the cost of new medical technologies, excess hospital beds, ineffective planning, and obsolete physical plants;

Stringent eligibility requirements, limited benefits and inadequate reimbursement rates under some State medicaid programs, as well as limits on direct State and local funding;

Bad management, manifested by poor accounting practices, inadequate collection efforts, unsophisticated purchasing practices, and inefficient staffing patterns; and

Physician shortages and no organized primary care systems, which result in individuals in medically underserved areas seeking

care in more expensive hospital outpatient department and emergency room settings.

HHS is taking an active leadership role in promoting a Federal/State/local strategy for addressing these problems, in order to maintain the viability of necessary hospitals and achieve critical system reform objectives. The HHS strategy is based on the following principles:

Federal assistance should concentrate on assuring access to care for our poorest citizens.

Given the current lack of knowledge of the nature and extent of the problem, aid should only be considered on a case-by-case basis.

Federal assistance should be directed toward achieving a smooth transition to NHP.

Given the current inefficiencies in the delivery of health care, system reforms, cost control efforts and management improvements should be an integral component of any proposal.

Major responsibility for supporting distressed hospitals rests with States and localities. Federal funds should not substitute for State and local funds; rather, State and local governments should assume their appropriate share of responsibility in providing assistance.

The Department must assure that efforts to eliminate or substantially reduce services do not have a disproportionately adverse impact on minorities.

Further information must be developed about the causes of financial distress.

Any Federal assistance should not become a long-term bailout with inefficient hospitals permanently dependent on Government aid.

On the basis of objective planning, access and system reform criteria developed pursuant to these principles, the types of hospitals most likely to be assisted under this strategy would be those:

Serving medically underserved populations as defined in section 330 of the PHS Act;

Providing services to a significant proportion of indigent individuals, especially minorities;

Located in areas where other providers are not available to serve indigent or uninsured patients;

Unable to remain open without Federal assistance and submitting a viable plan for self-sufficiency;

Certified as appropriate by State and local planning agencies; and

Willing to make management changes and any restructuring consistent with system reform objectives.

The basic features of the HHS approach are:

Establishing a coordinated HHS operating structure to assure consistency among HHS programs and to respond to requests for assistance. The Secretary has moved that operation into her office and has asked the Under Secretary to chair it.

Using existing and proposed medicare and medicaid demonstration and waiver authorities; and using certain existing PHS grant and loan programs.

Coordination of HHS programs to provide assistance to financially troubled hospitals is essential. Consequently, an HHS coordinat-

ing committee will be established to assure consistency among operating programs. The coordinating committee will:

Review all initial inquiries and requests for assistance from financially troubled hospitals on a case-by-case basis;

Provide advice to applicants seeking assistance about Department programs;

Channel requests for assistance, including requests for technical assistance, to the appropriate program;

Coordinate all requests for assistance involving HHS programs;

Report to the Secretary on the status of aid requests and Department actions undertaken; and

Make recommendations for future program changes.

We plan to use, as appropriate, existing and proposed HCFA demonstration and waiver authorities. These demonstrations will explore reimbursement for some currently unreimbursed closure and conversion costs, targeted expansions of medicaid eligibility, the role of public general hospitals as the primary care provider in inner cities, alternative delivery sites, and capitation reimbursement arrangements.

The administration will also use existing PHS authorizations and consider the most appropriate use of those programs in the fiscal year 1982 budget cycle to achieve the goals of providing comprehensive services to underserved populations; primarily in urban areas; and promoting system reforms by financing through capitation arrangements, and providing assistance to financially distressed hospitals.

I must emphasize that we believe current PHS authorizations give us an adequate statutory base for dealing with this problem.

As our knowledge base develops and the effectiveness of our existing programs in dealing with the problems of financially distressed hospitals is assessed, we will reevaluate the need for additional authorities.

I would like to close with some brief comments on the Financially Distressed Hospitals Assistance Act—S. 2840—and the Hospital Ambulatory Services Reimbursement Reform Act—S. 2841.

With respect to S. 2840, we believe that there are several problems: First, such a program would duplicate several existing programs and would require a new administrative structure.

Second, we believe the requirements for self-sufficiency over time are weak, as are the incentives for hospitals to improve their operations and financial management.

Third, we are concerned about the lack of requirements for substantial increases in State and local support, if necessary.

Fourth, the bill does not address inpatient deficits which are also a significant cause of financial distress in some hospitals.

Fifth, it is difficult to know if the criteria for financial distress are appropriate or can be easily administered.

Overall, we believe that given the authorities that already exist and the difficulties in both measuring financial distress and developing criteria, a new \$200 million grant program is premature at the present time.

Some of these same concerns apply to S. 2841. Requiring medicare and medicaid to pay a proportionate share of the costs of bad debts and charity care in certain financially distressed hospitals

was considered by us and has been frequently recommended by the hospital industry.

We have several concerns with this approach. First, for the reasons just stated, we believe that effective targeting criteria have not yet been developed. Without effective criteria, such payments in large numbers of hospitals could cost the Federal Government several hundred million dollars.

Second, this act has no requirement that the hospital must be determined to be necessary by the State and local health planning agencies.

Senator METZENBAUM. I would like to respond to the comment that Congress must address itself directly to national health coverage. I think it is fair to point out that many of us in Congress have been anxiously awaiting a cooperative effort on the part of the administration and have been totally disappointed that in a period of 3½ years such an effort has not been forthcoming, notwithstanding commitments made during the campaign period of 1976.

So when you say Congress ought to be doing it, Mr. Stark, I have to say the buck stops there, as I see it. I do want to hear Senator Javits' opening statement, and I have a number of questions for you. But I have one question in particular that I would like to ask you before I turn over to Senator Javits.

Your testimony suggests that HHS has the authority at present to provide at least partial relief to financially troubled hospitals. You cite section 328 of the Public Health Service Act, the primary care centers provision; section 1610, the life safety codes provision, and section 1641 through 1644, the closure and conversion provisions, as examples of your authority.

Frankly, Mr. Stark, how can you say that you are interested in helping these financially burdened hospitals when the administration's revised fiscal year 1981 budget request included only \$9.7 million for section 328, zero funds for section 1610, and zero funds for closure and conversion provision.

How do you reconcile yourself?

Mr. STARK. We are now entering a new round; I would hope we can be more persuasive as a department than we were last year, and that these hearings will aid us substantially in achieving our goals.

Senator METZENBAUM. Hope springs eternal, is that your point?

Mr. STARK. Not being a student of government, I am still eternally optimistic that you will act.

Senator METZENBAUM. We appreciate your optimism, but pragmatically speaking, it is very difficult for us to feel comfortable with your assurances as to what the administration is going to do under these various provisions, because you can't do very much in Government if you don't have the wherewithal to do it and, unfortunately, the administration budgetary allocations are almost totally insignificant for these programs.

Mr. STARK. Most everything that I have spoken about today is supportive of the national health plan, which is an administration proposal. And I think that would do more to assist us in helping not only those hospitals that we target as financially distressed, but all hospitals. In fact, forgetting about hospitals, our primary concern is whether we can help individuals. If a hospital has the

resource necessary to help an individual, we want to help that hospital. But there are many other facets of health care that can be accomplished if we work out a proper system on a national basis. Our national health plan and the CHAP proposal will certainly go a long way toward doing that.

Senator METZENBAUM. Senator Javits.

Senator JAVITS. Thank you, Mr. Chairman. I have a statement for the record which I request unanimous consent be included at the beginning of these proceedings after the chairman's statement.

Mr. Chairman, the witness and the department present an interesting dichotomy. On the one hand, I think Secretary Harris is a magnificent public servant, and an outstanding woman and is well motivated and wants very much to do whatever can be done to help.

On the other hand, the department sounds like the do-nothing idea is what commends itself to them, because we all know neither the national health plan nor CHAP is going anywhere for some time to come. How long? I don't know. I am very much devoted to both of them, as much as you or anybody else in the department.

So, I think, as Senator Metzenbaum does, that it is going to take something better than that.

What interests me, though, is the fact that you analyze these bills and point out the defects. I am not impressed that you have no authority or money, because authority and money is what these bills are all about.

That the Department claims it has necessary means impresses me even less. That is what I think you ought to study very carefully.

As recently as October 11, 1979, the Secretary, in respect to the very critical case in point, the Jewish Hospital and Medical Center of Brooklyn, said that she didn't have the authority, didn't have the legal means with which to help these hospitals.

Now you are trying to tell us that you have all the authority you need. This is one point which I strongly challenge you on, Mr. Stark. I don't think you have the authority that you need at all in order to do this job in the way in which it needs to be done.

As we see it, we are dealing, with about 20 million people who are medically indigent and located in areas such as New York where health professionals operate on the misconception that anyone worth his salt should practice on Fifth Avenue; they don't want to be in Harlem, Bedford-Stuyvesant, Brownsville or South Bronx where there is an acute shortage of facilities and the local hospitals are overwhelmed.

I notice also with grave interest that the Department has become extremely concerned about this situation at the 11th hour, and was able to announce yesterday not only the metropolitan bailouts but also a program designed to bail out the hospitals serving poor areas. Naturally, I am very much in favor of these proposals.

The thing that worries me, and I think should very seriously worry the Department, is that if you eliminate these facilities, they are not going to be recreated. Remember that many of these facilities are huge hospitals. Brooklyn Jewish, for example, has 400 beds and may have to be cut down, and so may these others. They are

very big facilities serving huge areas and they are absolutely critical.

I would strongly suggest a creative effort here. I would strongly suggest that the Department, myself and some of my colleagues on this committee who have joined in supporting the bills, should try to develop an immediate program to deal with the sickest situation.

I think it is very unfair to Secretary Harris that she has to make the selection. It is very tough, very tough; it is true that most of these sections to which you refer are mine.

I ought to know why I did it, why they lack financial resources that they need to have. I really believe that a package can be put together which will be a fair effort to carry us over this momentary hill we are on, so that the Secretary does not have to make these arbitrary selections like a prosecutor.

I know something about that business. It is a business that I was in. And at the same time, we must demonstrate that these programs can work and then we will progress into better ground and money and better ground and authority. Hopefully, over a period of time we will implement CHAP, national health program, et cetera, which will take up the slack.

But what is missing, I think, is any interim program at all. I do not agree with the Department. I hope the Department will review the bill, and that it has on the books what it needs. I believe also that my colleagues would agree to a practical plan, which is not an entitlement, and involves a good deal of self-help; that is why we brought in all providers; they have an interest.

I think we can work out an intelligent, prudent plan between the States and Federal Government which will accomplish these objectives. We have reached mutual agreements before and we will find modest resources.

I am not dreaming dreams, in order to implement this program; we may find that management and computers and paying bills on time and better bill collection techniques may prove to be as important as the money. We all understand that. For example, Senator Metzenbaum came up yesterday with a very gifted amendment on education. I couldn't go with him. It doesn't make it any less gifted. He used his head. That is what we are looking for.

Any comment you have, I would greatly appreciate it.

Mr. STARK. I want to assure you and the committee that our department will work together with you, your staff, in trying to accomplish what we feel is best for the needs of people.

Senator METZENBAUM. I would like to commend the Senator from New York for his suggestions, which are indicative of his experience around these halls. The Senator from New York has always been very practical and realistic in suggesting that we creatively try to develop some means to save these hospitals before they go under.

I know I speak for the chairman of the committee when I say that certainly we would be prepared to work with the administration, and with the Senator from New York, in attempting to put together a package that could move rapidly through the Congress, because, otherwise, I am afraid we are going to be bogged down and jockeying for positions for a number of months, which will certainly not help the situation.

Senator JAVITS. Mr. Chairman, I understand that there will be a vote in another committee of which I am a member, in about 5 minutes, if I could ask a couple of questions and yield to you.

First tell me about authority. Isn't it a fact that it would be desirable to codify the authority of the Department, to provide assistance in Public Health doctors, and clinical aspects of hospitals and experimental program, etc.?

Wouldn't you say it would be wiser to try to codify your authority in this field?

Mr. STARK. Well, I thought we had adequate authority to do just that.

Senator JAVITS. Only recently the question of authority was very seriously challenged. For example, the only reason that we pulled out the Brooklyn Jewish crises is that we had a very limited program for a demonstration project. That is hardly the basis for a program.

Mr. STARK. I understand. You are thinking of authority that would permit this to operate an ongoing program.

Senator JAVITS. That is right. To give you the necessary authority so you don't have to strain and reach for something that was never meant to apply.

Mr. STARK. I don't know. I think, sir, that would really put the Federal Government in the hospital business. If we are just talking about the private voluntary hospitals that are assisting in Bedford-Stuyvesant for example, the purpose is to put them on their feet and make sure they can become financially viable institutions and can support themselves.

Senator JAVITS. Putting the Government in the hospital business is your word, not mine. That is exactly what I mean when I say codify the authority.

The real problem is, as we have seen demonstrated in New York, concerns undocumented aliens? The United States is responsible for phasing them out. But if you are there, you are not going to expose them on a rock. That is our problem. That does have a United States aspect to it.

Mr. STARK. I am not sure, but the increased waiver and demonstration authorities the Department is seeking may be of assistance. Such an expansion of authority will allow the Department to experiment with waiver of additional provisions under medicare which currently restrict us from many of the things we would like to do. Additional full Federal funding of some section 1115 projects will also help. Alternative means for financing care provided to undocumented aliens could be one part of these expanded demonstrations.

There are no long-term care benefits, however, under this authority.

Senator JAVITS. Of course you have to have the Senate as well as the House. We will study that particular measure, and see what we can get out of it.

For the moment, before yielding to Senator Metzenbaum, I would like you to propose to the Department the idea of a tripartite effort in meetings to construct a bill which will be adequate for present purposes, and also will give us some basis for what might be

necessary in the future. For a year or two, however, it seems to me these hospitals will be forced to close.

There are no existing alternatives at the present, and it will be miserable if closure is compelled that way.

I agree with you regarding the involvement of regional hospital organizations, as an element in the final decision with respect to what is worth saving, and what isn't. I don't assume everything is worth saving any more than you do.

I could give you cross-examination that might or might not show your vulnerability, but I don't think it would advance the cause for the people who need this help.

I would like to make that suggestion to you, and I hope the Secretary will embrace it—rather than torture you with cross-examination. May I yield to you, Mr. Chairman?

Senator METZENBAUM. Thank you very much. I have already indicated to you that I subscribe to Senator Javits' approach. I think time is very much of the essence and would hope that we would hear from you, Mr. Stark, or the Secretary in the immediate future as to your inclination and disposition along this line.

One significant contributor to inflation in the health field is the support of unnecessary hospital beds. The administration has stated there are 130,000 unnecessary hospital beds that cost \$4 billion a year to maintain. Alfred Kahn just released a White House press release that attempted to deal with this problem.

The administration is proposing a massive reduction to Federal support to local planning agencies. Wouldn't this mean that decisions about location of hospital beds will be made by, Washington bureaucrats, possibly with little or no local input? If you eliminate the planning process, isn't that possibly penny wise and pound foolish?

Mr. STARK. You are striking a note very dear to my heart, Senator. I believe very firmly in the planning process. I think they should be strengthened in every way possible.

I think the problem facing the Administration was selecting our priorities among a great number of programs.

This year the health planning program, the HSA's felt the impact of this. There are other good programs that had to take very substantial cuts.

What I said to the National Planning Association and all of the local health systems agencies is that we have got to be creative, we have to find other means of support. There are other means of support.

I have been involved in the planning effort since 1960, and Government didn't come into health planning until very, very late. Business and industry, foundations and local governments and State governments have traditionally supported planning efforts. As Federal dollars came more and more to the fore, they withdrew more and more of their support.

Now is the time to try to reactivate these traditional sources of support to supplement what the Federal Government is able to do. I don't think they are going to renege on their responsibilities.

I think the HSA's are going to do everything possible in reducing the number of beds, in doing a good job of planning, despite budget cutbacks.

Senator METZENBAUM. I am told there is a study indicating that for every dollar spent in planning process, we are saving \$8. I think it comes back to my original comment that it is false economy.

Mr. STARK. I agree with you on the need and the outcome of what good planning can be, but I think stringent budget limitations and not any perception of program failure are more responsible for budget allocations.

Senator METZENBAUM. The what?

Mr. STARK. I say the stringency of our present budget, the attempt to balance it as best we can, and the problem of knocking out good programs or portions of good programs became a necessary part of that exercise.

Senator METZENBAUM. I would like you to point out to the budget drafters of the administration that if they used just the funds they are now providing for tobacco price supports, that a loan would be enough to take care of the \$200 million of the Javits bill, plus all the costs of the planning program, and I think you would be serving the Nation's best interest, and maybe have less people in the hospital as a consequence too.

Mr. STARK. I am not going to defend the position, but I might add of all the departments in Government, the Department of Health and Human Services took the least cuts of any Department, so at least there was a really strong desire to protect probably the most vulnerable of our citizens by keeping these programs well intact.

Senator METZENBAUM. Unfortunately, some of those costs were targeted down to zero, and that is a rather serious cut, particularly if you are interested in those programs.

Let me ask you one last question. Part of the reason that public hospitals are facing such difficult financial times is a result of "dumping" practices. Sending chronically ill and medically indigent to public institutions. Congress attempted to rectify their situation by passing free care provision of the Hill-Burton Act. What is your enforcement record on this provision, and what are you doing in the Department at the present time with this authority?

Mr. STARK. We have not had that authority for very long; I think our regulations on that went out less than a year ago in 1979.

Senator METZENBAUM. Haven't you had it in since 1948?

Mr. STARK. Well, we have not had strong regulations until 1979. The Hill-Burton Act has been on the books, I suppose, with the legal constraints—you are speaking of free care now—with legal implications that you must have a certain amount of free care and community service, but as far as I know the regulations coming out of HHS or HEW as it was called then, came out just last year.

Senator METZENBAUM. It is not a new concept for the Department?

Mr. STARK. No, but I think the monitoring of the hospitals is a new concept for the Department. I think we expect, as a matter of fact, to see approximately well over \$300 million in free care this year.

You can be sure we will be monitoring it, and I think the dumping syndrome has been very true in the past, but I think hospitals have in recent years taken on much more responsibility for caring for the poor and underserved.

Senator METZENBAUM. Thank you very much, Mr. Stark. I understand you are going to be leaving?

Mr. STARK. Yes, I am going to be leaving, but we are going to have a couple of our people stay on throughout the session, Dr. George Schieber and James Friedman will remain throughout.

Senator METZENBAUM. I think it is important that they hear some of the other witnesses, so they may bring their comments to your attention.

Thank you very much. We look forward in attempting to work out something with you.

Mr. STARK. Thank you.

[The prepared statement of Mr. Stark follows:]

FOR RELEASE ONLY ON DELIVERY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

BY

NATHAN STARK

UNDER SECRETARY OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

WEDNESDAY, JUNE 25, 1980

I appreciate the opportunity to be here today to discuss an issue of major concern to the Administration, the Members of this Committee and to me personally. I applaud this Committee's interest and initiative in this vitally important area. I have grappled with the problem of financially troubled hospitals for the past 10 years both inside and outside of government. I believe that all affected parties - the individuals and communities served, the hospitals themselves, the medical community and government at all levels - are committed to assuring the provision of necessary health care services. We recognize that this may entail maintaining the financial viability of certain vital institutions which serve many of the poorest individuals in this country.

Today, I would like to affirm this Administration's commitment to providing access to care to our nation's poor. We have dramatically expanded the funding of primary care programs such as the Community Health Centers and National Health Service Corps programs. In just two years, the number of Federally funded community health centers has increased from 432 to 903. The National Health Service Corps, a major source of primary medical care in underserved areas, has more than doubled during the same period. These programs are bringing needed primary care services to many poor Americans and in some areas are helping to alleviate the burden now borne by the outpatient departments and emergency rooms of financially troubled hospitals. We expect to be able to do more along these lines in the years just ahead.

We can also assure access to care through proposed new programs like NHP and CHAP and through system reform activities. In some cases, special assistance to certain financially troubled hospitals may also be necessary. However, it is also important to recognize that hospitals are community institutions and that primary responsibility for their viability must rest with States and localities.

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Nevertheless, I believe it is critical to point out at the outset that we are not addressing one isolated aspect of the health care delivery system - financially troubled hospitals. Rather, we are really discussing the full spectrum of basic health care issues: coverage, financing, reimbursement, planning, supply, and the delivery of health care services.

Some of this Administration's proposed health legislation will help financially troubled hospitals. Expansions of coverage under NHP and CHAP will provide new revenues to all hospitals, but especially those that serve large proportions of the poor. CHAP will extend Medicaid coverage to an additional 2 million poor children and 100,000 pregnant women. NHP will provide comprehensive coverage initially to an additional 10 million low income individuals by eliminating the current Medicaid categorical restrictions and establishing a minimum income level below which all persons will be covered. NHP will also assure more equitable ambulatory care reimbursement rates. While this assistance cannot be targeted to specific hospitals, expanded coverage and increased reimbursements will provide significant added revenues to those financially troubled hospitals treating large numbers of the poor.

As I will discuss in detail shortly, many of the problems faced by financially troubled hospitals relate not only to coverage issues but also to structural problems in the health care delivery system, poor management, and diminished support from State and local governments. Therefore, we cannot assume that more Federal dollars alone are the answer. During today's hearing, I would like to first discuss Federal responsibilities and activities relating to financially

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troubled hospitals. Second, I will describe our best estimate of the magnitude of the problem and discuss some of the underlying reasons for financial distress. Third, I will discuss the HHS strategy for addressing the problems of financially troubled hospitals. Fourth, I would like to discuss the legislation recently introduced by several Members of this Committee.

HHS Concerns and Programs

The Federal government, as the single largest purchaser of health care, has a major responsibility for promoting access to care and assuring an efficient and effective health care delivery system. Federal expenditures account for nearly 30 percent of total health spending. HHS's health financing programs, Medicare and Medicaid, are spending over \$50 billion to provide coverage for almost 50 million of our nation's most vulnerable citizens -- the elderly, the disabled and the poor. Our Public Health Service programs spend \$2.5 billion for health services research, delivery system reform, and to promote access for certain groups of underserved individuals. Our Office for Civil Rights is actively enforcing the civil rights laws that prohibit discrimination against any individual on the basis of race, color, national origin, age, or handicap by any health care provider receiving Federal funds.

The Department is concerned about maintaining access to care for individuals in communities threatened by closure of essential hospital services. Some of these endangered institutions may serve as the principal source of primary

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health care services in low income areas, and they are also major employers in their communities. Closure of these hospitals could threaten community residents' access to care. The Federal government has an obligation to assure that no minority group bears a discriminatory burden from a reduction in access to health services.

I must point out, however, that it is not appropriate for the Federal government to assure that all hospitals in financial trouble are assisted. We should not simply provide long-term assistance to inefficient or unnecessary institutions. Closure and conversion of excess hospital capacity is a fundamental component of the Administration's strategy for containing rising hospital costs. This country currently has an average of 4.5 beds per thousand population, although the National Health Planning Guidelines recommend less than 4 beds per thousand. This results in a national surplus of 130,000 hospital beds.

While there are no existing HHS programs designed exclusively to provide general assistance for financially troubled hospitals, we believe, at the present time, that our current and proposed legislative authority is adequate, if properly coordinated with State and local efforts, to address the problems faced by financially troubled hospitals. Various PHS programs provide aid to institutions to promote restructuring of the health care delivery system. Our hospital affiliated primary care centers authority (section 328 of the PHS Act) provides funding for restructured, hospital-based, primary care centers. Life safety code grants (section 1610(a)) and outpatient facility grants (section 1610(b))

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provide funds to hospitals for necessary construction and modernization. The PHS closure and conversion program (sections 1641-1644) could be used to promote the closure of unnecessary facilities and/or the conversion of such facilities to more appropriate uses.

Also, various PHS programs have the capacity to diagnose financial distress and its underlying causes in financially troubled hospitals, and we can provide case-by-case financial and management assistance for hospitals near or in default on title VI or XVI loans or loan guarantees. Such assistance may include the deferral of payments, loan renegotiations, the expenditure of funds for technical and consultative assistance and for temporary payment of interest and principal.

Furthermore, HCFA demonstration and waiver authorities can, in a limited number of cases, explore innovative reimbursement arrangements, make payments for currently unreimbursed closure and conversion costs, and expand Medicaid coverage to indigent individuals in the catchment areas surrounding financially troubled hospitals. For example, yesterday the Department of HHS and the city and State of New York agreed to conduct a health care delivery demonstration project in Harlem. Among the concepts tested will be the use of an inner-city public hospital to provide a complete case management system to ensure that medical needs of community residents are met in the most effective and efficient manner. Such projects can provide us with the basic information and experience needed for dealing not only with the multiplicity of problems faced by financially troubled hospitals, but also with possible Medicaid eligibility expansions, and with implementation of the low income component of NHP. These authorities are currently limited by statute, but the Administration has requested expansion of these authorities.

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In December 1979, Secretary Harris asked me to chair a Task Force to develop an appropriate HHS response to the problems faced by financially troubled hospitals. The Task Force completed its work last month. In the course of the investigation we:

- o looked into the magnitude of the problem;
- o examined the causes of financial distress; and
- o developed options and recommendations for a proposed Department strategy.

I would like to discuss the Task Force's estimate of the number of hospitals in financial distress, its analysis of the underlying causes of financial distress, and the Administration's strategy for dealing with financially distressed hospitals. I will then discuss the legislation introduced by Members of this Committee and relate it to the Task Force's work and the proposed Department strategy.

Magnitude of the Problem and Causes of Financial Distress

Determining the number and characteristics of financially distressed hospitals is difficult for a number of reasons:

- o First, there is no basic, objective definition of financial distress;

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- o Second, there is a paucity of reliable information on an individual hospital basis that can be brought together nationally in a consistent and comparable manner;
- o Third, without detailed studies, it is difficult to attribute financial distress to a hospital's particular operating characteristics; and
- o Fourth, it is difficult to define deficits for public and non-profit institutions which often receive large supplemental payments from local governments or philanthropic gifts.

Despite these problems, some information can be obtained on hospitals' financial status from a sample of Medicare cost reports and data from the American Hospital Association (AHA). According to data from the AHA, the hospital industry, as a whole, is generating a surplus. In 1978 total revenues to community hospitals were \$59.8 billion and total expenses were \$58.2 billion, resulting in a \$1.6 billion margin of "profit". While the industry as a whole is financially sound, data from both the AHA and the Medicare cost reports show that not all community hospitals are able to generate enough revenues to cover their expenses.

Data from both the AHA Annual Hospital Survey and financial statements submitted with Medicare cost reports indicate that about one quarter of all community hospitals, about 1400 institutions, ran a deficit (i.e., total expenses exceeded total revenue) in 1977 or 1978. Furthermore, 4-5 percent of these hospitals, about 300 institutions, had total revenues which were less than 90 percent of total expenses. The hospitals which operated at a deficit tended to be small,

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publicly owned, and located in rural (non-SMSA) areas. Although the problem appears to be more severe in rural areas based on numbers of hospitals running deficits, in terms of numbers of beds and magnitude of deficit, the bigger problems would appear to be in urban areas.

While these figures do indicate that a large number of hospitals are running deficits, it is important to understand both the reliability and meaning of these numbers, as well as their limitations for determining financial distress. First, it should be noted that the revenue and expense data extracted from financial statements submitted with the Medicare cost reports are not used for reimbursement purposes, and, therefore, their reliability is untested. The revenue and expense data from the AHA are based on information voluntarily reported in an annual survey of the nation's community hospitals. Second, deficits are quite common in this largely non-profit industry where hospital deficits attract philanthropic and State and local support, and where hospitals often unnecessarily purchase costly new medical technologies. Third, an operating deficit in one year says very little about an institution's overall net worth or its financial stability over a multi-year period. Fourth, deficits in certain instances may be an indication of the need to close all or part of an institution or convert the facility to other uses. Fifth, since these data include depreciation as an expense, they do not provide a valid picture of the cash flow and thus probably overstate, to an unknown extent, any actual cash deficits. In summary, these data are not terribly useful in revealing the number of hospitals in financial distress. Moreover, they provide little insight into the causes of financial distress.

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While we have very little hard information on the causes of financial distress nationally, studies from individual States and of individual institutions indicate that hospitals in financial distress are generally faced with some combination of the following problems:

- o significant amounts of uncollected revenues resulting from care provided to individuals with inadequate or no health insurance coverage;
- o rapidly rising operating expenses due to inflation, the cost of new medical technologies, excess hospital beds, ineffective planning, and obsolete physical plants;
- o stringent eligibility requirements, limited benefits and inadequate reimbursement rates under some State Medicaid programs, as well as limits on direct State and local funding;
- o bad management, manifested by poor accounting practices, inadequate collection efforts, unsophisticated purchasing practices, and inefficient staffing patterns; and
- o physician shortages and no organized primary care systems, which result in individuals in medically underserved areas seeking care in more expensive hospital outpatient department and emergency room settings.

I would like to elaborate briefly on these problems. Perhaps the most serious problem some hospitals face is uncollected revenues due to inadequate health insurance protection for many of the patients they serve. It is currently estimated that 22 million people, most of whom are poor or near poor, have no health

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insurance at all. Another 20 million individuals have inadequate coverage. Compounding this problem is the growing and uncertain number of undocumented aliens, perhaps about five million. Most are indigent, have no health insurance, and in emergencies seek care from local community hospitals. Furthermore, much health insurance provides poor coverage for ambulatory services. Such coverage deficiencies reduce incentives for physicians to treat patients in their offices, thereby shifting the burden of care for such uninsured individuals to hospital outpatient departments.

Hospital operating costs are also increasing at high rates due to inflation, rapidly advancing medical technologies, excess hospital beds, and ineffectual planning. Many urban inner-city hospitals are burdened by aging or obsolete physical plants which are costly to operate. Rural hospitals frequently have low occupancy rates and excess capacity because they serve sparse populations and are often too isolated to regionalize or share services.

Many State Medicaid programs have imposed stringent eligibility requirements, have limited benefits, and severely limited reimbursements for physician and outpatient hospital services. For example, 26 States have income eligibility standards of less than 55 percent of the Federal poverty level, and 17 States have physician reimbursement rates less than 80 percent of recognized market rates. These State-imposed limitations on eligibility prevent hospitals from receiving

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Medicaid reimbursement for care provided to many of the poor. Low Medicaid physician reimbursement rates discourage physicians from treating Medicaid patients who then seek care in more expensive hospital outpatient department and emergency room settings. In addition, some State Medicaid programs severely limit reimbursements for hospital outpatient services, thereby further exacerbating the financial pressures on certain hospitals.

In a similar vein, many State and local governments have reduced direct support for public hospitals. In some instances, local tax allocations have been capped, and elsewhere, operating budgets have been directly limited. This has resulted in further financial problems for some hospitals.

Bad management also contributes substantially to the financial distress of certain hospitals. In particular cases, hospitals have been extremely negligent in pursuing reimbursements from third party payors. In some public hospitals, the institution's income is independent of bill collections. Moreover, these collections are sometimes made by a wholly separate unit of local government. Accounting systems in some hospitals are so bad that receivables can only be tabulated on a cash basis.

Shortages of office-based physicians and lack of organized primary care systems in many inner city and rural areas further exacerbate the problems of financially troubled hospitals. Many hospitals must also function as the community physician.

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This is both costly and leads to inappropriate utilization of existing hospital facilities as well as the hospitalization of individuals because of the lack of primary care services to diagnose and treat certain conditions in their early stages.

HHS Strategy for Assisting Financially Troubled Hospitals

HHS is taking an active leadership role in promoting a Federal-State-local strategy for maintaining the viability of necessary hospitals and achieving critical system reform objectives. The HHS strategy is based on Department access and system reform objectives, current budgetary priorities, a shared Federal-State-local responsibility, and our current knowledge of the underlying causes of financial distress. The following principles were used in developing the HHS strategy:

- o Federal assistance should concentrate on assuring access to care for our poorest citizens.
- o Given the current lack of knowledge of the nature and extent of the problem, aid should only be considered on a case-by-case basis.
- o Federal assistance should be directed toward achieving a smooth transition to NHP.
- o Given the current inefficiencies in the delivery of health care, system reforms, cost control efforts and management improvements should be an integral component of any proposal.

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- o Given current budget restrictions, proposals to finance an aid program should concentrate on reprogramming savings from system reforms and management improvements.
- o Major responsibility for supporting distressed hospitals rests with States and localities. Federal funds should not substitute for State and local funds; rather State and local governments should assume their appropriate share of responsibility in providing assistance.
- o The Department must assure that efforts to eliminate or substantially reduce services do not have a disproportionately adverse impact on minorities.
- o Further information must be developed about the causes of financial distress.
- o Any Federal assistance should not become a long-term "bailout" with inefficient hospitals permanently dependent on government aid.

Furthermore, since a large number of hospitals are likely to consider themselves financially distressed, any available funds must be targeted to hospitals selected on the basis of objective planning, access and system reform criteria.

The types of hospitals that might be helped would be those:

- o serving medically underserved populations (as defined in section 330 of the PHS Act);

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- o providing services to a significant proportion of indigent individuals, especially minorities;
- o located in areas where other providers are not available to serve indigent or uninsured patients;
- o unable to remain open without Federal assistance and submitting a viable plan for self-sufficiency;
- o certified as appropriate by State and local planning agencies; and
- o willing to make management changes and any restructuring consistent with system reform objectives.

The basic features of the HHS approach are:

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

Coordination of HHS programs to provide assistance to financially troubled hospitals is essential. Consequently, an HHS coordinating committee will be established to assure consistency among operating programs.

The coordinating committee will:

- o review all initial inquiries and requests for assistance from financially troubled hospitals on a case-by-case basis;

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- o provide advice to applicants seeking assistance about Department programs;
- o channel requests for assistance, including requests for technical assistance, to the appropriate program;
- o coordinate all requests for assistance involving HHS programs;
- o report to the Secretary on the status of aid requests and Department actions undertaken; and
- o make recommendations for future program changes.

We plan to use, as appropriate, existing and proposed HCFA demonstration and waiver authorities. These demonstrations will explore reimbursement for some currently unreimbursed closure and conversion costs, targeted expansions of Medicaid eligibility, the role of public general hospitals as the primary care provider in inner cities, alternative delivery configurations, such as clinic networks and single service delivery sites, and capitation reimbursement arrangements.

The Administration will also use existing PHS programs and consider the most appropriate future use of those programs in the FY 1982 budget cycle to achieve the goals of:

- o providing comprehensive services to underserved populations, primarily in urban areas;
- o promoting system reforms by:
 - financing through capitation arrangements, and
 - coordinating Federal, State and local efforts; and
- o providing assistance to financially distressed hospitals.

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Furthermore, technical assistance to diagnose financial distress and its underlying causes and case-by-case management assistance for hospitals near or in default on certain Federal loans can be provided by the PHS. As our knowledge base develops and the effectiveness of our existing programs in dealing with the problems of financially distressed hospitals is assessed, we will re-evaluate the need for additional authorities.

We believe that this strategy will assure access for the poorest individuals, maintain the viability of selected hospitals most needing aid, develop a knowledge base for future programs, achieve system reform objectives, achieve management improvements, and create an effective partnership with State and local governments. It is also consistent with current budgetary priorities and implementation of the President's NHP.

Many alternative options were considered by the Department but not recommended. We do not support new legislation to require Medicare and Medicaid to pay a proportionate share of total bad debts (i.e., Medicare now pays for bad debts incurred by hospitals in providing covered services to its beneficiaries) or legislation for a new unrestricted PHS grant program. We rejected seeking legislation requiring Medicare and Medicaid to pay a proportionate share of total bad debts because such a proposal would be difficult to target, could cost in excess of \$500 million, and could establish a de facto medical assistance program controlled by the individual hospital administrator not the government. We felt that a new PHS grant program was unnecessary at the present time since many of the necessary system reforms and access enhancements can be accomplished under existing programs, and because a new program might become a permanent bailout for certain inefficient institutions.

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Comments on S. 2840 and S. 2841

I would like to make some brief comments on the "Financially Distressed Hospitals Assistance Act" (S. 2840) and the "Hospital Ambulatory Services Reimbursement Reform Act" (S. 2841). As I previously stated, the Department seriously considered the approaches embodied in these acts as viable options for addressing the problems of financially troubled hospitals.

With respect to the "Financially Distressed Hospitals Assistance Act", we believe that there are several problems with the proposed approach. First, such a program would duplicate several existing programs and would require a new administrative structure. Second, we believe the requirements for self-sufficiency over time are weak, as are the incentives for hospitals to improve their operations and financial management. Third, we are concerned about the lack of requirements for substantial increases in State and local support, if necessary. Fourth, the bill does not address inpatient deficits which are also a significant cause of financial distress in some hospitals. Fifth, it is difficult to know if the criteria for financial distress are appropriate or can be easily administered. For example, there are no data to indicate how many institutions in medically underserved areas have at least 60 percent of the charges incurred by Medicaid and uncovered patients. Overall, we believe that given the authorities that already exist and the difficulties in both measuring financial distress and developing criteria, a new \$200 million grant program is premature at the present time.

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Some of these same concerns apply to the "Hospital Ambulatory Services Reimbursement Reform Act". Requiring Medicare and Medicaid to pay a proportionate share of the costs of care of uninsured indigent individuals in certain financially distressed hospitals was considered by us and has been frequently recommended by the hospital industry as a solution to the problems of financially troubled hospitals.

We have several concerns with the approach espoused in S. 2841. First, for the reasons just stated, we believe that effective targeting criteria have not yet been developed. Without effective criteria, payment of a proportionate share of indigent care in large numbers of hospitals could cost the Federal government several hundred million dollars. Second, this Act has no requirement that the hospital must be determined to be necessary by the State and local health planning agencies. Third, as I stated previously, while this proposal focuses only on outpatient services, there is evidence that inpatient deficits are also critical factors in causing financial distress in some hospitals.

Fourth, we believe it is inappropriate for the Medicare share of indigent outpatient care to be based on Medicare's share of both inpatient and outpatient services. On average, Medicare accounts for about 30 percent of all inpatient but only 15 percent of outpatient reimbursements. The formula proposed in this bill is specifically designed to have the Medicare program (i.e., the Federal Government) pay a disproportionately large share of the payments for outpatient services. We do not feel it is appropriate to use the Medicare Trust Funds, which are financed on the basis of premiums and payroll taxes, to finance care for uncovered individuals. Similarly, it is inappropriate for Federal funds to simply pick up revenue shortfalls caused by State and local cutbacks in Medicaid or direct funding of hospitals.

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Fifth, we also believe there would be substantial difficulties in administering this provision. In particular, there would be many problems performing the 125 percent of poverty income test and defining deficits without a standardized cost reporting system and accounting rules.

In conclusion, I feel it is imperative to reiterate that Secretary Harris and I fully share your concerns about the financial viability of those institutions serving our poor. We feel that the proposed Department approach, given our current knowledge, current budgetary priorities, inadequate State and local support, and the clear need for management improvements and system reforms, is the appropriate approach.

We would be happy to work with Members of this Committee in this vitally important area. Thank you for this opportunity to present our views. My colleagues and I would be happy to answer any questions you may have.

Senator METZENBAUM. Our next group of witnesses is a panel, Allen Manzano, senior vice president and director, Washington Office, American Hospital Association; Donald M. Cook, executive director, Children's Hospital of Los Angeles; Robert Sweeney, commissioner, Cuyahoga County, and Robert E. Johnson, executive director, D.C. General Hospital.

I don't see Mr. Sweeney here.

Mr. Manzano, I would be happy to hear from you first. I will ask each of the witnesses to limit their comments to 8 minutes. We will include your entire statement in the record.

STATEMENTS OF ALLEN MANZANO, SENIOR VICE PRESIDENT AND DIRECTOR, WASHINGTON OFFICE, AMERICAN HOSPITAL ASSOCIATION; DONALD M. COOK, EXECUTIVE DIRECTOR, CHILDREN'S HOSPITAL OF LOS ANGELES, CALIF.; HENRY E. MANNING, PRESIDENT, CUYAHOGA COUNTY HOSPITALS, CLEVELAND, OHIO; AND ROBERT E. JOHNSON, EXECUTIVE DIRECTOR, D.C. GENERAL HOSPITAL, WASHINGTON, D.C., A PANEL

Mr. MANZANO. I would like to begin by expressing the deep appreciation of the American Hospital Association and its members and our gratitude to the committee and sponsors of the bill for their very timely and very sensitive response to the issue before us.

I would like to particularly acknowledge the leadership of Senator Javits in introducing legislation on financially distressed hospital assistance and hospital ambulatory services reimbursement reform, particularly at this time of troublesome economic considerations.

I am going to limit my statement, Senator, as you requested. I do have a brief oral statement I would like to make.

I think that the first thing to say is that the problem is not fundamentally a hospital crisis. It really is a community crisis. Hospitals exist simply because they serve communities. To the extent they are unable to serve those communities, the communities are in danger. The hospitals we are talking about are critical to the well-being of the communities.

They provide vital community services, and they are performed by a vital community work force. I think the root problem is exactly what you have stated. It is the inadequacy of funding for the care of the poor.

As you have also pointed out, hospitals have been asked to serve as a vehicle for funding of the care for people who are not covered by existing insurance mechanisms. This is often an unacknowledged role.

What hospitals do in effect is ask payors to pay for those who cannot pay for themselves.

Traditionally the hospital has been willing to perform this role, but as a particular institution's charge paying group begins to shrink, then the hospital finds it impossible to perform this transfer, and the services, quality and medical currency of the institution begin to deteriorate. This is like a treadmill which compounds the problem over time. The scale of the problem is very significant.

As you pointed out, there are large numbers of institutions affected all over the country. Our own indications from a survey we have conducted show that in some 200 institutions in urban centers there is an average deficit of about \$1 million a year incurred precisely because they are serving these kind of communities.

The public hospital problem is particularly grievous, although we do not have the data that supports this, primarily because, as you point out, there is a tax appropriation system which often blurs the nature of their deficits.

The public hospital, I think, has been a traditional vehicle for the community to express its concerns for the poor. But lately a deteriorating tax base and an increasing number of dependent people to be cared for have made it very difficult for hospitals to continue adequate performance of this role.

The legislation to assist financially distressed hospitals is a welcome concept. It addresses precisely the nature of their distress. The grants, we recognize as a stopgap measure, and they are stopgap until such time as we are able to develop some longer term, more fundamental reforms for reimbursement and payment systems that support the care of the poor.

We have some suggested changes to make, Senator, which will strengthen the bill and make it more effective in doing what the committee wants to see accomplished. I think the key to effective application of the limited resources that will be available under S. 2840 is really flexibility. We should be cautious that we not institute formalistic measures in legislation which might exclude hospitals that you would want to assist.

We need to be flexible, and we want to make sure that we don't exclude institutions which have significant roles to play in the care of people who otherwise would be without assistance.

There is a particular section of the bill which I think needs to be commended and that is that section which calls attention to the

problem of labor in the maintenance of institutions and in protecting them from some of the actions which may be necessary in order to continue vital services to the community.

This appropriate recognition also acknowledges the role of the labor force in the local economy, and acknowledges the need to protect the well-being of the individuals affected.

We do have some concerns that the requirement for certification by the Department of Labor may not demonstrate a great deal of sensitivity to the actual nature of the hospital work force, and thus may induce costs which will in effect not permit the funds to be used in the most effective way to continue the operation of the institution, which, after all, is what we are seeking.

The second bill, the Hospital Ambulatory Services Reimbursement Reform Act, is much more fundamental in terms of attacking some of the root causes. It is particularly creative in how it handles this, because it recognizes a significant part of the problem, and that is the inability of titles 18 and 19 to share in the cost of uncollectibles for people not eligible for those programs.

If we can find a way to have all payers share in the support of the nonpayers, obviously that would minimize payment shortfalls.

This is a particularly sensitive issue because of the fact that these problems are critical and most acute to the ambulatory care section of the hospital.

There are other issues which we have to address over the longer term. Congress will need to study the possibility of reasonable cost reimbursement for medicaid outpatient care, the extension of medicaid eligibility to cover all the poor and near poor, the scope of benefits the poor should have, and what standards should apply.

Thank you.

[The prepared statement of Mr. Manzano follows:]



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WASHINGTON OFFICE

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC AFFAIRS
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
ON FINANCIALLY DISTRESSED HOSPITALS

June 25, 1980

Mr. Chairman, I am Allen Manzano, Senior Vice President of the American Hospital Association. With me are Donald Cook, Executive Director of Children's Hospital of Los Angeles, and Henry Manning, President of Cuyahoga County Hospitals in Cleveland. On behalf of the AHA, representing over 6,100 hospitals and health care institutions, as well as more than 30,000 personal members, we would like to thank the subcommittee for scheduling these hearings and for recognizing the urgency of the problems facing financially distressed hospitals that provide a disproportionate amount of care to patients who cannot afford to pay. In addition, we would like to commend Senator Javits for his leadership in developing a legislative solution to these problems.

We are pleased to have this opportunity to present our views on S.2840, the Financially Distressed Hospitals Assistance Act, and on S.2841, the Hospital Ambulatory Services Reimbursement Reform Act, introduced by Senator Javits and several other members of the committee. Both bills address serious problems confronting the health care delivery system in providing needed care to medically indigent individuals residing in urban and rural areas across the country.

In order to assure these individuals quality medical services, the public and private hospitals committed to this objective must remain viable. We must find new ways to finance health care for those who lack adequate insurance coverage and the personal resources to meet the costs of necessary services.

BACKGROUND ON THE ISSUES

In discussions with individual hospital administrators, metropolitan and state hospital associations, and representatives from other national organizations, the AHA has determined that this problem is national in scope. It touches medically indigent individuals--the poor, the near-poor, the unemployed, migrant workers, undocumented aliens, and refugees in urban and rural areas who seek primary and emergency health care. Wherever there are large numbers of medically indigent populations, there is likely to be a hospital in financial trouble. In such communities, public and private hospitals are often the major providers of primary care and the only sources of emergency and trauma services.

In the course of a nationwide survey conducted by the AHA, data were collected to describe the financial conditions of some of these institutions and the kinds of patients they serve. For the purpose of the survey, "deficit" was defined as the excess of total expenses over total revenues. It is important to note, however, that financially distressed hospitals are not solely those that operate at a deficit for a long period of time. In fact, hospitals that merely break even may not be financially sound because of the lack of a sufficient operating margin which would prevent them from maintaining needed service capacity. For example, a hospital that does not generate any surplus during a long period of high inflation simply will not be able to maintain and operate the facility. If year after year a hospital lacks the resources to reinvest in maintaining the upkeep of the physical plant and in adopting advancements in medical care delivery, the facility will soon deteriorate to the extent that the accessibility and quality of care needed by its patients will be directly affected.

Our initial survey focused on urban communities and showed that more than 200 hospitals in these localities had deficits ranging from 1 to 40 percent of revenues in 1978. Our calculations place the total deficit among responding hospitals well in excess of \$200 million. Unfortunately, these deficit figures severely understate the condition of many public general hospitals in which deficits are partially offset by supplementary allocations of tax revenues by local units of government. As we will note later in our statement, however, the availability of these tax revenues is declining and, in view of the worsening

economic conditions in many of the communities served by public hospitals, it is reasonable to assume further deterioration of their financial condition. In a closer evaluation of the data, a study was conducted of hospitals with annual deficits averaging \$100,000 or more annually and with correspondingly large bad debts and charity care burdens. The study showed that 12 hospitals in 5 states had deficits ranging from 20 to 35 percent; 71 hospitals in 15 states had deficits between 10 and 20 percent; and 192 hospitals in 32 states had deficits ranging from 5 to 10 percent.

A focused review of the data for Los Angeles, Philadelphia, and New York provides even more dramatic evidence of the magnitude of this crisis. In Los Angeles, eight private hospitals had operating deficits ranging from \$40,000 to \$1.4 million, with the total for all eight institutions well in excess of \$4 million. In Philadelphia, 16 private, nonprofit hospitals operated with deficits, and 12 of these had a total deficit of \$12.4 million. Thirty-two private hospitals in New York City showed losses ranging from \$11,000 to \$13.9 million, with a total deficit of nearly \$57 million. Moreover, these figures drastically understate the crisis in New York, since data for the public institutions that comprise the Health and Hospitals Corporation of that city are not included.

In addition to providing essential medical services, urban hospitals also contribute to the financial well-being and stability of their communities as major employers and purchasers of goods and services. The institutions reporting deficits employ more than 230,000 people, with annual payrolls totaling \$2.6 billion. Closure of these facilities could have a significant impact on local economies. For example, the Los Angeles hospital we surveyed employed 7,400 people, with a total annual payroll of \$102 million. In Philadelphia, the total annual payroll is \$90 million for the salaries and wages of more than 11,000 employees. The 32 New York City hospitals in our survey employ some 60,000 people, with a total payroll well in excess of \$830 million.

Medically indigent patients often rely on the urban hospital for a host of related services such as alcohol and drug abuse treatment programs, mental health care, and family counseling services. In addition, some of these institutions provide consumer education programs and manpower training. These hospitals often direct patients to legal aid and social services programs, if during the course

of treatment it is determined that additional services may be necessary to ensure the well being of patients. The patients often are lacking in health prevention services or education and they suffer the consequences of inadequate diets and unavailable prenatal care. Often this means that the medically indigent patient may need more extensive and costlier treatment.

Some of the problems identified above also impact significantly upon rural hospitals, which are generally smaller than most urban hospitals. The financial plight of some of these hospitals is serious. Regulations, wide fluctuations in patient census, and problems of availability of health personnel have a great impact on such facilities. Also, because of their isolation, these hospitals are sole community providers and must make available many costly services which cannot be shared with other facilities, as is possible in urban areas, and which are not utilized with sufficient frequency to generate revenues to cover expenses. Obstetrical care in isolated settings, for example, can be quite costly. Often these services, although sorely needed, are more costly per unit of service as an institution seeks to recover its standby costs.

It often can be more expensive to provide health care in rural areas because of lack of economies of scale, as well as higher supply charges, even in facilities participating in group purchasing. Many rural hospitals must pay higher salaries to attract needed personnel. In addition, due to a smaller volume of patient care, rural hospitals often contract for certain services such as physical therapy, inhalation therapy, pharmacy, and professional physician services for pathology and radiology. Again, such contract services are generally more expensive per unit of service. Likewise, small hospitals often lack the expertise and personnel necessary to cope effectively with various regulations and therefore must hire additional personnel to deal with requirements imposed by licensing agencies, accrediting bodies and third-party payers.

The costs of providing needed care in many rural hospitals, combined with the often serious problem of bad debts arising from the care of medically needy patients, results in financial distress similar to that experienced by many urban institutions. Rural communities are often areas with low per capita income levels and, accordingly, they have high Medicaid and medically indigent patient populations. Significantly, the percentage of individuals without any health

insurance coverage is larger than that for the population as a whole. These gaps in health insurance coverage contribute substantially to the level of uncompensated care in such institutions. Moreover, in many western states, the tax base for many local governments is sharply limited, placing severe constraints on their contributions to the deficits of the public institutions in isolated areas.

Thus, it is important to recognize that financial distress in hospitals is not an exclusively urban problem. It occurs wherever there are institutions caring for large numbers of patients who lack health insurance or the personal resources to pay for the costs of necessary hospital services.

We would now like to identify in greater detail the various factors that have caused the problem of financial distress in many hospitals.

NATURE OF THE PROBLEM

In our country today, an estimated 23 million people have no health insurance coverage whatever, and another 20 million have coverage that is inadequate. Many of the working poor have incomes that exceed state Medicaid eligibility levels but are insufficient to finance adequate private health insurance coverage or to pay directly for necessary medical expenses. Contributing to this problem is the growing number of undocumented aliens in the United States who are without insurance coverage and Medicaid eligibility. These people frequently are unable to pay, in whole or in part, for health care.

Many of the poor and working poor would be eligible for coverage were it not for state-to-state variations in the Medicaid program. The limitations on eligibility, as well as variations in the scope of benefits, contribute significantly to the gaps in coverage that exist among the medically indigent. These gaps are becoming wider as some states fail to adjust their income-related eligibility levels to take into account the impact of inflation on the working poor.

In the past, it has been possible for voluntary hospitals to recoup a portion of their losses on services to patients without insurance coverage by passing this

cost on to private-pay patients. This approach becomes less workable, whenever there is a steady decline in the number of patients who pay the full cost of their care. Increasingly, the charge-pay patient is being replaced by persons covered by Medicare, Medicaid, or other less-than-cost payers.

A similar problem exists for public hospitals. In the past, their deficits were usually made up by appropriated funds from local governments. Now, however, the availability of tax revenues and, in some cases shrinking tax bases, have sharply curtailed such payments and placed more and more of these institutions in financial jeopardy.

A review of one public hospital in distress can help give us a better understanding of the severity of the problem. Grady Memorial Hospital in Atlanta is a 1,046-bed teaching hospital. The hospital is operated under a contract with Fulton and DeKalb Counties, whereby the two counties finance the operating deficit of the hospital based on the ratio of eligible patient days of use by patients of the two counties. The counties are contractually bound to pay operating deficits to the extent that they do not exceed 5 mills of tax on the property of the counties.

In recent years, the 5 mills tax limit has not been sufficient in Fulton County to cover its portion of the operational deficit of the hospital. This condition has become acute, and for several years it has been necessary to delay badly needed salary increases for employees. The funding crisis continues in 1980 and at present, prospects for granting salary increases to employees are not bright. In fact, funding of current operating expenses at present levels appears doubtful.

The primary burden on the local governments that support Grady is the cost of indigent care. It has been estimated that approximately 25 percent of the medically indigent in Georgia reside in the metropolitan Atlanta area. Thus, it becomes the responsibility of Grady to provide a vast majority of the health care needs of these indigents. Grady continues to operate at an annual deficit of about \$1.3 million, and cutbacks in services and staff are anticipated if the institution is to remain open.

These trends at Grady and other hospitals are the beginning of a downward financial spiral. As the net financial status of these hospitals deteriorates, the institutions are forced to reduce their scope of services and their staffs, making it more difficult, in turn, to retain medical staffs, other health professionals, and to attract a sufficient proportion of charge-pay patients who can share the costs of uncompensated care.

In many areas, a substantial portion of operating deficits result from services provided in ambulatory settings. Outpatient departments and emergency rooms of public and private hospitals are the major points of entry into the health care system for medically indigent persons. In New York City, for example, a total of 10 million hospital-based ambulatory visits in 1978 represented between one-fourth and one-third of all physician contacts in the city, and probably 90 percent of such contacts were made by patients who were poor or near-poor. Unreimbursed ambulatory care in all New York City hospitals that year totaled \$253 million. For the voluntary hospitals in this group, ambulatory care services accounted for three-quarters of their total deficits. The New York rate-setting program has been so restrictive in the past few years that it is no longer possible for hospitals to offset their deficits with revenues from inpatient services.

In developing approaches to alleviate the financial crises facing these hospitals, we must address two overriding concerns. First, over the short-term, these institutions must be able to fulfill their commitments to provide health services to community residents, especially the medically indigent. We are pleased, therefore, that S.2840 would authorize a program of short-term financial distress grants, although we do not believe that such a program alone could resolve this complex problem. A hospital that is in financial distress will experience the same distress after the rescue period unless it reduces the amount of care provided to these individuals or finds new and continuing financing sources.

Second, we must address the underlying causes of financial distress. In our view, the existing system of health care financing, because of inequities in reimbursement for inpatient and outpatient care and gaps in insurance coverage has contributed substantially to the crisis now being faced by many hospitals.

We are pleased, therefore, that S.2840 and S.2841, taken together, recognize both of these concerns, and we would like now to comment specifically on each of these proposals.

The Financially Distressed Hospitals Assistance Act, S.2840

S.2840 would authorize the Secretary of HHS to make grants to financially distressed hospitals in order to maintain the essential health services provided by such hospitals. To be eligible for these grants, hospitals would have to meet a specified set of criteria and submit recommendations for appropriate improvements in their managerial practices. In addition, prospective grantees would be required to provide certain assurances related to financial performance and the maintenance of support from state and local governments. Grant monies could be applied to existing debt and the expenses necessary to initiate the recommended changes in institutional management. Certain provisions are made for the protection of employees who might be adversely affected by changes in hospital management practices. A National Council on Hospital Financing Stabilization and Reorganization would be established to advise the Secretary and to make recommendations respecting grant applications. For Fiscal Year 1981, the bill would authorize \$200 million for the program.

A program of distress grants could only be of temporary help. As we have noted, long-term solutions to the problems of financially distressed hospitals must focus on the deficiencies in the existing system of health care financing that prevent these hospitals from recovering their full costs of operation. Nonetheless, we are in agreement that there is an urgent need for assistance to certain hospitals now bearing the consequences of existing financial policies. Hospitals in imminent danger of closure are providing important health services to the poor and near-poor in their communities, and these services must remain available.

AHA therefore supports the intent of S.2840 to provide immediate financial assistance to these hospitals. We believe that this assistance must be enacted in conjunction with S.2841, which contains a broader plan for health financing reform. We would like, at this time, to suggest some changes in S.2840 which, we believe, would increase the fairness of the program, clarify potential ambiguities, and improve the program's ability to achieve its stated purpose.

Eligibility criteria proposed for section 1626(a)(1)(C) of the Public Health Service Act would require prospective grantees to primarily serve a medically underserved population as defined under Section 330 of the Act. We believe the use of the word "primarily" in this section would unintentionally exclude many hospitals that are intended beneficiaries of this program. The bill appropriately recognizes, through other criteria, that the major portion of the financial shortfall experienced by distressed hospitals arises from services provided in outpatient departments and emergency rooms to persons in low income groups. Many large-volume urban hospitals in such situations nonetheless have significant numbers of inpatients with private insurance coverage. This inpatient volume is necessary both to retain and support an adequate medical staff, including specialists, and to subsidize, in part, substantial outpatient deficits.

The word "primarily," however, implies that a majority of the hospital's total patient population must come from medically underserved areas--a condition that may not be met by some hospitals in need of assistance. We recommend that this criterion be deleted in light of the subsequent criterion in paragraph (E) defining the required characteristics of a prospective grantee's outpatient department and emergency room patient load. At a minimum, the criterion in paragraph (C) should be limited to the population served in the outpatient department and emergency room.

Prospective grantees also must demonstrate, in accordance with paragraph (E), that a minimum of 60 percent of their total charges for outpatient department and emergency room services are incurred by persons either eligible for Medicaid (or other state and local medical assistance programs), or lacking any form of insurance coverage for such services and are otherwise unable to pay. We believe that this is an unnecessarily arbitrary criterion and one which could preclude assistance to many urban hospitals in financial jeopardy. Many of the hospital representatives with whom we have discussed this proposal have expressed the opinion that the threshold established by this section would be so high that it could become, in effect, a sole criterion for assistance. Unfortunately, it cannot, of itself, provide a useful measurement of the relative need of a given provider or a specific community for financial relief.

Information compiled from Philadelphia hospitals supports this contention. Specifically, without regard to whether the requirements for a net patient care deficit in outpatient and emergency services, severe cash flow impediment, or lack of credit could be met, only five of the 12 hospitals reporting an overall operation deficit could today meet the 60 percent limitation. The remaining seven of these hospitals would be excluded from consideration regardless of the severity of their financial conditions.

We recognize that not all financially distressed hospitals can be assisted from limited federal resources and that some criteria must exist by which to establish priorities for such support. We further recognize the desire to limit this support to institutions in which financial problems are due to a greater than average commitment to the provision of health services to the poor and near-poor. Our main objection, however, is the use of a strict formula approach to assessing this factor. It cannot be said that 60 percent is a more appropriate number than 59 or 50 percent. Arbitrary percentages such as these are a shorthand method for evaluating what is, in reality, a complex combination of factors. Such numbers cannot provide a true comparative measure across communities for which demographic and health systems characteristics vary widely.

The AHA recommends that the requirement of a numerical minimum be replaced with one of demonstrating qualitatively the importance of the institution to the provision of outpatient and emergency services to the specified patient groups and that a significant portion of outpatient and emergency room charges result from this commitment. This approach would allow more appropriate consideration of the actual experience of program applicants and would permit the Secretary and the Advisory Council flexibility to make maximum use of available grant resources.

Another concern with the interpretation of the criteria arises in paragraph (F)(1), which requires the applicant to demonstrate financial distress through liquidation and utilization of any and all financial resources at the disposal of the hospital. We believe the intent of this requirement is to ensure that hospitals seeking financial assistance demonstrate their commitment to continued

operation through the use of all monies that appropriately could be used for patient care. We do not believe, however, as the term "liquidation" might imply, that the intent is to require prospective grantees to apply all financial resources to operating deficits in order to demonstrate financial distress. Such a requirement would, of course, be counterproductive to the goals of maintaining high quality patient care and could result in further erosion of the financial viability of an institution. We recommend that this provision be amended to require demonstrated utilization of financial resources which are consistent with prudent management practices. We believe that this modification of the liquidation of assets criterion would ensure that essential hospital services would continue and that only the most severely distressed hospitals would be assisted under the grant program.

Finally, a concern arising from the eligibility criteria is that public general hospitals and hospitals owned or operated by public benefit corporations would be exempted from the requirements pertaining to the demonstration of a net patient care deficit, and from all other criteria defining financial distress. It is our understanding that the sponsors of this legislation intend that grant funds be awarded on an equitable basis, without regard to type of hospital ownership. At the same time, we recognize that the exemption for public hospitals would be based on the fact that such hospitals would not be eligible to apply grant funds as payment for existing receivables and the administrative difficulty inherent in determining the amount of an operating deficit for institutions that receive appropriations from their sponsoring authorities. Senator Javits' staff has indicated to us a willingness to develop appropriate criteria for public hospital applicants that would be applied fairly and could result in identification of institutions with the greatest needs. We are anxious to provide assistance in the development of such criteria.

The administrative difficulties of documenting financial distress in public hospitals can be overcome. To be sure, it is difficult to determine the existence and magnitude of deficits and financial distress merely by examining routine financial statements. We suggest that alternative approaches to this issue may include (a) amending the definition of "revenues" in subsection (1) to specifically exclude appropriations received from a local unit of government or

other sponsoring authority, or (b) using the resources of the Advisory Council and prospective applicants to develop equivalent measures and evidence of financial distress. Such equivalent measures might, for example, include trend data on appropriations, adjusted for changes in services and inflation, and the necessity, if any, for supplemental appropriations to meet operating expenses.

With regard to the proposed limitation on the use of grant funds awarded to public hospitals, it is our belief that this limitation would be too restrictive. This provision appears to be predicated on a perception that the financial obligations of these hospitals will be covered adequately by appropriations in the future, and that modification or restructuring of public hospital services or other management reforms should be the priority.

Such a rationale obscures the fact that the principal cause of financial distress for these hospitals is a commitment to the provision of services to persons who are unable to pay. The efficacy of managerial practices is at best a secondary reason and should not be the principal purpose for such grants to public hospitals. Further, local units of government are facing shrinking tax bases and declining tax revenues, and their ability and inclination to provide increasing appropriations is diminishing. Therefore, the AHA recommends that grants to public or private hospitals be available for the same purposes.

Labor protection agreements, as described in Section (e)(1)(C) of the bill, would provide that no application shall be approved unless the Secretary of Labor certifies that fair and equitable arrangements have been made to protect the interest of employees affected by changes in management and services resulting from this grant program. This labor protection provision is, in our opinion, unnecessary in view of other provisions of the bill requiring that (1) arrangements be made by the hospital for the protection of interests of employees affected by the discontinuation of hospital services (section (b)(5)(C)), (2) retraining costs are an allowable use of grant monies (section (d)(1)(D)), and (3) a representative from organized labor shall be appointed to the Advisory Council (section (f)(2)(D)).

The AHA has two fundamental objections to the inclusion of Section (e)(1)(C) in the bill. First, it would substantially change the focus of the grant program

from one of assuring the continuation of essential health services for persons who are unable to pay for them to one of assuring that the financial crisis in hospitals does not adversely impact the local labor market. Resolution of pressing issues in the delivery of health services should not be complicated by attempted intervention in the labor market's short-run allocation of resources. Such labor protection provisions are not appropriate in every instance in which government assistance may result in changes in the allocation of resources in a limited segment of the economy, but only when government action results in a fundamental change in employment relationships. For example, a similar provision was contained in the Urban Mass Transit Act (49 U.S.C.A. 1609(c)). That Act authorized federal support for the takeover of private transit companies by local units of government. It represented a fundamental change in the employment situation of transit workers, one in which the widespread frustration of collective bargaining rights could be anticipated. However, it is in significant contrast with the original goal of S.2840 which is the continuation of necessary health services in an area.

The second objection is related to our experience with the implementation by the Department of Labor (DoL) of similar provisions in other statutes. Specifically, DoL has proposed regulations that would supercede existing collective bargaining agreements, as well as state and local laws regulating labor activities, particularly with respect to the imposition of arbitration requirements on employers. Affected industries have not been able to obtain judicial review of such decisions by the Secretary of Labor because the statutes have been determined to make the Secretary's discretion absolute.

We believe also that the requirements that potentially would be imposed by DoL would not be sensitive to the already precarious financial position of the applicants under this program, nor to the peculiar characteristics of the hospital labor market. We base this conclusion on our experience with DoL in reviewing draft regulations to implement the labor protection provisions of the hospital closure and conversion assistance program established by Public Law 96-79. Our review of the draft regulations led to the conclusion that the cost of the labor protection arrangements that would be required would, in most cases, exceed the assistance received under the program, especially in view of the program's limited authorization (\$10,000,000). Our representatives were told

directly by the Department that this potential frustration of the closure and conversion program was not their concern. Their approach appears to be that labor protection arrangements must be the same in all cases, regardless of the industry involved. We have no reason to believe that this inflexible stance would be changed in behalf of the program proposed by S.2840.

The AHA recognizes, nonetheless, that hospitals should provide assistance to affected employees consistent with their resources. We believe that other provisions in the bill, cited above, addressing labor concerns are adequate to address this obligation and that existing collective bargaining agreements would be undisturbed by the awarding of these grants. We also believe that the Secretary of HHS, in periodically reviewing the performance of grantees, could ensure that they fulfill the assurances they would provide in their applications. For these and all of the foregoing reasons, we strongly recommend deletion of Section (e)(1)(C) from the bill.

Recognition of Uncollectible Bills-S.2841, The Hospital Ambulatory Services Reimbursement Reform Act

It is the position of the AHA that all payers, including government, should assist hospitals in the financing of care for the medically indigent by paying a proportionate share of the uncollectible bills of these institutions. We are pleased that in S.2841 Senator Javits has also recognized this financing policy. In our opinion, the payment practices of Medicare and Medicaid have contributed to the current crisis by not recognizing hospital uncollectible bills as costs of doing business. In Chicago, for example, if all third-party payers recognized their proportionate share of uncollectible bills, the Medicare-Medicaid share would have been an estimated \$22 million in 1977. We believe that such costs are a legitimate part of operational expenses. They result largely because hospitals continue to fulfill their commitments to provide a full range of health care services to the poor and near-poor, regardless of their ability to pay.

Equitable apportionment of the costs of uncompensated care has special merit for the following reasons: (1) it realistically recognizes that many uninsured persons who are at the core of this problem, such as undocumented aliens, cannot effectively be reached in the short run by public assistance programs; and (2) it

is capable of providing relief to financially distressed institutions immediately upon implementation.

There are precedents for this type of program. For example, under a law enacted in 1974 in New York State, the inpatient payment rates for Blue Cross and certain other payers include a share of the ambulatory service loss in private hospitals. Unfortunately, Medicare and Medicaid have not agreed to participate in this program. Medicare and Medicaid are, however, paying for collection losses in both inpatient and outpatient care in Maryland under a special waiver from the Department of Health and Human Services. It also is worth noting that recognition of collection loss already is a part of many Blue Cross contracts in other areas of the nation.

We believe the time has come to eliminate federal statutory constraints that have barred the Medicare and Medicaid programs from participation in the financing of uncompensated care. S.2841 would accomplish this objective, at least in part by including community service costs incurred in a hospital outpatient department and emergency room as part of the "reasonable cost" determination for Medicare and Medicaid reimbursement. The proposed formula would allocate these costs on the basis of the percentage of all hospital patients that are beneficiaries of each program. The AHA believes that, if enacted, S.2841 would substantially improve the financial state of many distressed hospitals. We wish, however, to call to your attention some constructive improvements to the bill that we believe should be favorably considered.

The new Section 1882(a)(1) identifies those persons whose outpatient care would be considered a component of a hospital's community service costs. These include individuals who have family incomes not in excess of 125 percent of the poverty level; are not covered under a state medical assistance plan; and are not covered by insurance and are unable to pay for services. Hospitals may incur some administrative difficulties related to the determination of individual need or the existence of other insurance or resources. In addition, a literal reading of this criterion would exclude persons who have any form of medical insurance, regardless of the adequacy of coverage provided. Many of the persons seen in hospital outpatient departments and emergency rooms have rudimentary inpatient coverage and have no, or very limited, outpatient coverage. We recommend that

Section 1882(a)(1)(C) be amended to read "who are not adequately covered by insurance...." This change would remove the possibility of excluding a significant portion of the patient load from the hospital's community service costs and better express what we believe to be the intent of the bill.

Section 1882(b)(1) specifies criteria that must be met by hospitals wishing to participate in the reimbursement reform program. We wish to call to the Subcommittee's attention the change we recommended in our comments on S.2840, relating to the use of the word "primarily" in criterion (C). We also would again note that we do not believe it is necessary to exempt public hospitals from meeting criterion (D)(ii), which would require an institution to demonstrate a net operating deficit. And, finally, we do not believe that the quantitative requirement that at least 60 percent of the charges for outpatient services be attributable to Medicaid-eligible or uninsured individuals is an appropriate method for determining eligibility for the reimbursement reform program.

In Section 1882(c)(2), which lists the elements that must be included in a hospital's application for participation in the reimbursement reform program, subsection (c) would require the hospital and the state "to provide any additional information or reports which the Secretary may require." In order to avoid potentially burdensome requests for unnecessary and inappropriate data, we would suggest that the word "relevant" be substituted for "additional" in this criterion. Further, we recommend that the period of approval for participation in the reimbursement reform program be extended to two years.

OTHER ALTERNATIVES

Enactment of the distress grant and reimbursement reform programs proposed in S.2840 and S.2841 could provide substantial assistance to financially distressed hospitals, and we are pleased that the Subcommittee has chosen to address this complex issue. Other more comprehensive mechanisms also could provide long-term solutions to the problems faced by distressed hospitals that provide large amounts of uncompensated care to the poor and near-poor. We appreciate that such solutions may incur financial obligations which may not be feasible in light of the pressures to balance the federal budget.

Reasonable Costs for Outpatient Services Under Medicaid

Recognition of "reasonable costs" in Medicaid outpatient payments would work a substantial improvement in the financial condition of many hospitals. Presently, Medicaid does not require payment for outpatient services on a reasonable cost basis, and many states impose arbitrary payment limitations. For example, in Pennsylvania, payment on behalf of Medicaid recipients for outpatient visits is limited to a fixed dollar amount which is insufficient to meet the costs of such services. The result is an inequitable payment system that does not recognize the legitimate costs of doing business as a hospital, creating a serious obstacle to fulfillment of community health care obligations.

Recognition of reasonable costs also would have added benefits by shifting the incentives for, and the focus of, health care provided to Medicaid beneficiaries from the inpatient setting to the less costly outpatient setting. Moreover, this approach would provide immediate, as well as long-term, relief to financially distressed hospitals.

Standardization of Minimum Medicaid Benefits

Finally, we would note that standardization of minimum benefits in the Medicaid program would close many of the existing gaps in coverage for the medically needy, thereby reducing the burden of uncollected debts in hospitals over the long run. These gaps have created barriers in access to health care and, as a result, have placed significant financial burdens on hospitals that must cover the cost of care provided to those who cannot afford to pay. As an initial step, we would suggest that eligibility criteria be standardized and minimum benefits improved. We would further propose that total reliance on the categorical approach to eligibility determination be discontinued in favor of an income-level determination which recognize regional cost-of-living variances.

CONCLUSION

Mr. Chairman, we thank you for the opportunity to present our views and recommendations on S.2840 and S.2841. We would be pleased to respond to any questions that you or members of the Subcommittee might have, or to provide further assistance to you or your staffs.

Senator METZENBAUM. I think I will hear from all witnesses first, and then Senator Javits and I will ask our questions.

Our next witness is Donald M. Cook, executive director, Children's Hospital, Los Angeles, Calif.

Mr. COOK. I am Donald Cook, chief executive officer of Children's Hospital in Los Angeles, and I would like to summarize my prepared statement in the next 4 or 5 minutes.

A word about Children's Hospital, to understand our situation, we are a tertiary level children's medical center. We are the most prominent children's hospital in the Western United States, because of the number and range of high quality specialty diagnostic and treatment programs

The hospital was founded at the turn of the century. We are a nonprofit voluntary hospital of 331 beds. We are a major teaching institution, with full institutional affiliation with the school of medicine at the University of Southern California. We serve California, Western United States, and we draw patients worldwide for certain of our specialized programs.

Children's Hospital today dramatically represents what happens to a nontax supported institution, when its proportion of patients covered by Government cost reimbursement programs becomes too high.

Our institution today is in very serious financial trouble, as a result of inadequate reimbursement by MediCal which is our own special breed of medicaid.

At present the hospital has an operating debt of about \$15 million. How did we get there?

During the midseventies, patient mix on the basis of pay classification in our institution took a dramatic swing away from the private insured self-pay patient to MediCal patient.

During a several year period, private patient days decreased from 47,000 to 29,000 out of a total of about 80,000. This means that our private pay patient increased from about 16 to 33 percent, and that is where it is today.

Conversely, our MediCal population went from about a third to over 60 percent of our inpatient side and during this same period between 50 and 55 percent on the outpatient side.

As a result of this, the hospital began to incur severe operating deficits over the past 2 years.

Over the past 2 years we have lost \$4½ million each year in operation after adding in nonpatient revenues—totalling about \$4½ million in each of those 2 years.

Looking specifically at our ambulatory care programs, because here the problem is greater, as a tertiary care teaching hospital, we operate a wide range of clinics, and a large emergency department.

Our outpatient visits run around 155,000 a year, emergency visits an additional 70,000 a year. MediCal reimbursement for outpatient services runs less than 50 percent of our cost.

Over half of our patients in outpatient clinics are on MediCal and about 55 percent of the patients in—

Senator METZENBAUM. How do you keep your doors open with that kind of deficit?

Mr. COOK. We are not sure we will keep our doors open much longer. Our operating losses in 1978-79 in the outpatient area were

\$2.3 million, and in 1979-80 were \$2.9 million. Many of the patients who use our outpatient clinics and emergency room have no alternative for care, either because of economic constraints or because of medical necessity.

However, we can no longer provide the same volume of outpatient services to these patients. We are scaling down our outpatient programs in order to survive. This is creating hardship for many of the families who must seek other sources of care.

I can tell you that since April of this year the repercussions of the cutbacks in our institution have reached all the way to the Governor's office in Sacramento. Since April of this year we have laid off almost 400 of our staff, out of 2,100.

The cuts have taken place in every activity in the hospital, including faculty and residency programs. We are in the midst of grievance procedures now for the faculty who were terminated from USC, who have tenure or a position of security at Children's.

Our only alternative to survive is to reduce operating costs, to eliminate those programs which are most heavily dependent on MediCal funding, because these are without exception deficit programs because of totally inadequate and unrealistic levels of reimbursement.

It is important to note that we have raised our rates to the point that we are probably the highest priced hospital in the State. This is directly attributable again to inadequate reimbursement by MediCal.

Senator METZENBAUM. What is your room rate?

Mr. COOK. About \$250 a day.

Senator METZENBAUM. That is for single or double?

Mr. COOK. Double. The base rate in our intensive care units is \$750 a day.

And about 50 percent of our beds are intensive care beds.

Senator METZENBAUM. When Mr. Stark was testifying, he very strongly felt that much of the responsibility belonged to State and local governments, and there are very few States in the country that have the image of the wealth of California. What about California being able to help you?

We provided some special exemptions in windfall profits tax bill to make it possible for California to pick up some fantastically large amounts of dollars, vis-a-vis oil revenues.

What about availability of State funds, and is it a State responsibility?

Mr. COOK. I think it is a governmental responsibility. I would say that the question of whether or not it is a State responsibility, we have had a tremendous influx in California in recent years of immigrants and refugees, most recently the continuing influx of the boat people.

Pressure from Government is there on our institution to care for these people, and we are told they all have MediCal cards.

The interesting thing is we get reimbursed about 80 percent for those patients on inpatient basis, and less than 50 percent for outpatient care. And there has been no flow of Federal funds to subsidize MediCal for care of these immigrant and refugee populations.

The taxpayers in California are being unduly burdened with this additional problem.

With all of the attendant publicity that has occurred in the local media in the Los Angeles area in the last couple of months, the public in California is becoming aware of two very important economic facts in the health care industry.

One, inadequate reimbursement by MediCal, and second, the shifting of these uncovered costs to private and privately insured patients.

We are now getting comments from families who say they will no longer use Children's when they realize they must subsidize the cost for caring for MediCal patients.

Patients are price shopping in our area of California at the present time. In summary, unless Government moves to provide more adequate reimbursement for outpatient care, we will be forced to cut back these services in our hospital to that which is needed to support our education program. This is going to create hardship on those patients who depend on our institution for their total care.

Children's is not atypical of the situation in other inner city hospitals in our country today. For us it has now become a question of ultimate survival. I would also be happy to answer any questions.

[The prepared statement of Mr. Cook follows:]

PREPARED STATEMENT OF DONALD M. COOK

I AM DONALD M. COOK, CHIEF EXECUTIVE OFFICER AND EXECUTIVE DIRECTOR, CHILDRENS HOSPITAL OF LOS ANGELES.

I AM PLEASED TO HAVE THIS OPPORTUNITY TO PRESENT CERTAIN RELEVANT INFORMATION ABOUT OUR HOSPITAL TO THIS COMMITTEE.

CHILDRENS HOSPITAL OF LOS ANGELES WAS FOUNDED IN 1901. TODAY THE HOSPITAL IS A 331 BED TERTIARY CHILDREN'S MEDICAL CENTER. THE HOSPITAL IS A MAJOR TEACHING HOSPITAL WITH INSTITUTIONAL AFFILIATION WITH THE SCHOOL OF MEDICINE OF THE UNIVERSITY OF SOUTHERN CALIFORNIA. MAJOR TREATMENT PROGRAMS CONDUCTED BY THE HOSPITAL INCLUDE THE LARGEST PEDIATRIC DIALYSIS AND TRANSPLANT PROGRAM IN THE WORLD, THE LARGEST HEMATOLOGY-ONCOLOGY PROGRAM ON THE WEST COAST, THE LARGEST CYSTIC FIBROSIS PROGRAM IN THE WESTERN UNITED STATES, CARDIOLOGY AND CARDIOVASCULAR SURGERY, NEONATAL INTENSIVE CARE, NEUROLOGY, OPHTHALMOLOGY, OTOLARYNGOLOGY. IN ADDITION TO THE BROAD RANGE OF TERTIARY LEVEL DIAGNOSTIC AND TREATMENT PROGRAMS AND SERVICES, CHILDRENS HOSPITAL CONDUCTS MAJOR EDUCATION AND RESEARCH PROGRAMS. THE RESEARCH PROGRAM IS COMPRISED OF BOTH BASIC AND CLINICAL SCIENTIFIC INVESTIGATION.

THE HOSPITAL'S PRIMARY SERVICE AREA IS SOUTHERN CALIFORNIA. HOWEVER, PATIENTS COME FROM A WIDE AREA IN THE PACIFIC SOUTHWEST AND SOME FOREIGN COUNTRIES TO RECEIVE DIAGNOSIS AND TREATMENT IN THE HOSPITAL'S SPECIALIZED PROGRAMS.

LAST YEAR THE HOSPITAL PROVIDED ABOUT 85,000 DAYS OF CARE TO THE 13,000 PATIENTS WHO WERE ADMITTED. OVER 150,000 PATIENT VISITS WERE RECORDED IN THE HOSPITAL CLINICS AND EMERGENCY DEPARTMENT.

AS SHOWN IN THE ATTACHED REPRINT OF A MAJOR STORY WHICH APPEARED IN THE LOS ANGELES TIMES ON APRIL 22, 1980, CHILDRENS HOSPITAL OF LOS ANGELES IS FACING A SEVERE FINANCIAL CRISIS.

THE INCREASING MEDI-CAL PATIENT VOLUME IN RECENT YEARS, INFLATION, AND THE CURRENT FAILURE OF THE STATES NEW FISCAL INTERMEDIARY IN PROCESSING MEDI-CAL CLAIMS ARE THE MAJOR CONTRIBUTING FACTORS TO THE HOSPITAL'S FISCAL CRISIS. OPERATING DEFICITS OF NEARLY \$4.5 MILLION IN EACH OF THE HOSPITAL'S LAST TWO FISCAL YEARS AND CURRENT CASH FLOW PROBLEMS DUE TO SLOWDOWN IN REIMBURSEMENT FROM MEDI-CAL AND CALIFORNIA CHILDRENS SERVICES HAVE PLACED THE HOSPITAL DEEPLY IN DEBT.

AS THE TIMES ARTICLE STATED, WE HAVE MADE MAJOR REDUCTIONS IN STAFFING. WHEN THE FACULTY CUTS BECOME EFFECTIVE JULY 1, WE WILL HAVE ELIMINATED ALMOST 400 POSITIONS. I SPENT THE BULK OF LAST WEEK TESTIFYING IN A GRIEVANCE HEARING CONDUCTED FOR FACULTY MEMBERS WHOSE POSITIONS ARE BEING DELETED.

OUR MOST SERIOUS FINANCIAL PROBLEM ARISES IN OUR OUTPATIENT AND EMERGENCY SERVICES. AS A TERTIARY HOSPITAL WITH A MAJOR EDUCATIONAL ROLE, WE MAINTAIN AN EXTENSIVE ARRAY OF OUTPATIENT CLINICS AND EMERGENCY SERVICES. REIMBURSEMENT BY STATE PROGRAMS FOR OUTPATIENT SERVICES IS TOTALLY INADEQUATE.

FOR THIS REASON WE HAVE REDUCED SERVICES IN OUR OUTPATIENT CLINICS AND SEVERAL VERY IMPORTANT PROGRAMS WERE ELIMINATED. THE CUT-BACKS HAVE CREATED HARDSHIPS FOR PATIENTS AND PARENTS WHO MAY HAVE NO PLACE ELSE TO GO TO SEEK THE PARTICULAR TREATMENT THEY REQUIRE.

IT IS ESTIMATED THAT ABOUT 50% OF OUR OUTPATIENTS AND ABOUT 55% OF OUR EMERGENCY PATIENTS CAN BE DESIGNATED AS POOR BASED UPON THE ACTUAL NUMBERS OF PATIENTS WHO ARE COVERED BY MEDI-CAL AND/OR CALIFORNIA CHILDRENS SERVICES. WE ARE UNABLE TO ESTIMATE HOW MANY MORE WOULD FALL UNDER THE POVERTY GUIDELINES SET BY THE COMMUNITY SERVICES ADMINISTRATION.

FOR THE LAST TWO FISCAL YEARS, OUR LOSSES IN THE OUTPATIENT AND EMERGENCY SERVICE ARE AS FOLLOWS:

OPERATING LOSSES

	<u>FY 78-79</u>	<u>FY 79-80</u>
Outpatient	\$ 2,100,000	\$1,900,000
Emergency	260,000	970,000
	<hr/>	<hr/>
Total Losses*	\$ 2,360,000	\$2,870,000

* Excludes bad debts

CHILDRENS HOSPITAL OF LOS ANGELES IS NOT ATYPICAL AMONG THE NATIONS HOSPITALS WHICH CONDUCT LARGE AMBULATORY CARE PROGRAMS. THE MAJOR CHILDREN'S MEDICAL CENTERS WITH LARGE TEACHING PROGRAMS HAVE LARGE AMBULATORY CARE PROGRAMS. AN INCREASINGLY LARGE PROPORTION OF THE PATIENTS IN THESE PROGRAMS ARE LOW INCOME COVERED BY VARIOUS FEDERAL, STATE AND LOCAL PROGRAMS WHICH REIMBURSE PROVIDERS AT LESS THAN TOTAL COST. AS CONTRACTUAL ALLOWANCES (REDUCTIONS IN REVENUE) RESULTING FROM THESE LEVELS OF REIMBURSEMENT INCREASE, WE ARE FORCED TO INCREASE THE CHARGES FOR OUR SERVICES IN ORDER TO SHIFT THE UNCOVERED PART OF THE COST OF CARING FOR THESE PATIENTS TO THE PATIENTS WHO ARE SELF-INSURED OR SELF-PAY. IN THE INCREASINGLY COMPETITIVE HEALTH CARE MARKET WE FIND OURSELVES IN, PATIENTS ARE SHOPPING AND DOING PRICE COMPARISONS.

WE ARE LOSING SELF-INSURED PATIENTS WHO ARE NO LONGER WILLING TO SUBSIDIZE THE CARE OF PATIENTS COVERED BY VARIOUS GOVERNMENT PROGRAMS. WHILE ACTUAL NUMBERS OF MEDICAL DAYS HAVE INCREASED AT OUR HOSPITAL, WE HAVE HAD A DECREASE OF 33 PERCENT IN THE ACTUAL NUMBER OF DAYS OF INPATIENT CARE PROVIDED TO SELF-INSURED, SELF-PAY PATIENTS SINCE 1974.

CHILDRENS HOSPITAL OF LOS ANGELES MAY BE FORCED TO FURTHER REDUCE ITS OUT-PATIENT SERVICES IF THE CURRENT FINANCIAL SITUATION CONTINUES. THIS WILL RESULT IN HARDSHIPS FOR THOSE POOR FAMILIES WHO HAVE NO OTHER ALTERNATIVES, THOSE FAMILIES WHO DO NOT HAVE ACCESS TO A PRIVATE PHYSICIAN'S OFFICE.

UNLESS THE APPARENT CONTRADICTION BETWEEN THE STATED AIM OF GOVERNMENT TO REDUCE HEALTH CARE COSTS AND GOVERNMENT REIMBURSEMENT PROGRAMS WHICH PENALIZE OUT-PATIENT SERVICES IS ELIMINATED, FURTHER CURTAILMENT OF OUT-PATIENT SERVICES AT OUR HOSPITAL IS INEVITABLE.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS.

THANK YOU.

Childrens Hospital to Cut Back Staff 20%, Reduce Services

400 Jobs to Be Lost; Increasing Debt Crisis Cited

By JOAN SWEENEY
Times Staff Writer

Childrens Hospital of Los Angeles, confronted with mounting debt, confirmed Monday it would reduce its staff by 20% and slice some services, with the brunt of the cutbacks being borne by outpatient clinics.

Donald M. Cook, the hospital's executive director, said the 20% staff reduction would translate into 400 full-time jobs and that notices to the employees had gone out Monday.

Cook was joined at a news conference by representatives of two other Los Angeles hospitals who said their institutions were facing financial difficulties because of problems with Medi-Cal payments.

Cook said it was not possible to list all the individual programs that would be eliminated or reduced. However, he said the poison information center would be closed and that outpatient clinics providing psychiatric, dental and general pediatric services would be reduced substantially.

However, such major outpatient clinical programs as hematology, oncology, kidney dialysis, eye, ENT (ear, nose and throat), and neurology and seizure will remain intact, he said.

He blamed the financial difficulties on the hospital's growth and expansion and on an increasing number of patients covered by Medi-Cal and California Children's Services (CCS), which do not pay the full cost of recipients' care.

"Our current financial crisis and the decision to cut back was due to a continuing situation in which it is costing us significantly more to operate than we are generating in revenues because of the failure of government programs to pay our bill charges," Cook said.

Presently, about 60% of the hospital's inpatient admissions and 54% of its outpatient visits are covered by Medi-Cal and CCS. But, he said, Medi-Cal and CCS reimburse the hospital only for 81% of the charges it bills for inpatients and 42% for outpatients.

As a result of the cutbacks, many outpatients—both private and Medi-Cal—will have to seek services elsewhere. During the last fiscal year, the hospital handled 151,540 outpatient visits, a spokesman said.

On inpatient service, Cook said, "We are going to be much more careful in determining Medi-Cal eligibility on elective admissions."

Cook said the staff cutbacks will save about \$5 million annually.

He said a final deficit figure was not yet available for the last fiscal year, which ended Feb. 25, but during



the preceding three years the hospital's operating loss totaled \$15 million to \$17 million.

Stephen W. Gamble, president of the Hospital Council of Southern California, who was also at the news conference, said other California hospitals, particularly the 55 that handle 50% of the Medi-Cal load, were also faced with financial hardship.

Gamble said that statewide Medi-Cal pays only 85% of the average inpatient care charge and 50% of outpatient care for a total loss to hospitals of \$410 million, which increases the cost to private patients.

James W. Leisner, board chairman of Childrens Hospital, said the payment percentage was even lower for Children's because treating children was "more labor intensive" than treating adults.

Gamble said that in 1978 a private patient in a Southern California hospital paid about \$88 per patient day more than a Medi-Cal patient.

But as the percentage of private pay patients drops, so does the hospi-

tal's ability to meet costs, the hospital officials said.

"You reach a point where you don't have enough other patients to spread it over," Cook said.

"Government is taxing the private patients in our hospitals," Cook contended. "It should pay closer to the actual charges and spread this over the general tax base, rather than taxing the patients."

(The state maintains it reimburses hospitals on a cost plus basis, but the hospitals and the state dispute how those costs are figured.)

Gamble said the chronic underpayment by Medi-Cal has been exacerbated by a new claims processing system, which the hospitals went on Dec. 1, that has significantly reduced cash flow to hospitals.

Gamble warned, "If the system continues its current rate of deterioration, some hospitals will be shut down."

He said one purpose of calling the news conference was to try to "prevent the system from breaking down."

Representatives from two other Los Angeles inner city hospitals, White Memorial Hospital and California Hospital Medical Center, told reporters that their institutions had both faced serious cash flow problems as a result of the new billing system.

Richard Hergert of White Memorial said before the news conference that as of last Thursday the hospitals had billed \$4.2 million in claims since it went on the new system in December and had had only \$1.4 million of them adjudicated.

As a result, the hospital had to borrow \$500,000 at 21% interest and may have to borrow an additional \$1 million next month.

The spokesmen for both White and California Hospitals said they had not laid off staff nor had any immediate plans to cut back on services or turn away Medi-Cal patients.

Senator METZENBAUM. Thank you very much. We will hold our questions also until we have heard from Mr. Johnson.

Mr. JOHNSON. Good morning. Thank you very much, Senator Metzenbaum and members of the committee.

My name is Robert Johnson. I am executive director of D.C. General Hospital. Last week, many Washington area residents had the opportunity to be exposed to an indepth series of articles about D.C. General Hospital which we believe for the first time have conveyed to the residents of the District of Columbia and area residents a better picture of D.C. General Hospital, both our strengths and our weaknesses.

D.C. General Hospital is the only public general acute care hospital in Washington, D.C. We are a 500-bed hospital, with 57 bassinets. We serve approximately 200,000 people.

We had 150,000 outpatient visits last year, and slightly under 90,000 emergency room visits. We had in excess of 11,000 admissions to the hospital. D.C. General Hospital recently was removed from the Department of Human Resources and set up as an independent agency within the District government. That move, we think, contributes significantly to the success of the hospital experiences today.

Currently we are operating on a \$61 million annual budget, made up significantly of contributions directly from local tax supported dollars. However, our patient mix is very different. We have approximately 34 percent of our patients that have medicaid or medicare, about 6 percent of our patients who have either private insurance or Blue Cross, and 60 percent of our patients who have no known insurance.

However, our financial resources come approximately 45 percent from local tax dollars, and 55 percent from third party collections.

As one can easily tell, those lines will converge pretty soon in terms of the deficit that will occur in our operating budget as the level of patients that have no insurance coverage goes up and the amount of local tax dollars go down.

We are expecting about a \$4 million reduction in our operating budget, from tax supported sources in next fiscal year. We think D.C. General Hospital has many institutional strengths required to be a viable institution. We have a governing body that has full authority to operate and govern activities of the hospital which in some cases is different than other public hospitals. We have a major plan improvement program underway right now with about an \$18 billion construction program.

We are making some improvement in physical appearance of the plant, and some amenities associated with well-run hospitals.

We are affiliated with Howard University and Georgetown University for our medical services. We have recently developed a 5-year plan for the provision of services to the hospital patient population that addressed our major priorities, principally among those improvements in our ambulatory care services, namely, emergency rooms and clinics. We think as a public institution we currently enjoy good support from local government.

However, as everyone knows in this area, the District of Columbia government is undergoing a major problem of financing its operation, one that was accumulated over many years. There is

sizable shortfalls in revenues to support the many services provided by local government.

We are currently attracting, we believe a well qualified medical staff and administrative personnel to assist us in delivering high quality services.

However, as an institution we have many shortcomings as well. We serve an enormous population that does not have insurance. We also have an aging fiscal plant, even though we are providing additional resources for improvements, it is a plant that goes back to 1937, in terms of the oldest building, most recent innovation being last year.

We also have shortcomings in the degree of financial flexibility, personnel administration, and contracting and procurement practices.

We think that our problem is not unique to D.C. General Hospital in terms of a shortage of adequate resources to provide care to an enlarged population that is dependent on public hospitals

However, we believe this responsibility for the care of the indigent must be shared between the Federal Government and the local government. That local government alone cannot care for the size and patient population that we are responsible for providing care to. There needs to be a significant reexamination of the level of medicaid eligibility for those individuals who are poor or near poor. Other people have recommended that there needs to be a reexamination of the responsibility of medicaid, medicare, and other private insurances to pick up a greater portion of bad debt for those patients served by each institution.

Also, we think in the final analysis there needs to be a serious look at the financing of medical education in public hospitals. Right now public hospitals provide probably 30 to 40 percent of all the training of interns and residents in this country, and those costs are principally supported by patient revenues, rather than by general tax support of revenues; yet, the delivery of training programs really provides a community resource of training figures to care for people other than those in public hospitals. There needs to be some reexamination of funding.

If public hospitals and urban hospitals are to survive, there needs to be immediate infusion of new money, associated with the care of people without insurance, or the raising of the level of eligibility for those who are currently eligible for medicaid. Again, I would be glad to answer any questions the committee may have.

Senator METZENBAUM. Thank you very much, Mr. Johnson.

Henry Manning, I did not mean to skip over you. I figured since you are from my home community, I would hold the best stuff for the last.

Mr. MANNING. I regret Mr. Sweeney is not going to come.

Senator METZENBAUM. You tell him we are disappointed by his failure to show, since he called me personally to see whether he would be on the schedule. His failure to come is a great disappointment which has ruined my day. I am very happy to hear from you, though.

Mr. MANNING. I appreciate the opportunity to appear today and tell you something about the greatness, as well as some of the growing problems of Cuyahoga County Hospital, Cleveland, Ohio.

My name is Henry E. Manning, and I have been employed as president of this public hospital for the past 10 years.

Cuyahoga County Hospital is a system of comprehensive inpatient, outpatient, and outreach social services which has the primary mission of serving the medically indigent population of Cuyahoga County.

The system is known locally as County Hospital.

It consists of a hospital and clinic facilities, some of which were formerly operated by the city of Cleveland and transferred to county auspices in 1958.

Presently, the system serves more than 2,500 citizens daily for care ranging from the most complex tertiary hospital care to neighborhood health services. These services are delivered through one acute care hospital, known as Cleveland Metropolitan General, a rehabilitation hospital, Highland View; a large skilled nursing facility, Sunny Acres; and community clinics and outreach facilities known as Clement Center, Chronic Illness Center, County Clinic, and others.

The citizens of Cuyahoga County are justifiably proud of their public hospital system and have regularly supported our call for tax levies for construction and operating funds. The system is managed by a 10-member board of trustees who are selected and appointed pursuant to public statutes and have been broadly representative of the citizenry of the county.

The trustees serve 6-year terms without compensation.

The medical programs of the hospital are administered by a highly competent and skilled group of physicians and dentists who are also faculty of the medical and dental school of Case Western Reserve University. In addition to their patient care responsibilities, our staff teaches medicine and surgery to about 40 percent of the medical students at the university and trains over 200 resident physicians each year.

As president of the hospital, I am proud of our record of recruiting and retaining a broad range of talented administrators for the public hospital sector. Among our ranks we have over 15 men and women with advanced degrees in hospital administration and health care management.

The strong leadership of the board of trustees, the support of the board of county commissioners, and the high caliber of the hospital's professional staff have made it possible for this public hospital to develop and progress so that today it is one of the stronger public hospitals in the United States.

Our work force of more than 4,000 dedicated people is fully capable of carrying out the missions that we have designed for ourselves and our facilities are technologically modern and cost efficient.

The use of the word "mission" as it relates to local responsibilities of public hospitals is appropriate. In Cleveland, we undertook a formal planning exercise with the local health planning agency, the county commissioners and others in 1970 to identify our mission and programs for the future.

Our blueprint for the system, published in early 1971, predated current Federal mandates and other public policies concerning health planning and cost containment. It was, however, a blueprint

which was specifically aimed at reductions of beds, elimination of duplicated facilities, and expansion of primary outpatient services. Except for some final reconstruction of clinics now underway, all elements of our 1970 plan have been accomplished.

As a consequence, the occupancy rates of our acute care and rehabilitation inpatient facilities increased by approximately 8 percent in 1979; the average length of stay for all patients decreased by one-half day; and the institution's per diem expenses were the lowest of all large teaching hospitals in the region.

Our blueprint did not lose sight of the role of the hospital as the principal source of care for poor people, but the mission of this public hospital was expanded to serve a larger cross section of the population.

Our services are available to all residents of Cuyahoga County, regardless of economic circumstances. People with limited means, but not eligible for medicaid, are given charitable allowances. Those who are insured and have the means to pay, do so.

In 1978, nearly 27 percent of the hospital's admissions were for people from suburban areas of Cleveland within Cuyahoga County, and more than 9 percent of our admissions were from areas outside Cuyahoga County. Noncounty residents must show proof of ability to pay for the services contemplated, except for emergency admissions.

Approximately 15 percent of all our admissions are patients who have a private patient relationship with a member of our medical staff. These data underscore the County Hospital's policy of serving all segments of the population. Such a policy was recently recommended to all urban public-general hospitals by a national study commission.

In order to keep this testimony in proper context, it is important to point out that the County Hospital is only one of 51 hospitals in the Greater Cleveland area. We have some strong and willing partners sharing responsibility for the care of medically indigent people.

The Greater Cleveland Hospital Association reports, however, that only 5 of the 51 hospitals provide 90 percent of the unreimbursed indigent care in the area. This fact says more about the geographic positioning of hospitals than any implication of unwillingness to show responsibility.

These five hospitals are: County Hospital, University, Mount Sinai, St. Luke's, and St. Vincent Charity.

Incidentally, the association has also documented that approximately 80 percent of all unreimbursed indigent care in Cleveland is for outpatient, clinic, and emergency services.

As a general guideline, it can be stated that hospital services for medically indigent people in Cleveland are about evenly shared between the County Hospital and the large private institutions.

Senator METZENBAUM. You, of course, make a major exception for Cleveland Clinic, which does not accept any indigent patients; is that not so?

Mr. MANNING. I expect they do. This testimony comes from the Cleveland Hospital Association; and I do not think Cleveland Clinic was included in their data.

Senator METZENBAUM. It is not included. It is located in the heart of a medically indigent area in Cleveland, and does not accept any indigent patients, as I understand it.

Am I correct about that?

Mr. MANNING. What I can say to confirm it, sir, is that the data I have concerns five hospitals, and published by—

Senator METZENBAUM. Cleveland Clinic is not a member of the Greater Cleveland Hospital Association?

Mr. MANNING. Yes.

Senator METZENBAUM. Why did you not include data concerning them?

Mr. MANNING. I am sorry; I am not prepared to say. I am quoting data and testimony of the hospital association.

Senator METZENBAUM. They stand out like a sore thumb in Cleveland for not accepting a share of responsibility. Are we not entitled to some factual data as pertains to that institution as well?

Mr. MANNING. Yes, sir. I imagine that the Cleveland Clinic and the hospital association will be willing to provide it. I just do not have it.

What I would say for Cleveland Clinic is, they are affiliated—Cleveland Clinic is an affiliate of County Hospital and provides assistance to us in management and operation of Clement Center. They have here today contributed over \$1 million directly to budgets of County Hospital for support of Clement Center. As a matter of fact, it is \$1.2 million. They do have that role that I can comment on. I cannot directly comment to your other question.

Senator METZENBAUM. It does continue to have concerns with the Federal Government, and as I understand it, is indifferent to accepting their funding for some of their programs. I think those of us who come from that community do feel that the hospital association itself has not used the kind of peer pressure that might have been brought upon Cleveland Clinic to accept their share of responsibility. They are right square in the heart of the area where it should be, they are extremely well—off financially, and I have been told by the former director, they are unquestionably one of the most profitmaking operations of any hospital in the country. Yet they share no responsibility. I just want to make it clear that I do not accept their role and I do not accept the fact that the hospital association in Cleveland is not bringing them in as a part of your presentation.

I think it is part of your responsibility.

Mr. MANNING. I understand your sentiment, sir.

I would say with respect to our own public programs in County Hospital, Cleveland Clinic has been very supportive and has made very large money contributions. I do not disagree with the other sentiments that you have expressed, however.

Senator METZENBAUM. Thank you.

Mr. MANNING. I would like to summarize my statement to the committee by saying that, while I represent an urban public hospital that has in the past been well supported by its community and has been relatively successful in serving the community, I foresee serious future economic problems for us.

Both the County Hospital and our partners in the private sector are faced with growing numbers of people who cannot afford to pay

for necessary medical care and at the same time are not eligible for medicaid or other payment programs. The private sector is loudly complaining about the risk of financial insolvency that these circumstances impose. The ability of the County Hospital to absorb larger portions of the caseload is clearly in doubt.

Thank you.

[The prepared statement of Mr. Manning follows:]

SUBCOMMITTEE ON HEALTH
COMMITTEE ON HUMAN RESOURCES
U.S. SENATE
June 25, 1980

Mr. Chairman and members of the Health Subcommittee of the Senate Committee on Human Resources and Labor. I appreciate the opportunity to appear today and tell you something about the greatness, as well as some of the growing problems of Cuyahoga County Hospitals, Cleveland, Ohio. My name is Henry E. Manning, and I have been employed as President of this public hospital for the past ten years.

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struction and operating funds. The system is managed by a ten-member Board of Trustees who are selected and appointed pursuant to public statutes and have been broadly representative of the citizenry of the County. The Trustees serve six-year terms without compensation. The medical programs of the hospital are administered by a highly competent and skilled group of physicians and dentists who are also faculty of the Medical and Dental School of Case Western Reserve University. In addition to their patient care responsibilities, our staff teaches medicine and surgery to about forty percent of the medical students at the University and trains over 200 resident physicians each year.

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exercise with the local health planning agency, the County Commissioners and others in 1970 to identify our mission and programs for the future. Our blueprint for the system, published in early 1971, predated current federal mandates and other public policies concerning health planning and cost containment. It was, however, a blueprint which was specifically aimed at reductions of beds, elimination of duplicated facilities, and expansion of primary outpatient services. Except for some final reconstruction of clinics now underway, all elements of our 1970 plan have been accomplished.

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1. Quarterly Cost Report, Dec. 31, 1979, Blue Cross of Northeast Ohio.

of all our admissions are patients who have a private patient relationship with a member of the Medical Staff. These data underscore the "County Hospital's" policy of serving all segments of the population. Such a policy was recently recommended to all urban public-general hospitals by a national study commission.^{2.}

In order to keep this testimony in proper context, it is important to point out that the County Hospital is only one of fifty-one hospitals in the Greater Cleveland area. We have some strong and willing partners sharing responsibility for the care of medically indigent people.

The Greater Cleveland Hospital Association reports, however, that only five of the fifty one hospitals provide 90% of the unreimbursed indigent care in the area. This fact says more about the geographic positioning of hospitals than any implication of unwillingness to show responsibility. These five hospitals are - County Hospital, University, Mount Sinai, St. Luke's, and St. Vincent Charity. Incidentally, the Association has also documented that approximately 80% of all unreimbursed indigent care in Cleveland is for outpatient, clinic and emergency services. As a general guideline, it can be stated that hospital services for medically indigent people in Cleveland are about evenly shared between the County Hospital and the large private institutions. It is crucially important that the private sector remain committed and capable of continuing to sustain this mix of responsibility. The County Hospital has never been capable of carrying the whole load of indigent care in the Cleveland community, and with all the cost effective efforts that I have described, our Hospital is today

2. Report of the Commission on Public-General Hospitals, Hospital Research and Educational Trust.

experiencing severe financial problems. In January of this year, we were forced to eliminate through layoffs and attrition, more than \$1 million from our 1980 salary budgets and make other major reductions in expenses. These financial and staffing setbacks come at a time when medical indigency in the community is growing due to unemployment and demands on the Hospital for indigent care are expected to increase.

I have already stated that the taxpayers of Cuyahoga County have been extremely supportive of the Hospital and in their behalf the elected County Commissioners make annual appropriations to the Hospital to support indigent care. Currently, about 25 percent of the Hospital's income is provided from this source. For the information of the Committee members, I have appended a 1979 income and expense analysis for our Hospital which shows that 69 percent of our unreimbursed expense was attributed to outpatient operations.

I understand that the Committee has invited Mr. Robert E. Sweeney, President of the Cuyahoga County Board of Commissioners to testify, and I am certain that he will have some important statements to make about the increasing burdens upon our County taxpayers for essential health services and their inability to cope with the expected increased demands.

Mr. Chairman, I would like to summarize my statement to the Committee by saying that while I represent an urban public hospital that has in the past been well supported by its community and has been relatively successful in serving the community, I foresee serious future economic problems for us. Both the County Hospital and our partners in the private sector are faced with growing numbers of people who cannot afford to pay for necessary medical care and at the same time are not eligible for medicaid or other payment programs. The private sector is loudly complaining about the risk of financial insolvency that these circumstances impose. The ability of the County Hospital to absorb larger portions of the case load is clearly in doubt.

Thank you.

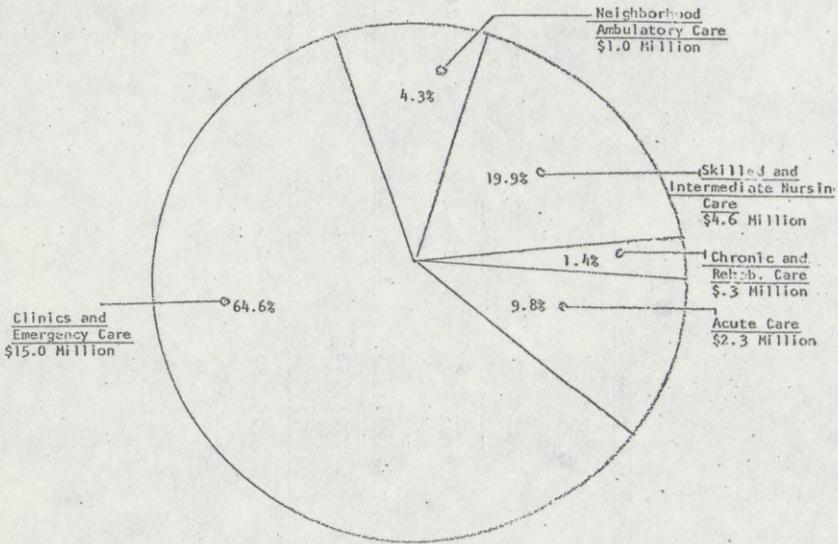
OPERATIONS ANALYSIS

1979

	<u>Metro IP</u>	<u>HVH IP</u>	<u>Metro OP</u>	<u>Clement Center</u>	<u>Sunny Acres</u>	<u>Total CCH</u>
Net Revenue (excl. Approp.)	\$44,736,719	\$10,779,655	\$ 4,370,598	\$1,375,738	\$ 5,452,748	\$66,715,458
Expenses	<u>47,014,981</u>	<u>11,099,952</u>	<u>19,371,644</u>	<u>2,376,133</u>	<u>10,058,900</u>	<u>89,921,610</u>
Operating Loss	(2,278,262)	(320,297)	(15,001,046)	(1,000,395)	(4,606,152)	(23,206,152)
Appropriation	<u>2,278,262</u>	<u>320,297</u>	<u>14,974,894</u>	<u>1,000,395</u>	<u>4,606,152</u>	<u>23,180,000</u>
	-0-	-0-	(26,152)	-0-	-0-	(26,152)

1979 ALLOCATION OF COUNTY APPROPRIATION
\$23.2 Million

CUYAHOGA COUNTY HOSPITAL SYSTEM



1/10/80
VS

Senator METZENBAUM. I am going to have to leave and Senator Javits is going to conclude the hearing; but first, I have a few questions.

Mr. Manzano, it seems to me that one of the key problems in this debate relates to the lack of reliable information concerning financial distress and other related issues. Yet, every time the Department of Health and Human Services proposes reforms to help establish uniform data bases, the American Hospital Association is opposed to these reforms.

It is my understanding you even went so far as to litigate against standardized hospital reporting requirements.

Why?

Mr. MANZANO. From the hospital's perspective, HRS is not merely a straightforward reporting system, it is a reimbursement system. The hospitals are presently reporting to HRS through their annual cost reports. Attached to those reports are audited statements, and to review those audited statements I think would clearly indicate the hospitals encountering difficulty—

Senator METZENBAUM. You misunderstood my question. The thrust of my question is that you cannot compare apples with oranges, and if you are going to find out which hospitals are financially distressed, then you need uniform accounting procedures, uniform data bases. It is my understanding that the Department has been attempting to work that out, and the American Hospital Association has been in opposition.

Why? What could be objectionable to the American Hospital Association in seeing to it that everybody speaks the same language?

Mr. MANZANO. I think there are two things.

We do support the concept of uniform reporting. It is the way uniform reporting is structured and implemented. The way it has been proposed by the Department, we feel, is unnecessarily burdensome, and we do not think it will provide greater improvement in data for their purposes. We think the purposes behind AHA's structure are not really consistent with the concept of uniform reporting as much as they are directed toward the concept of data for reimbursement control purposes.

Senator METZENBAUM. Do you have an alternative for a uniform data system? Does the American Hospital Association have an alternative?

Mr. MANZANO. We have developed what became in effect the material used in the development of HRS, and that does have a reconciliation system.

Senator METZENBAUM. These bills are reimbursement bills, and what would you suggest the reimbursement be based upon?

Mr. MANZANO. I think what Senator Javits has proposed in the second bill, which is to reimburse on the basis of cost, is really critical, particularly in the ambulatory area. I think what we are talking about is a difference as to what we perceive as cost.

Our concept of cost, of course, is that full and total cost of care should be met. A key element of cost, which has not been met in government reimbursement programs, has been a proportionate share of uncollectables because of the role of many hospitals in taking care of people—

Senator METZENBAUM. How do you determine which hospitals are entitled to it if you do not have a uniform data base? How do you then determine which ones are financially distressed?

Mr. MANZANO. I think there is data available from individual hospitals, which include structure, their financial information, in ways that can be observed and studied.

One of the things I think is that hospitals are not apples or oranges in the sense that they cannot really be made uniform. They are different kinds of institutions.

Senator METZENBAUM. Explain that to me. I do not understand that at all. I am a simple-minded person who can read a financial statement, and I can understand what it says.

Now, tell me what is so different about Hospital A in California and Hospital X in Des Moines, Iowa.

Mr. MANZANO. One of the things, obviously, is the kinds of services that they perform are very different. The kinds of patients that they serve are very different. That is the kind of thing which I think is a unique characteristic of a children's hospital.

Senator METZENBAUM. What has that to do with the accounting procedure? Why can there not be uniform data, uniform accounting procedures for all hospitals in this country?

Mr. MANZANO. Accounting systems are essentially designed for internal management purposes, so you can get data to understand what is occurring in institutions, so you can direct your attention to management issues that need to be resolved, and get information that gives you the basis for managing and operating effectively.

There is a discrepancy when you look at accounting systems and structure them essentially for reporting for control purposes. Now, that is the basic difference, and I think people in hospitals recognize the need and we acknowledge the need for there to be purposeful, useful information for the Government in its appropriate controls of expenditures.

The question is, what is appropriate? To what extent the kind of system that is being proposed is appropriate. Our view is it is an excessive system, excessively costly.

Senator METZENBAUM. Do you have an alternative? All you want to do is get reimbursed on the basis of cost. You have no basis for determining when a hospital is financially distressed except to say that they failed to collect adequate, a fair share of their collectible. Now, the American Hospital Association could very well have called in seven major accounting firms and created a committee to come up with a formulation in order to say all hospitals ought to operate this way and take it to the Government and say, does this not make sense? Let Government participate.

Mr. MANZANO. I think that is an excellent proposal, Senator. If you would like to propose that we do that, I am sure we would be very glad to do it.

Senator METZENBAUM. I am not proposing that you do it, but it just seems to me so simple that I wonder why some Senator has to suggest something that is as obvious as the nose on my face.

Mr. MANZANO. The Senate and House did pass legislation which authorized the Department to establish a uniform reporting system. We have been actively working with them in that regard.

I think one of the interesting things, of course, is the product that they have come out with does not reflect the information, the comments they received universally, including that which came from significant accounting firms.

Senator METZENBAUM. Let me then make a formal request:

The American Hospital Association create a committee with top accounting firms participating and the Government—and I do not mean to get the job done 5 years from now; I mean promptly. Let me hear from you whether or not it will be done; will you?

Mr. MANZANO. I certainly will, Senator.

Senator METZENBAUM. Mr. Manzano, although AHA represents both private and public hospitals, it appears to me it has not opposed dumping of poor and sick and medically needy people from private hospitals to the public. In fact, you have adamantly opposed the Hill-Burton free care regulations.

Given your activity in this area, why should Congress provide relief to private hospitals rather than just to the public hospitals?

Mr. MANZANO. I do not think we have opposed the concept of rendering free care under Hill-Burton regulations. As a matter of fact, the interesting thing about the new regulations is they eliminated a previous regulation which permitted hospitals to have what was called an open-door policy, and defined for us continuing percentage basis and a certain amount of contribution in free care year by year. In some cases, this was difficult because of the location of the hospital and the kind of population served may not have been able to generate that amount, and also instituted a system which in effect put that requirement into perpetuity, a perpetuity mode.

I do not think hospitals would or would not provide free care simply because they participated in Hill-Burton or not. I do think they do, and they recognize that role in the Hill-Burton regulations, which as you previously observed have been in existence for quite a long time. They have recently been revised again, but this certainly has not precluded or prevented hospitals from performing what I think has been a generally good role in carrying out that responsibility under those grants.

Senator METZENBAUM. Mr. Manning, we have heard testimony today suggesting when the money crunch comes, hospitals are forced to either cut services or compromise on quality of care.

What has been your response to this dilemma?

Mr. MANNING. Well, we have had a particular problem in my own hospital just this year, Senator Metzenbaum. One of our very important social outreach services for the elderly was put at risk for being closed because of budget constraints.

One of the reasons those kinds of services come into risk is they are not supported by patient revenue, normal sources of revenue. This was a threat to a vital service and the board of trustees had to face the possibility of closing that service.

I thought it was a very dramatic example of what can happen with respect to these financial problems faced by public hospitals.

Senator METZENBAUM. I am going to have to leave. I am particularly sorry to have to leave because I wanted to hear from Mr. Mark Ravenscraft, who is a personal friend, and will testify later this morning. I have another commitment.

Senator Javits has indicated a willingness to conclude the hearing. I am very grateful to him for that.

Senator JAVITS. Thank you, Senator Metzenbaum. Thank you for your support on both bills.

I am rather puzzled by one of the replies, Mr. Manzano, as to the possibility of uniform accounting, because in New York there is a State statute, which seems to be complied with—

Mr. MANZANO. Senator, it is always easier to follow a system if it is specified under the law.

The question I addressed was whether or not that was useful and whether that really served the purpose of the legislation.

Senator JAVITS. Does AHA have any idea of the sources and magnitude of the deficits in those hospitals which are likely to come under these bills? Do you have any facts and figures on the subject?

Mr. MANZANO. We did do a preliminary survey, and I think this is something we will continue to study, Senator. A preliminary study was addressed to the urban community only.

In those communities, we identified only 200 hospitals that were in deficit positions. The amounts of their deficits were about \$200 million in a given year. That probably understates the cost because of offsetting tax appropriations, where we do not have adequate data. I think it would be more than that.

Senator JAVITS. What about the sources of these deficits? Have you done any analysis of that?

Mr. MANZANO. Senator, I think that is a very good question.

One of the things that comes to mind is, what exactly causes that deficit. There are a number of things that do cause the deficit. Generally, one is shortfalls in payments, certain cost-reimbursements programs, clearly. Another source might be the fact that reimbursement billing for other kinds of programs run into individuals who have no sources for paying those bills. That is a combination of things which could occur.

The other sort of things that could happen in institutions would relate to the sorts of things that normally occur in other businesses.

Senator JAVITS. Do you have any specificity on the basis of studies? After all, we have to prove a case here.

Mr. MANZANO. No, but we will be—

Senator JAVITS. To what extent can we look to you for a study on the subject?

Mr. MANZANO. I think you can look to us within our available resources.

Senator JAVITS. What can you give us and how soon can you give it to us?

Mr. MANZANO. I cannot give you a specific answer on that, Senator. I would like to get back to you, if I can.

Senator JAVITS. Would you do that?

Mr. MANZANO. Yes.

Senator JAVITS. Let us know in about a week.

Mr. MANZANO. I will get back to you relative to that question. I would hope to get back to you by then.

Senator JAVITS. I ask you specifically, what are the sources of the deficits of the hospitals that are meeting this problem of an impact

on their services, which are covered by these two bills? And would you let us know within a week what you feel you can do and what it will be based on?

I might say to you by way of observation that your view on the alterations and medicare and medicaid programs as to financial solutions for financially distressed hospitals is not likely to get anywhere within the time that we need; would you concur in that?

Mr. MANZANO. Yes, I would, Senator.

Senator JAVITS. One other thing.

You take into account in your comments on my bills that we will be dealing with both the rural and urban setting. We are not going to be dealing solely with urban settings.

Mr. MANZANO. That is correct.

Senator JAVITS. Do we have any data? If not, I am requesting information regarding the trends in the use of hospitals as the division between ambulatory and primary care services; that is, inpatient and outpatient.

Mr. MANZANO. We do have data which indicates trends in volume of ambulatory care.

Senator JAVITS. It is in—which way—

Mr. MANZANO. Up. Outpatient is increasing.

Senator JAVITS. Whatever data you can give us on that score will also be appreciated.

Mr. MANZANO. Surely.

Senator JAVITS. Now, what about the way of dividing the deficit? Would it have any correlation with the inpatient and outpatient situation?

Mr. MANZANO. Senator, the deficit—is it already indicated whether the hospital is outpatient or inpatient?

Senator JAVITS. Yes.

Mr. MANZANO. Yes; I think it is correlated to institutions highly invested in ambulatory care where they are rendering services to individuals who cannot pay. I think there is a strong correlation.

Senator JAVITS. If you can give us whatever data is possible on that.

Mr. MANZANO. Yes.

Senator JAVITS. Finally, as I mentioned before, I would like to get your judgment on the contributions we can make to dealing with this problem, in terms of improving the management available to hospitals. You know, I have introduced a bill, S. 2378, which seeks to be responsible for the improvement of management skills and management capability, as an important contribution to the operation of the hospitals.

Would you give us your opinion in this regard or supply it to us for the record on what contribution they could make?

Mr. MANZANO. It is very difficult for me to assess that. I would have to take a look and understand what given situation, the given situation is in large communities of hospitals relative to what is feasible through management modifications.

I do think that there is always something that can be done in the management area, practically universally, almost any kind of institution—I guess the concern I might have is that I would not want to over-emphasize that as a source to guarantee continuation of services.

Senator JAVITS. Gentlemen, the questions I had were pointed at the association. If you would like to add anything or make any other comment, either on my questions or those of Senator Metzbaum, please do so now. We could just start at the end with Mr. Manning.

Mr. MANNING. The only thought that occurred to me, sir, is, I believe there is considerable testimony that I have read that is about to come before this committee or has already come before it, to indicate the very large proportions of these losses on patient services do flow to outpatient care.

In the city of Cleveland, we believe that 80 percent of all of those losses flow to outpatient services.

Senator JAVITS. I might tell you, if it is 80 percent in figures, our preliminary figures indicate it is about two-thirds in New York.

Mr. MANNING. I read that in the testimony, yes, sir.

Senator JAVITS. Mr. Cook, did you wish to add anything to the testimony so far given?

Mr. COOK. No; I have no other comments.

Thank you.

Senator JAVITS. Mr. Johnson?

Mr. JOHNSON. Only to say that we certainly think that local government has a role to play in support of local hospitals, particularly public hospitals; but it is clear that role is limited in terms of their ability to increase support as cost of care goes up, and therefore there may be a need to have basic commitment on the part of local government, that clearly the supplement is needed from the Federal Government.

Senator JAVITS. Gentlemen, thank you very much. You have been extremely helpful, and we are very grateful for your testimony.

The record will be kept open for a week so Mr. Manzano can supply the information.

Mr. MANZANO. Thank you.

[The following information was received for the record:]



AMERICAN HOSPITAL ASSOCIATION
444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-
WASHINGTON OFFICE

July 3, 1980

Honorable Jacob Javits
United States Senate
Washington, D.C. 20510

Dear Senator Javits

In response to your request for specific information on financially distressed hospitals, I would like to outline for you the data collection and analysis activity that AHA is presently conducting which will enable us to respond to your inquiry. This effort involves a short-term study, expected to be completed by September 15, and a long-term study, to be finished in May, 1981. Our goal is to develop an accurate analysis that will be useful to you and your colleagues on the subcommittee.

The first step in our study will be to formulate a model for analysis to include:

- 1) criteria for measuring distress
- 2) sources of distress
 - services responsible (outpatient, inpatient)
 - community characteristics
 - Organization hospital characteristics (e.g., type of hospital, bed size, occupancy rate, etc.)

By September 15, AHA will complete two phases of the study. First, we will identify a sample of hospitals that meet the criteria developed in step one. The basis for our data will be the 1978 AHA Annual Survey, the most current data available in the U.S. The 1978 results will be compared to the 1979 Annual Survey when it becomes available for analysis in August. The second phase will be to complete a survey based on a sampling of hospitals identified above, to test our methodology. Analysis of data obtained in the pilot survey will be based on the following characteristics:

- geographic location
- ownership
- type of community
- size of deficit
- services responsible (inpatient, outpatient)
- payor mix (Medicare, Medicaid, Blue Cross, etc.)
- charity care/uncompensated care
- contractual adjustments (the difference between what third parties—e.g., Medicare and Medicaid or some Blue Cross plans—pay for hospital charges for those same services)

The final step, to be completed by May 15, would be a study of all the hospitals that meet the criteria developed in step one. In case the pilot survey of September 15 is not representative of all classes of hospitals, AHA will survey all hospitals that meet the criteria of distressed hospitals.

As each of these steps is completed, AHA will make the findings available to you. I look forward to working with you and your staff on the further development of legislation.

Sincerely,

Allen J. Manzano

Allen J. Manzano
Senior Vice President



AMERICAN HOSPITAL ASSOCIATION
444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100
WASHINGTON OFFICE

July 3, 1980

Honorable Howard M. Metzenbaum
United States Senate
Washington, D.C. 20510

Dear Senator Metzenbaum:

During hearings of the Subcommittee on Health and Scientific Affairs, which you chaired last week on financially distressed hospitals, you requested our assistance in an effort to more accurately identify hospitals in financial distress. We are anxious to work with representatives of the major accounting firms, the Department of Health and Human Services (HHS), and others toward this end.

Let me say at the outset that we do not believe that the Annual Hospital Report (AHR) as recently proposed by HHS would be useful for this purpose. Because of its currently designed focus on reimbursement applications, it would not generate information concerning the nature and causes of hospital deficits.

Alternatively, we believe this identification can be addressed in a much more rapid and cost-effective manner. We, therefore, propose to create a special task force comprised of knowledgeable individuals representing HHS, the Hospital Financial Management Association, the American Institute of Certified Public Accountants, and the AHA. The purpose of this task force would be the identification of measures to assess the financial stability, liquidity, and viability of hospitals, and the data required for these financial indicators. Following completion of this task, the group would next identify existing data sources and what, if any, additional data should be collected and the most cost-efficient means of collection.

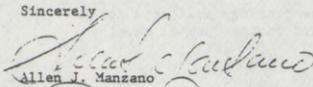
It is our belief that much, if not all, of the requisite data are currently available, primarily in the Medicare cost reports and accompanying institutional financial statements.

Most financial analysts base their assessments of financial stability on published financial statements which are included as attachments to Medicare cost reports. Our initial assumption is that hospitals could supply the data by reporting the appropriate values necessary to compute the identifying ratios and indicators from information contained in their financial statements. This would require a minimum reporting burden and cost, but would permit identification of those institutions in financial distress.

In advocating this approach, I would like to add an important caveat. It is not appropriate to delineate specific thresholds that conclusively determine whether or not an institution is financially distressed. The indicators can only be used to identify those providers that have signs of a potential financial crisis. Specific examination of individual institutions must ultimately be undertaken.

The American Hospital Association shares your commitment to develop the necessary data base to assist those hospitals in the greatest need, consistent with limited resources. We would be pleased to discuss this proposal in more detail with you or your staff at a mutually convenient time.

Sincerely


Allen J. Manzano
Senior Vice President

Senator JAVITS. Our next panel consists of Emilio Morante, chairman, Community Coalition to Save Metropolitan Hospital, New York; Virginia Ramsey, chapter chairperson, Grady Memorial, Hughes Spaulding Hospitals, Atlanta, Ga.; Judy Berek, National Union of Health and Hospital Employees, New York, N.Y.; and Lucy Brand, R.N., vice president, Michigan Nurses Association, Detroit General Hospital, Detroit, Mich.

Please take your seats.

STATEMENTS OF EMILIO MORANTE, CHAIRMAN, COMMUNITY COALITION TO SAVE METROPOLITAN HOSPITAL, NEW YORK, N.Y.; VIRGINIA RAMSEY, CHAPTER CHAIRPERSON, GRADY MEMORIAL, HUGHES SPAULDING HOSPITALS, LOCAL 1644, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, ATLANTA, GA.; AND LUCY BRAND, R.N., VICE PRESIDENT, MICHIGAN NURSES ASSOCIATION, DETROIT GENERAL HOSPITAL, DETROIT, MICH.

Ms. RAMSEY. My name is Virginia Ramsey. I am a representative of the American Federal of State, County and Municipal Employees from the International level. I work at Grady Hospital in Atlanta, Ga., and we are here in support of this bill.

We support the Javits bill because it is vital to the survival of Grady Hospital. It is vital to the lives of over a quarter million poor people in Atlanta, and we support it and ask its effectiveness immediately.

Grady Hospital is a hospital in a crisis, the only hospital for the poor in all of Atlanta, Ga., since 1892.

Grady has a current \$5 million deficit.

Grady serves 250,000 poor people each year—their only source of health care.

There are lives in danger because of Grady's financial plight. Over 5 percent of all babies born each week at Grady Hospital have to be rushed to other hospitals because there are not enough staff and equipment to care for them. There are babies that suffer long-term illnesses, such as chronic cardiopulmonary disease, babies that have to have colostomies, babies that have to have other medical attention because they are so sick, they have to be transferred out because we do not have the staff to watch these babies and take care of them as they should be cared for.

Grady is in such a financial crisis that it has already forced one area, the area of paranatal care center to shut down and merge with prenatal care center.

The patients who cannot feed themselves have lapsed into diabetic coma. Patients have suffered cardioembolisms, and patients have suffered arrests at Grady because there is not enough staff to watch after these patients.

There are husbands and wives and immediate families of patients at Grady Hospital who have to assist in their care and feeding them because their survival depends solely upon their being fed properly and cared for properly.

The staff at Grady cannot appropriately give total patient care because the census of 30 patients should be divided up equally among several employees. But a census of 30 patients has to be

divided up among three or four employees who cannot efficiently give total patient care to these many patients.

We have poor people at Grady, indigent people, who are being turned away because they cannot pay part of their medical treatment, nor can they pay for their medication. They have increased the cost of the medication and medical treatment to indigent patients at Grady because Grady is in such a financial bind and such a financial crisis.

We have poor people who have been wheeled into emergency clinics and outpatient clinics for treatment such as sickle cell anemia, people dying from sclerosis had to be wheeled out because they did not have the moneys to pay for treatment.

We have had patients to collapse into cardiac arrest outside of the doors of administration because they did not have the appropriate staff to care for them and they did not have the funds to get the kinds of treatment they needed for this kind of heart disease.

Consequently, poor people in the city of Atlanta, Fulton and DeKalb Counties, have nowhere else to go but Grady.

The tax burden is too heavy for the citizens of Georgia to continue to raise the taxes to support Grady Hospital. Cutbacks in medic-aid and hospital finances have forced Grady to deny clinic care to thousands of people. People cannot get the necessary drugs that they need to continue to survive; and the majority of these people are indigent and very poor people.

Already, over 25 percent of Fulton County's budget goes exclusively to Grady from Fulton and De Kalb Counties. Citizens are becoming more and more outraged because of their increases in tax.

They are refusing to accept a tax increase. We are understaffed horrendously at Grady. Several employees have to work 16-hour shifts, not because somebody makes them, but because we are concerned for our patients that come into Grady Hospital and have to double up on shifts to try and make sure that they get some kind of patient care, although it is not total.

Workers have lost thousands of dollars over the last 8 years to a raging 9-percent general inflation rate.

The hospital finances are so bad that pay raises have averaged 4.5 percent for each year for the past 8 years.

Senator JAVITS. May I interrupt?

I wish you would bring your statement to a close because I will have to go and vote.

Ms. RAMSEY. For 2 years, employees worked without a pay raise at all. We are asking that this bill be supported by other institutions and other hospitals.

The Javits bill is very vital to the survival of public general hospitals.

Senator JAVITS. Thank you.

Ms. RAMSEY. I would like to introduce for the record a copy of the American Federation of State, County, and Municipal Employees' statement.

Senator JAVITS. It will be received and appropriately put in the record.

[The statement referred to follows:]

American Federation of State, County and Municipal Employees
 1625 L Street, N.W., Washington, D.C. 20036
 Telephone (202) 452-4800
 Telex 89-2376

Jerry Wurf
 President
 William Lucy
 Secretary-Treasurer

STATEMENT
 OF THE
 AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES
 BEFORE THE
 SUBCOMMITTEE ON HEALTH AND SCIENCE
 COMMITTEE ON HUMAN RESOURCES
 ON AID TO FINANCIALLY DISTRESSED
 HOSPITALS

June 25, 1980

Bob Anderson
 Jefferson City, Mo.
 Dominic J. Badolato
 Berlin, Conn.
 Rev. Albert B. Blatz
 St. Peter, Minn.
 Joseph Bolj
 Richmond, Ind.
 Joseph M. Bonavita
 Boston, Mass.
 Robert A. Brindza
 Cleveland, Ohio
 Ernest B. Crofoot
 Baltimore, Md.
 Albert A. Diop
 New York, N.Y.
 Irving Flaumenbaum
 Hempstead, N.Y.
 Thomas G. Gerber, Sr.
 Eau Claire, Wisc.
 Larry Goodman
 Olympia, Wash.
 Victor Gotbaum
 New York, N.Y.
 Bob Johnson
 Garden City, Mich.
 Henry LeBer
 Baton Rouge, La.
 Gerald W. McEntee
 Harrisburg, Pa.
 Georgia M. McGhee
 Grand Rapids, Mich.
 William L. McGowan
 Albany, N.Y.
 Jack Merkel
 Trenton, N.J.
 Richard P. Morton
 New York, N.Y.
 John Siferian
 Manhattan Beach, Cal.
 Earl Stout
 Philadelphia, Pa.
 Lee A. Tafel
 Miami, Fla.
 David K. Task, Jr.
 Honolulu, Hawaii
 Maynard White
 Houston, Texas

The American Federation of State, County and Municipal Employees appreciates the opportunity to present its views on an issue of grave concern to our more than one million members -- the future of this nation's financially troubled hospitals. As representatives of more than 100,000 employees in public general hospitals, we are especially aware of the precarious condition of most public general hospitals. We applaud the efforts of Senator Javits and this Subcommittee to develop solutions to this pressing problem.

The survival of one of the most essential components of this nation's health care delivery system is in jeopardy. Public hospitals traditionally have served as hospitals of last resort for the poor, as the only place where everyone is guaranteed care regardless of their ability to pay. They provide health care to the uninsured, to residents of urban and rural medically underserved areas. And they employ many with little or no opportunity for other employment.

Yet these essential hospitals, as well as non-profit hospitals serving primarily indigent patients face the prospect of financial collapse. Their survival is threatened by recent economic trends, including spiraling inflation, cutbacks at all levels of government and increasing numbers of uninsured individuals. The root of their instability lies, of course, in the fact that they are not adequately reimbursed or reimbursed at all for so many of the services they provide.

It is becoming increasingly clear that the federal government has a responsibility to ensure the continued survival of these hospitals and the continued availability of health care for America's medically indigent.

The problem has reached such proportions that it threatens to undermine this nation's commitment, in theory at least, to provide for the health and welfare of all its citizens. Closures have already occurred and more will occur if nothing is done. Urban and rural hospitals all over the country are affected. 85 hospitals closed between 1974 and 1977. In 1977, Philadelphia lost its only public hospital. Twenty-one California county hospitals were closed or sold in the last six years. Homer G. Phillips, a hospital serving the Black community in St. Louis, closed in August 1979. Just last week Detroit decided to close its only public hospital. If not for federal aid granted this past fall, Brooklyn Jewish Hospital, an invaluable provider of health care in the low income Bedford Stuyvesant section of New York, would have closed. And Metropolitan Hospital in New York City's Harlem community was only just saved by promises of federal aid.

Other hospitals, which have yet to benefit from this kind of assistance may soon be forced to close their doors. Many

have already been forced, because of severe financial constraints, to curtail the quality and level of services. They are less able to attract medical personnel, less able to make necessary physical improvements, and less able to provide the level of services necessary for patient health and safety. The declining quality of care at these hospitals in itself merits our concern. Significantly too, however, as these hospitals deteriorate they become easy targets for closure.

Mayor Koch has not abandoned his plans to shrink the municipal hospital system. Cook County Hospital in Chicago, with 1,300 beds and 8,000 employees, was only temporarily saved by a state loan this past fall. In Los Angeles, six county hospitals with 5,000 beds and 26,000 employees are threatened with cutbacks and possible closure. Last year unreimbursed costs at these hospitals reached \$350 million -- an estimated \$80 million of which was due to undocumented aliens.

The list of affected hospitals is endless and the implications clear: without a specific program of interim emergency aid and a more fundamental restructuring of the entitlement programs, the continued availability of health care for the indigent is doubtful.

Inadequacies in the Medicare and Medicaid programs, escalating health care costs and the recent spate of state and local government cutbacks are at the root of the hospital financing crisis. Public hospitals, because they depend so heavily upon Medicare and Medicaid, because they provide care for individuals not covered by third-party payers (either private insurers or the Federal entitlement programs), and because they are so vulnerable to state and local cutbacks, are under tremendous pressure.

There are an estimated 23 million Americans without any health insurance coverage and an estimated 19 million with inadequate coverage. There are, in addition, millions of undocumented aliens, especially in many large urban areas, for whom public hospitals and certain inner-city private hospitals are the only source of health care.

Provisions allowing for reimbursement of free care, or legitimate "bad debt" are notably absent under Medicare and Medicaid. Additionally, these programs do not cover, or cover inadequately, outpatient services. Senator Javits, in developing S. 2840 and S. 2841 has rightfully recognized that the lack of adequate third-party coverage of primary care is a major cause of the growing hospital financial crisis.

State and local funding cutbacks also compound the problem. Many states are reimbursing fewer services and at lower rates in an effort to contain costs. Medicaid eligibility levels have not

been adjusted to compensate for spiraling inflation so that the number of poor people who are not covered by the program has increased and probably will continue to do so. Local governments experiencing their own fiscal crises, cannot afford to augment their subsidies to these hospitals.

Public hospitals are a vital resource in our health care delivery system. Despite federal efforts to finance health care for the poor and the aged through Medicare and Medicaid, the public hospital is the only source of care for millions of Americans. This includes the millions ineligible for Medicare and Medicaid, yet unable to afford health care.

Public general hospitals serve an especially important role as providers of primary care. With only 24 percent of all community hospital beds they account for 45 percent of all visits to outpatient departments. In inner cities this role is even more apparent: with 14.7 percent of the beds in large cities they account for 45 percent of the outpatient visits and 27 percent of the emergency visits. The outpatient departments in these hospitals have come to serve as the "family doctor" for residents of medically underserved areas.

Significantly, too, public hospitals provide a disproportionate amount of special services such as psychiatric programs, alcohol detoxification and treatment units, neonatal intensive care and burn care units.

In addition to being major trainers of health care professionals, public general hospitals are major employers, especially of minority and low-paid workers. Non-supervisory hospital employees earn considerably less than their counterparts in manufacturing. Underpaid, they are now being forced to live under the constant threat of unemployment. Often these minority and low-income workers are least able to find employment elsewhere. Especially in inner-city neighborhoods where public hospitals are practically the only employers, the effect of closure on their employees and on their community is potentially devastating. We cannot ignore the broad social costs of hospital closures. Responsible health care policy must provide for the health and welfare of the patients as well as the workers who rely on public hospitals.

The legislation introduced by Senator Javits would do much to alleviate the problems currently faced by these essential hospitals. Both S. 2840 and S. 2841 would direct assistance towards those hospitals that are the major source of essential services to indigent persons. It is clear that these hospitals will not long survive without such assistance.

The existing mechanisms for acquiring federal aid are limited and less than expeditious. The Department of Health and Human Services has limited authority to provide grants for research and demonstration projects. That authority was used to restructure

services around Brooklyn Jewish Hospital and recently the municipal hospitals in the Harlem community. S. 2840 and S. 2841 are needed to provide similar assistance in a more systematic and timely fashion. They would do so in a manner requiring state and local participation and promoting needed reforms.

The Financially Distressed Hospitals Act would provide the short-term relief necessary to ensure the continued existence of private hospitals on the brink of financial collapse. Since tax levies make it more difficult to determine when a public hospital is on the brink of financial collapse, all public hospitals incurring a deficit in their emergency room and outpatient departments and serving a large proportion of indigent patients are eligible for assistance. This provision will enable public hospitals to stay open when local governments are not able to adequately increase their contribution to hospital revenues. The bill's maintenance of effort provisions will prevent cutbacks in the present support which eligible hospitals receive from state and local governments.

Grants under this legislation will provide useful incentives towards restructuring and improving health care services at the local level. Senator Javits has wisely recognized that any changes may result in displacement for employees at the recipient hospitals. AFSCME strongly supports the provisions included in the legislations which protect employees affected by reorganization plans. These protections are an essential part of any such plans. It is important that the federal government assure, as it has in the Health Planning Amendments, that employees are not adversely affected by a federal grant program.

The grant program is absolutely necessary to ensure the survival of hospitals on the brink of closure. However, without long-term reforms, financial aid will do little more than postpone the future curtailment of services. Un-sponsored patients and inadequate coverage of outpatient services will not disappear. The reimbursement reforms provided for in the Hospital Ambulatory Services Reimbursement Act though somewhat limited, strike at the core of the hospital financing crisis. The legislation would enable Medicare and Medicaid to pay for uncovered outpatient services and a "reasonable cost" basis. Short of a more comprehensive national health insurance program, such reimbursement reforms will remove the existing penalties against those institutions serving as the family doctor in low income and medically underserved urban and rural areas.

We cannot overemphasize the urgency of the hospital financing crisis, and particularly the public hospital crisis. While the Financially Distressed Hospitals Act and Hospital Ambulatory Services Reimbursement Act do not obviate the need for more comprehensive reforms such as national health insurance, they do represent a positive first step towards saving a valuable resource and guaranteeing that all people will have access to health care.

Senator JAVITS. If you will excuse me, I will need 5 minutes to vote and then I will be right back.

The committee will recess for 5 minutes.

[Brief recess.]

Senator JAVITS. The committee will come to order.

Will you proceed, Mr. Morante.

Mr. MORANTE. In a way, much has already been said, so I do not know exactly where to start.

One of the things I want to be very careful about is when we were spoken to, some of us got the impression that what we had to do was come over here and talk about horror stories and sensationalism, and maybe that is the way we might get an ear from Senate hearings. Basically, if that is the case, what has to be done now is basically outline problems in the Harlem community that, to a greater extent, most of us know.

Senator JAVITS. May I interrupt and ask you who told you you have to give horror stories?

Mr. MORANTE. I think that is the notion. No one said that. That is what the press wants. That is the impression all of us get.

Senator JAVITS. I am sorry you had that. It is not true in this committee. Tell us what you think and what you believe.

Mr. MORANTE. In a way, in Harlem, it is pretty clear.

In the Harlem area, tuberculosis is at an epidemic rate. In the East Harlem area, it is having an alarming rise. There is an astounding rate of mental retardation, the highest rate of teenage pregnancy, along with all the problems of mental retardation; this is the whole question of malnutrition, which we tend to forget that in large urban centers, malnutrition still exists.

In the papers last year, there were articles written speaking to parents who were cutting into their food allotment in order to pay rent. It is not unusual to talk about seeing children with Coca-Cola in their milk bottles and their diets being Coca-Cola and Twinkies. We can go on and on.

There is the whole question of the medically indigent.

I was talking to a family around 6 months ago and a man was explaining to me why the metropolitan hospital is important, the fact that he has two children that have diabetes and because of insurance, you can only go to municipal hospitals because the voluntaries won't cover those and his plan does not have that type of coverage.

We can talk about a 40 to 50 percent unemployment rate, and all those people who depend on medicaid and the fact that many of the major voluntaries do not respect medicaid. We can talk on those facts.

In light of that, we talk about hospital conditions.

One, we know we have lost Sydenham as a municipal hospital. Metropolitan Hospital as a prime dispenser of services in East Harlem, we have a lack of supplies, no sheets, pajamas, no soap, no towels, no simple medication, and so on. We spoke to Mr. Rangel and convinced him to come to the hospital, and he was shocked to see there was a patient lying in one of the wards completely naked and not covered. This was a surprise visit, not a setup, a surprise visit. They did not believe it, thought we were trying to dramatize the whole situation so we can have people go and take a look.

In the past year, we have had our residency program completely decimated. What was considered one of the best programs in the Nation right now, droves of doctors have left.

In the past year, they were not given any type of assurance that the hospital would be around. A lot of those residencies would have to complete 2 years before they were eligible to complete medical education.

We have interns that knowingly were rejected from other medical institutions, not that they are incompetent, but they are not of the high quality that we had before. Still, with that we are still short by 31 doctors as of next Tuesday.

The nursing staff is difficult to recruit. Only 75 percent of the nurses that we need have been recruited.

There is a high turnover because of forced overtime. The same is true for other professional staff. The result of that is excessively long periods between appointments for patients. We have had people say, hey, I am not going back. They came there in desperate need of assistance or aid. Some are given appointments for 4 weeks. They are overworked. Other patients are given 7 months between appointments.

Discussing the Patient Advocacy Committee and the Community Advisory Board does not simply come from me.

We continue to mention it; the doctors were reprimanded around an incident that I am going to quote now. The fact is that two patients—there is documented evidence that two patients died because of the cuts in Metropolitan Hospital. They reprimanded the chief of the renal dialysis unit. The unit was eliminated because he documented that. The fact is that we had an elderly resident from East Harlem who was accustomed to going to Metropolitan Hospital to receive twice-a-week treatment in renal dialysis. They have closed it.

What happens?

They tried to send the patient to Bellevue, which is over a half hour. She was not able to make it one day. It was predictable, and the woman died.

Another one, gunshot wound. Take them to Metropolitan Hospital and find out they have no renal dialysis, and they tried to rush to Bellevue, and that person also died. We are talking about people literally dying right now.

In general, in terms of the Harlem situation—well, just take a walk to 110th Street and Lexington Avenue, walk the entire street from 116th to 125th, or maybe you can go from 116th and 118th, and you will see wall-to-wall people. We know what the unemployment rate is. Those people are dependent on Municipal Hospital. The voluntaries do not guarantee they will be serviced.

What is the situation overall?

They are actually telling us that we have excess beds. If so, what are the voluntaries building up additional beds in New York City as in the case of Mount Sinai. We have one doctor per 1,000. All this information we are aware of. We do not have any preventive services. That means 9 out of 10 times, somebody who walks into Sydenham or Harlem and gets admitted into a hospital, chances are that person is seriously ill. That is when they get admitted.

With all of that, we have had in the past 5 years 12 hospitals to close.

What I am trying to say is, it is obvious; it is documented, and if you do not want to look at the document, go and observe. There is insufficient health services in the Harlem community. That is the situation we are faced with. In light of that, recent proposals, while it gives breathing time, it was a setback. There was no need to close down Sydenham Hospital. How can you talk about not saving a hospital that perhaps needs a couple million dollars more because it serves the people who cannot pay, while \$18 million more because it serves the people who cannot pay, while \$18 million are being used to maintain a brand new hospital that has been closed for several years, Woodhall. We can continue talking about all these contradictory aspects, and yet the city continues closure of hospitals.

Commitment on the part of the Federal Government has been, as far as we are concerned, very minimal. The recent proposals have been absolutely deceptive. This is one of the reasons why we did decide that we wanted to come here to the Senate hearings, one, to support your bills, Senator Javits; and, second, to sound the alarm and to say that we have not been handed any type of solution. It is the same old thing of a question of continuously being handypandied.

Thank you.

Senator JAVITS. Thank you.

Ms. Brand?

Ms. BRAND. I am a registered nurse and first vice president of the Michigan Nurses' Association. Formerly, I was director of the intensive care unit at Detroit General Hospital, a large, emergency-care metropolitan hospital whose predominant patient population originated from the economically deprived sector.

I am pleased to have the opportunity to discuss here today an issue which is of deep concern to prospective patients and nurses across the country; that is, the detrimental impact of budgetary cuts for nursing care of patients in this institution and others like it.

At this very moment, Detroit General Hospital is closed and the city is no longer involved in the business of providing acute health care to its indigent population.

I will relate some examples of the impact of financial restraints which occurred during my 16-year tenure, and which, even at that time, indicated the future of Detroit General Hospital; its sale to a private corporation.

Decreased working capital in a health care agency has its most immediate effect upon quantities—quantities of services, quantities of providers, and quantities of supplies. Obviously, these decreases inevitably result in decreased quality, and ultimately, increased risk to patient welfare.

For example, our unit cared for six patients suffering severe trauma, major surgery, or life-threatening illness; yet, we worked for 6 to 8 years to acquire cardiac monitors for each patient. We were constantly forced to decide which patient had the most urgent need of the monitor, and which could survive without it.

Critically ill patients are high-risk candidates for complications. One of the primary functions of an intensive-care unit is provision of close observation for detection of impending crisis. Lack of appropriate equipment forced our use of secondary methods, intermittent direct auscultation and palpation. But a cry for help from a heart not in contact with an electrode or stethoscope will go undetected; a very real source of increased risk for patient welfare.

Utilization of life-support mechanisms is commonplace in intensive-care units. The most frequently used is the respirator—a machine designed to sustain those unable to breathe adequately.

There are a variety of ventilators, each one being best suited for the treatment of a specific respiratory problem. It was not unusual for us to be forced into substituting one for another that was unavailable, and it simply did not perform the job as well. This obviously meant an increased risk to the patient.

Not only did we lack urgently needed equipment, the time required for repairs on the equipment we had was extensive. There were three hypothermia units for reduction of body temperature from fever levels to normal ranges. It was not uncommon for two of the three to be tied up for repairs due to lack of funding. This necessitated implementation of primitive nursing measures not as effective, very time consuming, and extremely uncomfortable to the patient.

Due to the difficulty in acquiring new equipment and prolonged repair work time, the staff had no choice but to utilize equipment which had been repaired on a makeshift basis. For example, one of our patients was a pedestrian accident; a little 12-year-old girl who underwent a total hip and right leg amputation. She was deeply depressed, so we tried to provide some diversionary activity—a wheelchair ride. The only available wheelchair we could find required rope and adhesive tape to hold it together for support of the injured rider. This was not an unusual activity.

The deficiency of supplies was announced annually via an agency memorandum, and year after year, it read the same: "We are nearing the end of our fiscal year—as of—'til—we will be short of the following items: Suction catheters, sterile four by four dressings—et cetera."

During such a period, all personnel would involve themselves in the process of recycling disposable items. Items that could not be recycled were ordered on a short-term, small-volume, charge-account, emergency basis at costs prohibitive in comparison to large-volume purchases. More than once, our credit was terminated, driving us from vendor to vendor before finally acquiring a product.

Patient medications were ordered on a stock supply basis, rather than an individual charge. Every morning we sent our request to the pharmacy. Frequently, our afternoon delivery contained the duplicate order sheet marked "out of" after such regularly used drugs as potassium I.V., aqueous penicillin, and Levophed. Our choices were to either canvass the hospital in an attempt to borrow from other wards, or wait, hoping that the emergency order would arrive before the vendor's closing time and before our last vial was used. Either of these choices was very costly, both in terms of personnel stress and hospital dollars.

Many patient comfort supplies were not even available, and the nursing staff personally financed such items as deodorant, shaving cream, and televisions. We acquired special foods for patients with low-fat and protein blood levels and very poor appetites.

The diet kitchen was unable to meet the special request of a critically ill, poorly nourished patient who might think of how good chicken might taste that day. If it wasn't on the menu, it wasn't available.

The most critical shortage appeared in nursing personnel. Frequently, a freeze was placed on positions because of nonexistent funds. On three or four occasions, for a period of several months each, we were forced to reduce our total patient census from six to five due to insufficient numbers of nurses. This decrease in service resulted in decreased revenue and a decreased revenue meant a vicious cycle.

We implemented 10-hour days, on call schedules, and increased the number of part-time nurses in an effort to compensate. Staff were overtired, thus more susceptible to upper respiratory infections—a high-risk problem in ICU's—resulting in increased sick time, which led to an even greater shortage of personnel and increased cost for benefits.

The real impact of shortage of nursing personnel evidenced itself when I and the physician made patient rounds and tried to determine which patient could possibly survive without intensive care assistance, or if a patient might no longer benefit from intensive care, as there was another patient in need of the space.

We were both frustrated in our awareness of the unoccupied unit and the critical need for pressing it into service. We were likewise aware of the risks to which we were subjecting the patient selected for premature discharge, but our choices were severely limited.

It was a daily wartime triage decision—supposedly made in peacetime—but in reality, at war with the retreating dollars.

Hospitals denied reimbursement for services rendered to patients not able to pay and not covered by medicaid or private insurance are really up against it. As a provider of care, I am delighted that this committee is considering means of assisting such hospitals.

Thank you for the opportunity of appearing before you.

Senator JAVITS. Thank you, Ms. Brand, for the eloquence of your testimony. I similarly thank you, Ms. Ramsey; thank you, Mr. Morante. You certainly have supplied the specific detail about the misfortune, how it affects some of our citizens who have no place to go but these hospitals for absolutely essential care.

You encourage me and hearten me greatly in what I am trying to do in these bills.

Thank you very much.

Ms. BRAND. Thank you.

[The prepared statement of Ms. Brand follows:]

Testimony
on

S. 2840, Financially Distressed Hospitals Assistance Act
and
S. 2841, Hospital Ambulatory Services Reimbursement Reform Act

June 25, 1980

To
Labor and Human Resources Committee
Subcommittee on Health
U.S. Senate

By
Lucy Brand, R.N. and
First Vice President of the Michigan Nurses' Association

DETROIT GENERAL HOSPITAL, DETROIT, MICHIGAN

My name is Lucy Brand. I am a Registered Nurse and First Vice President of the Michigan Nurses' Association. Formerly, I was director of the intensive care unit at Detroit General Hospital; a large, emergency-care, metropolitan hospital whose predominant patient population originated from the economically deprived sector.

I am pleased to have the opportunity to discuss here today an issue which is of deep concern to prospective patients and nurses across the country; i.e., the detrimental impact of budgetary cuts for nursing care of patients in this institution and others like it.

At this very moment, Detroit General Hospital is closed and the city is no longer involved in the business of providing health care to its indigent population.

I will relate some examples of the impact of financial restraints which occurred during my sixteen-year tenure, and which, even at that time, indicated the future of Detroit General Hospital; its sale to a private corporation.

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Not only did we lack urgently-needed equipment, the time required for repairs on the equipment we had was extensive. There were three hypothermia units for reduction of body temperature from fever levels to normal ranges. It was not uncommon for two of the three to be tied up for repairs due to lack of funding. This necessitated implementation of primitive nursing measures not as effective, very time consuming, and extremely uncomfortable to the patient.

Due to the difficulty in acquiring new equipment and prolonged repair-work time, the staff had no choice but to utilize equipment which had been repaired on a makeshift basis. For example: One of our patients was a pedestrian accident; a little twelve-year-old girl who underwent a total hip and right leg amputation. She was deeply depressed, so we tried to provide some diversionary activity -- a wheelchair ride. The only

wheelchair we could find required rope and adhesive tape to hold it together for support of the injured rider. *This was not an unusual activity*
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Thank you for the opportunity of appearing before you.

Senator JAVITS. Our next witnesses are Mark Ravenscraft, and John B. DeHoff.

Could you limit your statement to 10 minutes, Mr. Ravenscraft? Also, I do not know whether you were here when Senator Metzbaum said you were a personal friend and he wished to extend his respects to you. He said he had to do something else at this moment.

STATEMENTS OF MARK RAVENSCRAFT, CHAIRMAN, HEALTH AND EDUCATION STEERING COMMITTEE, NATIONAL ASSOCIATION OF COUNTIES, AKRON, OHIO; AND JOHN D. DeHOFF, COMMISSIONER OF HEALTH, CITY OF BALTIMORE, REPRESENTING THE CONFERENCE OF MAYORS

Mr. RAVENSCRAFT. Thank you, Senator, and members of the committee staff.

I particularly am pleased that the committee has afforded me an opportunity on behalf of the National Association of Counties to appear before you.

My name is Mark Ravenscraft, commissioner of Summit County, Ohio. I am also chairman of the health policy committee of the National Association of Counties.

Mr. Chairman, we are very heartened by today's hearing and the introduction of S. 2840 and S. 2841, to aid financially distressed hospitals. The need for financial assistance by many of our public-general and other inner-city hospitals is an immediate and urgent concern of our association's membership.

Certainly, the comments expressed by the committee, Senator, and also the concern expressed by the staff we have worked with indicate a certain command of knowledge of this problem and we are very appreciative.

According to data published in 1977 by the Hospital Research and Education Trust, some 750 of our Nation's 1905 public hospitals are county owned and partially supported by local tax revenues, and another 61 public hospitals are owned jointly under a city/county arrangement.

An additional 518 public hospitals are partially financed by local public funding, through local hospital district revenues. Counties are, therefore, directly responsible for operating and financing over 40 percent of all public hospitals.

Indirectly through the taxing authority of hospital districts, counties have an interest in the revenue requirements of an additional 25 percent of public hospitals. I might just note here that in the drafts of the bills that I have, the National Advisory Council to be established under the bill does not provide for local official representation. We urge that local officials be included, since their involvement is crucial, to ensure adequate financial support.

Public hospitals are the major focal point for the delivery of health care to our Nation's poor and indigent. But in many communities, rural and urban, they are also centers for tertiary care, providing a wide range of special services for all residents. Our hospitals also have a major role in the education of physicians, training nearly 40 percent of this Nation's interns and residents. Their role in rural areas is even broader, where half of all public

hospitals are located and where half of these are the only hospitals in the counties they serve.

These are heavy responsibilities, which we take very seriously, and about which we have serious concerns. But we have often found ourselves wondering whether that responsibility is as seriously taken by others as well. Certainly, the holding of this hearing and introduction of this legislation is a positive note.

It is no secret that public hospitals—and other hospitals serving predominantly poor patients—have not fared well in our system of health care delivery and financing.

A lack of reimbursement for services rendered is, of course, the basic problem. But beyond that, our systems of reimbursement have artificially increased overall costs and utilization of institutional services, thereby lending this Nation's capacity to extend health care coverage to more of our poor.

Medicaid eligibility levels have fallen far behind the inflationary spiral.

In Cook County, the proportion of patients certified as eligible for medicaid has declined from 62 percent in 1973, to 22 percent this year. The income eligibility level for a family of four is now \$4,200 per year, equivalent to \$80 per week. The U. S. poverty level for a family of four is \$8,200. Regulatory policies and levels of reimbursement have followed this trend, further undermining support for public facilities and their capacity to serve their patients.

I might note at this time my reaction to some of the things said by Undersecretary Stark in his testimony this morning. We of course were very pleased yesterday that the administration announced plans to implement demonstration projects as a way of beginning to address these concerns as an interim measure before the adoption of the National Health Plan.

It was also announced by the administration that there would be additional funding made available for financially distressed hospitals in fiscal year 1982.

We are very pleased that the administration plans to address the issue this year and has in fact initiated two such projects in New York City. However, no funding levels have been specified, and at present, we do not know the degree to which the administration proposal would address the needs of hospitals currently experiencing financial stress.

If no funding is being requested, the administration approach would be complementary to the proposals we are addressing today.

We are also somewhat concerned by the Secretary's reference to cutbacks in local funding for public hospitals. We believe this is not the rule by any means.

Several months ago, in an effort to determine the degree of local funding for public hospitals, our organization undertook a limited survey. We did so with our own resources, because that data was otherwise unavailable.

Perhaps the department has since gathered such information, and indeed, Mr. Stark referred to certain conclusions reached by the task force appointed by the Secretary, but most of the counties that provided us with data showed the amount of local taxes going to public hospitals has increased substantially, doubling and tripling county contributions over the last decade.

I must emphasize that our survey results were far from conclusive, but I think it calls into question the blanket statement that local governments have cut their support for public hospitals.

We stand ready to refute that and we welcome the opportunity to discuss that with the administration officials. We hope this matter can be clarified, and it certainly highlights the need for conclusive data.

Clearly, it is a difficult situation on all sides. Our system of financing is out of control. At the county level, we are bearing the full brunt of it on a daily basis, coping with the problems created by the system itself.

From this vantage point, we see that the public hospital is being bled to death. It is their responsibility to provide services to people without reimbursement and to provide services for which there is no reimbursement at all. Added to that is the fact that levels of reimbursement are inadequate to meet the real costs of service.

There is no way that local taxes can keep up, even if we increase our contributions to these public general hospitals. Sometimes we wonder why we do not just give up the struggle and, indeed, the sad fact is, the committee has heard this morning, some have done just that.

Several months ago, in an effort to address the concerns of financially distressed public hospitals, and to assist in formulating some answers, our organization convened a group of public hospital administrators and local officials to meet with staff of this subcommittee and other congressional staff members.

I would like to add a note of thanks for the response that we received from the committee staff and from individual Senate staff people.

As you might imagine, the depth of frustration and concern expressed by those representing the public sector during that meeting was considerable. The top administrators of some 15 hospitals from around the country, including New York City, Los Angeles, Cook County, Dade County (Miami), Wayne County (Detroit), cleared their calendars and came to Washington on little more than a week's notice.

On that day, it did not take long for the issues and a series of recommended action to emerge from the discussion. Optimistically, recommendations were formulated to address both short-term and long-term needs. Emergency grants and reimbursement reforms, measures similar to those proposed by Senator Javits, topped the list, to address the most pressing of financial needs.

There followed a list of broader measures to address the long-term needs for relief and reform, some of which had previously been recommended by the Commission on Public General Hospitals under the auspices of the American Hospital Association several years ago.

Today, the needs for relief and reform are even more acute than they were when the commission issued its report.

Therefore, the National Association of Counties can do nothing less than pledge its full support to achieve passage of the two bills which are the subject of today's hearing. But we are realistic, too, and quite frankly, we wonder where the necessary funding will come from. For as small as the total amount is relative to the

enormity of the task involved and the positive benefits that would result, we are keenly aware of the current mood in Washington.

I say this not to negate or backtrack in any way on our commitment of support, but to request your support for an additional measure which might be readily adopted by this Congress to assist public hospitals, possibly as an amendment to H.R. 934, which has been reported by the Senate Finance Committee.

This measure would amend the Social Security Act by removing the restriction on the proportion of medicare and medicaid enrollees in publicly sponsored HMO's. Data analyzed by an HHS/HCFAs-funded section 222 demonstration project in California has shown that medicaid costs can be reduced by an average of 15 percent under HMO and prepaid health plans in contracts.

The current restriction on Medicaid and Medicare enrollees was originally enacted in relation to concerns involving private HMO plans, and should not be applied to the public sector. We believe that this change would be of assistance to public hospitals and their patients and would also be in the interests of reducing overall health care costs in the public sector.

We look forward to working with you, Senator Javits, to achieve the adoption of these short- and long-range reform measures which are so urgently needed. We are in a state of desperate need at the present time and we salute you for recognizing that.

Thank you very much.

[The prepared statement of Mr. Ravenscraft follows:]



National Association of Counties

Offices • 1735 New York Avenue N.W., Washington, D.C. 20006 • Telephone 202/783-5113

STATEMENT OF
THE HONORABLE MARK RAVENSCRAFT
COMMISSIONER
SUMMIT COUNTY, OHIO
ON BEHALF OF THE
NATIONAL ASSOCIATION OF COUNTIES
BEFORE THE
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
COMMITTEE ON LABOR AND HUMAN RESOURCES
JUNE 25, 1980
WASHINGTON, DC 20006

STATEMENT OF THE HONORABLE MARK RAVENSCRAFT, COMMISSIONER, SUMMIT COUNTY, OHIO, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES*, BEFORE THE SUB-COMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES.

THANK YOU, MR. CHAIRMAN. I AM MARK RAVENSCRAFT, COMMISSIONER OF SUMMIT COUNTY, OHIO. I AM ALSO CHAIRMAN OF THE HEALTH POLICY COMMITTEE OF THE NATIONAL ASSOCIATION OF COUNTIES.

MR. CHAIRMAN, WE ARE VERY HEARTENED BY TODAY'S HEARING AND THE INTRODUCTION OF S. 2840 AND S. 2841 TO AID FINANCIALLY DISTRESSED HOSPITALS. THE NEED FOR FINANCIAL ASSISTANCE BY MANY OF OUR PUBLIC-GENERAL AND OTHER INNER-CITY HOSPITALS IS AN IMMEDIATE AND URGENT CONCERN OF OUR ASSOCIATION'S MEMBERSHIP.

ACCORDING TO DATA PUBLISHED IN 1977 BY THE HOSPITAL RESEARCH AND EDUCATIONAL TRUST, SOME 750 OF OUR NATION'S 1905 PUBLIC HOSPITALS ARE COUNTY-OWNED AND PARTIALLY SUPPORTED BY LOCAL TAX REVENUES, AND ANOTHER 61 PUBLIC HOSPITALS ARE OWNED JOINTLY UNDER A CITY/COUNTY ARRANGEMENT. AN ADDITIONAL 518 PUBLIC HOSPITALS ARE PARTIALLY FINANCED BY LOCAL PUBLIC FUNDING, THROUGH LOCAL HOSPITAL DISTRICT REVENUES. COUNTIES ARE, THEREFORE, DIRECTLY RESPONSIBLE FOR OPERATING AND FINANCING OVER 40% OF ALL PUBLIC HOSPITALS. INDIRECTLY THROUGH THE TAXING AUTHORITY OF HOSPITAL DISTRICTS COUNTIES HAVE AN INTEREST IN THE REVENUE REQUIREMENTS OF AN ADDITIONAL 25% OF PUBLIC HOSPITALS. I MIGHT JUST NOTE HERE THAT THE DRAFTS OF THE BILLS THAT I HAVE REFER ONLY TO MUNICIPALITIES, AND THAT THE NATIONAL ADVISORY COUNCIL TO BE ESTABLISHED DOES NOT PROVIDE FOR LOCAL OFFICIAL REPRESENTATION, I ASSUME THAT THESE WERE MERELY OVERSIGHTS.

*NACO IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN AMERICA. ITS MEMBERSHIP INCLUDES URBAN, SUBURBAN, AND RURAL COUNTIES JOINED TOGETHER FOR THE COMMON PURPOSE OF STRENGTHENING COUNTY GOVERNMENT TO MEET THE NEEDS OF ALL AMERICANS. BY VIRTUE OF A COUNTY'S MEMBERSHIP, ALL ITS ELECTED AND APPOINTED OFFICIALS BECOME PARTICIPANTS IN AN ORGANIZATION DEDICATED TO THE FOLLOWING GOALS: IMPROVING COUNTY GOVERNMENT; SERVING AS THE NATIONAL SPOKESMAN FOR COUNTY GOVERNMENT; ACTING AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT; AND, ACHIEVING PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

PUBLIC HOSPITALS ARE THE MAJOR FOCAL POINT FOR THE DELIVERY OF HEALTH CARE TO OUR NATION'S POOR AND INDIGENT. BUT, IN MANY COMMUNITIES, ^{rural areas} THEY ARE ALSO CENTERS FOR TERTIARY CARE, PROVIDING A WIDE RANGE OF SPECIAL SERVICES FOR ALL RESIDENTS. OUR HOSPITALS ALSO HAVE A MAJOR ROLE IN THE EDUCATION OF PHYSICIANS, PROVIDING TRAINING FOR NEARLY 40% OF THIS NATION'S INTERNS AND RESIDENTS. THEIR ROLE IN RURAL AREAS IS EVEN BROADER, WHERE HALF OF ALL PUBLIC HOSPITALS ARE LOCATED AND WHERE HALF OF THESE ARE THE ONLY HOSPITALS IN THE COUNTIES THEY SERVE.

THESE ARE HEAVY RESPONSIBILITIES WHICH WE TAKE VERY SERIOUSLY, AND ABOUT WHICH WE HAVE SERIOUS CONCERNS. BUT SOMETIMES WE WONDER WHETHER THAT RESPONSIBILITY IS AS OF SERIOUS CONCERN TO OTHERS AS WELL.

IT IS NO SECRET THAT PUBLIC HOSPITALS--AND OTHER HOSPITALS SERVING PREDOMINANTLY POOR PATIENTS--HAVE NOT FARED WELL IN OUR SYSTEM OF HEALTH CARE DELIVERY. A LACK OF REIMBURSEMENT FOR SERVICES RENDERED IS, OF COURSE, THE BASIC PROBLEM. BUT BEYOND THAT, OUR SYSTEMS OF REIMBURSEMENT HAVE ARTIFICIALLY INCREASED OVERALL COSTS AND UTILIZATION OF INSTITUTIONAL SERVICES--THEREBY LIMITING THIS NATION'S CAPACITY TO EXTEND HEALTH CARE COVERAGE TO ~~MORE OF OUR POOR.~~ MEDICAID ELIGIBILITY LEVELS HAVE FALLEN FAR BEHIND THE INFLATIONARY SPIRAL. IN COOK COUNTY (CHICAGO) THE PROPORTION OF PATIENTS CERTIFIED AS ELIGIBLE FOR MEDICAID HAS DECLINED FROM 62% IN 1973 TO 22% THIS YEAR. THE INCOME ELIGIBILITY LEVEL FOR A FAMILY OF FOUR IS NOW \$4200 PER YEAR (EQUIVALENT TO \$80 PER WEEK). THE U.S. POVERTY LEVEL FOR A FAMILY OF FOUR IS \$8200. REGULATORY POLICIES AND LEVELS OF REIMBURSEMENT HAVE FOLLOWED THIS TREND, FURTHER UNDERMINING SUPPORT FOR PUBLIC FACILITIES AND THEIR CAPACITY TO SERVE THEIR PATIENTS.

CLEARLY, IT IS A DIFFICULT SITUATION ON ALL SIDES. IT IS A SYSTEM OUT OF CONTROL. AT THE COUNTY LEVEL, WE ARE BEARING THE FULL BRUNT OF IT ON A DAILY BASIS, COPING WITH THE PROBLEMS CREATED BY THE SYSTEM ITSELF. FROM THIS VANTAGE POINT, WE SEE THAT THE PUBLIC HOSPITAL IS BEING BLED TO DEATH. IT IS THEIR RESPONSIBILITY TO PROVIDE SERVICES TO PEOPLE WITHOUT REIMBURSEMENT AND TO PROVIDE MANY SERVICES FOR WHICH THERE IS NO REIMBURSEMENT AT ALL/ADDED TO THAT IS THE FACT THAT LEVELS ARE, AS I NOTED A MOMENT AGO, INADEQUATE TO MEET THE REAL COSTS OF SERVICE. THERE IS NO WAY THAT LOCAL TAXES CAN KEEP UP. SOMETIMES WE WONDER WHY WE JUST DON'T GIVE UP THE STRUGGLE--AND SOME, OF COURSE, HAVE TRIED JUST THAT APPROACH. BUT WE KNOW THE PRIVATE SECTOR TO A LARGE EXTENT CANNOT, AND MANY CASES, WILL NOT, MEET THE NEEDS OF THE POOR FOR OUR SERVICES.

SEVERAL MONTHS AGO, IN WHAT I CAN ONLY NOW TERM A "VALIANT EFFORT" TO ADDRESS THE CONCERNS OF FINANCIALLY DISTRESSED PUBLIC HOSPITALS, AND TO ASSIST IN FORMULATING SOME ANSWERS, OUR ORGANIZATION CONVENED A GROUP OF PUBLIC HOSPITAL ADMINISTRATORS AND LOCAL OFFICIALS TO MEET WITH STAFF OF THIS SUBCOMMITTEE AND OTHER CONGRESSIONAL STAFF MEMBERS.

AS YOU MIGHT IMAGINE, THE DEPTH OF FRUSTRATION AND CONCERN EXPRESSED BY THOSE REPRESENTING THE PUBLIC SECTOR DURING THAT MEETING WAS CONSIDERABLE. THE TOP ADMINISTRATORS OF SOME FIFTEEN HOSPITALS FROM AROUND THE COUNTRY, INCLUDING NEW YORK CITY, LOS ANGELES, COOK COUNTY, DADE COUNTY (MIAMI), WAYNE COUNTY (DETROIT), CLEARED THEIR CALENDARS AND CAME TO WASHINGTON ON LITTLE MORE THAN A WEEK'S NOTICE.

ON THAT DAY, IT DID NOT TAKE LONG FOR THE ISSUES AND A SERIES OF RECOMMENDED ACTIONS TO EMERGE FROM THE DISCUSSION. OPTIMISTICALLY, RECOMMENDATIONS WERE FORMULATED TO ADDRESS BOTH SHORT-TERM AND LONG-TERM NEEDS. EMERGENCY GRANTS AND REIMBURSEMENT REFORMS, MEASURES SIMILAR TO THOSE PROPOSED BY SENATOR JAVITS TOPPED THE LIST, TO ADDRESS THE MOST PRESSING OF FINANCIAL

NEEDS. THERE FOLLOWED A LIST OF BROADER MEASURES TO ADDRESS THE LONG-TERM NEEDS FOR RELIEF AND REFORM, SOME OF WHICH HAD PREVIOUSLY BEEN RECOMMENDED BY THE COMMISSION ON PUBLIC GENERAL HOSPITALS UNDER THE AUSPICES OF THE AMERICAN HOSPITAL ASSOCIATION SEVERAL YEARS AGO.

TODAY, THE NEEDS FOR RELIEF AND REFORM ARE EVEN MORE ACUTE THAN THEY WERE WHEN THE COMMISSION ISSUED ITS REPORT. YET THE PROSPECTS FOR IMMEDIATE ASSISTANCE--WHICH SEEMED AT LEAST A REMOTE POSSIBILITY FOR THIS CONGRESS SEVERAL MONTHS AGO--NOW APPEAR TO BE DIM, SINCE THE LAST ROUND OF BUDGET-CUTTING BY THE ADMINISTRATION AND THE CONGRESS.

AS YOU KNOW OUR ORGANIZATION HAS SUPPORTED THE PRINCIPLE OF ACHIEVING A BALANCED BUDGET. BUT IN SO DOING WE HAVE ALSO RECOGNIZED THAT IS SHORT-SIGHTED AT BEST TO SEEK CUTBACKS IN ESSENTIAL HEALTH AND SOCIAL SERVICES, PARTICULARLY IN ECONOMIC TIMES SUCH AS THESE. SUCH SHORT-TERM SAVINGS CAN ONLY RESULT IN THE CONTINUED CRIPPLING OF OUR HEALTH CARE SYSTEM AND HIGHER LONG-TERM COSTS, MEASURED BOTH IN DOLLARS AND IN HUMAN LIVES.

THEREFORE, THE NATIONAL ASSOCIATION OF COUNTIES CAN DO NOTHING LESS THAN PLEDGE ITS FULL SUPPORT TO ACHIEVE PASSAGE OF THE TWO BILLS WHICH ARE THE SUBJECT OF TODAY'S HEARING. BUT WE ARE REALISTIC TOO, AND QUITE FRANKLY, WE WONDER WHERE THE NECESSARY FUNDING WILL COME FROM. FOR AS SMALL AS THE TOTAL AMOUNT IS RELATIVE TO THE ENORMITY OF THE TASK INVOLVED AND THE POSITIVE BENEFITS THAT WOULD RESULT, WE ARE KEENLY AWARE OF THE CURRENT MOOD IN WASHINGTON.

I SAY THIS NOT TO NEGATE OR BACKTRACK IN ANY WAY ON OUR COMMITMENT OF SUPPORT, BUT TO REQUEST YOUR SUPPORT FOR AN ADDITIONAL MEASURE WHICH MIGHT BE READILY ADOPTED BY THIS CONGRESS TO ASSIST PUBLIC HOSPITALS, POSSIBLY AS AN AMENDMENT TO H.R. 934, WHICH HAS BEEN REPORTED BY THE SENATE FINANCE COMMITTEE.

THIS MEASURE WOULD AMEND THE 1972 SOCIAL SECURITY AMENDMENTS BY REMOVING THE RESTRICTION ON THE PROPORTION OF MEDICARE AND MEDICAID ENROLLEES IN PUBLICLY-SPONSORED HMO'S. AN HHS/HCFA-FUNDED SECTION 222 DEMONSTRATION PROJECT IN CALIFORNIA HAS SHOWN THAT MEDICAID COSTS CAN BE REDUCED BY AN AVERAGE OF 15 PERCENT UNDER HMO AND PREPAID HEALTH PLAN IN CONTRACTS. THE CURRENT RESTRICTION ON MEDICAID AND MEDICARE ENROLLEES WAS ORIGINALLY ENACTED IN RELATION TO CONCERNS INVOLVING PRIVATE HMO PLANS, AND SHOULD NOT BE APPLIED TO THE PUBLIC SECTOR. WE BELIEVE THAT THIS CHANGE WOULD BE OF ASSISTANCE TO PUBLIC HOSPITALS AND THEIR PATIENTS AND WOULD ALSO BE IN THE INTERESTS OF REDUCING OVERALL HEALTH CARE COSTS IN THE PUBLIC SECTOR.

WE LOOK FORWARD TO WORKING WITH YOU, MR. CHAIRMAN, TO ACHIEVE THE ADOPTION OF THESE SHORT AND LONG-RANGE REFORM MEASURES WHICH ARE SO URGENTLY NEEDED.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY.

Senator JAVITS. Thank you very much.

I am sure Senator Metzenbaum would express great satisfaction with this testimony.

Dr. DeHoff?

Dr. DEHOFF. I am Commissioner of Health for Baltimore City. I am president of the U.S. Conference of City Health Officers, which is an element of the U.S. Conference of Mayors.

The U.S. Conference of Mayors knows how valuable are the general hospitals which its cities operate under difficult circumstances.

Public general hospitals have been scapegoated by consistent underfunding and progressive neglect. Staffs have dwindled in number and in quality. Buildings and equipment are obsolescent or worn out. Newer regulations have not been understood by other municipal support staffs. Governance groups have not adjusted to changes in a complex health care delivery system. Various governmental funding sources have not increased payments needed to maintain solvency.

The U.S. Conference of Mayors has been deeply concerned over the deterioration of large public hospitals, and welcomes legislation to improve their funding. Mayors approach this issue with a unique perspective.

As the chief representatives of community interests, they advocate easy access to available medical care. Mayors are responsible for administration of some 250 public hospitals and for provision of public health services through hundreds of local health departments. Their concerns also include the economic health of their communities. Maintenance of a tax base encouraging development of business and job opportunities, and insuring a balanced budget, are issues here.

Decisions are not easily made to close or to keep open public hospitals, or to transfer them to organizations over which mayors have no control, or to purchase services in other hospitals. Nor

have the benefits from any of these decisions been sufficiently clear cut or predictable to provide guidance.

Chains of events which lead to closure or to transfer vary from hospital to hospital. Although insolvency is the cause, it has resulted in large part from a welfare image, and a resistance of all governments to provide full ranges of broad support which successful hospital operation today requires. Adequate dollars to meet these acknowledged goals and good management will reduce the substantially and recurring deficits which are so troublesome.

Likewise, municipal hospitals do succeed when transferred to another management more oriented to business management. They also continue to be expensive. Nonetheless, the benefit of lower cost to the city or improved service to large numbers of poor and near poor cannot be guaranteed.

Private or some voluntary hospitals find it easy to avoid costly or nonreimbursable-patient problems. Not so, the municipal hospitals. Mayors find it impossible to avoid providing care to the gray-area indigents, the legal refugees or undocumented aliens, or the long-term dirty hospital cases. Other general hospitals, which used to refer most charity patients to city hospitals, now find them well covered by medicare or other insurance, and the public hospital is denied these needed sources of income.

Public general hospitals do have a unique mission which normal hospital income cannot support. Most cities have accepted a deficit in hospital operation as their obligation for the care of poor people. Growing concentrations of poor person in cities, continued influx of refugees, better care by voluntary hospitals for paid-up patients, and increased cost of hospital-based ambulatory and emergency care are nonetheless causing some mayors to rethink responsibility for this health resource.

If the budget tradeoff results in hospital closure, three to four employees per hospital bed are laid off, poor persons receive less care or that which is more expensive, a building complex is razed, and the city is that much weaker to respond to its citizen needs.

The closure of each municipal general hospital is a sad event, especially in light of the prosperity of voluntary or teaching hospitals in the same city.

The U.S. Conference of Mayors strongly supports this legislation, and wishes to offer several suggestions:

One, immediately determine how many urban hospitals are nearing intolerable insolvency;

Two, recommend effective management techniques and policies for municipal general hospitals, including relief from outside interference;

Three, insist on modern collection management to improve income;

Four, assure a fair distribution of low-pay patients through Hill-Burton regulations;

Five, participate in cost containment, but assure management payment for accepted cost;

Six, encourage less expensive but suitably reimbursed ambulatory care away from the hospital, in partnership with the municipal health department;

Seven, consider closure or conversion only after careful study by the local government and planning agencies;

Eight, expand health department preventive services and ambulatory care;

Nine, certify public hospitals by an independent accounting firm, as required for hospitals [9(a)(1)(D)];

Ten, a national health program covering current gaps in the medical service system would answer problems of hospital financing. Special attention must be given to prevention programs delivered in city hospitals and in local health departments;

Eleven, a government policy should maintain and strengthen facilities serving the poor. That policy should contain two features:

a. Entitlement coverage should include a wider range of services. Inequities between inpatient and outpatient services should be eliminated. Reimbursement must reflect true service costs.

b. Public hospitals serving the poor and indigent should receive Federal subsidies based on the percent of complicated cases and indigent served.

The U.S. Conference of Mayors and its affiliate, the U.S. Conference of City Health Officers, will be pleased to continue working with this subcommittee in tackling one of the major health problems facing local governments today.

Senator JAVITS. Thank you, Dr. DeHoff.

Thank you both, gentlemen.

In view of the time limitation, will you answer written questions addressed to you?

Dr. DEHOFF. Delighted.

Senator JAVITS. The record will be held open then for 1 week so that questions may be submitted and answered.

[The prepared statement of Dr. DeHoff along with additional material submitted for the record follows:]



UNITED STATES CONFERENCE OF MAYORS

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FINANCIALLY DISTRESSED HOSPITALS

Statement before the Senate Subcommittee on Health
and Scientific Research

On behalf of The United States Conference of Mayors
and The United States Conference of City Health Officers

By

John B. De Hoff, MD, MPH
Commissioner of Health for Baltimore
President, United States Conference of City Health Officers

25 June 1980

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4. Assure a fair distribution of low-pay patients through Hill-Burton regulations.
5. Participate in cost-containment, but assure management payment for accepted costs.
6. Encourage less expensive but suitably reimbursed ambulatory care away from the hospital, in partnership with the municipal health department.
7. Consider closure or conversion only after careful study by the local government and planning agencies.
8. Expand health department preventive services and ambulatory care.
9. Certify public hospitals by an independent accounting firm, as required for other hospitals [(a) (1) (D)].
10. A National Health Program covering current gaps in the medical service system would answer problems of hospital financing. Special attention must be given to prevention programs delivered in city hospitals and in local health departments.

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11. A government policy should maintain and strengthen facilities serving the poor. That policy should contain two features:
 - a. Entitlement coverage should include a wider range of services. Inequities between inpatient and outpatient services should be eliminated. Reimbursement must reflect true service costs.
 - b. Public hospitals serving the poor and indigent should receive federal subsidies based on the percent of complicated cases and indigents served.

The US Conference of Mayors and its affiliate, the US Conference of City Health Officers, will be pleased to continue working with this Subcommittee in tackling one of the major health problems facing local governments today.

**association of american
medical colleges**JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

202: 828-0460

July 10, 1980

Honorable Edward M. Kennedy
Chairman, Subcommittee on Health and
Scientific Research
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

In response to the invitation made by yourself and Senator Javits in recent correspondence to me, the Association of American Medical Colleges (AAMC) appreciates this opportunity to submit its comments and viewpoints for the hearing record on S. 2840--"The Financially Distressed Hospitals Assistance Act" and S. 2841--"The Hospital Ambulatory Services Reimbursement Reform Act."

The hearing is of special interest and concern to the Association because the outpatient departments, clinics and emergency rooms of the 420 institutions that comprise its Council of Teaching Hospitals (COTH) are the only point of entry to the health care system for many indigent and "working poor" patients, and often serve as the principal source of care in their communities. COTH members account for 18 percent of the admissions and approximately 30 percent of the ambulatory services provided by non-federal short-term hospitals in the nation. In addition to 37 major city or county hospitals, the Council's membership includes most of the large, urban, and university hospitals recognized for their long-standing traditions of accepting the burden for charity or uncompensated care for the poor. While poverty is certainly not restricted to urban areas, it is recognized that a majority of its victims reside in cities and often cannot pay for the hospital services they use. Thus, the financial distress which is plaguing many, primarily urban, hospitals is of direct concern to the membership of the AAMC, whose outpatient and emergency room facilities have become the "family doctor" of indigent inner-city residents.

The Association agrees that federal action is necessary if the dilemma facing these financially troubled institutions is to be adequately addressed before the roots of the problem grow more deeply entrenched within our health care system. Without such action, the AAMC fears that the continued fiscal deterioration of these hospitals can only lead to erosion in the quality of care provided to a significant segment of our populace, the discontinuance of medical education and community programs in areas where they are of greatest need, the loss of countless jobs among hospital personnel in areas where the levels of unemployment are among the highest already, and ultimately the demise of essential services and facilities due to bankruptcy.

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THE ROLES OF URBAN AND RURAL HOSPITALS

Over the past quarter century, the proportion of the indigent and "working poor" populating the neighborhoods of the nation's major cities has generally increased. These people historically have been dependent for their medical care primarily on the short-term general hospitals in or near the neighborhoods in which they reside. The hospitals serving these people usually fall into one of two general categories: (1) public general hospitals which were originally established to provide care for the indigent and are operated by a local unit of government or a special public governing body and (2) voluntary nonprofit hospitals who have traditionally accepted responsibility to provide access to health services to all members of their communities.

Both of these types of institutions provide essential inpatient and outpatient care for the medically indigent. In the inner-city, such hospitals are not only often the major providers of primary care, but also function as the center for trauma and intensive care. Aside from traditional medical services, these institutions also commonly serve as community-based mental health centers, operate alcohol and drug abuse treatment programs, offer family counseling services, sponsor health education and information outreach programs, and directly refer patients to social and legal service programs. In addition, these institutions also frequently have a major commitment to specialized tertiary care and to the training of medical and allied health manpower. Thus, the urban hospital often serves an area larger than its immediate community although for the population in its proximate vicinity it is undeniably an irreplaceable resource.

Though generally smaller than most urban hospitals, many rural hospitals display similar characteristics to those described above. Because of the isolated settings in which they serve, rural hospitals must also function as sole community providers, fulfilling both a medical and social role for their service populations. These populations are often highly comprised of medically indigent patients, reflecting the generally low per capita income levels found in rural communities.

NATURE OF THE PROBLEM

Despite the vital contributions being made by public and private urban and rural hospitals to the health and welfare of their communities, many of these institutions are facing serious financial difficulty. Certainly inflation and the increase costs of labor, energy, and malpractice coverage are taking their toll on these hospitals. However, the underlying root of their current financial throes is the large and ever-increasing volume of care they provide to the medically indigent--the poor, the working poor, the unemployed, migrant workers, undocumented aliens, and refugees who have settled in urban and rural areas. The fact that these patients often suffer the consequences of inadequate diet, in-availability of prenatal care, insufficient health prevention services, limited education, and the generally worsening socio-economic condition of their communities, often creates the need for more extensive and costlier treatment from their area hospitals. Thus, these hospitals must care for more and more patients who do not have health insurance or are unable to pay for health care services from their own resources. The public programs established to assist these

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individuals provide inadequate coverage, frequently reimburse at "below cost" rates, and in many cases have restrictive eligibility standards. At the "bottom line" then, are institutions providing care to these patients but not receiving sufficient payment to cover their operating expenditures.

In the past, public general hospitals relied on sources other than patient payments to fund deficits resulting from the treatment of patients who could not pay. For example, most could rely on local governments to cover hospital deficits from tax revenues. Times have changed, however, and local governments are now facing shrinking tax bases along with escalating costs for providing basic services. The resulting "belt-tightening" has led many local officials to be less willing to extend or realign their budgets to meet the growing fiscal requirements of operating public general hospitals. Proposed cutbacks in federal revenue sharing and many other aid programs for local governments will further contribute to the inability of local communities to live within their budgets. Therefore, public general hospitals may well suffer directly from the shift in federal policy towards a balanced budget. Clearly, the public general hospital is caught in a bind. Its costs are increasing dramatically, while its traditional primary source of funding is growing either more reluctant or less able to meet the requirements for furnishing quality hospital services to its indigent population.

The voluntary nonprofit hospitals in many urban areas around the nation face a similar situation with traditional sources of funding for charity care shrinking as well. Historically, these institutions relied on paying patients and philanthropy to support costs of providing uncompensated and partial pay care to the medically indigent. Currently, the proportion of patients for whom payment is made on a cost basis has increased to the point where a very small number of "full charge" paying patients can no longer be expected to subsidize this uncompensated care. Additionally, changing demographic patterns have increased the proportion of medically indigent in many areas, while the hospitals treating them have experienced a reduction in the number of private, self-pay patients who pay full charges as described above.

A further critical factor in the changing demographic patterns of communities which both public and private hospitals serve is the influx of illegal and undocumented aliens who come to the United States with extremely limited personal resources. These aliens are not eligible for Medicare or Medicaid, nor are they covered by private health insurance. With no existing federal policy on providing health care for these people, the responsibility for their medical care by default has been left to the public and private hospitals located where these individuals live or work. These institutions cannot recover the cost for this care, and both local governments and the governing boards of private hospitals are finding it more difficult to find the funds to finance this care. The financial plight faced by these institutions is by no means exclusively an urban phenomenon. The level of uncompensated care provided in rural institutions is substantial due to the fact that the percentage of individuals in rural communities without any health insurance coverage is significantly higher than that for the population as a whole.

Of particular concern to the Association is the effect of the fiscal stringencies on graduate medical education programs. In many cases, the residency training programs in such institutions have been able to attract only foreign medical graduates, a phenomenon which in tandem with the financial crisis jeopardizes standards of education and patient care.

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POSSIBLE SOLUTIONS

The financial problems these institutions face cannot be attributed merely to poor management or inefficiency. These hospitals are facing overwhelming financial problems which cannot be solved without external assistance. In the long-run, reforms in the financing of health care for the medically indigent through expansion of benefits to the poor and improved payments for these services may resolve the situation, but currently it appears such wide ranging changes are unlikely. However, the AAMC is supportive of the intent of S. 2840 and S. 2841, which taken jointly, appear to recognize the need for such eventual change.

Other possible alternatives in the present environment which could alleviate some of the fiscal pressures on the financially distressed hospitals should be explored. At least for the short-term, some relief would result from changing Medicare and Medicaid reimbursement policies to provide more funds for these hospitals. First, the Medicaid participation requirements for states could be changed to require more reasonable payment of actual costs. In addition, AAMC analysis of the financial impact of the routine service limits imposed under Medicare Section 223 of P.L. 92-603 have shown that a disproportionate share of the unreimbursed costs are borne by public hospitals and large voluntary hospitals in urban areas. This concentration of the impact of limitations strongly suggests that the present methodology for establishing limits fails to adequately recognize the characteristics of urban hospitals and medically-underserved areas. The Association believes that the Health Care Financing Administration (HCFA) should be required to study and report on the characteristics of hospitals being penalized by the limits to ensure that implementation of Section 223 is not proceeding contrary to Congressional intent in urban hospitals. Second, Medicare and Medicaid reimbursement policies should be broadened to pay a proportion of the bad debts and uncollectible accounts these hospitals experience. A further reform to assist these hospitals would be to establish federal incentives to encourage states to extend the eligibility for Medicaid to previously unqualified lower-income individuals and to standardize the scope of basic Medicaid benefits nationwide.

Additionally, to help meet the critical capital needs for renovating the physical plants and updating the equipment of these financially troubled urban and rural hospitals, funds could be allocated under Title XVI of the Public Health Service Act to make special project support available to modernize facilities. Without this assistance many of these urban and rural hospitals will face increasing problems with meeting accreditation and certification standards. Finally, the federal government must make the financial survival of these urban and rural hospitals, where the need for them has been clearly demonstrated, a specific priority budget item, not allowing the reduction or demise of revenue sharing and categorical program funding to local governments to result in a reduced financial commitment to hospitals providing the care for the medically indigent underserved. More specifically, federal funding should be made available to financially distressed urban and rural hospitals to: (a) offer them incentives to provide preventive and primary care more economically; (b) eliminate Medicaid reimbursement delays; (c) encourage more federal-state pilot projects such as the one recently funded at the Jewish Hospital and Medical Center of Brooklyn; and (d) reimburse for the care of undocumented aliens.

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COMMENTS ON S. 2840 AND S. 2841

At issue here is the survival of a vital component of our nation's health care delivery system--that segment of the hospital industry which has historically served as the "last resort" for the poor, guaranteeing care regardless of ability to pay. If there is a national commitment to ensure health care as a right for all Americans, then the federal government must be responsible for assisting the distressed hospitals which serve the medically indigent in keeping their doors open and regaining financial stability. The existing mechanisms for acquiring federal assistance lack structure and expedience, as has been demonstrated by DHHS' recent bail out of a number of urban institutions by means of demonstration project funds. What is needed is a specific program of interim emergency assistance that would operate in a systematic and timely manner, as well as a basic restructuring of the entitlement programs. Therefore, the AAMC applauds the efforts of Senator Javits and his colleagues on the Subcommittee in developing S. 2840 and S. 2841 which contain programs that, if implemented jointly, would work toward these ends.

S. 2840, "The Financially Distressed Hospital Assistance Act," would make emergency grants available to severely distressed hospitals to avert closure. Under the bill, grant funds could be used to pay current debts, to encourage improved management practices, and to undertake appropriate reorganization of health services in a hospital and surrounding community. The AAMC firmly believes that care for the medically indigent must remain available and strongly encourages the passage of this measure as a short-term mechanism to provide transitory relief to financially troubled urban and rural hospitals on the brink of closure. However, the Association emphasizes that without long-term reforms which will address the inequities of current reimbursement policies and the gaps in health insurance coverage, S. 2840 will do little more than temporarily veil the continuing threat of bankruptcy and closure unless services to unsponsored patients are curtailed or new and more permanent financing sources are found, both of which are not highly likely to occur at present. The AAMC believes that S. 2841, "The Hospital Ambulatory Services Reimbursement Act," at least takes positive first steps toward addressing needed long-term reimbursement reforms, and is therefore viewed by the Association as a measure which should be adopted in combination with the distressed grant program.

S. 2841 is designed to keep acute financial crises from recurring once stability has been achieved and to prevent such crises from occurring in other hospitals which serve large numbers of medically indigent persons. It would accomplish this by requiring Medicare and Medicaid to pay their proportionate share of the non-reimbursed cost of delivering covered outpatient services for medically indigent persons to hospitals which meet specified eligibility criteria. This would eliminate federal statutory constraints that have penalized hospitals serving the poor and medically underserved. In hospitals meeting the criteria for financial distress, community service costs incurred in the outpatient department and emergency room (currently an uncovered uncollectible item) would be included for reimbursement under the entitlement programs on a "reasonable cost" basis. The AAMC considers this a major reform in federal reimbursement policy that will contribute greatly to assuring the future financial viability of many distressed urban and rural hospitals.

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While the Association favors the dual enactment of S. 2840 and S. 2841, the following specific refinements to these measures are recommended for your serious consideration:

- Section 1626 (a)(1)(F)(i) of S. 2840 requires that hospitals applying for grants must exhibit severe financial distress as demonstrated by "liquidation and utilization of any and all financial resources at the disposal of the hospital consistent with the maintenance of high quality essential health services." The Association does not believe it was intended that all of a hospital's financial resources need be "liquidated" to meet operating deficits because such a requirement would serve to further the hospital's financial instability and negatively impact upon the continued provision of high quality patient care. Moreover, the AAMC would oppose any requirement that would jeopardize the continued support of medical education programs being conducted at prospective grantee institutions. These educational programs contribute to the training of our nation's future health manpower, who have a vital role to play in the provision of quality care to those most in need both today and in the years ahead. Therefore, the AAMC recommends that the criterion in Section 1626 (a)(1)(F)(i) be rewritten to require that prospective grantees must utilize their financial resources toward operating deficits to the extent determined through demonstrated sound management judgment, deleting the term "liquidation" entirely. Furthermore, we believe that Section 1626 (d)(1) should provide that grants awarded under this program may be used to assist the hospital in payment of the cost of medical education programs that have demonstrated their importance in relation to the institution's ability to continue to provide quality care to its patient population.
- Section 1626 (a)(1)(C) of S. 2840 and Section 1882 (b)(1)(C) of S. 2841 require that for a hospital to be considered financially distressed it must "primarily" serve a medically underserved population. The Association believes that these bills already adequately recognize, through criterion(E) in both sections that the most critical area of financial shortfall for these distressed hospitals is in the provision of uncompensated care through their outpatient departments, clinics, and emergency rooms. Despite a significant volume of private, insured inpatients which serve to retain and support adequate medical staffs, many large urban institutions still face considerable outpatient deficits that would otherwise make them eligible beneficiaries under these financial assistance programs if there was no requirement that the majority of their patient population be defined as underserved. Therefore, the AAMC calls for the deletion of this criterion in both bills, or at least limiting the provision to the patient populations served in the hospital's outpatient and emergency facilities. In addition, though the Association believes criterion(E) strikes directly at the area where these hospitals incur much of their deficits, we object to the use of the arbitrary numerical limitation of 60 percent as the amount of total outpatient and emergency charges which must be incurred by persons eligible for Medicaid (or other state and local medical assistance programs) or who were not covered by health insurance and were unable to pay for the services rendered to them. We believe

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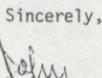
Hon. Edward M. Kennedy

this strict formula approach will be difficult for many financially distressed hospitals to meet and will preclude many intended beneficiaries of the financial assistance programs from receiving desperately needed aid. Therefore, the AAMC recommends that the criteria be amended to permit hospitals to substantiate their commitment to the care of these specific patient groups by demonstrating that a "significant" portion of their outpatient and emergency charges are directly identifiable to these groups. This will provide accurate comparative data that would allow the HHS Secretary to adequately account for demographic and other variances among differing hospital settings and equitably apply this knowledge to the funding decision-making process under the assistance programs.

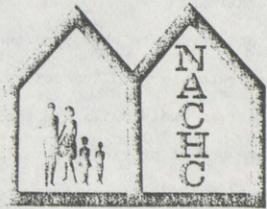
- Section 1626 (e)(1)(C) of S. 2840 would require that a distress grant application not be approved by the HHS Secretary unless "the Secretary of Labor has determined that fair and equitable arrangements have been made for the protection of the interests of employees affected by a reduction of beds, the discontinuance of any hospital services, or a restructuring of health care delivery proposed in the hospital services reorganization plan." In light of the fact that: (1) Section 1626 (b)(5)(C) requires a hospital's application to include a description of its arrangements for protection of the interests of employees affected by any discontinuance of hospital services; (2) Section 1626 (d)(1)(D) permits the distress grants to be used for the payment of the costs of retraining and appropriate severance pay for personnel affected by any discontinuance of hospital services pursuant to the hospital services reorganization plan; and (3) that Section 1626 (f)(2)(D) provides that one member of the National Advisory Council on Hospital Financing Stabilization and Reorganization to be established shall be an individual who represents an organization representing hospital employees, the AAMC does not see the necessity of involving the Secretary of Labor to protect the interests of hospital employees under the financial assistance program. Thus, rather than add another bureaucratic administrative layer to the process, we call for this provision to be removed from the bill.
- Section 1882 (a)(1) of S. 2841 provides a listing of the characteristics that would define those persons whose outpatient care would be considered a component of a hospital's community service costs. Aside from the difficulties that hospitals will have in assessing the extent of a patient's personal resources and health insurance coverage, the AAMC is concerned that the criteria would exclude from the definition patients possessing any form of health insurance coverage, not withstanding its scope or adequacy. While many patients visiting hospital outpatient and emergency facilities lack, or have limited, outpatient coverage, they may have some form of very basic inpatient coverage. Thus, if read literally, Section 1882 (a)(1)(C) would inaccurately and unfairly exclude these individuals from the hospital's community service costs. The AAMC recommends that this criterion be revised to include individuals who are not adequately covered by insurance and "are not able to pay for such services after the hospital has made reasonable efforts to collect all charges for such services."

In closing, the AAMC supports the dual enactment of these two pieces of legislation and hopes that its comments and recommendations will prove helpful to the members of the Subcommittee and its staff in refinement of the bills, as well as in consideration of future long-term alternative solutions to this critical issue. I, and members of the AAMC staff, would be pleased to discuss these matters with you further at any time.

Sincerely,


John A. D. Cooper, M.D.
President

**National Association of
COMMUNITY
HEALTH CENTERS, Inc.**
1625 I Street, NW.-Suite 420
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[202] 833-9280



TESTIMONY ON

"AID TO FINANCIALLY DISTRESSED HOSPITALS"

BY

IRVIN OVERTON

SENIOR VICE-PRESIDENT

BARONESS ERLANGER HOSPITAL

CHATANOOGA, TENNESSEE

PRESIDENT OF THE NATIONAL ASSOCIATION

OF COMMUNITY HEALTH CENTERS

AND

HARVEY HOLZBERG

VICE-PRESIDENT

LUTHERAN MEDICAL CENTER

BROOKLYN, NEW YORK

VICE-SPEAKER OF THE HOUSE OF THE

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

JULY 3, 1980

Mr. Chairman:

We appreciate this opportunity to comment on this issue of vital concern. The issue centers around the delivery and availability of health services to medically underserved individuals and those hospitals which have incurred operating deficits as a result of providing services to those who are inadequately insured. We have reviewed the Administration's tentative proposals, the proposed legislation S. 2840 and S. 2841, and related testimony presented by the American Hospital Association and Administration. Let me state from the outset, basic tenets of our position:

1. As a primary mission, our organization advocates for the provision of high quality health care to medically underserved populations and views these proposals as an attempt to achieve that goal.
2. We are supportive of a program designed to assure that these distressed hospitals remain open and viable in the years ahead.
3. The financially distressed hospitals should clearly be defined as public general hospitals and community/voluntary hospitals which clearly demonstrate they provide services to all in their area without regard to ability to pay and as a result of providing services to the uninsured, have incurred a deficit (versus mismanagement or an institution which has discriminatory policies in who it serves).
4. The program must address both short range financial assistance and long-term reform aimed at high quality care delivered efficiently as well as linkages between hospitals and related federal programs.
5. Community and Migrant Health Centers which provide primary and ambulatory care, also serve many of the same areas served by these hospitals and, given their track record in terms of relative cost and quality, should be utilized to the fullest extent possible.

Currently, we are working with the AHA to examine the details of a plan which would form a partnership between the hospitals and health centers, which would link programs to accomplish this goal. We would hope you share our enthusiasm in this venture.

General Situation

You have accurately described a situation which seriously threatens many urban and rural area communities, i.e., the closure of financially distressed hospitals. In recent statements, Senator Javits, the American Hospital Association

through Mr. Manzano and Mr. Hess, and Undersecretary Stark have provided data about the severity of the situation and the number of institutions affected. We need not be repetitive because there is general agreement about the magnitude of the problem. We would point out, however, that these statistics do not begin to address the needs of some 26 million medically underserved Americans who do not have access to health care, but rather concerns those who are being served but do not have adequate income or insurance to pay for the cost of their health services. Community health centers are well aware of this problem. Seventy-two percent of the families served by health centers have family incomes below \$6000; eighty-nine percent are below \$9000. While we continue to maximize third party payments and patient fees, third party programs often provide insufficient payment relative to cost or exclude services provided on an outpatient basis. Preventive services are seldom covered and low income families are often forced to choose between essentials (such as food, rent, gas, health) in the allocation of their meager resources. And, as is the case with many of the distressed hospitals, centers are all too often the "dumping ground" for patients who have been rejected by the private sector because of a lack of income or third party coverage. In many rural areas, there simply is no other alternative. The situation is also true in urban areas. Despite the existence of private providers, seldom do these private providers accept patients who cannot demonstrate an ability to pay or in some cases, these providers are not situated in close proximity to the patient, thereby requiring costly travel.

As you are aware, the real issue here is the lack of a national health policy which provides financing and access to health care for all people on one hand while bringing about sufficient system and financing reform to control costs on the other. It is difficult for citizens to understand how policy makers can talk about reduced government spending on one hand and oppose hospital cost containment on the other. It is also difficult to understand a reimbursement system which rewards waste and encourages high-cost inpatient care while discouraging prevention.

How will policy makers explain HCFA's projection that health costs will increase threefold by the next ten years. While some immediate action for distressed hospitals is essential, a simple "bail-out" will fail. It must initiate some reforms which will begin to address the longer range problem. We encourage you to act now.

Legislative Authority

We would agree with Undersecretary Stark in that there exists already sufficient legislative authority to make grants to these hospitals, particularly Section 328 of the PHS Act. The problem has been one of insufficient funding of this authority. It was created only two years ago to assist in solving this same problem. Neither in public testimony nor off the record, have I heard of substantial criticism of the legislation, other than inadequate funding. In his position paper, Art Hess discusses the feasibility of using Sections 328 and 330 of the PHS Act. Accordingly, I would ask, why then do you seek new legislation? While S. 2840 gives considerable detail to defining a "distressed hospital," it pays precious little detail to either reform or coordination with existing federal programs. Section 328 does not define "distressed" but does attempt to bring about system reform which is crucial to long range survival. These include:

1. A separate and distinct administrative unit,
2. A defined set of required "primary" health services consistent with other primary care programs of DHHS,
3. A defined primary care group practice (with at least three primary care physicians),
4. Linkage arrangements concerning emergency, specialty outpatient, staff and admitting privileges, and residency arrangements,
5. Specifically allows for the usage of non-physician providers,
6. Defines the physician/patient relationship relative to quality and continuity of care,
7. Community involvement through either a governing or advisory board, and
8. The non-duplication of federal resources where health centers or other providers exist.

These reforms are reasonable, desirable and achievable. We would insist on their inclusion. Moreover, the government should demand some meaningful reform for its investment--a goal which should be shared by the hospital as well. The definitions of financially distressed in S. 2840 could be added to Section 328 as a condition for funding. It should be amended to specify "hospitals which provide services to all without regard to ability to pay" for other than public hospitals.

Consumer Involvement

Our organization has and continues to speak very clearly on the issue of consumer, i.e., user involvement in the decision-making process. It is this involvement which cements the bond which has assured community support and assures the longevity of a program. Without it, you are doomed to failure. The sad part is a number of hospitals are not willing to recognize this or will use any excuse to avoid it.

Let me cite four examples of more enlightened hospitals, all of which have consumer majority boards for their outpatient/health center/primary care center:

1. Lutheran Medical Center, Brooklyn, New York
2. San Francisco General Hospital, California
3. Baroness Erlanger Hospital, Chattanooga, Tennessee
4. Peter Brent Brigham (Affiliated Hospital Center of Boston), Boston, Mass.

In each case, the "health center" has a governing board which through contractual arrangement, either governs the program or serves as a community board which develops policies and has veto power over policies for the primary care center. The second alternative works well where local laws prohibit the delegation of corporate powers. In each of these cases, the Administrators admit the strong advantage of strong consumer involvement. In San Francisco, the community has rallied time and again to stop cutbacks in local support. In Brooklyn, the community was responsible for meeting with the State Legislature and City Council to obtain an old foundry which was renovated into the 530 bed Lutheran Medical Center

with Sunset Park Family Health Center at its core. With the new facility, the hospital stayed in the area rather than moving to a more affluent section, and has worked hand in hand (sharing resources) with the community in projects of economic development, housing, and issues affecting their day to day lives. There is no financial distress here. In Boston and Chattanooga, the consumers were instrumental in obtaining community health center and other funding sources to assist in payment for services to the indigent as well as local support. This has been crucial to their survival and success.

If the question is one of "turfdom" then I say to you--Yes, hospitals and health centers must learn to share. But the payoff is much greater in the long run--for both the community and the hospital. The four examples above demonstrate clearly this point. I have submitted more detailed descriptions of these programs. The point is, patients should have a say in their destiny. This includes not only making decisions which are both easy and tough--but being a member of the team--a team that will come to your aid and work with you because it is their investment as well.

CAN HEALTH CENTERS ASSIST IN THIS EFFORT?

We believe they can and should. There are over 900 federally-supported community and migrant health centers, which have significant track records and successfully deliver outpatient primary care in many of the same areas served by the distressed hospitals. Because their focus is primary care, they do a better job in this area, in most cases, and do it at a considerably less cost. Let me cite some examples:

1. Independent studies show that health centers reduce hospitalization between 25% and 62% .
2. For the same services, health center costs are 33% to 50% lower than hospital OPD/ER costs. If one examines reimbursements in D.C., for example, health centers are reimbursed at \$20.30 per inclusive visit compared to the OPD/ER rate of \$69.70 (averages).
3. Comparing total ambulatory costs, the CHC average user cost is \$96, compared to \$155 per Medicaid recipient, and \$172 for the average U.S. citizen.

This data suggests that health centers may well serve as partners with hospitals by providing primary ambulatory care, either in whole or part, for the hospital. Hospitals should offer services in areas in which they have performed well, i.e., inpatient, specialty outpatient, and true emergency care.

Because most of the established health centers are themselves operating at capacity and many are in deficit or have substantially reduced services (due to inflation, indigent care, and insufficient grant support), additional funds would be required. But, if this federal effort intends to:

1. avoid duplication of resources,
2. bring about high quality health care delivered most economically and in a coordinated systems approach,
3. demand a reform aimed at long-range survival, and
4. reduce hospital ambulatory care/OPD deficits (cited by most financially distressed hospitals as the major cause of deficits),

then such a proposal would, at a minimum, merit serious consideration.

Short-Range Support

The Administration's proposal seems to make the most sense in terms of the Grant (S. 2840) program. It should be viewed as a service program first and foremost. The capitation payment provides an incentive to maximize efficiency. Sections 328 and 330 provide sufficient authority and would call for reform aimed at long-range survival; including some meaningful consumer participation. S. 2840 allows hospitals to calculate into the grant the current and projected operating deficits whereas the Administration makes no allowance. We sympathize with this problem and it may have to be considered beyond the capitation arrangement. We would hope financially distressed health centers would also be allowed this option; otherwise, further service reductions and layoffs will occur at both hospitals and centers. Section 330 grant funding has not been sufficient to cover the cost of care for the uninsured, particularly in light of high inflation and Medicaid cutbacks. We hope this does not continue to be ignored in this program. Coordination with states, localities, and planning agencies are essential and their support at a minimum must be maintained.

AN EFFECTIVE PARTNERSHIP

Specifically, we would propose that where health centers exist, grants should be made (on a capitated basis related to need and service to the uninsured) in a manner that assures a strong linkage between a CHC and distressed hospital.

Recommendations

1. Where health centers (Sec. 329 and 330) exist and have demonstrated a capability, the grant should specify that the health center assume responsibility for primary ambulatory care and receive a portion of the capitation payment for providing such care.
2. The hospital would continue the provision of inpatient, outpatient specialty, and true emergency room services, the linked health center agreeing to utilize that hospital for such services.
3. The health center physician would obtain staff and attending privileges at the hospital. Service requirements could be met by virtue of service in the OPD/health center or supervision of specialties.
4. A grant could be made to either the health center or hospital under agreement by both parties. Not less than 40 percent of the capitation payment would be available in a fixed amount for primary ambulatory care.
5. If a particular health center could not handle the patient load all at once, a phase-in agreement would be negotiated.

Rationale

This approach would avoid duplication, provide maximum quality, efficiency, and coordination. The distressed hospital would have the bulk of its financial problems alleviated. Community and strong consumer support would be generated.

Recommendation

1. In areas where health centers were non-existent or did not have the capability, a grant could be made under Section 328, thereby providing financial assistance and desired reform. If a health center did exist, a grant condition should be required such that both parties clearly define a catchment area and service population to avoid duplication.
2. In such instances, linkage arrangements described in recommendations 2, 3 and 5 should be required.

Rationale

Maximum coordination of federal effort, avoidance of duplication, financial assistance to the distressed hospital and desired reform.

Mr. Chairman: As I mentioned earlier, currently we are working with AHA to further develop this proposal and would be happy to meet with you and your staff when details are finalized. We feel very positively about this proposal because this approach begins to address some of the long-range problems as well as benefit all parties, and most importantly, the uninsured or underserved patient who is at risk. /

Financing Alternatives

S. 2841 begins to approach the longer range financing problem. While the bill would provide financing for a small portion of those uninsured or underserved, and would subsidize insufficient reimbursements under Medicare and Medicaid, it would apply only to those served by distressed hospitals. Further, there are insufficient controls to assure that generated costs would remain within reasonable limits. However, we sympathize with the problem. Many health centers are now also distressed as funding sources have not fully subsidized care to the uninsured. S. 2841 simply is too limited. However, the waiver approach is also undesirable because of its instability.

We have consistently advocated the need for a comprehensive national health service. In its absence, the Administration's National Health Plan would, in our opinion, be considerably more desirable than S. 2841 as an alternative. Under such a plan, innovative financing could be utilized to assure the stability of distressed institutions providing care to the underserved.

Again, we thank you for this opportunity and would welcome any questions.

The following is an excerpt from a grant application written by Sunset Park Family Health Center. It describes the extremely successful relationship between Sunset Park Family Health Center and Lutheran Medical Center, a relationship which has existed almost eleven years.

The Sunset Park Family Health Center has a uniquely close relationship with its grantee, Lutheran Medical Center. Since its inception, the Center has been an integral component of the hospital and is fully integrated into the organizational structure.

The Family Health Center serves as the hospital ambulatory care unit and provides outpatient training for its house offices. This relationship has strong advantages in that the institutional resources are fully available to the program. The Chiefs of Service and the Department Head of the hospital are responsible for the quality of their respective services. This has enabled the services to be coordinated, quality of care monitored, and duplication eliminated. All health center physicians and dentists are on the attending staff of the hospital and participate in the ongoing training and education program offered by Lutheran Medical Center. Moreover, because the Center is, in essence, the outpatient department of the hospital, all consultants and specialists are provided to the program in an integrated fashion.

To further insure coordination and control, the Project Director of the Health Center is Associate Vice-President of Lutheran Medical Center, and this joint appointment enables the Center's programs to be integrated with all other hospital functions.

In addition, the hospital emergency services provide care to the patients when the Center is closed. Self-paid, non-insured patients are charged the same all-inclusive sliding scale fee that they are charged at the Center. Each morning, all emergency service charts and abstracts of hospital discharges are routinely forwarded to the Health Center for follow up and incorporation into the patients records. With rare exceptions, the Center's patients that require hospitalization, are admitted to Lutheran Medical Center.

Description of Relationship Between Baroness Erlanger Hospital and Alton Park Avenue Community Health Center - Chattanooga, Tennessee

The Alton Park Avenue Community Health Center is a congruent part of the Chattanooga Hamilton County Hospital Authority. The Health Center's function under the sponsorship of the Hospital Authority is a part of the outpatient program of Berlanger Hospital. The health centers have their own governing board which meets the requirements for funding by the Department of Health and Human Services for 330 grants. The Hospital Authority has delegated the operational responsibility for the community health centers to the governing boards under a special bylaws arrangement. Under this arrangement, the governing board determines policy for center operations and hires an administrative staff to implement these policies. The governing board, also, is responsible for the quality of care given at the health center and has delegated the responsibility for medical care quality assurance back to the medical staffs of the hospital who performs audits of care and reports the finding of the audit to the health center's governing board and hospital authority board. The governing board develops a budget for operation and presents it to the hospital authority for approval before it is submitted to the regions for Health and Human Services Department of the Federal government. When there is conflict between the two boards regarding matters of policy, which are not resolved through the bylaws or by the management team, there is a mandated joint conference committee between the two boards whose purpose is to resolve the conflict in the mutual interest of both parties.

The hospital managerial staff serves as a technical component to the center's management team. This resource is quite valuable and has presented the need for hiring certain types of professionals and consultants. Most notably, this backup expertise has impacted the high level of reimbursements from Medicaid and Medicare. The hospitals specialty clinics serve as specialty and subspecialty referral

sources for health center physicians and patients, thereby, reducing the cost of medical service to the centers. The hospital's education program (residence) are not involved at the center but sees patients from the centers by referrals in the specialty clinic at no cost to the health centers. The health centers also benefit from the hospital purchasing program by paying for supply items and drugs at a cheaper cost than what they would have to pay for them in the marketplace because of the buying power of the hospital. Also, because of this unique arrangement, the health centers are covered under the hospital self-insured program for medical malpractice liability at no cost. These are only a few of the ways in which the relationship of the hospital to the health center have a beneficent effect. The health center's reduced costs of care to the hospital by seeing a large number of medically indigent patients in the health centers. If these patients were seen at the hospital, outpatient costs would rise approximately \$3 million a year. The health center also reduced the crowdedness of the hospital outpatient facilities by allowing a large number of patients seeking primary care to be served at the decentralized sites. If these two things were not occurring, the hospital would, perhaps, be financially distressed.

The reason these two entities are able to work so well together, is because both boards--the hospital authority board and the health center's governing board--wants the arrangements to work. Both boards have charged their respective administrative staff to work diligently at facilitating these arrangements. To assure that the facilitation occurs, the hospital authority has representatives on the health center's governing board and the hospital administrative staff has assigned one of its administrators to be a liaison person between the two entities. There is further a mutual feeling of need that exists between the hospital and the health center's governing board.



Brookside Park Family Life Center

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ADULT MEDICINE
DENTAL
EDUCATION
MENTAL HEALTH
OBSTETRICS
PEDIATRICS
SOCIAL SERVICES
SPEECH AND HEARING

TESTIMONY

Before the House Sub-Committee on Health and
Environment

August 10, 1978

given by

Mr. Charles E. Cloherty
Center Director
Brookside Park Family Life Center
3297 Washington Street
Jamaica Plain, MA, 02130

A
NEIGHBORHOOD
HEALTH
CENTER
ASSOCIATED WITH



THE
PETER BENT BRIGHAM
HOSPITAL
AND



THE
CITY OF BOSTON

I. INTRODUCTION

The Brookside Park Family Life Center is a comprehensive community health center providing a broad range of ambulatory health care and social services. These services offered are as follows:

- a) Medical, including adult medicine, pediatrics, obstetrics/gynecology, and nutrition;
- b) dental;
- c) social services;
- d) mental health;
- e) developmental and educational services, including speech, hearing and language services

In FY '78 the center operated on a budget of approximately \$1.1 million, provided 45,000 patient visits and served a registered population of 24,000 individuals.

The Center, as the name suggests, provides services to families as a unit. When one member of a family registers for care, we register the entire family. Additionally, services are provided by comprehensive health delivery teams. All care providers from all disciplines work as members of a team using the variety of professional skills, i.e. physician, nurse practitioner, social worker, to identify and solve health and social problems. Finally, the population we serve is approximately 40% Spanish speaking (from a variety of birth places), 20% black English speaking, and 40% white-English speaking.

Over 52% of the visits are to people under 21 years of age and the majority of the families (62%) are below the median income. The insurance coverage for the users is:

36% Medicaid & Welfare, 26% Medicare, Blue Cross and other Commercial Insurance and the remainder (38%) with no third party coverage.

II. BACKGROUND AND HISTORY

The Brookside Park Family Life Center was established in 1970 by the Boston Model Cities Administration under the H.U.D. Cities Demonstration Act of 1967.

The Center is licensed with, and operates as an affiliate of, the Peter Bent Brigham Hospital, a major Boston Teaching Hospital associated with the Harvard Medical School. The Center is located about 4 miles from the hospital.

The Center also has relationships with other Boston area hospitals for services not available at the Peter Bent Brigham Hospital.

The relationship with the Peter Bent Brigham Hospital was established in the planning stages of the Center. This relationship was developed in part as a result of a concept known as The Sackette plan. In the early 1960's the then Commissioner of the City's Department of Health and Hospitals, Dr. Sackette, developed a proposal which provided for the major Boston teaching hospitals taking responsibility for sections of the City and the Peter Bent Brigham Hospital accepted responsibility for the Jamaica Plain area. Members of the hospital staff participated in the planning of the Health Center and during the early stages of the Center's development medical services were contracted by the Model Cities Administration to the Peter Bent Brigham Hospital, while other portions of the program were operated by the City or through other contractual relationships. As the Model Cities funding diminished and our reliance on income from services increased, the relationship with other agencies ceased and in 1974 the entire program became an operating department of the Hospital.

III. FINANCIAL DEVELOPMENT

In the initial stages the program received 100% support from Model Cities grant funding. This included funding for planning, start up, and facilities.

By 1973, we had developed the capacity to bill for services, which included the license relationship with the hospital. This also coincided with a decline in available grant support. With the exception of one year, when there was an operating deficit which was met by the hospital, the Center has operated on a breakeven basis. Income from services now supports approximately 85% of the operating costs and the remainder comes from grant support from the Boston Department of Health and Hospitals and H.U.D. Community Development Block Grant Funds. I would like to point out here that the Department of Health and Hospital grant, called The Matching Grant Program, provides up to \$50,000 to community health centers with the condition that it is matched by private hospitals in either services or funding. In FY '79, The Peter Bent Brigham Hospital will match this grant for the full \$50,000. While we are proud of our high percentage of support from income from services, we are of the opinion that there will always be some need for grant support primarily because of the number of clients with no insurance and the limited coverage provisions of some commercial insurance programs.

IV. OPERATING RELATIONSHIP WITH THE HOSPITAL

The planning process was developed in the community, and as a result the community, that is the Jamaica Plain area initially through Model Cities mechanisms, and later through the Brookside Park Family Life Center Policy Board, has always had responsibility and control of the program.

To some extent, in the early days this was required by citizen participation in Model Cities programs. However, the Hospital has always had respect for community participation and gave a high degree of responsibility and authority to the Policy Board.

Initially this was on an informal basis but recently this has been both formalized and legalized by an agreement between the Board of Trustees of the Hospital, (now known as the Affiliated Hospitals Center, a merger of the Peter Bent Brigham Hospital and two other institutions) and the Brookside Park Family Life Center and another health center in our neighborhood. (A copy of this agreement is attached). During both the informal stages and in this agreement the hospital has agreed to and supported the right of a community elected Policy Board or Board of Directors to have the responsibility to hire and fire staff, set policy on such things as programs of service, sliding fee scales, hours of service etc. The limitations of this arrangement are:

- 1) the Family Life Center support its own operations, i.e., generate enough revenue, either from income or grant support, to meet the Centers' operating expense; 2) those Family Life Center staff who are to be given hospital appointments (physicians, nurses, etc) meet the same professional requirements as hospital staff, 3) that the center conform with hospital and licensing regulations on such things as staffing, safety, affirmative action, physical plant requirements etc.

These limitations or conditions are all items which the Center would have to meet, in order to provide services with or without the hospital affiliation. This relationship with the hospital was developed by a positive, strong community/consumer Policy Board. The Center, both in its program of service and in its relationship with the hospital has been successful because of this community control. Dr. Donald Fink, Director of Outpatient and Community Services, San Francisco General Hospital, and Dr. David Rosenbloom, Commissioner of Health and Hospitals in Boston, have stated that the success of the hospital based primary care programs in San Francisco and the satellite community health centers in Boston was primarily based

on the fact both programs are under the direction of consumer controlled boards.

Our relationship with the hospital has not been without problems, and I could relate several both humerous and difficult anecdotes concerning this. However, the message I carry to you is that the Brookside Park Family Life Center is a successful example of a community controlled primary care delivery system affiliated with a major public hospital. Based on this success and that experienced by my colleagues, I strongly urge that this committee require that any funding for primary care services include the participation and control of a consumer dominated policy setting board.

CEC:vah

AGREEMENT BETWEEN
AFFILIATED HOSPITALS CENTER
AND THE
BROOKSIDE PARK FAMILY LIFE CENTER BOARD OF DIRECTORS,
THE SOUTHERN JAMAICA PLAIN COMMUNITY HEALTH COMMITTEE

The purpose of this statement is to clarify the relationship between the community boards of the Brookside Park Family Life Center and The Southern Jamaica Plain Community Health Committee (hereinafter known as "Community Boards") and the Affiliated Hospitals Center (hereinafter known as the "Hospital"). This statement shall define the areas of responsibility for the issues outlined below.

For their part the Community Boards fully recognize that all decision relating to the governance of the two Health Centers are subject to restrictions placed on the Hospital as licensee and also the overall policies established by the Boards of the Hospital.

1. The Community Boards shall have responsibility or delegate such responsibility, for the following items relating to Health Center staff and program:
 - A. Monitoring the quality of care delivered in the Health Center services and submitting semi-annual reports on the monitoring of quality of care to the Hospital Board of Trustees through the Office of Community Health and the Director of Ambulatory Care for the Affiliated Hospitals Center and through the appropriate Chief of Service.
 - B. For development of new programs and organizational structures consistent with previously approved budgets (revenue and expenditures) and policies of the Hospital.
 - C. For the hiring and dismissal of Health Center staff consistent with Hospital policies regarding personnel procedures, contracts and professional staff policies (with review by the appropriate professional department).

continued -2- AGREEMENT - AFFILIATED HOSPITALS CENTER

- D. Any person designated to work with the Community Boards, or to be placed in the Health Centers shall be approved by the Community Boards.
2. The Community Boards shall be responsible for developing jointly with the Hospital a free care budget and policy to be implemented at the Health Centers. The Community Boards shall develop such a free care policy at a future date and shall append it to this agreement. This free care policy shall be consistent with Federal, State and other laws and regulations regarding free care.
3. The Community Boards shall be delegated the following responsibilities regarding the fiscal relationship between the Health Center and the Hospital:
 - A. The Community Boards shall review and make recommendations concerning their respective Health Center's annual budget. The budgets shall be submitted to the Hospital through the Director of the Office of Community Health by the Health Center administrators.
 - B. The Community Boards shall have the responsibility for approving changes in the Health Center's budgets consistent with previously approved budget constraints and with appropriate considerations to the effects such changes will have on succeeding budgets. Changes which affect future budgets shall be submitted by the Health Center administrators to the Hospital through the Director of the Office of Community Health.
 - C. The Community Boards will monitor projected income and expenditures and will make recommendations through the Health Center administrator to the Hospital concerning surpluses and deficits.
4. The Community Boards shall review and monitor grants which will affect Health Center program, staff or clients. Such grants must be subsequently reviewed and approved by the appropriate structures of the Hospital.

continued - page -

Continued -3- AGREEMENT - AFFILIATED HOSPITALS CENTER

5. Health services or other programs provided by the Hospitals in Jamaica Plain shall have the early involvement and prior approval of the affected Health Center's Community Board.
6. The A.H.C. Office of Community Health shall be the channel of Administrative and Fiscal relationship between the Hospital and Health Centers. In matters of policy, the Community Boards shall have access to the A.H.C. through the Committee on Ambulatory and Community Health Services and the Hospital Boards.
7. This document shall be consistent with the by-laws of the Hospital and the Community Boards. Copies of the Community Boards' by-laws are appended hereto.
8. This document may be amended by mutual agreement of both parties. The agreement will be reviewed annually in order to insure its continuing currency and relevance.
9. This agreement may be terminated by either party with 60 days written notice of the intent to terminate. Such notice shall specify up to 120 days for preparation of severance agreements.

William S. Howard
Affiliated Hospitals Center

Conrad W. Robinson
Brookside Park Family Life Center
Board of Directors

Date 5-16-78

Date 5-18-78

William F. Bone
Southern Jamaica Plain Community
Health Committee

Date 5-30-78

Remarks

Mr. Richard A. Berman, Director
NYS Office of Health Systems Management
Before the Subcommittee on Health and
Scientific Research

ON

The Financially Distressed Hospital Assistance Act
and the Hospital Ambulatory Services Reimbursement
Reform Act

Mr. Chairman, Senator Javits, and members of the Subcommittee on Health and Scientific Research, I am Richard Berman, Director of the New York State Office of Health Systems Management.

It gives me no pleasure to report to you today that there is a crisis in the health care system and that the plight of many hospitals worsens daily. Their ability to continue providing essential services to an already medically deprived population is now questionable.

The introduction of the Financially Distressed Hospital Assistance Act and the Hospital Ambulatory Services Reimbursement Reform Act by Senator Javits emphasizes the fact that we can no longer ignore this problem. While some naively cling to the hope that the problems confronting urban society will vanish if we pretend that they do not exist. Yet, history has shown that "make believe" is a poor substitute for reason in the search for solutions.

This is not the first time that Congress has been faced with legislation that addresses basic human needs. During the 1960's, we witnessed the enactment of a number of landmark health and social programs. Probably the most important were Medicare, which hoped to improve access to basic health services for our elderly, and Medicaid, which has provided essential health services to the poor and disadvantaged. While these original programs were limited, it was widely believed that they would be expanded after enactment by future congresses and could eventually become the nucleus of a comprehensive national health program.

Fifteen years later, we are left disillusioned. Many Americans are still disenfranchised from our health care system, hospitals face mounting deficits, and today's Congress lacking the spirit of reform that was so prevalent in the Congress of the 1960's, is yet reluctant to act. While I can understand the concerns of a Congress that sees unchecked health care inflation, inefficient and wasteful management, and fraud and abuse in our public program, the fact remains that today as many as 37 million Americans have either no health coverage or grossly inadequate coverage. In New York State alone, two million of our 18 million citizens have either inadequate health care coverage or no coverage at all. In addition, according to our best estimates, there are over one million undocumented aliens in New York without any coverage whatsoever.

For these New Yorkers and for so many others across the nation, needed health care has become an expensive luxury that can be ill-afforded by those just barely able to make ends meet. If health care inflation is left unchecked, we will soon see health care become an unobtainable luxury for a growing number of middle-class families as well.

Those who cannot readily afford health care services have few options available to them. Evidence has shown that few physicians want to start or even maintain a private practice in areas with the poorest housing and lowest per capita incomes and where patients cannot always pay their bills. And unlike the private practitioner, a hospital cannot easily move as neighborhoods change and its traditional community of patients leaves for the suburbs or more fashionable parts of town. Thus, by default, hospital outpatient departments and emergency rooms have become the only source of care available to the poor and those who are unable to pay for medical care.

The most recent and, perhaps, only reliable data available on hospital deficits in New York State is from the Office of Health Systems Management's 1980 Report on Ambulatory Care. These data show that 48 percent of all emergency room visits and 47 percent of all outpatient visits are classified as "self pay" or "no pay". In practice, this means that hospitals will receive, at best, partial payment and, at worst, no payment from a substantial number of the patients they serve in their outpatient departments.

New York State
Hospital Deficits - 1978
(in millions)

<u>Upstate</u>	<u>Expenditures</u>	<u>Deficits</u>	<u>% of Expenditures</u>
Inpatient	2,247.9	40.2	(1.8)
Outpatient	88.2	44.7	(50.6)
Emergency Room	157.5	19.7	(12.5)
Total Operating Expenditures & Deficits	2,493.6	104.6	(3.8)
"Bottom Line" Expenditures & Deficits*	2,776.5	29.3	(1.1)
<u>New York City</u>			
Inpatient	2,134.2	39.6	(1.9)
Outpatient	195.5	77.6	(39.7)
Emergency Room	83.5	25.2	(30.2)
Total Operating Expenditures & Deficits	2,413.2	247.0	(5.5)
"Bottom Line" Expenditures & Deficits*	2,608.7	70.7	(2.7)
<u>Total New York State</u>			
Total Operating Expenditures & Deficits	4,906.8	247.0	(4.6)
"Bottom Line" Expenditures and Deficits*	5,385.0	100.0	(1.9)

* Bottom Line expenditures and deficits include government grants, philanthropy, rental income, research grants, etc.

Excluding HHC

Despite all the evidence, some still adhere to the popular and convenient myth that hospital deficits are the dark by-product of cost containment, review of inappropriate health care utilization and government regulations. This is simply not true.

New York has succeeded in keeping annual increases in hospital costs at just over half the national average, thus keeping health affordable for government business and the consumer alike. The savings we have achieved have been used to fund new and innovative health programs and have allowed us to chart a course for the future which holds the promise of being able to maintain needed services.

Yet, reason and compassion should force us to see growing hospital deficits as more than the symptoms of a troubled health care system. In reality, these symptoms tell of a deficient national health care policy and a national failure to cope with the growing urban crisis. This crisis is not unique to New York or the Northeast; its roots exist within every city in America.

The dwindling tax base of municipalities has resulted in a diminishing ability to finance many essential services, such as firefighting, police protection, education, and health care. Without doubt, reduced public protection most severely affects the poor and indigent who have nowhere else to turn.

It is inexcusable that a state like New York, with its high concentration of poor urban populations and high costs of living, is slighted by federal formulas that favor rural areas and ignore costs of living differentials. The Medicaid formula must be revised to allow New York to progress from its federal matching percentage of less than 50 percent to 60 percent or more, a return that many rural states enjoy.

Without doubt, financing care for the poor and indigent is a national responsibility. We look to Washington for guidance, but our national leaders have been reluctant to assume leadership. In the absence of a cogent national policy, New York has endeavored to create its own solutions. But without question, any new programs undertaken by New York do not absolve the need for a national strategy and should be viewed as an interim measure until a national solution is forged.

We in New York have enacted legislation that requires not-for-profit health care insurers such as Blue Cross to assume a portion of hospital ambulatory care deficits within their inpatient rates of payment. This legislation provides for the apportionment of outpatient and emergency room deficits on the basis of the ratio of each health program's inpatient utilization to total inpatient utilization. This same legislation requires the State Medicaid program to assume its portion of the cost of outpatient bad debt, but only to the extent that these costs would be eligible for federal Medicaid matching funds. To date, the federal government has deemed the cost of bad debts ineligible for federal matching funds and it is certain that one state cannot shoulder this entire fiscal responsibility alone.

However, it is certain that the long range national strategy for financing care to the medically indigent cannot be created in a vacuum. It requires an overhaul of the way we currently envision programs for the needy. Welfare and other third-party insurance programs must be reformed, and incentives must be built into these systems for sound administration, positive incentives to providers and consumers to seek more efficient and effective methods of care, and expansion of community, non-institutional services. Such reform must go hand in hand with improved health facility management. And, a program of national health insurance is vital to ultimate success.

In this context, I have several specific comments about the bills before you today. First, while the Hospital Ambulatory Services Reimbursement Reform Act will allow New York and other states to provide assistance to hospitals delivering ambulatory and emergency services to patients who have no means to pay for these services, it does not address the basic inequities in federal reimbursement formulas.

Financially distressed hospitals in states or municipalities unable to afford any additional fiscal burdens and hesitant to apply for assistance may receive little benefit from this bill. In order to remove this barrier, I would suggest that any increase in state Medicaid payments as a result of this program be associated with an increase in the federal matching percentage up to a level similar to that of other special programs such as the Child Health Assurance Plan (CHAP).

Second, it is important to modify the bill so that community service costs be apportioned on the basis of the ratio of each program's inpatient utilization to total inpatient utilization. Under the proposed formula of each health program's hospital charges to total hospital charges, a hospital providing substantial amounts of care to those who cannot pay will receive proportionately less assistance than a hospital providing much less care to such patients. This penalizes the very institutions that have lived up to their responsibilities.

Third, I would suggest that Congress avoid the creation of new bureaucracies or additional recordkeeping burdens upon facilities we are trying to aid. It is unreasonable to ask hospitals to ascertain and record the socioeconomic status of every patient served. Hospitals do not know in advance who will not pay and thus, hospitals would be required to ask and record the income of every patient prior to rendering either emergency or ambulatory service. I believe this places an unwarranted burden upon facilities and, worse, may result in a barrier to patients seeking needed care.

In addition, I believe the establishment of the National Advisory Council on Hospital Financial Stabilization and Reorganization represents an unnecessary new layer of bureaucracy. At a time when every branch of government should seek ways to streamline its regulatory activities and increase the efficiency of its operations, we do not need a new advisory council creating more paperwork.

In this regard, I would also suggest that the Secretary be required to draw on the expertise and experience of the states. The Financially Distressed Hospital Assistance Act all but ignores local and state planning agencies, state health plans, and the vast reservoir of knowledge each state has about its health facilities and health needs. I believe that the states could provide a format for establishing priorities of health needs to assist the Secretary in such matters. States should also be allowed to assume a larger role in managing this program. Each participating state could be required to monitor the performance of hospitals receiving funds under this program -- thus eliminating the need for additional federal bureaucracy.

Fourth, we believe the criteria for participation requiring that, "the hospital primarily serves a medically underserved population..." should be changed to "the hospital outpatient and emergency room primarily serves a medically underserved population..." Unless this criteria is amended, many financially distressed hospitals primarily serving a medically underserved population within their outpatient department but not on an inpatient basis, may not qualify for either program. This is especially true of older urban institutions with fine medical reputations. These institutions continue to attract patients from the suburbs and elsewhere, but at the same time, have become an essential source of outpatient and emergency care to the residents of the area.

Fifth and last, I do not believe that states and municipalities should be required to maintain Medicaid and other funding at levels not lower than that given the preceding year. We are all aware that many states and municipalities are facing severe financial constraints coupled with a dwindling tax base which makes maintenance of effort an unnecessary hardship. Moreover, many states, by law, are unable to provide such assurances and hence, obligate future legislatures and future funding.

If Congress finds that a maintenance of effort is necessary, then I would strongly urge that there be no requirement that this level of effort be increased yearly. It is clear that few states have the ability to increase this level of effort and remain financially solvent. Moreover, there is little justification for linking mandated yearly increases to the Consumer Price Index (CPI). Some states like New York have been able to keep annual increases in hospital costs well below annual increases in the CPI. In this regard, I would suggest that at the very minimum this provision be waived by statute for any state able to contain increases in aggregate hospital costs below increases in the CPI.

In conclusion, the two bills before you represent important and necessary interim measures. The grant program under the Financially Distressed Hospital Assistance Act and the enriched rates of reimbursement under the Hospital Ambulatory Services Reimbursement Reform Act will ensure for at least the short term, the survival of hospitals on the verge of bankruptcy and closure. However, without long term reform, our short term efforts will ultimately be for naught. These measures do not obviate the need for a comprehensive national health program, welfare reform, or a meaningful cost containment program, but rather emphasizes the need for such programs. It is only when Congress can address the long term solutions will bills, like the two before you today, be unnecessary.

Comments by S. David Pomrinse, M.D.
President, Greater New York Hospital Association

for the

Hearing Record on S.2840 and S. 2841

United States Senate Subcommittee on Health
and Scientific Research

July, 1980

On behalf of the 75 not-for-profit member hospitals of the Greater New York Hospital Association, I have the honor of submitting this statement on S. 2840 and S. 2841, to assist financially distressed hospitals. Before commenting on the specific provisions of these bills, I would like to describe the social, demographic and financial conditions which now threaten the very existence of many hospitals in cities across the country and thus their ability to serve their patients.

The good news is that upwards of 90% of Americans are protected against the costs of inpatient hospital care. The bad news is that only a minor fraction have coverage which pays for any meaningful part of the cost of ambulatory care, either in the hospital or in free standing neighborhood health centers. Despite the growth of HMOs (which serve only those for whom a monthly premium is paid), a large number of working people have little or no ambulatory service coverage. Typically, these are people whose incomes are below or slightly above the poverty level; they are able to pay rent, buy food and clothing, and pay taxes but they are simply unable to cope with the cost of needed medical care. They often work in small firms or work part-time, or they are seasonally employed and subject to frequent unemployment. These may be the very people who do much of the hard, dirty work necessary in our society and they struggle to maintain themselves and their families--until they get sick.

Then they become dependent upon public or charity care. Since they are too "rich" for Medicaid and too young for Medicare, they become "self-pay, no-pay" patients of hospital clinics.

These "working poor" people tend to live in parts of the cities which no longer have significant numbers of practicing physicians. The doctors left because they were unable to maintain a viable practice due to the very limited economic resources of these neighborhoods.

In major cities, these people constitute a significant part of the population. In the older cities of the Northeast and Midwest, estimates range between 10% and 25% of the population. These "working poor" tend to use their local hospitals, so some hospitals have a highly disproportionate share of the total community load. And it is just these hospitals which tend to have fewer Alternative sources of revenue; they have fewer inpatients paying full charges from whom a surplus can be derived, they have sharply limited potential for charitable donations, they have relatively few privately practicing physicians and must employ more salaried physicians to care for this population.

This basic problem of limited alternative sources of revenue to balance the cost of providing care to the working poor is compounded and becomes critical in those states having mandatory hospital revenue control programs. In these states, hospital revenue limits are calculated so as to reimburse the hospital for only the bare-bones cost of the patients for whom the program is responsible.

Indeed, because of the language of Title XVIII, Medicare carves out obstetrics and pediatrics, and thus pays 2%-3% less than average actual costs. At best, hospitals in these states break even on third party covered patients. But they certainly cannot generate funds to pay for either inpatient or ambulatory care for the "uncovered" patients.

The problem has become severe in many voluntary hospitals which care for the poor as well as in many public hospitals throughout the country. The voluntaries spend out their available reserves and many have gone into bankruptcy and closed as a result of their effort to fulfill a community responsibility. Public hospitals have also been closing as city governments, limited by a shrinking tax base, have sought to reduce their financial exposure. Those which continue to function are increasingly hard-pressed as the volume of care for the uncovered as well as the cost of the services increase. The general inflation is forcing more people to seek "free" care as they use their limited incomes for food, clothing and shelter.

Hospital clinics provide the bulk of ambulatory services to this population. In New York City, hospitals report a total of 12 million clinic and emergency room visits while Neighborhood Family Care Centers provide about one million. Thus, while discussion and experimentation with alternative delivery systems continue, it is vitally important to maintain the major resource--hospitals--providing care to a large segment of the population. When a hospital closes, the patients simply move to the next closest hospital and add their volume of uncompensated care to its clinics and push

it closer to the financial brink. Maintaining an adequate number of hospital ambulatory facilities to care for this group becomes an ever more serious problem. While health planners generally encourage the provision of ambulatory care and seek to improve its quality and accessibility, the reality of the financial situation leads to ever lower quality and ever shrinking accessibility. S. 2840 and S. 2841 hold out real hope of stemming this tide of breakdown of the only system presently available to care for millions of people and the Greater New York Hospital Association enthusiastically supports their passage. The following comments are meant to strengthen and clarify these bills.

S. 2840

Section 1626 (a)(1)

c. "The hospital primarily serves a medically underserved population....."

Determining the origin of patients served by a hospital clinic presents serious technical problems. For the past six months a large group of technically oriented persons have been trying to evolve a method to do this for all New York City hospitals and they are becoming increasingly discouraged by the complexity of the problem. I would suggest that if this language is retained, the legislative history make it clear that there be a presumption that a hospital which otherwise qualifies meets this criterion too, and that a two week sample of patients showing that 35% or more live in defined medically underserved areas satisfies this requirement.

E.(ii) "who were not covered by any form of health insurance....."

Many patients have sketchy coverage which purports to pay for some of these services. Often such insurance covers only 5%-10% of the cost of the services and can be collected only at a cost greater than the reimbursement. I would suggest that the language be changed to "not covered by health insurance which pays 25% or more of the charges for the services provided" and were unable.....

F. (i) "liquidation and utilization of any and all financial resources....."

To be a viable business entity, a hospital must have some, albeit minimal resources. Could not this problem be solved by requiring certification by an independent auditor that the hospital's financial ratios are below those accepted as minimal for a going concern in this industry? These ratios are widely accepted as revealing the true state of a hospital's finances and are readily understood by accountants and health care program administrators.

B. Public general hospitals should be able to provide adequate financial reports. Otherwise the total funds appropriated under this act will be used to assume liabilities which are now covered by local tax funds. The bill should require the reports in D and F and also demonstrate that there has been no diminution in local tax contributions during the prior two year period. The concept of maintenance of effort by the locality will help to

assure equity in the use of the funds appropriated under this act.

(e)(1)(c) It must be recognized that since labor constitutes well over half of total hospital expenses, any program to reduce spending must anticipate that much of the reduction will come about by reducing the number of employees. This section will militate against accomplishing that goal. Clearly, valid labor contracts must be maintained, but certification by the Secretary of Labor is bound to lead to protracted negotiations, additional expense and reduced flexibility in the effort to maintain the jobs of the remainder of the work force.

S. 2841

Section 1862 (a)(1) "...costs incurred in providing servicesto any individual...."

Arriving at the community service cost on the basis of losses incurred by individual patients is a monstrous administrative task. Hospitals normally aggregate the costs rather than saying that they lost \$8 by caring for Mr. Jones and \$20 for Mr. Smith. In addition, no institution, to the best of my knowledge, could retrospectively determine which of its patients were below the income cutoff. I would urge that 1. the hospital determine its ambulatory care loss in accordance with current federally mandated accounting practices, deduct collected charges and Hill Burton requirements; 2. a prospective sample of patients be queried in regard to their income over a two week period and the percentage of total non-Medicaid patients whose income is below 125% of the poverty level be determined;

3. multiply 1. by 2. to determine total community service factor.

The major concern is the need to develop data on patient incomes which is not presently on hospital records. In addition, language should be inserted to the effect that the hospital must accept whatever the patient says regarding his income and may not undertake an investigation into the accuracy of the statement.

(b)(1)(c) primarily serves a medically underserved population (see comments re: Section 1626 (a)(1).

In summary, these technical comments are in no way to be regarded as lessening our support for this vitally needed legislation. The concept of modifying the reimbursement formulas for Medicare and Medicaid by adding a community service factor gets at the heart of the problem by recognizing that everyone who uses a hospital must bear a proportionate share of the total costs of running the enterprise and cannot avoid their share of the responsibility for the cost of care to the working poor.

Finally, requiring that ambulatory care payment for Medicaid must be at "reasonable cost" levels corrects a long-standing inequity. States cannot be permitted to say that they are providing service to those eligible for Medicaid and then pay less than the cost of the service. It's just not fair.

The Greater New York Hospital Association would be pleased to assist in the further development of these bills and applauds the wisdom and courage of Senator Javits and his cosponsors for introducing these bills during this period of fiscal stringency. Recognition of the needs of the sick and of the institutions which serve them is a hallmark of our society. The relatively modest sums involved (in comparison to the cost of various national health insurance programs) make this program economically attractive and assures the ability of committed hospitals to continue to serve their communities.

STATEMENT OF THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
TO THE SENATE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

REGARDING

S. 2840 ("FINANCIALLY DISTRESSED HOSPITALS ASSISTANCE ACT")

AND

S. 2841 ("HOSPITAL AMBULATORY SERVICES REIMBURSEMENT REFORM ACT")

New York City Health and Hospitals Corporation
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Joseph C. Hoffman
President

David A. Mannis
Director
Intergovernmental Relations

The New York City Health and Hospitals Corporation is pleased to comment to this subcommittee on S. 2840 and S. 2841. We are particularly grateful to Senator Javits for introducing legislation which seeks to aid distressed hospitals. Whenever hospitals in this country serve the indigent and the near-poor, they face the chronic question of how to finance care provided to persons who cannot pay and who are not eligible for existing reimbursement programs. Legislation which offers even a partial solution to this difficult but crucial fiscal problem is welcomed and enthusiastically supported by the Health and Hospitals Corporation.

The New York City Health and Hospitals Corporation ("Corporation") consists of seventeen hospitals and numerous clinics. These facilities provide 3,300,000 days of inpatient care and approximately six million outpatient and emergency room visits annually. Of these outpatient visits, we estimate that about 64% are made by "self-pay patients." These patients are billed by the Corporation according to their means, but they actually remit only a tiny fraction of the cost of their care. The Corporation treats these persons because we know that they cannot obtain hospital care in the private sector and, in many cases, they live in neighborhoods where private doctors no longer practice.

The policy is essential to its beneficiaries, but expensive: outpatient treatment of uncovered patients costs the Corporation over \$230,000,000 each year.

The cost is assumed by the City of New York, together with all deficits caused by inadequate reimbursement, bad debts, and various

medical services which the Corporation provides for the City. In the fiscal year which just ended, although the Corporation netted \$27,000,000 in revenues beyond the City's expectations, the City's direct subsidy to the Corporation nevertheless exceeded \$440,000,000.

In addition, New York City--pursuant to State law--contributed twenty-five percent of all Medicaid dollars spent in the City (fifty percent of all Medicaid for services not reimbursed by the Federal government); through the Medicaid program alone, the City provided approximately \$108,000,000 of revenue to the Corporation last year.

Thus, the taxpayers of New York City contribute a total of \$548,000,000 each year to provide public hospital care.

The financial burden the City assumes on the Corporation's behalf is staggering but should not be surprising. Our outpatient population, of whom 34% are covered by either Medicare or Medicaid and only 2% have private insurance, personifies the liabilities faced by any hospital, public or private, which is willing to serve the indigent.

We believe that when it comes to providing hospital care for the indigent, differences between public and voluntary hospitals, and differences among hospitals in different parts of the United States are merely quantitative. Relief must be made available wherever a threshold level of care to indigent self-pay patients is provided, and should be available to eligible institutions on the basis of the quantity of such care provided.

The Corporation has had a chance to review some of the reactions to S. 2840 and S. 2841 and, knowing that many of our reactions to the proposed legislation have already been thoughtfully presented to the subcommittee, we will confine our comments to questions of program eligibility. These issues are common to both bills.

Eligibility of Public Hospitals

Both bills contain provisions exempting public general hospitals from certain of the criteria which other hospitals must meet when applying either for grant assistance under the terms of S. 2840 or ongoing additional reimbursement under S. 2841.

Thus, in S. 2840, a public general hospital need not show an actual deficit at the end of two consecutive accounting years (Sec. 1626 (a) (1) (D) (i)) or give evidence that assets have been liquidated and credit denied (Sec. 1626(a) (1) (F)). Similarly, S. 2841 excuses public hospitals from showing an accounting deficit (Sec. 1882(b) (1) (D)).

It would appear that the purpose of these exemptions is not permissiveness toward public hospitals--although, given the growing reluctance and inability of localities to fund public hospitals, special assistance is justified in our view--but rather to excuse public hospitals from specific types of evidence of insolvency which are not germane to public institutions.

Where a municipal facility serves the poor and also shows no deficit at the end of the year, that municipal hospital is tapping

the strained resources of local government to make up its losses. The fact that municipal hospitals in many cities have been closed (adding to the burdens of neighboring voluntary hospitals) and others are threatened with closing should demonstrate that municipal hospitals' need for relief is real, and as urgent as that of distressed hospitals under private auspices.

Therefore, we urge that S. 2840 and S. 2841 continue to measure eligibility of public institutions on the basis of volume of service to the indigent, but that every effort be made--by amending the bills if necessary--to assure the entire health community that public hospitals will fully document need before receiving assistance as distressed hospitals.

Determination of Non-paying Patient Population

Both S. 2840 and 2841 require a hospital to demonstrate that sixty percent of its patient charges are made against patients who are either Medicare- or Medicaid- eligible, or who are unable to pay despite diligent billing efforts by the hospital. In addition, S. 2841 provides relief in direct proportion to the number of uncovered patients in a hospital whose income does not exceed 125% of Community Services Administration income poverty guidelines.

These requirements would force many hospitals to confront questions which have too often been perceived as impossible to answer; i.e., exactly how many non-pay outpatient visits does a hospital receive, and what are the precise income characteristics of those visitors.

Since a detailed and accurate outpatient census requires a tremendous number of man-hours, many hospitals cannot divert the administrative resources necessary to do the job, even though the information such a census would yield is essential to hospitals and, in the case of public hospitals, the governments which support them.

Therefore, we suggest that outpatient census programs should be viewed as reimbursable activities for distressed hospitals, rather than a predicate for obtaining relief. S. 2841 in particular should contain provisions offering Federal assistance, through reimbursement or grant, to hospitals which undertake comprehensive surveys of indigent outpatients. These surveys should, if undertaken by enough hospitals, provide for the first time an accurate data base for resolution of such issues as hospital care for illegal aliens and the proper distribution and reimbursement of non-paying patients in the hospitals community.

Maintenance of Effort

S. 2840 and S. 2841 require that a distressed hospital must, as a condition of receiving assistance, provide assurances that State and local aid to that hospital will be maintained and, indeed, be increased in proportion to the inflationary growth of health care costs.

Such a requirement works a real hardship on a public hospital which, in deference to the financial straits of its municipality, is learning to live with a no-growth budget, or a hospital in a state

like New York where Medicaid assistance has been systematically reduced over the last few years. A municipal hospital--for whom deficit is matched by local funding--could not take advantage of this legislation to achieve the goal most distressed hospitals strive for: continuation of service on a more efficient basis with reduced deficits. To express the issue another way, a public hospital which has been forced to reduce services due to loss of state and local funding could restore those services under S. 2841, but a hospital could not use the legislation to avoid prospective reductions which local fiscal conditions dictate.

To resolve this vexing problem, we propose a number of alternatives:

1. Maintenance of funding levels should not be subject to the health care inflation rate if the budget of a hospital has contracted or shown no growth;

2. The same exception should apply when a hospital is funded by a municipality whose budget has shrunk or grown less than the inflation rate;

3. Institutions should not be barred from distressed hospital status because of Medicaid reductions and, in the case of public hospitals, local maintenance of effort should exclude any contribution made to offset reductions of funding at the state level;

4. Maintenance of local funding of a public hospital should exclude any monies paid for the care of illegal aliens.

Some combination of the above-stated alternatives would allow public hospitals to reorganize services pursuant to S. 2840 and S. 2841 without forcing local governments to continue shouldering health care

costs which, until now, no one else was willing to accept.

We hope that the subcommittee will take into account the concerns we have raised on behalf of municipal hospitals. Since public and municipal institutions historically have treated non-pay patients, and continue to make the most concentrated contribution to the care of such patients, we think it legitimate to seek those special eligibility criteria which will allow us to benefit from these worthwhile bills.

Thank you.

Senator JAVITS. Again, the committee expresses its gratitude to you.

The hearing is adjourned.

[Whereupon, at 12:40 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

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