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- P1 National Security Classified Information [(a)(1) of the PRA]
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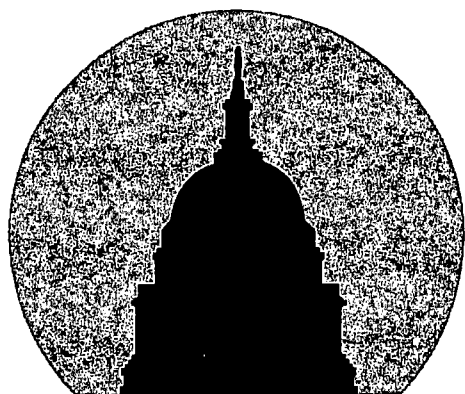
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

January 1993



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# HOSPITAL ADVOCACY PRIORITIES

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Health Care Reform  
Medicare & Medicaid  
Public Health  
Taxation  
Legal Issues

AHA

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While fundamental health care reform is hospitals' number one advocacy priority, there are a number of other issues on our advocacy agenda. Many of them are incremental steps toward our larger reform vision. Others are related to public health, taxation, or legal questions.

The enclosed issue papers use a standard format — Background, Recent Activity, AHA Position — to address this broad range of issues that concern hospitals as they go about their work of delivering patient care. The papers are three-hole punched so they may be kept for future reference and updated from time to time. For specific questions not addressed in the papers, call your AHA Washington Office staff contact.



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# Medicare and Medicaid “Fraud and Abuse”

## Background

The Medicare and Medicaid Fraud and Abuse “anti-kickback” statute is a broad statute intended to prevent hospitals and physicians from realizing financial gain from excessive referral of Medicare and Medicaid patients. The HHS Office of Inspector General examines financial arrangements between physicians and health care entities to determine whether the arrangements create inducements for referral and incentives for overutilization of services. Generally, the anti-kickback law prohibits direct and indirect payment (e.g. investment interests, compensation arrangements, and leases) in exchange for referrals of patients for Medicare or Medicaid services.

Notes & Questions:

## Recent Activity

In July 1991, the HHS Inspector General’s office issued regulations defining 11 “safe harbors,” and describing arrangements that would be shielded from civil actions by HHS or criminal prosecution by the Justice Department. Protection from liability under the fraud and abuse laws can be gained by falling within a safe harbor; however, failure to fall within a safe harbor does not mean that the arrangement necessarily violates the law. More recently, in November 1992, the OIG issued a proposed rule including safe harbors for certain managed care arrangements. Additional safe harbors are being developed, including a provision addressing hospital recruitment of physicians.

The HHS Inspector General, in May 1992, issued a “Special Fraud Alert” on “Hospital Incentives to Physicians.” It describes suspect hospital incentive arrangements with physicians that are not protected by the “safe harbor” regulations and may violate the Medicare and Medicaid anti-kickback statute. A fraud alert is intended to provide guidance to the field regarding OIG views on potentially unlawful activity by highlighting elements of arrangements that may subject a hospital or physician to scrutiny.

Additional activity included an OIG Management Advisory Report issued in October 1991, “Financial Arrangements Between Hospitals and Hospital-Based Physicians.” The report suggests that hospitals are able to use arrangements with hospital-based physicians to direct the flow of business in a manner that violates the fraud and abuse laws. Hospitals contest the premise that they control patient referrals in this manner and have communicated this position to the OIG.

Congressional activity included a hearing held by the Ways and Means Health Subcommittee in September 1992, to address Medicare fraud, waste, and abuse.

## AHA Position

AHA opposes the proliferation of financial arrangements that truly lead to overutilization of Medicare and Medicaid services, thereby resulting in unnecessary expenditures of federal health care funds. The fraud and abuse law is very broad, however, and existing regulations and guidance leave many legitimate hospital business practices open to OIG scrutiny. The effect is to potentially limit the services a hospital offers its community. AHA continues to seek additional guidance from, and provide educational information to, the HHS Office of Inspector General. AHA believes that an advisory process available on a case-by-case basis would be beneficial to the health care community.

# Ethics in Patient Referrals

## Background

Physician investment in and compensation from entities to which they refer patients is under continued scrutiny. Financial relationships involving sophisticated technologies, clinical laboratories, freestanding health care facilities, and hospitals have sparked a debate on the ethics of doctors referring patients to those facilities. Many such arrangements are joint ventures between physicians and hospitals. Some recent studies have suggested that physicians order more health care services from facilities in which they have invested, and critics charge many such services are medically unnecessary.

Notes & Questions:

## Recent Activity

Legislation introduced by Rep. Pete Stark (D-CA) in 1989 bars physicians from making Medicare and Medicaid referrals to clinical laboratories in which they or family members have a financial stake and billing for services rendered. Stark has consistently pledged to toughen this law. In 1992, Stark introduced a health care reform proposal, H.R.5502, that included significant expansions of the physician referral law, extending the prohibition to services other than clinical laboratories. "Designated health services" specified in the proposed legislation include: clinical laboratory, physical and occupational therapy, radiology and diagnostic imaging services, furnishing of durable medical equipment, furnishing of parenteral and enteral nutritional equipment and supplies, ambulance, home infusion therapy, and inpatient and outpatient hospital services. In addition, Stark proposed that the prohibition be broadened to include all payers, not just Medicare and Medicaid.

Congress did not pass H.R.5502. Some variations of the physician referral provisions contained in H.R.5502, however, were also contained in H.R.11, a comprehensive bill passed by the House and Senate. This legislation included provisions addressing, for example, group practices and services provided by group practice laboratories under arrangements with hospitals. Because H.R.11 was vetoed by the President, these provisions did not become law.

## AHA Position

AHA opposes referral of patients for health care to an entity, facility, or venture in which the referring individual or an immediate family member has an ownership interest or from which compensation is received, except in very limited circumstances. Those circumstances are to ensure that essential services are available when they would not otherwise be available.

# Hospitals and Tax-Exempt Status

## Background

Three currents have come together to increase scrutiny of not-for-profit hospitals' tax-exempt status. The first is hospitals' response to 1980s' incentives to be "more businesslike." Reduced federal funding, cost containment efforts by insurers and employers, and increased competition among health care providers all contributed to these incentives. Reconfigured hospitals, often with for-profit subsidiaries, are one reason for increased congressional interest.

At the same time state and local governments' revenue streams have been diminished by the persistent economic recession. A number of jurisdictions looking to make up revenue shortfalls are asking hard questions—sometimes in court—about whether their local hospital continues to merit tax-exempt status.

Another motivating factor is the number of uninsured Americans. Some members of Congress see mandating hospital care for the uninsured—without regard to whether hospitals can continue to stretch resources to meet such a growing need—as an easy solution to this problem.

Currently, hospitals are granted tax-exempt status on the basis of providing a community benefit and serving the public interest. Before 1969, tax exemption was determined on a narrower basis, that of admitting and treating patients who were unable to pay, to the extent of the hospital's financial ability.

## Recent Activity

In 1991, several members introduced bills to return to a narrower "charity care" definition as the basis for hospital tax-exempt status. These bills were sponsored by Rep. Brian Donnelly (D-MA) and Edward Roybal (D-CA). The House Ways and Means Committee held hearings on the issue and further attention may be expected.

At present, however, most of the attention to hospitals' tax-exempt status comes from the Internal Revenue Service. The IRS has beefed up its scrutiny of a whole range of hospital issues, including organizational structure, business practices, and physician relationships. Furthermore, it released expanded and more detailed tax-exempt audit guidelines last year. Auditors now look more closely at emergency department access; hospital admission policies, especially ability-to pay issues; Medicare and Medicaid admissions; charity care; and governing board composition, with special attention to whether the board is composed of independent leaders *from the hospital's community*.

The IRS has also launched a program—the Coordinated Examination Program, or CEP—that uses a whole range of specialists to perform the accounting

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equivalent of microsurgery on selected “large” hospitals. About 20 hospitals were given, or will be given, such top-to-bottom treatment in 1992-93.

## AHA Position

AHA understands that tax exemption brings with it responsibilities for meriting that status. But not-for-profit hospitals’ tax-exempt status should be based on broad community benefit, not specified levels of charity care. To focus only on the indigent would ignore the broad public service roles hospitals fulfill. These range from medical research, community education, and physician training to establishing outreach programs for teen-age mothers or the at-home elderly.

At the same time, hospitals, too, are concerned about the growing number of the uninsured. But this problem cannot be solved by eliminating tax exemption and mandating hospital care. What is needed to solve the problem of medical indigence is a basic restructuring of our health care system to more efficiently use resources and allow expansion of access to services. And that can only be achieved by fundamental health care reform, such as proposed by the nation’s hospitals under their umbrella organization, the American Hospital Association.

The AHA proposal allows expanded access and cost control through local community care networks. Such networks conserve resources by eliminating expensive duplication of services and technology and by defining a basic benefit package that would be made available to all. Networks also assume responsibility for community health status and provide greater public accountability and stronger community-hospital linkages.

# Hospitals and Medical Waste

## Background

Hospitals are the largest generators of medical waste. As such, they have received much of the attention of policymakers seeking to safeguard the public from illness or injury caused by medical waste, and to protect the environment. Yet the story behind hospitals and medical waste is very different from the impression left by initial reporting of medical waste occurrences, and from policymakers' motivation in targeting hospitals as the solution to the problem.

Most hospital waste is no more harmful than waste from an office building, a hotel, or a restaurant. The roughly 15 percent of waste that is potentially infectious is carefully segregated and disposed of separately by virtually every hospital. In fact, surveys of hospital waste disposal practices reported in academic journals show that many hospitals overmanage their wastes. Despite the fact most cases of improper medical waste management have been linked to home use or small clinics typically exempt from regulation, public attention focuses on hospitals because they are the largest sources of medical waste.

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## Recent Activity

The American Hospital Association (AHA) supports federal agency activity that is designed to ensure that medical waste is responsibly handled and disposed. AHA recognizes that there is the potential for real occupational risk associated with certain types of medical waste, specifically microbiologic waste and used "sharps." AHA also recognizes that other types of medical waste, such as liquid blood and pathological waste, while not posing a major risk to health care and waste disposal workers, must be handled responsibly.

The problem with federal agency activity to date, however, is that at least five agencies have authority over and are actively involved in influencing health care medical waste management activity. OSHA's standard on bloodborne pathogens went into effect in 1992, and the Department of Transportation regulations are scheduled to go into effect in April 1993.

Overregulation of medical waste has boosted some hospitals' expenses for managing waste by as much as 400 percent in the past few years. For example, in 1988, Congress approved the Medical Waste Tracking Act, a demonstration project. EPA predicted hospitals would spend an average of \$3,750 yearly to comply with the additional sorting, treatment, tracking, and transportation provisions in the Act. Many hospitals' actual costs prove to be dramatically higher, however.

The Medical Waste Tracking Act's demonstration programs ended in June of 1991. Although the last Congress did not extend the Act's definition of medical

waste and other provisions to all states, that is still a possibility. Reauthorization of the Resource Conservation and Recovery Act is the most likely vehicle for hospital medical waste legislation in the current Congress.

## **AHA Position**

AHA is committed to protecting the health and safety of health care workers, waste disposal personnel, the public at large, and the environment. But the risk of exposure to medical waste is primarily occupational, and regulatory initiatives should focus on reducing risks to health care workers and waste handlers. Scarce health care resources must be allocated on the basis of scientific assessment of risk, not on emotion or fear. Public understanding of the actual risks associated with medical waste should be furthered through public education programs. AHA has produced a communications kit for its members, "Talking to Your Community about Medical Waste and the Environment," to help them do just that.

AHA calls for the relevant federal agencies to examine their current regulations and recommendations and develop a reasonable, coordinated policy on medical waste. Specifically, AHA will seek legislation that sets out a scientifically based definition of medical waste and emphasizes regulatory coordination.

# Tuberculosis

## Background

Tuberculosis, once thought to be nearly eliminated, has recently reemerged as a public health problem. From 1953, when the U.S. Centers for Disease Control and Prevention (CDC) began tracking the disease, until 1984, the number of TB cases reported in the U.S. decreased steadily. However, this decline halted in 1985. CDC estimates that between 1985 and 1991, there were 39,000 more reported cases of TB than would have been expected had the previous decline continued. Much of the recent increase in TB cases is believed to be associated with the HIV epidemic.

Currently, CDC officials estimate that 10 to 15 million Americans are infected with the TB bacteria but are not infectious to others. The risk of an otherwise healthy, infected person's developing active TB is 10 percent over a lifetime. While some infected people may progress to clinical illness over the course of months, years, or decades, many people harboring latent TB never develop symptoms at all. In patients whose immune systems have been compromised, however, such as in those who are HIV-positive, the risk of progression to active disease is markedly increased. HIV-positive persons infected with the TB bacterium have over a 10 percent chance each year of developing symptoms. The CDC has estimated that the incidence of TB in HIV-infected individuals is 500 times greater than in the general population.

The difficulty in controlling TB has been exacerbated by an increase in outbreaks of drug-resistant strains of TB, which make treatment more difficult and costly; and a number of continuing social problems such as poverty, homelessness, substance abuse, lack of access to health care, increases in incarcerated and institutionalized populations, and fiscal constraints at all levels of government.

The reemergence of TB is of particular concern to hospitals, because of the increasing number of patients infected, the difficulty in identifying and treating infected patients, especially those who are immuno-compromised, and the increased potential for transmission to other patients, staff, and visitors posed by undetected cases. Hospitals in metropolitan areas that are already coping with significant AIDS, trauma, homeless, and indigent care caseloads have been especially hard hit.

## Recent Activity

Recognizing the significant challenge to hospitals in preventing the spread of TB, AHA sent a technical briefing to its members in February 1992 that called for immediate attention to TB-control measures. AHA also collaborated with CDC

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in a survey of more than 1,200 hospitals to assess the current status of infection control measures, skin-testing programs, laboratory capabilities, and the number of patients with multidrug-resistant TB. The study was presented at the World Congress on TB in Bethesda, Maryland, in November 1992. The results of this survey will be used to identify areas where additional resources may be needed and to seek funding to improve the capability of hospitals to prevent TB transmission.

AHA actively participated in a coalition of health-related and community-service organizations to secure more congressionally appropriated funds for TB research and treatment. As a result of these efforts, the House of Representatives, in their fiscal year 1993 Labor, Health and Human Services and Education appropriations bill, included a total of \$105.4 million for TB control efforts, compared to \$31 million in the FY 1992 appropriation.

In addition, AHA, in a letter to the House and Senate appropriations committees, requested additional financial aid to hospitals to combat TB.

## **AHA Position**

AHA continues to strongly support additional funding for hospitals to diagnose and treat patients with TB. In addition, AHA supports efforts to focus on TB prevention, the development of programs to educate and protect health care workers from infection, and additional funding for outreach and research activities.

# Acquired Immune Deficiency Syndrome (AIDS)

## Background

More than a decade into the AIDS epidemic, the total number of cases continues to grow, affecting all segments of the population. Hospitals are faced with the growing burden of treating those infected with HIV. In addition, hospitals continue to expand efforts to minimize the risks of HIV transmission to both patients and health care workers.

More than 19,000 new AIDS cases were reported during the first nine months of 1992. The Centers for Disease Control and Prevention (CDC) lists AIDS as the second leading cause of death in males ages 18-44. It is among the top five causes of death among young women. By the end of 1993, cumulative U.S. AIDS deaths will rise to over 350,000.

CDC's revised definition that will be used for AIDS epidemiologic tracking beginning in January 1993 is expected to almost double the official AIDS case-load in 1993.

In 1991, 70 percent of hospitals provided general inpatient care for patients infected with HIV. Annual direct medical care costs for treating a person with AIDS were \$38,300 in 1991, and the average cost of providing early intervention for an HIV-positive patient who does not yet have AIDS was estimated to be \$10,000. The Department of Health and Human Services (HHS) puts lifetime costs of medical care at \$102,000 for individuals expected to be diagnosed during 1992-1995. This number is higher than previous estimates because of increases in the average level of services used by HIV-infected individuals, expanded use of costly outpatient drugs, and extended length of life.

## Recent Activity

CDC issued guidelines in 1991 on managing HIV- and HBV- (Hepatitis B Virus) infected health care workers who perform exposure-prone procedures. The Occupational Safety and Health Administration's bloodborne pathogens standard took effect on July 6, 1992. The standard, which covers all employees who can reasonably be expected to come into contact with human blood and other potentially infectious materials, mandates engineering controls, work practices, and personal protective equipment, coupled with training, to reduce risks of bloodborne infection. It also requires employers to have a written exposure control plan and to offer free voluntary hepatitis B vaccinations to employees with occupational exposure.

In a July 1992 report on preventing HIV transmission in health care settings, the National Commission on AIDS outlined general principles and specific

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recommendations to minimize risks of transmission of bloodborne infections. The report also addressed HIV-antibody testing, restrictions on health care workers performing invasive procedures, and disclosure of health care workers' HIV status to prospective patients.

## AHA Position

Hospitals are committed to providing a safe environment and compassionate care for HIV-infected patients. Scientific knowledge, not hysteria, should drive hospitals' approach to testing of patients and workers and to managing HIV-infected health care workers. Rigorous use of universal precautions is the cornerstone of AHA's position on preventing transmission of bloodborne pathogens.

AHA opposes mandatory testing of all hospital employees and patients. Such a costly initiative would do little to decrease the risk of HIV transmission in the health care setting or to control the HIV epidemic. AHA also opposes routine "lookback" programs—programs to retrospectively notify patients treated by HIV- or HBV-infected health care workers—in the absence of evidence that the worker presented an increased risk of transmission.

AHA supports case-by-case determination of fitness for duty of HIV-infected health care workers. AHA also supports protecting the confidentiality of HIV testing information and the antibody status of patients and employees. AHA maintains an internal work group and a policy advisory group to advise and inform hospitals on AIDS issues on an on-going basis.

AHA believes it is urgent to fully fund the Ryan White (PL101-381) AIDS Act, in addition to increasing funding for AIDS research and educational programs, especially AIDS prevention activities.

# Medicaid Voluntary Contributions and Provider Assessments

## Background

The Medicaid program provides health care coverage for nearly 27 million poor Americans, half of them children. It is jointly funded by the federal and state governments—the federal government matches state expenditures for Medicaid services at a rate between 50 percent and 79 percent, based on a state's per capita income.

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With the persistent economic recession resulting in increased demand for Medicaid services and diminished state tax revenues, states have found it increasingly difficult to meet their obligations to fund their share of the program's costs. In 1985, state Medicaid expenditures were \$37 billion. By 1991, those expenditures more than doubled to \$88 billion. Early estimates indicate that Medicaid expenditures grew another 20 percent in 1992.

States have increasingly turned to health care providers for help in financing Medicaid, through providers' voluntary contributions or through provider-specific taxes. In many states the allied hospital associations have worked with their governors to improve coverage, especially for children.

## Recent Activity

In early 1991, the Bush Administration sought to curb federal Medicaid costs. The Administration focused specifically on limiting the states' use of provider contributions and taxes, as well as on reducing payments to disproportionate-share hospitals.

After considerable debate, Congress passed and the President signed, legislation that restricts the states' ability to finance their Medicaid programs through provider voluntary contributions and provider-specific taxes (P.L. 102-234). The new law caps the amount of provider taxes at 25 percent of the state's share of Medicaid dollars until September 30, 1995; defines permissible provider taxes as taxes that are broad-based, uniformly imposed, and do not hold taxpaying providers harmless; and virtually eliminates provider donation by permitting only limited donations.

The new statute also limits states' Medicaid disproportionate share hospital payment programs. A state can spend no more than 12 percent of total Medicaid outlays on payment adjustments to disproportionate-share hospitals (DSH).

In November 1992 HCFA published rules implementing the statute, as well as the preliminary limits for disproportionate-share spending in Fiscal Year 1993. HCFA's rules, for the most part, restate the statute. Significant policy decisions were made, however, in the restrictive application of the disproportionate-

share limits, particularly in regard to low-DSH states that were promised a growth factor.

The funding restrictions imposed on states through P.L. 102-234 and the implementing rules come as hospitals' Medicaid payments continue to fall short of costs. Hospitals now receive, on average, only 82 cents of every dollar of cost in treating Medicaid patients. In many states, the shortfall is much greater.

## **AHA Position**

Providing medical care to the poor and the uninsured is a broad societal responsibility, and programs to finance such care should spread the obligation as widely and equitably as possible. Provider-specific assessments, therefore, are not the preferred mechanism for financing state Medicaid or indigent care programs. In the absence of comprehensive health care reform, however, states must find a way to adequately fund Medicaid and should have flexibility to raise state Medicaid funds for purposes of the federal match.

The starting point for improvements should be enforcement of the federal requirement that state payments be "reasonable and adequate" (as required by the Boren amendment) to meet costs incurred by efficiently operated health care facilities. But the solution to Medicaid's funding problems ultimately lies in systemwide changes in how we deliver and pay for health care in this country. The American Hospital Association's comprehensive reform plan calls for Medicaid to be folded into a new, adequately funded public program. Cost savings would come from delivering care through integrated community care networks, and through setting a basic benefit package.

Until fundamental health care reform is in place, AHA will continue to seek fair and reasonable implementation of P. L. 102-234. AHA will monitor the treatment of voluntary contributions and provider assessment programs and work with allied hospital associations to address their concerns.

# Medicare Payments for Outpatient Surgery and Radiology Services

## Background

Under current law the coinsurance paid by Medicare beneficiaries for hospital outpatient services, including outpatient surgery and radiology services, equals 20 percent of hospital charges. For most other Medicare Part B services, beneficiaries pay 20 percent of either Medicare's allowable costs or actual payment. The Prospective Payment Assessment Commission (ProPAC) estimates that coinsurance payments made by beneficiaries amount to as much as 35 percent of the total payment to hospitals for outpatient surgery services and 46 percent of the total payment for outpatient radiology services.

Current law also stipulates that Medicare payment to hospitals for outpatient surgery and radiology services is the lesser of hospital charges, allowable costs or a blended rate based partially on hospital-specific costs and partially on prospective payment rates for ambulatory surgery centers and radiologists. Due to a "quirk" in the Medicare statute, program payments to hospitals paid under the blended rate methodology are not offset by the full amount of beneficiary coinsurance, resulting in what the Health Care Financing Administration (HCFA) characterizes as a "formula-driven overpayment" by Medicare to those hospitals.

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## Anticipated Action

Congress is likely to consider proposals to reduce the level of beneficiary coinsurance for hospital outpatient services. ProPAC and the General Accounting Office (GAO) have recommended to Congress that beneficiary coinsurance be reduced from 20 percent of hospital charges to 20 percent of Medicare's allowable cost or payment. In addition, a recent report by a senior citizen advocacy group regarding this issue has increased pressure on Congress to reduce beneficiary liability for hospital outpatient services.

Reducing beneficiary coinsurance liability for hospital outpatient services would increase Medicare expenditures and add to the federal budget deficit. In order to hold Medicare expenditures at or near the current level while reducing beneficiary coinsurance liability, Congress also is likely to consider changing the blended payment to eliminate the "formula-driven overpayment" for outpatient surgery and radiology services, as ProPAC, GAO and HCFA have all recommended.

According to ProPAC, these proposed changes could substantially reduce payments to hospitals for outpatient surgery and radiology services. ProPAC

estimates that Medicare already pays hospitals 15-17 percent below costs for outpatient surgery services and 20-25 percent below costs for radiology services.

## **AHA Position**

Congress, hospitals and older Americans must recognize that the problem of rising beneficiary coinsurance ultimately stems from flawed incentives in Medicare's predominately fee-for-service delivery system. To help alleviate this problem in the short term and to begin moving the Medicare program in the direction that overall health reform appears to be heading, Congress should consider measures to encourage beneficiaries to select managed care options available through the Medicare program. In the long term, the best way to slow the rate of increase in the cost of health care for all Americans, including Medicare beneficiaries, is to restructure the entire delivery system into community care networks.

In the meantime, AHA does not oppose reducing beneficiary coinsurance liability for hospital outpatient services, provided that any measure to reduce beneficiary coinsurance liability assures that total payments to hospitals for outpatient services are not reduced.

# Antitrust Law and Hospitals

## Background

An increasing number of hospitals are exploring innovative ways to cooperate with one another in serving their communities. Hospitals may wish to share services and equipment or agree to emphasize different specialties as a way to avoid expensive duplication of technology and services. Some hospitals consider mergers as a way to reduce excess capacity. Such agreements, as well as other collaborative initiatives, may be challenged by the Justice Department and the Federal Trade Commission on antitrust grounds, however.

Federal antitrust policy presumes that competition is the best allocator of resources and always benefits the consumer. Health care, though, is not a commodity purchased like groceries or automobiles. Sick patients can't always shop for care; typically, they choose a hospital at the suggestion of their physician. Furthermore, hospitals can't fully exercise market power since public programs such as Medicare and Medicaid set payment rates.

Notes & Questions:

## Recent Activity

There is support in Congress from both Democrats and Republicans for relaxing antitrust restrictions on health care providers. At least five bills were introduced in the last session of Congress to prevent antitrust laws from impeding hospital collaboration. H.R.2406, introduced by Rep. Jim Slattery (D-KS), called for exempting certain mergers and joint activities between hospitals that receive more than 40 percent of their gross revenues from government programs and are located in cities of less than 125,000. Sen. William Cohen (R-ME) and Rep. Tom Campbell (R-CA) introduced S.2277 and H.R.4472, respectively. Each bill would have suspended antitrust laws for 10 demonstration projects for up to five years so that hospitals could share equipment and services. H.R.5244, introduced by Rep. Peter Hoagland (D-NE), would have allowed 20 demonstration projects between hospitals and other providers to share medical technology and services, and establish an expedited Department of Justice review process for hospital collaborative requests. Hoagland has introduced similar legislation, H.R.73, in the current Congress. And the House GOP health reform bill, H.R.5325, called for the removal of antitrust barriers for certain hospitals agreeing to share technology and services.

## AHA Position

The AHA believes antitrust policy should allow hospitals and their communities to assess local health care needs and reduce expensive overcapacity and unnec-

essary duplication to more efficiently meet those needs. Changes and clarifications in antitrust law and enforcement practices are necessary, for example, to implement AHA's reform vision of a restructured health care delivery system based on provider cooperation. Even in cases where antitrust laws may not pose an actual threat, a chilling effect that discourages innovative arrangements is created as a result of inadequate guidance from federal agencies, the potential for treble damages, confusion about the law, and the time and expense necessary to respond to an inquiry or possible challenge. AHA has spelled out these problems in a report published late last year, "Hospital Collaboration: The Need for an Appropriate Antitrust Policy." To realize a more effective and efficient community-focused health system, federal agencies overseeing antitrust policy must recognize that the health care market is unique, and that better guidance from the enforcement agencies concerning hospital cooperation and collaboration is needed.

# Medical Liability Reform

## Background

The current medical liability system costs far too much and works much too slowly. It fails to provide access to the legal system or fair compensation for many injured patients while providing exorbitant awards to others. It adds billions of dollars to the national health care bill by encouraging physicians to practice “defensive medicine” as a hedge against potential claims and lawsuits. The cumulative effect threatens access to health care, especially in certain high-risk services such as obstetrics and emergency department care.

Notes & Questions:

## Recent Activity

President Clinton has included medical liability reform as one element in his approach to health care reform. Indeed, most of the major health care reform proposals introduced on Capitol Hill last year contained some provisions for medical-liability reform. AHA supported earlier bills (S.489 and H.R.1004) introduced by Sen. Orrin Hatch (R-UT) and Rep. Nancy Johnson (R-CT), respectively, that would mandate medical liability reform at the national level. Health care reform proposals crafted this year are also likely to contain medical liability reform provisions.

## AHA Position

The AHA supports efforts to reform the tort system to ensure its effectiveness in promoting delivery of quality health care for all. Hospitals are convinced that medical liability reform is one action that can be taken immediately as the nation works toward long-term health care reform.

Specifically, the AHA supports medical liability reform that permits

- Cost-effective and equitable resolution of claims;
- Limits on noneconomic damages and attorneys’ fees;
- Elimination of legal rules of joint liability that may require hospitals to pay for damages caused by others, and of rules that permit duplicate recovery of amounts from collateral sources;
- Payment of malpractice awards over time rather than in a lump sum; and
- Examination of alternative dispute resolution (ADR) mechanisms instead of litigation to resolve claims.

In addition, AHA believes that improvements in the medical liability system must be coupled with clearer medical practice guidelines to help determine the most appropriate and effective care. Such guidelines would also afford some protection to providers in medical liability actions. This combination of reforms would be the best way to decrease costs associated with defensive medicine.

# Administrative Cost Savings

## Background

Administrative costs—including billing, processing, and payment of claims—result in a mass of paperwork that burdens providers, payers, and patients alike. While projections that we could reap enough in administrative savings to fund health care coverage for the uninsured are overstated, there is no doubt that significant savings could be achieved.

Notes & Questions:

## Recent Activity

A flurry of legislative and regulatory proposals surfaced in 1992 to deal with the administrative cost issue. Rep. Pete Stark (D-CA), the chairman of the House Ways and Means' health subcommittee, introduced a bill that called for a uniform billing system to streamline patient claims processing, billing, and insurance information. Existing technology would be used to create a universal system of electronic billing, uniform bills, and "smart cards," which would be issued to consumers. The cards would permit providers to verify patients' insurance eligibility and benefits and to track co-payment and deductible information.

In the current Congress, as part of a comprehensive health care cost containment bill, Stark introduced similar provisions seeking to reduce administrative costs by creating a uniform electronic billing system. The bill, H.R.200, also calls for universal health insurance identification cards for patients to allow providers easy access to information about eligibility and coverage.

On the Senate side, Sen. Christopher Bond (R-MO) offered the Bush administration's plan to phase in over five years an electronic billing and claims-processing system. This bill also called for the implementation of an electronic patient care information system containing detailed clinical information. The administration estimated the plan would save \$4 billion annually.

When Congress adjourned in October without passing any legislation designed to lower administrative health costs, HHS announced it would begin testing automated health cards this year. This pilot program is the first phase of a plan to usher in an electronic health care network that would speed claims processing and attack administrative waste.

## AHA Position

The AHA is working with HHS, insurers, and providers both to streamline billing and claims processes and to identify incremental steps to support the development and implementation of computerized patient records. (AHA Presi-

dent Dick Davidson chairs a work group on patient information that will soon be issuing recommendations.) The goal of all these efforts is not only to simplify current administrative systems but also to establish needed information systems to support overall health care system reform.

Hospitals' key concern in reducing administrative costs is that the costs of both providers and payers are taken into account so that the result is an effective as well as efficient administrative system. We must make sure that administrative simplification for payers does not mean increased administrative burdens for providers.

The first step—before computerization—is standardization and streamlining of required billing and medical information. Real cost savings can be achieved in this area if hospitals are required to provide only a common set of data essential for conducting medical and claims review, not the sum of all the information every payer may desire.

Hospitals understand that health reform must go beyond simplifying current administrative systems. To achieve even greater efficiencies, we must overhaul the way we deliver and pay for health care.

The AHA's broader vision for health care reform restructures health care delivery around "community care networks." Networks would provide opportunities for streamlined administrative systems. They would also do much more, however. They would realign financial incentives and encourage the efficient use of health care resources by everyone for true system-wide reform.

# Outcomes Research and Physician Practice Parameters

## Background

Whether you're treated with bed rest or with surgery for lower back pain can sometimes be determined more by where you live than by the details of your complaint. A number of studies have documented such geographic variations in treatment—in cardiac care, in the frequency of cesarean sections and hysterectomies.

These differences inevitably lead to questions: is bed rest just as effective as surgery? Is angioplasty more effective than medication therapy?

Answering these questions is important for at least two reasons. The first, of course, is to insure the best possible patient outcomes. Escalating health care costs are the second big reason to look at the effectiveness of treatment options. Bed rest costs the health care system a lot less than surgery. Since there is a growing consensus among policymakers and providers that the rate of growth in health care spending must be moderated, cost saving is an important concern.

Notes & Questions:

## Recent Activity

Surprisingly, it is only fairly recently that health care providers and researchers have begun to look systematically at treatment effectiveness questions. This research got a boost from the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), which established the Agency for Health Care Policy and Research (AHCPR) as part of the U.S. Public Health Service. AHCPR's mission is to "conduct and support research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures."

AHCPR is concentrating on conditions that both account for significant Medicare expenditures and show a significant variation in treatment pattern. The Agency's 1991 report to Congress outlined its work in low back pain, myocardial infarction, cataracts, and prostate disease.

To complement AHCPR studies, the Health Care Financing Administration is now developing the Uniform Clinical Data Set (UCDS), which will automate case selection and standardize current methods of peer review. It will generate a sizable clinical data base for outcomes research. In addition, an Institute of Medicine committee adopted a strategy in 1990 for improving hospital and physician performance through the analysis of outcomes data. Taken together, these efforts will provide the foundation for giving solid guidance to physicians and other caregivers on the most effective ways to treat illness and injury.

## **AHA Position**

AHA strongly supports investment in outcomes research and the development and dissemination of medical practice parameters and clinical guidelines based on that research. Such improved information will lead to better service to patients and wiser use of health care resources.

# State Efforts and Health Care Reform

## Background

While 1992 brought no federal-level action on health care reform, lots of state-level efforts were bubbling up across the nation. Some states, such as Hawaii, already have comprehensive reform in place. Others, such as Oregon, are working toward reform in public programs—in Oregon's case, in Medicaid.

The situation in Oregon illustrates a common problem in implementing state-level health care reform, however. Oregon has redesigned its Medicaid program to extend coverage to 120,000 currently uninsured poor residents. Oregon wants to pay for the expanded access by prioritizing health care procedures and dropping payment for those at the bottom of the list if Medicaid funding falls short.

In order to try this approach, however, Oregon needs a federal waiver from Medicaid regulations. Preparing such a waiver request is a complex—even Byzantine—process. And, in Oregon's case, the request was denied. The Bush Administration turned it down on the grounds that failing to fund some of the medical procedures judged to be low priority may run afoul of the Americans with Disabilities Act. Oregon officials have resubmitted their request.

Other states have more successfully sought federal waivers of Medicare and Medicaid regulations in order to implement “managed care” plans for these programs. Managed care plans, typically Health Maintenance Organization-like approaches, attempt to improve care and stretch resources by planning and coordinating patient treatment and by using only selected caregivers. More than 30 states have implemented such plans.

Another roadblock to state-level reform efforts are state mandated insurance benefit laws. By specifically defining what medical procedures must be covered by insurance plans operating in the state, these regulations effectively preclude putting together basic health care benefit packages that concentrate on core services. Such laws also encourage employers to set up self-insured health care plans, since such plans are exempt from mandated-benefit laws. More than half of U.S. employers have chosen the self-insured route.

States also find ERISA regulations (the Employee Retirement Income Security Act) a stumbling block in implementing reform plans. This federal law was designed primarily to protect employee pension plans by setting federal regulations for employee-benefit programs. The courts have also interpreted the act to mean that states are prohibited from mandating that employers provide worker health coverage, however. This is a potential barrier to state efforts to spread funding for the medically indigent by making every employer either insure its

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workers or pay into a state fund to provide basic coverage for the otherwise uninsured. ERISA also impedes state efforts to develop streamlined administrative procedures—including uniform claims forms and billing systems—and to establish negotiated rate systems.

## Recent Activity

Congress has taken note of the cumbersome Medicaid waiver process. Sen. Daniel Patrick Moynihan (D-NY) introduced S.3191 in the last session of Congress to enable states to establish or expand Medicaid managed care programs without going through the waiver process. It is thought that the Clinton Administration may be more sympathetic to state reform experimentation and may therefore be likelier to grant waivers.

Congress also tried to address state ERISA concerns. Last session, Sens. Patrick Leahy (D-VT) and David Pryor (D-AR) introduced S.3180, which would allow 10 states to establish health care demonstration projects with immunity from ERISA regulations. Also last summer, Sen. Dave Durenberger (R-MN) introduced S.3223, which would amend ERISA and allow states a narrow exemption from federal law to include self-insured employers as a funding source for state reform initiatives. Similar bills are likely to be introduced in the current Congress. Passage is uncertain, however, since both business and organized labor may oppose ERISA changes.

Meanwhile, a federal appeals court upheld a federal district court ruling that ERISA preempts a New Jersey hospital rate-setting law that would have mandated self-insured plans to pay surcharges to cover uncompensated care costs. The ruling could further restrict state reform efforts.

## AHA Position

AHA believes states should have flexibility in implementing their approaches to health care reform—state reform efforts should be encouraged because they serve as useful models and guideposts in achieving national health care reform. Toward that end, the federal Medicare and Medicaid waiver process should be simplified, although never at the expense of jeopardizing Medicare and Medicaid beneficiaries' access to high-quality care. ERISA changes should also be made.

AHA also maintains that nationwide comprehensive reform is needed in the long term. A number of governors involved in health care reform have said this as well—that the problem is too large, and has too many ramifications beyond state borders, to be solved state-by-state.

AHA has confidence that its approach to health care reform, centered on community care networks, is a workable solution at the national level. Community care networks provide improved care by emphasizing prevention and by untangling the current fragmented health care delivery system, and they hold promise for moderating rapidly rising health care costs through eliminating expensive duplication of services and technology. And, the AHA plan's federally defined basic benefit package would obviate the need for state mandated-benefit laws.

# Data Disclosure

## Background

The demand for health care data related to cost and quality has increased noticeably in recent years. Federal and state government, accreditation organizations, third-party payers, and providers themselves all have sought more detailed information on patient outcomes and the cost of providing care. The primary purposes of data disclosure are positive—to promote public accountability on the part of health care providers and to supply consumers with valid information on which to base health care decisions. Unfortunately, though, few current data collection and analysis efforts have reached a level of sophistication allowing such valid measurements and informed decision making.

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In an early step, the Health Care Financing Administration began publishing hospital mortality rates for Medicare patients in 1986. In response to academic and provider criticism regarding the data's ability to measure hospital performance, HCFA has modified its methodology. Although these improvements have made the data more useful to clinicians, the data still do not measure quality and are of limited value to the average consumer.

## Recent Activity

Roughly 20 states now make public varying levels of cost and quality data. In addition, a number of health care reform bills introduced in the last Congress required the reporting of clinical outcomes information. And, the Joint Commission on Accreditation of Healthcare Organizations is considering releasing its quality-related data.

## AHA Position

The AHA supports the public availability of useful information related to the quality and cost of health care services. The data must be suitable to its purpose and be prepared and released in a way that enables the public to make accurate judgments. The AHA supports efforts to develop refined quality measurement and assessment techniques. AHA believes that such measurements must be an integral part of fundamental health care reform because they will both improve patient care and help ensure cost-effective use of scarce resources.

# National Health Care Commission

## Background

While no overall consensus on the shape of health care reform emerged last year, there was movement toward common elements in a number of reform proposals. One of these was the need for an independent national health care commission.

Such a commission would determine a basic set of health care benefits that would be covered by government health care programs—that is, by Medicare and Medicaid—and serve as a floor for private coverage. Rapidly escalating health care spending is leading policymakers to conclude that this nation cannot continue down the path of providing virtually unlimited health care services to most of its citizens—while at the same time letting one out of seven citizens go without health care coverage. It is clear that a reallocation of resources is needed, along with a mechanism to slow cost increases. Defining a basic set of health care benefits is one way to move toward these goals.

That shift, however, will involve some very tough choices—choices such as what types of care will be provided under what circumstances. It may prove very difficult to make these choices through the political process, given regional, demographic, and cultural differences. That is why many health care reform proposals would put these decisions in the hands of a commission, independent of congressional budgetary and political pressures. Two models mentioned most often as likely to assure the commission's independence are the Federal Reserve Board, which oversees the nation's monetary policy, and the Securities and Exchange Commission, which oversees the securities markets.

Beyond defining a basic benefit package, the commission could also be charged with advising Congress on various aspects of the healthcare system, giving them the information they need to set an appropriate budget target for the public program or programs. The commission might also monitor whether funding is adequate to provide the defined package.

## Recent Activity

A number of major-player proposals contain such a commission. The Senate Democratic leadership plan (S.1227) introduced in the last session of Congress and the reform strategy developed by the National Leadership Coalition for Health Care Reform, a broad-based group containing both business and labor representatives, both contain independent commissions. The Washington Business Group on Health, made up of large corporations, also has a health care reform plan containing a national commission as one element. And, the Conservative Democratic Forum's (CDF) proposal, introduced in the last session of Con-

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gress as H.R.5936, also used an SEC-like National Health Board to set benefits and standards for reporting prices and treatment outcomes. Under the CDF bill, the commission would also provide broad oversight of how local health care delivery plans would interact with purchasers.

## AHA Position

The American Hospital Association's health care reform proposal also contains a role for an independent national commission. AHA's strategy envisions the commission performing the two roles suggested above—defining a basic benefit package and providing advice to Congress on the benefits that could be supported at specified funding levels—as well as a third role.

The additional role grows out of the basic building block of the AHA reform proposal, community care networks. Community care networks are coordinating groups of local providers that give patients a single entry point for all health care services. The networks would be paid a set annual fee, known as a “capitated” fee, for each person enrolled. The commission would set an actuarially sound capitated rate under the public program to allow community care networks to deliver the basic set of defined services. The commission also would adjust the rates to reflect broad differences in health risk in network enrollees, such as age, and for geographic differences in the cost of providing care.

# Incentives for Developing Community Care Networks

## Background

The American Hospital Association's health care reform proposal is centered on community care networks. Such networks are made up of cooperating, rather than competing, local providers organized to meet local health needs. As such, they hold promise for improving the health of our nation efficiently and cost-effectively. For example, better care would be provided through network emphasis on prevention and by helping consumers navigate the now-fragmented health care system. Cost savings would come through eliminating expensive duplication of technology and services, and through restructuring financing and delivery systems based on consistent incentives. Networks' improved use of resources would in turn allow expanded delivery of health care services to those now uninsured, without the huge jump in health care spending that would result if access is expanded to our current fragmented system—although universal access cannot be achieved without some increase in spending.

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Just how many of these positive changes can be made, however, depends in large part on how flexible the public is in adapting to changes in the health care delivery system. Public opinion surveys show that while Americans overwhelmingly believe that fundamental health care reform is needed, the currently insured may not be so willing to make changes in their own health care delivery arrangements.

In order to more fully realize the potential benefits of community care networks, broad public policy changes may be needed to encourage consumer use. Such changes might include tax incentives, such as allowing a larger deduction for services delivered through a network, for example. Or, consumers might be responsible for a larger co-payment when using services outside a network. Such policy changes could make a dramatic difference in how widely community care networks are used.

## Recent Activity

The basic concept of providing health care services through provider cooperation is shared by a number of health care reform proposals. These include proposals from the Blue Cross and Blue Shield Association, the Catholic Health Association, and the Washington Business Group on Health, as well as a centrist congressional bill sponsored last year by the Conservative Democratic Forum.

Such cooperative arrangements, already being implemented by a number of hospitals, have sometimes run up against antitrust regulations, however. Both the Justice Department and the Federal Trade Commission have challenged

cooperative arrangements on the grounds that they limit competition and therefore harm consumers. AHA has initiated discussions with both agencies to explain our view that competition in health care markets often results in expensive duplication of services and technology and therefore does not benefit consumers.

The barrier presented to health care reform by antitrust regulation has been recognized on Capitol Hill. At least five bills were introduced in the last session of Congress by both Democratic and Republican members to address the problem. Similar bills are likely to be introduced in the current session, and congressional hearings are expected as well.

The current tort system for medical liability is also an obstacle to innovative approaches to health care reform because it encourages test-intensive defensive medicine and lengthy and expensive courtroom litigation. Here, too, remedial legislation was introduced in the last session of Congress—including provisions in most of the major health care reform proposals—and is expected to surface again in the current session.

Congress has also addressed the need to shape network incentives. The Managed Competition Act of 1992, introduced by Reps. Cooper (D-TN), Stenholm (D-TX), and Andrews (D-TX), and Sens. Breaux (D-LA) and Boren (D-OK), would limit tax deductibility of health insurance costs to the lowest cost benefit plans offered by a qualified “Accountable Health Plan.” Community care networks would be accommodated under the “accountable health plans” defined by the legislation.

## AHA Position

This nation’s ability to deliver better care and conserve health care dollars will depend on the extent to which community care networks are established throughout the country and used by consumers as their health care source. The formation of networks and consumer selection of networks should be encouraged by:

- medical liability reform;
- tax code changes; and
- consumer cost sharing.

In addition, the barriers presented to network formation by current antitrust regulations should be removed.

Federal grants to encourage network formation may also be called for. Current federal programs could be used as catalysts for network formation. Medicare’s EACH/PEACH and Rural Health Care Transition Grant programs can already serve as network building blocks. Other current initiatives, such as the use of Health Maintenance Organizations and the similar Competitive Medical Plans to deliver Medicare and Medicaid services, could be strengthened and evolve into community care networks.

# Medicaid Managed Care

## Background

States are increasingly turning to managed care plans to control rising Medicaid costs and improve the delivery of health care services to those eligible for Medicaid. Such plans—HMOs are one example—strive to ensure cost-effective care by using selected caregivers and coordinating patient treatment. As of this writing, 36 states are placing those eligible for Medicaid in some type of managed care. These states include some of the largest—New York, California, and Michigan, for example.

A recent Health Care Financing Administration (HCFA) report notes that states with “freedom of choice” waivers—the federal waivers needed to implement state managed care plans—have saved \$325 million in Medicaid spending. But the waiver application process is cumbersome and time-consuming. States are demanding that it be streamlined so that they can more easily pursue health care delivery reform for Medicaid recipients.

Notes & Questions:

## Recent Activity

Senators Daniel Patrick Moynihan (D-NY) and Dave Durenberger (R-MN) introduced the Medicaid Managed Care Improvement Act in 1991 to allow states to develop Medicaid managed care plans without seeking federal waivers. A series of hearings on the legislation were held in 1992 in both the Senate Finance Committee and the House Energy and Commerce Subcommittee on Health, but no further action was taken. The National Governors Association and the American Public Welfare Association, representing state Medicaid directors, endorsed the legislation and are expected to continue to advocate changes in the Medicaid waiver process. Reintroduction of similar legislation is expected in the current Congress.

## AHA Position

The American Hospital Association embraces the goal of the Medicaid Managed Care Improvement Act, which is to deliver health care services in the most appropriate setting. This effort has the potential to improve care and reduce costly and inappropriate services. AHA’s proposal for fundamental health care reform, centered on local networks to deliver coordinated care, embodies many of the principles inherent in managed care plans.

AHA has also expressed concern, however, that if the main focus of implementing such managed care programs is simply to manage *costs* but not to man-

age *care*, there is little gain for the Medicaid patient. As part of a coalition (including the Association of American Medical Colleges, the National Association of Public Hospitals, and the National Association of Children's Hospitals and Related Institutions), AHA has suggested changes in the legislation to maintain current safeguards for patients and providers as shifts to managed care programs are made.

AHA recommends that state Medicaid managed care programs

- focus on the management of health care, not costs alone;
- allow hospitals a meaningful role in the program; and
- demonstrate a commitment to working with managed care and with health care providers.

# The Federal Budget and Medicare and Medicaid

## Background

Medicare and Medicaid were established in 1965 for two main reasons: to reduce the worry of the elderly over how they were going to pay for medical expenses, and to provide medical care to the poor. These were important goals; goals our country could be proud of.

Meeting these goals has proven difficult, though, and increasingly so in the wake of the recent and persistent economic recession the nation is only now working its way out of. Today, Medicaid covers only about 40 percent of the poor. Coverage has eroded as states, who now share responsibility for the program with the federal government, have restricted eligibility requirements in order to keep Medicaid spending within what they believe are reasonable amounts—even as laid-off workers and the increasing number of children in poverty increase the need. Payments for those who are covered have eroded as well. American Hospital Association surveys show that hospitals are paid, on average, only 82 cents for every dollar they spend in providing care to Medicaid patients; in some states, the shortfall is much more dramatic. And, distribution of Medicaid funds has become skewed as well, as an increasing proportion of Medicaid dollars has gone to underwrite long-term care for the indigent elderly, leaving a higher percentage of poor children uncovered.

A similar scenario has been played out at the federal level for Medicare. As our population has aged, demand for Medicare services has grown accordingly. At the same time, the federal government has experienced severe budget deficits—partly induced by the recession; partly the result of questionable budget and tax policy in the 1980s. The federal government has responded much as the states have, by squeezing down the payments going to hospitals to pay for Medicare services—without regard to how that squeezing affects hospitals' ability to deliver Medicare services to a growing segment of their patient population. The Prospective Payment Assessment Commission (ProPAC), the official body that advises Congress on the Medicare payment system for hospitals, estimates that hospitals had a 10.2 percent Medicare payment shortfall in 1991-92.

Clearly, further cuts to Medicare and Medicaid can only be made with the risk of severely undermining quality of care, further limiting access to care, or increasing cost-shifting to the private sector.

Medicare and Medicaid are still extremely vulnerable to further funding reductions, at both the federal and state levels. The reason? Because they serve such large numbers, the money set aside for these programs is also concomitantly large. And that makes these funds a tempting target for budget deficit reduction—for moving funds from their column of the ledger over

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to columns that pay for other programs. (In today's budget deficit environment, few programs are proposed that aren't "budget neutral"—that is, that aren't paid for by shifting already-available funds from somewhere else. New funding, which would increase the deficit, is virtually a political and budgetary impossibility.)

Medicare and Medicaid funding are vulnerable to two "raiding" approaches. The first is through continued ratcheting down of payments to health care providers, as has occurred over the years. We're still expecting cuts in indirect medical education, reductions in the PPS update factor, and a delay in when the update factor goes into effect under this approach in the current congressional session. Legislators are also likely to try to fill up this same bucket with revenue increases generated by some kind of Medicare means testing and/or increasing payments into its trust fund by increasing the FICA caps.

The second approach is the relatively new idea of arbitrarily *capping* the amount spent on these programs. To attack what are perceived as unacceptable rates of increase in Medicare and Medicaid spending will be far more difficult than simply setting a cap, though. It will require fundamental restructuring of our health care delivery system, to do away with current fragmentation and wasteful duplication of services and technology. More attention will have to be paid to prevention, and to providing health care coverage for everyone, so that illness is treated early, before it develops into the urgent cases that too many hospitals see—unnecessarily see—in their emergency departments.

The American Hospital Association has an approach to health care reform that does these things. That delivers efficient care through cooperating providers at the local level. That allows the federal government to define a basic benefit package for Medicare and Medicaid, to better plan health care expenditures. This kind of fundamental reform, that addresses the underlying reasons for growing health care costs, is what is going to assure the long-term viability of the Medicare and Medicaid programs—programs that are at the very center of what this country is all about. That is why Medicare and Medicaid patients should be given powerful incentives to receive health care through community care networks, the building block of AHA's reform plan.

# Medicare-Dependent Rural Hospitals

## Background

The Medicare-dependent rural hospital provision began to expire for some hospitals in the spring of 1992, and will have expired for all hospitals by next spring.

As a result of legislation originally introduced by Sen. Lloyd Bentsen (D-TX) and Robert Dole (R-KS), the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) contained a provision that allowed Medicare-dependent small rural hospitals to be paid the greater of their target amount based on their 1982 costs, their target amount based on their 1987 costs, or federal PPS rates. Eligible for the adjustment were hospitals located in rural areas with 100 beds or fewer, not classified as sole community providers, with 60 percent or more of their days or discharges attributable to Medicare during the base period of 1987. The intent of the legislation was to provide the adjustment for three years, but the way the statute was drafted resulted in many hospitals receiving the additional payments for only two years.

The provision applies for cost-reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993. According to the Health Care Financing Administration (HCFA), 564 hospitals are currently eligible for this designation.

Notes & Questions:

## Recent Activity

An extension of the Medicare-dependent hospital provision was included in H.R.11, the Urban Aid Act/Revenue Act of 1992. All hospitals eligible for the adjustment would have received it for the promised three full years, and then would have received half the payment adjustment until the elimination of the urban/rural differential, on September 30, 1994.

H.R.11 was passed by the Congress in October of 1992 and was vetoed by President Bush on November 3.

## AHA Position

AHA supports the extension of the Medicare-dependent rural hospital provision as outlined in H.R.11. These provisions are now contained in H.R.21, a bill introduced by House Ways and Means Committee Chairman Dan Rostenkowski (D-IL) on the first day of the current session.

# Rural Health Care Transition Grant Reauthorization

## Background

The authorization for rural transition grants expired at the close of Fiscal Year (FY) 1992. The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) created the Rural Health Care Transition Grant program to assist rural hospitals with fewer than 100 beds in modifying their services in order to maintain access to health care for Medicare beneficiaries. The Health Care Financing Administration (HCFA) provides annual planning grants for two years to such hospitals to help them determine how to convert acute care facilities to other uses to provide services essential to their communities. Such services might include emergency, ambulatory surgery, mental health (including alcohol and drug treatment), home health, respite, and hospice care.

Grants are limited to \$50,000 per hospital per year, not to exceed two years.

Appropriations were authorized at \$15 million for FY 1989, and at \$25 million a year for FYs 1990 through 1992.

Notes & Questions:

## Recent Activity

The rural transition grant program was reauthorized as a part of H.R.11, the Urban Aid Act/Revenue Act of 1992. H.R.11 authorized appropriations at \$30 million a year for FYs 1993 through 1997. H.R.11 was passed by both houses of Congress in October 1992 and was vetoed by President Bush on November 3.

## AHA Position

AHA supports the reauthorization of the grant program. Provisions to do so are now contained in H.R.21.

# HCFA Changes in Outlier Payments

## Background

The Prospective Payment System (PPS) final regulation for Fiscal Year (FY) 1993 changes certain elements of the day outlier formula to shift outlier payments from day outlier cases to cost outlier cases.

Notes & Questions:

The Health Care Financing Administration (HCFA) proposed to shift monies from day to cost outliers based on research indicating that (1) the per diem outlier payments exceeded the cost of an additional day of care (once it has crossed the length of stay threshold) by about 25 percent; and (2) nearly 40 percent of day outlier payments were made for cases that, with outlier payments included, were profitable.

To make the payment shift from day outlier cases (which exceed specified length of stay thresholds) to cost outlier cases (which exceed specified cost thresholds), HCFA used a simple average length of stay—rather than the geometric mean—to compute the per diem DRG rate and then applied a 55 percent marginal cost factor—instead of 60 percent—to figure the payment for each outlier day. At the same time, cost outlier payments are increased by lowering the cost outlier threshold.

## Recent Activity

In our comment letter on the proposed rule, AHA supported the overall direction of the change from day outlier to cost outlier payments, but indicated that for some states this change would lead to severe reductions in payments. As a result, we urged that HCFA phase the change in over two years, allowing the affected hospitals an opportunity to adjust managerially and to preserve patient access to care.

HCFA rejected AHA's recommendation that this change in policy be phased in over two years, but the Congress included a two-year phase-in as a part of H.R.11, the Urban Aid Act/Revenue Act of 1992. H.R.11 was passed by both houses of Congress in October of 1992, but was vetoed by President Bush on November 3.

## AHA Position

AHA supports *measured* movement from day outliers to cost outliers. Because the current HCFA outlier policy change will result in significant and abrupt payment shifts to some hospitals, we support a two-year phase-in to temper the effects of this particular change. AHA is working to support passage of these provisions, now contained in H.R.21, along with other Medicare-equity provisions included in the bill.

# Geographic Reclassification Urban Hold-Harmless Provision

## Background

Some urban hospitals, as a result of neighboring hospitals being reclassified into another wage area, have been subject to a dramatic and uncontrolled drop in their area wage indices.

The Medicare Geographic Classification Review Board (MGCRRB) was established by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) as an independent appeals body to address payment inequities arising from the use of metropolitan statistical area (MSA) boundaries to group hospitals for payment purposes. Through the appeals process, a hospital can seek to be classified in a nearby geographic area that has a higher standardized payment or higher wage index.

Urban hospitals remaining in their wage area while neighboring hospitals were reclassified into another wage area are protected from dramatic payment losses because the statewide rural wage index is set as a floor beneath which an urban hospital's area wage index cannot fall.

However, some urban wage indices are already lower than the statewide rural wage index in their states, and some states have no rural hospitals and therefore no statewide rural wage index to serve as a floor. In these cases, there is no effective floor protecting such urban hospitals from excessive declines in their wage indexes.

Notes & Questions:

## Recent Activity

H.R.11, the Urban Aid Act/Revenue Act of 1992, contained a hold-harmless provision for those urban hospitals located either in states where the rural wage index is higher than some or all of the urban wage indices, or in an urban area that is the only urban area in a state with no rural hospitals.

H.R.11 was passed by Congress in October 1992 and was vetoed by President Bush on November 3.

## AHA Position

AHA supports inclusion of this hold-harmless provision for certain urban hospitals adversely affected by Medicare's geographic reclassification process. The provision is now contained in H.R.21, a bill introduced by House Ways and Means Committee Chairman Dan Rostenkowski (D-IL) on the first day of the current session.

# Rural Referral Centers

## Background

Some rural referral centers lost that status for cost reporting periods beginning on or after October 1, 1992.

Notes & Questions:

Rural hospitals may be classified by the Secretary of Health and Human Services (HHS) as rural referral centers (RRCs) if, by meeting certain criteria, they can demonstrate that they have similar operating characteristics to a typical urban hospital located in the same census region. RRCs are paid on the basis of the “other urban” rate, rather than the rural rate, adjusted by the hospital’s area wage index.

The Secretary had intended to review the status of each RRC every three years to determine whether the hospital sufficiently met the RRC criteria. The Omnibus Budget Reconciliation Act of 1986 (OBRA 86), however, provided that any hospital classified as an RRC on October 21, 1986, would retain that status through cost reporting periods beginning before October 1, 1989, whether or not they currently met RRC qualifying criteria. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) further extended RRC status so that any hospital classified as an RRC on September 30, 1989, would continue to be so classified for cost reporting periods beginning before October 1, 1992.

## Recent Activity

H.R.11—the Urban Aid Act/Revenue Act of 1992—provided that any RRC so classified as of September 30, 1989, including those retaining that status as a result of the OBRA 86 provision, would continue to be paid as an RRC until the elimination of the urban/rural differential on October 1, 1994. At that time all rural hospitals will be paid on the basis of the “other urban” rate.

H.R.11 was passed by the Congress in October of 1992 and was vetoed by President Bush on November 3.

## AHA Position

AHA supports the extension of rural referral status for this group of hospitals until the elimination of the urban/rural differential, as provided in H.R.11. These provisions are now contained in H.R.21, a bill introduced by House Ways and Means Committee Chairman Dan Rostenkowski (D-IL) on the first day of the current session.

# Wage Index and Geographic Reclassification

## Background

The area wage index adjusts hospital payments under the Medicare prospective payment system (PPS) to reflect relative hospital wage levels across geographic areas. Specifically, the wage index for any area is the ratio of the average hourly wage paid by all hospitals in that area to the average hourly wage paid by all hospitals nationwide. The Health Care Financing Administration (HCFA) has historically used metropolitan statistical areas (MSAs) or statewide non-MSAs as its wage index areas. Hospitals can appeal to the Medicare Geographic Classification Review Board (MGCRB) to be reclassified to neighboring areas with a higher wage index (or standardized amount).

Because the national average wage index value is set at 1.00 each time the wage index is updated, any wage index update is redistributive: hospitals in areas where wages rose more rapidly than the national average reflected in the index will experience an increase in their wage index, while hospitals in areas where wages rose more slowly than the national average will experience a decrease.

Several changes to the wage index are likely over the coming months. These include

- Adoption of updated Metropolitan Statistical Areas (MSAs) based on the 1990 Census and reflection of these revised MSAs in the hospital wage index;
- Update of the hospital wage index based on data from FY 1990 cost reports (the wage index is currently based on 1988 hospital wage data);
- Geographic reclassification of fewer hospitals for wage index purposes in accordance with more stringent requirements for comparison of a hospital's wages with average hospital wages in their own area (adopted in the final PPS rule published September 1, 1992); and
- Possible reconfiguration of hospital wage index areas to use alternatives to MSAs and non-MSA rural areas, based on recommendations of the Prospective Payment Assessment Commission or HCFA research.

The incorporation of any changes such as these into PPS will be published by HCFA in its May 1993 proposed rule updating PPS for FY 1994 and will be subject to public comment. If adopted, these changes will be effective for Medicare discharges occurring on or after October 1, 1993.

Notes & Questions:

## Recent/Anticipated Activity

*New MSAs:* On December 28, 1992, the Office of Management and Budget announced revised MSA definitions based on the 1990 Census. Continuing urbanization of the nation's population resulted in the creation of several new MSAs and the expansion of old ones. In addition, in many areas, separate adjacent MSAs have been combined into larger, single MSAs. When MSAs are thus combined, the new wage index for the resultant MSA will be lower than that for the highest wage areas and higher than that for the lowest wage areas within the new MSA.

Assuming HCFA continues to define wage index areas in terms of MSAs and statewide non-MSA areas, the new MSAs will be reflected in the proposed FY 1994 Medicare PPS update to be published in May 1993 and effective October 1, 1993. However, ProPAC and HCFA are both studying alternative configurations of wage index areas that might be used in lieu of MSAs.

*Wage Index Update:* In accordance with the Omnibus Budget and Reconciliation Act of 1989, HCFA is preparing to update the wage index effective October 1, 1993, and annually thereafter. The FY 1994 update will be based on hospital wage data from FY 1990 Medicare cost reports. Medicare's fiscal intermediaries are currently attempting to verify data elements from the 1990 cost reports that have been identified as erroneous or questionable upon initial review.

*Geographic Classification:* The MGCRB has received about 1300 applications for FY 1994 reclassification. Only about half of these cases are expected to be reclassified based on the criteria adopted by HCFA in its final FY 1993 PPS rule published September 1, 1992. The remaining cases are "protective appeals," that is, applications by hospitals that meet the old but not the new criteria for wage index reclassification. Hospitals filed such applications because the new wage index reclassification criterion—that a hospital's average hourly wage be at least 108 percent of the average hourly wage for hospitals in its labor market area—has been challenged in the courts. Should the legal challenge be successful, the Board may act favorably on these protective applications. A hearing on the case is set for January 19, 1993. If the court invalidates the 108-percent wage threshold, cases would have to be adjudicated consistent with the court's ruling.

## AHA Position

AHA supports annual updating of the hospital wage index in order to minimize the redistributive impact of each successive update. Absent new funding to finance policy changes that redistribute significant levels of Medicare payments across hospitals, AHA supports phase-in of the change.

# Essential Access Community Hospital (EACH) Program

## Background

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) created the EACH program. It provided that up to seven states would receive appropriated monies from the Federal Hospital Insurance Trust Fund to set up rural health networks in consultation with state hospital associations and rural hospitals within the state. These networks would consist of essential access community hospitals and rural primary care hospitals. For each of FYs 1990, 1991 and 1992, appropriations of \$10 million to states and \$15 million to hospitals were made. Funding for states to develop EACH networks ended with the appropriations made for Fiscal Year (FY) 1992.

Notes & Questions:

## Recent Activity

During 1992, a number of technical amendments to the EACH program were included in various pieces of legislation—including the Medicare/Medicaid Technical Amendments of 1992 (H.R.1555/S.750) and the Stark/Gephardt Bill (H.R.5502)—that were not ultimately passed.

A reauthorization of appropriations for FYs 1993, 1994, and 1995 was included in H.R.11, the Urban Aid Act/Revenue Act of 1992, along with an increase (from seven to nine) in the number of states eligible for grants under the program. H.R.11 also included a number of technical amendments designed to add flexibility to EACH requirements.

H.R.11 was passed by the Congress in October 1992 and was vetoed by President Bush on November 3.

## AHA Position

AHA supports the reauthorization of the EACH program, the addition of two more states, and the technical amendments providing additional flexibility. These provisions are now contained in H.R.21, a bill introduced by House Ways and Means Committee Chairman Dan Rostenkowski (D-IL) on the first day of the current session.

## **THE CLINTON HEALTH CARE REFORM:**

### **How to fix a system that no longer makes sense**

We must fundamentally reform the health care system in order to preserve and protect what's best about American health care. We must take control of a system that makes no sense and has driven costs out of sight. All Americans will be asked to take responsibility for their health, and in return, will be guaranteed the security that they will always be covered. The Clinton health care plan: health care that's always there.

### **A SYSTEM OUT OF CONTROL**

Our health care system is out of control. Everyone fears losing their coverage and every month, 2 million people do. Our nation's health costs have nearly quadrupled since 1980. And costs are rising at a rate that would double the cost of health care to American families by the end of the decade -- \$14,000 for each family by the year 2000.

Today's system is rigged against American families and small businesses. Insurance companies hold all the cards. They pick and choose who they cover. They charge small businesses twice the rates as the big guys. And they drop you when you get sick and need your insurance most.

Everything that is wrong with our health care system is threatening everything that is right about American health care. We must fix the system -- preserving your choice of doctor and ability to get high-quality, affordable care -- before the system self-destructs.

### **GOALS OF REFORM**

The Clinton reform proposal is designed to achieve two major goals. It is designed to get the system under control. And it is designed to protect and expand high-quality care for American families.

**The Clinton proposal gets the system under control.** In today's system, health care costs are skyrocketing, fraud and abuse thrive in a maze of loopholes and fine print, and doctors and patients alike are awash in a sea of bureaucracy and red tape. The Clinton plan gets the system under control by:

**a. Eliminating red tape.** The Clinton plan will slash the red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. It will enable doctors and nurses to spend more time caring for patients -- and less time filling out forms.

**b. Cracking down on fraud.** The reform proposal makes it illegal to game the system, imposing stiff criminal penalties on the profiteers. It stops the kickbacks that some labs give doctors in an effort to get patients. And it tells the con artists that filing a fraudulent claim will mean punishment -- not financial reward.

**c. Reforming malpractice.** Serious malpractice reform will eliminate the "defensive medicine" that drives up costs -- doctors ordering extra tests because they have lawyers looking over their shoulders. It will protect both doctors and patients but reduce frivolous lawsuits.

**d. Controlling costs.** The Clinton plan will include tough measures to stop the overcharging that goes on in the current system, including drug prices that are three times higher here than they are overseas. For the first time, we will get a handle on spiraling costs.

**e. Imposing budget discipline.** Today's system has mixed-up incentives. Doctors get more money for ordering more tests and procedures -- whether it keeps the patient healthy or not. The Clinton proposal creates incentives for doctors and hospitals to keep you healthy -- rather than ordering unnecessary tests and procedures when you get sick.

**The Clinton proposal protects and expands high-quality American health care.** Without reform, one out of every four people will lose their insurance in the next two years. Reform will give American families the security of knowing they will never lose their insurance – no matter if you move, switch jobs, lose your job or start a small business. The Clinton proposal does this by:

**a. Guaranteeing a comprehensive benefits package.** All Americans will receive a health security card that means that you will never lose your insurance. The card gives you a benefits package that is as comprehensive as those offered by most Fortune 500 companies. And no boss or insurance company can change that.

**b. Emphasizing preventive care.** The Clinton reform proposal goes beyond virtually all current insurance plans by covering a wide range of preventive services. It puts a new emphasis on preventing illnesses before they become medical crises. Prevention will save money and keep people healthier at the same time.

**c. Increasing options for long-term care.** The Clinton plan will make it possible for more Americans to continue to live in their homes and communities while receiving care. It doesn't make sense that the elderly and disabled are forced into nursing homes even though they would receive less expensive care at home with their families.

**d. Outlawing insurers' practices that hurt small businesses and consumers.** The Clinton proposal will make it illegal for insurers to drop people for any reason. No more denying coverage because of a pre-existing condition. No more losing your insurance when you lose your job. No more pointing to loopholes and fine print as an excuse for not covering benefits. And no more charging small businesses twice as much as the big guys.

**e. Putting consumers in the driver's seat.** The Clinton proposal brings competition to health care – unleashing the market forces that lower costs and improve quality. Allowing small businesses and consumers to band together in health alliances will level the playing field and give them the same bargaining power as big businesses. Consumers will have the choice of a variety of health plans and be armed with report cards on quality and patient satisfaction to help them choose among health plans. And everyone will have the right to choose their doctor.

## **FINANCING:**

The Clinton reform proposal offers a new idea based on an old-fashioned value: **responsibility**. The plan guarantees a comprehensive benefits package that covers a wide range of preventive services -- to keep you from getting sick while asking you to take responsibility for your own health. It says to doctors: we'll get the lawyers off your backs and cut your paperwork, but we're going to continue to hold you accountable for delivering the highest quality of care in the world. And the plan says to all employers and employees: we'll control your costs but we'll ask you to take some responsibility for paying for your health care.

The Clinton plan reaffirms an American principle: that **our health care system should be rooted in the private sector**. Some say that we should hand the system over to the government. But the Clinton proposal will preserve our employer-based, privately financed system of health care. It will control the costs that are hurting American businesses ability to compete. And it will help small businesses provide affordable insurance to their employees.

More than half of the reform is financed through savings in Medicaid and Medicare. This savings will primarily be used for subsidies to small businesses to help them cover their employees. There is also likely to be a cigarette tax to help pay for long-term care for the elderly and disabled.

The rest of the reform is financed by asking all employers to take responsibility for covering their employees -- while asking all employees to chip in as well. Most businesses -- large and small -- already cover their employees. And the rest want to but just can't afford it.

The plan prevents insurance companies from discriminating against small businesses and charging them outrageous rates. It gives small businesses the same bargaining power as the big guys. And it offers subsidies and a phase-in period to make it easier to provide coverage. With these steps, the Clinton proposal will help all small businesses cover their employees.



American Hospital Association

**Richard J. Davidson**  
*President*

June 15, 1993

Hillary Rodham Clinton  
The White House  
1600 Pennsylvania Avenue, NW  
Washington, DC 20500

Dear Mrs. Clinton:

In a further follow up to our meeting of June 4, I wanted to give you some additional information on the joint invitation we issued to the President or you to speak at the American Hospital Association's 1993 convention in Orlando, Florida. The meeting is set for August 9, 10, and 11 at the Convention Center.

The convention is attended by thousands of hospital leaders -- executives, trustees, and physicians -- from across America. The educational programming this year is almost completely geared to the implications of the Administration's reform proposal -- most notably managed collaboration and the coming together of integrated delivery networks.

When we wrote to the President on February 26, we indicated that we would hold time on all of the days to give him or you maximum flexibility. Ideally, it would be best from a membership and media standpoint if you could lead off the convention on Monday morning, August 9. Enclosed is a copy of our letter to the President and the convention brochure.

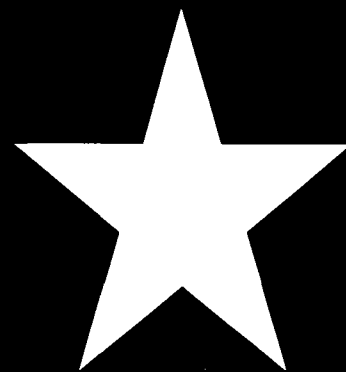
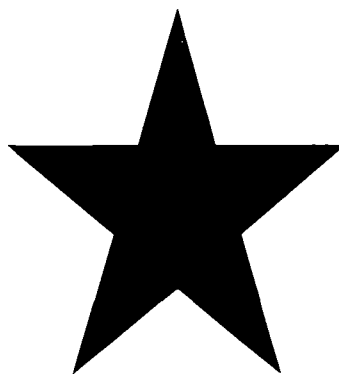
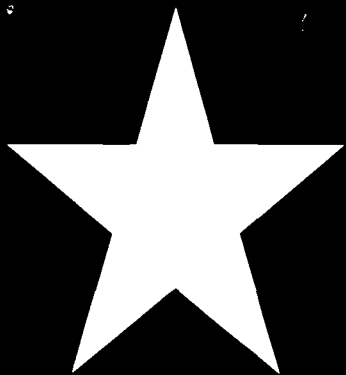
As we work to build support for health reform this year, it would be very important for our members to hear from the leadership of the health reform movement. You carry the message with enormous credibility and meaning.

By the way I caught some of the coverage of your American Medical Association appearance ... very skillfully and effectively done!

Sincerely,

50 F Street, N.W., Suite 1100  
Washington, D.C. 20001  
202.638.1100

840 North Lake Shore Drive  
Chicago, Illinois 60611  
312.280.6000



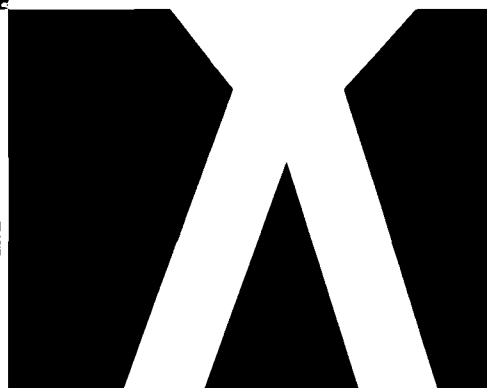
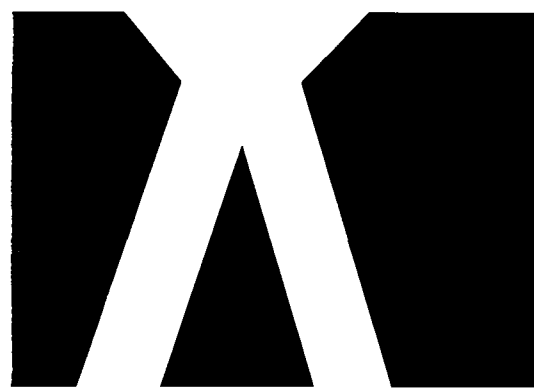
1993 AHA  
Annual  
Convention &  
Exhibition

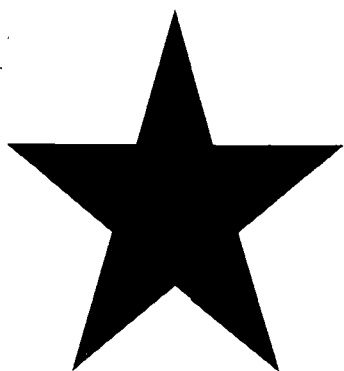
**August 9, 10, 11  
Orange County  
Convention/Civic Center  
Orlando, FL**

**In collaboration with the  
Florida Hospital Association**

Where  
the Future of  
Health Care  
Delivery  
Takes Shape

**American Hospital Association**





Sharing  
a National  
Vision...  
Initiating  
Community  
Action

## **1993 AHA Annual Convention & Exhibition**

### **"Where the Future of Health Care Delivery Takes Shape"**

For hospital executives concerned about the future of health care, there will be no better place to build strategies and solutions than the 1993 AHA Annual Convention & Exhibition. This will be your greatest and most cost-effective opportunity to gain practical insights, capitalize on networking, and explore the latest in hospital technology, products, and services.

#### **New Perspectives, Incisive Discussions**

Explore the red-hot issues of today and the strategies of tomorrow: Community linkages... coalitions with business... the politics of health reform... managed care networks... continuum of care... hospital/physician relations... public accountability... and more!

#### **Our Nation's Key Figures**

Hear firsthand what's on the national agenda from top government leaders who will examine the challenges and vision for the future of health care delivery.

#### **Vital Involvement**

There will be plenty of opportunities for networking and sharing insights on health care advocacy and reform. From the lively Roundtable Discussions to the exciting AHA Community Center, you'll exchange ideas with peers from across the nation who are making changes to improve the delivery of health care.

#### **Hundreds of Exhibits**

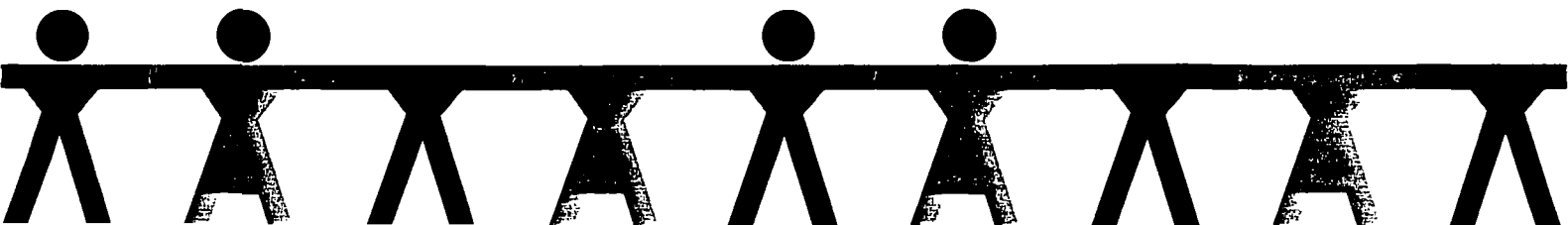
Ample time will be designated for exploring the nation's largest exhibition of hospital technology, products, and services. Visit the exhibits often to view the latest offerings up close, build relationships with suppliers, and discuss your specific needs with experts on hand. Luncheons and coffee breaks will be held on the exhibit floor.

#### **New and Refreshing Approach**

In the spirit of getting ready for action, we'll be "rolling up our sleeves" to reshape the nation's health care delivery system. So shed your business attire... with the exception of Sunday's AHA/ACHE Opening Reception and other formal evening functions, **the dress is casual.**

#### **Registration Is Easy. Do It Today!**

To ensure the best selection of hotel rooms and travel discounts, register as soon as possible. Use the form provided in the center foldout. To make it even easier, register by fax using a credit card. Or mail in your registration soon.



# *Shaping a New Era in Health Care*

As the cry for health care reform continues unabated, the 1993 AHA Annual Convention & Exhibition will set the stage for the dawning of change. Join your peers and help usher in a new era in health care. Come to where the action will be for shaping reform.

This year's event has a unique dual focus. On one hand, you will explore the crucial role of hospitals as stewards of community health... as innovators and leaders in restructuring health care delivery. On the other hand, you will have the rare opportunity to hear government leaders and other distinguished guests discuss Washington's perspective on national reform.

So come to Orlando in August and join us in carrying the banner for vision and change. Now more than ever, AHA is poised to lead the way in health care reform. Don't miss this opportunity to help shape tomorrow's health care delivery system.

## **1993 AHA Annual Convention & Exhibition**

**August 9, 10, 11**

**Orange County Convention/Civic Center**

In conjunction with:

American Hospital Association's

Department of Volunteer Administration  
and Auxiliary Services

Division of Hospital Governance

Section for Aging & Long-Term Care Services

Section for Health Care Systems

Section for Metropolitan Hospitals

Section for Small or Rural Hospitals

American College of Healthcare Executives

American Society for Healthcare Materials Management

Florida Hospital Association

Forum for Health Care Planning

National Forum of Women Health Care Leaders

# Community Initiatives... and the National

Never before has health care captured such interest among Americans. That's why this year's AHA Convention & Exhibition will probe two crucial areas of interest: your leadership role in reshaping health care in the community... and the new Administration's initiatives for national reform.

Leadership, innovation, direction, action—all the dynamics that comprise the mosaic of reform—will be the thrust of the entire 1993 AHA Convention, from start to finish.

## President's Report to the Membership

At the Opening Session on Monday, August 9, from 9:00 to 10:30 a.m., AHA's President Dick Davidson will report to the members on the state of the national movement for health care reform. He'll review the status of the national debate on President Clinton's plan and how it may affect providers. You'll learn how it meshes with what's happening in communities across America where AHA's national vision is being transformed into community action.



**AHA President  
Dick Davidson**

## Special Keynote on Federal Proposal

A key member of the Clinton Administration will provide a special keynote on the federal proposal for reform.

## Tenth Annual Roger G. Larson Memorial Lecture

Monday, August 9, noon to 1:30 p.m., will be the Roger G. Larson Memorial Lecture, presented by Rob McCord, executive director, Congressional Institute for the Future, a bipartisan political think tank that focuses on the future implications of emerging trends, technologies, and policy decisions. The Institute was created at the recommendation of former Senators John Heinz and Al Gore. Vice President Gore remains involved in the Institute, and in recent months, Mr. McCord has spent much of his time advising leaders on the possible implications of current policy choices.

To commemorate the Tenth Anniversary of the lectureship, luncheon attendees will receive a gift of original essays by past Larson lecturers including: James E. Burke, Robert A. Derzon, Uwe Reinhardt, Ph.D., Arnold S. Relman, M.D., Robert Ebert, M.D., Merlin (Monte) Duval, M.D., C. Everett Koop, M.D., Dan Rostenkowski, and Nancy K. Austin.

Tickets are \$45 per person. The lectureship has a tradition of being a "sold-out" event, so reserve your tickets and Tenth Anniversary gift by using the registration form in the brochure.

## Parker B. Francis Lecture: "The Politics of Health Care Reform"

On Tuesday, August 10, from 2:00 to 3:30 p.m., political journalist Gloria Borger will discuss how health care initiatives fare on the political scene. As chief congressional correspondent for *U.S. News & World Report* and panelist on PBS's *Washington Week in Review*, Borger will draw from her experiences covering various Washington beats.

The Parker B. Francis Foundation Distinguished Lecture is presented by the American College of Healthcare Executives (ACHE). This memorial lecture is sponsored by the Parker B. Francis Foundation in tribute to Parker Francis and his wife, Mary, principals in the founding of the Puritan-Bennett Corporation of Kansas City, MO, manufacturers of basic respiratory equipment used in hospitals and other health care facilities.

For more information on other ACHE programs and activities held in conjunction with the AHA Convention, see pages 14-15 of this brochure. Or call Arlene Ventura at ACHE, 312/943-0544, for an Annual Meeting brochure.

## Special Session: "Reforming the Research Agenda for Women"

On August 9, from 11:30 a.m. to 1:00 p.m., Bernadine Healy, M.D., director of the National Institutes of Health, will be the keynote speaker of this timely session examining today's call for more studies on women's health. Program moderator will be Mary Jane England, M.D., president, Washington

- to show still?  
- same stage  
- design

# Agenda

Business Group on Health: responders will include Bess Hughes, M.D., associate professor of medicine, Tufts University, and Donna Williamson, corporate vice president, Caremark International, Inc.

## Forums: Providing Focused Education

After their highly successful debut last year, the educational Forums will once again provide consolidated presentations on major issues facing hospitals today. Expert panelists will better equip you to mold a new health care delivery system in your community. Attendance can be submitted to ACHE for Category II credit.

## Lively Roundtables: For Networking and Information

AHA's lunchtime Roundtable Discussions will be ideal for exchanging ideas with other health care executives from around the country. You will receive one complimentary lunch ticket to use Monday or Tuesday. Be sure to pick up the list of topics for each day when you arrive at the Convention Center.

## AHA Community Center: Your "Home Base"

Conveniently located at the entrance to the exhibit floor, the AHA Community Center will be a focus of activity for advocacy and health care reform. Consider this your "home base" for networking, learning more about the convention and AHA, and more.

## Program at a Glance

### Sunday—Evening

AHA/ACHE Opening Reception

### Monday—Morning

Small or Rural Hospitals Breakfast\*

Opening Session: President's Report to the Membership

Special Keynote on Federal Proposal

Exhibits Open (Stop by any time from

10:30 a.m. to 4:00 p.m.)

Dedicated Exhibit Time (with coffee)

Special Session: "Reforming the Research Agenda for Women"

### —Noon

Roundtable Discussions on Exhibit Floor (Use your free lunch coupon Monday or Tuesday)

10th Annual Roger G. Larson Memorial Luncheon Lecture

### —Afternoon

Forum A: 10th Anniversary Roger G. Larson Forum: "Making the Transition from Medicine to Health: What We Need To Know When We Care for Communities"

Forum B: "The New Health Care Executive"

Dedicated Exhibit Time

### Tuesday—Morning

Metropolitan Hospitals Breakfast\*

Trustee Breakfast\*

Auxiliary Breakfast Roundtables

Exhibits Open (Stop by any time from 8:30 a.m. to 4:00 p.m.)

Dedicated Exhibit Time

Forum C: "The Physician of the Future"

Forum D: "Community Accountability and the Role of Governance"

AHA Forum (Attend this panel discussion with questions and answers)

### —Noon

Roundtable Discussions on Exhibit Floor (Use your free lunch coupon Monday or Tuesday)

Auxiliary Luncheon\*

Federal Luncheon\*

### —Afternoon

Washington Update I

Forum E: Parker B. Francis Lecture: "The Politics of Health Care Reform"

Forum F: "Practical Steps Toward a Community Health Focus"

Dedicated Exhibit Time

### Wednesday—Morning

Small or Rural Hospitals Breakfast Roundtables

Exhibits Open (Stop by any time from 8:30 a.m. to 12:00 noon)

Washington Report

Forum G: "The Rural Community Care Network": Issues and Challenges"

Forum H: "The Metropolitan Community Care Network: Issues and Challenges"

Closing Session: Washington Update II

### Concurrent Meetings

Aging and Long-Term Care Services

Small or Rural Hospitals

Auxiliaries & Volunteers

American Society for Healthcare Materials Management

American College of Healthcare Executives

Forum for Health Care Planning

National Forum of Women Health Care Leaders

\* To register for these sessions, check the appropriate box on the registration form in this brochure



# Forums

## Forum A

### Tenth Anniversary Roger G. Larson Forum

#### Making the Transition from Medicine to Health: What We Need to Know When We Care for Communities

Monday, August 9

Rob McCord

Congressional Institute for the Future

Jack Lewin, M.D., (invited)

Hawaii Department of Health

Carolyn Lewis

Greater Southeast Healthcare System

**Successful reform of the nation's health care system requires a break from the past in vision, mindset, and belief system—and a new commitment to something larger than the institution itself.**

Health system reform presents the challenge of getting all providers to accept a common mission of responsibility for the health status of the community covered. To put that into action, providers must change the way they think about themselves and reshape their image as the medical model is replaced by an emphasis on keeping people well.

In this session, a panel of major stakeholders—representing public health, business, health care leadership, and primary care medicine—will discuss how to put into action the vision of improving community health status.

## Forum B

### The New Health Care Executive

Monday, August 9

Thomas C. Dolan, Ph.D., FACHE

American College of Healthcare Executives

Reginald M. Ballantyne III

PMH Health Resources, Inc.

**In moving toward a network environment, health care executives will need a new set of skills ... as they examine, interpret, and carry out the hospital's new role of putting the health of communities first.**

The reawakened sense of community partnership provides a direct test of, and opportunities for, the leadership and vision of the health care executive. Strategic management in a network environment requires basic changes in the health care executive—and today's leaders are beginning to "reinvent" themselves in this era of reform.

In this session, a panel of experts will discuss how health care executives are reshaping themselves to be more responsive to local needs and desires, communicate more effectively with their constituents, and become closer partners with the community than ever before.

## Forum C

### The Physician of the Future

Tuesday, August 10

Michael C. McGee, MD

Pennsylvania Hospital

**Physicians are critical players in health system reform. Progressive leadership of this group will be defined as a focus on community health and public accountability as a priority, acknowledging interdependence with institutions and other health and human service organizations.**

Measures of success for the new physician will include: (1) working with other providers to measurably improve community health status; (2) taking the collective responsibility for conserving health care resources by providing only appropriate and necessary care; and (3) being an effective member of a health care team accountable for promoting the coordination and quality of care across providers and settings over time.

This forum will feature a panel of experts who will discuss incentives, partnerships, graduate medical education reform, and the primary care physician's role in meeting community needs.



## FORUM E

### **Community Accountability and the Role of Governance**

Tuesday, August 10

John D. Leech

Calfee, Halter & Griswold

Dorothy Mann

Group Health Cooperative of Puget Sound

**As we exercise the responsibility to create healthier communities, effective and accountable governance will mean a far more visionary and proactive role.**

After a decade of competition, trustees must refocus their attention and stewardship beyond the hospital walls. Within a particular institution, the vision and experience of the governance team is critical in pioneering new territory.

Providing leadership that supports improvement in the community's health becomes the hallmark of responsible and effective governance, rather than peak economic performance. Governance will need to redefine the measures of success in terms of promoting wellness rather than just acute interventions.

## FORUM E

### **Parker B. Francis Lecture: The Politics of Health Care Reform**

Tuesday, August 10

Gloria Bolger

U.S. News & World Report

(Cosponsored by the American College of Health-care Executives)

**With health care reform a top priority of the Clinton Administration, the politics of getting health care legislation passed will not only be more important than ever — it will also be more complex.**

How is politics shaping the future of health care reform? Guest speaker Gloria Borger, a Washington

journalist who has covered Congress and other beats in the nation's capital since 1978, will share her observations on this subject.

Ms. Borger is chief congressional correspondent for *U.S. News & World Report* and a panelist on public television's *Washington Week in Review*. Ms. Borger also appears frequently as a political commentator and interviewer on CBS's *Face the Nation*, NBC's *Meet the Press*, and various segments of CNN.

## FORUM F

### **Practical Steps Toward a Community Health Focus**

Tuesday, August 10

Gloria Cooper

Mount Carmel Hospital

Joanne Mower

Mercy Health Corporation

**A primary goal of developing Community Care Networks is improving the health of the community. Under AHA's vision, community care networks would reach into their communities and work with public health, social services, or other organizations that can help improve health.**

Working through communitywide collaboration, networks will be able to generate common action toward improved health by assessing health needs, rationally allocating resources and energies to meet those needs, and determining the impact of their health improvement efforts.

In this Forum, health care leaders will discuss four steps they took toward a community health focus:

- Adopting a community health orientation at the



top, via the mission, and through coordinated community health programming.

- Strengthening primary care and the link between community health and clinical sciences.
- Developing collaborative arrangements in which multiple organizations work toward improving the community's health.
- Engendering an organizational culture that encourages involvement in improving the community's health.

## Forum G

### **The Rural Community Care Network: Issues and Challenges**

Wednesday, August 11

Forum G and Forum H will each feature an expert panel which will speak to the specific issues and challenges of rural hospitals and metropolitan institutions.

## Forum H

### **The Metropolitan Community Care Network: Issues and Challenges**

Wednesday, August 11

Don Snell

Grady Health System

William G. Gonzalez

Butterworth Health Corporation

**AHA envisions a healthy America through a fair, rational and effective delivery system that puts the health of the community first. To make this vision a reality, the special concerns and challenges of rural hospitals and metropolitan hospitals must be understood and addressed.**

Community care networks bring more rational incentives to current delivery systems by promoting

health and preventing illness, encouraging collaboration among providers to avoid duplication of services, and conserving resources through appropriate and necessary care.

This integrated model of health care organization and delivery means just what it says: The various elements of the health care sector (such as hospitals, physicians, nursing homes, home care agencies, and other providers, along with institutional payers of care) that have operated more or less independently all these years to treat a patient's episode of illness must now come together under a cooperative framework.

The goal is to coordinate services to a much greater degree, offering people — not just patients — a true "system" of care, one that is "seamless" from prevention to long-term care and one that minimizes unnecessary or cumbersome administrative procedures.

## **AHA Forum with Dick Davidson**

Tuesday, August 10

10:45 a.m. - 11:45 a.m.

Bring your questions to the AHA Forum, where President Dick Davidson and the AHA executive management team will address key issues for hospitals this year and beyond. This forum will give you the opportunity to talk one-on-one and gain a better understanding of the association's position on issues which are vital to you and the future of the health care field.

(SM) CCN, Inc. and San Diego Community Healthcare Alliance use the name Community Care Network as their service mark and reserve all rights.

# 1993 Concurrent Meetings

## **10th Annual Conference for Aging and Long-Term Care Services**

August 7-8 • Peabody Hotel

Join us for the 10th Annual Conference of the Section for Aging and Long-Term Care Services, a national educational forum designed to address important issues in advancing health care reform and the integration of services along a continuum of care for the older adult.

This conference targets leaders and innovators and offers participants:

- 10 educational, general, and concurrent sessions on innovations in chronic and transitional care delivery, financing, and developing components of provider networks
- A Washington Update on the latest information from Capitol Hill on aging and long-term care
- Networking opportunities at the Chairman's Reception and Section's Luncheon and Annual Business Meeting at no additional fee
- Poster exhibits and a Resource Center, with information and ideas on programs and initiatives from hospitals across the country that include seniors in the continuum of care
- Complimentary registration to the AHA Annual Convention & Exhibition, just across the street in the Orlando Convention Center

### **Registration Fees:**

Include entry into the Section's Annual Conference and the Section's luncheon, Chairman's Reception, and the AHA Annual Convention & Exhibition.

\$350 AHA Members

\$475 Nonmembers

\$300 Poster Session Presenters

### **For More Information:**

Call the Section for Aging and Long-Term Care Services at 312/280-6671.

## **National Forum of Women Health Care Leaders: "Seeds of Reform"**

On Sunday, August 8, from 11:00 a.m. to 4:00 p.m., keynote speaker Carolyn Roberts, AHA chairman elect and president of Copley Health Systems, will open the National Forum of Women Health Care Leaders' program on "Seeds of Reform." Moderated by Carolyn Lewis, board chairman, Greater Southeast Healthcare System, the program will feature panelists Sister Irene Kraus, chief executive officer, Sacred Heart Hospital; Marlene Marschall, commissioner, Minnesota Department of Health; Jeanie

Keller, president, Vermont Health Care Alliance; and Paige Sipes-Metzler, executive director, Oregon Health Services Commission.

Registration is \$50. See the registration form in this brochure.

## **16th Annual Conference for Small or Rural Hospitals**

August 8-11 • Peabody Hotel

(Cosponsored by the Small and Rural Hospital Council of the Florida Hospital Association)

### **Health Care in Transition: Positioning the Rural Hospital for Change**

What does health care reform mean for small or rural hospitals and their communities? How can they position themselves to take part in a reformed system? Join other hospital leaders for interactive discussions on how you can best implement networking strategies to meet today's challenges and capture tomorrow's opportunities.

Find out how other rural hospitals are forming networks ... learn how to structure collaborative arrangements and discover ways to develop and maintain effective relationships with physicians and other area providers.

Some highlights include:

- Educational sessions on negotiating and contracting for managed care and ways to involve physicians in collaborative and hospital networking activities.
- Cost-containment strategies to analyze costs, demonstrate cost accountability and quality, and improve the hospital's financial performance.
- Networking opportunities at the Chairman's Reception, educational programs, and breakfast roundtables.
- An address by nationally recognized health reform planner Paul M. Ellwood, M.D., founder of the Jackson Hole Group, which has been central in the development of the Clinton Administration's health care reform proposal.

### **Registration Fees:**

Include entry into both the section's Annual Conference and the AHA Annual Convention & Exhibition.

\$275 AHA Members

\$375 Nonmembers

Reduced fees for second and third attendees from the same hospital registering at the same time

### **For More Information:**

Call the Section for Small or Rural Hospitals at 312/280-6395.



### **Third Annual Convention for Auxilians & Volunteers**

August 9-11 • Clarion Hotel and the Orange County Convention/Civic Center

#### **Visionaries of the Future**

Gain the leadership edge at the Third Annual Convention for Auxilians and Volunteers. This year's program will help you make sure your auxilians and volunteers play an important role in AHA's vision of the future in health care.

Among the highlights:

- Two preconference workshops: (A) "Fundamentals of Auxiliary Management" and (B) "Gift Shop Management" on Sunday, August 8, for an additional fee of \$100 and \$50 respectively.
- Educational sessions addressing hospital community initiatives, quality, collaboration, leadership development, and health care reform.
- Nationally recognized speakers such as Binnie Bailey, Marilyn Moats Kennedy, Louise Berry, and David Reed.
- A keynote speech on the Abilene Paradox, by Jerry Harvey, Ph.D., Professor of Management Science, George Washington University.
- A gala banquet celebrating the 45th Anniversary of the Committee of Volunteers.

You'll also receive a resource book of material from the sessions—a reference you'll use again and again.

#### **Registration Fees:**

Include entry into both the Auxilians & Volunteers Convention and the AHA Annual Convention & Exhibition.

\$150 AHA Member

\$250 Nonmember

See registration form for special events tickets.

#### **For More Information:**

Call the Department of Volunteer Administration and Auxiliary Services at 312/280-6436.

### **American Society for Healthcare Materials Management Annual Conference & Exhibition**

August 8-11 • Stouffer Orlando Resort

The sessions at ASHMM's 31st Annual Conference & Exhibition will help you prepare for the tasks at hand as well as equip you with strategies for the future. This year's conference offers many practical approaches, case studies, and open discussions.

Among the highlights:

- Educational sessions on topics ranging from purchasing methods to new jobs in support services to point-of-use inventory in the cath lab.
- New roundtable sessions to exchange insights and opinions with your colleagues.
- The ASHMM Keynote Session and the AHA Opening and Closing Sessions, where health care leaders will explore imminent changes.
- ASHMM's Second Annual Exhibition featuring the latest products and services designed for materials managers.
- Networking opportunities... at ASHMM's opening party, roundtable sessions, and other events.

#### **Registration Fees:**

Include entry into both the ASHMM Annual Conference and the AHA Annual Convention & Exhibition.

\$375 ASHMM Members

\$435 AHA Members

\$475 Nonmembers

#### **For more Information:**

Call the American Society for Healthcare Materials Management at 312/280-6137.





## **"Community Leadership in the Dawn of Reform: Who Is Accountable?"**

Saturday, August 7 • Peabody Hotel  
8:30 a.m. - 4:30 p.m.

The seeds for health care reform have been cast. Activist government leadership at the federal level is pressing simultaneously for access expansion and cost constraints, pushing inevitable resource allocation decisions to the local level. Not in recent memory have the reins of leadership dangled so precipitously in faces of local leaders or potential leaders.

The 1993 Annual Health Planning Forum will focus on the kinds of leadership needed to make health care reform work at the local level, and will highlight specific examples of people and techniques—including new tools for hospital governance and community needs assessment—that can help address these challenges. The morning will be devoted to an examination of the need for a paradigm shift for health care leadership. The afternoon session will explore new partnerships and tools in providing the leadership necessary to meet the challenges of health care reform.

### **Registration Form:**

**Annual Health Planning Forum on "Community Leadership in the Dawn of Reform: Who Is Accountable?"**

**Please mail or fax this form to:**

The Forum for Health Care Planning  
2111 Wilson Boulevard, Suite 850  
Arlington, VA 22201  
Fax: 703/243-2874 Phone: 703/516-6192

☐ Please send me a program brochure for the Conference on August 7, 1993.

## **Program Highlights**

### **Keynote Address:**

**"Health Care Leadership in a New Age"**

*Edward J. Connors*

### **Morning Session:**

**"Is a New Paradigm for Leadership Needed?"**

Moderator:

*Barry A. Passett*

Panel:

*Edward J. Connors*

*Livingston S. Francis*

*Reed V. Tuckson, M.D.*

*Sister Mary Roch Rocklage, RSM*

*Richard H. Wade*

### **Awards Luncheon:**

*Frederick C. Green, M.D.*

William R. Haney Award of Merit Recipient

### **Afternoon Session:**

**"New Partnerships and New Tools: A Survival Kit for the '90s"**

Moderator:

*J. David Seay*

Panel:

*David Edwards*

*Linda Cundiff*

*Timothy Eckels*



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|              |                 |
|--------------|-----------------|
| Name         | _____           |
| Phone        | _____           |
| Title        | _____           |
| Organization | _____           |
| Address      | _____           |
| City         | _____           |
| State        | _____ Zip _____ |

### **This seminar is cosponsored by:**

American Hospital Association; Section for Health Care Systems; Society for Healthcare Planning and Marketing; Congress of Hospital Trustees; American Institute of Architects Committee on Architecture for Health; Catholic Health Association of the United States; Florida Hospital Association; The Healthcare Forum; National Association of Health Services Executives; National Forum of Women Health Care Leaders; Sisters of Mercy Health Corporation; United Hospital Fund of New York; Voluntary Hospitals of America.

# American College of Healthcare Executives Annual Meeting

August 7-11

Disney's Yacht and Beach Club  
Convention Center  
Orange County Convention/  
Civic Center  
(In conjunction with the 1993 AHA  
Annual Convention & Exhibition)

## Board of Governors Examination in Healthcare Management

Monday, August 9  
7:45 a.m. - 5:00 p.m.

Only Nominees who have submitted applications for advancement to Membership and who have been authorized by the Committee on Credentials may take the Board of Governors Examination in Healthcare Management. Proof of authorization must be presented at the exam.

## Administrative Communication Techniques (ACT)

Monday, August 9  
7:45 a.m. - 1:00 p.m.

Discover how your written business communication measures up—in terms of clarity, organization, and appropriateness of wording. Participants receive four hours of Category I (ACHE education) credit toward advancement and recertification in the College. The registration fee is \$120 for ACHE affiliates and \$140 for non-ACHE affiliates.

## General Management Assessment

Monday, August 9  
8:00 a.m. - 3:00 p.m.

This program helps you measure your applied knowledge in 11 health care management areas—all in strictest confidence. With your areas of strength and need identified, you use your profiles to develop a continuing education plan. The program provides you with objective measures of your management skills and knowledge through structured exercises using "scenario-based" questions. Program participation and completion of an educational plan qualify for 10 hours of Category I (ACHE education) credit toward advancement and recertification in the College. The registration fee is \$295 for ACHE affiliates and \$350 for non-ACHE affiliates.

## Ambulatory Care/Medical Group Management Assessment

Monday, August 9  
3:00 p.m. - 5:00 p.m.

If you are an ambulatory care or medical group management executive, this program is for you. Scenario-based exercises will help assess your applied knowledge in general management, assets management, and market-based management. An innovative "simulation" technique will evaluate your problem-solving and decision-making skills. You'll receive objective feedback on your proficiency, efficiency, and on errors of both omission and commission. This program has been approved for two hours of Category I (ACHE education) credit toward advancement and recertification in the College. The registration fee is \$120 for ACHE affiliates and \$140 for non-ACHE affiliates.

*The combined program fee for the General Management Assessment and the Ambulatory Care/Medical Group Management Assessment is \$385 for ACHE affiliates and \$450 for non-ACHE affiliates.*

## Advancement Information Session (AIS)

Monday, August 9  
Advancement to Fellowship:  
1:00 p.m. - 3:00 p.m.  
Advancement to Membership:  
3:00 p.m. - 5:00 p.m.

An Advancement Information session will show you how to move through ACHE Membership and Fellowship with speed, efficiency, and satisfaction. Learn everything you need to know about the application process, Membership exams, and Fellowship project requirements. Participants should enroll in either the Fellowship or Membership portion of the program. AIS qualifies for "participation in health care affairs" credit toward advancement in the College. The registration fee is \$65.

## Recertification Information Session

Tuesday, August 10  
4:00 p.m. - 5:00 p.m.

This special complimentary session is intended to provide information on recertification regulations for ACHE Members and Fellows. While registration is required, there is no fee for this session.



### Continuing Education Seminars

#### **"Techniques of Negotiating Contracts: Emphasis on Managed Care"**

Sunday, August 8  
8:30 a.m. - 4:00 p.m.

#### **"Revolution or Retreat: The 103rd Congress and Health Care Reform"**

Wednesday, August 11  
8:30 a.m. - 4:00 p.m.

Consider taking one of the two excellent seminars offered by the College during the AHA convention.

"Techniques of Negotiating Contracts: Emphasis on Managed Care" will be presented by Robert S. Bonney, FACHE, of Health Midwest, a Kansas City, Missouri, multihospital system. The seminar will help participants develop the skills needed to maximize their contractual relationships with payers.

"Revolution or Retreat: The 103rd Congress and Health Care Reform" will be presented by Ann N. James, Ph.D., J.D., of the law firm Jenkins & Gilchrist, and Barbara S. Blaine, J.D., of the law firm Bryan Cave. Participants will learn to better prepare their organizations to adapt to the new era of health care reform and to enhance their influence on legislative developments.

Each seminar qualifies for six hours of Category I (ACHE education) credit toward advancement and recertification in the College. The registration fee for each seminar is \$375 for ACHE affiliates and \$450 for non-ACHE affiliates. Lunch is included.

### Convocation Ceremony

Sunday, August 8  
2:00 p.m. - 3:00 p.m.  
Grand Harbor Ballroom

This traditional cap-and-gown ceremony recognizes new Fellows and acknowledges the professional commitment of advancing Members as well as new Nominees. In addition, the ceremony introduces Members and Fellows who successfully completed their recertification requirements in 1993 and features College officers Robert R. Fanning, Jr., FACHE, chairman; Ronald G. Spaeth, FACHE, chairman-elect; and Paul S. Ellison, FACHE, immediate past-chairman.

### Honorary Fellowship

Each year the College grants Honorary Fellowship to one or more distinguished professionals who have made exceptional contributions to health care management. This year's Honorary Fellow will be installed at the 59th Convocation Ceremony.

### AHA/ACHE Opening Reception

Sunday, August 8  
6:00 p.m.  
Grand Harbor Ballroom Foyer

The American College of Healthcare Executives and the American Hospital Association invite adult attendees to join their colleagues and program faculty at this reception. Business attire is requested.

### Annual Banquet

Sunday, August 8  
7:30 p.m.  
Grand Harbor Ballroom

This event features presentations of the College's Gold Medal Awards for excellence and leadership in health care management. In addition, testimonial awards are given to College officers who are completing their terms of office. The Annual Banquet also features entertainment. This year, the Best of Disney Stage Show will delight banquet attendees.

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*All affiliates of ACHE will receive an Annual Meeting brochure, complete with registration forms for the preceding ACHE-sponsored events, by early June. If you are not affiliated with ACHE but would like further information and registration materials for these events, contact Arlene Ventura at 312/943-0544.*

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### **Parker B. Francis Lecture: "The Politics of Health Care Reform"**

#### **Forum E of the AHA Convention**

Tuesday, August 10  
2:00 p.m. - 3:30 p.m.  
Orange County Convention/  
Civic Center

This year's Parker B. Francis Lecture will be given by Gloria Borger, chief congressional correspondent for *U.S. News & World Report*. Refer to pages 6 and 9 of this brochure for more information on the lecture. This Forum is offered to all registrants of AHA or ACHE programs.



# Special Activities

## **Added Opportunities for Educational and Social Exchanges**

### **AHA/ACHE Opening Reception**

The American Hospital Association and the American College of Healthcare Executives invite all adult attendees to join their colleagues and friends at the Reception on Sunday, August 8, from 6:00 to 7:30 p.m. Your badge is required for admittance. Business attire is requested.

### **Small or Rural Hospitals: Reception and Breakfasts**

The Chairman's Reception on Sunday, August 8, from 6:00 to 7:30 p.m., will give attendees the opportunity to meet with colleagues and program faculty. At the Section's Annual Convention Breakfast, on Monday, August 9, from 7:00 to 8:15 a.m., a guest speaker will discuss key health issues. Tickets are \$20. Also featured will be announcements of the Governing Council's Class of 1996 and the recipient of the 1993 Shirley Ann Munroe Leadership Development Award. On Wednesday, August 11, from 7:30 to 8:50 a.m., Breakfast Roundtables will provide an informal setting for networking.

### **Auxilians and Volunteers: Banquet, Breakfast, and Luncheon**

This year's banquet on Sunday, August 8, from 7:00 to 10:00 p.m., will be a gala celebration of the 45th Anniversary for the Committee on Volunteers, and the 25th Anniversary of the American Society of Directors of Volunteer Services. For informal discussions on a variety of topics, come to the Breakfast Roundtables on Tuesday, August 10, from 7:30 to 9:00 a.m. Also scheduled on Tuesday, from noon to 2:15 p.m., is the Auxilian Luncheon, where you'll hear presentations from 1993 AHA Hospital Awards for Volunteer Excellence (HAVE) winners.

Tickets for the 45th Anniversary Banquet and Auxilian Luncheon are each \$35. See the registration form in this brochure.

### **Section for Metropolitan Hospitals Breakfast: Hospital - Physician Relations Explored**

On Tuesday morning, August 10, from 7:00 to 8:45 a.m., Stanley J. Pappelbaum, M.D., M.B.A. will share his vision of how the organizational behavior of hospitals and medical staffs must change to meet the mandate of a changing market under health care reform.

In this presentation, Dr. Pappelbaum will identify critical success factors for health care providers and discuss how the relationship of hospitals and physicians will fundamentally change in the dawning of an era of managed competition. He'll draw from his experiences with the California "managed competition experiment" as chairman of the Subcommittee on Medical Quality and as a member of the Health Benefits Advisory Committee of the California Public Employees' Retirement

System (CalPERS), which represents some 900,000 covered lives and operates as a managed competition model under the chairmanship of Alain Enthoven.

Also, Section chairman Daniel M. Couch will present a mid-year report of Section activity and announce the election results for the 1994 governing council.

This breakfast is cosponsored by Hellmuth, Obata & Kassabaum, a leading architectural/engineering/planning firm offering facilities planning and design services to health care institutions across the United States and abroad.

Tickets are \$20. See the registration form in this brochure.

### **Trustee Breakfast**

Addressing this breakfast on Tuesday, August 10, from 7:00 to 8:45 a.m., will be a prominent speaker who will discuss key issues for hospital trustees in implementing health care reform.

Tickets are \$20. See the registration form in this brochure.

### **Federal Luncheon**

Interact with community and federal hospitals to learn about the efforts of each in the era of health care reform. The luncheon will be held on Tuesday, August 10, from noon to 1:30 p.m. Tickets are \$25.

# Tours

## **Florida's Magical World of Orlando Awaits You**

### **Orlando City Tour**

Discover Orlando—the “City of Lights,” dating back to 1857. This motorcoach tour takes you along the streets of Orlando and points of interest from Martin Marietta to the Naval Training Center. This fun-filled tour winds up at Church Street Station, an open market-place. Price: \$21 per person.

Saturday, August 7  
1:00 p.m. - 4:30 p.m.

Sunday, August 8  
1:00 p.m. - 4:30 p.m.

### **Bass Fishing**

Rise and shine to a morning of bass fishing. Your guide will escort you to a scenic lake only minutes from your hotel. In addition to fishing, you'll experience many varieties of Florida wildlife from deer and wild turkey to the bald eagle. Two fishermen per boat. Price: \$130 per person (includes required fishing license, tackle bait, beverages, and a box lunch).

Saturday, August 7  
6:30 a.m. - 12:30 p.m.

### **Leu Gardens Tour with Orlando Art Tour**

Stroll the paths of Leu Gardens and delight in Florida's foliage. Enjoy a one-hour tour in the garden and then visit the turn-of-the-century museum featuring Victorian furniture. From there, you'll visit the Orlando Museum of Art for a guided tour of famous paintings, including pre-Colombian, African, and 20th century American pieces. Price: \$25 per person.

Sunday, August 8  
12:30 p.m. - 4:30 p.m.

### **Grand Rivership Romance**

Spend a lazy afternoon cruising the St. John's River, where Florida's golden years of winter tourism

began over a century ago when pioneering steamer captains gave curious visitors a glimpse of Florida's tropical wilderness and exotic wildlife. Today, aboard a modern rivership with luxurious amenities, you'll experience the same wilderness adventure seldom discovered by conventional visitors: a close-up of the river's inhabitants—fishermen, houseboat enthusiasts, gentle manatees, and not-so-gentle alligators sunning themselves along the river banks—as you relish the lush landscape. This entertaining luncheon cruise teases you with a taste of St. John's River cruising. A Great Table of appetizers and light entertainment greets you as you board. Later, a full-course meal is served to your reserved table. Price: \$53 per person.

Sunday, August 8  
10:00 a.m. - 3:00 p.m.

### **Sea World**

Enjoy the world's most popular marine life park! Featured are hands-on exhibits with dolphins and stingrays and exciting shows, including “Shamu: New Visions,” “Clyde and Seamore 10,000 B.C.,” and the new “Whale and Dolphin Discover.” Other new attractions: “Mission: Bermuda Triangle,” and “Shamu's Happy Harbor”—a play area just for kids. Price: \$48 per adult; \$42.50 per child (3-9).

Sunday, August 8  
10:30 a.m. - 4:30 p.m.

### **Walt Disney World® Shopping Village and Lunch**

Like a charming seaside resort town, Disney's Village Marketplace invites you into a world of enchantment, where wooden and weathered brick shops offer treasures from across the globe. Stroll through waterfront shops where you'll see a skilled glass cutter performing his craft, one-of-a-kind gifts, the latest in Mickey fashions,

and much more. Price: \$43 (includes a group luncheon).

Monday, August 9  
12 Noon - 4:00 p.m.

### **Walt Disney World® Behind-the-Scenes Tour**

See the Walt Disney World® Resort like you've never seen it before! This fascinating seminar and tour showcases the innovative systems and technologies in usage across the 43-square-mile resort. You'll visit a variety of “onstage” and “behind-the-scenes” locations unseen by most tourists. Must be at least 16 years old; theme park admission not required. Price: \$75.

Monday, August 9  
9:00 a.m. - 1:00 p.m.

### **Cypress Gardens and Luncheon**

Visit the home of the world's most photographed water ski show combining daredevil excitement with artistry and laughter. Ski-jumping champions and hang gliders provide the thrills, water clowns provide the laughs, and ballet aqua-maids perform with beauty and grace. After these performances, meander through lush gardens of over 12 million flowers, and experience the vibrant panorama of exotic birds and animals including the Florida “gator.” Includes a private group luncheon in the pavilion area. Price: \$50.50 per adult; \$42 per child (3-9).

Monday, August 9  
10:00 a.m. - 4:00 p.m.

### **Park Avenue Shopping and Tour**

This open-air boat ride of five beautiful lakes and canals offers a unique tour of historic Winter Park, with its splendid mansions, gardens, and attractions. Then browse along Park Avenue and the quaint “Little Europe” district—a haven for boutique shoppers and gourmet palates—and visit the Morse Art Gallery, with the



world's largest collection of Tiffany glass. Price: \$29 per person.

Tuesday, August 10  
10:00 a.m. - 2:00 p.m.

### A Glimpse of Universal Studios with Lunch

Get the scoop on your favorite Hollywood stars and famous movies on a one-hour tour down the streets of New York, Hollywood, and San Francisco. Then take off on your own for 3 hours of leisure shopping and sightseeing. A lunch coupon is provided so you can choose from several restaurants. Price: \$60 per person.

Tuesday, August 10  
12 Noon - 5:00 p.m.

### Kennedy Space Center

Space exploration is alive at the

Space Center! View the shuttle assembly building, actual launch pads, astronaut training facilities, and rocket museums. See a breathtaking film on a five-story IMAX screen, and enjoy ample time to explore the exhibits and have lunch on your own. Price: \$32 per adult; \$27 per child (3-11).

Tuesday, August 10  
8:30 a.m. - 4:00 p.m.

### Walt Disney World® Combination Tickets

Avoid the ticket lines in Orlando and get special savings, too! AHA has arranged discounted tickets for attendees and their families to enjoy Walt Disney World® Theme Parks between July 31 and August 21, 1993. The tickets can be used for the Magic Kingdom®, EPCOT Center®, or the Disney MGM Stu-

dios®, and need not be used on consecutive days. Each ticket also includes one-day admission to either Pleasure Island or River Country (Disney's water park for children)—a \$12 - \$15 value! These tickets are available only through AHA; unused portions are nonrefundable.

1 Day/1 Park Pass plus Pleasure Island or River Country:  
\$44.00 per adult;  
\$31.35 per child (3-9)

3 Day/3 Park Pass plus Pleasure Island or River Country:  
\$117.70 per adult;  
\$94.05 per child (3-9)

4 Day/3 Park Pass plus Pleasure Island or River Country:  
\$132.00 per adult;  
\$105.60 per child (3-9)

## Tour Registration Form

AHA Annual Convention & Exhibition  
August 7-10, 1993

Name \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Guest Names \_\_\_\_\_

Children's Names & Ages \_\_\_\_\_

Please complete this form and mail payment to address listed below.

All tours include round trip transportation on a modern motorcoach, admissions, tax, gratuity, and professional tour guide. All events are on first-come, first served basis and require a minimum of 35 people.

Please register by July 16, 1993. Complete this form and mail with check (payable to Convention Planning Services, Inc.) to: Convention Planning Services, Inc., 5422 Carrier Drive, Suite 203, Orlando, FL 32819. For additional information, call 800/777-5333.

I wish to have my order charged to (check one):

☐ Mastercard ☐ Visa ☐ Discover

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature \_\_\_\_\_

| Date/Time                            | Activity                       | Cost Per Person                     | #of Persons | Total |
|--------------------------------------|--------------------------------|-------------------------------------|-------------|-------|
| Saturday, Aug. 7<br>1:00pm - 4:30pm  | Orlando City Tour              | \$21.00                             |             |       |
| Saturday, Aug. 7<br>6:30am - 12:30pm | Bass Fishing                   | \$130.00                            |             |       |
| Sunday, Aug. 8<br>1:00pm - 4:30pm    | Orlando City Tour              | \$21.00                             |             |       |
| Sunday, Aug. 8<br>12:30pm - 4:30pm   | Leu Gardens With Orlando Art   | \$25.00                             |             |       |
| Sunday, Aug. 8<br>10:00am - 3:00pm   | Grand Rivership Romance        | \$53.00                             |             |       |
| Sunday, Aug. 8<br>10:30am - 4:30pm   | Sea World                      | \$48.00 Adult<br>\$42.50 Child 3-9  |             |       |
| Monday, Aug. 9<br>12 Noon - 4:00pm   | Disney Village Shopping        | \$43.00                             |             |       |
| Monday, Aug. 9<br>9:00am - 1:00pm    | Disney World Behind the Scenes | \$75.00                             |             |       |
| Monday, Aug. 9<br>10:00am - 4:00pm   | Cypress Gardens                | \$50.50 Adult<br>\$42.00 Child 3-9  |             |       |
| Tuesday, Aug. 10<br>10:00am - 2:00pm | Park Avenue Shopping           | \$29.00                             |             |       |
| Tuesday, Aug. 10<br>12:00pm - 5:00pm | Glimpse of Universal Studios   | \$60.00                             |             |       |
| Tuesday, Aug. 10<br>8:30am - 4:00pm  | Kennedy Space Center           | \$32.00 Adult<br>\$27.00 Child 3-11 |             |       |

### Walt Disney World® Convention Tickets Valid July 31-August 21, 1993

Admission to theme parks only; transportation not included.

|                                                                  |                                                 | #Of Persons | Total |
|------------------------------------------------------------------|-------------------------------------------------|-------------|-------|
| 1 Day/1 Park Plus One Pleasure Island or River Country           | \$44.00 Adult<br>\$31.35 Child 3-9              |             |       |
| 3 Day/3 Parks Plus One Pleasure Island or River Country          | \$117.70 Adult<br>\$94.05 Child 3-9             |             |       |
| 4 Day/3 Park Plus One Pleasure Island or River Country           | \$132.00 Adult<br>\$105.60 Child 3-9            |             |       |
| Advance Purchase of WDW Convention Tickets—Postage, Handling Fee | \$3.00 per order USA<br>\$5.00 per order Canada |             |       |
|                                                                  |                                                 | Grand Total |       |

# Registration Guidelines

## **Registration Deadline: July 16**

### **Registration**

Register before July 16, and you will receive by mail your Convention and hotel confirmations, badge, and special events tickets.

### **Three Ways To Register:**

#### **By Mail** (Check or Credit Card)

Registration and hotel reservations can easily be done by mail. Simply complete the Registration Form and send with your deposit check or credit card information to:

American Hospital Association  
Annual Convention  
Box 825, 104 Wilmot Road  
Deerfield, IL 60015-0825

#### **By Fax** (Credit Card Only)

For your convenience, when payment is by credit card, you may fill out both pages of the AHA Registration Form and fax it to:

*Fax Number:* 800/521-6017  
or 708/940-1364  
(24 hours a day, every day)

#### **By Telephone** (Credit Card Only)

When paying by credit card, you may phone your request to:

*Telephone Number:* 800/225-1535  
or 708/940-2155  
(8:00 a.m. - 6:00 p.m. Central Time, Monday-Friday)

### **Express Registration Information**

You will receive your meeting and hotel confirmation by mail within 10 days of receipt of your Registration Form, if your form is received no later than July 16, 1993, or you will receive it by fax if you provide your fax number. We will mail your badge and special events tickets no later than two weeks before the meeting.

## **Room Guarantees**

A deposit of \$100 is required for each room. Please refer to the hotel chart.

### **Big Savings on Accommodations**

Children under 18 can stay at the hotels for *free* when staying with a parent! So bring the whole family and enjoy all the magic that Orlando offers for kids and adults. See page 20 for hotel accommodation rates.

### **Changes/Cancellations**

You may make changes to your hotel reservations before July 16. Provide your name(s), hotel name, arrival/departure dates, and room type.

You may cancel before July 16, for a full refund of your registration fee and room deposit.

All changes and cancellations must be made in writing to:  
American Hospital Association  
Annual Convention  
Box 825, 104 Wilmot Road  
Deerfield, IL 60015-0825

### **After July 16**

If you register after July 16, you will receive Convention confirmations by mail, BUT you must pick up your badge and special events tickets at the Registration Counter in the Orlando Convention Center.

No hotel reservations can be made through the AHA after July 16.

## **Between July 26 and August 8**

Call the Hotel Reservation Hotline for a recorded message of updated room availability and hotel phone numbers:

*Hotel Hotline:* 708/940-2116

Call hotels directly to make or change room reservations. The discounted Convention rate cannot be guaranteed.

### **On-Site Registration**

You may register on-site at the AHA Registration Counter in the Orange County Convention/Civic Center using a check or credit card. On-site registration will be available during the following times:

Sunday, August 8 ..... 10:00 a.m. - 4:00 p.m.  
Monday, August 9 ..... 7:30 a.m. - 4:00 p.m.  
Tuesday, August 10 ..... 7:30 a.m. - 4:00 p.m.  
Wednesday, August 11 ..... 8:30 a.m. - 12 Noon

### **Save on Your Airfare to Orlando**

Reserve your air travel through I.T.S., the official travel management firm for the 1993 Convention. I.T.S. provides our attendees with discounted Convention fares on our official carriers, United and Delta Airlines, at the lowest available fare with one easy toll-free call. 5% off the lowest published promotional fare, including first class. 10% discount off the unrestricted coach fares.

Full mileage credit for all frequent flyer club members and easy payment by all major credit cards.

To receive the discounted airfare,



just call I.T.S. at 800/621-1083 from 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday. You may also call United Airlines at 800/521-4041 and mention code #526PN; or Delta Airlines at 800/241-6760 and mention code #D0100B.

### Car Rental Discounts

Special Convention discounts have been arranged with Avis Rent-A-Car, featuring unlimited mileage rates beginning at only

\$23.90 per day, \$89.00 per week. Our program is designed to guarantee these rates or confirm 5% off the lowest promotional rate at the time of booking at all Avis rental locations in Florida. For rental car reservations, call I.T.S. at 800/621-1083 or call Avis directly at 800/331-1600. Please reference Avis Worldwide Discount (AWD) number B791512 when making reservations.

### A Special Note for the Disabled

The American Hospital Association wishes to ensure that no individual

with a disability is excluded, denied services, segregated, or otherwise treated differently from other individuals because of the absence of auxiliary aids and services.

If you need any of the auxiliary aids or services identified in the Americans with Disabilities Act, please call Convention Services at 312/280-6317 (TDD phone: 708/940-2160), or write to this department at the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611.

### Hotel Rates

| Code | Hotel                            | Single<br>1 Person | Double<br>2 Persons | Triple<br>3 Persons | Quad<br>4 Persons | Junior<br>Suite | 1-Bdrm<br>Suite | 2-Bdrm<br>Suite    |
|------|----------------------------------|--------------------|---------------------|---------------------|-------------------|-----------------|-----------------|--------------------|
|      | DEPOSIT REQUIRED                 | \$100              | \$100               | \$100               | \$100             | \$100           | \$200           | \$300              |
| A.   | Best Western Plaza International | 68                 | 68                  | 68                  | N/A               | 83              | N/A             | N/A                |
| B.   | Clarion Plaza                    | 85                 | 85                  | 95                  | 105               | 100             | 185             | 270                |
| C.   | Marriott Orlando World Ctr.      | 125                | 125                 | 125                 | 125               | 325             | 325-1100        | 350-1200           |
| D.   | Orlando Marriott                 | 68                 | 78                  | 78                  | 78                | 200             | 300             | 300                |
| E.   | The Peabody Orlando              | 115                | 115                 | 130                 | 130               | N/A             | 350-1100        | 495-1300/Conc. 145 |
| F.   | Quality Inn Plaza                | 51                 | 51                  | 51                  | 51                | N/A             | N/A             | N/A                |
| G.   | Stouffer Orlando Resort          | 112                | 122                 | 132                 | 142               | N/A             | 270-1000        | 405-1000           |
| H.   | Walt Disney World Swan           | 110                | 110                 | 110                 | 110               | N/A             | 325             | 525                |
| I.   | Disney's Yacht Club Resort       | 122                | 122                 |                     |                   |                 |                 |                    |

### Hotel Amenities

| Code | Hotel                            | Restaurant/<br>Cafe | Lounges | Room Svc. | Business<br>Center/Fax | Scheduled<br>Trans./Airport<br>One Way | Child Care | Health Club | Pool | Local Calls | Scheduled Trans.<br>to Disney<br>Per Day | Long Distance<br>Carrier | Efficiency<br>Available | Handicap<br>Rooms |
|------|----------------------------------|---------------------|---------|-----------|------------------------|----------------------------------------|------------|-------------|------|-------------|------------------------------------------|--------------------------|-------------------------|-------------------|
| A.   | Best Western Plaza International |                     |         |           | ●                      | \$10.00                                |            |             | ●    | .50         | \$9.00                                   | ITT                      | ●                       | ●                 |
| B.   | Clarion Plaza                    | ●                   | ●       | ●         | ●                      | \$11.00                                | ●          |             | ●    | .75         | \$10.00                                  | Sprint                   |                         | ●                 |
| C.   | Marriott Orlando World Ctr.      | ●                   | ●       | ●         | ●                      | \$11.00                                | ●          | ●           | ●    | .75         | \$4.00                                   | ATT                      |                         | ●                 |
| D.   | Orlando Marriott                 | ●                   | ●       | ●         |                        | \$18.00                                |            | ●           | ●    | .75         | \$8.00                                   | ATT                      |                         | ●                 |
| E.   | The Peabody Orlando              | ●                   | ●       | ●         | ●                      | \$11.00                                | ●          | ●           | ●    | .75         | \$5.00                                   | ATT                      |                         | ●                 |
| F.   | Quality Inn Plaza                | ●                   | ●       |           |                        | \$12.00                                | ●          |             | ●    | .66         | \$8.00                                   | Sprint                   | ●                       |                   |
| G.   | Stouffer's Orlando               | ●                   | ●       | ●         | ●                      | \$10.50                                | ●          | ●           | ●    | .75         | \$6.00                                   | ATT                      |                         | ●                 |
| H.   | Walt Disney World Swan           | ●                   | ●       | ●         | ●                      | \$13.00                                | ●          | ●           | ●    | .75         | FREE                                     | ATT                      |                         | ●                 |
| I.   | Disney's Yacht Club Resort       | ●                   | ●       | ●         | ●                      | \$13.50                                | ●          | ●           | ●    | .75         | FREE                                     | ATT                      |                         | ●                 |



American Hospital Association

Richard J. Davidson  
President

June 15, 1993

Hillary Rodham Clinton  
The White House  
1600 Pennsylvania Avenue, NW  
Washington, DC 20500

Dear Mrs. Clinton:

In a further follow up to our meeting of June 4, I wanted to give you some additional information on the joint invitation we issued to the President or you to speak at the American Hospital Association's 1993 convention in Orlando, Florida. The meeting is set for August 9, 10, and 11 at the Convention Center.

The convention is attended by thousands of hospital leaders -- executives, trustees, and physicians -- from across America. The educational programming this year is almost completely geared to the implications of the Administration's reform proposal -- most notably managed collaboration and the coming together of integrated delivery networks.

When we wrote to the President on February 26, we indicated that we would hold time on all of the days to give him or you maximum flexibility. Ideally, it would be best from a membership and media standpoint if you could lead off the convention on Monday morning, August 9. Enclosed is a copy of our letter to the President and the convention brochure.

As we work to build support for health reform this year, it would be very important for our members to hear from the leadership of the health reform movement. You carry the message with enormous credibility and meaning.

By the way I caught some of the coverage of your American Medical Association appearance ... very skillfully and effectively done!

Sincerely,

*Rich Davidson*

50 F Street, N.W., Suite 1100  
Washington, D.C. 20001  
202.638.1100

840 North Lake Shore Drive  
Chicago, Illinois 60611  
312.280.6000

① copy to Helen for  
pending letter  
② file ori. in August  
file

THE WHITE HOUSE

WASHINGTON

July 9, 1993

MEMORANDUM FOR MAGGIE WILLIAMS, MELANNE VERVEER AND PATTI SOLIS

FROM: Mike Lux

SUBJECT: American Hospital Association Convention

I think it is critically important for Mrs. Clinton to go to the American Hospital Association convention in August (copy of invitation attached.) We have a real shot at getting their endorsement for the health reform package, but it is not yet-a done deal.

There is enormous jealousy and competition between AHA and AMA, an organization which has never been as friendly or constructive as AHA. Having gone to the AMA convention, if she doesn't go to AHA, it will send a really bad signal and would truly endanger any chance of endorsement from them.



American Hospital Association

**Richard J. Davidson**  
President

June 15, 1993

Hillary Rodham Clinton  
The White House  
1600 Pennsylvania Avenue, NW  
Washington, DC 20500

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By the way I caught some of the coverage of your American Medical Association appearance ... very skillfully and effectively done!

Sincerely,

THE WHITE HOUSE

WASHINGTON

July 14, 1993

TO: Maggie Williams  
FROM: Marilyn Yager  
RE: HRC Speaking at the Am. Hosp. Assn. Convention

---

Just wanted to add my views to the chorus of comment regarding the worthiness of Mrs. Clinton speaking at the AHA convention in Orlando, Aug. 9-11.

I feel very strongly about the importance of accepting this invitation. Dick Davidson and Rick Pollack with the AHA have worked strenuously over the past two years to prepare their membership for the endorsement of exactly the type of health care reform that we intend to propose.

They have consistently refrained from criticizing the Medicare provisions of our reconciliation proposal (though not the Senate activity); they expressed their concerns to us privately after her SEIU speech (unlike the AMA who vet every view in the press), and they have negotiated faithfully with Ira and Judy.

They are likely to be the largest health provider organization to endorse our proposal and one of the most moderate to conservative groups to endorse our proposal. They are politically savvy and can truly help sell the proposal.

If HRC does not attend the AHA convention, after having attended the AMA convention, it would send a very negative message -- that those who criticize and work against us get better treatment than those who have consistently worked with us.

I have attended several of the AHA conventions, and can verify fertile ground for an audience, i.e., administrators, nurse managers, benefit managers, venders, etc.

cc; Melanne Verveer  
Patty Solis✓



Patti

7/27

Kimley  
Tully

Some names of panelists  
were added after this  
brochure announcing  
the convention was  
published in the spring.

It will give you a  
feel for the program  
content however.

Thanks for everything.

Rick

**Rick Wade**  
Senior Vice President  
Communications

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## **Clinton Presidential Records Digital Records Marker**

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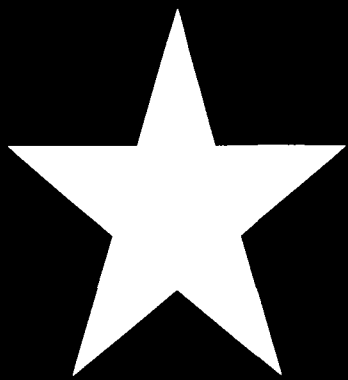
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

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Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

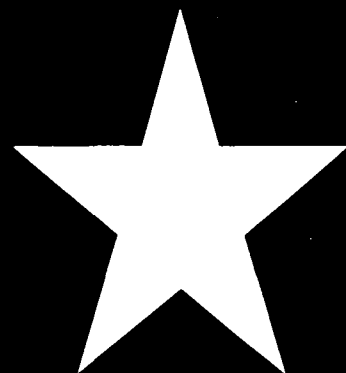
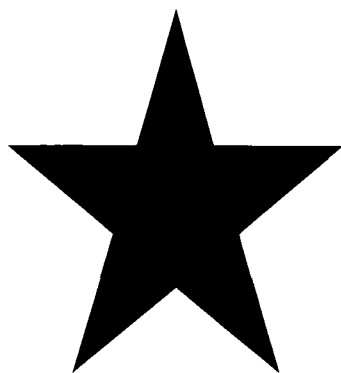
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1993 AHA  
Annual  
Convention &  
Exhibition

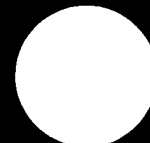
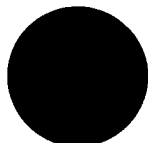
**August 9, 10, 11  
Orange County  
Convention/Civic Center  
Orlando, FL**

**In collaboration with the  
Florida Hospital Association**



Where  
the Future of  
Health Care  
Delivery  
Takes Shape

**American Hospital Association**



## Association Focus

### Mathis: AHA plays a significant role in shaping health reform

*The following text constitutes the mid-year report of Larry L. Mathis, chairman of the AHA board of trustees and president and CEO of The Methodist Hospital, Houston.*

In the first six months of 1993, health care reform dominated the agenda for the new administration, states and communities, and for the AHA.

In national health care reform (as in most public-policy issues), results will come only after a lengthy process.

However, it is already clear that the AHA's and hospitals' activities will be a significant factor in shaping the eventual outcome. At the national level, the AHA is actively preparing for and aggressively pushing for national health care reform.

*Mathis*

On the local level, hospitals are beginning to prepare for and move toward a restructured health care-delivery system that best fits their communities.

Overall, I perceive a pervasive spirit of America's hospitals today—a deep and abiding determination to seize the opportunity to redesign the health care-financing and delivery system in a way that makes sense for our patients and our communities. We have begun to realize that the time is now... that for health care reform, later may be too late.

We cannot let the momentum for reform slip away, leaving a health care

# AHA News

PHOTOCOPY  
PRESERVATION

American Hospital Association

Vol. 29 No. 30

July 26, 1993

## Conferees look to split difference on Medicare

Budget conference chairmen Rep. Dan Rostenkowski (D-IL) and Sen. Daniel Patrick Moynihan (D-NY) last week sought to split at \$54 billion the difference between the House and Senate numbers on Medicare savings. But Rep. Pete Stark (D-CA) attempted to keep House conferees behind the chamber's \$50 billion figure for Medicare.

"I can think of no good reason" to go beyond the House position on Medicare-spending reductions, Stark said July 22 after a round of budget talks, in explaining his opposition to a compromise. He is the prime author of the House's two-year freeze on Medicare-provider payments, which is expected to be dropped in conference.

Meanwhile, as the budget conferees continued to wrangle over differences in House and Senate Medicare-spending levels, hospitals greeted with disappointment reports that the Clinton administration would be willing to accept the Senate's \$58 billion in five-year Medicare savings.

In a July 22 letter to White House Office of Management and Budget Director Leon E. Panetta, AHA President Dick Davidson said the administration was abandoning its commitment to "shared sacrifice" in developing a \$500 billion deficit-reduction package.

"Given our willingness to work in a responsible manner to achieve a fair and balanced response to the president's call for

'shared sacrifice,' it is disturbing that the administration appears ready to abandon its own budget," Davidson said.

He added: "This lack of commitment by the administration to its own position raises serious concerns about our ability to forge a reliable partnership to win health reform in the months ahead."

Davidson's letter was prompted by Panetta's remarks last week that the administration was moving toward the Senate's position on Medicare.

In a related development, the AHA July 22 joined a group of 50 health care and business organizations in calling on congressional budget conferees to limit the reconciliation measure's ban on physician self-referrals to Medicare and Medicaid services, and to exempt managed care programs.

The measure's physician self-referral restrictions would "interfere with the development of integrated delivery systems... and also would seriously undermine other managed care organizations, which have strong incentives to control inappropriate utilization of services caused by self-referral and other factors," the groups stated.—*Gary Luggiero*



Stark

## Davidson: Calls to members of Congress can't wait

The House/Senate conference committee is at this moment hammering out a budget compromise. Its timetable is tight: Negotiators are trying to finish before the summer recess begins Aug. 6.

What action conferees take on Medicare spending levels is important to every patient you serve and to the prospects for health reform down the road. The Senate version calls for

## Briefs

- Eight out-of-state physicians have filed suit challenging a 2 percent tax to be levied against them as part of the MinnesotaCare insurance program. They say the tax is un-

Overall, I perceive a pervasive spirit of America's hospitals today—a deep and abiding determination to seize the opportunity to redesign the health care-financing and -delivery system in a way that makes sense for our patients and our communities. We have begun to realize that the time is now ... that for health care reform, later may be too late.

We cannot let the momentum for reform slip away, leaving a health care system facing increasing payment shortfalls from government programs, large numbers of uninsured people and spiraling costs. We cannot let the momentum stall, or the vision of community-responsive and provider-based delivery organizations could be replaced in the not-so-distant future by a micromanaged, single-payer, government-controlled approach to health care delivery.

Activities that stepped up the pressure for national health care reform be-

(continued on page 5)

"Given our willingness to work in a responsible manner to achieve a fair and balanced response to the president's call for

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## Davidson: Calls to members of Congress can't wait

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What action conferees take on Medicare spending levels is important to every patient you serve and to the prospects for health reform down the road. The Senate version calls for \$58 billion in Medicare savings—the House version calls for \$50 billion.

If you have not yet acted on our earlier alert, pick up the phone, call the U.S. Capitol switchboard at (202) 224-3121 and ask to speak with your members of Congress. It is vital that you contact—today—your senators and representatives, *even if they are not on the conference committee.*



Ken Heinan

Every member of Congress must know and let their colleagues on the committee know that the Senate version goes beyond shared sacrifice to the point of punishing providers that are trying to work responsibly with the government to reduce the deficit. The House savings—\$50 billion—are in line with the president's call for shared sacrifice. The conference committee must be convinced to adopt the House version's savings.

The intensity of the budget debate grows daily. You cannot afford to wait. The AHA has only one advocacy tool that we know works with every member of Congress, regardless of party affiliation or position. That's you ... the voice from home telling them straight from the shoulder what effect their actions will have on their hospitals and their communities.

Last week, the AHA brought to Washington, DC, leaders from many of the hospitals that will be hardest hit by the additional Medicare reductions. They were extremely effective in opening the eyes of their members of Congress to how "savings" will affect patients, health care workers and communities. I am more convinced than ever before that your one-on-one advocacy can make a big difference in the budget-reconciliation outcome.

Please act today.

*Dick Davis*

## News Flash!

**First lady Hillary Rodham Clinton has accepted the AHA's invitation to be the keynote speaker at the Aug. 9 opening session of the association's annual convention in Orlando, FL.**



Clinton

## Briefs

- Eight out-of-state physicians have filed suit challenging a 2 percent tax to be levied against them as part of the MinnesotaCare insurance program. They say the tax is unconstitutional and violates laws governing commerce between states. A similar suit is pending by out-of-state hospitals.
- Karen M. Ignagni, director of employee benefits for the Washington, DC-based AFL-CIO, last week was named president of the Group Health Association of America, Washington, DC. She will replace James F. Doherty, who will retire next year.
- The financially troubled Blue Cross and Blue Shield of the National Capital Area, Washington, DC, has received \$60 million from a group of 37 independent Blues plans and BCS Financial Corp., Chicago. Also, the plan's CEO, Benjamin W. Giuliani, announced his resignation last week.
- The American Organization of Nurse Executives (AONE), an AHA subsidiary, named Cathy Holmgren, R.N., acting executive director, effective Aug. 1. Holmgren, the AONE's director of membership services, will replace Carol Boston, R.N., who has resigned to become a senior consultant in the Chicago office of the Hay Group.
- Twenty-six people were laid off recently at the Chicago-based Blue Cross and Blue Shield Association as part of a restructuring that narrowed the number of the group's divisions from 10 to six.
- HCFA recently proposed regulations that would allow federally qualified HMOs to offer point-of-service plans and to use the resources of parent organizations to meet fiscal-soundness requirements.

American Hospital Publishing Inc.  
737 N. Michigan Ave., Suite 700  
Chicago, IL 60611  
Telephone: (312) 440-6800

SECOND CLASS

## Key players question cost-cutting aspects of Clinton reform plan

Key health-reform players on Capitol Hill last week appeared to be heading for a showdown with President Clinton over his reform plan's ability to control costs and not threaten jobs.

During a July 19 briefing, House single-payer sponsor Rep. Jim McDermott (D-WA) said soon-to-be released results from a Congressional Budget Office scoring of his bill based on new federal budget figures look "very promising."

Clinton's reform plan, on the other hand, will not achieve "meaningful cost containment" if not tied to budget controls, according to McDermott.

A White House health-reform task force

spokesman July 22 said two-thirds of national health spending will be subject to a budget



McDermott

under the Clinton plan, adding that the administration won't attempt to control individuals' out-of-pocket expenditures.

McDermott said true cost containment

hinges on a budget and universal access. "You cannot get cost control until you have everybody in the system" and cost shifting is eliminated, he said.

And some lawmakers believe enthusiasm

for the Clinton plan may be waning.

"Is there an obvious period of uncertainty [now]? ... yes," Sen. Harris Wofford (D-PA) July 20 told reporters when asked if health care reform is losing momentum with the delay of the Clinton plan. But Wofford believes "there will be major momentum" for reform again when the president unveils his plan.

Sens. Phil Gramm (R-TX) and John McCain (R-AZ) soon plan to introduce legislation based on the medical individual retirement account concept espoused by the Heritage Foundation, Washington, DC. A July 6 Heritage Foundation report said such a plan would not lead to job loss but that Clinton's employer-mandate proposal would

## Sen. Bond to introduce information-exchange bill

Sen. Christopher S. Bond (R-MO) said last week that he plans to reintroduce legislation to establish standards for a health-information electronic data-interchange network before members of Congress leave for their summer recess Aug. 6.

Bond's "Health Information Reform Act" calls for public- and private-sector electronic data exchange standards to be set by a panel consisting of representatives from HHS and other federal agencies.

The bill calls for standards for financial and administrative transactions to be set within nine months, for an initial quality-



indicator data set derived from financial information to be in place within a year and for a clinical-data set to be established in two years.

Estimates indicate that administrative

plied with a new national policy to train 50 percent of medical residents as primary care physicians. Now, only 30 percent of U.S. physicians are trained in primary care, according to the Public Health Service.

The bills would establish a national work force advisory board to implement the new policy, encourage Medicare payment for training in non-hospital settings and fully fund the National Health Service Corps through 2000, said Rockefeller July 15 during a seminar sponsored by the Alliance for Health Reform, Washington, DC.

"This is not an easy matter ... tough decisions will have to be made," Rockefeller said, adding that he wants all payers, not just Medicare, to share in GME training expenses under health care reform.

The bills come on the heels of GME reform legislation introduced July 13 by Sens. Nancy Kassebaum (R-KS) and Alan K. Simpson (R-WY), which also aims for a 50/50 split in the training of primary care physicians and specialists.

cutbacks in retiree health benefits [that] they fought for, worked for and were promised by their employers," Wofford said.

Wofford called his bill a "stop-gap measure" to address this problem, which ultimately must be rectified for all through comprehensive health reform, he said.

## Shalala says children's vaccine bill will pass

Acknowledging that in Washington, DC, "you don't always get what you want," HHS Secretary Donna E. Shalala last week said she was confident she will nevertheless get what the country needs: an effective child-vaccine



policy.

Shalala July 21 told a group of voluntary-health program officials that she is in "deep discussion"

Her conciliatory stance was a departure from her intense lobbying for a \$1-billion federal child-vaccine program that would have provided free or inexpensive vaccines to American children of all income levels.

She said she has problems with Bumpers' proposal to link welfare checks to child vaccines but that she is open to studying the idea as part of welfare reform.

## House may act to reform veterans health care

By underscoring the need to reform veterans health benefits, information gathered last week by a House panel "brought the Congress closer to taking some action" without waiting for a national health-reform plan, according to one congressional staff member.

Access to outpatient care at VA hospitals varies widely because eligibility rules are set locally and are often unclear, a July 16 General Accounting Office (GAO) report stated.

"Inconsistency, in fact, may be the most consistent aspect of VA outpatient care eligibility decision making," said Rep. Lane Evans (D-IL), House Veterans Affairs oversight panel chairman, at a July 21 hearing.

Because eligibility rules are so abstruse, veterans must gamble in "a health care lottery where their chances of receiving care are heavily dependent on which center they visit, which physician examines them or which day of the year they need care," said David P. Baine, GAO director of federal health care-delivery issues.

Stephen A. Trodden, Department of Veterans Affairs (VA) inspector general, said he was frustrated by problems he has investigated for years. He said the eligibility rules

and administrative transactions to be set within nine months, for an initial quality-



Bond

indicator data set derived from financial information to be in place within a year and for a clinical-data set to be established in two years.

Estimates indicate that administrative simplification could save between \$50

billion and \$150 billion in health costs, Bond noted during a July 21 press briefing. "Lowering administrative costs ought to be one thing everybody can agree on," he said, adding that he will seek bipartisan support.

"Without universal agreement to common standards ... hospitals and doctors will still have administrative waste and will still see it as part of their bottom line," he said.

White House officials who have reviewed drafts of his bill say Bond's approach is similar to one under consideration by the administration as part of health reform, according to an aide to the senator.

## Bills to redirect GME funds would increase training of primary care physicians

Sen. Jay Rockefeller (D-WV) this week is expected to introduce a bill that would redirect the more than \$5 billion Medicare spends annually on graduate medical education (GME) to increase the number of primary care physicians trained nationally.

Rep. Henry A. Waxman (D-CA) is expected to introduce a companion bill in the House. The bills would restrict payments to only those residency programs that com-

said, adding that he wants all payers, not just Medicare, to share in GME training expenses under health care reform.

The bills come on the heels of GME reform legislation introduced July 13 by Sens. Nancy Kassebaum (R-KS) and Alan K. Simpson (R-WY), which also aims for a 50/50 split in the training of primary care physicians and specialists.

## Wofford bill addresses retiree health care benefits

Sen. Harris Wofford (D-PA) July 20 introduced legislation that would prevent employers from terminating or reducing their commitment to retirees' health benefits.

As they grapple with skyrocketing health care costs, employers increasingly are cutting such benefits. In a report released earlier this month on retiree health plans, the General Accounting Office reported that employer liability for such benefits has jumped from \$227 billion in 1988 to an estimated \$442 billion this year.

But Wofford said some companies are now trying to transfer the responsibility for health care to the government.

"When companies cut off retiree benefits, what they're really doing is shifting those health care costs right onto the taxpayers, because many of those older citizens will have to turn to Medicare and Medicaid," Wofford said during a July 20 press briefing.

Under Wofford's bill, courts would order employers to maintain retiree health benefits during litigation over benefit reductions, and the burden would fall on employers to prove that their health-plan language allows for cuts in coverage.

"Across this country, workers who've dedicated decades of their lives to their companies are being left out in the cold by

... you don't always get what you want, HHS Secretary Donna E. Shalala last week said she was confident she will nevertheless get what the country needs: an effective child-vaccine policy.



Shalala

Shalala July 21 told a group of voluntary-health program officials that she is in "deep discussion" with Sen. Dale Bumpers (D-AR)—the man who in the 11th hour last month gutted the president's child-immunization plan. She believes Congress will eventually pass a worthy bill, she said.

"The important thing is to get every child properly immunized by age 2," Shalala said. "How we get there is less important to me."

## AHA to HCFA: Payment redistribution may harm hospitals

Significant redistribution of hospital payments, combined with the overall inadequacy of those payments, could further undermine the solvency of many financially vulnerable hospitals, the AHA told HCFA last week.

In July 22 comments to HCFA on its May 26 proposed PPS rules for FY 1994, the AHA said hospitals have had a heightened sensitivity to potential payment redistributions since June, when the Prospective Payment Assessment Commission (ProPAC) estimated that aggregate PPS margins will fall to -9.9 percent in FY 1993.

Medicare hospital payment redistributions would occur as a result of implementation of new Metropolitan Statistical Area (MSA) definitions; reclassification of substantially fewer hospitals for wage index purposes in FY 1994 and use of FY 1990 cost-report data to construct the FY 1994 wage index.

The AHA's comments raise questions about how HCFA collected, edited and verified the FY 1990 data that would be used to set the wage index for FY 1994, which begins Oct. 1. To alleviate potential problems, the AHA recommended that HCFA implement a blended wage index for FY 1994 based on wage data from FYs 1988 and 1990.

In addition, the AHA suggested that HCFA work with the hospital field to improve the process for collecting, editing and verifying wage data.

In response to HCFA's request for comments on ProPAC's "nearest-neighbor" proposal, the AHA noted that HCFA should work with ProPAC to decide how geographic boundaries for hospital labor market areas could best be constructed. "While the nearest-neighbor proposal has conceptual appeal, our definitive judgment as to its feasibility depends ultimately on where HCFA would draw the lines around hospitals," the AHA stated.

tery where their chances of receiving care are heavily dependent on which center they visit, which physician examines them or which day of the year they need care," said David P. Baine, GAO director of federal health care-delivery issues.

Stephen A. Trodden, Department of Veterans Affairs (VA) inspector general, said he was frustrated by problems he has investigated for years. He said the eligibility rules were written at a "time when medical care meant inpatient care" and urged panel members to "change the law."

C. Wayne Hawkins, VA deputy undersecretary for health, said VA Secretary Jesse Brown likely will unveil major changes in the fall when the president presents his reform proposal. But Trodden, subcommittee members, VA physicians and officials of several veterans groups said eligibility reform shouldn't wait.

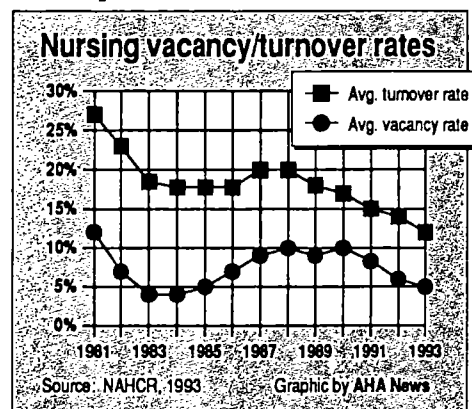
## RN-vacancy rate dips to 5 percent; recruitment incentives down

The registered-nurse (RN) vacancy rate at hospitals nationwide fell to 5 percent last year, and the average of 16 RN vacancies per facility approached the record low of 13 reported in 1983, new survey data show.

However, another round of hospital-RN shortages may be on the horizon, according to Karen Hart, executive director of the Akron, OH-based National Association for Health Care Recruitment (NAHCR), which sponsored the survey of 402 health care recruiters representing 396 hospitals.

"Once the economy turns around, we're going to have the same situation we had before," Hart predicted, adding that competition for RNs from non-hospital providers is rising.

RN-turnover rates also are on the de-



cline, according to the NAHCR survey. The turnover rate last year was 12 percent, down from 14 percent in 1991 and 30 percent in the early 1980s.

Other findings in the survey:

- Perks designed to enhance RN staffs—such as retention benefits and refresher courses to retrain returning nurses—showed slight declines.
- Work atmosphere, flexible scheduling and salary were considered most helpful in the retention of nurses. Salary was considered more important than any other factor in retaining allied-health workers.
- More than one-quarter of respondents reported increases in their recruitment budgets, down from 41 percent in 1991.
- The average cost per RN hire was \$3,167, up 26 percent from a year earlier.
- The average cost per allied-health worker hired was \$3,749.

## Providers need ability to contest Medicare decisions, brief argues

An amicus brief filed July 16 in an appellate court states that HHS decisions about Medicare payment and coverage must be subject to Provider Reimbursement Review Board (PRRB) and judicial review. If they are not reviewed, HHS could arbitrarily disallow reimbursement to health care providers of any item or service.

The brief was filed jointly by the AHA and the Denver-based Colorado Hospital Association with the 10th U.S. Circuit Court of Appeals, Denver, in the case *National Jewish Center for Immunology and Respiratory Medicine vs. Shalala*.

The Denver hospital is challenging a May ruling by a lower court that it lacked the jurisdiction to review an HHS official's decision to reduce the amount of Medicare

troubles, with several state and federal probes into admissions practices at its psychiatric facilities, and lawsuits by insurers claiming fraudulent billing practices. NME last week announced net income of almost \$160 million for FY 1993, up from \$104 million the year before. Net operating revenues were \$3.8 billion in 1993, down from nearly \$4 billion in 1992.

Fourth-quarter net income was nearly \$2.8 million on revenues of \$956 million, which compares with a loss of \$78.3 million on revenues of \$1 billion in 1992.

|                                                                                     |                                |                    |
|-------------------------------------------------------------------------------------|--------------------------------|--------------------|
|  | <b>Fourth-quarter earnings</b> |                    |
|                                                                                     | FY 1993                        | FY 1992            |
| Net revenue                                                                         | \$956.5 million                | \$1.0 billion      |
| Net income < loss >                                                                 | \$2.8 million                  | < \$78.3 million > |
| Source: NME, 1993. Graphic by AHA News                                              |                                |                    |

NME rehabilitation hospitals' fourth-quarter operating profits were 73 percent lower than they were in 1992's fourth quar-

and productive work experience, enabling them to envision a more promising future," said Commonwealth Fund President Margaret E. Mahoney.

Participating hospitals are: Albert Einstein Medical Center and Hahnemann University Hospital, Philadelphia; Barnes Hospital at Washington University Medical Center, St. Louis; Beth Israel Medical Center and Mount Sinai Medical Center, New York City; Cedars-Sinai Medical Center, Los Angeles; Duke University Medical Center, Durham, NC; Elmhurst (NY) Hospital Center, Maine Medical Center, Portland; MetroHealth System, Cleveland; University of Michigan Medical Center, Ann Arbor; University of Rochester (NY) Medical Center/Strong Memorial Hospital; Vanderbilt University Medical Center, Nashville, TN; and Washington (DC) Hospital Center.

Washington, DC, area, one of the country's top 10 markets, said Laurie Scarborough, Humana's director of investor relations.

Despite GHA's financial problems, the company—with 134,000 members—has a strong presence in the area and has growth potential, Scarborough said. Humana, with its large capital base, is "willing to infuse capital and build business there," Scarborough added.

## Several Pennsylvania hospitals slash work force

Impending reductions in Medicare and Medicaid reimbursements and the anticipated fallout from changes under health care reform are taking a toll on the hospital work force in Pennsylvania.

Since Jan. 1, some 1,500 workers have been laid off, and 2,300 positions have been eliminated at more than three dozen Pennsylvania hospitals.

Recent examples include the University of Pittsburgh Medical Center, which eliminated 500 positions and laid off 250 workers; Geisinger System Services, Danville, cut 387 positions and laid off 149 workers at two hospitals and 42 clinic sites; Hamot Medical Center laid off 161 people; Pittsburgh's Shadyside Hospital slashed 140 positions and laid off 60 people; Miner's Hospital of Northern Cambria, Spangler, laid off 83 of its total work force of 294 employees.

Patricia Jurczak, a spokeswoman for the Hospital Council of Western Pennsylvania, Warrendale, said the widespread layoffs are attributed to expected cuts in Medicaid and Medicare reimbursement.

Barbara Bloom Kreml, director of the AHA's Department of Human Resources, said hospital-employee layoffs are "a grow-

The brief was filed jointly by the AHA and the Denver-based Colorado Hospital Association with the 10th U.S. Circuit Court of Appeals, Denver, in the case National Jewish Center for Immunology and Respiratory Medicine vs. Shalala.

The Denver hospital is challenging a May ruling by a lower court that it lacked the jurisdiction to review an HHS official's decision to reduce the amount of Medicare reimbursement owed to the facility for patient-education services.

Hospital officials contend that HHS arbitrarily determined that the dispute was not a "payment" matter but a "coverage" one, which is not subject to PRRB or judicial review, to avoid making the payment.

AHA Associate Counsel Jeffrey Teske said HHS is "sort of mixing apples and oranges" in the process to deny National Jewish Center the right to appeal.

## NME's Eamer and Cohen resign their positions

National Medical Enterprises Inc. (NME) last week announced the resignations of Chairman Richard K. Eamer and Vice Chairman Leonard Cohen.

The announcement came less than three months after Santa Monica, CA-based NME disclosed that its co-founders Eamer, 65, and Cohen, 68, were stepping down from their positions as CEO and chief operating officer (COO), respectively. The two men will keep advisory posts at NME.

Eamer June 1 was replaced as CEO by Jeffrey C. Barbakow.

Cohen's spot as COO was filled in April by Michael H. Frocht Sr. NME has not announced who will replace Eamer and Cohen on its board of directors.

The hospital system is facing legal

|                                                                                                                |                 |                    |
|----------------------------------------------------------------------------------------------------------------|-----------------|--------------------|
|  <b>Fourth-quarter earnings</b> |                 |                    |
|                                                                                                                | <b>FY 1993</b>  | <b>FY 1992</b>     |
| Net revenue                                                                                                    | \$956.5 million | \$1.0 billion      |
| Net income < loss >                                                                                            | \$2.8 million   | < \$78.3 million > |
| Source: NME, 1993      Graphic by AHA News                                                                     |                 |                    |

NME rehabilitation hospitals' fourth-quarter operating profits were 73 percent lower than they were in 1992's fourth quarter, and revenues fell 10 percent. Fourth-quarter operating profits at the system's general hospitals were 8 percent higher than they were in the 1992 fourth quarter, and revenues rose 8 percent. Revenues for NME's Psychiatric Division declined 35 percent in the fourth quarter and 41 percent for the year.

Last month, Moody's Investor Service, New York City, downgraded ratings on the hospital system's senior unsecured debt from Baa1 to Baa3 based on its legal problems and difficulties in its psychiatric- and rehabilitation-hospital operations.

## New program provides mentors for students

Fourteen metropolitan hospitals will participate this fall in a program to help students complete high school and continue their education or join the work force.

Sponsored by New York City's Commonwealth Fund and Johns Hopkins Hospital, Baltimore, the Youth Mentoring Program links at least 50 staff members at each hospital to students who primarily are from low-income and single-parent families.

Each hospital will receive \$50,000 in start-up funds.

The program "reflects our belief that hospitals are a natural environment for providing young people with caring mentors

land; MetroHealth System, Cleveland; University of Michigan Medical Center, Ann Arbor; University of Rochester (NY) Medical Center/Strong Memorial Hospital; Vanderbilt University Medical Center, Nashville, TN; and Washington (DC) Hospital Center.

## Humana offers to buy GHA for \$50 million

Humana Inc.'s goal to become a national presence in the managed care market was underscored recently by its plan to purchase Group Health Association (GHA), Washington, DC, for about \$50 million.

The acquisition would be the Louisville, KY-based company's first move into the

Hospital of Northern Cambria, Spangler, laid off 83 of its total work force of 294 employees.

Patricia Jurczak, a spokeswoman for the Hospital Council of Western Pennsylvania, Warrendale, said the widespread layoffs are attributed to expected cuts in Medicaid and Medicare reimbursement.

Barbara Bloom Kreml, director of the AHA's Department of Human Resources, said hospital-employee layoffs are "a growing phenomenon" nationally as a result of mergers and CEOs looking to reduce costs by using less expensive workers.

"California is having some real problems," Kreml said.

She noted that a nursing-school official in that state inquired about where shortages were occurring nationally because the school was turning out nurses who could not find hospital jobs.

## Quality of nursing-home care has improved: Vladeck

Quality-improvement efforts at U.S. nursing homes have led to better patient care in the past 15 years, but continued evaluation of settings, resident demographics and needs, and health-service integration is needed, according to HCFA Administrator Bruce C. Vladeck.

Vladeck discussed changes in the nursing-home field during a conference last week in Chicago that was sponsored by the Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

"We've come a long way in the last 15 years," said Vladeck, author of the 1981 book "Unloving Care: The Nursing Home Tragedy."

In recent years, he said, nursing-home care has become more professional, patient-centered, and tied to a rational assessment of patient needs and higher service quality. He added that there has been "enormous progress" in emphasizing the problems of the frail elderly in education programs for nursing-home workers. "But we still have a long way to go," he said.

Ironically, as the nation moved away from "medical-based" long-term care to "community-based" care, nursing-home patient populations were becoming sicker, Vladeck said. He said the creation of "sub-acute care" facilities and "long-term care hospitals" that specialize in providing care to those patients, and that are eligible for higher reimbursement, may not have been the best way for the market to respond.

More analysis of the field is needed, Vladeck said. He added that he was surprised that greater integration of nursing-home management has not occurred, even after many hospitals in the early 1980s began to acquire nursing-home facilities.



Vladeck

**Constituencies**

# Rural hospitals are devising creative ways of staffing and utilizing their laboratories

Rural hospitals have developed innovative strategies to cope with the personnel shortages and financial pressures that can adversely affect their clinical laboratories.

"What we're seeing is a great deal of creativity in providing cross-training, in sharing personnel, in seeking additional income," said Paul Pomerantz, executive vice president of the Clinical Laboratory Management Association, Malvern, PA.

For example, when the lab at Sacred Heart Hospital, Eau Claire, WI, had trouble meeting staffing needs a few years ago, officials decided to cross-train the lab's specialized technicians, said Judy Lien, Sacred Heart's director of laboratory services.

Now, if the lab is short-staffed in the blood bank, for example, someone can be pulled from chemistry to fill in, she said. About half of the lab's technical staff is trained in two areas, and Lien would like to expand cross-training so that some employees are skilled in three different areas.

Sacred Heart may also begin some cross-departmental training. Under such a system, a lab worker might take X-rays or an electrocardiogram.

Cross-departmentalization of lab workers would save the hospital money by using employees more efficiently, especially during the evening hours when work slows down, Lien said.

It also fits in well with the idea of patient-centered care—a concept Sacred Heart is moving toward. One staff member would be in charge of a patient's overall needs. This way, she said, patients would receive "more personal attention—they'd become the key issue."

To help ensure that the laboratory is fully staffed, Sacred Heart has agreements with the University of Wisconsin-Eau Claire and the Chippewa Valley Technical College.

Under the arrangements, students who are studying to be medical technicians and histotechnicians work in the hospital as interns. Some of them end up staying at the hospital as regular employees once they've completed their education, Lien said.

Besides taking measures to make sure they have qualified personnel, rural hospital labs have also come up with

Many rurals are located in areas with few resources and large elderly populations. According to the AHA's 1992 Environmental Assessment for Rural Hospitals, revenues from patient care fell short of expenses at nearly 70 percent of rural hospitals in 1990.

Rural hospitals face "uncertain times," said Karen Searle, laboratory manager at Livingston (MT) Memorial Hospital.

About 70 percent of Livingston's patients are on Medicare or Medicaid. And, although the hospital just finished a strong fiscal year, changes in federal reimbursement could make or break it, Searle said. The hospital has outreach programs that both improve the community's health and help strengthen the hospital's bottom line through marketing.

For the past six years, Livingston's laboratory has offered area residents low-cost health screenings for cholesterol, blood-sugar, potassium and bilirubin levels.

"From a marketing standpoint, it gets people in our hospital," Searle said. During the last three-week special screening program, the lab did 1,000 profiles—a large number for a community of about 7,000 people, she said.

"People came in and saw that we have a hospital with state-of-the-art equipment, Searle said.

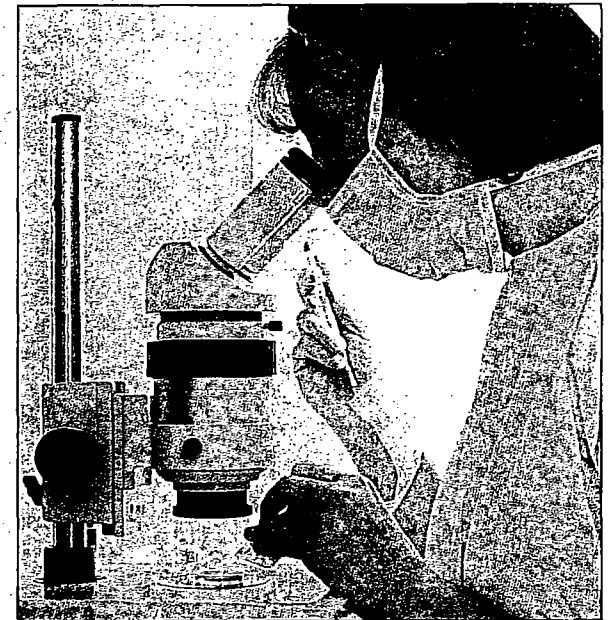
In addition to providing an opportunity for the hospital to give something back to the community, she noted, the screenings allow patients to take responsibility for maintaining their health.

Livingston's sense of community extends beyond its relationship with patients to its ties with other laboratories in the area. Searle does some consulting with nearby non-hospital labs. They, in turn, use Livingston as their main reference lab, which gives the hospital extra business.

"It makes us a team, instead of every man for himself," Searle said.

Another hospital with cooperative ties with an outside lab is Western Missouri Medical Center, Warrensburg. The hospital does testing in certain cases for the hospital at nearby Whiteman Air Force Base, and the base hospital sometimes does testing for the medical center, said Carol Pilkington, laboratory administrative director.

The relationship with the base also helps the medical cen-



*Cross-training of laboratory personnel is becoming a necessity in more rural hospitals.*

the base hospital sometimes moonlight at Western Missouri when help is needed on weekends, at night or when a staff member goes on vacation, Pilkington said.

In addition, three of the medical center's lab employees are dependents of people affiliated with the base.

"That's where our labor pool comes from," Pilkington said, "Otherwise, we'd be in a fix."

Western Missouri also relies on flexible schedules and cross-training to meet staffing needs, she said. Because of the flexible schedules, there isn't a division between shifts.

Consequently, "everybody knows that everybody is working just as hard as they are," Pilkington said. "It's a real team feeling."

For rural hospital labs, extra business sometimes comes from unconventional clients. For example, Northeastern Vermont Regional Hospital, St. Johnsbury, does reference laboratory work for four area veterinarians.

Some of the veterinarians use the hospital as their main reference lab, and others use it primarily in emergencies when there's no time to ship off a sample, said Jennifer St. Hilaire, Northeastern's laboratory manager. The service brings in extra money and strengthens community ties, she

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Besides taking measures to make sure they have qualified personnel, rural hospital labs have also come up with ways to help their facilities financially, Pomerantz said.

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## Health needs of women veterans emphasized in VA pilot project

Four comprehensive health centers have been established at Veteran Affairs (VA) hospitals across the country to focus on the special health care needs of female veterans.

The hospitals include James A. Haley Veterans Hospital, Tampa, FL; the VA medical centers in San Francisco and Minneapolis; and VA hospitals in Philadelphia's Southeast Pennsylvania Network.

The VA opened the health centers because studies have shown that women veterans haven't had the access to health care that the men have had, said Tampa Women Veterans Program Coordinator Peggy Mikelonis.

The centers will provide the full range of health care services as well as preventive care and counseling to women who may have suffered sexual assault or harassment while in the service.

Each center will emphasize different areas of women's health: The Tampa program will focus on the early detection and treatment of cancer, Minneapolis will target preventive medicine, San Francisco will emphasize primary care, and Philadelphia will stress general women's health care.

The VA hopes these pilot programs will demonstrate what can be done to reach the growing number of women in the military, according to Susan Mather, M.D., assistant chief medical director for environmental medicine and public health at the VA central office.

"Our hope is that we will fund more of these as time goes on," she said.



**'Three-point' Paxson visits fan**  
*John Paxson, the Chicago Bulls' three-point shooting star, visits fan Jennifer Hebda at the Rehabilitation Institute of Chicago. After emerging from a five-month coma, Hebda spoke her first words during the playoffs when she called Paxson "hot." Paxson made a critical shot during the National Basketball Association finals that helped lead the Bulls to their third championship.*

## In other news...

- Gerald W. Mungerson, president of Chicago's Illinois Masonic Medical Center, has received the George Howell Coleman Award from the Institute of Medicine of Chicago. The award honors a person who has made outstanding contributions to the welfare of the community "above and beyond the practice of his profession."
- Mercy Hospital, Springfield, MA, and Providence Hospital, Holyoke, MA, members of the Sisters of Providence Health System, are

exploring ways to increase consolidation and cooperative efforts. Task forces will explore potential areas of collaboration.

- Continental Medical Systems Inc., Mechanicsburg, PA, has agreed to develop and manage a 30-bed comprehensive medical rehab unit for Hurley Medical Center, Flint, MI.
- The number of people infected with HIV worldwide will more than triple, to more than 40 million, by the year 2000, according to the United Nations Population Fund.

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# Nurse practitioners help hospitals fill basic primary care void

Responding to an increasing shortage of primary care physicians, a growing number of inner-city and rural institutions are turning to nurse practitioners (NPs) to help meet the demands for basic medical care.

At Bronx Municipal Hospital Center, New York City, NPs are serving as outpatient adult and pediatric primary care providers, providing follow-up care in the emergency department as well as staffing the neonatal intensive care unit (NICU).

"Basically, they do everything that the physician had been doing in the NICU," said Ellen Levine, R.N., the institution's assistant director for nurse practitioners.

Currently, there are 25,000 to 30,000 NPs providing primary care services nationally in areas underserved by physicians, according to the American Association of Colleges of Nursing (AACN), Washington, DC. That number is expected to rise, as more schools develop NP-training programs to meet the expected growth in demand for primary care services under reformed state and national health care systems.

A recent AACN study found that additional master's degree nursing programs are planned at 45 U.S. schools for fall 1993 or 1994. The programs include NP specialties in family health, adult health, gerontological care, women's health, pediatrics, obstetrical/gynecological care, neonatal care, acute care, and psychiatric and mental health.

"As the demand for primary care providers increases, the NPs will be able to provide that kind of service, and they have shown to be very effective and cost efficient," said AACN Executive Director Polly Bednash, R.N.

A 1986 study by the congressional Office of Technology Assessment found that nurse practitioners can deliver up to 80 percent of the health services and up to 90 percent of the pediatric care provided by primary care physicians, at equal or better quality.

At least 43 states currently allow NPs to prescribe medications, and some physicians are starting to view NPs as competitors. But Debbie Folkerts, R.N., a nurse practitioner who directs a rural clinic in Concordia, KS, sees NPs work-

ing not in competition with physicians but with them as part of a team.

"What we do is free up the physicians so they can take care of patients who have more complicated, life-threatening illnesses," she said.

The clinic in which Folkerts practices began using NPs in July 1990, when the physician who previously operated it retired and gave the building and its contents to the St. Joseph Hospital Foundation. In February 1992, another local physician took over the clinic, but most of the services continue to be provided by a nurse practitioner, Folkerts said.

"We care for all family practice-type patients, from pedi-

can be on call 24 hours a day, seven days a week.

Many communities are finding that retention of NPs also can be difficult because they too often burn out.

"Unfortunately when they are the only health care provider in a place, they're having the same demands as the physicians," said Folkerts, who plans to leave her practice once a replacement is found.

To improve NP retention, she suggested that clinics adopt team approaches in sharing patient calls, perhaps implementing a communitywide call system in rural areas to give the providers some time off.

Communities in other parts of the nation also are utilizing nurse practitioner-run clinics to supply needed primary care services.

In Ocala, FL, for example, an indigent care clinic operated by NPs through a joint venture of HCA Marion Community Hospital and Munroe Regional Medical Center is working with the local health department to address the medical needs of the local indigent population.

Faye Gaston, R.N., HCA Marion's assistant administrator, said the goal of the Community Health Services (CHS) clinic is to serve people who would "slip through the cracks" and wind up seeking care in expensive hospital emergency departments.

CHS, which is funded by Marion County but overseen by the two sponsoring hospitals, is operated by nurse practitioners—three full time and one part time. They work independently, but they also have two medical directors who serve as a back-up in case the NPs have questions. The NPs are allowed to prescribe Category 1 drugs, which include antibiotics, hypertensive agents and antihistamines, but not tranquilizers or controlled substances, according to Gaston.

In addition, physicians from the sponsoring hospitals have volunteered through a local We Care program to provide specialty care services. For example, if a patient enters the CHS clinic with a sore throat and a breast lump is detected, that patient can get access to a surgeon.

"In the past, the system failed those kinds of people because there was no way to get them that specialty back up," Gaston said.—Jeffrey Green



## Supporting points for nurse practitioners:

- The annual net income for physicians in 1991 was \$170,600. Although salary by specialty varied, pediatricians earned an average of \$119,300. The average salary for a nurse practitioner (NP) that year was \$42,000; \$42,300 for a clinical nurse specialist.
- The cost of initial visits by an NP range from 12 percent to 45 percent less than comparable first visits by physicians, and the cost for continuous care is 7 percent to 40 percent below that of comparable physician visits.
- The cost to society for not using advanced-practice nurses to their fullest potential—80 percent of adult-health and 90 percent of pediatric-office visits—range from \$6 billion to \$9 billion.

Source: American Nurses Association, Washington, DC.

atric to geriatrics," she said.

In Kansas, Folkerts noted, NPs operate under "protocols" through which they can prescribe medications.

"We write prescriptions for those medications in our protocols with our supervising physician," she said. "We work in collaboration with the physician, but we bill and can be reimbursed independently by Medicaid, Medicare and third-party payers in the state of Kansas."

Folkerts also has admitting privileges at local hospitals, and when her patients are admitted, she and a physician oversee their care. Some Kansas hospitals allow NPs to be their patients' sole care-giver, Folkerts said.

Much of the demand for nurse practitioners in rural areas such as Concordia stems from difficulties recruiting and retaining general-practice physicians. To some physicians, rural lifestyles are not conducive for long stays because they

have shown to be very effective and cost efficient," said AACN Executive Director Polly Bednash, R.N.

A 1986 study by the congressional Office of Technology Assessment found that nurse practitioners can deliver up to 80 percent of the health services and up to 90 percent of the pediatric care provided by primary care physicians, at equal or better quality.

At least 43 states currently allow NPs to prescribe medications, and some physicians are starting to view NPs as competitors. But Debbie Folkerts, R.N., a nurse practitioner who directs a rural clinic in Concordia, KS, sees NPs work-

in collaboration with the physician, but we bill and can be reimbursed independently by Medicaid, Medicare and third-party payers in the state of Kansas."

Folkerts also has admitting privileges at local hospitals, and when her patients are admitted, she and a physician oversee their care. Some Kansas hospitals allow NPs to be their patients' sole care-giver, Folkerts said.

Much of the demand for nurse practitioners in rural areas such as Concordia stems from difficulties recruiting and retaining general-practice physicians. To some physicians, rural lifestyles are not conducive for long stays because they

are allowed to prescribe Category 1 drugs, which include antibiotics, hypertensive agents and antihistamines, but not tranquilizers or controlled substances, according to Gaston.

In addition, physicians from the sponsoring hospitals have volunteered through a local We Care program to provide specialty care services. For example, if a patient enters the CHS clinic with a sore throat and a breast lump is detected, that patient can get access to a surgeon.

"In the past, the system failed those kinds of people because there was no way to get them that specialty back up," Gaston said.—*Jeffrey Green*

## Board's mid-year report

(continued from page 1)

gan early in the year. Knowing the new Clinton administration would stress health care, the AHA's policy-development bodies turned to refining AHA's vision for national health care reform, weighing options against the backdrop of the still-malleable administration proposal.

It has been a classic case of experienced and innovative leaders discussing, interacting, shaping and advising on issues of national importance. This valuable insight guided the AHA staff in its continuing discussion with the Clinton administration.

Among the topics examined were cost-containment options, the composition and role of the independent commission, the role of health alliances, and the scope and locus of needed regulatory activities.

Clearly, the AHA's vision has much in common with the views of the Clinton administration—similarities underscored in meetings with the administration's health task-force leaders Hillary Rodham Clinton and Ira Magaziner.

Both the AHA and President Clinton support universal coverage and community-oriented health care networks. Both support employer mandates, broad benefits, multiple choices for consumers and capitation payment to networks. Both support revision in antitrust and malpractice laws, and reductions in administrative costs.

The AHA, of course, continues to monitor progress on important but still undecided issues, maintaining continual communications with administration and congressional decision makers.

One of the AHA's paramount concerns has been maintaining the pluralistic financing and delivery system. Although the administration ostensibly shares this goal, design of the financing mechanisms and the role of the health alliances could make the program resemble a single-payer system by using payroll premiums or taxes paid directly to the federal government and by requiring all businesses to purchase coverage through health care alliances. These concerns have been communicated directly to the administration.

The timetable for reform? Most set the clock for federal action before the November 1994 mid-term elections. However, even without national action, hospitals nationwide are moving forward, often rapidly, with reform at the local level. Hospitals are beginning to work collaboratively with other hospitals, physicians, community health agencies and other providers. They are beginning to understand the need to focus on community health status and community health needs. Hospitals are talking networks, thinking networks and forming the beginnings of networks.

The AHA is committed to providing the tools members need in moving toward the restructured health care-delivery system.

Clearly, other issues have needed the AHA's attention through the policy-development process and through political advocacy, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), strategic planning, leadership development and public-policy issues.

The AHA board of trustees supported taking a stronger leadership strategy with the JCAHO. Even as the JCAHO wrestles with its current challenges of demonstrating public accountability while retaining its counseling and adviser role for hospitals, it is coming to grips with the question of its role in a restructured delivery system. The AHA is committed to being actively involved in these decisions.

Strategic planning at the association gained a formal board-level component with the establishment of a new committee of board members, former board members and allied hospital association representatives. The Strategic Planning Committee has begun to assess the association's environment and to develop a strategic plan for the association's priorities and activities for consideration by the board of trustees.

A special committee looked at how the AHA can ensure that it has high-caliber leaders in the future. Recommendations for changes, some of which will be brought to the House of Delegates in the form of by-laws amendments this summer, are:

▼ Including up to two members on the board who are not affiliated with an institu-

tional member and who have high national profiles; are from business, professional, and academic backgrounds; and are actively concerned with health issues

▼ Enhancing diversity within the association's leadership, including gender, race and ethnicity

▼ Ensuring that regional policy boards follow similar guidelines in selecting their chairmen (who serve as AHA board members) and use the same criteria as is used for the at-large board members

▼ Providing the board with a formal vehicle for communication with the Committee on Nominations on qualifications and expertise for future board members and chairmen

On the political scene, the AHA continues to influence the administration and Congress on such critical issues as the federal budget and Medicare payment. Although the budget process is still to be completed, the AHA successfully worked with members of Congress to avoid punishing and unfair entitlement caps and minimize efforts to achieve deficit reduction by penalizing health providers.

The AHA and hospitals will continue to work toward achieving national health care reform. By making initial delivery-system changes today at the hospital and community level and by supporting strongly appropriate action on reform on the national level, we can ensure success for our hospitals, our patients and our communities.

# Tomorrow's health care reform—Can we get there from here?

Larry Sanders



Like other health care executives, I've spent the better part of this year reading, talking and even writing about health care reform. On an intellectual level, I've understood the implications of reform. On a personal level, I now know I had no idea where it was taking us until two seemingly unrelated experiences

made me realize that we're on a bullet train to a new world, and we'd better know where we're headed and what we're going to do when we get there.

As chairman of the Georgia Hospital Association, I'm frequently on the road, traveling to district meetings and visiting member hospitals. A few months ago, while driving across rural Georgia late one night on my way to a district meeting in the southeastern part of the state, it occurred to me that health care-reform discussions in Washington, DC, are unlikely to result in one plan that will address the needs of urban and rural America. What works in large cities probably won't work in the heartland or in the deep South. We may have the same destination, but we're traveling different routes to reach it—and the view may be different from my window than yours. The challenge for the Clinton administration will be to ensure that the accommodations once we arrive are equitable for everyone.

I continued to make a mental comparison between traveling through south Georgia and traveling toward health care reform as two events made this particular trip across the state more of an adventure than usual: I had failed to make motel reservations at one destination and was routed to a nearby town for overnight lodging. The following morning, I was late to my meeting because of well-intended but inaccurate directions to the conference site.

Although south Georgia is beautiful, I saw more of it that morning than I had intended, but I realized several

things along the way. I realized that, if you don't take the time to plan your journey, you may arrive later than everyone else—only to find there's no room left for you. If you take directions from someone who doesn't know where he's going, you probably won't get where you want to go. If you only depend upon your old instincts and values when faced with new vistas, you'll be like a visitor to a foreign country with no knowledge of the language or the customs, and you won't enjoy the trip.

I was a visitor to what seemed like a foreign country just a few days before my misadventures on the south Georgia highways. In early April, I participated in the first CEO summit of the Fifth Annual National Managed Health Care Congress in Washington, DC.

The experience was a real eye-opener. There were more than 6,000 preregistrants for the conference, yet relatively few were my colleagues in the "hospital business." The participants included a significant number of major purchasers of health care—corporations, cities, insurers and the like. It was quite obvious this highly structured and growing organization was not focused on hospitals.

The conference attracted hundreds of exhibitors, again with little focus on hospitals. This was the only meeting I've attended where wearing a color-coded badge identifying me as a hospital CEO made me a marked man that few, if any, exhibitors wanted to approach. I discussed this with a fellow Georgian and expressed my surprise at this emerging managed care subculture. But I realized that it may not be a subculture at all. It's the hospital culture we have known so long that, because it is rapidly declining, soon may be relegated to subculture status in this new world that is our destination.

What's the connection between these revelations in Washington, DC, and my wrong turns in south Georgia a few days later? It has to do with direction. Even though physicians and hospital CEOs may be uncertain where health care reform is taking us, we are on the road to change, like it or not. We must learn the language and the customs so we

can survive and prosper when we reach our destination.

We must find that point in our separate journeys where our paths merge and travel the rest of the way together.

Some of us—particularly those of us in the hospital business—recognize this and are making efforts to adapt, but we have a long way to go. We've spent years maintaining our position with little regard for those alternative providers entering the marketplace. We've paid little attention and given little credence to the managed care and capitation folks who wanted to discuss business opportunities with us. We had the power. We controlled the field by controlling the flow of information, the influence and the money. And now, some are questioning just how well we discharged our social and fiduciary responsibilities.

Should the tide turn and control in the health care field shift from hospitals and physicians as we've known it throughout our careers, we must hope those with whom we'll be working—and those of our own ranks who choose to join the new regime—will be friendlier toward us than we've been toward them.

You've heard the story of the lost traveler who stops to ask directions of a farmer, only to be told, "You can't get there from here."

It's true: We can't get to equitable health care reform from here as long as "here" is an environment in which we lack direction and don't communicate with each other and those planning the itinerary. We can't get there if we don't accept the realities of a new order in which our agenda is not the only agenda, and may not be the best one. We don't yet know where we're going and won't until the Clinton administration provides the ultimate destination. But with that destination, a clear sense of direction and a compass pointing toward health care in the best interests of the people we serve, we *can* get there from here—together.

*Larry Sanders, chairman and CEO of Columbus (GA) Regional Healthcare System, is chairman of the Georgia Hospital Association.*

Contributions of potential candidates in accordance with the behavior of all hospitals

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## Contributions to political candidates made on behalf of all hospitals

Donald C. Wegmiller



The AHA Political Action Committee (AHAPAC) was created to enhance the advocacy efforts of the AHA through financial support of federal candidates. The candidates receiving AHAPAC contributions are those who support the goals of the hospital and health care community, and represent hospitals in the national health-reform debate.

AHAPAC contributes on a bipartisan basis to federal campaigns for the U.S. House of Representatives and Senate. Contributions are based on a candidate's stance on issues of importance to the health care community.

When individuals contribute to the AHAPAC, they help to ensure that those members of Congress who understand the serious issues facing hospitals will remain in a position to protect our nation's health care system. Although an individual can certainly make a contribution directly to a candidate, that contribution will not speak as loudly as a contribution that is clearly made on the behalf of the entire hospital field.

By supporting candidates who are supportive of hospital issues, we stand to advance our regulatory and legislative agenda and have our views considered more seriously by government. All contributions to the AHAPAC go out as contributions to candidates. PAC dollars are not used toward staff salaries, supplies or other office-related expenses.

The operations of AHAPAC are overseen by a 17-member steering committee that, according to the articles of the association, "has such powers as may be delegated from time to time by the Executive Committee of the AHA board of trustees."

The AHAPAC steering committee consists of a chairman, treasurer, the chairs of the nine AHA regional policy boards, two representatives chosen from the personal membership groups of the AHA, one representative from the American Organization of Nurse Executives, two state hospital association executives, one representative from the Congress of Hospital Trustees and the executive vice president of federal relations.

The AHAPAC faced a chaotic 1992 election cycle with a record number of open congressional seats. Raising more than \$526,000 in 1992, the AHAPAC was allowed to participate in this unique election at an exceptional level. The AHAPAC contributed more than \$460,000 in campaign contributions and supported the winning candidate in 85 percent of the races. The AHAPAC also contributed to 38 successful freshmen in Congress out of a total number of 100 open seats.

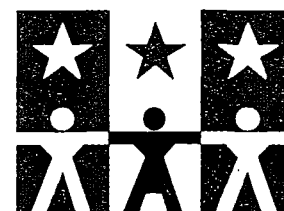
The 1994 election cycle also will be a challenge for AHAPAC, with many members

seeking re-election for the first time. Historically, those candidates seeking first time re-election face a tougher race than incumbents who have a history of winning. Your support will ensure that AHAPAC can provide financial support to the freshman class in Congress who understand and advocate the concerns of the health care community.

The AHAPAC plays a significant role in AHA's advocacy strategy but could not succeed without the ongoing efforts of those who make up our contribution base: leadership of member hospitals, the allied hospital associations, the personal membership groups, and the individuals who work for the AHA. Support is crucial since federal campaign finance law limits AHAPAC solicitation to salaried employees of member hospitals and supervisory, managerial/administrative positions with professional responsibilities.

It is often said that there is strength in numbers. Our strength is our willingness to join together to make contributions on behalf of all hospitals in America.

*Donald Wegmiller, chairman of the AHA Political Action Committee, is president of MCGIHealthCare Compensation, Minneapolis. This column was adapted from an article that appeared recently in Patient Representation and Consumer Affairs, the newsletter of the AHA's National Society for Patient Representation and Consumer Affairs.*



### AHA Convention Watch

*For information about the 1993 AHA Annual Convention, which will be held Aug. 9-11 in the Orange County Convention/Civic Center, Orlando, FL, call (800) 225-1535 or (708) 940-2155.*

#### Where the Future of Health Care Delivery Takes Shape

Forum A, Aug. 9, titled "Making the Transition From Medicine to Health: What We Need to Know When We Care for Communities," will address how the vision of improving community health status can be put into action. The

moderator will be Rob McCord, executive director of the Congressional Institute for the Future. Panelists will include Carolyn Lewis, chairwoman of the board of Greater Southeast Community Hospital, Washington, DC, and assistant director of investment management at the Securities & Exchange Commission; Stanley S. Bergen Jr., M.D., president of the University of Medicine and Dentistry of New Jersey, Newark; and Julie Hanson, manager in health and wellness services, Quaker Oats Co., Chicago.

## Alaska

### Supreme Court upholds Boren law

The Alaska Supreme Court July 16 ruled that the state's cap on Medicaid reimbursement for nursing homes was illegal under a 1981 federal law.

Under the federal Boren amendment, state Medicaid payments to health care facilities must be "reasonable and adequate."

The lawsuit was brought by the Juneau-based Alaska State Hospital and Nursing Home Association (ASHNHA) on behalf of nine member facilities located in isolated, rural areas.

"Our small, rural hospitals exist because of nursing homes," said ASHNHA President Harlan Knudson. Many of the association's members are combined acute and long-term care facilities.

In August 1988, the state instituted the caps on nursing home Medicaid rates, Knudson said. In response, the association filed a lawsuit opposing the caps in 1990 and won its case in a superior court in 1992, Knudson said. But the state took its appeal to the state Supreme Court, he said.

Knudson estimated that the nine hospitals could receive \$5 million to \$15 million in back payments from the state. The association is looking into whether the court ruling would apply to all nursing-home facilities in the state, he said.

Knudson said that the state has 60 days from the court decision to decide if it will appeal the court's decision before the U.S. Supreme Court.

He also noted that Alaska is one of 21 states working with a Washington, DC-based law firm to change the Boren amendment in the U.S. Congress.

## California

### Hospitals fight federal budget cuts

Officials from several state hospital groups descended on Washington, DC, last week to tell members of Congress and the Clinton administration how the Medicare and Medicaid cuts proposed in the FY 1994 budget-reconciliation package will affect California facilities.

As members of a joint House/Senate conference committee last week began negotiating the specifics of a proposal to trim between \$58 billion and \$66 billion from the Medicare and Medicaid programs, representatives from three groups told policymakers that such cuts will wreak long-term havoc on California hospitals. The groups were the Sacramento-based California Association of Hospitals and Health Systems (CAHHS), the Pleasanton-based Hospital Council of Northern and Central California, and the Hospital Council of Southern California, Los Angeles.

State facilities would face reductions of up to \$2.8 billion in Medicare payments alone over the next five years under the proposal budget conferees are considering, according to CAHHS. The hospital groups last week called for Medicare and Medicaid budget-reconciliation targets of no more than \$56 billion and a "balanced"

method for achieving such savings rather than the House-passed two-year provider payment freeze.

"While reductions in federal spending are essential, we cannot afford to focus only on short-term savings at the expense of long-term solutions," said CAHHS President C. Duane Dauner in a statement released last week.

## Illinois

### Debate over new county hospital

Several Cook County commissioners have opposed tentative efforts to build a new Cook County Hospital at a site eight blocks from its current Chicago location.

Commissioners John Stroger and Bobbie Steele are among those opposed to moving the hospital from its present West Side location. According to published reports, they believe it would be a sign that the county is abandoning the area where County Hospital has stood for 80 years so that the land can be opened up for commercial development—even though state law restricts the use of the site to medical or technological facilities.

The new hospital is projected to cost between \$300 million and \$500 million.

## Maryland

### Hospitals welcome Blues changes

The new head of Blue Cross and Blue Shield of Maryland, Owings Mills, last week announced changes that may bode

well for the state's health care field.

"My review of Blue Cross and Blue Shield of Maryland, its subsidiaries and the health care environment makes it clear that we must place more emphasis on customer service, managed care, market-segment needs and cost-sensitive products," said William L. Jews, Blues president and CEO, in a statement.

Jews, a former Maryland hospital CEO, July 12 announced a strategic plan to improve service, maintain the company's financial health, increase efficiency, eliminate duplication and centralize operations.

To do that, the company will take steps to consolidate and strengthen provider networks; improve communications with its employees, subscribers and the community; and streamline its operations, according to Jews. The company, a not-for-profit health insurer serving more than 1.4 million people in Maryland, didn't release any specifics on what those steps would be.

The company also now provides services through four HMOs: Columbia Medical Plan, CFS Health Group, Willse & Associates and Paradigm.

A spokeswoman for the Lutherville-based Maryland Hospital Association said that, although such changes at the Maryland insurer won't affect hospitals directly, they nevertheless welcome them.

"Mr. Jews is an individual who has enormous respect for the needs of health care providers," she said. "[His changes] are definitely viewed by the hospital association as something that needs to happen."

## Allied Outlook on Issues:

*This monthly feature focuses on allied association executives' views on a specific health care issue affecting their members. Richard E. Meiers, president and CEO of the Healthcare Association of Hawaii, Honolulu; Dennis P. May, president of the Connecticut Hospital Association*

## States react to changing managed care climate

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## Allied Outlook on *Issues:*

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Hawaii has been a pioneer in managed care. In 1974, the state passed the Prepaid Health Care Act, which in essence provides universal access to health care for all of Hawaii's working citizens.

However, HCFA recently approved the state's request for a waiver to implement its new Medicaid demonstration project, called Hawaii's Health QUEST.



Meiers

The program will restructure a portion of the existing State Medical Assistance Program, and develop and test a health care-delivery system in a managed-cooperative setting that promotes cost containment, encourages prudent resource utilization and emphasizes preventive care for services provided to medical-assistance recipients.

We support Health QUEST, which has the potential to reduce health costs as well as improve the quality of care. The Healthcare Association of Hawaii will be part of a team that will help design the implementation phase of the program. It is hoped the program will be operational by April 1, 1994.

The movement to develop a more comprehensive managed care plan was among the topics we discussed with first lady Hillary Rodham Clinton during her recent visit here.

Our efforts to expand managed care in Hawaii have been helped by the strong relationship that exists between hospitals/long-term care facilities and the insurers. For the most part, we don't experience the strong competitive issues that hospitals/long-term care facilities and insurers face on the

# States react to changing managed care climate

mainland. This collaborative spirit also allows us to control costs. Although our health care costs are rising, they are still about 35 percent lower than the rest of the United States.



During the past couple of years, managed care has had a dramatic effect on Connecticut hospitals. Currently, there is about a 22 percent HMO penetration in the state. There are 12 HMOs in Connecticut, many of which are competing in the same service area.

Where managed care has probably had the most significant effect has been in inpatient psychiatry, where lengths of stay have been significantly shortened and hospital admissions are being eliminated.



May

Blue Cross and Blue Shield of Connecticut, North Haven, which owns a lion's share of the private-insurance market, has just sent out a request for proposal (RFP) to all hospitals in the state asking them for bids on an exclusive contract. This is the first time Blue Cross said it is not going to deal with all 34 of the state's acute care hospitals, but rather a subset that will be selected based on the hospitals' responses to the RFP.

The smaller hospitals in the state are worried about selective contracting, especially regarding Aetna health plans, an insurance program jointly created by Aetna Life and Casualty and certain Connecticut hospitals. Since the rural hospitals were excluded from the process, they formed an alliance to position themselves better the next time this comes around.

To gain greater input into the managed care process, the Connecticut Hospital Association's board of trustees recently created a committee to design a health care-reform plan that is expected to be introduced in the 1994 legislative session. The proposal may call for creating provider networks, bringing together the various provider communi-

ties to avoid the dislocations that have happened in other parts of the country.



Illinois is currently experiencing consolidation within the managed care market as regional and local insurers become absorbed by large national and regional entities.

It is too early to tell what the full impact of the consolidation process will be, but hospitals have continued to adapt and position themselves in the marketplace by developing hospital networks that offer geographical and service diversity, increasing integration and cooperation with medical staffs, exploring new contracting opportunities, and developing sophisticated data resources that will enhance decision making in a more complex environment.



Robbins

Hospital-merger activity continues to occur in Illinois. This is due to many factors: decreasing profitability as traditional markets erode, response to changing community needs and recognition by hospital leadership of the necessity of becoming more cost efficient. Managed care contracting plays an indirect, but not insignificant role in this process.

Meanwhile, rural hospitals in Illinois are under pressure to begin contracting with managed care entities as these firms attempt to become statewide networks in response to national health reform. The Illinois Hospital Association's job will be to educate rural providers on managed care negotiations and contracting, restructuring under managed care and the acceptance of risk under managed care contracts.

Rural hospitals that serve limited populations are extremely vulnerable under risk contracts. Traditional managed care models may not fit the rural environment and models that focus on appropriate delivery of quality care. These models, which will utilize rewards rather than incentives that are based strictly on pricing discounts or risk sharing, may be more suitable and realistic.



## Books

**Health Promotion Programs for Older Adults: A Planning and Management Guide.** This book, written by Cathy Stauffer Kimble and Mary E. Longe, focuses on the critical aspects of program management: assessment, design, implementation and evaluation. It includes step-by-step directions for investigating, planning, promoting, evaluating and improving new or established senior health-promotion initiatives. It is a source of new ideas for programming strategies, resources and in-

formation on special needs. 429 pages, 1989; 7 tables, 34 figures, 4 appendixes, bibliography, index. Catalog no. A55-070192. (\$37.50; \$30 for AHA members. Add \$7.95 for shipping/handling, \$6.95 for AHA members.)

**Bridging the Communication Gap with the Elderly: Practical Strategies for Caregivers.** Written by Barbara J. Cox and Lois Lord Waller, this book is designed to be used either for self-study or as part of an in-service training program. It provides care-givers at all levels with helpful strate-

gies to turn communication challenges into opportunities to work more effectively with the elderly. The co-authors have combined clinical health care and communications experience in developing the practical strategies provided in the book. Strategies for overcoming the major communication barriers, including confusion, hearing loss, paranoia and grieving, are explored through practical examples drawn from a variety of care-giving situations. Exercises help readers measure their own progress and attitudes toward working with elderly patients. There are four appendixes:

Appendix A provides information on discussing health care choices with elderly patients; Appendix B is a sample advance directive; Appendix C provides chapter outlines for use in training programs; and Appendix D includes model answers to the exercises. 126 pages, 1991. Catalog no. A55-130104. (\$25.95; \$19.95 for AHA members. Add \$6.95 for shipping/handling, \$4.95 for AHA members.)

**Progressive Healthcare Management Strategies.** This book, written by Donald N. Lombardi of the Center for Human Resources/InterVista Inc., shows hospitals how to build a work force committed to the highest standards of service to the patient and community. In doing so, the book explains the personal values, humanistic standards, business norms and executive principles that are the hallmarks of successful and ethical health care organizations. The book also presents a methodology for motivating employees and evaluating their performance according to 20 suggested organizational values. 383 pages, 1992; 13 figures, 1 table. Catalog no. A55-088300. (\$49.95; \$39.95 for AHA members. Add \$7.95 for shipping/handling.)

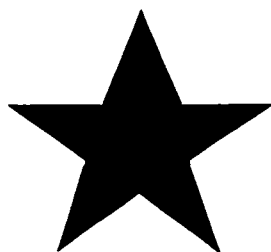
*To order, write to AHA Services Inc., P.O. Box 92683, Chicago, IL 60675-2683. For faster service, call (800) AHA-2626. Visa, MasterCard, American Express and purchase-order numbers accepted. Add sales tax in California, Colorado, Georgia, Illinois, Massachusetts, Missouri, New York, Ohio and Texas.*



## Educational programs

**Health Care Marketing and Public Relations**

"Building Bridges," Sept. 11-14, San Francisco. Sponsored by the AHA's American Society for Health Care Marketing and Public Relations, this conference will help



# Don't miss this year's AHA Annual Convention!

August 9-11 • Orlando, Florida

Opening Session, August 9

First lady Hillary Rodham Clinton, who heads the President's Task Force on National Health Reform, is scheduled to be the keynote speaker.



Closing Session, August 11

John McLaughlin will recreate his award-winning public affairs television program, The McLaughlin Group, with some of his regular panelists.

Where  
the Future of  
Health Care  
Delivery

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**Panelists:**

- Fred Barnes, Senior Editor, *The New Republic*
- Morton Kondracke, Senior Editor, *The New Republic*
- Clarence Page, Columnist, *The Chicago Tribune*
- Mara Liasson, White House Correspondent, National Public Radio

**Special Session:**

**Bernadine Healy, M.D.**, past director of the National Institutes of Health, will be the keynote speaker at a special session, *Reforming the Research Agenda for Women*, on Monday, August 9.

**Moderator**

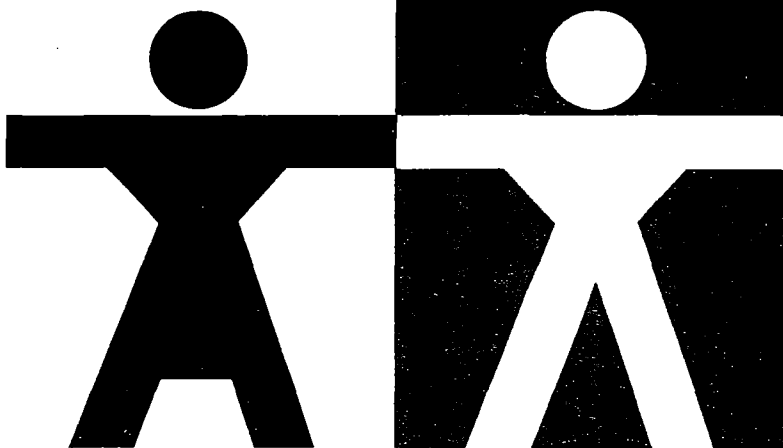
Mary Jane England, M.D., President, Washington Business Group on Health

**Responders:**

- Bess Hughes, M.D., Associate Professor of Medicine, Tufts University
- Donna Williamson, Corporate Vice President, Caremark International, Inc.

**To register, call 1-800-225-1535**

**For more information,  
call 1-312-280-6157**



# the Future of Health Care Delivery Takes Shape



**American  
Hospital  
Association**

*Illinois, Massachusetts, Missouri, New York, Ohio and Texas.*

## **Educational programs**

### **Health Care Marketing and Public Relations**

"Building Bridges," Sept. 11-14, San Francisco. Sponsored by the AHA's American Society for Health Care Marketing and Public Relations, this conference will help participants learn more about new provider partnerships that are evolving, learn about the vital link between communication and strategy as well as gather knowledge and techniques for managing change in the way health care is organized, delivered and financed. Political strategist James Carville, who helped Bill Clinton during the 1992 presidential election, will speak on the "Politics of Health Care Reform."

To register to attend an educational program using Visa, MasterCard or American Express, call (708) 940-2138. All programs are subject to change.

## **New AHA Publications**

- **Managing Health Care Construction Projects: A Practical Guide** A55-055100: \$42.50 (AHA members \$32.50)
- **Hospital Home Care: Strategic Management for Integrated Care Delivery** A55-079200: \$60 (AHA members \$48)
- **Engineering a Hospital Turnaround: Proven Strategies for Reinvigorating Financial and Operating Performance** A55-001120: \$45 (AHA members \$36)
- **Estimated Useful Lives of Depreciable Hospital Assets** A55-061170: \$25 (AHA members \$20)
- **Managing Hospital-Based Patient Education** A55-070194: \$68.95 (AHA members \$54.95)
- **A Swing-Bed Planning Guide for Rural Hospitals** A55-184140: \$50 (AHA members \$40)

# Health planners start job

Their work will help determine what health services millions of Floridians will be offered.

By CAROL GENTRY  
Times Staff Writer

ORLANDO — A panel of Floridians appointed to decide which health services are absolutely necessary met for the first time Thursday after pep talks by the governor and an assistant to the president.

Health officials told the group that its job of designing a "basic benefits package" for the state is vitally important. But it will also be tough.

"You're going to need the wisdom of Solomon and Ruth ... to determine what the funding priorities are going to be," said Doug Cook, director of Florida's Agency for Health Care Administration. "It's an extraordinary challenge."

Glancing at the observers from pharmaceutical companies, for-profit hospitals and other vested interests, Cook warned committee members, "You're going to take a lot of heat."

The basic benefit standard will serve as the floor for all insurance plans in the state. Under a law passed in 1992, the state ordered itself to provide all Floridians access to at least the basic benefits by Dec. 31, 1994.

At a news conference, Gov. Lawton Chiles conceded that goal will be tough to meet, especially because there is no requirement that individuals or employers buy the insurance. But Chiles, who has been advising President Bill Clinton on health reform, said the package will be so attractive employers will want to provide it.



Lawton Chiles likes being in the forefront of health reform.

## Health from 1B

The committee's work is part of Chiles' managed competition plan, a system of health reform that pools small businesses and uninsured individuals in a buyers' club that has the clout to demand good prices and quality. The Legislature passed the plan as the Health Care and Insurance Reform Act of 1993.

The buyers' clubs called Community Health Purchasing Alliances or "chippas," are being formed in each part of the state and will begin taking competitive bids early next year.

Clinton, a fan of managed competition, is watching Florida's progress closely in preparing his proposal for Congress.

Those who have been chosen to design the basic benefits plan know it.

"What comes out of this will shape national policy, and it's going to have huge implications for Florida," said member Dee Jeffers, a program faculty member at the University of South Florida in Tampa. "I feel privileged to be part of it."

Other committees meeting at Florida Hospital's conference center Thursday afternoon also were beginning work with important implications.

One is designing a standard insurance claim form to reduce confusion.

One is setting up a data system that will enable consumers to know which hospitals and doctors offer the best quality for the most reasonable cost.

One aims to kill the wasteful practice of "defensive medicine" by setting up guidelines that will free doctors from the threat of lawsuits if they follow them.

The committees have little time to waste. The state health plan must be ready by Dec. 31 so it can be considered by legislative committees leading up to the 1994 legislative session, which begins Feb. 8. The Legislature must pass the plan to meet the state's self-imposed deadline.

Florida, along with Hawaii and Washington, is in the vanguard of states plunging ahead in health reform, said John P. Hart, deputy assistant to the president and the state governments' liaison to the White House health reform task force.

"Many of us from Washington should visit your state to take a few lessons in ending gridlock," Hart told the standing-room-only crowd of more than 300 Thursday morning before the committees began work.

Chiles revels in Florida's speedy pace in health reform.

AUG 06 1993

ST. PETE TIMES

ORLANDO SENTINEL

# Chiles likens health-care pressure to 'gun to

By Mike Oliver

OF THE SENTINEL STAFF

Gov. Lawton Chiles told 300 health-care reformers in Orlando on Thursday that pending reform in Washington and a 1995 state deadline for providing health coverage to all Floridians are like a "gun to the head."

But "with the spirit I sense today, we are going to be able to put together a product," Chiles said to the overflow of doctors, lawyers, hospital

ministrators, consumer advocates and assorted lobbyists who gathered at Florida Hospital to begin fleshing out the state's new health-care reform law.

The law, passed this year, aims to lower the cost of health care and provide insurance for the 18 percent of the state's population that now has none.

Three-fourths of those without health insurance are employed or the dependents of employed persons.

Chiles said Florida wants to have its managed competition health-care system in place before the federal govern-

ment enacts similar legislation. The word from Washington is that a national plan for universal health-care coverage will be announced by the Clinton administration next month, to go into effect by the end of 1996.

"The further in front that we can get in putting together our idea ... we will have more say-so" in how the national plan develops, the governor said.

Any national program will likely be flexible enough so that states such as Florida continue their paths toward reform. The state will

likely set broad standards for states, with sanctions for those who do not meet them.

"Our reform will not look to undo your efforts but build on them," said John Hart, who works in the White House Office of Intergovernmental Affairs. "The federal government will establish and set standards, but it will be up to you to tailor the program to meet the standards."

The Florida plan is based on the theory of managed competition in which businesses and health plans

Orlando Sentinel, Friday, August 6, 1993 B-5

# the head'

s ces with government help to negoti-  
ate for lower cost health care and health  
rance premiums.

The Florida law sets a 1995 deadline  
for providing coverage to all uninsured  
residents. Chiles said the state will not  
that deadline without help from  
Washington.

The governor is pushing for waivers  
to federal Medicaid Medicare rules  
so the state can the federal n  
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THE WHITE HOUSE  
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FIRST LADY HILLARY RODHAM CLINTON  
REMARKS TO THE AMERICAN HOSPITAL ASSOCIATION  
ORLANDO, FLORIDA  
AUGUST 9, 1993

DRAFT

It is a privilege to be here with you today to address a subject we all care deeply about. I know health care reform is on your minds, and it is also on mine.

Let me say from the outset that the president sends his thanks for your organization's firm support of Dr. Joycelyn Elders, the nominee for U.S. Surgeon General. I think we all know that she has the conviction and backbone to be a great leader in promoting better health for all Americans.

And let me also say that the Clinton Administration is deeply grateful for the courage and commitment the American Hospital Association has shown in working to improve our health care system.

As representatives of hospitals serving patients of every stripe in every state, your mission is one that commands great respect. You have shouldered the most pressing health care burdens of this nation, providing superb medical treatment to every segment of American society. For decades, your organization has demonstrated a spirit of caring and community that is all too rare today. For that and more, you deserve heartfelt praise and thanks.

In 1988, when I joined the board of the Arkansas Children's Hospital, I thought I had a working knowledge of the challenges American hospitals face day in and day out. I had learned about "DSHs" [pronounced dishes] and PROs and PPOs and HMOs. I knew what the AHA was, along with the CHA, the AAP and the ACP.

But, like most non-health care people, I didn't fully appreciate the complex undertakings of hospitals like yours. Now, five years later, I understand much more. And I am that much more grateful for the thousands of dedicated hospital managers around the country who grapple with vexing health care issues every day.

I don't need to tell you that walls of fear and stubbornness stand between us and health care reform. But these walls must be scaled if we want our nation to thrive and prosper in a competitive 21st century.

formalized my relationship with AHA by joining their board

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So much is at stake. Because ultimately health care reform is not just about controlling costs and reducing paperwork and lowering prescription drug prices. It's not just about the ratio of primary care physicians and specialists. It's not just about devising more efficient ways of delivering health care services. It's not just about restoring integrity and trust to the practice of medicine.

At its core, health care reform is really about changing our vision of American society and renewing an ethos of civic responsibility and caring that is under threat of disappearing.

Those of you working for reform may not agree with all the fine print in the president's plan. But we should all remember that, whatever our differences, we are united by common concerns and common goals. We all share a vision of America in which hope and optimism triumph over apathy and cynicism. We all share a vision of a world that is safe and healthy for our children. We all share a belief that every American, regardless of race, ethnic origin, gender or economic station in life, should have access to quality, affordable health care.

These shared ideals are the reason we must seize this moment and reshape -- together -- our nation's future. That is our primary responsibility to each other as individuals. It is our primary responsibility as a government. It is the legacy we can leave for the next generation of Americans. And it is what health care reform is really about.

So how do we get there?

Fortunately, we have already made great strides, thanks to organizations like the AHA. While some have resorted to loud exhortations and ultimatums about reform, the AHA has consistently provided the Administration with quiet -- constructive -- counsel. And your ideas have not fallen on deaf ears.

You were among the first to promote community care networks -- a concept that lies at the heart of revitalizing our health care system. You have long been proponents of universal coverage -- a fundamental condition of health care reform. You are committed advocates of preventive and primary care. You are living, breathing examples of why we must reduce paperwork and micromanagement and allow hospitals to spend their time treating patients instead wrestling with bureaucratic beaurocracy.

You also know that we do not need wholesale revolution in our health care system. We have the finest hospitals in the world. We have the best-trained doctors and nurses anywhere. We have the most sophisticated technology and the most modern

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equipment. These strengths make us the envy of every other nation -- and we want to stay that way.

At the same time, we know we can do better when millions of Americans are haunted by the fear of losing their benefits at any moment -- and when tens of thousands citizens are knocked off the insurance rolls every month. We know we can do better when it's easier to get coverage for a bypass operation than for a child's immunization.

We know we can do better when hospitals must hire four new administrators for every new doctor simply to handle the avalanche of insurance forms and paperwork now blanketing health care providers. I spoke to one nurse recently who summed up the maze of red tape this way: she said she went into nursing to care for people. If she had wanted to be an accountant, she said, she would have gone to work for an accounting firm.

Retooling a health care system that accounts for 14 percent of our national budget and is a prime culprit in our economic crisis is not a task for the weak-willed. Not every step will be smooth and painless. As we have learned from the recent budget reconciliation process in Congress, there will be times when we are forced to settle for compromises that seem ill-advised or unfair.

I know you, as hospital representatives, are discouraged by the spending limits in Medicare and I appreciate your concern. Let me just say that Medicare is a reminder of why we must address health care reform systemically rather than piece by piece. A victory here and a setback there will not determine the success of our effort overall. But our success will be determined by our courage to rise above the fray . . . our courage to transcend partisan politics, selfish interests and historical odds and fight for the larger goals we all believe in.

I'm confident that, when the dust clears and health care reform is etched into law, a new system will emerge that embraces your most vital concerns.

Why am I so confident? Because so many of the Administration's ambitions for health care reform mirror your ambitions for health care reform.

The president's plan will start from a simple premise: that Americans who work for a living, who pay the bills to take care of their families, should not be burdened by the insecurity of wondering whether they will have access to quality health care.

Security must be the heart and soul of our system. To that end, we will provide every American with a health security card that will guarantee access to a comprehensive package of

*correct*

benefits, no matter where a person works, where a person lives or whether he or she has ever been sick before.

Universal coverage is critical not only for the 40 million Americans who lack insurance, but also for you, who end up providing services to them.

Too often, people assume that hospitals are profit-hungry businesses that view patients as anonymous statistics on a financial ledger. I know it's not that simple. I know that more often decisions about who to admit and who to treat are based on medical realities and hard economics. I know a decision to absorb too many uninsured patients today might force you to close your doors tomorrow. And I know you look forward to the day when you don't have to interrogate every prospective patient about their insurance coverage.

When all Americans have a comprehensive package of benefits, hospitals will be liberated from these unfair ethical and financial dilemmas. Health care facilities like Cook County Hospital in Chicago and King/Drew Hospital in Los Angeles, which treat large populations of indigents, will be able to serve the needy people in their communities knowing they will be compensated for the care they give.

With prudent reform, we can build a new system that makes quality the first condition of health care business. We can build a system based on results, not on thousands of forms and invisible bureaucrats in offices thousands of miles away.

Still, the real trick to universal coverage and core benefits lies in expanding our philosophy of health care. We need a philosophy that encourages primary and preventive care, not expensive, Draconian interventions applied when it's too late. A philosophy that encourages doctors to practice where they are most needed. A philosophy that encourages hospitals and employers and doctors and nurses to join together to devise innovative ways of serving their communities.

Community care networks, like ones in Wellsboro, Pennsylvania and rural southwest Georgia, are wonderful examples of the broader philosophy I'm talking about. In a 10-county region of Georgia where people's lives are routinely scarred by poverty, poor nutrition, lack of medical care and chronic disease, a public-private partnership of health care providers around Columbus has shifted the emphasis from curative treatments to preventive care -- with significant results.

The Community Health Care Network developed a health status baseline to learn about the medical problems most prevalent in the region. The network has set up primary care clinics in rural areas and is working to consolidate the region's pediatric

services in one facility. A 40-foot van, equipped with two examination rooms, a mammography suite and a staff of four health care professionals offers mobile medical services to residents in the region's outer reaches.

This is clear evidence of how a community can work creatively to solve its own problems.

The president's health care plan will bolster such efforts by strengthening health care in areas historically ignored. Funds will be targeted to promote integrated delivery networks that link community-based centers with other hospitals and providers.

The Administration will also take a hard look at ways to help health care providers -- like networks in Iowa, Cape Cod, and Ukiah, California -- offer more efficient services for their communities. Hospitals should not have to spend coveted funds and file hundreds of forms and wait years and years to share an MRI machine or pool advanced ultrasound equipment.

The Administration's plan also will provide incentives for the national health service corps to encourage doctors to practice in remote and challenging parts of our country -- where many of your hospitals are located.

Everywhere I go I hear about the paucity of doctors in underserved areas. Right in the nation's capital, not far from The White House, is a stunning example of the imbalances plaguing our system: The poorest section of Washington, D.C. -- Ward 8 -- is home to 25 percent of the city's children, the highest proportion of premature babies in the city, the most children with AIDS and the largest number of infants who die before their first birthdays. Yet Ward 8 has only 6 percent of the city's pediatricians and only one of 15 city-run clinics [ck].

As a result, the only hospital in that part of the city, Greater Southeast Community Hospital, has been transformed into a giant receiving dock for every sick person in the surrounding neighborhood -- ranging from the child with a runny nose to the senior citizen suffering from a stroke. Hospital officials have estimated that 40 percent of the children who use the emergency room do not really need emergency services. By treating all of those patients -- 11 percent of whom were uninsured -- the hospital for years gave away more than \$11 million in free services and was nearly forced into insolvency.

The good news is that hospital officials at Greater Southeast broke free from the conventional mold of thinking about health care and devised imaginative new ways to bring preventive and primary care to their communities -- while also saving money.

Greater Southeast opened a school-based clinic, launched ambulatory care programs, and organized volunteers to perform blood pressure screenings at Sunday church services. The hospital made judicious investments in technology based on the needs of its community -- opting, for example, for a state-of-the-art kidney dialysis machine rather than equipment to perform open heart surgeries.

Hospital officials and community leaders also established a network of child health services that go well beyond traditional boundaries of medical care. To curb disease and illness, the hospital attacked the underlying social and physical roots of poor health: such as housing, lack of education, and emotional instability.

As hospital president Tom Chapman explained not long ago [1992] in an interview with the Harvard Business Review: "We don't just treat the illnesses our patients bring to us; we try to treat the diseases that are racking our community -- poverty, illiteracy, drugs and violence."

Thanks to the hospital's enlightened approach to health care, residents of Ward 8 are better served now and Greater Southeast is financially viable again.

These inventive, compassionate, cost-saving efforts are not going unnoticed. The president's health care plan will help connect providers with those in need and restore caring and conscience to our health care system. And his plan will make sure every American has a doctor and a health care facility within reach.

Much like your community care networks, the president's plan will create regional health alliances that offer a variety of benefits packages to consumers and businesses in a given geographic area.

The Administration's plan also will harness runaway costs and streamline our system in ways that inject new dignity and pride into the health care professions.

We will start by untangling the web of paperwork and regulation so patients and health care providers are confronted with only one insurance form -- not 1,500. We will do away with intrusive micromanagement so that hospital administrators, doctors and nurses can make decisions based on sound medical judgment rather than on reimbursement schedules. We will also simplify well-intentioned regulations like CLIA that currently burden the system.

The president's plan will also apply more vigilance to the special problems of older Americans, many of whom now seek

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treatment in your facilities. There will be increased options for home and community-based care services and greater protections for nursing home residents. There will be a new federal home care program for disabled citizens, regardless of income.

These innovations will help shift the emphasis from institutionalization to a broad range of settings. Again, the result will be more cost-effective, higher quality care.

Finally, we will insist that, for the first time ever, everyone pay their fair share in the health care system. That means the government, hospitals, drug companies, doctors, nurses, individuals, and so on.

After all, why should drug companies charge twice or three times in America what they charge overseas for prescription drugs?

Why should employers who don't provide coverage for their workers be allowed to drive up costs for businesses who do?

And why should individuals who think insurance is unnecessary force the rest of us to pick up the tab when they have a serious accident or an unforeseen illness and end up in the emergency room or the ICU.

We must establish new priorities, new incentives, and new partnerships. We must all take responsibility. We must all contribute.

Obviously, reaching a consensus on health care reform and drafting it as legislation and navigating it through Congress will not be easy. There will be skeptics and naysayers and special interests who resist change of any sort. There will be some who are uncomfortable with portions of the plan and will nibble around its edges. There will be others who -- instead of acting -- prefer talking, dissecting, analyzing.

But if the rest of us are brave enough to demand change now -- if we are brave enough to demand more humanity, more fairness and more efficiency in our system -- we will spare our nation unprecedented chaos and agony in the years ahead.

Too many times, individuals and interest groups -- and particularly the government -- have marched to the edge of health care reform, only to cower in fear and walk away.

Too many times, we have had the chance to save millions of dollars and millions of lives and instead we have turned our backs and walked away.

GOOD  
STAND  
ENDING

Too many times, we have watched as one political party blamed the other for a system gone awry -- and while they were all pointing fingers, the problems got worse and our government walked away.

Now, after wasting so many opportunities. . . after witnessing two decades of rising health care costs and watching our problems grow more intractable . . . we have reached a crisis point where change is our only option.

How many more meetings do we need? How many more plans? How many more brochures? How many more dollars piling on to our national debt before we show the courage to step up and take responsibility?

This is not a partisan or ideological issue. It's about our ability to lead our children and grandchildren into the future. It is about our moral duty to leave them a better world than the one we found.

Right now, we are poised on the brink of historic change. We have an opportunity to reform our system before it's too late.

With your record of progressive thinking on medical care, with your courage as health care innovators, we have one more chance to make a difference for a generation of Americans who are depending on us to act. If we are bold enough, we can join together now -- not as Democrats or Republicans or liberals or conservatives -- but as Americans committed to safeguarding our nation's future health and well-being.

This time, let's not walk away. This time, let's lead the way.

Thank you all very much.

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**American Hospital Association**  
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**"FAX" COVER SHEET****To:** Amy Nemko - White House Communications**From:** Alicia Nulty**Date:** 8/4/93**Pages:** 12

**Comments:** Amy - I will fax you the listing of award recipients as soon as it's available. You should have everything else that you need. Please call me @ 202-2339 if you need additional information. Thanks -  
Alicia

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### COLLECTION:

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#### Presidential Records Act - [44 U.S.C. 2204(a)]

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American Hospital Association

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Office of the President

840 North Lake Shore Drive  
Chicago, Illinois 60611**RICHARD L. DAVIDSON**

Dick Davidson has been president of the American Hospital Association since July, 1991. He came to the AHA after 22 years as president of the Maryland Hospital Association.

Born [REDACTED] (b)(6) [REDACTED] he earned his bachelor's and master's degrees in education from West Chester State College and Temple University, respectively, both in Pennsylvania, and a doctorate in education from Washington, D.C.'s George Washington University.

He began his health care career as a patient. He was recuperating from a back injury in a Delaware hospital in 1965 when the then-school teacher and principal was recruited by the hospital administrator for the job of director of education for the Maryland-District of Columbia Hospital-Delaware Association.

Davidson became the Maryland Hospital Association's first president in 1969. During his years there, he was involved in many local, state and national health policy groups and initiatives. Under his leadership, the organization was recognized nationally for its work on trustee involvement in state association affairs, payment reform, the development of clinical quality indicators, and medical and corporate values and ethics in the hospital setting. He consulted for national foundations, served on editorial boards and earned a wide reputation as a writer and speaker on contemporary health issues, as well as the future of health care financing and delivery in America. He was also a volunteer leader and officer with a Maryland organization devoted to the health care needs of an unpopular segment of the population: the homeless.

He has been active with the AHA for 25 years, volunteering his time for task force and advisory bodies on issues as diverse as nursing and prospective payment.

He resides in the nation's capital with his wife Janet. They are the parents of three sons and have three grandchildren.

The American Hospital Association, with offices in Washington, D.C. and Chicago, is the nonprofit organization that serves as the national advocate for hospitals and the patients and communities they serve. It provides education and information for its members and informs the public about hospitals and health care issues.

## 1993 AHA BOARD OF TRUSTEES

### Chairman Officers

#### **Mathis, Larry L., Chairman of the Board of Trustees**

Mr. Mathis has been president and CEO of Methodist Hospital, Houston, since 1983, following a career at Methodist that began in 1971 as administrative resident. He received his BA from Pittsburgh State University, Pittsburgh, KS, and his MHA from Washington University, St. Louis.

As chairman of the Board of Trustees, he also chairs the Executive Committee and attends meetings of the Finance Committee. Mr. Mathis was a member of the Board of Trustees through 1991 and served as chairman of the Institutional Practices Committee and as a member of the Executive Committee. He was chairman of the Council on Research and Development in 1987, and was a delegate in the AHA House of Delegates. He served on the governing council of the Section for Metropolitan Hospitals, on the Special Committee on Mission and Priorities, and on the Policy Committee. He has been active in the Texas Hospital Association and the Greater Houston Hospital Council. He was born in 1943, is divorced, and has two daughters. His term on the Board will expire in 1994.

**BYLAWS OF THE AMERICAN HOSPITAL ASSOCIATION****ARTICLE 1 - NAME AND OBJECT**

1.1 This Association shall be known as the American Hospital Association.

Mission  
Statement

1.2 Its mission shall be to promote high-quality health care and health services for all the people through leadership in the development of public policy, leadership in the representation and advocacy of hospital and health care organization interests, and leadership in the provision of services to assist hospitals and health care organizations in meeting the health care needs of their communities.

**ARTICLE 2 - MEMBERSHIP**

2.1 Membership on an institutional or a personal basis shall be available to organizations and individuals interested in the object of the Association, on application and election as provided herein. The term "state," wherever used in these bylaws, shall include states of the United States of America, the District of Columbia, and the Commonwealth of Puerto Rico.

2.2 Conditions of membership and definitions of the terms hospital, health care system, and health delivery and educational organizations shall be determined by the Board of Trustees as set forth in the Association Regulations.

2.3 Hospital members shall be of the following types:

2.3.1 Type I shall include hospitals, both general and special, that care primarily for patients with conditions normally requiring a comparatively short stay. Type I-A shall include short-term hospitals that are freestanding or operating units of health care systems not holding type III membership, and type I-B shall include short-term hospitals that constitute the operating units of health care systems holding type III membership.

2.3.2 Type II shall include all other hospitals that provide inpatient care. Type II-A shall include long-term hospitals that are freestanding or operating units of health care systems not holding type III membership, and type II-B shall include longer-term hospitals that are operating units of health care systems holding type III membership.



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**AMERICAN HOSPITAL ASSOCIATION  
OFFICERS/BOARD OF TRUSTEES  
RPB, Committee and Subsidiary Board Assignments**

Effective January 1, 1993

| <u>NAME</u> | <u>BUSINESS ADDRESS &amp; TELEPHONE</u> | <u>HOME ADDRESS &amp; TELEPHONE</u> |
|-------------|-----------------------------------------|-------------------------------------|
|-------------|-----------------------------------------|-------------------------------------|

Chairman of the Board

Larry L. Mathis

President/Chief Executive Officer  
The Methodist Hospital System  
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President

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Exec. Sec.: Barbara Brown (Washington)  
Nevin Crouse (Washington)  
Staff Assoc.: Nancy Kennedy (Chicago)  
312/280-6487  
Fax # 312/280-4153

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M.D.

(Suzanne)

Term expires 1994

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(Mary Ruth)

Term expires 1996

RPB #6 (at-large trustee)

Fin. Comm.

President & CEO  
Christian Health Services  
11155 Dunn Road, Suite 300-N  
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Fax # 314/653-4499

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St. Mary Caritas, S.P.  
Term expires 1993

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Mercy Hospital  
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Fax # 413/781-7217

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(617) 738-1193

Secretary: Karen Poznick

- 3 -

C. Duane Dauner  
(Colette)

Term expires 1996

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Hearing Comm.

PAC Comm.

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Secretary: Barbara Ochalski

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Hearing Comm.

PAC Comm.

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PAC Comm.

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Secretary: Jean Harrison

Robert B. Kennedy  
Term expires 1993

RPB #8 (at-large trustee)

Fin. Comm.

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(801) 322-8000  
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Salt Lake City, UT 84102  
(801) 355-7507

Secretary: Virginia Ready

- 4 -

John D. Leech  
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4702 Richey Road  
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(509) 966-3006

Secretary: Millie Haupt

Henry E. Manning  
(Hope H. Snider, M.D.)  
Term expires 1993  
RPB #5 (at-large trustee)  
AHPI Board

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The MetroHealth System  
Southpoint Office  
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Secretary: Linda Knable

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IPC (CH)  
Exec. Comm.

Executive Director  
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Secretary: Sharon Altman

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Secretary: Virginia Ralston

\*Preferred mailing address

- 5 -

Michael D. Pugh  
(Drucilla)  
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Hearing Comm.  
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President/CEO  
Parkview Episcopal Medical Center  
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Secretary: Cindy Moore

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Hearing Comm.

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Secretary: Jean Scanlon

Gail L. Warden  
(Lois)  
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RPB #5 (at-large trustee)  
Pol Dev Coord Comm

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Secretary: Joyce Tassinare

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Hearing Comm.  
Fin. Comm.  
PAC Comm.

President  
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Fax # 915/670-2209

1810 Woodridge  
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Secretary: Judy Arthur

Donald H. Zornes  
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Term expires 1993  
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Hearing Comm.  
PAC Comm.

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Columbus Community Hospital, Inc.  
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Fax # 402/563-9673

2860 Maple Road  
Columbus, NE 68601  
(402) 564-6180

Secretary: Hazel Saalfeld

**Background, Awards Presented at  
Opening Session, AHA Orlando Convention  
August 9, 1993**

**Justin Ford Kimball Award**

(Named after the founder of the concept of voluntary prepayment for health insurance; first presented in 1958. The award honors an individual who has contributed to the development of private alternatives to financing health care and hospital services.)

Presented to Dr. John C. Lewin, director of Hawaii's Department of Health.

In part, the award citation reads:

"He has carried out Hawaii's groundbreaking effort for universal coverage primarily through workplace coverage. And, as a final piece, he created the public-private partnership of the State Health Insurance Program, where the state, private insurance companies, and providers work hand-in-hand to assure services ranging from preventive measures to hospital care."

**Foster G. McGaw Prize**

(The prize is awarded annually by The Baxter Foundation in cooperation with the American Hospital Association, and carries with it a \$75,000 cash award. It honors hospital excellence in community service, particularly in meeting diverse health and social needs. The Prize is intended to inspire hospitals and communities to examine their responsibilities and strive for new solutions to health problems.)

This year's winner is The Cambridge Hospital, Cambridge, Massachusetts. John O'Brien is its CEO, and is scheduled to accept the award. The multicultural staff of this 186-bed public teaching hospital serves a diverse community that includes an unusually high proportion of families in poverty. Despite the reputation gained from its prestigious educational institutions, a significant portion of the residents of Cambridge have a high incidence of infant mortality, substance abuse, family violence, AIDS, and homelessness. The Cambridge Hospital has developed an array of programs to address these problems, including:

- o Health Care for the Homeless
- o Housecalls for the Homebound Elderly
- o Multidisciplinary AIDS program

- o School-based Teen Health Center
- o Linguistic Mental Health Teams (serving Latino, Portuguese, and Haitian patients)

### Distinguished Service Awards

(The highest honor the American Hospital Association can present to an individual in the field of health care administration. Nominee qualities include: improving welfare of hospitals patients and the community; improving administration methods; serving local, state, or national health care organizations; assisting or collaborating with other hospitals.)

Two distinguished service awards are being given this year. The first goes to Ed Connors, president emeritus of Mercy Health System, Farmington Hills, Michigan. His award citation reads in part: . . . an unswerving dedication to the fundamental dignity and worth of each person, and a deep compassion for individuals in need. It is reflected in his seminal role in developing and promoting integrated regional health care systems, and leadership in national policy debate."

Jack Owen has served in many hospital association leadership capacities, including president of the New Jersey Hospital Association in the 1960s. As director of AHA's Washington Office from 1982-1989, he earned a reputation for integrity and reliability in the highly-political Washington environment, forging a bond of trust that benefitted all hospitals. Jack has also served as AHA interim president (immediately before current president Dick Davidson's tenure) and now serves as president of the American Hospital Association Services, Inc., the holding company for AHA's publishing and insurance subsidiaries.

# U.S. Factory Orders Rose 2.6% in June; Weakness Is Still Seen in Manufacturing

## Washington Wire

A Special Weekly Report From  
The Wall Street Journal's  
Capital Bureau

AI

**CLINTON MUST COURT** Republicans on key issues beyond the budget bill.

With strong protectionist sentiment among Democrats, he can't win the free-trade pact without GOP support. Health-care overhaul also will require a bipartisan approach. Some Republicans are eager to prove they aren't obstructionists, but Clinton must show more acumen to reach them.

New York Rep. Boehlert, a moderate Republican who at times has backed Clinton, says he is "amazed" at the lack of contact from the White House. Clinton aides begin regular strategy sessions with GOP lawmakers who favor the trade pact. Republicans will be invited to high-profile events such as Clinton's visit with the pope.

*Clinton continues to consult with Nixon on foreign policy; next weekend he will visit and golf with Gerald Ford in Vail, Colo.*

**TEMPORARY TAX PROVISIONS** keep giving and campaign donations alive.

The research tax credit, which had big money behind it, would be extended through June 1995. The 26 corporate members of the Council on Research and Technology gave more than \$2.3 million in direct campaign donations last election, according to an analysis by the Center for Responsive Politics. Among the biggest givers: Eli Lilly, Southwestern Bell and Pfizer.

Four other provisions, including a targeted jobs tax break for hiring the disadvantaged, would be kept alive only through 1994. "Lobbyists delight at the endless crises of expiring provisions; they pay the mortgage," says California Rep. Stark. That's "cynical" and "insulting," retorts William Signer, a lobbyist for the jobs tax credit.

**POLITICAL LOSERS** outnumber winners in the messy budget debate.

"Republicans look terrible. Ross Perot looks worse, the president looks phenomenally weak," says political analyst Charles Cook. Oklahoma Sen. Boren makes enemies in Washington for cutting out on Clinton, but probably scores at home. Rep. Gibbons, the No. 2 man on the Ways and Means panel, upsets colleagues with comments that he is ready to take the top post if Rep. Rostenkowski is indicted.

Among the winners: Black Caucus head Rep. Mfume and New York Rep. Rangel, who got key demands such as earned income tax credits for the working poor in the final bill. House Majority Leader Gephardt also "looks pretty good" by keeping House Democrats in line, says GOP political analyst Doug Bailey.

*Another possible winner: The congressional term-limit movement, which is working toward ballot initiatives in eight states in 1994.*

**LEFTOVERS:** Unable to get a "nanny tax" revision now, Sen. Moynihan promises to try again to raise the wage threshold for paying Social Security taxes for domestic workers from the current \$50 a quarter. Also pending are tax simplification proposals.

**FIRE AND BRIMSTONE:** The Christian Coalition spent more than \$150,000 on radio ads, phone banks, mailings and other actions to fight the budget bill as "anti-family," says coalition director Ralph Reed. Among 14 targeted House members in 11 states, Texas Rep. Stenholm deserted the White House this week.

**FUEL FIGHT:** The methanol industry failed to get a lower fuel-tax rate for both methanol and ethanol in the budget bill partly because ethanol advocate Sen. Daschle wouldn't back it. Ethanol champion Sen. Dole also sat out the debate.

**JEOPARDY?** A solicitation for a Virginia political fund-raiser last weekend featuring former federal prosecutor Jay Stephens suggested that, if asked, he "will take you into" his investigation of Rep. Rostenkowski. Stephens, whose public comments have been criticized as unethical by legal experts, refused to return calls.

**BUDGET-BILL FALLOUT** raises concerns about the next big battle: health care.

Many doctor and hospital groups that accepted Clinton's proposed \$50-billion Medicare cutbacks feel burned by his willingness to agree to even more reductions when the going got tough. "What we saw is that when you get into a fight, you can get thrown overboard by some other interest," says Dick Davidson, the American Hospital Association's president.

Administration officials eye Sept. 21 as a possible launch date for the health-overhaul proposal. Clinton plans to set the stage for a big health-care push in a mid-August speech to a governors forum in Tulsa, Okla.

*The key remaining decision: How to pay for the plan. Clinton may find that the budget debate has only heightened anti-tax sentiment.*

**MINOR MEMOS:** Some Republicans suggested Missouri's Danforth instead of Dole to give the GOP's televised attack on Clinton's economic plan, but had second thoughts about the multimillionaire senator bashing a bill that raises taxes on the rich. ... Former Bush economic adviser Michael Boskin writes that Clinton deserves the "Dizzie Dean Award" for "illiterate" budget remarks; Is there a Dizzie Dean award for illiterate sports metaphors?

—RONALD G. SHAFER

By ELIOT MORGAN

Staff Reporter of THE WALL STREET JOURNAL  
**WASHINGTON** — Orders to U.S. factories increased in June for the first time in four months, but analysts are still wary about the manufacturing sector's health.

The Commerce Department said new orders jumped 2.6% to \$254.77 billion in June, the biggest rise of the year. But the increase was concentrated in aircraft, a category that tends to swing wildly from month to month.

"This is a bounce back in a fairly volatile sector. While that is encouraging, it would certainly be nice to see a more broadly based rebound," said John Godfrey, chief economist of Barnett Banks Inc. in Jacksonville, Fla.

### A Rocky Road

The manufacturing sector has been on a rocky road since the start of the year, with employment cutbacks and slowdowns in production and new orders. Analysts said June's big increase in factory orders didn't change the picture of a weak industrial sector.

Aside from transportation, only orders for electronic equipment improved among durable goods—those intended to last more than three years. Orders for stone, clay and glass products and industrial machinery and equipment declined. In the nondurable goods sector, orders for chemicals, allied products and food increased. The largest drops were in orders for paper products, petroleum and coal.

Some analysts said the automobile sector is the brightest spot in the manufacturing picture. Orders for motor vehicles and parts jumped 4.6% in June, suggesting increased production and, possibly, employment.

"Auto manufacturers have said they will have their assembly lines humming," said James Smith, professor of finance at the University of North Carolina. "A better auto sector . . . will boost the manufacturing sector back to positive territory."

### Unfilled Orders Fell

A trouble spot in the factory-order report was the fourth consecutive drop in unfilled orders. That suggests manufacturers will not add significantly to employment because they are meeting demand with their current work force.

Separately, the Labor Department said initial claims for state unemployment benefits fell 60,000 in the week ended July 31 to 336,000 from a revised 396,000 the previous week. It was the largest drop since August of last year and stemmed mainly from the end of layoffs in the auto industry. Economists say there could be a pickup in automobile production prior to labor negotiations and a potential strike this fall. The Labor Department said part of the big drop also comes in part from flooding in the Midwest, but estimates of the flood's impact aren't yet available.

The four-week moving average of claims, which analysts say is a better marker of labor-market conditions, was 353,000, up from 352,250 in the previous week.

All figures have been adjusted for normal seasonal variations.

#### FACTORY ORDERS

Here are the Commerce Department's latest figures for manufacturers in billions of dollars, seasonally adjusted.

|                          | June 1993 | May 1993 | % Chg. |
|--------------------------|-----------|----------|--------|
| All industries           | 254.77    | 249.34   | + 2.2  |
| Durable goods            | 131.65    | 126.78   | + 3.8  |
| Nondurable goods         | 123.12    | 121.55   | + 1.3  |
| Capital goods industries | 39.25     | 35.37    | + 11.0 |
| Nondefense               | 33.37     | 29.93    | + 11.5 |
| Defense                  | 5.88      | 5.43     | + 8.1  |
| Total shipments          | 254.45    | 254.81   | - 0.1  |
| Inventories              | 381.34    | 381.59   | - 0.1  |
| Backlog of orders        | 454.24    | 442.15   | + 2.7  |

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