URGENT SUPPLEMENTAL APPROPRIATIONS BILL, 1981

HEARING

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

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PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS

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URGENT SUPPLEMENTAL APPROPRIATIONS BILL, 1981

FRIDAY, JULY 17, 1981.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH SERVICES ADMINISTRATION

PUBLIC HEALTH SERVICE HOSPITALS AND CLINICS

WITNESSES

HON. NORMAN DICKS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON
HON. BARBARA MIKULSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND
HON. GUY V. MOLINARI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK
HON. JOEL PRITCHARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON
HON. MIKE LOWRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON
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ANTHONY ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET

TESTIMONY OF MEMBERS OF CONGRESS

Mr. NATCHER. The committee will be in order.

At this time we take up an emergency supplemental request pertaining to the Public Health Service hospitals and clinics. The amount of the request is $16,800,000. We have before the subcommittee at this time a number of our friends and colleagues in the House.

We want to welcome all of you before the committee at this time and to say to you that we appreciate the assistance that you have given us through the last several months on this matter pertaining to the Public Health Service hospitals and clinics and we are delighted to have you.

We know all about this matter. It has been before the committee during the regular hearings on the bill. We understand the situation fully.

I only speak for myself; I don't speak for the other members of the subcommittee. But we are friends on this subcommittee. We are delighted to have you.

Now, how shall we proceed? Mr. Dicks, you are a member of the full committee, suppose you start off.

Mr. DICKS. I will be very brief. I just wanted you to know that Congressman Pritchard, Congressman Lowry and I, and our delegation from the State of Washington strongly support this $16.8 million emergency supplemental, especially because the citizens of Seattle, Washington are very interested in a community takeover of this hospital. In fact, they have already submitted such a takeover plan to the Secretary of HHS.

Without this $16.8 million to keep the PHS hospitals operating through the end of this fiscal year it will be impossible for any plan for community takeover to be fully considered by the Secretary. Without these funds the hospitals will have to begin shutting down their operations very soon and this action will undercut the viability of any plan for community takeover. For this reason and the others in my statement, I strongly urge the committee to approve this supplemental. I also must say it is hard to understand how a mistake of this magnitude could be made by the Administration, particularly since a rescission of over $36 million was just sent to this committee.

However, it has been made and I hope the committee will support the $16.8 million, requested.

Mr. NATCHER. Mr. Dicks, we want to thank you for your statement.

As a member of the full Committee on Appropriations, you know that when we acted on the supplemental appropriation, the rescissions and the deferrals, we stated in the report that this subcommittee would consider any reasonable request that was made for the Public Health Service hospitals and clinics.

Mr. DICKS. I would like to ask the consent of the subcommittee to have placed in the record a copy of my full statement and a copy of a letter sent by Mayor Royer and Governor Spellman to Secretary Schweiker on this matter.

Mr. NATCHER. Without objection, it is so ordered.

[The statement and letter referred to follows:]

REMARKS OF HON. NORMAN D. DICKS

Thank you, Mr. Chairman. I appreciate the opportunity to testify on this very important matter.

Mr. Chairman, I strongly support this $16.8 million emergency supplemental appropriation for the continuation of Public Health Service hospital and clinic operations during the remainder of fiscal year 1981.

As you will recall, earlier this year I expressed my opposition to the administration's proposal to rescind $36,155,000 in fiscal year 1981 funds from PHS hospitals and clinics. At that time, I expressed my belief that a rescission request of this magnitude was extremely unwise since these hospitals and clinics continue to provide necessary and valuable health care to many of this Nation's citizens.

I also indicated that if the subcommittee determined that Federal support and operation of these hospitals was inappropriate due to economic and budgetary constraints, I would support, although reluctantly, a viable proposal which would permit the satisfactory transfer of operation of these hospitals to communities which could successfully continue their services.

As you know, on May 4, 1981, The Appropriations Committee approved the administration's rescission request to close these hospitals and clinics, and approved a report which endorsed allowing communities to take over these hospitals. In fact,

the committee's report added that "should any of these communities make a firm commitment to take over one of the hospitals, the committee will seriously consider a request to add funds to the 1982 bill to upgrade the facility for community use."

Mr. Chairman, I supported this action and this subcommittee's recommendations because I believe we should provide those communities who desire to take over a PHS hospital an opportunity to do so.

Unfortunately, if this emergency supplemental appropriation is not approved by this subcommittee and passed by the Congress, these communities will be denied this opportunity and thousands of the country's citizens will fail to receive necessary health care.

I don't know how or why the administration miscalculated or failed to anticipate a shortfall of this magnitude, but I do know that the consequences of this shortfall will be very severe and unfair to many Americans.

Unless the proposed supplemental funding request is approved, all temporary civil service employees will be terminated effective August 1, 1981 and all civil service employees, with the exception of caretaker personnel to be designated later, are to be furloughed on or about August 15, 1981.

If these employees are furloughed the hospitals will close down in October of this year.

This would also effectively end any possibility for community takeover of these hospitals.

Additionally, it would unfairly penalize cities, like Seattle, Washington, which have worked diligently and at considerable expense for community takeover of its PHS hospital.

Just weeks ago, the city of Seattle conveyed a plan for the continued operation of its PHS hospital under community control to Secretary Schweiker at the Department of Health and Human Services.

The plan was developed to meet a July 1 deadline specified by Secretary Schweiker, and represented an investment of hundreds of hours of labor by citizen volunteers, health care leaders, patient representatives and city, county, State and congressional staff.

A task force was formed and completed an objective study of the alternatives to closure of the Seattle PHS hospital and assessed the impact of closing the facility. Significant contributions from both the private sector and public agencies made this work possible.

Both Governor Spellman and Seattle Mayor Royer embraced the recommendations of the task force and advised the Secretary of their intent to preserve the hospital under local control.

They took this step because the Seattle PHS hospital serves a vital and irreplaceable role in the local health care delivery system. Unlike other cities with PHS hospitals, Seattle has no surplus hospital beds.

Not only does the hospital serve some 52,000 Federal beneficiaries, the vast majority of whom will continue to be eligible for Federal health care benefits even if the merchant marine entitlement is repealed, but it also sustains a network of some 22 neighborhood primary care clinics, serving another 50,000 persons.

In addition, the Seattle hospital is a major research and teaching center critical to local educational institutions. These functions cannot easily or completely be absorbed by other Seattle-area hospitals.

If this supplemental appropriation is not approved, this valuable health resource will be lost to the people of Seattle and Washington State, and thousands of patients, employees and citizens will be detrimentally affected.

In my view, this would be interpreted by a community which has acted in good faith with the Federal Government as a demonstration of extreme insensitivity to local health care needs by that Government.

Mr. Chairman, by its action on the fiscal year 1981 appropriations and rescission bill and on the omnibus reconciliation act, this Congress made a commitment to communities, like Seattle, to continue the service and operations of PHS hosptials while the Secretary of HHS reviewed their plans for a community takeover and arranged for viable transfers to local control of these hosptials.

This Congress also made a commitment to provide quality, effective health care to this Nation's citizens.

Mr. Chairman, I urge you and the subcommittee to help us meet these commitments by approving this supplemental appropriation request.

Again, thank you for the opportunity to testify on this matter.

State of Washington

JOHN SPELLMAN, Governor

OFFICE OF THE GOVERNOR

June 30, 1981

The Honorable Richard Schweiker
Secretary
Department of Health and
Human Services
Hubert H. Humphrey Building
Washington, D.C. 20201

Dear Mr. Secretary:

With this letter, we are conveying a plan for the continued operation of Seattle's Public Health Service Hospital under community control.

The plan was developed to meet the July 1 deadline specified in your letter of June 1, 1981, and represents an investment of hundreds of hours of labor by citizen volunteers, health care leaders, patient representatives and city, county, state and Congressional staff. A task force created at the request of our Congressional Delegation has completed an objective study of the alternatives to closure of the Seattle PHS Hospital. The task force also retained a consulting firm to assess the impact of closing the facility. Contributions from both the private sector and public agencies made this work possible. As you know, we embraced the recommendation of the task force and on June 4, 1981 advised you of our intent to preserve the hospital under local control.

Quite simply, the Seattle PHS Hospital serves a vital and irreplaceable role in the local health care delivery system. Unlike other cities with PHS hospitals, Seattle has no surplus hospital beds. From this standpoint alone, outright closure of the facility is not acceptable. Not only does the hospital serve some 52,000 Federal beneficiaries, the vast majority of whom will continue to be eligible for Federal health care benefits, even if the Merchant Marine entitlement is repealed, but it also sustains a network of some 22 neighborhood primary care clinics, serving another 50,000 persons. The Seattle hospital also is a major research and teaching center critical to local educational institutions. These functions cannot easily or even completely be absorbed by other Seattle-area hospitals.

Our intent in moving forward with this transition is to preserve for the future a health care system which has succeeded in meeting a variety of health care needs. We have made every attempt to craft a

plan which will continue the hospital's services to traditional Federal beneficiaries and to the working poor referred from Seattle's community clinics. We have planned for the continuation of the hospital's major role in teaching and research, and expect to retain its dedicated staff. We are hopeful that the transition will allow the hospital to continue as an innovative force in our community, capable of responding to future challenges as effectively as it did to the Boeing recession of the early 70's and the influx of Indochinese refugees during the past three years.

To make the transition possible, the Seattle community has already taken the following steps:

A charter is pending for a "Public Health Hospital Preservation and Development Authority," a public corporation, chartered by the city of Seattle to operate in the health field, and specifically to operate the Seattle PHS Hospital. A more complete description of this corporation is included in the plan, and the charter is enclosed as an appendix.

A governing council for the authority is being recruited which includes community leaders with expertise in all aspects of hospital and medical facility operations and with ties to the existing patient community. This council will be the governing board for the hospital and assume full responsibility for the institutions's financial and operational well-being.

The hospital's medical staff has taken the necessary steps to form a non-profit group practice to provide health services in cooperation with the public authority.

We appreciate the opportunity to work with the Administration to preserve the Seattle PHS Hospital. Transition to local control not only demonstrates your sensitivity to local health care needs but presents an opportunity to continue to provide care to Federal beneficiaries through the Seattle hospital without the disruption which would accompany closure and, perhaps more importantly, at substantial long-term savings to the Federal government. If together we are successful in making this transition, the Administration will have demonstrated its concern for our community and the hospital's patients and employees by helping us to save an absolutely vital facility.

If our efforts are to bear fruit, the Federal government must now take the necessary actions to allow the transition to succeed. These are enumerated in the enclosed plan. Obviously, discussions regarding these actions must proceed apace, given the Administration's announced deadline for transferring the hospital to

community control. We previously designated Tom Byers of Mayor Royer's staff (206-625-4000) as the person through whom your staff should communicate with us. We would appreciate an indication to Mr. Byers shortly after the July Fourth Congressional recess of how we can proceed to resolve the outstanding issues. This will enable us to coordinate with our Congressional Delegation regarding the hospitals specific needs in the context of the fiscal year 1982 appropriations process.

Thank you for your continuing interest in facilitating this transition.

Sincerely,

John Spellman
Governor

Charles Royer
Mayor, City of Seattle

Mr. NATCHER. Mr. Dicks, if you would for us, please present these other Members of the House to the Committee. Who do we have next?

Mr. DICKS. Mr. Chairman, we have Congressman Pritchard from Seattle next.

Mr. NATCHER. Go right ahead.

Mr. PRITCHARD. I will be very brief, Mr. Chairman. You understand the situation.

What has happened has shocked us because we thought we were on track in keeping good faith with the direction that this Administration wanted, which is to turn this facility into a local facility, and, of course, the main thing, to bring health care to the people in our area. This furlough, which I think is absurd, must be rectified by you.

So we appeal to you. You understand the situation. If you can get us through this short period, we think we can carry on locally, which is what we all want. We appreciate your concern at this time.

Mr. NATCHER. Thank you, Mr. Pritchard. We appreciate your assistance.

Mr. LOWRY. Mr. Chairman, I want to thank you and the panel for your understanding. We have been on the phone many hours, with our colleague, Mr. Livingston; he is uniquely interested in this.

You are working hard at solving this severe problem in health care for the people of this country and I want to thank you for that, we all want to thank you for that. This supplemental of course, requires immediate action and you are well aware of that.

Mr. NATCHER. Thank you, Mr. Lowry.

We want you to know that we appreciate your assistance in this matter.

Mr. DICKS. Mr. Chairman, we also may want to talk to you before the mark-up of the fiscal year 1982 appropriation bill about the necessity for some Federal assistance to make this transition

possible. We hope that you and the subcommittee will give this request sympathetic consideration.

Mr. LIVINGSTON. Mr. Chairman?

Mr. NATCHER. Yes.

Mr. LIVINGSTON. If the chairman will yield I want to tell this panel that I share their problem. My colleague, Lindy Boggs, and I have a Public Health facility in our district, at least in the City of New Orleans, Lindy Boggs' district, and our phones have been ringing off the hook just as yours have.

We are vitally concerned about this problem. We had expected an orderly transition, of course, to go forward in October. But this caught us all by surprise.

I want to say that the chairman has been most helpful to us all. He has cooperated with us and bent over backwards to make sure that this matter is handled expeditiously. We have gotten similar assurances from the Secretary who will be represented here later on to express his viewpoint as well as the Director of the Office of Management and Budget.

I think between all of them we can get some pretty good cooperation and I think we will have this problem solved.

Mr. NATCHER. Ms. Mikulski, it is a pleasure to have you before the committee.

Ms. MIKULSKI. Thank you very much, Mr. Chairman.

I am here speaking on behalf of the Public Health hospital in Baltimore that employs approximately 700 people, and the entire Maryland delegation who support this legislation.

As has been stated, you are familiar that we are now caught with a cash flow problem that jeopardizes any type of orderly transition.

There is no doubt that some will be closed and some will move to community conversion. My own hospital has submitted a plan for community conversion to Secretary Schweiker. We understand it has received tentative favorable review. It has the support of the Governor of Maryland.

What we need now is the money to keep those 700 people from being furloughed. When we talk in macrometric bucks, like $16 million and 700 people, we forget who we are talking about. I just want you to know who those 700 people are. One is a janitor who came from the concentration camps of Germany, still so scared he walks around with his belongings everywhere because he is afraid that something is going to happen to him; a nurse who is a widow supporting children, putting them through local Catholic colleges; to very highly skilled surgeons and radiologists.

What we are doing in Baltimore is a good job meeting the needs of the people. We need that help. We would appreciate any consideration you can give us.

Mr. NATCHER. We want to thank you not only for your appearance today but also for your full assistance on this matter all down through the weeks and days that we have had it before the committee.

Mr. Molinari, we know the importance of this particular request to you and to your people. We appreciate your attendance. We would be glad to hear from you.

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Mr. MOLINARI. Thank you, Mr. Natcher. I certainly appreciate the opportunity to be able to address you briefly on this serious question.

I represent the largest Public Health hospital in the system which employs some 1,100 employees. As a result of the notice of closure, my hospital, and I am sure the others, is experiencing difficulties in retaining key personnel.

I have a letter from Mr. Schweiker that I received the day before yesterday wherein he says that what we need is an aggressive recruitment to assure the level and quality of the services which now characterize operation of that hospital.

Well, that is what we have been attempting to do. We have a plan that has been submitted. But once the furlough notices hit the community, well, I tell you, the resignations started to fly and we are faced with a life and death situation.

The hospital in question had an occupancy rate as high as 93 percent. We have no other facilities that can take over the patient load. It is a very critical matter. Of this $16.8 million supplemental request 75 percent of that sum was occasioned by the notice of closure itself.

I think we in Congress owe this funding to the facilities that are attempting to take over and operate these hospitals for the sake of the communities. I made a promise that I would be brief but I cannot emphasize too strongly how critical it is to the hospital and the community that I represent.

I again thank the members for permitting me to say a few words on it.

Mr. NATCHER. Mr. Molinari, we appreciate your attendance before our committee and you can rest assured that every consideration will be given to your request.

At this point we will insert statements and letters from a number of our colleagues in the House and in the Senate pertaining to this matter. They will be placed in the record in their entirety.

[The statements follow:]

LINDY (MRS. HALE) BOGGS, M.C.
2D DISTRICT, LOUISIANA

COMMITTEE:
APPROPRIATIONS

WASHINGTON OFFICE:
2353 RAYBURN BUILDING
WASHINGTON, D.C. 20515

PEG KAVALJIAN
ADMINISTRATIVE ASSISTANT

Congress of the United States
House of Representatives
Washington, D.C. 20515

July 16, 1981

Honorable Jamie L. Whitten
Chairman
House Committee on Appropriations
H-218 - The Capitol
Washington, D.C. 20515

Dear Mr. Chairman:

It is my understanding that the Subcommittee on Labor, Health and Human Resources, and Education will hold a hearing on the Reagan Administration's request for a Supplemental Appropriation for Fiscal Year 1981 of about $16.8 million to continue the orderly operation of the U.S. Public Health Service Hospital System for the balance of this fiscal year.

According to information received from Mr. Albert Stapler, Assistant Director of the New Orleans Hospital, as many as 400 employees would be furloughed for approximately six weeks and about 4,000 nationally. The shortfall in funds is approximately $1.25 million locally and, of course, about $16.8 nationally.

Although many employees have either found employment elsewhere or have tendered their resignation in order to seek other employment, there are many employees still remaining with the system.

I am, therefore, writing to you to urge your very kind consideration of this matter.

With all good wishes.

Sincerely,

Lindy

Lindy (Mrs. Hale) Boggs, M.C.

LB:wc

STATEMENT BY THE HONORABLE WALTER B. JONES
CHAIRMAN OF THE MERCHANT MARINE AND FISHERIES COMMITTEE
BEFORE THE SUBCOMMITTEE ON APPROPRIATIONS
ON
LABOR, HEALTH, EDUCATION AND WELFARE
JULY 17, 1981

THANK YOU FOR ALLOWING ME TO SUBMIT THIS STATEMENT FOR THE RECORD. WHILE I CAN'T SPEAK TO YOU IN PERSON, THE ISSUE BEFORE YOUR COMMITTEE IS OF THE UTMOST URGENCY, AND I WANT TO STRESS ITS IMPORTANCE.

I STRONGLY URGE THAT YOU APPROPRIATE $16.8 MILLION IN FY81 SUPPLEMENTAL MONIES TO THE PUBLIC HEALTH SERVICE (P.H.S.) HOSPITALS AND CLINICS IN ORDER TO MEET THE PAYROLL OF ITS EMPLOYEES. WITHOUT THIS ADDITIONAL MONEY, SOME 5,000 PHS EMPLOYEES, INCLUDING DOCTORS AND NURSES, WILL BE FURLOUGHED FOR SIX WEEKS BEGINNING ON AUGUST 15 AND THEN CALLED BACK TO WORK THE END OF SEPTEMBER, ONLY TO BE TERMINATED ON OCTOBER 1, 1981 WHEN THE PHS SYSTEM WILL BE CLOSED. THE SHUTDOWN OF EIGHT HOSPITALS AND EIGHT CLINICS IN SUCH A SHORT PERIOD OF TIME IS A DIFFICULT PROCESS. THE SKILLS OF THESE EMPLOYEES WILL BE NEEDED DURING THE PERIOD THEY ARE NOW TO BE FURLOUGHED IN ORDER TO PHASE THIS SYSTEM OUT IN AS ORDERLY AND COMPETENT MANNER AS POSSIBLE.

THE CLOSING OF THE PHS SYSTEM IS JUST ONE OF THE SIDE EFFECTS OF THE DRASTIC ACTION THE CONGRESS HAS CHOSEN TO TAKE IN THE FY81 BUDGET. SOON WE WILL HAVE TO FACE THE REAL HARDSHIPS WE HAVE CAUSED FOR SO MANY PEOPLE. IT IS NEVER EASY TO FIRE SOMEONE WHO HAS PERFORMED COMPETENTLY AND WITH DEDICATION. BUT THE LEAST WE CAN DO IS TO SEE THAT THE TERMINATION OF THESE PROGRAMS, INCLUDING THE PHS SYSTEM, ARE CARRIED OUT IN A RATIONAL, SYMPATHETIC MANNER.

STATEMENT BY SENATOR HENRY M. JACKSON
ON THE
EMERGENCY SUPPLEMENTAL BUDGET REQUEST
FOR
THE PUBLIC HEALTH SERVICE HOSPITALS

I first want to commend Congressman Natcher's quick response to the Administration request for an emergency supplemental of $16.8 million for the continued operation of the Public Health Service Hospitals through FY81.

I have long been concerned for the future of the Public Health Service Hospitals, particularly Seattle's, since the facilities were threatened with closure in the early 1970s. The Seattle PHS Hospital has increasingly focused its resources on the unmet needs of the Pacific Northwest and is an integral element of the medical system in this region. I simply do not agree with the Administration's policy to close these hospitals.

I believe that by objective standards the Seattle Hospital is one of the finest, most cost-effective hospitals within our public health care system. It is of vital importance to the delivery of health care in the Northwest. Over 50,000 people in the Northwest depend on the PHS Hospital for the delivery of health care. The traditional beneficiaries of the PHS Hospital include seamen, fishermen, defense and other federal personnel, retirees, dependents and Native Americans. The Seattle private sector cannot absorb this number. Regardless of the outcome of the PHS system, the federal government will continue to be obligated to provide health care to many, if not all, of these groups.

The Mayor of Seattle, at the request of several members of the Washington State delegation, convened a task force in February that included representatives of patient groups,

private medicine, state and local governments, health care planning agencies and other interested groups to examine the options in the event the hospital were closed. The task force has made much progress toward the establishment of a City-chartered public authority to operate the hospital. All this was done in reliance on the Administration's assurances that it would aid the communities in their efforts to take over its facility. The Congress also addressed the issue of federal assistance to communities wishing to take over their facility. The conference report language (H.Rept. 97-124) of the President's rescission package gives priority for allocating FY81 funds to those hospitals "whose communities have made a firm commitment to assume their operation..." Without this supplemental request, the task force's efforts, as well as those efforts made in other communities, will have been meaningless. No community can be expected to take over their hospital prior to the end of FY81; never was there that expectation. Both the Administration and the Congress have made commitments which necessitate the passage of this supplemental.

I was much pleased at the support of the PHS Hospital system I received from my colleagues in the Senate as we worked through the FY81 supplemental measure and the FY82 appropriations. Senator Hatfield, as chair of the Senate Appropriations Committee, and Senators Stevens, Johnston and D'Amato, all members of that Committee, were most helpful during the committee process. Senator Stevens continues to be willing to do what he can to maintain the Seattle facility.

What we need is the $16.8 million to get us through to October 1, 1981. I believe the investment would represent substantial savings to the federal government in the future

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by adding the necessary time for the now-federal institutions to be turned into local entities capable of serving federal beneficiaries at a lower cost than would otherwise be possible. The need is realistic. And the transition needs to be consistent with the assurances of the Administration to try to ease the way for the creation of a viable new entity.

This $16.8 million needed to achieve the FY81 transition is well within the realm of possibility and well within the contemplation of both the Administration and Congress as they both dealt with the possibility of local control.

The Seattle hospital is a nationally recognized facility supporting a remarkable network of primary care facilities in Seattle and throughout the region. The critical role it plays in our area's health care system has led Governor Spellman and Seattle Mayor Royer to advise Secretary Schweiker that they intend to pursue local control of the facility.

I hope that the Subcommittee will agree that the best and long-term interests of the federal government would not be served simply by locking the doors of facilities whose communities have gone far down the road toward takeover. That is the alternative to this supplemental budget request. Such an action would prove penny-wise and pound-foolish in terms of providing care to federal beneficiaries, let alone our continued obligation to others in the population who depend upon that fine hospital and its dedicated staff and who literally have no alternatives.

JULY 17,1981

STATEMENT OF SENATOR SLADE GORTON TO THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES.

Mr. Chairman, Members of the Subcommittee, I want to thank you for your prompt consideration of the emergency supplemental request of the Department of Health and Human Services. Swift action on this request is not only necessary to assure the continued efforts of the affected communities to develop plans for assuming control of the hospitals but is vitally important to the employees of the hospitals and certainly to the patients.

While it is unfortunate that this supplemental request is necessary, particularly since we have just finished with the Supplemental Appropriations and Rescissions bill, we should not let the circumstances under which the request has arisen cloud our consideration of its merits. In the course of the Supplemental Appropriations and Budget processes the Congress has shown its clear intent that, if the Public Health Service hospitals are to be closed, the communities in which they are located are to be given the opportunity to assume the operation and control of the facilities.

In Seattle, the Public Health Service hospital plays a key role in providing both health care and as a teaching and research facility. It is estimated that the Seattle area will have a shortage of more than 400 hospital beds by 1985 even without the closure of the Public Health Service hospital. There can be no doubt that the closure of the hospital will have a devastating impact on the delivery of health services in the Seattle area, as well as aggravating the area's unemployment problem.

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Because of this, the Washington State delegation, the City of Seattle, the State and many other interested parties have spent numerous hours and great efforts to develop a plan for the assumption of control of the hospital by the community. That plan has already been submitted to the Secretary of HHS as have the plans of several other communities. We are hoping to be able to work with the Department in the coming months to perfect the plan. If this supplemental request is rejected, there can be no community take-overs and the good faith efforts of citizens around the country will have gone for naught.

I urge you to support the promise Congress has made to these communities. We owe them a reasonable chance to salvage what, in many instances, is a medical resource that cannot be replaced.

Senator Jackson and I will do all that we can to obtain the approval of this request by our Senate colleagues. We hope we have your support.

Mr. NATCHER. Now, before these ladies and gentlemen leave, I yield on either side. Mr. Conte, do you have any observations?

Mr. CONTE. I sympathize and fully understand the problem. I have heard from most of these witnesses. Mr. Molinari has been in touch frequently. We will expedite this.

We have a good chairman here, a great chairman. We work as a team, together; we will move this thing out so fast it will break all records.

Mr. NATCHER. Thank you.

Any others on either side?

Mr. EARLY. I am sure you know there is one Public Health hospital in Massachusetts; it is not in Mr. Conte's district nor in mine. The chairman has cooperated on this matter. I suspected from the testimony we had when we considered rescissions that there would be no layoffs until the end of the year.

There were assurances to this committee that that would not happen.

Mr. DICKS. Just a comment. Mr. Chairman, I think it is shocking that the Administration forced these notifications to go out when Congress is considering this supplemental appropriation. I can't believe the Administration took this action.

These people don't know what the Administration's position is and they are asking: "Should we stay or quit?" For those trying to keep the hospitals alive, this was a very serious blow.

Mr. NATCHER. Thank you very much. We appreciate all you Members appearing before the Subcommittee.

Mr. DICKS. Thank you.

TESTIMONY OF THE ASSISTANT SECRETARY FOR HEALTH

Mr. NATCHER. We have before the committee at this time Dr. Edward N. Brandt, Assistant Secretary for Health. Dr. Brandt, who do you have with you at the table?

Dr. BRANDT. Sitting on my far right is Mr. Anthony Itteilag, who is the Acting Deputy Assistant Secretary of the Department for budget affairs.

Next to him is Ms. Alair Townsend, Deputy Assistant Secretary for Health Operations. Next to me, Mr. John D. Mahoney, Chief of the Budget Branch of the Public Health Service.

To my left, is Dr. John Marshall, Acting Associate Administrator for Operations of the Health Services Administration. Finally, I have with me Mr. John Kelso, who is the Acting Administrator of the Health Services Administration.

Mr. NATCHER. We are delighted to have all of you ladies and gentlemen before the committee.

Dr. Brandt, we will be pleased to hear from you.

Dr. BRANDT. Mr. Chairman, members of the committee:

I am very grateful to you for this opportunity to appear before you to discuss our fiscal year 1981 emergency supplemental request for the Public Health Service Hospitals and Clinics system.

I wish to begin by conveying to you, Mr. Chairman, and the other members of this committee, the urgency with which the Administration is proposing this supplemental request.

The Congress has directed the Department to keep the hospitals open until October 1, 1981 and to pursue actively and effectively the transfer of hospitals for community use. We share these goals and wish to comply.

However, because of the shortage of funds, neither goal can be achieved. The $16.8 million which we are requesting is critical in order for the PHS Hospitals and Clinics to continue operating for the remainder of fiscal year 1981.

Unless these funds are appropriated, it will be necessary for the 8 general medical-surgical hospitals and 27 outpatient clinics to close in August of this year. Operations will continue at the National Hansen's Disease Center in Carville, Louisiana.

I am before you today requesting your expedited approval of the emergency supplemental, cognizant of the short timeframe which is being provided Congress to consider this request, and grateful for this prompt hearing.

Earlier in the year, rising hospital costs necessitated a series of management actions to operate within budget levels. It was projected that these actions, coupled with congressional approval of the President's revised 1981 budget, would provide sufficient funds to accomplish an orderly phase-down of hospital operations.

However, Mr. Chairman, several subsequent events have resulted in a funding shortage:

First, and most significant, is our recent projection of revenues which indicate that we will have a $12.5 million shortfall in reimbursements from patients served by the system.

These patients, principally DOD patients and others, have not used the system in the numbers which had been projected earlier. Hence, the level of services rendered has declined as has the money collected.

Second, on June 4, 1981, the U.S. District Court ordered the Department to continue the provision of contract medical care and to maintain PHS hospital and outpatient clinic operations at the 1973 level as required by Public Law 93-155 without regard to current budget restraints.

While this Order was vacated by the appellate court on June 25, 1981, compliance with the Order during the effective period is estimated to have cost $1.7 million.

Third, the 1981 Supplemental Appropriations and Rescission Act increased the rescission for the Hospitals and Clinics by $1.1 million above the President's request.

Fourth, this same Act established a funding limitation of $128.4 million for Hospitals and Clinics operations.

This limitation precluded the Administration from requesting a $1.5 million reprogramming request from Building and Facilities funds needed to assist the PHS Hospitals and Clinics in their efforts for an orderly phase-out.

These factors, in total, have produced a $16.8 million operating deficiency. Without these funds the Administration will be forced to terminate inpatient care by August 1, 1981, and outpatient services on September 1, 1981.

In addition, over 4,000 civil service and wage grade employees would have to be furloughed, and would not receive severance pay or lump-sum leave pay until next fiscal year when funds become available.

Unemployment compensation may be applicable in some cases during the furlough period but benefits have to be determined by the local unemployment office.

Early closure of the hospitals and clinics is not consistent with the President's plan and congressional intent, and would also seriously jeopardize community takeover of these facilities. Such community takeover is an important element of the President's proposal for the closure of the PHS Hospitals and Clinics system.

I hope, Mr. Chairman, that I have been able to convey the urgency of this need.

At this time, I will be happy to answer any questions which you and the committee might have.

Mr. NATCHER. Dr. Brandt, thank you very much for your statement.

REIMBURSEMENT SHORTFALL

Now, if you will, please, tell us when the Department first became aware of the shortfall in the hospital system's operating budget and give us the principal reason, if you can, for the shortage there.

Dr. BRANDT. The principal reason for the shortage is the deficit or the revenue shortfall of $12½ million. That accounts for two-thirds of it. We became aware of the magnitude of this problem approximately two weeks ago, roughly July 1.

FURLOUGH NOTICES

Mr. NATCHER. Have furlough notices gone out to all of the employees at the hospitals and clinics?

Dr. BRANDT. No, sir. We have sent to all of the employees of the hospitals and clinics a letter informing them that there might be a furlough and informing them that we have requested this supplemental appropriation in an attempt not to have to furlough them. But they have not been given a furlough notice yet; we have only informed them that there might be a furlough.

ADEQUACY OF REQUEST

Mr. NATCHER. Are you confident that the $16.8 million now before the committee will be sufficient to carry the hospitals through the end of October?

Dr. BRANDT. This will be sufficient to carry them through the end of September. Then there are funds in the 1982 budget for the month of October.

Mr. NATCHER. If a smaller amount of money, less than the $16.8 million is made available, could you keep the hospitals open and operate them at a reduced level? Is there any means of reducing the $16.8 million without causing serious trouble?

Dr. BRANDT. The major way that we would have to deal with less than the $16.8 million would be to begin closing down some of the clinics.

The problem with hospitals is that you still have to maintain the 24-hour day coverage, seven days a week. It is very difficult to cut down services. So we would begin to close the clinics if we receive less than $16.8 million.

CURRENT COST REDUCTION EFFORTS

Mr. NATCHER. What specific steps, if any, have you taken so far to reduce costs in the hospital system to make up for the shortfall? Have you taken any steps up to this time?

Dr. BRANDT. Yes, we have.

We have, for example, reduced and in fact eliminated contract care. That is care that seamen can receive from physicians under contract.

We have reduced our maintenance and rehabilitation expenditures to essentially zero.

We have reduced the purchase of supplies considerably and attempted to, thereby, cut money.

In fact, we have reduced our total operating budget as projected by $25.8 million since March.

OCCUPANCY RATES

Mr. NATCHER. What percentage of the system's inpatient beds are currently occupied, just approximately? Any figure on that?

Dr. MARSHALL. It is difficult to be able to provide those figures in terms of occupancy because, as we have cut back on the various expenses, Mr. Chairman, we have had to consolidate some kinds of wards. But, right now, by the census of occupancy, we have 812 beds filled, as compared with 1,161 beds filled a year ago at this time.

So we are down by about 30 percent in the occupancy.

SUPPLEMENTAL/RESCISSION BILL

Mr. NATCHER. Thank you.

Now, Dr. Brandt, as you know, this committee is very much concerned about this matter. In fact, in our report that we carried in the supplemental bill, the supplemental appropriations and rescissions for 1981, on page 207 we incorporated the following language and I quote:

> The committee has heard testimony from the Administration indicating that several of the communities in which these hospitals are located are considering the possibility of taking over operation of a particular facility.
>
> Should any of these communities make a firm commitment to take over one of the hospitals, the committee will seriously consider a request to add funds to the 1982 appropriation bill to upgrade the facility for community use.

Dr. Brandt, we would appreciate it if you and the others in the Department would keep that in mind; not only in addition to this $16.8 million, but in regard to all of the other matters pertaining to these hospitals and the clinics to help these communities as much as possible.

Dr. Brandt, you will find this subcommittee will be very cooperative as far as your requests are concerned.

Mr. Conte, I yield to you.

Mr. CONTE. Thank you, Mr. Chairman.

ACCURACY OF ESTIMATE

Now, Doctor, you are seeking $16.8 million in an emergency supplemental. How confident are you that this is in fact the amount you will need to keep the Public Health Service hospitals operating through the end of the fiscal year?

Dr. BRANDT. We have taken every pain possible to study our needs between now and October 1.

We believe this is realistic, we have reduced our revenue expectations on the basis of our reduced patient load and we feel confident that this will carry us through the end of September.

Mr. CONTE. Was this estimate based on the ideal circumstances in every factor, proceeding as planned, or have you built in some room for additional problems such as dwindling reimbursements?

Dr. MARSHALL. We have predicted that the reimbursements will continue to fall off slightly. When we look at our obligation rates there probably is perhaps $2 million of maneuvering room between the best case of everything going exactly the way we want it to and the worse case.

This estimate is fairly close to the worse case. By worse case I mean we would continue the strict controls we have over expenditures but reimbursements might fall off further than anticipated.

Mr. CONTE. So you left that elbow room in there?

Dr. MARSHALL. Yes.

Mr. CONTE. Nearly $9 million of the amount you seek will go for personnel compensation and benefits.

The question I have is why could you not have anticipated these costs more accurately when you put together the supplemental rescission bill?

Dr. MARSHALL. Those are the personnel costs that we anticipated at that time; the shortfall comes in the difference between the

revenue we had anticipated and the revenue receivables that we have actually been able to collect in that period.

The personnel staffing during that period of time was projected somewhat higher, because, at that time, we anticipated that we would have about 177 new interns and residents arriving on July 1. Hence we would have the costs of bringing them to duty, their salaries in the fourth quarter. Approximately half of those costs materialized.

The problem was not in the estimate of personnel expenditures but in the shortfall on the other side.

DATE OF POTENTIAL CLOSURE

Mr. CONTE. If we don't provide these additional funds through this urgent supplemental, what is your estimate of the date that the hospital system would exhaust all available resources?

Dr. BRANDT. All of the resources would be exhausted by September 1. In order for that to occur, we would stop admitting patients to the hospitals on August 1, furlough the employees of the hospital by August 15, because it would take us that long for all of the patients in the hospital to recover or be sent to other hospitals, and close the outpatient clinics on September 1, seeing no more patients. At this point in time, we would be essentially out of money.

FURLOUGH NOTICES

Mr. CONTE. As I understand it, you sent furlough notices as of the 15th of July. To how many Civil Service and Wage Board employees were the furlough notices sent?

Dr. BRANDT. According to Civil Service rules, Mr. Conte, we have to alert or notify the employees of a potential furlough. They have not received an official furlough notice yet. They have received a notice that a furlough is a possibility, if this appropriation is not granted.

We sent that to approximately 4,000 employees—it would be a few less than that.

Mr. MAHONEY. Thirty-eight hundred.

Mr. CONTE. Those are just notices, not actual furloughs?

Dr. BRANDT. That is correct. No one has been furloughed and no one has been notified officially that they will be.

Mr. CONTE. Were any of the hospitals exempted from the furlough notices or do you anticipate that should you actually have to lay off employees in August that any hospital might be exempted from across-the-board layoffs?

Dr. BRANDT. If we receive none of the supplemental funds it will not be possible to exempt any hospital from the layoff and that, of course, is assuming that in all of this we are not including the National Hansen's Disease Center at Carville, because we in no way plan on closing that facility.

Mr. CONTE. Once the furloughs go into effect, how many employees and commissioned officers would be left at each hospital?

Dr. BRANDT. There would be simply a small number of people to maintain the—to keep the building secure and to go through a closing phase, that is all. All the rest of them would be furloughed.

Mr. CONTE. What are the numbers?

Dr. BRANDT. Two hundred fifty people would be kept on.
Mr. CONTE. How many would be furloughed?
Mr. MAHONEY. Thirty-eight hundred.

CONTINGENCY PLANS

Mr. CONTE. Your statement indicates that inpatient care would be terminated on August 1. What contingency plan have you formulated to place patients who are not medically ready for discharge on August 1 and how many patients do you estimate fall into that category?

Dr. BRANDT. Our plan calls for no admissions after August 1. We would maintain all patients in the hospital until August 15. We don't anticipate there would be any patients left after that date, but should there be, we will have made or will make arrangements with other Federal hospitals and if there are no other facilities available, with private hospitals for those patients.

But we do not anticipate that we would have any patients left in the hospital after August 15.

Mr. CONTE. Is it realistic to think that you will have adequate staffing to continue outpatient service until September 1st?

Dr. BRANDT. Yes, sir. We will maintain the independent clinics until September 1.

REPROGRAMMING ALTERNATIVES

Mr. CONTE. To what extent did you consider requesting a reprogramming of funds within the Office of Assistant Secretary rather than seeking a supplemental?

Dr. BRANDT. We examined the possibility of reprogramming. At this level of money, $16.8 million, should we have to reprogram funds, we would have to cut off continuation grants to grantees in the States in the area of health services research, health statistics, health care technology; we would not be able to continue the health maintenance organization commitments; and we would begin to reduce continuation grants, not new ones, continuation grants, in adolescent pregnancy, smoking and health and other programs.

To take the money from a reprogramming would mean that we would have to do away with commitments already made to grantees.

Mr. CONTE. You feel that if the Congress can act on this supplemental before the August recess that you are in good position to continue on?

Dr. BRANDT. Yes, sir. If this is acted upon favorably by the Congress by the August recess we will have the clinics open. As soon as action is taken, we will notify all the employees and move on.

Mr. CONTE. Do you have any estimates, good estimates of the amount of the unobligated funds at this time in the Office of the Secretary?

Dr. BRANDT. Unobligated; yes, sir.

Mr. CONTE. Can you provide a table for the record?

Dr. BRANDT. Yes, we will provide it to you.

[The information follows:]

Office of the Assistant Secretary for Health (OASH)

Obligations by Activity
(Dollars in thousands)

Office of the Assistant Secretary for Health Activities:	Total FY 1981 Funds Available	FY 1981 Obligations Through 7/20/81	Planned Fourth Quarter Obligations		
			Program Continuation Requirements	Administrative Mandatories 1/	Available for New Awards
Health Services Research	$30,122	$19,444	$ 5,802	$2,908	$1,968
Health Statistics	38,006	36,884	---	1,122	---
Health Care Technology	3,989	1,820	---	455	1,714
Program Management	1,079	869	---	210	---
Health Maintenance Organizations	28,912 2/	15,458	11,234	2,220	---
Adolescent Health	9,983	894	6,360	1,200	1,529
Smoking and Health	12,062	1,034	9,500	1,528	---
Health Promotion	2,306	1,078	---	1,228	---
Physical Fitness	789	604	---	185	---
International Health	779	675	---	104	---
Regional Management	5,374	4,040	---	1,334	---
Program Direction	16,904	12,829	---	4,075	---
PHS Termination Expenses	40,000	---	---	40,000	---
TOTAL	$190,305	$95,629	$32,896	$56,569	$5,211

1/ Includes salaries and expenses and her necessary administrative costs to conduct OASH programs.
2/ Includes $8,675,000 in carryover funds from 1980 appropriations.

IMPACT ON COMMUNITY CONVERSION OPTION

Mr. CONTE. What do you estimate would be the impact on the community takeover of these hopsitals if we do not provide the funds and they were forced to close on August 1?

Dr. BRANDT. I think the major problem that would interfere with the community takeover would be principally the loss of staff. That would be the major difficulty that would be faced by the communities that wanted to take them over. No community that we are aware of would be prepared to take it over by the time we would have to close down, which would be August 15.

I think they would lose a large number of staff and it would slow down their process by three to six months.

Mr. CONTE. Has there been any community that submitted a preliminary proposal for taking over the hospitals? Can you give us a list of those?

Dr. BRANDT. Yes, sir. I can tell you that we have received proposals from Seattle, Baltimore, Staten Island, Boston, and Norfolk; we have also received a request from the City of Nassau Bay that they be permitted just to take it over.

Mr. CONTE. Could you supply for the record a breakdown of just how the $16.8 million will go to each hospital?

Dr. BRANDT. Yes, sir.

[The information follows:]

Baltimore	$1,785,000
Boston	$1,245,000
Nassau Bay	$1,781,000
New Orleans	$3,592,000
Norfolk	$1,176,000
San Francisco	$1,345,000
Seattle	$1,996,000
Staten Island	$3,880,000
Total	$16,800,000

Mr. CONTE. Have you talked to the Department of Defense at all to see if they can assist in providing necessary funds to keep some of the hospitals going through September?

Dr. BRANDT. We have projected, although at less money, that they will continue to provide payment for their beneficiaries to us as we take care of them, yes, sir.

Mr. CONTE. As I understand it, there are two hospitals that will be taken over fully by the military, is that right?

Dr. BRANDT. We are not sure that they will take over either one. The San Francisco Hospital is actually owned by the Department of Defense, not by us. They may or may not take it over, depending on whether other groups want to.

REIMBURSEMENTS

Mr. CONTE. Doctor, is the hospital system collecting fully the reimbursements owed to it for the services it has rendered for the refugees?

Dr. BRANDT. For the refugees? Yes.

Mr. CONTE. You are being fully reimbursed?

Dr. BRANDT. Yes.

Mr. CONTE. Thank you, Mr. Chairman.

Mr. NATCHER. Yes.
Mr. Roybal.
Mr. ROYBAL. No questions.
Mr. NATCHER. Mr. Livingston?
Mr. LIVINGSTON. Thank you, Mr. Chairman.
First of all, again I want to reiterate my gratitude to you and to the ranking minority member, Mr. Conte. Both of you have been very responsive to the needs of the members of the House who are affected by this emergency. We appreciate your efforts.

FURLOUGH NOTICES

Doctor, you mentioned that just notices of furloughs went out. As I understand it, the employees were divided into two categories, I think the unclassified civil servants were expected to be furloughed on August 1. At least this was the impression I got back from my district from the people affected. And perhaps the classified employees expected to be furloughed August 15. I can tell you, whether those notices say they are notices or not, those people think they are going to be without jobs.
Could you elaborate?
Dr. BRANDT. The distinction is part-time versus full-time employee. Part-time employees were notified that their furloughs would begin on August 1 because at that time we would quit taking new patients into the hospital.
Mr. LIVINGSTON. So with respect to those people, whether it is a notice of furlough or a furlough itself, they are going to be without jobs on August 1?
Dr. BRANDT. Unless——
Mr. LIVINGSTON. Unless we act?
Dr. BRANDT. Yes.
Mr. LIVINGSTON. And how many people are involved in that category?
Mr. MAHONEY. Approximately 497 temporary employees.
Mr. LIVINGSTON. 497 throughout the country?
Mr. MAHONEY. Yes, sir.
Mr. LIVINGSTON. And the remainder would be facing furlough on August 15 unless we act?
Dr. BRANDT. The remainder in the hospitals, there would be a group of employees in the outpatient clinics who would not be furloughed until September 1.
Mr. LIVINGSTON. At any rate, we are facing a possible loss of some 400-odd jobs within the next two weeks. So indeed it is an emergency with respect to those people?
Dr. BRANDT. Yes, sir.

POSSIBLE SENATE ACTION

Mr. LIVINGSTON. And it concerns me greatly.
I just wonder how much contact you have had with the other side? I have no doubt that the House is going to act rapidly. I am concerned about the Senate. The supplemental can be brought up under their rules and any nongermane amendment can be tacked onto the darned thing. I can imagine something like an abortion issue being tacked on it, who knows what else, in an effort to make

it a political issue. Then where are we? We are looking at a two-week deadline.

How can you be sure what the Senate is going to do; what assurances does the Secretary have from his former colleagues over there, and do we think we are going to get action in the next two weeks?

Dr. BRANDT. We are working with various members of the Senate in an attempt to get this. A hearing is tentatively scheduled at 2 o'clock on Monday concerning emergency appropriations.

I do not know that we have any assurances at the present time, but there is certainly a lot of contact by us with the Senate. And, as you know, the senators whose states have one of the hospitals are very active.

Mr. LIVINGSTON. Doctor, I can tell you, based on politics of such issues that have come before us in the past, I am not at all sure that this matter is going to be handled expeditiously. I am concerned about it.

To that end I contacted the Director of Office of Management and Budget yesterday and the Secretary himself and hoped we might be able to get an agreement on reprogramming.

REPROGRAMMING

I understand your problem. You have funds dedicated to other areas in the Public Health Service that you don't feel that you can pull out of those programs right now. Can you give me more elaboration?

I understand that within the Office of Assistant Secretary you have continuation grants that total approximately $35 million, funds available for new programs or grants totaling $3.3 million, unobligated mandatory account funds totaling approximately $56 million. What about reprogramming from these accounts?

Dr. BRANDT. Well, the $3.3 million available for new activities is a sum for which there are no commitments. They are totally unobligated moneys.

The $35 million is for continuation grants in all of those areas. These are noncompeting type continuation grants that are made for projects in such areas as adolescent pregnancy, smoking, and health, and other activities important to the Public Health Service. It would mean clearly that we would not be able to meet our commitments. These are fourth-quarter commitments, some of which were due July 1. We have delayed them.

Mr. LIVINGSTON. I hope you appreciate my position. It seems to me when we passed the legislation through the whole Congress under the reconciliation and appropriations process, we more or less had a commitment to at least keep the Public Health hospitals open through October. So indeed we have some degree of commitment to these people and their jobs. Lo and behold, they get notices of furloughs that they can start looking a little bit earlier than they had to.

I wonder if the Department is prepared to tell the Congress that if you guys can't get your political game in order, whether on the Senate or House side, if we can't pass that supplemental, are you then prepared to submit a reprogramming request and permit us to go ahead and make the emergency arrangements that we need to

make in order to get these people taken care of between now and October?

Dr. BRANDT. It is our view that the best approach, should there be no supplemental, would be to go ahead with our plan to close the hospitals. That is why we are here, because that looks to us as the only feasible approach to go in order to keep these hospitals open.

I can assure you that I am as distressed as you are that this has become necessary. It is unfortunate that this whole series of events occurred, including the spending limitation and the other factors that have resulted in this. We would much prefer to keep them open, then in an orderly fashion, phase them out, and deal with the employees in a much more effective way. But, on the other hand, we can't keep them open without money.

Mr. LIVINGSTON. You are telling me you are not prepared to reprogram funds in the event the supplemental does not pass in the next few days?

Dr. BRANDT. We are not prepared to do so, no.

Mr. LIVINGSTON. I would like to be able to take my shot at changing your mind on that one.

Dr. BRANDT. Yes.

CONTRACT CARE

Mr. LIVINGSTON. You said you have cut out the seamen's contract here. Is that a fait accompli at this moment?

Dr. BRANDT. Yes, sir.

Mr. LIVINGSTON. What are they doing for health care now?

Dr. BRANDT. They can come to the hospitals and clinics.

Mr. LIVINGSTON. For as long as they are open?

Dr. BRANDT. Yes, sir. I should say that for emergencies and life-threatening situations we have maintained the contract carrier. This is one of the management changes that we made in the system in May in order to avoid being here in District Court, which had issued an injunction against us forcing us back into the contract care services. That order was overturned finally by the courts so that we again were permitted to shut it off.

COMMUNITY TAKEOVER

Mr. LIVINGSTON. Finally, with respect to the community takeover of the hospitals throughout the country, can you tell me if you have approved any of the plans that have been submitted; if not, can you tell me whether it appears the Public Health System is going to approve of these plans or exactly what are your plans with respect to these takeovers?

Dr. BRANDT. The answer to your question is no, we have not approved any takeover plans. We are reviewing them. All we have at this time are preliminary plans from the communities. They are developing more detailed plans. We will certainly make decisions by sometime in September.

NEW ORLEANS FACILITY

Mr. LIVINGSTON. In your listing of cities in which plans had been submitted, you did not mention New Orleans. Have you been in

touch with the Veterans Administration with regard to the hospital?

Dr. BRANDT. The VA in New Orleans has expressed an interest in the hospital, yes. We have not received anything from the central office.

Dr. MARSHALL. We have received a letter from the Central Office saying they are willing to look at it. My undertanding is that they have a survey team in New Orleans this week, and they have said they will give us a clear indication of their intent by the end of July.

Mr. LIVINGSTON. Thank you very much.

Thank you, Mr. Chairman.

Mr. NATCHER. Yes.

Mr. Stokes?

Mr. STOKES. Thank you, Mr. Chairman.

Dr. Brandt, if the subcommittee approves the supplemental request for $16.8 million, will the additional funds enable you to keep open all of the hospitals and all of the clinics; that is, none will be closed?

Dr. BRANDT. That is correct.

Mr. STOKES. What about the level of service? Will the hospitals and clinics operate at the current level of service or some lower level of service?

Dr. BRANDT. They will operate at the current level of service.

Mr. STOKES. Thank you.

I have no further questions.

Mr. NATCHER. Yes.

Mr. Porter?

Mr. PORTER. I have no questions.

Mr. NATCHER. Mr. Early?

Mr. EARLY. Thank you, Mr. Chairman.

BUDGET INCONSISTENCIES

Dr. Brandt, this is very confusing to me, how we could get to this stage. We just finished the supplemental rescission bill.

Less than 60 days ago, the Administration sent up a rescission for $36 million. Now you ask for a supplemental budget authority for the close-out, you are here with a $16 million supplemental.

Why wasn't the shortfall of cash foreseen?

Dr. BRANDT. Well, I think there are a variety of reasons.

One is that the census has begun to fall at a rapid rate.

Mr. EARLY. You certainly should have suspected that.

Dr. BRANDT. You mean because of the closing?

Mr. EARLY. Because of the suggested reduction in the intake in patients.

Dr. BRANDT. But that was not projected for several months. We are talking about the census beginning to fall several months ago, after the rescission was sent up here. It has begun to go down sharply much faster than I think anyone would have projected or anticipated.

Mr. EARLY. But the rescission was still pending a month ago. It didn't get to the President until June. When did you start to put together this supplemental request?

Dr. BRANDT. I am sorry.

Mr. EARLY. When did you start to put together this supplemental request?

Dr. MARSHALL. Somewhere after the 1st of July.

Mr. EARLY. My goodness, you didn't know until July 1 you were going to be short this money and now you are telling us you need $3.5 million for materials and supplies?

Dr. BRANDT. Yes.

Mr. EARLY. You didn't put the thing together until July 1?

Dr. MARSHALL. No. We became aware in late June that the third party reimbursements we were projecting would not materialize. It is very difficult to remain current on predicting third party reimbursements because generally when dealing with insurance companies—it is even worse when dealing with the government's insurance companies, Medicare and Medicaid—there is a lag of between 90 and 118 days between the time you submit a bill and the time you receive the money.

Our accounting system is keyed to the receipts rather than to the billing. We were, therefore, unaware of how rapidly this was falling off until late in June. That was all in the context of our being under the court injunction until the 24th of June. At that time we were looking to our obligations almost day-by-day. So it was very close. In those last days of June or the first days of July we became aware that we had a deficit which we simply could not absorb by any other management control system which we might be able to put in place.

Mr. EARLY. Do you think that rationale would hold with any of our constituency to say that we took back $36 million last month because you weren't going to need it, you were going to be able to supply the quality service you had told us you would supply, but now in July you say you need $17 million back?

Dr. BRANDT. In our projections for reimbursements through May of this year, we estimated we would collect $44.3 million. The actual collections through May was $44.3 million.

In June, we projected $5.8 million income; we collected 4.6.

In July, we projected 5.7; at the current rate of collections projected through July we will collect 3.5.

It is on those bases that we projected. The downturn did not occur until June. That accounts for ⅔ of the money.

Mr. EARLY. Wasn't the reason for that reduction because of the number of patients being served?

Dr. BRANDT. That is correct.

Mr. EARLY. So therefore, through May you were collecting what you projected, $44 million?

Dr. BRANDT. That is right.

Mr. EARLY. In June you dropped off roughly 25 percent, now you are down to 45 percent. You are only serving half the patients you were serving then?

Dr. BRANDT. Half of the reimbursable patients, yes.

NEW RESIDENCIES

Mr. EARLY. Tell me, the justifications mention that one of the problems is the loss of clinical staff and the reduction of new interns and residents reporting to duty. Hasn't the Department

declined to make PHS Corps assignments to the Public Health Service hospitals?

Dr. BRANDT. Haven't we what?

Mr. EARLY. Declined to make PHS Corps position assignments to the PHS hospitals?

Dr. BRANDT. If so, we are unaware of it.

Mr. EARLY. Well, I am aware of it. I know of youngsters to whom it was suggested they were being appointed and their appointments were cut back two or three months ago.

Dr. BRANDT. Are you talking about the interns and residents?

Mr. EARLY. I am talking about the scholarship people, the people appointed to PHS, they had a promise from the government which we reneged on.

Dr. BRANDT. Those were the interns and residents, Mr. Early. When it became clear that the hospitals were going to close, we informed all of the interns and residents that the hospitals were going to close and that it might not be possible for them to complete their year as an intern or a resident. All of them were issued orders to report.

Mr. EARLY. That is right. How responsible that was on the government's part.

Dr. BRANDT. To inform them?

Mr. EARLY. No. To lead them to believe they were going to be assigned there and two or three months before their appointment say, we are not going to appoint you there. Many did not have alternative places to go.

DECLINE IN PATIENT LOAD

Tell me, on the decline in reimbursements, shouldn't you have anticipated some of that with the phaseout? On these months here where through May you collected what you expected and then your reduction from 5 to 4.6 in June, shouldn't you have suspected that in May when you were suggesting a phaseout?

Dr. BRANDT. That the number of patients would decrease?

Mr. EARLY. Yes.

Dr. BRANDT. During the phaseout?

Mr. EARLY. Yes.

Dr. BRANDT. Well, you know you can argue those in a whole variety of ways. Quite frankly, my own personal feeling was that our patient census would increase. That is what frequently happens when veterans' hospitals and other hospitals have closed, your workload goes up considerably. In our case, however, it has gone precisely the other way.

Mr. EARLY. There must be a reason for that, for such a drastic reaction.

Dr. BRANDT. Well, I think that the patients for whom reimbursement is available have a lot of options. They have opted to go to other places.

Mr. EARLY. To project 25 percent decline in June, then a 45 percent decline in July; what are you projecting for August on your reimbursement.

Dr. BRANDT. $2.1 million income, which is about a 70 percent reduction from our anticipated 5.7.

Mr. EARLY. What was your original computation when putting together the rescission, what did you anticipate for reimbursements in August?

Dr. BRANDT. 5.7.

Mr. EARLY. What do you now expect for September?

Dr. BRANDT. About $200,000.

Mr. EARLY. If you anticipate that, then you are not closing the hospitals on October 1, you are closing them at the end of August. I think the Congress told you to close them in October. You are not expecting any reimbursements?

Dr. BRANDT. We are expecting very little reimbursements in September, that is correct.

Mr. EARLY. I do not think you have lived within the intent of the Congress to stay open until October 1.

Dr. BRANDT. The facilities are going to be open, they are going to be staffed and the patients are certainly going to be eligible to come there.

Mr. EARLY. You don't expect to have many patients if you only expect $200,000 in reimbursements.

Dr. BRANDT. But recognize that most of the care we provide is not reimbursed.

Mr. EARLY. If it is not reimbursed, most of the care, then the reimbursements shouldn't be dropping off so drastically.

Dr. BRANDT. Except the patients who do pay for care are the ones that are dropping off.

Our primary beneficiaries are not dropping off that rapidly. It is the secondary beneficiaries who pay for their care that are choosing to go elsewhere and are making other arrangements.

Mr. EARLY. If we take all these numbers that you give me for June, July, August, and September, we still don't come to a shortfall of $16.8 million.

Dr. BRANDT. You come to a shortfall of $12.5 million.

Mr. EARLY. I can't see how we have a rescission of $36 million in June and a supplemental in July.

Dr. BRANDT. Well——

Mr. EARLY. You know this is the philosophy we are talking about, this Administration is talking, just cut, cut, cut. If they are going to err, they are going to err on the side of the shortage of service. I think that is irresponsible. If you were going to err, I would have thought you erred on the side to at least live up to what our commitments were.

Dr. BRANDT. That is our reason for being here, sir.

Mr. EARLY. I have no further questions, Mr. Chairman.

CONFERENCE REPORT

Mr. NATCHER. Dr. Brandt, further, along the same line with Mr. Early, we do have language in the conference report now, agreed to by the House and the Senate, and I guess you know about this language that Mr. Early referred to, and I place it in the record at this point.

"The conferees are agreed that any community may submit a plan for community use of these facilities and that no hospital should be closed prior to October 1, 1981."

You know about that language?

Dr. BRANDT. Yes, sir.
Mr. NATCHER. All right.
Mr. Dwyer?
Mr. DWYER. No questions, Mr. Chairman.

COMMUNITY TAKEOVER PLANS

Mr. NATCHER. Dr. Brandt, how many communities have submitted plans to take over and operate hospitals after the Federal Government pulls out and how many more proposals do you expect?

Dr. BRANDT. We have received five, Mr. Chairman, plus the potential of the VA in New Orleans. We anticipate that there is a possibility of another one for San Francisco. However, at the present time that would really fall into the domain of the Department of Defense rather than us because the hospital actually belongs to them.

Mr. NATCHER. All right.

In your best professional judgment, Dr. Brandt, how many of these plans do you expect to be viable?

Dr. BRANDT. I really can't answer that, Mr. Chairman. I have not read any of them at the present time. So I just don't know, I just don't know.

Mr. NATCHER. Dr. Brandt, if you would, tell the committee who will make this final decision. Will you make it or who will make it?

Dr. BRANDT. The final decision will be made by the Secretary. The Public Health Service will make its recommendations to the Secretary.

Mr. NATCHER. To the Secretary?

Mr. EARLY. Mr. Chairman, is that the Secretary of OMB, or the Secretary of Health and Human Services?

Dr. BRANDT. The Congress passed a law saying the Secretary of Health and Human Services shall recommend to the Congress.

Mr. NATCHER. All right.

Dr. Brandt, when will the Department be in a position to tell us how many plans are acceptable and how much money will be required?

Dr. BRANDT. Our current timetable is to try to get that information here by no later than September 13.

Mr. NATCHER. Is it the intention of the Department to ask for funds to help the communities in a transition plan?

Dr. BRANDT. I am sure that we will if in fact that is required for the transition to occur.

Mr. NATCHER. All right.

Dr. Brandt, assuming there are two or three or more of these hospitals where there is no move by the communities or anyone in the state or the vicinity to take over the hospital, if there is no move to take it over, what do you intend to do with them?

Dr. BRANDT. We will follow the standard procedures for disposing of government property, which I presume goes through General Services Administration.

Mr. NATCHER. Through General Services Administration?

Dr. BRANDT. Yes.

Mr. NATCHER. All right.

Mr. Conte?

REIMBURSEMENT SHORTFALL

Mr. CONTE. Doctor, why have the hospitals been failing to collect these large sums of money that they are owed?

Dr. BRANDT. Why have they?

Well, in part because of the decrease in the number of patients from whom we can legally bill. That is the major problem.

Dr. MARSHALL. I think the major problem is—it depends on the hospital—there are some hospitals where they bill very aggressively, but what happens is that the bills don't get paid largely by Medicare and Medicaid because of either State policies, in the case of Medicaid, or because of things that are not reimbursable, in the case of Medicare.

Not all of the hospitals follow the normal policies for aging and writing off the accounts receivable. So when you look at accounts receivable by what is due in 1 to 30 days, 30 to 60, or over 90, you see that about $19 million of the $22 million presently carried out there is in the over-90-day category. Some of it goes back several years. That is because in those hospitals they haven't been writing them off. We have been looking at that to see what has been happening.

A second problem has to do with the general problem that the government has when it tries to collect money. When you are trying to run a hospital, trying to operate against limited resources, and billing clerks is a category where you have turnover and you don't replace them, it is hard to get them, and in some cases we just don't have the apparatus for aggressively pursuing it.

The government is not one that hires a collection agency that goes out and duns people for small amounts of money. They see their role as being a community service role, taking care of people in the community who have no other resources.

Mr. CONTE. Could you give us a breakdown by hospital of what the revenue is that is owed to those hospitals?

Dr. MARSHALL. Yes.

[The information follows:]

Currently the State of New York's Medicaid program owes the Staten Island PHS hospital $4.3 million in overdue revenues. New York represents the only state with overdue revenues owed PHS hospitals. This problem is rooted in the fact that the State of New York has continually refused to reimburse the Staten Island PHS hospital. New York State bases this position on their contention that the hospital requires a New York State operating certificate as a condition for medical certification and reimbursement. The Bureau of Medical Services has contested this agreement on the basis of Federal hospitals' exemption from State licensure requirements. After a prolonged period of non-responsiveness to the hospitals' arguments, this issue was forwarded to the PHS general counsel where it is currently being studied.

Mr. CONTE. You feel very confident from the answer that you presented here today that this $16.8 million will cover you now and take care of all your problems, you won't be coming up here for another supplemental or reprogramming?

Dr. BRANDT. I can assure you, sir, that if this isn't adequate I seriously doubt I will be asked to come back here.

Mr. CONTE. Thank you, Mr. Chairman.

Mr. EARLY. Mr. Chairman?

Mr. NATCHER. Mr. Early.

ASSISTANCE TO EMPLOYEES

Mr. EARLY. Is the Department going to do anything to assist personnel in finding other employment?

Dr. BRANDT. Each hospital director is already supposed to have something in operation to advise the employees, and so forth, about other opportunities.

Mr. EARLY. Do you think that is something to help or is it something to just satisfy the question?

Dr. BRANDT. No, sir. We have been in contact with the VA and with the Department of Defense in an attempt to get them to look at our employees first when there are vacancies in areas where there are facilities close by, et cetera. We have attempted, of course, not to force those because we didn't want to lose the staff until the hospitals actually close. But we have all of the background work done and we are ready to start the out-placement arrangements at such time as we know for sure when they are going to close.

SUPPLIES BUDGET

Mr. EARLY. How about the $4 million on supplies and materials? I hope we are not just buying enough, so that on the last day we are going to have the last aspirin. Is that adequate?

Some of these institutions are supposed to be fine institutions. I hope we are not playing it too close on $3.5 million for supplies and materials.

Dr. BRANDT. Well, we are not playing it close; I mean we are not planning on playing it close, we are not planning on cutting quality.

Mr. EARLY. Thank you, Mr. Chairman.

Mr. NATCHER. Yes. This concludes the hearing on the emergency supplemental request for the Public Health Service hospitals and clinics. Dr. Brandt, we want you to know we appreciate the urgency of this matter. This committee understands fully, you do, and the Department does. We do hope every consideration will be given to moving this on as quickly as possible and we will do so on the Hill.

Thank you.

Dr. BRANDT. Thank you.

Mr. NATCHER. This concludes the hearing. The committee will stand in adjournment, subject to the call of the Chair.

[The following questions were submitted to be answered for the record:]

Public Health Service Hospitals

Mr. Natcher. What is the range of occupancy rates at the various facilities?

Dr. Brandt. The latest information available, through April 1981, shows the following range of occupancy rates at the PHS facilities.

Hospital	Occupancy Rate
Baltimore	73.38
Boston	89.75
Nassau Bay	77.79
New Orleans	66.45
Norfolk	77.87
San Francisco	68.66
Seattle	84.86
Staten Island	83.29

Mr. Natcher. How does the current volume of outpatient activity at the hospitals and clinics compare to the level at this time last year?

Dr. Brandt. Through the month of April, the latest period available, outpatient activity for FY 1981 at the Hospitals show a total of 589,189 visits, a 2 percent increase over the 577,909 visits for the comparable period of 1980. The 482,149 outpatient visits, through April 1981, at the clinics compare to 494,897 visits for 1980, a decrease of 2.5 percent. Combined totals of Hospitals and Clinics through April show a total of 1,071,338 outpatient visits in 1981 compared to 1,072,806 visits in 1980, a decrease of less than 1/2 of 1 percent.

Mr. Natcher. How many employees have already left the system in anticipation of its closure?

Dr. Brandt. While it is difficult to determine whether or not the employees have left the PHS hospital and clinic system in anticipation of its closure, as of May the field employment totalled 5,265 and in July, it was 5,000 as compared to 5,480 in July 1980.

Mr. Natcher. Would you review for the Subcommittee the close down schedule for the system with and without this additional money.

Dr. Brandt. If the $16.8 million supplemental is provided by August 1, all PHS hospital and clinic employees will be kept on duty through October 31, 1981. The facilities would close on October 1, 1981. (A precise schedule of activity leading up to the October 1 closure has not been finalized).

If the $16.8 million supplemental is not granted, the following schedule of activities would take place in order to stay within available funds.

July 15	-	Notice will be issued to full-time permanent/part-time permanent staff of intention to furlough.
	-	Cease purchasing supplies for the system.
Aug 1	-	Cease inpatient admissions.
	-	Terminate temporary staff.
Aug 15	-	Furlough part-time permanent staff.
	-	Discharge or transfer remaining inpatients.
Aug 22-Sept 9	-	Furlough all civilian full-time permanent staff except 95 employees (for maintenance and security), PHS Commissioned Corps, and approximately 155 employees needed to stay on during interim furlough period (security guards, medical records, general services, telephone, and personnel staff).
	-	Cease outpatient activities.
Oct 1	-	Recall all furloughed staff for RIF process.
Oct 31	-	RIFs effective for all except 95 employees for maintenance and security. PHS Commissioned Officers transferred.

Mr. Natcher: Have any steps been taken to reduce spending elsewhere in your Salaries and Expenses budget to meet any portion of this shortfall?

Dr. Brandt. Once the $25.8 million shortfall was identified, we took very specific management action to correct the situation, specifically:

1. The PHS hospitals implemented a series of management savings actions which produced savings of $15.4 million. These actions included reductions in a variety of non-essential expenditures. For example, reductions were made in the purchase of equipment (-$3.7 million) and supplies (-$2.4 million), as well as maintenance and repair (-$2.5 million). Various other program reductions amounting to $6.8 million were carried out at the direction of the individual hospital directors.

2. The Secretary, on May 8, issued regulations revising the manner in which contract patient care activities would be provided - this action would have produced an $8.9 million savings.

Subsequent to these actions being implemented several events occurred which could not have been projected, namely:

1. On June 4, 1981, the U.S. District Court for the Northern District of California ordered the Department to continue not only the provision of contract medical care but also PHS hospital inpatient and clinic outpatient operations at the level required by P.L. 93-155 and without regard to current budget restraints (this decision repealed the Secretary's May 8 revision to the contract patient care regulations). While our appeal was eventually approved by the appellate court on June 25, compliance with the order during the effective period cost us $1.7 million.

2. P.L. 97-12 signed into law on June 5, increases the rescission for the hospitals by $1.1 million over the President's request.

3. P.L. 97-12 also placed a funding limitation of $128.4 million for hospital operations. This action precluded the Administration from forwarding a $1.5 million reprogramming request necessary for hospitals operations (funds would have come from Building and Facilities).

4. Last, and most significant, is our recent projection of revenues which indicates that we will have at least a $12.5 million shortfall in reimbursements from patients served by the system. This shortfall has been primarily due to the uncertainty surrounding the closure of the system.

As a result of the previous steps taken to reduce the initial shortfall of $25.8 million, we are unable to take any further steps to reduce our spending level without adversely affecting patient safety.

Mr. Natcher. As you know, there could be objection to bringing out a supplemental at this time for a system which you are planning to close in October. Tell us why the Secretary rejected reprogramming as a solution to this problem?

Dr. Brandt. Because of the funding limitation placed on the Public Health Service Hospitals line item, reprogramming can only come from within the OASH appropriation. Of the unobligated funds available, very little could be used for reprogramming. Excluding the $40 million available to the PHS Hospitals and the Bureau of Medical Services Program support, a total of $54.7 million is unobligated. Of this balance,$16.6 million is required for salaries and administrative costs of OASH employees, and $32.9 million is required to fund continuation costs. This leaves only $5.2 million for new awards.

We do not think it is appropriate to reprogram from continuation funds because:

o Most of these funds support the continuation of existing projects--only $5.2 million is for new awards. I believe we have a commitment to our grantees to maintain these efforts to their completion.

o By terminating these programs at this time, we would lose the investments made in prior years. Both the Adolescent Health and Smoking and Health programs have been operational only 1 or 2 years while the HMO grantees would be entering their development phase after having completed their planning process.

o Finally, Smoking and Health and Adolescent Health grantees would be phased out before alternative funding became available through the Block Grant mechanism in FY 1982.

Mr. Natcher. We understand from your staff that one of the principal reasons for rejecting a reprogramming is that it would distort allocations in 1982 under your proposed block grant. Isn't it true, however, that the total in the block grant would be unchanged by a reprogramming and that allocations under the block grant, if it becomes law, would be shifted less than 1%?

Dr. Brandt. It is true that the total amounts available for the block grant would stay the same and that shifts in State allocations, while impossible to predict, would be small. However small, a reduction in the allocation would probably be viewed as significant by the State.

The impact on the specific projects, however, is quite significant. The effect would be to phase out these programs before alternative funding became available through the block grant mechanism in FY 1982.

Mr. Natcher. The Assistant Secretary for Health account includes approximately $182 million in 1981 of which we understand less than half has been obligated. Which activities in this account currently have unobligated balances and how will these funds be used?

Dr. Brandt. We will insert in the record at this point a list of the unobligated balances prepared by the Department.

[The information follows:]

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH
Status of Funds
($000)

	1981 Availability	Obligations thru 7/20	Unobligated thru 7/20	Spending Plan for the Unobligated Balance: Continuations	Mandatories Including Comp & Benefits	Available for new Activities
Assistant Secretary for Health						
1. Health Research, Statistics and Technology						
(a) Health Services Research.....	$ 30,122	$19,444	$10,678	$ 5,802	$ 2,908	$ 1,968
(b) Health Statistics.....	38,006	36,884	1,122	---	1,122	---
(c) Health Care Technology.....	3,989	1,820	2,169	---	455	1,714
(d) Program Management.....	1,079	869	210	---	210	---
Subtotal, Health Res, Stat, and Tech.....	73,196	59,017	14,179	5,802	4,695	3,682
2. Health Maintenance Organizations..	28,912 1/	15,458	13,454	11,234	2,220	---
3. Health Initiatives						
(a) Adolescent Health.....	9,983	894	9,089	6,360	1,200	1,529
(b) Smoking and Health.....	12,062	1,034	11,028	9,500	1,528	---
(c) Health Promotion.....	2,306	1,078	1,228	---	1,228	---
(d) Physical Fitness & Sports....	789	604	185	---	185	---
(e) International Health.....	779	675	104	---	104	---
Subtotal, Health Initiatives.	25,919	4,285	21,634	15,860	4,245	1,529
4. Public Health Service Management						
(a) Regional Management.....	5,374	4,040	1,334	---	1,334	---
(b) Program Direction and Support Services.....	16,904	12,829	4,075	---	- 4,075	---
Subtotal, PHS Management.....	22,278	16,869	5,409	---	5,409	---
5. PHS Termination Expenses.....	40,000	---	40,000	---	40,000	---
Total.....	$190,305	$95,629	$94,676	$32,896	$56,569	$5,211

1/ Includes $8,675,000 in carryover funds from 1980 appropiations.

Mr. Natcher. According to your justifications, the largest single reason for this crisis is the fall-off in reimbursements. Would you describe for us in a bit more detail why this happened?

Dr. Brandt. The principal cause appears to be adverse publicity generated by the announcement of the intended closure of the system. The impact of the announcement has manifested itself primarily in two ways:

First, the number of patients seeking care from our facilities has declined. Prospective patients, concerned over the continuity of the care they expect to receive, go to other providers who have a more certain future. Second, the personnel of our facilities that actually provide the care are leaving the system in order to secure their personal careers. Staff losses in other direct care areas are similarly causing reduced capacity and curtailment of services. Consequently, the reimbursable workload and the income it generates is declining at an accelerating rate as the date of proposed closure approaches.

Mr. Natcher. Can you tell us how much in reimbursements was received in fiscal year 1980, how much was anticipated for 1981 when you submitted your rescission proposal and how much you now expect?

Dr. Brandt. In fiscal year 1980 the Hospital and Clinic system earned $56.8 million from patient care reimbursements. The anticipated fiscal year 1981 earnings from patient care reimbursements was $67.2 million until recent events made it apparent that this could not be realized. The current estimate for patient care reimbursements in fiscal year 1981 is $54.7 million.

Mr. Natcher. We understand that the hospital system has a substantial volume of uncollected debts. As an example, we have been told that one State medicaid program owes the system over $17 million. Could you tell us if this is true and if so what steps have been taken to collect these funds?

Dr. Brandt. Over the past year significant steps have been taken to improve the capability of the hospitals to recover uncollected debts. Uniform procedures pertaining to the management of accounts receivable have been implemented in each of the hospitals. Additionally, a sophisticated design for a computerized accounts receivable management system had been recently developed.

The State of New York represents the most significant problem of uncollected debts. This problem is rooted in the fact that the State of New York has refused to reimburse the Staten Island PHS hospital. New York State bases this position on their contention that the hospital requires a New York State operating certificate as a condition for medical certification and reimbursement. The Bureau of Medical Services has contested this agreement on the basis of Federal hospitals' exemption from State licensure requirements. After a prolonged period of non-responsiveness to the hospitals' arguments, this issue was forwarded to PHS general counsel where it is currently being studied.

Mr. Natcher. Is the hospital system owed any significant amount of money by other Federal agencies or programs which might be used to offset this budget shortfall?

Dr. Brandt. There is no additional money owed to PHS from other Federal agencies or programs which can be used to offset the current budget shortfall. Money owed, from other Federal agencies or programs, has already been considered in addressing our total requirements.

Mr. Natcher: How much of the $16.8 million would go to each of the 8 hospitals?

Dr. Brandt.

Baltimore	$ 1,785,000
Boston	1,245,000
Nassau Bay	1,781,000
Norfolk	1,176,000
New Orleans	3,592,000
Seattle	1,996,000
San Francisco	1,345,000
Staten Island	3,880,000
Total	$16,800,000

Mr. Natcher. Why is it that New Orleans and Staten Island need so much more money than the other hospitals?

Dr. Brandt. These two General Medical and Surgical hospitals have consistently surpassed the remaining six GM&S hospitals in terms of total admissions and average daily patient load. Consequently, the medical and personnel expenditures are higher in these two facilities as opposed to the other hospitals. Therefore, these facilities will require a larger proportion of the requested supplemental in order to continue operating.

Mr. Natcher. The schedule of obligations in your justifications indicate that an additional $3.4 million will be required for supplies and materials. This doesn't seem to make much sense for a system which is being closed down. Tell us why these funds are necessary?

Dr. Brandt. Currently, inventory levels of the eight general medical and surgical hospitals have been severly depleted, and would have to be supplemented immediately to avoid endangering the health and safety of patients now receiving care in these hospitals. Of particular concern is the availability of drugs needed for the

treatment of these patients. Recent financial data indicate that the hospitals and clinics normally spend $1.9 million per month for supplies and materials. At this rate of expenditure, $3.4 million would be sufficient to support medical care for less than a two month period.

Mr. Natcher. Is there any evidence to suggest that facilities which are candidates for community take over are stockpiling equipment or supplies in excess of their normal requirements?

Dr. Brandt. We have no evidence that stockpiling items such as supplies or equipment is taking place. The funding level available to the Hospitals and Clinics in 1981 is very austere and it is highly doubtful that any such stockpiling could be done.

Mr. Natcher. How much was spent on supplies and materials in the hospital system in 1980 and how much do you believe will now be required for 1981?

Dr. Brandt. In FY 1980 the hospital and clinic system obligated $26,735,000 for supplies and materials. In fiscal year 1981 the system will require $29,475,000.

Mr. Natcher. The justification also indicates that an additional $4.1 million will be required for "other services." How will these funds be used?

Dr. Brandt. The additional $4.1 million required in object class 25.0 "other services", will be used to purchase the necessary medical consultant services, specialized diagnostic, laboratory and therapeutic services, maintenance contracts on high-technology equipment, accounting and computer services, and the minimum amount of structural maintenance and repairs needed to keep the facilities safe and functional.

Mr. Natcher. How much did the hospital system spend for these services in 1980 and how much do you now anticipate for 1981?

Dr. Brandt. In fiscal year 1980, $50,374,000 was obligated in "other services" in the hospital and clinic system. The current estimate for this category in fiscal year 1981 is $55,904,000.

Mr. Natcher. Will any of this supplemental be used to augment funds in the Bureau of Medical Services program support activity over the amount approved in the Supplemental/Rescission bill last month?

Dr. Brandt. No. The supplemental request will not be used to operate the Bureau of Medical Services program support activity. These funds will be used to continue direct operations in the PHS Hospitals and Clinics in the fourth quarter of 1981.

Mr. Natcher. Congress recently approved $40 million for termination costs. Is this money being used exclusively to run the hospitals?

Dr. Brandt. Of the $40 million Congress approved for termination costs, $37.9 million will be used to fund direct operations in the PHS Hospitals and Clinics, which is consistent with Senate language. The remainder, $2.1 million, will be used to fund fourth quarter expenses for the Bureau of Medical Services Program Support activity.

Mr. Natcher. What is the total amount of Federal money potentially to be requested by communities who are considering a takeover?

Dr. Brandt. While we do not know the full potential to be requested by the communities, at the present time we have received $82.1 million in requests from four communities; $54.7 million for facilities, $25.7 million for operations, and $1.7 million for research and training.

JUSTIFICATION OF

SUPPLEMENTAL APPROPRIATION ESTIMATE

FOR COMMITTEE ON APPROPRIATIONS

1981

Department of Health and Human Services
Health Services Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Services Administration

Health Services

For an additional amount for "Health Services," $16,800,000; provided further, that the Public Health Service Hospitals and Clinics shall operate at a level of services not to exceed $145,199,000.

Health Services Administration
Health Services
Amount Available for Obligation

	1981
Appropriation	$1,311,216,000
Proposed supplemental for PHS Hospitals and Clinics	+16,800,000
Pay Raise Supplemental under P.L. 97-12	+5,310,000
Rescission of Appropriation Provided under P.L. 97-12	-49,776,000
Consultant Services Rescission under P.L. 97-12	-2,465,000
Subtotal, adjusted budget authority	$1,281,085,000
Receipts and reimbursements from "Federal funds"	+55,723,000
"Non-Federal sources	+7,500,000
Unobligated balance, start of year	+5,474,000
Unobligated balance, end of year	---
Total Obligations	$1,349,782,000

Summary of Changes

1981 Presently Available Budget Authority.....	$1,264,285,000
1981 Revised Estimated Budget Authority.....	1,281,085,000
Net Changes, Proposed Supplemental	+$16,800,000

	1981 Base Pos.	1981 Base Amount	Change from Base Pos.	Change from Base Amount
Increases				
Program				
PHS Hospitals and Clinics				
Enables the PHS Hospitals and Clinics to operate at their current level through the remainder of FY 1981	5,510	$128,399,000	---	+16,800,000
Total, increases				+16,800,000

Budget Authority by Activity

	1981 Presently Available		1981 Revised Estimate		Proposed Supplemental	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Hospitals and Clinics	5,510	128,399,000	5,510	145,199,000	---	+16,800,000
(Obligations)		(177,461,000)		(194,333,000)		(+16,872,000)
Items not affected by supplemental	3,660	1,135,886,000	3,660	1,135,886,000	---	---
(Obligations)		(1,155,449,000)		(1,155,449,000)		(---)
Total, Budget Authority	9,170	1,264,285,000	9,170	1,281,085,000	---	+16,800,000
(Obligations)		(1,332,910,000)		(1,349,782,000)		(+16,872,000)

Obligations by Object

	1981 Presently Available	1981 Revised Estimate	Proposed Supplemental
Total number of permanent positions	9,170	9,170	---
Full-time equivalent of all other positions	608	608	---
Total compensable work year	9,078	9,078	---
Personnel compensation:			
Permanent positions	178,365,000	182,486,000	+4,121,000
Positions other than permanent	10,301,000	11,383,000	+1,082,000
Other personnel compensation	12,953,000	14,583,000	+1,630,000
Subtotal, personnel compensation	201,619,000	208,452,000	+6,833,000
Personnel benefits	39,312,000	41,396,000	+2,084,000
Travel and transportation of persons	6,734,000	6,809,000	+75,000
Transportation of things	2,131,000	2,321,000	+190,000
Rent, communication and utilities	8,075,000	8,190,000	+115,000
SLUC	7,233,000	7,233,000	---
Printing & reproduction	1,079,000	1,147,000	+68,000
Other services	37,539,000	41,657,000	+4,118,000
Project contracts	9,409,000	9,409,000	---
Supplies & materials	18,384,000	21,773,000	+3,389,000
Equipment	2,974,000	2,974,000	---
Land and Structures	8,174,000	8,174,000	---
Investments and Loans	500,000	500,000	---
Grants, subsidies and contributions	989,747,000	989,747,000	---
Total obligations by object	1,332,910,000	1,349,782,000	+16,872,000
[TOTAL Budget Authority]	(1,264,285,000)	(1,281,085,000)	(+16,800,000)

PHS Hospitals and Clinics

Authorizing Legislation - Title III, V, and XI of the Public Health Service Act

	1981 Presently Available		1981 Revised Estimate		Proposed Supplemental	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Budget Authority	5,510	$128,399,000	5,510	145,199,000	---	+16,800,000
(Obligations)		(177,461,000)		(194,333,000)		(+16,872,000)

Purpose and method of operations - The primary purpose of this program is to provide comprehensive health services to American Seafarers, active duty members of the Coast Guard, and Commissioned Officers of the Public Health Service and National Oceanic and Atmospheric Administration. Health Services capacity above the requirements of statutory primary beneficiaries are authorized to be used to provide services, primarily on a reimbursable basis, to other Federal beneficiaries. This is accomplished through a system of eight general medical and surgical hospitals located in major coastal cities; the National Hansen's Disease Center at Carville, Louisiana; 27 urban free-standing outpatient clinics; and a network of contract health care providers located nationwide. The care provided is supported by direct funding and third party reimbursements.

Rationale for supplemental request - The Administration in the Amended Fiscal Year 1981 Budget Request to Congress proposed the orderly phase-out of the eight general medical and surgical PHS Hospitals and 27 Clinics effective October 31, 1981. Specifically, the Administration's plan called for Congressional passage of authority to change the manner in which services would be provided at PHS Hospitals (P.L. 97-12 has provided the Administration that authority). This change allowed for an orderly phase-down of patient care operations in which new admissions to all PHS Hospitals and Clinics would gradually cease before the end of the fiscal year, and the provision of limited contract care to primary beneficiaries. Central to the Administration's plan for the closure of the PHS Hospitals and Clinics was providing localities in which the PHS Hospitals exist the opportunity to decide on whether or not they would take over the operation of these PHS facilities in their areas.

The budgetary requirements to carry out the Administration's plan were initially calculated to be $168.4 million. This included a $40 million supplemental request for the Office of the Assistant Secretary for Health to cover phase-out costs (P.L. 97-12 has approved the supplemental request).

Recent projections now indicate that $185.2 million, including the Office of the Assistant Secretary for Health supplemental will be required in order to adequately carry out the President's plan for closure of the PHS Hospitals

Clinics. This new level is $16.8 million more than is currently available for PHS Hospitals and Clinics use. The added requirements have resulted from the following factors which could not have been projected when the Administration submitted its initial plan:

(1) Recent projections of revenues indicate that we will have at least a $12.5 million shortfall in reimbursements from patients served by the system. The decline in reimbursements began in May and has continued to accelerate. This has been primarily due to the impending closure of the system which has resulted in a loss of critical existing clinical staff and the reduction in the new interns and residents reporting to duty. Without this staff, the system cannot provide revenue generating patient services.

(2) P.L. 97-12 (1981 Rescission/Supplemental Act) increased the rescission for the Hospitals and Clinics by $1.1 million above the President's request. Moreover, P.L. 97-12 established a funding limitation of $128.4 million for Hospitals and Clinics operations. This precluded the Administration from requesting a $1.5 million reprogramming request, from Building and Facility funds, needed to assist the PHS Hospitals and Clinics in their efforts for an orderly phase-out.

(3) The U.S. District Court ordered the Department on June 4, 1981, to continue not only the provision of contract medical care, but also PHS hospital and outpatient clinic operations at the 1973 level as required by P.L. 93-155 without regard to budgetary constraints or P.L. 97-12. While the order was eventually vacated by the appellate court on June 25, 1981, compliance with the order during the effective period cost an estimated $1.7 million.

These factors, in total, produced a $16.8 million operating deficiency. Without additional funding, we estimate that the system will exhaust all available operating funds some time during August. Thus, to avoid violating the antideficiency act, the Department would be forced to close down the hospitals and clinics system before the end of the fiscal year. Inpatient care would be terminated by August 1 and outpatient services would cease on September 1. Over 4,000 civil service and wage board employees would have to be furloughed prematurely, and would not receive the severance pay and lump sum leave they are eligible for until next fiscal year when funds become available. Contract care would continue to be provided to PHS and NOAA Commissioned Officers, Coast Guard active duty personnel and merchant seamen in life-threatening situations. This not only is inconsistent with the President's plan, and with Congressional intent, but may seriously jeopardize the takeover by communities of these facilities, an important element of the President's proposal.

PHS Hospitals & Clinics
Actual Obligations as of 9/30/80
FY 1980
($ in Thousands)

Baltimore Jurisdiction:	$23,113
Boston Jurisdiction:	11,880
Carville Jurisdiction:	11,719
Nassau Bay Jurisdiction:	13,899
New Orleans Jurisdiction:	27,343
Norfolk Jurisdicition:	13,386
San Francisco Jurisdiction:	27,884
Seattle Jurisdiction:	22,995
Staten Island Jurisdiction:	37,626
Independent Clinics:	3,130
Sub Total (Field)	$192,975
Headquarters 1/	$ 9,626
Non Federal Contract Patient Care	$ 29,600
Total	$232,201

1/ Field expenses paid for in Headquarters such as ADP services, Federal CPC, accounting services, FTS, etc.

7/15/81

Estimated Obligations FY 81 for Hospital Jurisdiction 1/

	Cummulative			4th Q	
	1st Q	2nd Q	3rd Q(est.)	OASH Supplemental	Deficit Supplemental
Baltimore	5,622,582	13,197,807	17,851,096	3,698,374	1,785,000
Boston	2,860,804	6,177,382	8,640,116	1,603,839	1,245,000
Carville	3,122,933	5,972,952	9,303,196	2,212,079	-0-
Nassau Bay	3,697,040	9,102,941	11,809,951	2,093,810	1,781,000
New Orleans	7,564,521	18,730,752	22,226,895	2,997,817	3,592,000
Norfolk	3,142,315	7,408,180	9,805,759	2,199,051	1,176,000
San Francisco	7,168,938	15,745,357	22,115,089	5,044,014	1,345,000
Seattle	5,970,488	14,134,107	18,573,297	3,346,654	1,996,000
Staten Island	9,290,902	20,501,743	31,368,937	5,856,594	3,880,000
Independent Clinics	789,226	1,580,541	2,585,653	766,851	-0-
Headquarters 1/	2,486,000	3,970,000	5,788,000	2,421,000	-0-
NF/CPC 2/	9,515,250	19,030,500	25,176,011	5,662,917	-0-
Total	61,230,999	135,552,262	185,244,000	37,903,000	16,800,000

1/ Field expenses paid for in Headquarters such as ADP services, Federal CPC, accounting services, FTS, etc.

2/ Commitments

WITNESSES

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