Records Mgmt.

THE WHITE HOUSE

WASHINGTON

November 17, 1993

Paul Samuels/Ellen Weber
Legal Action Center
236 Massachusetts Avenue, NE
Suite 510
Washington, DC 20002

Dear Paul and Ellen:

Thank you for your recent letter on how the Administration can increase federal funding for drug treatment and prevention programs. Carol Rasco and I appreciate you taking the time to share your policy recommendations with us, and we're pleased that you thought the Interim Drug Strategy made a "compelling case."

The Administration is currently reviewing options for the President's FY 1995 budget, and increasing drug treatment and prevention funds is one of the drug priorities on which we are focusing. Along with the other social investments that the Administration was not able to obtain in the FY 1994 appropriations process, we -- and that includes the President -- were not pleased about the cuts in treatment and prevention monies and are determined to do better next fiscal year.

We can also do a better job of interdiction, and the Administration -- by way of a Presidential Decision Directive recently signed by the President -- has embraced a new international drug control policy that calls for a "controlled shift" from generalized interdiction activities to other more effective international programs. However, given that monies in the drug budget are not necessarily fungible, we are reluctant to tie any increases in drug treatment and prevention to a "shift" from our interdiction accounts. We believe are drug treatment and prevention investments are too important to be tied to the fate of other programs.

Again, thank you for your letter. Carol and I will keep your suggestions in mind as we make our through the budget process during this next month.

Sincerely,

Jose Cerda III
Senior Policy Analyst

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

16-Nov-1993 05:54pm

TO: Rosalyn A. Miller

FROM: Jose Cerda, III
Domestic Policy Council

SUBJECT: Draft of Legal Action Center -- "weber.let"

Roz,

I have attached a draft of the Legal Action letter in case you or Carol would like to review it. I'll send it out tomorrow afternoon. Please call me beforehand if you should have any edits. Thanks.

Jose

A PC Data File is attached. Use PCT SAD to download to your PC

OFFICE OF DOMESTIC POLICY

THE WHITE HOUSE

FROM THE OFFICE OF: **CAROL H. RASCO**
ASSISTANT TO THE PRESIDENT
FOR DOMESTIC POLICY

OCT 28 REC'D

TO: Jose

DRAFT RESPONSE FOR CHR BY:

PLEASE REPLY (COPY TO CHR):

PLEASE ADVISE BY:

LET'S DISCUSS:

FOR YOUR INFORMATION:

REPLY USING FORM CODE:

FILE:

RETURN ORIGINAL TO CHR:

SCHEDULE:

REMARKS:

Sonya Sligo reply needed by 11/11

Tickle File Friday 11/5

x2564 for Reply

Sent/Logged 10/29

LEGAL ACTION CENTER

236 Mass. Ave. NE, Suite 510 • Washington, DC 20002 • (202) 544-5478 • FAX: 544-5712

OCT 2 8 REC'D

October 25, 1993

Carol Rasco
Assistant to the President
for Domestic Policy
The White House
1600 Pennsylvania Avenue, N.W.
West Wind 2nd Floor
Washington, D.C. 20500

Dear Ms. Rasco:

We are writing on behalf of the Legal Action Center and the National Coalition of State Alcohol and Drug Treatment and Prevention Associations to urge you to invest at least $1 billion in new funds for drug and alcohol treatment and prevention services in the Administration's FY 1995 budget.

The Legal Action Center is a not-for-profit organization specializing in the legal and policy issues surrounding drugs, alcohol and HIV/AIDS. The National Coalition is composed of the undersigned twenty state-based treatment and prevention associations whose members provide services to persons with the most chronic drug and alcohol problems -- those who are the focus of your new drug strategy.

We applaud your Interim Drug Strategy for making the compelling case for elevating treatment and prevention to the forefront of our Nation's drug and alcohol control efforts. You clearly understand how drug and alcohol problems underlie so many of our most serious problems, including violence, HIV/AIDS, family disruption and homelessness.

But your new strategy can only work with a firm commitment of new funds. At the unveiling of the strategy before the Senate Judiciary Committee, there was broad bipartisan support for increased funding for treatment and prevention. Senators from both sides of the aisle advocated for an equal split in funds between treatment and prevention, on the one hand, and law enforcement and interdiction, on the other.

We and many other national organizations support the shifting of funds from ineffective international and boarder interdiction efforts to treatment and prevention. We have attached a position paper endorsed by 50 organizations calling for a shift in funds to support the priorities in your drug strategy.

153 Waverly Place • New York, NY 10014 • (212) 243-1313 • FAX: (212) 675-0286

We cannot wait until the passage of health care reform to begin the expansion of treatment and prevention services. We urge you to increase funding for these services by at least $1 billion in your FY 1995 budget and to make this funding a priority in the FY 1995 appropriations process.

Thank you for considering our views.

Sincerely,

Paul Samuels
Paul N. Samuels
Director/President

Ellen Weber
Ellen M. Weber
Co-Director of National Policy

◆ ◆ ◆

National Coalition of State Alcohol and Drug Treatment and Prevention Associations

Alabama Alcohol and Drug Abuse Association
Arizona Association of Behavioral Health Programs
California Association of Alcoholic Recovery Homes
California Therapeutic Communities, Inc.
County Alcohol and Drug Program Administrators Association of California
Florida Alcohol and Drug Abuse Association
Georgia Association for the Prevention and Treatment of Substance Abuse
Illinois Alcoholism and Drug Dependence Association
Iowa Substance Abuse Program Directors' Association
Maine Association of Substance Abuse Programs
Massachusetts Alcoholism and Drug Abuse Association
Nevada Association of State Drug Abuse Programs
New Jersey Association for the Prevention and Treatment of Substance Abuse
New York State Association of Substance Abuse Programs
North Carolina Association of Alcohol and Drug Service Administrators
Association of Ohio Substance Abuse Programs
Drug and Alcohol Service Providers Organization of Pennsylvania
Drug and Alcohol Treatment Association of Rhode Island
Tennessee Alcohol & Drug Association
Wisconsin Association on Alcohol & Other Drug Abuse

A NEW DRUG BUDGET:
RECOMMENDATIONS FOR NEW FUNDING PRIORITIES

August 1993

Endorsed By:

ACORN
AFL-CIO
AIDS Action Council
Alcohol and Drug Problems Association
American Association for Marriage & Family Therapy
American Counseling Association
American Federation of State, County and Municipal Employees (AFSCME, AFL-CIO)
American Hospital Association
American Methadone Treatment Association
American Nurses Association
American Psychological Association
American Public Health Association
American Society of Addiction Medicine
Association of Halfway House Alcoholism Program
Association of Halfway House Alcoholism Programs of North America
Association of Junior Leagues International
Association of Maternal and Child Health Programs
Center for Science in the Public Interest
Catholic Charities, USA
Child Welfare League of America
Children of Alcoholics Foundation
Clergy for Enlightened Drug Policy
Consortium of Comprehensive Addiction Programs
CURE
Family Service America
International Substance Abuse Education Association
Latino Council on Alcohol and Tobacco
Legal Action Center
National Association of Addiction Treatment Providers
National Association of Alcoholism and Drug Abuse Counselors
National Association of Black Substance Abuse Workers, Inc.
National Association for Children of Alcoholics
National Association of Public Hospitals
National Association of State Alcohol & Drug Abuse Directors

National Black Police Association

National Center for Clinical Infant Programs
National Coalition of State Alcohol and Drug Treatment and Prevention Associations
National Consortium of TASC Programs
National Council of Community Mental Health Centers
National Council on Alcoholism and Drug Dependence
National Health Care for the Homeless Council
National Treatment Consortium, Inc.
PITCH - Prevention, Intervention and Treatment Coalition for Health
Service Employees International Union
Society of Americans For Recovery
The Center for Child Protection and Family Support
The Criminal Justice Policy Foundation
The Marin Institute
Therapeutic Communities of America
Women's Legal Defense Fund

A NEW DRUG BUDGET:
RECOMMENDATIONS FOR NEW FUNDING PRIORITIES

I. Ineffectiveness of the Current Federal Drug Policy

Drug dependence and alcoholism are complex health problems that affect all Americans, devastate families and communities and cost an estimated $140 billion to $300 billion every year.

Our nation's drug and alcohol problem is severe:

- Heroin addiction among adults and serious drug use among adolescents are again on the rise;
- Courts, jails and prisons are overflowing with individuals who have drug problems, but few receive adequate treatment;
- Emergency rooms and other health care facilities are filled with addicts and alcoholics whose drug and alcohol problems often have not been diagnosed;
- The child welfare system is at the breaking point, unable to care for the increasing numbers of infants and children who need foster care placement as a result of their parents' addiction;
- The AIDS epidemic is increasingly fueled by drug users who infect their needle-sharing and sexual partners and children, accounting for over 1/3 of all reported AIDS cases and most new cases.

Over the past twelve years, the Federal Government has invested more than 70% of the anti-drug budget —- nearly $50 billion from 1982 through 1993 —- in law enforcement and interdiction activities. That substantial investment has not reduced the supply of drugs in the country, drug-related crime or violence or the number of people with serious drug and alcohol problems. **Prevention and treatment programs, however, do effectively reduce the demand for drugs and alcohol and must be an equal partner with domestic law enforcement efforts.**

II. Recommendations for a New Federal Policy

1. Add $3 billion to FY 1994 and FY 1995 appropriations for "demand reduction" programs — education, prevention, rehabilitation, treatment and research – to implement the Senate's Sense of the Congress Resolution of March 25, 1993 calling for equalization of funding between demand reduction and supply

reduction activities

2. **Pay for this expanded prevention and treatment by transferring to the Department of Health and Human Services approximately $3 billion from interdiction and international efforts (not domestic law enforcement), as follows:**

   - **Department of Defense interdiction and counter-drug activities: $1.168 billion requested in the Administration's FY 1994 budget.**

   - **Coast Guard and Customs Service interdiction activities: $986 million requested in the Administration's FY 1994 budget.**

   - **Andean Drug Initiative: Approximately $700 million remaining for FY 1994.**

These funds should be used to:

- expand effective and accessible prevention services in schools, communities, workplaces and locations that have contact with out-of-school youth, women and unemployed adults;

- move toward "treatment on demand" by extending effective and accessible treatment to the estimated 2 to 3 million individuals who need but cannot obtain it;

- enhance the infrastructure and workforce of the existing publicly funded treatment and prevention system and enable these programs to provide primary health care and child care services required by federal law;

- provide treatment to all with drug or alcohol problems in the criminal justice system, both within prisons and jails and through diversion programs to community-based treatment programs for the large percentage of addicted offenders who need not be incarcerated; and

- expand treatment services for drug and alcohol dependent women and their children.

III. The Benefits of a New Federal Policy

The societal costs and human suffering associated with drug and alcohol abuse could be reduced dramatically if we invested funds to prevent and treat these highly treatable illnesses.

Numerous studies show that treatment works, dramatically reducing drug and alcohol

use, reducing crime and slowing the spread of AIDS. Moreover, the cost of treatment is more than offset by lowering health care and emergency room utilization and reducing criminal justice and foster care costs. A University of California study found that for every $1 spent on treatment, $11.54 was saved in health care, criminal justice and lost productivity costs.

The proposed FY 1994 drug control budget is modeled after the lopsided, supply reduction-driven budgets of the previous administrations. The Nation cannot afford to let another year pass without addressing the fundamental problem that truly drives the nation's drug crisis: the demand for drugs by people with serious drug and alcohol problems and those at high risk for such problems who continue to go untreated.

***

For additional information, please contact Ellen Weber or Susan Galbraith of the Legal Action Center (202) 544-5478

NATIONAL AIDS POLICY OFFICE
OFFICE OF THE COORDINATOR

ROUTING SLIP

DATE: 11/21

TO: Rosalyn Kelly

FROM: ✓ W. STEVE LEE

✓ For your information

____ For your action

____ Review and comment by (date) ____

____ Prepare reply for Coordinator's signature

____ Reply directly and blind copy Coordinator

____ **Circulate**/forward to: ____

____ File

COMMENTS: This is our standard response to what appears to be a standard request.

Steve.

NOV 29 REC'D

Records Mgmt.

THE WHITE HOUSE

WASHINGTON

November 21, 1993

Gloria Maki, Project Director
New York City Pediatric/Adolescent
Family HIV Comprehensive Center
New York Department of Health
Corning Tower
Albany, NY 12237

Dear Ms. Maki:

I am just starting my review of agency proposals for the FY95 budget. The funding for Ryan White programs, including Title IV, is of particular concern and I will be paying close attention to requests in this area. The pediatric programs you describe have been a critical part of our efforts to serve children with HIV. Thank you for writing.

Sincerely,

Kristine M. Gebbie
National AIDS Policy Coordinator

cc: ✓Carol Rasco, Domestic Policy Council
Surgeon General Joycelyn Elders

OFFICE OF DOMESTIC POLICY

THE WHITE HOUSE

FROM THE OFFICE OF: **CAROL H. RASCO**
ASSISTANT TO THE PRESIDENT
FOR DOMESTIC POLICY

TO: Gabbie

DRAFT RESPONSE FOR CHR BY: _____

PLEASE REPLY (COPY TO CHR): _____

PLEASE ADVISE BY: _____

LET'S DISCUSS: _____

FOR YOUR INFORMATION: _____

REPLY USING FORM CODE: _____

FILE: _____

RETURN ORIGINAL TO CHR: _____

SCHEDULE: _____

REMARKS:

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

NOV 15 1993

November 8, 1993

Kristine Gebbie, R.N.
National AIDS Policy Coordinator
The White House
750 17th Street, NW
Washington, DC 20503

Dear Ms. Gebbie:

I am writing to thank you for supporting the FY 1994 consolidation of funding for the Pediatric/Family AIDS Demonstration Program within Title IV of the Ryan White CARE Act, and to urge a significant increase for Title IV in the President's Budget Request for FY 1995.

As you know, Congress recently completed the Labor/HHS appropriations conference. Despite the President's request of $21 million for the Pediatric/Family AIDS Demonstrations and $6 million for Title IV in FY 1994, the final appropriation was only $22 million. This represents a $1 million increase out of a total increase of $210 million for other Titles of the CARE Act. The pediatric, adolescent and family AIDS demonstrations that are now a part of Title IV have been essentially level funded for the past three years.

I am now writing to strongly urge that as the Department of Health & Human Services finishes its FY 1995 budget request and submits it to the Office of Management of Budget, that the funding request for Title IV of the Ryan White CARE Act be increased to $42 million. While consolidation of funding within Title IV will enhance the delivery of services and access to clinical trials for children, adolescents and families affected by HIV disease, it does not diminish the need for substantial new funding in FY 1995.

As you know, HIV infection rates among women, adolescents and children have rapidly increased. Many service sites in New York City and other urban areas of New York State have experienced a doubling or tripling of their caseloads while their funding levels have remained nearly static. Last year, following a thorough review of funding needs, the Pediatric AIDS Coalition and the National Organizations Responding to AIDS Coalition in Washington, D.C. recommended at least a $42 million appropriation for Title IV programs over current funding levels of approximately $21 million. These funds are vitally needed for reaching underserved, low income African-American and Hispanic women, adolescents, children and families who are disproportionately affected by HIV infection.

Title IV of the CARE Act has now become an important vehicle for providing funds to deliver specialized, comprehensive pediatric and adolescent HIV services throughout the United States. If you or your staff need further information related to programs funded under Title IV, please contact David Harvey, Coordinator for Public Policy at the National Pediatric HIV Resource Center (202-289-5970) in Washington, D.C.

Thank you for your consideration of this request.

Sincerely,

Gloria Maki

Gloria Maki
Project Director
New York City Pediatric/
Adolescent Family HIV
Comprehensive Center

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

November 8, 1993

Carol H. Rasco
Assistant to the President for Domestic Policy
Executive Office of the President
The White House
Washington, DC 20500

Dear Ms. Rasco:

I am writing to thank the Administration for supporting the FY 1994 consolidation of funding for the Pediatric/Family AIDS Demonstration Program within Title IV of the Ryan White CARE Act, and to urge a significant increase for Title IV in the President's Budget Request for FY 1995.

As you know, Congress recently completed the Labor/HHS appropriations conference. Despite the President's request of $21 million for the Pediatric/Family AIDS Demonstrations and $6 million for Title IV in FY 1994, the final appropriation was only $22 million. This represents a $1 million increase out of a total increase of $210 million for other Titles of the CARE Act. The pediatric, adolescent and family AIDS demonstrations that are now a part of Title IV have been essentially level funded for the past three years.

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Thank you for your consideration of this request.

Sincerely,

Gloria Maki

Gloria Maki
Project Director
New York City Pediatric/
Adolescent Family HIV
Comprehensive Center

DEPARTMENT OF HEALTH & HUMAN SERVICES

October 26, 1993

Office of the Assistant
Secretary for Health
Surgeon General of the Public
Health Service
Washington DC 20201

This correspondence was sent to my attention. I thought you might be interested.

M. Joycelyn Elders, M.D.

response sent from this office to sender. We also recvd direct reply. Copy sent to Dr Elders

Chris Gobble

PHS CORRESPONDENCE

160899

REFERRAL DATE: 9-23 **DUE DATE:** 10-7

TO:

2 ☑ ASH
3 ☑ DEPUTY ASH
4 ☑ SG
5 ☑ DASH-MO
☐ DASH-SE

☐ DASH-C
☐ DASH-DPHP
1 ☑ DASH-IGA / RHA
☐ DAS-IH
☐ DAS-MH
☐ DASH-PA
☐ DAS-PHP

☐ ADAMHA
☐ AHCPR
☐ ATSDR
☐ CDC
☐ FDA
☐ HRSA
☐ IHS
☐ NIH

6 ☑ NAPO
☐ NVP
☐ PCPFS

☐ OEEO
☐ OEP
☐ OGC / H
☐ OHL
☐ OHPE
7 ☑ OM
☐ OSIR
☐ OWH

8-9 ☑ ES / PHS RAR, VBW

☐ OTHER _____

ACTION:

☐ SECRETARY'S SIGNATURE
1 ☑ ASH SIGNATURE
☐ DIRECT REPLY
☐ _____ SIGNATURE
☐ DRAFT FOR OS SIGNATURE (WHITE HOUSE REFERRAL)

☐ REVIEW / CLEARANCE
2 ☑ NECESSARY ACTION
9 ☑ FOR YOUR INFORMATION

SPECIAL INSTRUCTIONS

PHS-5175A
Rev. 4/92

PHS / ES
Rm. 710H

Phone: 6908566

Routed by: [signature]

*U.S. Government Printing Office: 1992 — 321-428/69028 135

Sep 30 3 39 PM '93

19/2

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

September 14, 1993

Philip Lee, M.D.
Assistant Secretary of Health
HHH Building, Room 716G
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Lee:

It has recently come to our attention that the National AIDS Program office has withdrawn financial support for the Regional AIDS Coordinators. Additionally, we understand that these vital positions will not be supported by the Public Health Service as well. We find this extremely troubling and quite perplexing.

The AIDS Institute has been working with the Region II AIDS Coordinator, Barry Gordon, on a number of important issues over the past few years. He has not only been instrumental in identifying available federal HIV resources, but we have also been working closely with him to promote service integration and federal, state and city coordination of resources.

As health care reform becomes closer to reality and as funds for HIV services become scarce, it is imperative that there be a regional AIDS coordinator to work with state and city governments, as well as community based organizations to avoid duplication and overlap of scarce resources.

Mr. Gordon has been invaluable not only in his programmatic knowledge but as a true partner in our daily struggle to provide quality cost effective health care to the HIV infected in New York City.

We strongly encourage you to continue this effective partnership with us by retaining the Regional AIDS Coordinator position.

Sincerely,

Humberto Cruz
Director
Division of HIV Health Care
AIDS Institute

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

September 14, 1993

Audrey F. Manley, M.D., M.P.H.
Acting Deputy Assistant Secretary for Health
in Intergovernmental Affairs
HHH Building, Room 716G
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Manley:

It has recently come to our attention that the National AIDS Program office has withdrawn financial support for the Regional AIDS Coordinators. Additionally, we understand that these vital positions will not be supported by the Public Health Service as well. We find this extremely troubling and quite perplexing.

The AIDS Institute has been working with the Region II AIDS Coordinator, Barry Gordon, on a number of important issues over the past few years. He has not only been instrumental in identifying available federal HIV resources, but we have also been working closely with him to promote service integration and federal, state and city coordination of resources.

As health care reform becomes closer to reality and as funds for HIV services become scarce, it is imperative that there be a regional AIDS coordinator to work with state and city governments, as well as community based organizations to avoid duplication and overlap of scarce resources.

Mr. Gordon has been invaluable not only in his programmatic knowledge but as a true partner in our daily struggle to provide quality cost effective health care to the HIV infected in New York City.

We strongly encourage you to continue this effective partnership with us by retaining the Regional AIDS Coordinator position.

Sincerely,

Humberto Cruz
Director
Division of HIV Health Care
AIDS Institute

HEALTH CARE REFORM IN RURAL AREAS

An Invitational Conference Sponsored by
The Robert Wood Johnson Foundation
and
Arkansas Department of Health

Conducted by
Alpha Center

March 10-12, 1993

Excelsior Hotel
Little Rock, Arkansas

THE WHITE HOUSE
WASHINGTON

Roz

Pls. call Alpha Center
& ask them to fax
Over a copy of participants
list w/addresses that
was in the Rural Health
Conference notebook -- I
can't find my list nowhere,
I guess I lost it.

P6/(b)(6)

CHR

ALPHA
CENTER

THE WHITE HOUSE
WASHINGTON

- Thank you to Robert Wood Johnson Foundation, the Ark. Dept. of Health, Alpha Center

- Goodness, is it great to be in Ark. and see so many faces I know & admire so much! Many of you have taught me about real health care issues. & I know from the attendance roster that those of you whom I have it not have "real" exp. to offer as well.

- I'm sure the? on your minds is: Where is health care reform after the court ruling today?

I have talked to the W.H. since landing earlier today—

The Pres. is gratified by the decision which allows the T.F. + working groups to proceed.

1- TF meetings for advisory Pres can be closed

2- TF meetings for info & fact finding ~~closed~~ open

3- Working groups continue as is.

THE WHITE HOUSE
WASHINGTON

More importantly – what is the process?

30+ types
350+ people
Cluster ldrs.

New system organization
New system coverage
Infrastructure
Integration of currents progs into new system
Transition
Under Served Pops
Mental health inc. Sub abuse
LTC

THE WHITE HOUSE
WASHINGTON

Eco. impact
Audits → legal / numbers

Broadening phase closing
Narrowing now
~~May~~ Early May - a bill

Rural - several areas

This conf →
Topic parallel working grps
Many speakers / Adm meetings
We're here to listen
Need work into working grps
Briefings - your main takeaway

Finally – what's the bottom line

Restore confidence, hold out
- health security

Earliest memory of dealing
w/ this prob as a child
Dewitts

Families we've seen
- preexisting cond.
- lack of $'s

ALPHA CENTER
1350 Connecticut Avenue, N.W.
Suite 1100
Washington, D.C. 20036
(202)296-1818

DATE: March 22, 1993 **FAX # (202) 296-1825**

TIME: 3:04 pm

IMPORTANT -- PLEASE DELIVER IMMEDIATELY

TO: Roselyn

FAX # 456-2878

FROM: Kelly Thompson

COMMENTS:

Total Number of Pages, Including Transmittal Form: 12

HEALTH CARE REFORM IN RURAL AREAS

Excelsior Hotel
Little Rock, Arkansas

March 11-12, 1993

Participants List

Charlie Alfero
Director
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Santa Fe, NM 87502-6110
505/827-2613

John C. Anderson, M.D.
CleElum Family Medicine Center
201 Alpha Way
CleElum, WA 98922
509/674-5034

Penny Armstrong
Clinical Director
Frontier Nursing School
Community Based Nurse Midwifery Program
P.O. Box 528
Hyden, KY 41749
717/355-9981

David R. Arnold
Chairman of the Board
Merle West Medical Center
803 Main Street, Suite 201
Klamath Falls, OR 97601
503/885-2000

John Baker, Ph.D.
Professor and Chairman
Graduate Program in Health Administration
University of Arkansas at Little Rock
2801 South University Avenue
Little Rock, AR 72204
501/569-3293

Nancy L. Barrand
Senior Program Officer
The Robert Wood Johnson Foundation
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609/452-8701

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Department of Health Policy and Management
School of Health
201 Husted Hall, 135 Western Avenue
Albany, NY 12222
518/442-4025

Peter G. Beeson, Ph.D.
Director, Office of Planning
Department of Public Institutions
801 West Van Dorn Street
Lincoln, NE 68522
402/471-2851

Bruce Behringer
President
National Rural Health Association
Office of Rural and Community Health
P.O. Box 70412, ETSU
Johnson City, TN 37614
615/929-6423

James D. Bernstein
Director
North Carolina Office of Rural Health
311 Ashe Avenue
Raleigh, NC 27606
919/821-0485

Linda Bilheimer
Principal Analyst
Congressional Budget Office
Ford House Office Building
Washington, DC 20515
202/226-2673

Rachel Block
Executive Director
Vermont Health Care Authority
89 Main Street
Drawer 20
Montpelier, VT 05620-3601
802/828-2900

Sylvia Boeder
Director - Section for Small
or Rural Hospitals
American Hospital Association
840 N. Lakeshore Drive
Chicago, IL 60611
312/280-6635

Paul Brown
Chairman, Department of Gerontological,
Psychiatric and Community Health Nursing
University of Arkansas for Medical Sciences
4301 W. Markham Street, Slot 715
Little Rock, AR 72205
501/686-9608

Daniel M. Campion
Associate
Alpha Center
1350 Connecticut Avenue, N.W.
Suite 1100
Washington, D.C. 20036
202/296-1818

Tina Castanares, M.D.
Staff Physician
La Clinica del Carino
637 Highway 141
White Salmon, WA 98672
503/386-6380

Ray Christensen, M.D.
Minnesota Department of Health
717 S.E. Delaware Street
P.O. Box 9441
Minneapolis, MN 55440
612/623-5460

John Bennett Coombs, M.D.
Associate Dean for Regional Affairs
and Rural Health
University of Washington
School of Medicine, SC-64
Seattle, WA 98195
206/685-7034

Charles O. Cranford, DDS
Executive Director
AHEC Program, University of Arkansas for
Medical Sciences
4301 W. Markham, Slot 599
Little Rock, AR 72205
501/686-5260

James A. Crouch, M.P.H.
Executive Director
California Rural Indian Health Board, Inc.
650 Howe Avenue, Suite 200
Sacramento, CA 95825
916/929-9761

Robert M. D'Alessandri, M.D.
Vice President for Health Sciences
Dean, School of Medicine
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Workgroup Questions

1. Rural Health Service Areas

- What criteria should be used to define the boundaries of health service areas?
- Should service areas be "large enough" to allow competition? How much competition?
- Should rural areas be incorporated as part of larger regions which include secondary and tertiary facilities/services?
- Should separate rural health commissions/authorities be established for rural areas? If so, what kinds of governance structures would be needed? Should regulatory powers be assigned to rural health commissions/authorities? If so, what kinds of regulatory tools/authorities would be appropriate?
- What criteria should be used to identify "at-risk" and "access critical" hospitals?
- What should be the relationship between rural health commissions/authorities and health insurance purchasing cooperatives (HIPCs)?

2. Supply of Human Resources

- What are the implications of network development for organizational relationships between rural physicians, hospitals, and other health providers?
- How will rural physicians react to increased management and oversight of their practice?
- How can the recruitment and retention of rural physicians, midlevel providers, nurses and other health professionals be enhanced by health care reform?
- How should medical education be reoriented to meet the needs of rural areas?
- What changes in the location and availability of specialty services and technology should be promoted under health care reform? Which services and technology should be provided locally in rural areas? How should referrals to specialists be managed?
- How should differences in urban/rural practice standards be addressed?

- How can rural providers and administrators currently participating in rural-based HMOs/networks assist their colleagues in other rural areas in developing such entities?

3. Networks: Structure and Formation

- How quickly will rural providers react in developing rural health networks under the stimulus of health care reform? Will the initiative for network formation come primarily from rural providers or from urban-based health plans and health care organizations?

- Should rural-based networks be given priority in contracting/forming AHPs?

- What providers should be included in rural health networks?

- How do we encourage local public health agency and other local providers to collaborate?

- How can providers currently receiving direct government funding (CHCs, RMHC) be integrated into AHPs?

- What specific legal barriers to network formation currently exist (e.g., antitrust laws and corporate practice of medicine rules)?

- What steps should HIPCs take in areas where rural providers decline to participate in health plans?

- What type of competition should be promoted in rural areas -- between networks, between primary care providers?

- How should we deal with any shift of rural primary care providers into urban areas?

- The focus has been on inter-community networking, how can we encourage intra-community networking?

- What standards for chartering AHPs, particularly rural-based AHPs, would be particularly helpful or harmful to rural residents?

4. Networks: Financing

- Should rural networks be encouraged to participate in multiple health plans, or should they be awarded "franchises" to serve designated geographic areas?

- Under different reimbursement approaches, how strong should the financial incentives be for rural primary physicians to control or alter referrals to specialists?

- Can a network of rural providers assume responsibility for all of the medical care for rural communities or will they need to contract with urban-based providers for specialty services?

- How would community rates for insurance premiums be established for rural residents and how would those rates be risk-adjusted? What urban vs. rural issues might arise?

- How should rural providers be grouped for risk sharing?

- What are the implications of expenditure caps for rural providers? How would such caps be established?

- How should fee schedules be established and enforced for rural physicians, particularly if providers decline to join an AHP?

- What kinds of financial protections should/could be used to maintain certain providers deemed essential for assuring access to services in underserved areas?

- Should networks have sufficient capital to accept financial risk under prepayment?

- Policymakers are considering a variety of approaches for financing health care reform--such as employer mandates, individual mandates, "sin" taxes, and capping the tax exemption for employer-paid premiums. What are the implications of different financing approaches for rural communities?

- Should all coverage in rural areas come through an AHP? What are the implications for rural providers and network formation if some payors are excluded? (e.g., Medicaid, federal employees)

- What is the potential role of HIPC in financing medical education in ways that will improve recruitment and retention of professionals in rural areas?

5. Networks: Operations

- What kinds of administrative and governance structures would be needed to enable hospitals, emergency medical services, community health centers, long-term care providers, solo-practitioners, and other non-hospital providers work together within a network structure?

- What incentives can be created to foster local hospital-physician cooperation?

- What kinds of referral/transfer agreements need to be developed between network providers?

- How can quality improvement mechanisms/programs be implemented on a network-wide basis?

- What kinds of data should be shared between network members? How important would it be to transfer patient records electronically?

- If rural networks serve enrollees from multiple plans, would it be difficult for a single plan to exercise sufficient leverage on network providers to ensure meaningful participation in the plan's cost containment efforts?

- What are the probable strengths and weaknesses of urban-based AHPs versus rural-based AHPs?

- How will operational issues differ between "competitive" and "non-competitive" AHPs?

- Do rural providers and communities need adjusted standards under the Medicare fraud prohibitions against self referral?

6. Public Health

- To what extent could/should public health services be integrated with personal health services in rural network and/or covered under rural AHPs?

- What specific public health services should remain outside of the AHP (e.g., systems for tracking and reporting disease, environmental health, etc.)?

- Identify examples of public health service integration and coordination in rural areas that could provide useful models. What are the common characteristics of these exemplary systems?

- What special provisions should be made to meet the needs of vulnerable and traditionally underserved populations in rural areas.

7. State Government Roles: Service Delivery/Network Formation

- What are the most effective ways for states to stimulate rural network formation? How can existing capacity-building programs be incorporated under capitated rates?

- How aggressive should states be in enforcing antitrust laws when considering rural network formation? Will state action immunity be a successful strategy for permitting joint ventures that improve access and contain costs for rural populations?

- What role should the state play in coordinating/providing emergency medical services so as to provide access to these services in more remote areas?

- What considerations should the state make for designating/governing HIPCs serving rural areas?

- What kinds of technical assistance can states provide to providers seeking to form rural networks?

- The Jackson Hole Group suggests a role for Rural AHP Authorities. Is such an authority needed and what should be its function?

8. State Government Roles: Resource Allocation

- What roles should states play in determining how financial resources, technology, and health care personnel are deployed, especially in sparsely populated areas?

- How should states treat the allotment of medical education dollars to increase the supply of primary care providers in rural areas?

- What considerations should states make for the scope of practice for midlevel providers and for how they should be reimbursed?

- What role should the state play in collecting and disseminating health care information to the public? How will the special considerations of rural environments (e.g. low volume, relevant comparison groups, interest in patient referral process) be addressed?

- How would a federal-state determined global budget affect rural areas? What role should states play in implementing and enforcing budget limits and what special considerations, if any, should be made for rural areas? (Note: historical expenditure levels typically been lower on a per capita basis in rural areas.)

- What lessons/models from existing state rate-setting programs should applly to rural areas?

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March 16, 1993

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Dear Ms. Rasco,

I want to express my appreciation to you for spending time with us in Little Rock. It helped all of us to see your involvement and depth of understanding of the issues facing rural America with health care reform.

On Thursday morning you and Dr. Shalala met with a small group of us from the EACH/RPCH states. I found that meeting to be particularly useful and I hope you did as well. I'd like to reiterate that if you have further questions about EACH/RPCH or would like to visit a network, we in Colorado would be pleased to arrange that. Most of our RPCHs are located in frontier counties and this program appears to be a very viable solution to assuring access to those communities.

Again, I thank you for your time in Little Rock. I can honestly say I was pleased to meet you and know that you do understand our issues and will provide the kind of leadership we so desperately need at the Federal level. Please contact me if I can assist you in any way.

Sincerely,

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FOR IMMEDIATE RELEASE
February 18, 1993

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HIAA

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NEWS RELEASE

HIAA LAUDS CLINTON'S COMMITMENT TO HEALTH CARE REFORM, ENDORSES MANDATES TO ASSURE UNIVERSAL COVERAGE

WASHINGTON, D.C., February 18, 1993 -- Consistent with President Clinton's call in the State of the Union for comprehensive health care reform, the Board of Directors of the Health Insurance Association of America (HIAA) yesterday enhanced its own comprehensive health care reform proposal by calling for the federal government to require employers to help pay for at least part of the cost of an essential benefit package of health insurance for their employees and dependents.

The revised Vision language also calls for government subsidies to assist certain employers and individuals to purchase health care coverage. It continues to support the preservation of a pluralistic, competitive, employer-based private health insurance market to ensure sustained cost containment. Additionally, the Vision language calls for systemic change in financing and delivery systems, with an emphasis upon the continued evolution of managed care, including full participation of Medicare and Medicaid beneficiaries.

The Vision proposal also reaffirms language, previously approved by HIAA's Board of Directors, that calls for all Americans to purchase coverage and be covered under an essential package of benefits. It also calls upon the federal government to establish rules of market behavior for all payors, including insurers, that will ensure universal coverage.

- more -

According to the Vision reform, the federal government should also oversee the definition of an essential package of benefits, develop rules for providers to follow to ensure consistent payment levels to eliminate cost-shifting, and set standards for electronic data interchange and for reporting medical care outcome and cost information.

In announcing the action of the Board of Directors, HIAA President Bill Gradison applauded President Clinton's strong commitment to universal health care coverage and controlling health care costs. Mr. Gradison also said that meaningful reform of the health care financing system must build upon the strengths of the existing private sector employment-based system, and added that ultimately, HIAA's Vision for health care reform would go a long way in containing health care costs.

"Employers have a unique interest in maintaining employee health because it affects productivity," observed Gradison. "Unfortunately, because of cost-shifting, employers have ended up bearing a disproportionate share of the escalating costs of health care."

To remedy this, added Gradison, HIAA's Vision reforms seek to reduce health care costs by eliminating cost-shifting, increasing the use of cost-saving managed care techniques, reducing insurers' administrative expense, preempting costly state mandated benefits, and targeting subsidies to assist employer and individual participation.

"The active participation of employers in financing, selecting, and administering an essential package of benefits is critical to maintaining an open, flexible, and innovative health care system," noted Gradison. "Given their significant financial commitment, employers must retain control over their employees' health care coverage. For example, employers should not be required to participate solely through group purchasing pools which would invalidate the cornerstone of our employer-based system," he added.

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HIAA's reform proposal also calls for a change in the regulatory structure of health insurance to ensure that all public and private payors play by the same rules. To achieve this the regulatory framework must avoid duplicative or overlapping regulation among the states or between the state and federal levels, remove all state control over anti-managed care laws, mandated benefits laws and provider contracting laws, prohibit states from mandating additions to the essential benefit package, and amend ERISA to allow these changes to be implemented.

The proposal also calls for equitable tax policy that caps tax preferences at a level equal to the essential benefits package and extends tax breaks to the self-employed and those purchasing outside of an employment setting. Support by the industry for the tax changes is contingent on the revenue being used to help pay for health care reform and that cost-shifting is adequately addressed.

HIAA is a Washington, D.C.-based trade association representing the nation's leading commercial health insurance companies.

# # #

NOTE TO MEDIA: <u>On Friday, February 19, 1993 at 9am</u>, HIAA will hold an informal breakfast briefing for the media, with HIAA President Bill Gradison. The purpose of the briefing is to extend an opportunity to meet with Mr. Gradison, provide information about HIAA's Vision reform proposal and to offer reaction and analysis of the health care reform component of President Clinton's State of the Union address.

The briefing will be held at HIAA, located at 1025 Connecticut Avenue, N.W., in the 12th floor Board Room (go to the 12th floor reception area). To assure adequate seating, please R.S.V.P. <u>as soon as possible,</u> either to Richard Coorsh at 202-223-7787 or Gloria Tibby at 202-223-7810.

HIAA

Health Insurance Association of America

VISION STATEMENT

Our vision is a society of healthy individuals and communities. Our nation, through systemic change, will build upon our employer-based system to create a consumer-responsive, prevention-focused, affordable and cost-effective health system which fosters individual responsibility, human dignity, improved health status, and enhanced quality of life for all.

VISION GOALS

- *Promote a healthy and productive existence for all Americans, maximizing the dignity and quality of life for each individual.*
- *Recognize, as a society, that heroic efforts to extend life are not always appropriate or desirable. Dignity, quality of life, and the potential of returning to a healthy existence must be considered in treatment decisions and in the allocation of resources.*
- *Provide compassionate care to all people, especially to those who are chronically or terminally ill and cannot recover from their illnesses.*
- *Encourage Americans to take personal responsibility for maintaining good health regarding lifestyle factors within their ability to control.*
- *Stabilize health care costs as a percentage of individual financial capacity--earned income and other sources.*
- *Harmonize health care spending with other essential national requirements--the environment, education, the economy and security.*

February 18, 1993

1025 Connecticut Avenue, N.W., Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

GUIDING PRINCIPLES

Reform of our health care system requires comprehensive change. Change must include a shift in emphasis away from sickness and repair and toward health and wellness. The principles below comprise a unified whole, not a cafeteria menu. All elements integral to universal coverage and cost containment must be implemented together, not piece-meal nor staged over time one state at a time. HIAA believes that reform of our system must be guided by the following principles:

1. Reform must rely on competitive, pluralistic, and flexible delivery and financing systems in which all players--public and private alike--abide by the same rules. Government should not anoint winners; winners should be determined by the marketplace--a marketplace free to abandon failures and embrace promising new ideas.

2. Universal, "cradle to grave" coverage must be achieved by requiring all employers and individuals to pay for an essential package of benefits which should include primary, preventive and catastrophic coverage. Government cannot shirk its role; it must help subsidize those employers and individuals who cannot afford to purchase an essential package.

3. Insurers and other private payors must issue and renew coverage for all. To protect insurer solvency and maintain employer incentives to control costs and promote employee wellness, insurers can, within limits, establish premium rates which reflect risk. Coverage must be portable; there must be no pre-existing condition limits once in the system; and the problem of "job lock" must be eliminated.

4. Reform must build on our employment-based system. Employers' active participation in financing, selecting, and administering an essential package of coverage is critical to maintaining an open, flexible, and innovative health care system. Given their significant financial commitment, employers must retain control over their employees' health care coverage. Therefore, requiring employers to participate solely through group purchasing pools would invalidate the cornerstone of our employer-based system.

5. Changing the delivery system is fundamental. Managed care should be the primary vehicle for achieving sustained systemwide cost savings; we must allow it to evolve and develop into its next generation, including full participation of Medicare and Medicaid beneficiaries in managed care systems. A defining element of managed care

systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information. Employers and managed care systems will also provide incentives that promote healthy lifestyles and personal responsibility. Managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and provider rate regulation) should be explored as an additional means of controlling health care costs.

6. Government's role must be one of an enabler, not of a "doer". A primary and essential function must be to eliminate cost-shifting to private payors. Self-regulatory bodies will develop, implement and enforce rules of conduct for all players. These include rules of market behavior for all private and public payors, rules for providers to follow to ensure consistent payment levels which eliminate cost-shifting, and standards for electronic data interchange and for reporting outcome and cost information. Government-sanctioned self-regulatory bodies will also define essential package(s) of care, evaluate technologies for their cost-effectiveness, and establish a mechanism for pooling certain cost and utilization data. In addition, government must enact legislation reforming the malpractice adjudication system.

7. Tax preferences must be limited to the essential package of care, thereby motivating the public to seek the best value and providing additional revenue to finance expanded health care coverage.

CREATING A WORKING HEALTH CARE SYSTEM

We Americans have shorter life spans, higher infant mortality rates, and higher rates of violent death than do the citizens of other industrialized countries. Yet we pay more for health care per capita and more in total health costs--close to $900 billion a year--than does any other country in the world. Furthermore, an estimated 37 million people in the United States do not have health care coverage; if we as a society continue "business as usual," that number is expected to reach 40 million by the year 2000.

To make matters worse, the private sector has had to shoulder more than its fair share of the costs. The Prospective Payment Assessment Commission estimates that, in 1990, private payors paid $22.5 billion more than the costs incurred by their hospital patients to make up for losses hospitals experienced from the uninsured as well as Medicaid and Medicare patients. Put another way, private payors paid an average of 128 percent of actual

provider costs; this amounts to almost a 30 percent "tax" on hospital costs paid by the nation's employers.

Clearly, these trends must be reversed. Over the last year, the Vision Committee of the Board of Directors of the Health Insurance Association of America (HIAA) met to discuss health care reform. The Committee members approached their task as Americans who happen to know about health insurance rather than as health insurance executives who happen to be Americans.

HIAA's vision is a framework for comprehensive reform. Its underlying premise is that everyone with a stake in the success of American health care, including insurers, will have to do what it takes to create a working health care system. It reflects the conviction that the nation's health care needs can best be met by a competitive and pluralistic system, not a monolithic one, and that the private sector will continue to play a dominant role in financing health care. It calls for universal coverage for all and changes in the behavior of providers, payors, including insurers, and the public. It advocates that government be an "enabler," not a "doer," that it eliminate cost-shifting, and that it establish guidelines for everyone to follow. Our vision is premised on comprehensive reform; all initiatives central to its goal of universal coverage and cost containment must be implemented together, and in coordination with one another, to ensure maximum success.

Taken together, these reforms will lead to a sustainable reduction in the growth of health care costs and improve the health of the American people. We recognize, however, that these reforms will require significant new government spending. We have identified one possible revenue source--a limit to the tax preference employer-sponsored health insurance currently enjoys--but we recognize that other sources will be needed as well. It is critical that these newly generated tax dollars be applied only to building a health care system that will produce long-term sustainable savings; new revenues should not be wasted perpetuating the status quo.

The health insurance industry anticipates further discussion on many aspects of the system it proposes. Some areas need more thought, and some gaps need to be filled. As areas of uncertainty are clarified, this paper, which is not final, will be modified to reflect these changes. Some lack of specificity will have to be tolerated while we struggle to find solutions to difficult issues. (For purposes of this discussion, "health care" refers to services to prevent, diagnose or treat medical conditions. The reforms proposed here do not apply to coverage outside of the essential package, such as disability income, supplemental hospital indemnity, specified disease, Medicare supplement or long-term care insurance.)

COMPONENTS OF THE NEW SYSTEM

1. *Based on Pluralistic Financing and Delivery Systems*

Reform must rely on market-based pluralistic and competitive financing and delivery systems. Pluralism and choice are what engender competition--competition among ideas, among companies, among plans, and among values such as cost, quality and convenience. Only true competition can assure that our health care system remains flexible and open to innovation, so that it will continue to evolve to better meet consumers' needs in the future. A system with many buyers and sellers will assure breadth and depth of services and responsiveness to consumers. Market forces must be allowed to determine which systems shall succeed.

Comprehensive health care reform will require an expanded federal role to eliminate costly variations in state regulation and assure uniform standards--a level playing field--for all public and private payors. It will also require that government remove barriers to the growth of pluralistic, competitive systems.

2. *Builds on an Employer-Based Foundation*

Employers have a unique interest in maintaining employee health--as it affects productivity. Therefore, employers must provide coverage for all their employees and dependents. Employers will pay for at least part of this coverage. Some employers will receive government assistance to help cover their employees.

All employers, regardless of their size, will select plans based on the performance of competing managed care systems. A system built on an employer base is categorically inconsistent with the concept of exclusive group purchasing that bypasses employers altogether, thus relieving them of their responsibilities. Purchasing pools, such as group association and multiple employer plans, are common methods of obtaining coverage. We have no objection to a variety of demonstrations and experimentation with other forms of purchasing pools provided employer participation is voluntary. In no case should employers be required to buy health insurance solely through group purchasing arrangements.

A competitive and pluralistic system should allow purchasing pools to exist side by side with other methods of arranging coverage. **Insurance reform measures will prevent any one entity from bearing an inequitable share of risk because all payors will follow the same market rules to guarantee coverage.**

In addition, employers should:

- be free to experiment with and invest in a variety of approaches in providing an essential package of coverage;
- provide incentives to promote healthy behavior; and
- have incentives to help restrain costs because some element of their experience is considered.

3. *Achieves Universal Coverage for an Essential Package*

All Americans will have continuous coverage for an essential package of primary, preventive, and catastrophic care. Achieving universal coverage will require a series of mandates--on government, employers, insurers and individuals. How to divide these responsibilities will probably be the most difficult and controversial aspect of health care reform. Ultimately, it will be a political decision, not a health care decision. Clearly governments--federal and possibly state--will bear the cost of covering low-income people. Employers, in our view, should at the very least be required to incur the costs of offering health insurance to their employees.

HIAA supports a requirement that employers help pay for coverage for their employees and dependents. Even a modest employer payment would heighten employer cost consciousness and help restrain health care inflation. So-called employer mandates, however, are in effect a mandate on employees as well as employers, since employee premium contributions are envisioned in virtually all employer mandate plans. We are reserving judgment on how the costs should be shared between employer and employee, recognizing that there are practical limits on the ability of both employers and employees to shoulder the financial costs of a health care mandate. It may be necessary--however the cost is divided--to phase in the mandates over a period of years, taking account of any other employer mandates--such as increases in the minimum wage--that may be imposed at the same time. If an employer mandate is phased in, it will be necessary to coordinate it with other aspects of health care reform. For example, certain aspects of insurance market reform are not feasible absent a mandate; the two reform measures must be synchronized.

To achieve universal coverage, the following steps must be taken:

- Government must require all employers to arrange and help pay for an essential package of coverage for their employees and dependents. All individuals--those employed and those not connected to the work force--are required to obtain such coverage.

- Government must help employers and individuals who cannot afford to purchase an essential package. (Certain employers receive financial help, but they cannot "opt out" by paying a tax instead.)

- All individuals--those employed and those not connected to the work force--must receive the same tax incentives to purchase an essential package.

- The essential package covers primary, preventive, and catastrophic care. Government will authorize an independent body of providers, payors, employers and consumers to define the essential package of coverage. The design of this package must be flexible to encourage cost-conscious behavior; it must have inherent limits to prevent continuous expansion, recognizing that people's wants and desires may exceed society's resources; and it must not overlap or duplicate medical care coverage available elsewhere such as under workers' compensation and automobile insurance.

- There should be no difference in the essential package of coverage received by the poor and the non-poor. Government will finance coverage for low income individuals, but there will no longer be the need for a separate Medicaid program.

4. *Ensures Universal Coverage Through Market Reform*

Market reform must be premised on a government requirement that all individuals and employers purchase coverage. In this environment, all health plans will be subject to national rules of market behavior to guarantee universal and continuous coverage. The same rules will apply to all health plans, whether offered by commercial insurers, Blue Cross/Blue Shield plans, HMOs, self-insured employers, government, or any other entity. Problems such as "job lock" and lack of coverage for pre-existing conditions will be resolved. The rules of market behavior will:

- require that coverage be made available to every employee in an employment-based group;

- assure that every individual will be able to purchase the essential package, regardless of their health, financial or employment status;

- guarantee that coverage will not be cancelled, terminated or not renewed based on the health status or claims experience of any individual or group;

- prohibit insurer rating practices that create large rate differentials for groups of similar age, sex and geographic composition;

- maintain, at the same time, insurers' ability to calibrate rates to risk--pure community rating results in market disruption and works against cost containment in a variety of ways; and

- establish a form of reinsurance or risk-sharing to compensate for inequitable distribution of risk.

5. ***Creates Sustained Cost Containment By Systemic Change in Financing and Delivery Systems***

Changing the health care delivery system is fundamental. The actual delivery of care must be substantially better organized than it is today to meet the needs of patients, purchasers, and providers. Therefore, managed care should be the primary vehicle for achieving sustained systemwide cost savings, and must be allowed to evolve and develop to its next generation. Managed care systems will serve the health care needs of communities by offering essential packages of care; they may also offer supplemental coverage.

Different forms of managed care coverage will compete on a level playing field. These competing forms of coverage include plans employing managed care techniques such as utilization review as well as managed care structures such as HMOs, PPOs, other network-based health plans, and evolving models. However, a defining element of all managed care systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information across managed care systems.

Managed care systems will be permitted to pay providers in a variety of ways that encourage cost-effectiveness and quality care, including physician risk-sharing incentives, so that providers are rewarded for the cost-effective use of medical resources. New payment systems should encourage greater provider autonomy in decision-making and reduce the "hassle factor" that now results from micromanaging by payors.

Managed care systems will be user-friendly, efficient, and paperless. Administrative costs, and waste and fraud, will be significantly reduced. Improved alliances between providers and insurers will promote enhanced financial and managerial control of managed care systems, timely and responsive customer service, quality assurance programs, and fraud prevention.

Both managed care systems and employers will provide incentives that promote healthy behavior including discounts, promotions, and education. These incentives will reduce health care costs related to unhealthy lifestyle choices and will promote personal responsibility for one's health.

Given government's enormous buying power and its ability to influence provider costs, there should be strong incentives, perhaps requirements phased in over time, that Medicaid and Medicare beneficiaries fully participate in managed care systems to eliminate cost-shifting and control costs and utilization.

As managed care continues to develop, it will result in significant cost containment. However, managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and provider rate regulation) should be explored as an additional means of controlling health care costs.

6. *Controls Systemwide Costs Via New Government Role*

Government will establish an entity that oversees and relies on one or more self-regulatory bodies to develop, implement and enforce rules of conduct for all players in the health care system. The regulatory framework will include all interested parties in the health care system--providers, insurers, employers, government, and the public. One, or possibly several, self-regulatory bodies will perform the following functions:

- establish consistent rules of market behavior for all health plans--those provided by insurers, self-insured employers, HMOs, government, or any other entity (see point 4);

- define essential package(s) of coverage that is made available to all, regardless of their income, age or employment status (see point 3);

- establish rules for providers to follow which ensure that they set consistent payment levels for all public and private payors for the same service. These rules should:

    - recognize that different payors may use different payment methods; and

    - assure that payments reflect real economic costs and value to providers and payors (such as convenience, service, adherence to quality standards, cost-effective practice patterns, or meeting additional contractual obligations).

      (In no case, however, should the rules allow providers to grant discounts to one payor simply by increasing the cost to another payor. The most important outcome of these new rules is to eliminate government's chronic failure to pay the true costs of care for poor and elderly Americans. In other words, Medicaid and Medicare should no longer receive special deals with

providers at the expense of the rest of the population.)

- develop standardized guidelines for electronic data processing and a nationally uniform claim form to achieve an efficient and paperless system;

- evaluate technologies (i.e., drugs, procedures, and equipment) for their cost-effectiveness; sanction clinical guidelines (developed by appropriate professions) that can be used as legal defense against malpractice claims; determine valid experimental treatments eligible for reimbursement through participation in clinical trials;

- establish standards for the reporting of outcome and cost information published by managed care systems;

- establish a mechanism for pooling certain cost and utilization data on a regional, state and/or national basis to assist all payors in controlling costs and utilization, to help managed care systems produce outcome and cost data, and to help the government-authorized entity to develop guidelines that ensure that providers set consistent payment levels;

- enact legislative reforms of the malpractice adjudication system;

- enact legislation that allows insurers to exchange information for the purpose of identifying fraudulent providers; and

- consider actions needed to change the mix and supply of physicians and to increase the supply of physicians in inner cities and rural areas.

7. *Establishes Equitable Rules for All*

Government will require all public and private payors to play by the same rules. To achieve this level playing field, the regulatory framework must:

- avoid duplicative or overlapping regulation among the states or between the state and federal levels;

- remove all state regulatory control over anti-managed care laws, mandated benefits laws, and provider contracting laws;

- prohibit states from mandating additions to the essential benefit package; and

- amend ERISA to allow this regulatory structure to successfully implement the above responsibilities.

8. *Promotes Equitable Tax Policy*

Government must implement tax policies that eliminate perverse incentives for health care spending.[1] An unlimited tax preference for employer-sponsored health benefits does not promote cost-consciousness among employees. Instead, tax preferences for the essential package of coverage should be:

- capped at a level equal to the essential benefit package;
- extended to the self-employed and to those who purchase the coverage outside of an employment setting;
- inapplicable to any premiums for health benefits in excess of the essential package; and
- inapplicable to cost-sharing requirements, such as deductibles and copayments, for the essential package.

Employers would continue to be allowed to deduct 100 percent of their contributions to employees' health coverage, even if their contributions are for coverage in excess of the essential package. (But employees are taxed on the excess.) In addition, the inequitable taxation of various payors must also be addressed to help level the playing field in the new system.

The revenues from these tax changes should be used only to help pay for health care reform. HIAA could not support these tax changes if cost-shifting is not adequately addressed or if the revenues generated from these changes are not specifically applied to health care reform.

SYSTEMIC FACTORS DRIVING COSTS ARE SLOWED

We have proposed many ways to create a sustained reduction in the growth of health care spending. Everyone will have continuous coverage so people will not wait until they are ill before seeking care. Managed care systems will discourage excess doctor

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[1]As noted earlier, this vision addresses reform of the acute care medical system; it does not address long-term care financing reform. HIAA continues to support several recommendations in the latter area, including favorable tax treatment of long-term care insurance, on the grounds that the increased availability of affordable private insurance will have a significant impact on reducing future public (Medicaid) spending on long-term care.

visits, unnecessary hospital and specialist care, and technology use that is not cost-effective. Physicians will be empowered to practice effective, not defensive, medicine. Managed care systems will offer essential packages of care that will compete on price and value.

Providers will not be able to shift costs among payors, so true market competition will compel providers to become more efficient. A government-authorized entity will evaluate, and slow the use of, expensive technologies that are not cost-effective. Administrative simplicity, a paperless system, and standardized claim forms will save money and help control fraud and waste. Coverage of preventive care and incentives for healthy lifestyles will pay off over the long-run. Tax advantages will be limited to the value of the essential package of care, thereby motivating everyone to seek the best value.

Successful reform will yield measurable results and trends that will compare favorably to those of other nations on costs and on a variety of quality measures (such as mortality, percent who smoke, and height/weight standards).

HIAA will continue to refine its vision of health care reform. However, we are committed to achieving the objectives outlined. Fixing the health care system will lift a sizable burden from our collective shoulders, yielding resources and liberating energies for other critical issues on the nation's social agenda.

SEPARATE ISSUE PAPERS

Additional issue papers are being developed on selected subjects. In some instances, these are descriptive papers discussing the pros and cons of the issue. In other cases, these are supplemental papers providing more detail than what is proposed herein. Topic areas include:

1. Price controls
2. Global budgets or expenditure targets
3. Extent of tax-favored treatment for health insurance
4. Precise nature of federal and state responsibilities
5. Cost estimates and revenue sources for reform
6. Implementation and enforcement of employer and individual mandates (including how much an employer contributes, which employees qualify under the employer mandate, and how a subsidy program could be structured)
7. Centrality of employers in providing coverage (including a discussion of the concept of group purchasing arrangements)
8. Insurance in the new market
9. Determining the essential package of coverage (including a discussion of supplemental coverages)

10. Medicare and Medicaid
11. Technology assessment
12. Tort reform
13. Individual responsibility, wellness and prevention
14. Measuring and assessing results with other nations
15. Medical care coverage under Workers' compensation and auto insurance

HIAA

Health Insurance Association of America
America's Commercial Health Insurers
Protecting 95 Million People

CAMPAIGN TO INSURE ALL AMERICANS

March 10, 1993

PLEASE DELIVER THE FOLLOWING 24 PAGE(S). In case of problems with transmission, please contact **Kathleen Fyffe** at **202 223-7834.**

To:	Anthony Masso, Vice President Health Insurance Assoc. of America (attending The Robert Wood Johnson Foundation meeting, and not a hotel guest) c/o The Excelsior Hotel Little Rock, Arkansas
Phone:	800 527-1745
Fax #:	501 375-4721
From:	Kathleen H. Fyffe, Director of Payment Systems, HIAA
Message:	Please give to Mr. Masso. Thanks. Tony - Barbara Souder's fax is 24 pages. The most important for you is the first 3 pages.

HIAA Fax phones:

12th Floor (Main)	(202) 223-7897	Legal/State Affairs	(202) 828-4527
11th Floor	(202) 223-7896	Managed Care	(202) 828-4528
Education	(202) 223-7885	Policy Development & Research	(202) 828-4511
Executive Suite	(202) 223-7889	Provider Affairs	(202) 223-7545
Federal Affairs	(202) 828-4529		

March 10, 1993

Tony Masso

Messages for the Clinton Health Care Taskforce on EDI

Attached for your reference are:

(1) The Workgroup on Electronic Data Interchange (WEDI) Report Executive Summary (Recommendations)

(2) The WEDI First Quarter Update, 1993

(3) Press Release: February 2 Steering Committee Meeting

(4) Press Release: February 22-23 TAG Meetings

Key messages that you need to deliver:

(1) EDI is not a partisan issue; both Democrats and Republicans support it.

* Some on the Clinton team purportedly have said that WEDI is of the past administration and therefore should not be considered for that reason. Electronic Data Interchange (EDI) is a technology issue, not a political one.

* It should be noted that WEDI is made up of a broad public/private partnership and includes key health key leaders -- providers, payers, business, and government. (HCFA was very actively involved in formulating the policies.) The consensus WEDI reached was unheard of in health care; for years the industry has tried to adopt one standard for EDI in health care.

* At this time, seven additional organizations (particularly provider groups) joined WEDI in 1993 for the February meeting; others are asking to be on the Steering Committee; total 22.

* The Technical Advisory Groups (TAGS) have increased to 10. They are reviewing and making recommendations on a host of issues to implement EDI -- universal identifiers,

health care card technology, clearinghouse accreditation, confidentiality and privacy issues, data content, and implementation standards. The TAGS comprise a very broad base of representation.

(2) It is important to understand why the ANSI X 12 standard is superior to the current "national" standard used by Medicare.

* The use of EDI in health care is not new -- Medicare has been processing claims for 20 years electronically. In fact the technology has spawned 458 different standards. While EDI is in operational today, it is primarily one-and-two way communications, not interactive ones.

* The electronic standard selected is the "ANSI X 12." In plain English, this means the American National Standards Institute's (ANSI) electronic data interchange committee (numbered "X 12"). The ANSI standard was selected is a more efficient standard -- it sends only the pertinent data over the electronic highways.

* Today many standards, including the "national standard" used by HCFA, transmit empty spaces in addition to the data. In our future health care system, where data will take on an even more prominent role, transmitting it cheaply will be important.

* Finally, the ANSI X 12 standard is developed through a consensus process and encompasses all health care data, not just that relating to Medicare.

* We have heard the Clinton Team is looking for short-term savings by 1994, and fears start-up costs in switching to the ANSI standards will obliterate them. If they are looking to revamp the health care system, ANSI is the way to proceed because of its efficiency and breadth.

(3) All the ANSI X 12 standards are developed. HCFA has already sent notices out on two of them, giving time for transition.

(4) The Co-Chairs of WEDI would like to meet with the

Clinton Taskforce, including Secretary Schalala, to let them know first-hand what WEDI is doing in 1993.

(5) The WEDI Steering Committee will be sending a preliminary report to them on a few key issues very shortly.

(6) EDI is the foundation for the data and outcomes discussed in the managed competition proposal and Jackson Hole proposal. We are beginning with the less complex issues -- financial transactions.

(7) A question may arise about the hardship rural health providers will have to get EDI compatible. Either a PC or a telephone to connect one to a clearinghouse is all that's needed. Many providers now use an outside vendor to perform this service.

My office number is (203) 277-6080. I'll be there Thursday. Tonight and Friday I am in Boston P6/(b)(6)

Call me anytime.

Barbara

Barbara A. Souder

WORKGROUP FOR ELECTRONIC DATA INTERCHANGE

REPORT

To Secretary Of U.S. Department Of Health And Human Services

July 1992

Co-Chair
Joseph T. Brophy
President
The Travelers Insurance Company

Co-Chair
Bernard R. Tresnowski
President
Blue Cross and Blue Shield Association

Workgroup for Electronic Data Interchange

WEDI Co-Chairs

Joseph T. Brophy
President
The Travelers Insurance Company

Bernard R. Tresnowski
President
Blue Cross and Blue Shield Association

WEDI Steering Committee

George Belsey
Executive Vice President
American Hospital Association

Jim Bradley
Vice President, Information Systems
United Healthcare

Dick Connell
Vice President
Aetna Life & Casualty

Norwood Davis, Jr.
Chairman of the Board & CEO
Blue Cross & Blue Shield of Virginia

Barbara Gagel
Director, Bureau of Program Operations
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American Medical Association

Ernie Johnston
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John Motley
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Blue Cross and Blue Shield Association

Contents

WEDI REPORT

Workgrcup for Electronic Data Interchange (WEDI)

July 199?

WEDI REPORT

Executive Summary

Workgroup for Electronic Data Interchange
(WEDI)

July 1992

Executive Summary

In November 1991, Secretary of Health and Human Services, Dr Louis Sullivan, convened a forum of national health care leaders to discuss the challenges of reducing administrative costs in the U. S. health care system. At the forum, three health care industry-led workgroups were created -- the Workgroup for Electronic Data Interchange, The Taskforce on Patient Information, and the Workgroup on Administrative Costs and Benefits.

This report represents the findings and recommendations of the Workgroup for Electronic Data Interchange (WEDI) and reflects the efforts of a genuine public and private partnership over the last six months. Co-chaired by Bernard R. Tresnowski, President, Blue Cross and Blue Shield Association, and Joseph T. Brophy, President, The Travelers Insurance Company, the 15-member WEDI Steering Committee, supported by a technical advisory group of approximately 50 staff, convened to assess and mobilize the health care industry's use of technology to streamline health care financing.

This report has laid out aggressive but achievable goals to propel the health care industry toward the use of EDI quickly and effectively. WEDI has also developed a specific action plan for translating these goals into reality. WEDI believes the answer lies in a public/private partnership. Because EDI represents an opportunity where good public policy and good business sense converge, we believe the industry can and will respond as an effective partner with the government.

Automate Transactions

By fourth quarter 1994, 95% of Category I industry participants should implement EDI, directly or through a clearinghouse, for those core transactions listed above, offering the ANSI ASC X12 standard formats. Category I participants include major public and private payors; hospitals; major employers and self-insured plans; pharmacies; and clinics and group practices of 20 or more professionals. By fourth quarter 1996, 85% of Category II participants should implement EDI for core transactions, directly or through a clearinghouse, phasing in ANSI ASC X12 standard formats. Category II participants include all remaining health care payors; providers; employers and self-insured plans; and pharmacies. A longer phase-in period may be necessary for small employers implementing electronic enrollment transfer to payors.

Recommendation #2 from the WEDI Report

Between now and fourth quarter 1995, WEDI shall submit periodic reports to the Secretary regarding progress in achieving implementation percentage goals. If the industry has failed to make satisfactory progress in reaching these goals, WEDI will recommend that the Secretary take further action, including appropriate legislation to support these voluntary initiatives.

Recommendation #3 from the WEDI Report

Provide Incentives

Public and private payors should create incentives for increased use of EDI. Among the incentives available are: low- or no-cost software and maintenance support, quick payment incentives for electronic claims, cost/benefit analyses, and technical assistance. In addition, providers and other participants are urged to explore opportunities for partnerships to reduce development and implementation costs. For example, hospitals may provide electronic links to physicians to facilitate access to automated coding. Providers may create "informational partnerships" that reduce the development, transitional, and operating costs of EDI and avoid duplication of effort.

Recommendation #4 from the WEDI Report

II. Preliminary Savings Estimated at $4 to $10 Billion; WEDI Commits Funds for Further Study

WEDI will sponsor and fund continuing analysis of the benefits and costs of EDI as they relate to reduction in administrative costs. In particular, there is a need for research in the following categories:

- EDI implications for providers and employers, including an analysis of start-up costs and the ongoing impact on administrative costs.
- System-wide EDI investment requirements and implementation costs.

Recommendation #13 from the WEDI Report

III. Call for Congressional Action to Protect Consumer Confidentiality and Privacy Rights

Congress should enact federal pre-emptive legislation governing confidentiality by fourth quarter 1993 to facilitate and ensure the uniform, confidential treatment of identifiable information in electronic environments. WEDI shall create a task force to coordinate with other relevant groups and to assist in the timely technical drafting of this legislation, which should:

- Establish uniform requirements for preservation of confidentiality and privacy rights in electronic health care claims processing and payment;
- Apply to the collection, storage, handling, and transmission of individually identifiable health care data, including initial and subsequent disclosures, in electronic transactions by all public and private payors, providers of health care, and all other entities involved in the transactions;
- Exempt state public health reporting laws;
- Delineate protocols for secure electronic storage and transmission of health care data;

- Participants should utilize a unique identifier system, as cited above in recommendation #7, to facilitate instructional routing of information to support COB.

These three elements can support full implementation of electronic exchange of information for COB.

Recommendation #9 from the WEDI Report

A WEDI task force should be established to develop recommendations regarding the use of electronic card technology by second quarter 1993. The objectives of the task force are to:

- Determine options for using electronic health insurance cards within the health care environment and the types of electronic card alternatives, such as magnetic stripe cards and smart cards.
- Recommend an implementation process to ensure that standard and current information can be accessed.

Recommendation #10 from the WEDI Report

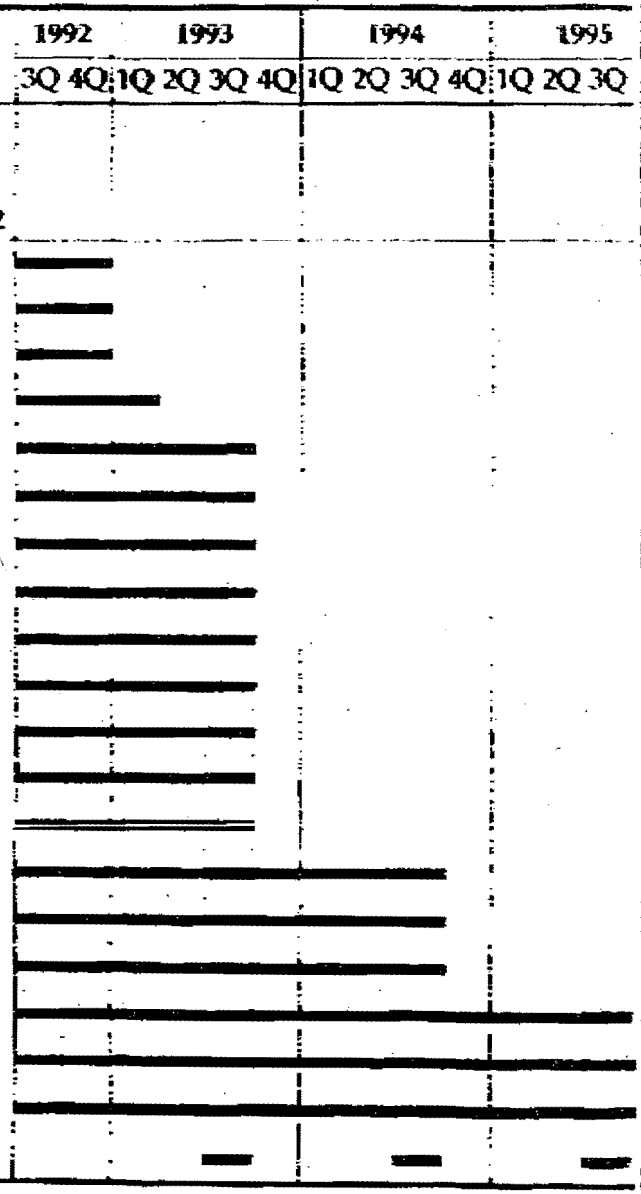
V. WEDI Continues Public/Private Partnership to Provide Leadership and Monitor Implementation

To oversee the industry's progress toward EDI, and to assist in the fulfillment of these recommendations, WEDI shall continue in existence as a collaborative effort among health care industry participants and shall report to the Secretary of DHHS each year on industry progress. By the end of 1992, WEDI shall create and approve a structure for its conduct, including additional membership and administration of the Steering Committee, standing task forces, and public input. Membership and participation in WEDI shall continue to be on a dual level with both executive management and technical support. The WEDI steering committee may be expanded up to 20 voting members to ensure diverse and balanced representation into the future. Technical group representation shall be open to other interested parties.

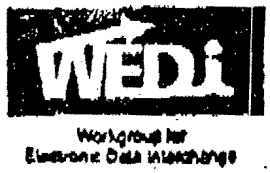
Recommendation #14 from the WEDI Report

HEALTH CARE INDUSTRY EDI IMPLEMENTATION SCHEDULE
GOAL: FULL EDI AUTOMATION WITHIN FIVE YEARS

Topic	Rec #[A]	Resp[B]	Task
		Government	DHHS forum on administrative costs 11/91
		WEDI	Began analysis of industry's use of EDI 1/92
		WEDI	Made EDI recommendations to DHHS Secretary 7/92
WEDI	14	WEDI	Creates structure for membership/task forces
WEDI	15	WEDI	Establishes work plan for publicity/education
CONFIDENTIALITY	8	WEDI	Drafts model confidentiality federal legislation
ID CARDS	10	WEDI/IND*	Develop recommendations for ID cards
FORMATS	1	Industry	Defines and publishes standard EDI formats
FORMATS	1	WEDI/IND*	Identify system for implementation guides
INCENTIVES	5	Congress	Examines tax credit incentives for EDI costs
BILLING	6	Industry	Adopts standardized billing content
IDENTIFIERS	7	WEDI	Determines system for unique identifier
CONFIDENTIALITY	8	Congress	Enacts federal confidentiality legislation
COB	9	Industry	Develop process/guidelines for COB
DEMONSTRATIONS	12	WEDI/IND*	Stimulate/publicize demonstration projects
ANALYSIS	13	WEDI/IND*	Conduct analysis of EDI costs
IMPLEMENTATION	2	Industry	95% Cat. I partners implement EDI/standards
COB	9	Industry	Creates crossover format for COB
CLEARINGHOUSES	11	Industry	Creates clearinghouse accreditation program
IDENTIFIERS	7	Industry	Adopts unique identifiers
INCENTIVES	4	WEDI/IND*	Create incentives for EDI use
IMPLEMENTATION**	2	Industry	85% Cat. II partners implement EDI/standards
IMPLEMENTATION	3	WEDI	Progress reports to DHHS Secretary



[A] *Recommendations Number in WEDI Report*
[B] *Responsibility For Task*
* *WEDI/IND: Initiated by WEDI, implemented by the Health Care Industry (Public and Private Sectors)*
** *By Fourth Quarter 1996*



WEDI UPDATE
FIRST QUARTER, 1993

WHAT IS WEDI?

The Workgroup for Electronic Data Interchange (WEDI) is an industry-led task force created to streamline health care administration through standardized electronic communications. The Workgroup was formed to develop an action plan following a national summit on health care paperwork convened in late 1991 by the Secretary of Health and Human Services. In 1992, WEDI convened 15 national health care leaders, representing private payors, government, providers and business, to outline the steps necessary to make electronic data interchange (EDI) routine for the health care industry by 1994. This Steering Committee, supported by a Technical Advisory Group of 50 experts, issued its report to the field in July 1992. The group is co-chaired by Joseph T. Murphy, President, The Travelers Insurance Company, and Bernard R. Tresnowski, President of the Blue Cross and Blue Shield Association.

WEDI calls for public-private partnership to achieve reform. The Workgroup envisions a health care industry which conducts its business transactions via computer, using one national standard format and interconnecting networks. Major payors, providers and employers will automate enrollment, eligibility, claims submission and remittances by fourth quarter 1994. Smaller entities will have until 1996 to achieve routine automation.

Central to this plan is the use of national data standards for these transactions to ease administration and reduce computer costs. WEDI participants have committed to using standards developed by the American National Standards Institute (ANSI) and to ensuring consensus on these formats has been reached by the end of 1993. WEDI has also called for a preemptive federal statute for confidentiality protection in an electronic environment and has drafted the principles necessary for this legislation. Finally, WEDI has committed to resolving a number of key implementation obstacles in 1993 to ensure that EDI can be achieved through a public-private partnership.

WEDI will continue to expand membership in the Steering Committee to guarantee broad representation of national health groups. The WEDI Technical Advisory Group will include all individuals interested in developing further industry consensus on EDI. Key issues to be resolved for our fourth quarter 1993 report include recommendations for: a universal identifier system for payors, providers and subscribers; coordination of benefits in an electronic environment; use of electronic cards; implementation assistance for data standards; and further progress on uniform data content. WEDI also looks forward to working with the new Congress on confidentiality legislation.

WEDI believes that a public-private partnership is critical for administrative reform and has committed to an aggressive time frame to make needed reform happen. However, WEDI's 1992 report makes clear that if the industry fails to meet its goals, it is prepared to recommend and accept further steps, including the possibility of additional legislative or regulatory action.

What are the benefits WEDI is seeking? Health care paperwork will no longer be the responsibility of consumers and will be greatly simplified for providers. Electronic communications will speed business transactions, improve accuracy and provide a standard approach for all health insurance plans to use. Annual savings for payors is estimated to range from $4 - $10 billion a year. Provider savings are difficult to estimate because of insufficient data, but are likely to increase the payback significantly. Finally, accomplishing, EDI for health care financing lays the ground work for future exchanges of sophisticated clinical data that can enhance the quality and effectiveness of medical care.

WEDI
Working Group for Electronic Data Interchange

WEDI: THE WORD GETS AROUND

★ Over 2,500 WEDI reports have been distributed since July, 1992 to various parties including the Federal government, health care providers, trade associations, vendors, state governments, employers and payors. All members of congress received a copy in Fall 1992.

★ Need a WEDI Report?

Call Margie Triplette at Blue Cross Blue Shield Association (312-440-5741) to request your copy. Help us spread the word!

★ Presentations on WEDI have been made to dozens of groups, including:

- American Medical Information Association
- Automated Medical Payments Conference (December - San Francisco)
- Congressional Staff
- Health Industry Manufacturer's Association
- National Council of Prescription Drug Programs
- National Medicare Conference

★ Among those who have expressed support for WEDI's work:

American Society of Internal Medicine
Computer-Based Patient Record Institute
Health Insurance Association of America
National Federation of Independent Business
The Conservative Democratic Forum (included many of WEDI's principles in its health reform proposal.)

★ The Short Term Strategies Workgroup welcomes proposals for Health Care EDI Demonstration Projects. Demonstration Project Proposals will be considered on the basis of the seven specific project objectives outlined in the WEDI Report. Demonstration Projects must 1) Be ecumenical, 2) Be close to the Public, 3) Show Industry cooperation, 4) Leverage existing infrastructures, 5) Add something new, 6) Have a defined location or user population, and 7) Have aggressive time frames.

For further details on submitting a proposal, contact the Short Term Strategies Workgroup through Marge Brown, (203)561-6398 (phone); (203)561-3007 (fax).

WEDI

Working Group for Electronic Data Interchange

SHORT TERM STRATEGIES DEMONSTRATION PROJECT UPDATE

As part of the initial WEDI recommendations, the Short Term Strategies Technical Advisory Group was given the mission "to achieve rapid public recognition of EDI's potential to reduce administrative costs; improve operational efficiency by promoting awareness of current EDI activity and identify and pursue opportunities for cooperation among public policymakers, providers, private payors, vendors, and employers to expand EDI."

Three Demonstration Projects were initiated to illustrate the value of EDI, recruit new participants, and expand the scope of EDI communications. These Demonstrations are the:

AT&T Demonstration Project which explores the value of automated enrollment between a large employer, AT&T and its three payors.

Twin Cities Demonstration Project which expands the users and uses of EDI in the 11 county area surrounding Minneapolis/St. Paul, Minnesota.

Virginia Demonstration Project which encompasses both urban and rural environments.

A brief update of each project follows.

AT&T DEMONSTRATION PROJECT

The objectives of the AT&T Demonstration Project are to automate the enrollment transaction using the ANSI 834 format, demonstrate cost-containing potential of EDI, demonstrate industry cooperation and establish an implementation model. AT&T is a large purchaser of health and insurance services with over 700,000 covered members. Costs associated with AT&T's benefit plan exceeds $1 billion annually. AT&T and its three payors (Travelers, Empire Blue Cross and Blue Shield, and Prudential) have embarked on automating the Group's enrollment using the ANSI standard (834). Previously, each carrier used a proprietary format to transfer enrollment data. The proprietary formats are being replaced with the ANSI 834 and the tape transfers are giving way to the use of a value-added network (VAN) for connectivity. Connectivity using the 834 has been established and tested with each payor. Additional system re-engineering is underway to maximize the cost savings, customer service and paperwork ("hassle") reduction inherent in the traditional tape transfer. For more information on this Demonstration, please contact Jim Monostero at AT&T (phone)201-898-2356;(fax)201-898-2498.

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TWIN CITIES DEMONSTRATION PROJECT

The objectives established by the WEDI Short-Term Strategies Committee for the Twin Cities Demonstration Project are threefold:

- Increase the number of providers using EDI technology
- Increase the number of claims submitted electronically by ten percent
- Extend eligibility transaction processing to selected commercial carriers

In August of 1992, over 450 recruitment letters were sent to physicians, hospitals, clinics, payors, professional associations and vendors in the eleven county area surrounding Minneapolis, St. Paul and Rochester. A press conference was held in September announcing the WEDI Twin Cities Demonstration Project and the joint efforts of Medica, a United Healthcare Corporation-managed plan, and Blue Cross and Blue Shield of Minnesota in their support of the demonstration project. Both health plans have programmed their electronic networks to capture and forward each others' claims, allowing access to an electronic network through one front-end application residing in the provider office. Senator David Duronberger also spoke at the press conference, reinforcing the impact of WEDI efforts on healthcare reform.

The Twin Cities of Minneapolis and St. Paul served as the pilot site for the creation of the cost data collection tool. Site visits were held with WEDI Short-Term Strategy committee members, the Tiber Group, the third party consultant retained to perform the cost savings analyses, and providers participating to refine the use of the data collection tool. Individual focus group meetings were then held with each health care constituency (physician, hospital and payor) to explain the data collection tool prior to its distribution for any necessary data collection/analysis assumption adjustments. Data collection has been in progress since November.

A monthly newsletter is distributed to all WEDI Twin Cities participants to keep them abreast of project progress and milestones, serve as a communication and education vehicle about EDI implementation, and remind participants of important meeting dates. In addition, an open monthly forum is held to encourage dialogue between all healthcare industry constituents in the Twin Cities area. Attendance is not limited to WEDI Twin Cities demonstration participants. Discussion topics have included WEDI demonstration project status (with regard to the objectives set for the project), EDI education and implementation, establishment of standards, parallel initiatives in the Minnesota state legislature, and the national WEDI perspective.

The WEDI Twin Cities Demonstration Project participants look forward to being an active voice of the industry as a conduit to the WEDI Steering Committee. Feedback is being solicited mirroring the structure of the WEDI Technical Advisory Groups for 1993. Open issues of particular interest appear to be unique physician and patient identifiers, EDI implementation planning and execution, creation and maintenance of health care cards, data content, and development of meaningful financial information. For more information on this Demonstration Project, please contact Maureen Ward at United Health Care (phone)708-250-3248;(fax)708-250-8490.

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VIRGINIA DEMONSTRATION PROJECT

The Virginia Demonstration Project has been running since October 1st for all participating payors/providers and transactions are continuing to increase. Transactions include claims, remittances, eligibility, benefits, referrals, electronic funds transfer (EFT), enrollment and E-Mail. The payors include Blue Cross Blue Shield of Virginia, Medicare A, Medicare B, Medicaid, Mutual of Omaha, Prudential, Aetna (through HIT) and a number of other commercial payors linked through NEIC. Approximately 5,000 physicians and 165 hospitals are submitting at least one type of transaction. There are more than thirty (30) payors receiving at least one type of transaction. Total transactions have reached over one million per month. In addition, Blue Cross Blue Shield of Virginia has connected its network to all of these payors and is currently delivering over 160 thousand claims per month to non-Blue Cross Blue Shield of Virginia entities.

Recent developments include:

- The new ANSI 835 standard remittance advice for Medicare A is in full production for those customers requesting it. Mod B ANSI 835 has been developed by Travelers and is ready to be sent to physician pilots. A flat file translator is being developed in order to transmit this information. EFT is being piloted and should be available by February.
- Referrals are in production for both Aetna and Blue Cross Blue Shield of Virginia managed care programs. Transactions have increased over 200% within the past two months.
- Commercial eligibility through NEIC's HCIN network is being tested with pilot sites and further rollout of the product is scheduled for this month.
- Enrollment transactions are being done in a proprietary format with three employers and test sites are being evaluated for the 834 format.
- Prudential remittances are scheduled for first quarter and it is expected that the 835 format will be ready during this time frame.
- E-Mail is being tested and applications are identified for multiple healthcare facilities to include hospitals, physician practices, Blue Cross Blue Shield of Virginia, Medicare, Virginia Hospital Association and others.

A press briefing is tentatively scheduled for early February to coincide with initial information on the results of the Tiber Study. Local press information has been sent out and articles are planned by the news media. Also, radio talk shows have included interviews with participants in the Virginia Demonstration. For more information on this Demonstration Project, please contact John Romer at Health Communication Services, Inc. (phone)804-965-6030; (fax)804-965-6018.

WEDI Update is published quarterly by the WEDI Education/Publicity Work Group. Ideas or questions should be directed to Lisa Lachowicz, Mutual of Omaha, Mutual of Omaha Plaza, Omaha, NE 68175. phone (402)978-2401 or fax (402)978-2553.

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NEWS SUMMARY: WEDI MEETS FOR FIRST 1993 SESSION; SEVEN NEW ORGANIZATIONS JOIN WORKGROUP FOR DATA INTERCHANGE

WASHINGTON, Feb. 2, 1993 -- The Workgroup for Electronic Data Interchange (WEDI), a public-private partnership working for administrative simplification in health care, began its 1993 efforts today to resolve remaining obstacles to full electronic interchange.

The group's co-chairs, Bernard R. Tresnowski, president, Blue Cross and Blue Shield Association, and Joseph T. Brophy, president, The Travelers Insurance Company, welcomed eight new national organizations to the coalition.

"These new organizations," Brophy said, "bring critical expertise on streamlining health care administration and ensure that the full spectrum of health care delivery is working toward automating our paperwork."

-- MORE --

WEDI MEETS 2-2-2

At today's meeting, the group committed to resolving the remaining implementation obstacles from its 1992 agenda, including a consensus on:

--creating a unique identifier system for patients, providers and payors;

--the standard information required on health care cards and the potential use of an electronic card to access health insurance information;

--the coordination of benefits (multiple carrier coverages for one person) using an electronic environment;

--telecommuting protocols; and

--uniform data content and standards implementation;

The group also agreed to establish subcommittees to coordinate outreach and education efforts on electronic data interchange (EDI); act as liaisons to state governments working to achieve EDI in their health reform plans and continue analyzing costs and benefits of a paperless system.

-- MORE --

WEDI MEETS 3-3-3

Tresnowski commended the group for helping foster industry consensus on administrative reform and said WEDI will issue a report to the industry and to the new secretary of health and human services in the fall.

"We have in place a public-private partnership that can make significant strides toward a simpler and more effective health care financing system under any reform scenario," Tresnowski added.

Brophy said that WEDI will share its expertise with the new Congress and the new administration as it works toward a health care reform package.

The group also heard progress reports on three initial demonstration projects sponsored by WEDI. The demonstrations include a pilot of automated health insurance enrollment among AT&T and its payors, cooperative efforts to exchange claims in the Minneapolis managed care environment and development of a broad array of EDI transactions in Virginia.

A final report on the projects, including costs analysis is scheduled for April release. WEDI also agreed to adopt a new demonstration project under development in Connecticut.

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WEDI MEETS 4-4-4

The first WEDI Technical Group meeting is scheduled for Feb. 22 and 23 in Chicago.

New member organizations: Self-Insurance Institute of America, American Dental Association, National Council for Prescription Drug Programs, Medical Group Management Association, National Association for Home Care, American Health Care Association, American Clinical Laboratory Association.

Previously-admitted members: American Hospital Association, United Healthcare, The Travelers Insurance Company, Humana, Inc.- Hospital Division, Blue Cross and Blue Shield of Virginia, American Medical Association, Mutual of Omaha, Aetna Life & Casualty, Health Insurance Association of America, Blue Cross of California, Connecticut Department of Income Maintenance, Blue Cross and Blue Shield Association, Health Care Financing Administration, American Health Information Management Association.

-- 30 --

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NEWS SUMMARY: WORKGROUP ON ELECTRONIC DATA INTERCHANGE TO DELIVER PROGRESS REPORT TO CLINTON ADMINISTRATION

CHICAGO, March 9, 1993--The Workgroup for Electronic Data Interchange (WEDI) is compiling a report on the group's progress towards reducing health claims paperwork. It expects to deliver the report to the Clinton administration later this month.

The action was taken during a meeting of the WEDI Technology Advisory Group (TAG), which met here on Feb. 22-23. More than 200 representatives from health care providers, insurers, government, employers, technology vendors and national health care industry associations attended.

It is part of the ongoing effort to implement WEDI's 1992 recommendations concerning moving the nation's health care system from a paper to an electronic system.

-more-

2-2-2-2

WEDI

By May, the TAG expects to draft preliminary findings and recommendations on a broad array of technical issues, including: establishing a unique identifier system for all patients, providers and subscribers; using electronic health card technology; coordinating benefits for patients with multiple insurance coverages via EDI technology; establishing basic requirements for electronic network performance standards; and implementing the ANSI 12 standards and uniform data requirements for health insurance information.

Other key activities include drafting language for federal protection of confidential, electronically-transmitted medical information; working with states to inform them of WEDI activities to simplify health care paperwork; broadening segments of the industry for outreach and education on EDI; and refining estimates of cost-savings by moving to computer communications.

As part of a short-term strategy, the TAG is overseeing EDI demonstration projects which are designed to help stimulate movement towards an EDI system across the country. Minnesota, Virginia and Connecticut have model EDI projects. An employee-payor project is also underway involving AT&T, The Travelers, Empire Blue Cross and Blue Shield and Prudential.

-more-

3-3-3-3

WEDI

Created in 1992, WEDI is co-chaired by Bernard R. Tresnowski, president and chief executive officer of The Blue Cross and Blue Shield Association and Joseph T. Brophy, president, The Travelers Insurance Company. The group is coordinated by a steering committee of 22 national organizations.

WEDI was formed to promote the routine use of electronic data interchange in health care. In 1992, WEDI committed to a public-private partnership and an aggressive workplan to achieve electronic data interchange. To realize this ambitious reform plan through industry initiative, WEDI's goals are to resolve implementation issues and engage health care trading partners in standardized automation.

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CENTER FOR COMMUNITY RESPONSIVE CARE, INC.

2096 Dorchester Avenue
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December 31, 1992

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3 xtra

President-Elect William Clinton
105 W Capitol St
Suite 400
Little Rock, Arkansas 72201

Dear Mr. Clinton,

Happy New Year!

In response to your open invitation voiced in Little Rock, I am writing to add my thoughts and contributions to the round table summit you held there on December 14 and 15. I want to add a perspective to the health care reform talks. I know that you have no dearth of advisors on issues related to health care, but I do not know whether anyone of those advisors speaks for the community and for developing training programs which will teach practitioners to work with communities to improve their health and quality of life. As a physician who has spent most of his career working to develop and implement such programs in several regions of the country, I would like to add lessons of my experience to your deliberations.

First, let me say that I believe that much of what is wrong with today's health care system lies in the fact that medicine and public health are separate and unequal. While the separation of these two mainstays of health may have been appropriate in the time of infectious disease, given the so-called "new morbidities" of modern times, that dichotomy can no longer hold. Recently in talks and in publications, people have begun to call for a merger of medicine and public health, but talk is easy; action must accompany it.

In Little Rock you spoke of the need for a paradigm shift in thinking. Indeed, that is what is needed to bring medicine and public health together. There is no magic to effecting this merger; we have known for decades how to do it. The difficulty has been in the lack of political will and the resistance of the health care establishment to change.

In the meantime, we continue to spend 97 cents of every health care dollar on repairing people after they have become sick or injured, and only three cents of that dollar on keeping them well. As you so aptly commented, we are spending far more on problems after we mess things up than on the opportunity to avoid those problems altogether. For what amounts to all of my career in medicine and public health, I have worked to teach and to apply the principles of what has come to be called community-oriented primary care. I want to explain how and why I think that applying the simple, low-technology principles of community-oriented primary care (COPC) should form the cornerstone of health care reform.

I discovered community oriented primary care (although it wasn't known by that name at the time) when I worked as a young physician on the Navajo Indian reservation in Arizona in the 1950's. At the Cornell University Many Farms Field Health Research Project, we took care of the people who came to the clinic (the numerator population), while simultaneously enumerating and conducting needs assessments of the entire population in the area for whom we were responsible (the

denominator population). In this way we combined clinical medicine's concern with the identified patient with public health's concern for health promotion and disease prevention for the population at risk. (An article we published in Science that explains the project and the approach is attached.)

The actual steps of COPC are simple and logical. As we teach and practice it, those steps are five in number. First, a primary care program defines and characterizes the community for which it has assumed responsibility to provide health care. (While seemingly simple, this step is critical because it forces one to acknowledge responsibility for a community's health.) Second, the program organizes and involves the community so that the groundwork for a community professional partnership is laid. The third step is to conduct a community diagnosis/needs assessment. Fourth, community based interventions are developed and implemented. Fifth, ongoing monitoring and evaluation takes place. While these are listed as steps, they are actually carried out in an ongoing cyclical way, constantly refining and fine tuning, all the while promoting and developing the community-professional partnership. I mentioned that we practiced COPC at Many Farms; the concept was initiated and developed in South Africa and Israel, and supported by a variety of advocates, including the Institute of Medicine, here in the United States. Nevertheless, it has not taken hold as the cornerstone it can and should be.

Why? Although COPC has been endorsed by prestigious governmental, philanthropic, and professional groups, there has never been an overall policy mandate on the national, regional, or local level. I think that this is essential if medicine and public health are to be merged, the key to an effective health care system reform policy.

While the COPC process requires a paradigm shift in thinking, to make and sustain that shift, a supportive policy environment is required. Support in terms of time to conduct community based public health, and support in terms of investment in health promotion and disease prevention. The changes the resource based relative value scale will bring about and the move to pay for clinical preventive services will begin to push in the direction of paying for the types of services needed in this country for individual patient care. However, no one other than ourselves is calling for the type of reform that will train and pay practitioners to work with communities to identify and address community health problems. Health care practitioners know that sick communities spawn unhealthy inhabitants. Until we look at communities as "patients" and address their common, collective problems, the one-on-one clinical (even when modified by the clinical preventive medicine approach) will continue to fall short of the goal of a healthy nation.

Nine years ago I began laying the groundwork for a COPC/preventive medicine residency training program at the postgraduate level here at Carney Hospital in Boston. With help from the W.K.Kellogg Foundation, whose interest is in community empowerment, we have developed a multidisciplinary training program which combines education/training with service. Fellows in the program remain at their community based site, practicing their clinical discipline, while learning and applying--also at that site--new public health skills. In this way they learn to combine numerator medicine with denominator public health. The dramatic growth of the program (the first class in 1988 was comprised of four Fellows; in 1992 we have 33 Fellows in the program) has led us to incorporate an independent entity that we term the Center for Community Responsive Care (CCRC). We needed to develop an independent center as a way to begin replication of what has been initiated at the Carney Hospital base, where we have been housed as a department of the institution. The need to move is because we are training practitioners in towns and cities beyond the radius of the hospital, and this summer began working with the state public health association on a statewide initiative to improve the public's health.

We have also linked closely with hospitals, encouraging them to be more active in the area of training and prevention. Indeed, through the paradigm shift in thinking, they would need to view

themselves as public health institutions, with a responsibility for the health and quality of life of the communities from whence come their patients. Hospitals across the country could establish COPC preventive medicine residency training programs of the type we have developed here in Boston. They could be housed in a department of "preventive medicine and/or community benefits." Such departments would take the lead in assuring that a critical mass of hospital staff were trained in merging medicine and public health, based on the community oriented primary care model. It would also have the responsibility of assuring that the institution was working to improve the health and quality of life of its denominator population.

I don't know if you saw the enclosed Wall Street Journal article concerning the need for preventive medicine and public health trained practitioners in the country. There is a need for replication of our COPC preventive medicine people in large numbers as the most appropriately trained practitioners for the 21st century. They should also be trained for the 600 community and migrant health centers (see the enclosed clipping from USA Today which alludes to that need; they are overburdened, underfinanced, and though they are staffed by skilled clinical practitioners, few are trained in public health competencies). Transformation of all community health centers from multidisciplinary primary care centers to mini public health departments through the COPC process will provide the paradigm shift that is needed. Of course, along with that is needed the environment, i.e., the organizational and financial suppport to sustain this orientation to practice.

We are all acutely aware of the current high cost of the health care delivery system; a system that places greater emphasis on acute hospital care than community based primary and preventive care. Proposals for change must address the organization and delivery of health care services, as well as the training of practitioners to work in and shape that delivery system. What we as a country craft as a system for the 21st century must create an equilibrium between medical care and health care, between public health and personal health services, and between curative and preventive care. The COPC model and the discipline of community and socially responsive medicine is a process for making a health care system more rational, accountable, appropriate, and socially relevant to the public. This model is at a pivotal point in its evolution, and should serve as a paradigm for reforming the organization, delivery, and training for health care services in America. I would hope that it would become a part of the health care reform debate leading to a consensus around it as basic for successful reform.

Sincerely yours,

Hugh S. Fulmer

Hugh S. Fulmer, MD, MPH
Director, Community-Oriented Primary Care Program
Executive Director, Center for Community Responsive Care, Inc.

Enclosures

cc: Members of the Board, Incorporators, and Friends of
Center for Community Responsive Care, Inc.

Wall St. Journal
11/23/92

HEALTH

Preventive Care Is Prescribed to Cut Costs, But Doctor Training Faces the Scalpel

By P. Mona Khanna
Staff Reporter of The Wall Street Journal

In New Jersey, they had to look for more than four months. In West Virginia, the search has gone on for five years. "These people are few and far between," says Frances J. Dunston, New Jersey's former commissioner of health.

The object of pursuit: physicians who specialize in disease prevention and public health. New Jersey needed someone to direct the state's programs for maternal and child services; West Virginia is looking for a doctor to monitor and study outbreaks of illness.

The two states, though, as well as numerous communities and hospitals across the country, have run up against one of the most pressing and disturbing problems in medicine. At a time when the idea of preventing disease is increasingly touted as a way to help limit spiraling medical bills, the very programs that provide training in prevention and public health are in danger of collapse.

In the past two years, for instance, five of the 45 residency programs in U.S. universities and health departments that specialize in the field have been forced to close their doors for lack of funds. Only 13 programs this year will receive some type of government funding, down from 20 in 1993. And the $1.6 million that universities received in the current fiscal year for training in preventive medicine and public health is set to be sliced from the 1993 federal budget.

Those programs are responsible for filling some of the most critical, but least-heralded, positions within the medical community. Specialists in the field investigate outbreaks of disease; they monitor the safety of food and water supplies, as well as toxic-waste disposal; they oversee the medical care of some 36 million Americans who are uninsured, providing prenatal care, well-baby checks and treatment of sexually transmitted diseases. On a daily basis, they counsel patients on diet, exercise—even seat-belt use.

All too often, however, their low-tech efforts seem insignificant in an era focused on high-tech medicine. "Americans are addicted to artificial hearts, magnificent new drugs and liver transplants," says C. Everett Koop, former surgeon general. "When you get to prevention, all they can think of is Nancy Reagan and 'Just say no.'"

Among employers and other payers of medical bills, preventive medicine is actually experiencing an awakening. If current trends in health care continue, the country's medical tab will total about $1 trillion by 1995. As companies and legislators search for tools to pare that figure, less-expensive prevention—in which fancy scalpels and minicameras are traded for old-fashioned counseling and education—becomes increasingly attractive.

Today, about 40 U.S. universities and health departments still offer training in preventive medicine and public health. Their graduates perform a myriad of services. Now an officer with the Centers for Disease Control and Prevention in Atlanta, Kim Yeager, a physician and graduate of the preventive medicine residency at the University of California at San Diego and San Diego State University, designed and opened a free immunization clinic for hard-to-reach, high-risk Hispanic children in San Diego County. Since March, the clinic has given 3,000 immunizations to uninsured patients who otherwise wouldn't have received them.

Despite the current emphasis on prevention, health-care workers that specialize in the field have traditionally found that their efforts and successes often go unrecognized. "It's hard to say that a person would have become ill, and now that person is not ill," says James Jekel, who is being forced to phase out Yale University's 23-year-old residency program in prevention.

What's more, specialists in the field often face animosity from fellow physicians and health-care workers, who often regard their diverse jobs with a good deal of suspicion.

Gustav Schönfeld, professor of medicine at Washington University in St. Louis, Mo., ran the university's department of preventive medicine for three years before it closed in 1987. Specialists in prevention "weren't thought to be the most academically gifted people," says Dr. Schonfeld. That stigma helped seal his department's fate, he adds. "It's the difference in being in the supply corps and on the front lines. The respect goes to the people who are thought to be doing the most difficult job."

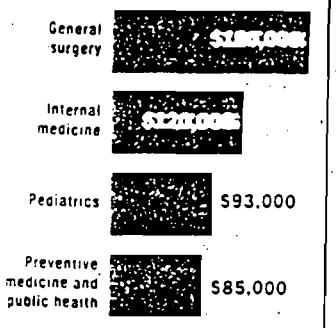
Not only the respect, but the money as well. Andrew Dannenberg, director of Johns Hopkins School of Public Health and Hygiene, says most of his residents, unlike those who work in the vast majority of hospital programs, aren't paid and routinely have to work a second job to make ends meet. Karen R. Kingry, a pediatrician in Silver Spring, Md., who is interested in preventive care, applied to the Johns Hopkins program and was accepted, but hesitated when she learned about the

Please Turn to Page B6, Column 5

Specialists in Disease Prevention and Public Health

Comparing Salaries

Median income of some medical specialties in 1989



Sources: American Medical Association; National Institutes of Health

What Prevention Experts Do

- Study and control outbreaks of diseases like measles
- Counsel patients on diet, exercise and nutrition
- Work as administrators and policy makers in local, state and federal health departments
- Conduct research in preventing disease
- Diagnose and treat disease in immigrant and indigent clinics
- Evaluate health hazards in workplaces
- Teach other health professionals and the public how to prevent disease
- Monitor the safety of food and water
- Ensure the safe disposal of toxic waste

Preventive Medicine Is Touted but Trainin Confronts the Scalpe

Continued From Page B1

lack of salary.

"Any residents who come straight of medical school," says Dr. Kingry, " going to look at this and say, 'I really wo like to go into health policy, but how a going to eat?' " Dr. Kingry, who has children and is still paying off her origi medical-school loans, adds that she deferred her admission at Johns Hopki

In July, the Council on Graduate Me cal Education, a part of the Departmen Health and Human Services, citing "continual shortage" and "virtual abse of funding" for preventive medicine re dencies, recommended that teaching h pitals pay doctors who specialize in field 40% more than the average resice So far, no changes are apparent.

Despite the difficulty many doct have staying afloat financially dur training, public-health jobs after grad tion are abundant. J. Lyle Conrad, officer with the CDC who helps pl graduates of the centers' training p gram, says he gets at least two calls a w for public-health officers.

"I tell our graduates not to worry wr they get through because there are pc tions available in virtually every state," says. The Epidemiology Monitor, a new paper published by the centers, lists hu dreds of positions each month.

Health officials in West Virginia, w have been looking for a public-hea officer for five years, insist that the st isn't in grave danger. But they conce that their ability to respond to outbreaks disease is limited only to the most press demands.

"We put out the fires," says Lore Haddy, an administrative director at state health department in Charlesto "We only do what we absolutely have do." Recently, she says, a company a proached her office trying to sell educ tional materials targeted at speci groups, like teenagers, that seek to p vent disease. While the material look promising, she says, she didn't have ti to wade through the information.

The lack of funding and specialis bodes ill for the future, says Kathle H. Acree, chief of disease prevention a health promotion for California. "If we going to move into the '90s, we're n going to do it by business as usual. Wh are we going to do if we don't have the people?"

"These funds [help] train people w are the equivalent of Harvard and Stanfc MBAs," adds Kevin Patrick, head of t preventive medicine residency program the University of California at San Die and San Diego State University. But t dwindling number of physicians who sp cialize in the field, he says, means th "states are woefully underprepared meet public-health needs."

Clinics are savior for poor, uninsured 11/3/92

Need grows in a weak economy

By Edward L. Kenney
USA TODAY

NEW CANTON, Va. — As appointment clerk at the Central Virginia Community Health Center, Delphine Stanton sees them come with all manner of ailments.

But in her six years at the clinic here in farm and timber country, Stanton can't remember seeing such a relentless flood of patients.

"Sometimes there's not even room in the waiting room for people to sit," she says.

Already waiting are people like Dorothy Owens, 55, of Dillwyn, who "can't pay the $100 you have to pay at a regular doctor, just for an office visit."

And Estelle Cabbell, 63, New Canton. She could no longer afford insurance when she retired. "Nowadays, if you don't have insurance, they don't want to see you," she says.

Tony Conwell, 30, of Buckingham, just started a new job, and his insurance coverage won't start for 90 days. "We'd be in a world of hurt if not for the clinic," he says. "It's about the closest one and it's the one we can afford to come to."

This center, about 45 miles southeast of Charlottesville, is part of a national system designed to serve the poor and geographically disadvantaged. Supported by patient fees, federal, local and private funds, it's not the only one pushed to its limits.

The USA's 550 community and migrant health centers — like emergency rooms in big-city public hospitals — are increasingly pressed. Started in 1965 as a demonstration project during President Johnson's War on Poverty, the centers served more than 5 million patients in 1990, an increase of 1.3 million from 1981.

"The health center program was envisioned as a companion to the Medicaid and Medicare programs," says Dan Hawkins of the National Association of Community Health Centers.

"The belief was that Medicaid was going to be able to help all the poor. Today, it helps a little more than half."

"There are hundreds of thousands of people out there who can't get the care they need," says Sylvia Drew Ivie of the T.H.E. Clinic for Women Inc. in Los Angeles. "We have patients in the hall and on the stairs leading to the clinic."

Ivie fears the worst if increases continue: "People will die," she says.

The Los Angeles and New Canton clinics were among 19 surveyed recently by the National Cooperative Bank, a leading private source of funding for such centers.

Two-thirds of those chosen to reflect a range of size and region had increases averaging nearly 25% over last year.

The other third — like Erie Family Health Center in Chicago and Los Barrios Unidos in Dallas — already were operating "at capacity," unable to accept new patients.

Photos by Chip Mitchell

MONEY CRUNCH: Cephas Goldman, former executive director of Central Virginia Community Health Center, says many clinic patients put off routine care, until a minor ailment turns into a crisis.

The biggest reasons for the increase, say centers surveyed: unemployment and loss of health insurance.

Bert G. Steeves, president of Hunter Health Clinic Inc. in Wichita, Kan., says half of its 35% increase is "folks who were formerly insured who weren't able to maintain private insurance due to the increase in rates. There is a national health crisis out there, and the question is: What are we going to do about it?"

"The vast majority of our patients are uninsured," Ivie agrees. She also blames some of her 66% increase on hardships caused by fires set during Los Angeles' riots last spring.

Hawkins says many of the nation's community clinics are experiencing "phenomenal increases and are wholly unable to cope with it."

Other reasons for overload: a shortage of rural doctors and rejection of Medicare patients by physicians who fear inadequate reimbursement.

The centers began seeing more uninsured in the early 1980s, Hawkins says, with more people who had jobs but couldn't afford medical insurance — or the $500 deductible patients often must pay.

"These are folks used to having a family doctor, and they want to have a regular source of care," he says. "They're turning to the health center be-

over ->

cause they see it as the closest thing to a family doctor that is affordable to them."

But Dr. John Brinley, 30, a staff physician at the New Canton clinic, says some patients have been skipping important preventive care — Pap smears, mammograms, cholesterol checks — because they say they can't afford it.

Brinley has been "coming in a little earlier, leaving a little later" to handle the crunch.

About 175 people are on a waiting list for routine dental care, says former executive director Cephas Goldman, a dentist and 13-year veteran who left the clinic recently for another job.

What patients may not realize: Putting off routine care can result in a crisis. One had such a swollen jaw from an infection it closed off his air passage and he had to be rushed to the hospital for an emergency operation, Goldman says.

"I said, 'Why didn't you come in?'" he adds. "He said he didn't have enough money."

TOO EXPENSIVE: George Twitty waiting with wife Juliette at the Central Virginia Community Health Center, says, 'A private doctor costs too much money. We're on Social Security. At 84 years old, you couldn't get a bandage from a private doctor.'

CENTER FOR COMMUNITY RESPONSIVE CARE, INC.
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This proposal requests funding for the Center for Community Responsive Care to demonstrate and evaluate the effect of incorporating payment to practitioners for practicing community based "denominator" medicine. Our hypothesis is that incorporating payment for this type of practice will catalyze the merger of medicine and public health through promotion of a new kind of delivery paradigm: a practitioner team functioning in both a clinical and community responsive public health capacity. Access and quality of care will improve for populations that traditionally have been un-or-underserved, as well as for those who have been served adequately through the traditional medical model of care. In the new paradigm the community will be empowered to work with a combined medical and public health practice that is responsive to community needs.

It is ironic that Abraham Flexner--the man viewed as responsible for the reductionist model of American medical education-- wrote that "'the physician's function is fast becoming social and preventive, rather than individual and curative.'" Virtually every decade since then, academics and practitioners alike have published papers calling for a new model of practice, usually one that incorporates the implications of Flexner's assertion. However, with the exception of demonstration projects that flower briefly and then die due to lack of major organizational and financial changes, the medical care system in this country has failed to expand beyond its narrowly construed one-to-one physician-patient relationship paradigm and evolve into a new system that would enable it to accept its social obligations. Indeed, the geometric growth of science and technology in the latter half of the 20th

century has driven the medical-industrial complex and its physicians and other health professionals towards specialties that are technology intensive. Reinforcing this trend has been a bias in financing health care that favors acute care rendered by specialists. As the system continues its downward spiral in the 1990s, continued efforts to patch here, and to fine tune there, are perpetuating failure. Even the early excitement of the potential effect of the Resource Based Relative Value Scale (RBRVS) recently adopted by Medicare as a payment framework has begun to be tempered. While paying relatively more for cognitive work, it ignores the practitioner who might have an expanded outlook and competencies; one who accepts the social obligation of medicine and practices community based primary care and public health. We must train, retrain, and then support physicians and other providers organizationally and financially to practice community based denominator medicine . The fundamental problem of the "physician mind set" and "the failure of medical education to keep pace" can be changed with the approach to payment reform that is outlined in this letter of intent.

A corollary to the historical bias toward acute care is the longstanding public and professional attitude that clinical care can only be practiced on a one-on-one level, and that the highest quality medicine is delivered by highly trained procedurally-oriented specialists. Yet the effectiveness of population based health promotion/disease prevention programs developed in partnership between practitioners and communities can have a potent and far reaching impact on health and the quality of life. The attitude that public health clinicians do not practice medicine and the consequent perception that is reflected in their relatively low compensation must change if we are to become community responsive and meet the challenge of worsening patterns of disease and disability disproportionately affecting the more disadvantaged

sectors of society.

Recognizing the longstanding trend favoring subspecialty, high technology practice, in 1988 the WK Kellogg Foundation gave initial funding to a Boston based training program in community-oriented primary care/preventive medicine. The major goal of the program has been to train clinicians in preventive medicine and public health skills which they then combine with clinical primary care in a new community responsive paradigm of practice.

These hybrid practitioners have been able to combine public health activities with clinical medicine only because they have been part of a funded demonstration project of basic training merging medicine and public health. Once trained, there is no payment mechanism available to sustain them or to enable them to practice their new competencies. We propose to demonstrate and evaluate the impact of a financing structure to compensate this new community responsive clinician for that portion of time devoted to public health activities. These activities will constitute the core tasks of the new clinician-public health practitioner who is responsible for the health of the denominator community served by a primary care practice. Market salaries for the new primary care/public health specialist are essential to attract and retain practitioners, as well as to legitimize this group as an accepted member/leader of the health care team as the paradigm shifts from the medical to the community responsive model of care.

The purpose of the new financing structure is threefold:

* to attract physicians and other health care professionals into the field of community oriented primary care practice and to develop realistic incentives to ensure they remain in this field;

* to develop an incentive-based, outcome oriented reimbursement system for hybrid practitioners;

* to accelerate the process wherein health professions education schools and training programs reorient their educational perspective towards a COPC approach that merges medicine and public health.

We are requesting five years of funding for up to ten practitioners each year, for that portion of their time that is allocated to community based public health activities. The majority of these new hybrid practitioners will be physicians; however, each year two to four non-physicians, e.g., nurses, dentists, will also be supported.

Parameters of outcomes, process and structure will be identified and measured through quantitative and qualitative research approaches. In monitoring outcomes, factors such as the percentage lowering of identified risk factors for specific populations could be an appropriate benchmark. Some data bases to test this level of impact of community public health intervention are already available. Others will be developed. Structure and process aspects include, for example, the development of epidemiologic data bases which communities can use for setting priorities, or the recruitment and training of community health visitors.

Training programs that combine community based primary care with public health will produce a cadre of health care practitioners who will work as teams in partnership with communities to identify and address health problems. However, for hybrid practitioners to be able to use these skills, the payment system must be restructured so that they are compensated for their time at a level that reflects their value to society, and is, at the least, competitive with their colleagues in other specialties.

COPC HYBRID PRACTITIONER JOB DESCRIPTION

Overview

The hybrid practitioner must participate in the five steps of community diagnosis and treatment. These steps are: 1) Defining and characterizing the community; 2) Involving the community; 3) Identifying community health problems; 4) Developing an intervention program; and 5) Monitoring program impact. In addition, a COPC practitioner must work as a change agent in his or her practice to foster the development of COPC both within the practice and in the community at large.

Qualifications - Community Oriented Primary Care Training

1. Primary care training (usually three years post graduate medical education.)
2. COPC training: Two-year preventive medicine and public health residency
   a. Academic training in public health including the disciplines of medical administration, epidemiology and biostatistics, environmental sciences, and behavioral sciences.
   b. Practicum training in applied COPC.

3. Continuing medical education

Responsibilities

I. Work as Agent of Change; Contribute as integral member of COPC team in:

1. Administrative role in medical practice,
2. Meeting with other key people in practice,
3. Designing and delivering staff education programs,
4. Arranging and participating in community meetings and working to create relationships with other community groups and leaders,
5. Designing and delivering community education programs,
6. Developing community-professional partnership,
7. Continual, ongoing evaluation

II. Involve the Community

1. Meet with community leaders.
2. Attend community meetings.
3. Develop task force(s) to participate in data gathering and interpretation.
4. Encourage opportunities for leadership training.

III. Define and Characterize the Community

1. Collect and analyze secondary demographic data.
   Work with other institutions to obtain relevant census and other

data. Encourage collection and aggregation of data in unit useful for the practice. Engage in ongoing data analysis.

2. Key informant data.
   Meet with community leaders and health professionals to incorporate their perspectives on the community and its health problems.
3. Collect and analyze primary data for target population.
   Develop primary data gathering instrument.
   Collect data via community survey
   Analyze quantitative and qualitative results; compare to secondary data analysis.
4. Update information periodically.
5. Collect and analyze demographic data on active patient population; compare to other data sets (i.e., secondary and primary).

IV. Define Health Problems in the Community through the Planned Approach to Community Health (PATCH).

1. Identify and meet with key informants
2. Recruit and train community participants
3. Collect primary data
   Design health risk assessment survey
   Data collection
   Data analysis
   Quantitative and qualitative
4. Secondary sources of data
   Identify sources. This can include census data, vital statistics, hospital discharge data, medical examiner data, police and fire information.
   Collect and analyze data
5. Identify determinants of health problems
   Ongoing literature review
   Research in community epidemiology
6. Collect and analyze health data on active patient population.
7. Work with community groups to set priorities for intervention.
8. Meet periodically with representatives of State Department of Health regarding activities directed at defining the health problems.

V. Design Intervention Program

1. Plan in conjunction with community and other health center staff
2. Program development
3. Network with other community organizations; encourage their participation
4. Program administration
   Grant writing
   Personnel hiring and supervision
5. Staff training
6. Examples of program implementation:
   Vary mix of primary care services
   Primary care programs to target special high-risk groups
   Improve access to services
   Health education programs

Outreach programs
Lay community health worker programs
Community organization and voluntary activities
Political advocacy

VI. Evaluation

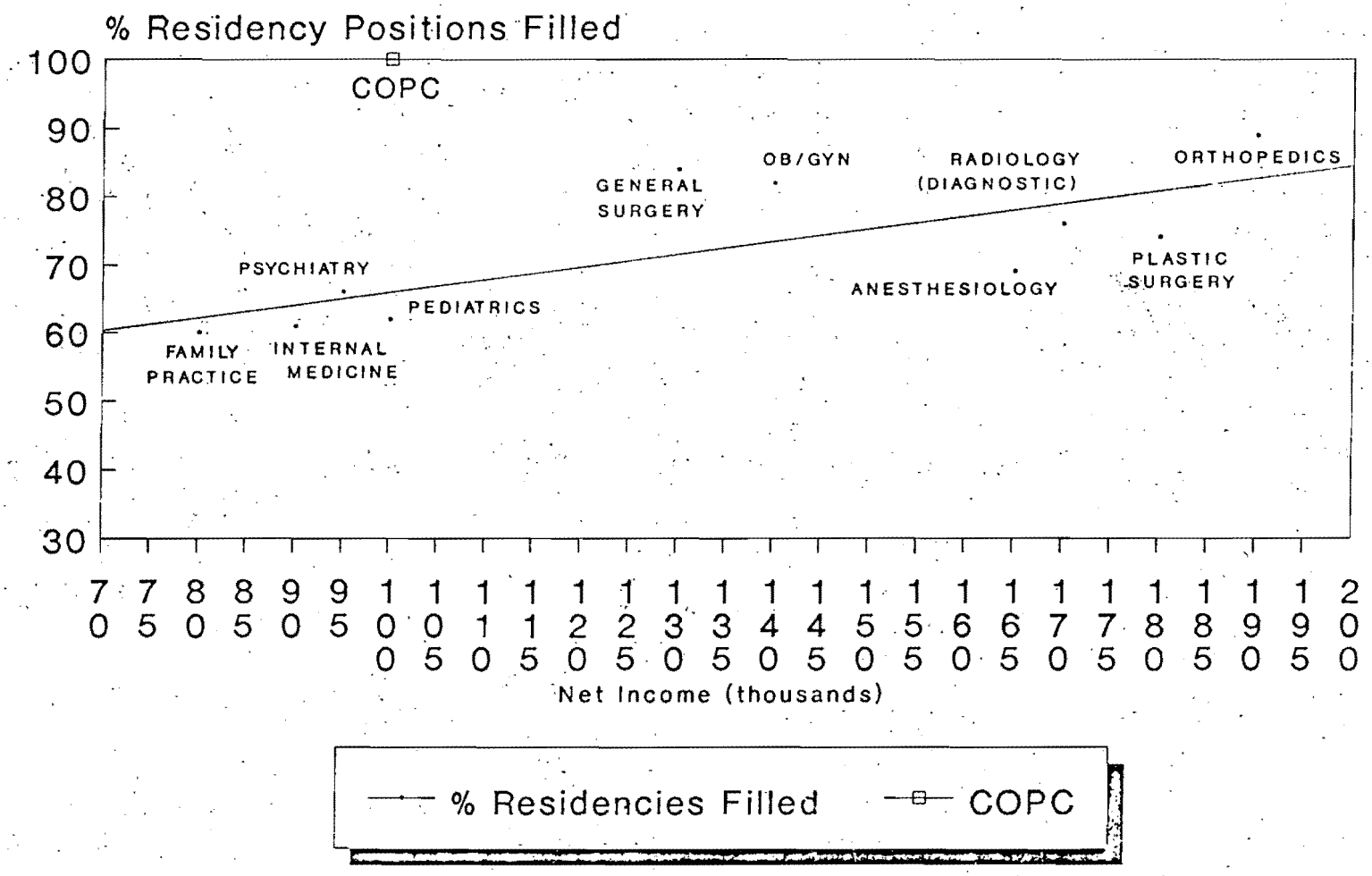
1. Incorporate into program design
2. Conduct ongoing epidemiologic research and qualitative assessment
3. Periodic process and outcome monitoring

Approximate Allocation of Time

Clinical Work:	
Direct Patient Care	16 hours
Patient Follow-up	4 hours
Community-Oriented Primary Care *	
Teaching and Change Agent Work	4 hours
Data Collection/Analysis	6 hours
Program Design	2 hours
Program Implementation	3 hours
Program Evaluation	2 hours
Administration and Community Organization	3 hours

* The 20 hours of COPC time is divided above based on anticipated average time and is done for illustration only. Weekly allocations of time to various activities will vary greatly both week by week and also over time as change and organizing become less of a focus and program implementation and evaluation are on-going.

Medical Specialties
Income to % Residency Positions Filled



Source: NRMP Data - April, 1989

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DRAFT PROPOSAL
for the
RURAL MANAGED CARE NETWORK
MEDICARE DEMONSTRATION PROGRAM

Executive Summary

The Health Reform Study Group sponsored by the Rural Referral Center Coalition proposes a five-year Medicare demonstration program to develop models of Rural Managed Care Networks (RMCN) through exclusive payment franchise arrangements for the care of Medicare beneficiaries within a defined market area. The RMCN would be responsible for creating a service network that offers the full range of Medicare covered services, with the addition of preventive services defined in the Federally Qualified Health Center Program. While Medicare beneficiaries would retain complete freedom of choice as to whether they used providers within the RMCN or outside the RMCN, there will be significant incentives to encourage their use of the RMCNs. For instance, we are hopeful that at least several sites would offer an option to join Exclusive Provider Organizations (EPOs) established by RMCNs, through which beneficiaries could have access to an expanded benefit package or to discounts on services not covered by Medicare. For those beneficiaries not in EPOs, other incentives could be used, such as waiver of copayments for services provided by the RMCN.

The purpose of the proposed RMCN program is to demonstrate in up to 10 states the effectiveness of provider networks, coordinated by a large service provider (network organizer), as a workable way to organize the market while maintaining or expanding access, containing costs, rationalizing the delivery system, and providing improved measures of quality outcomes. In addition, the program is designed to provide for a much more participative local planning process with considerably less cost than an externally regulated system.

In this demonstration, Rural Referral Centers (RRC) or other large rural providers would act as "network organizers". In the model, the network organizer is the hub in a wheel of network arrangements with "network providers" that are under contract with or employed by the network organizer. The network organizer will be responsible for providing or arranging for access to Medicare-covered clinical services for the Medicare population living within a defined geographic market area, as well as for assuring the proper distribution of services and coordinating their use within the network. Each network organizer will be paid on a capitated basis and will be entitled to use its capitated payments to manage the care of the Medicare beneficiaries. The network organizer will be at risk for paying for all covered services, regardless of whether the services are provided within the RMCN. A complex strategy of blended risk pooling is proposed to protect beneficiaries and the

Medicare program. The risk mitigation strategy is governed by a Risk Management Cooperative composed of all RMCNs in the demonstration.

The RMCN program is a bold step to link rural providers into integrated networks of care. We are continuing to explore the extent to which legal waivers, including from Medicare and Medicaid fraud and abuse laws, and limited exemption from potentially applicable state insurance and HMO requirements would be necessary.

While this demonstration is designed principally as a Medicare demonstration program, it has significant potential for setting a course for health care reform with rural non-Medicare populations. Any proposed change in the health care system should be measured against its expected performance in:

1) improving access;
2) containing costs;
3) assuring quality; and
4) rationalizing the delivery system.

The RMCN demonstration contains powerful incentives for the health care networks to "do the right thing" in all of these areas of performance.

Access will be improved because, given that beneficiaries will retain freedom of choice, it will be in the networks' best interest to provide convenient points of service in order to hold patients within the system. State and federal oversight will guide the development of RMCNs and their points of access. Further, payment rules will protect existing special providers like Rural Health Clinics, Federally Qualified Health Centers and Sole Community Hospitals, so as to retain these significant rural points of access.

Costs will be contained by the RMCN program by paying the network organizer on a capitated basis at the current amount of fee-for-service payments for Medicare beneficiaries (100 percent of AAPCC), while constraining the increases in these costs over the life of the demonstration. By design of the program, the RMCNs will have incentives to develop and employ cost saving procedures throughout the networks.

Quality will be assured through the continued use of PRO reviews and by the addition of a unified medical data system that will provide new information on the process and outcomes of care. A new provider-consumer Quality Assurance Council structure is proposed as a way assuring accountability and sensitivity to local concerns and variations in local standards of care. The demonstration program anticipates developing system-wide practice parameters and guidelines that will be applicable to all network providers. Also, because the network organizer is at-risk for all care to the Medicare beneficiaries in the area, RMCNs will have a financial incentive to provide highly acceptable care in order to encourage beneficiaries to stay within the network.

This Medicare demonstration would provide powerful local incentives for rationalizing the delivery system as networks seek to attain efficiencies within their systems. Granting network organizers geographic payment franchise and capitated payments offers strong incentives to rationalize and regionalize health care services.

In addition to the basic demonstration program, a small grant program for capacity development at the state and local level is also proposed. The Network Development Grant Program is proposed to provide grants in five areas:

1) Grants for up to 10 states to participate in developing RMCNs within existing state planning processes;
2) Grants for potential RMCNs to conduct feasibility and market studies;
3) Grants for RMCNs to acquire consultative technical assistance in network formation;
4) Grants for networks to acquire comprehensive clinical and administrative data systems; and
5) Grants for networks to develop or expand telecommunications capacity within the network.

Funds for this small grant program could be obtained from the current Hospital Transition Grant Program.

In summary, the Rural Managed Care Network Demonstration Program and its accompanying Network Development Grants Program provide all the right incentives for delivering accessible, cost-effective, quality care in rural areas that have a large provider as the dominant force in the region. The program encourages networking and rationalization of the health care system, and does so through a system of incentives, rather than governmental directives. At the same time, the demonstration includes important roles for both state governments and the federal government in planning for network development by striking a public/private partnership with government to solve certain public policy problems regarding health services delivery. By seeking a partnership with government, this demonstration could be a key component of a national health care reform strategy.

Importantly, both the demonstration and the grant programs can be accomplished <u>without</u> new infusion of money into the Medicare system or new appropriations, and the programs provide a useful precursor for significant health care reform in rural America.

Draft Proposal

Rural Managed Care Networks
Medicare Demonstration Program

Prepared for the

Health Reform Study Group
of the
Rural Referral Center Coalition

By

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DRAFT PROPOSAL
for the
RURAL MANAGED CARE NETWORK
MEDICARE DEMONSTRATION PROGRAM

Introduction

At his economic conference in December 1992, then President-elect Bill Clinton enthusiastically noted that the nation cannot solve its fundamental economic problems without addressing the important issue of health care. Now President Clinton has reiterated his commitment, and has appointed his wife, Hillary Rodham Clinton, to head a special committee to shape a legislative proposal for consideration by the U. S. Congress in May 1993.

Preliminary discussions around the nation on the shape of national health care reform have centered on the need to contain costs, while maintaining or increasing access, and rationalizing the delivery system. The primary method for developing a more rational delivery system in any reform package is through the development of health care networks.

Much of the recent discussion of national health reform has included some aspects of the "managed competition" approach as propounded by Jackson Hole Group. Managed competition relies on the development of competing "accountable health plans," defined as comprehensive organized delivery systems competing on the basis of cost and quality within a given market. In an article in the *New England Journal of Medicine* (Vol. 328, No. 2, pp. 148-152) in January 1993, Kronick, et. al. concluded that managed competition would work only in middle-sized and large metropolitan areas large enough to support three or more competing plans. Rural areas and smaller metropolitan centers, containing about one-third of the U. S.. population, would require some other forms of organization and regulation. Ellwood, one of the architects of the Jackson Hole proposals, has suggested that one way of serving sparsely populated rural areas would be through the use of "exclusive franchise arrangements."

Another concern that has arisen from recent health care reform discussions is the limited scope of coverage for rural residents. As currently envisioned, health reform would exclude Medicare beneficiaries and those covered by ERISA plans and Federal Employee Health Benefit Plans (FEHBP). Such a scheme would conceivably leave only Medicaid recipients, those employed by small businesses, self-employed, and the currently uninsured covered by the new plan. By omitting these large coverage groups the purchasing agent (e.g., a Health Plan Purchasing Cooperative) could be left without much leverage in rural areas, because in many parts of the country, most rural residents that have insurance coverage are covered by either Medicare, ERISA, or FEHBP plans. In the state of West Virginia, for example, 1.3 million of the state's 1.8 million population are covered by Medicare, ERISA, or FEHBP.

In the Spring of 1992, certain hospital members of the Rural Referral Center Coalition, a group of 90 of the nation's Rural Referral Centers (RRCs), established a Health Reform Study Group (the Study Group) to frame an approach to health reform that centered around the use of rural health care networks sponsored by RRCs or other large rural providers. The Study Group reached consensus on the goals of health care delivery system networking, as follows:

1) to increase access to needed services for both patients and providers;
2) to improve the continuity of services by reducing fragmentation and improving quality; and
3) to improve efficiency and lower costs by eliminating duplication, excess capacity, and waste.

To achieve these goals, networks seek to meet all or some of the following objectives:

a) To increase access to technology for underserved populations;
b) To stabilize prices within a market;
c) To improve the ability to control costs;
d) To increase access to specialty care for patients;
e) To increase access to administrative support services for providers;
f) To reduce unnecessary duplication of services;
g) To reduce the number of beds in services;
h) To define quality (clinical and operating standards); and
i) To share information systems.

RRCs or other large rural providers could provide a focal point for effective health care network development. These providers possess the range of clinical and administrative expertise needed; the patient care volume necessary to spread cost and generate capital; and the physical capability in terms of technology and systems to support the network development. Very importantly, because they are rural as well as large providers, they have the sensitivity and motivation to work with smaller rural providers and communities. In some markets, smaller rural providers are themselves able to pull themselves together into networks of a viable size, but their success is highly dependent on their leadership and the density and richness of their markets and services.

Because of their size and complexity, RRCs and other large rural providers, are in a unique position to play major roles in achieving all the above-stated objectives. Recognizing this, the Study Group seeks the opportunity to define a Medicare demonstration program for immediate implementation.

Rural Managed Care Network Program Outline

The purpose of the proposed Rural Managed Care Network (RMCN) program is to demonstrate in up to 10 states the effectiveness of provider networks, coordinated by a large service provider (network organizer), as a workable way to organize the market while maintaining or expanding access, containing costs, rationalizing the delivery system, and providing improved measures of quality outcomes. In addition, the program is designed to provide for a much more participative local planning process with considerably less cost than an externally regulated system.

RMCNs will employ various payments rates and mechanisms in working with Medicare providers. The demonstration will place high value on local variation which responds to local provider resources and characteristics.

Similarly, the demonstration retains patient freedom of choice, and it will offer an array of options for Medicare beneficiaries, ranging from continuing under current fee-for-service arrangements to joining in an exclusive provider organization (EPO). For beneficiaries who choose the EPO option, in exchange for their commitment to use only network providers (i.e., those under contract with or employed by the RMCN), the range of additional entitlements might include an enhanced service package or discounts on additional services. It will be important for networks to develop health plan options that encourage more use of services within the network or the benefits of network formation could be lost. The demonstration envisions that each RMCN demonstration site may design its own incentive package.

1. Coverage:

a. Population to be served

For the purposes of this demonstration, all Medicare beneficiaries having their principal residence (i.e., where they get their social security checks) within the geographic market area would be considered the RMCN's service population. This provision would exclude beneficiaries who are only temporary, seasonal residents of the RMCN's defined service area (e.g., "snowbirds").

b. Beneficiary options

The RMCN demonstration would continue to offer Medicare beneficiaries who do not select an EPO option full freedom of choice to obtain services wherever they choose. The RMCN would be required to pay for Medicare covered services regardless of whether they are provided within or outside the network and to coordinate the care of beneficiaries.

The fact that non-EPO-participating beneficiaries will have freedom of choice to go outside the plan for care, will be an important incentive for the RMCN to provide excellent service, as well as financial and service incentives to encourage beneficiaries to use the RMCN. Therefore, the demonstration proposes that when beneficiaries choose network providers, their Medicare copayments would be waived. On the other hand, if beneficiaries choose to use non-network providers, the regular Medicare copayments and deductibles would apply.

As a local option, some RMCNs may offer an alternative option for beneficiaries to enroll for managed care in an EPO. If beneficiaries elect the EPO option, they will agree to seek their care within the RMCN exclusively and they may receive enhanced benefits, discounts on Medicare non-covered services, or other incentives. The type and scope of these additional incentives for beneficiaries' EPO enrollment will be developed as a local option by RMCNs which will encourage innovation within the demonstration. EPO enrollees will also be matched with a primary care physician who will provide a "gatekeeping" function for beneficiaries' care.

The range of beneficiary choices is represented in the table on the following page:

Beneficiary Choice	Beneficiary Service	Beneficiary Incentives
Regular Medicare	Medicare covered services by any Medicare provider.	None
RMCN provider usage	Medicare covered services, plus FQHC preventive services. Coordinated care provided by RMCN.	Copayment waived
RMCN-EPO enrollment and exclusive use of network providers.	Medicare covered services, plus FQHC preventive services and gatekeeper service by primary care provider.	Copayment waived and other incentives, such as discounts or vouchers for additional services (such as glasses, dentures, hearing aids, etc.)

c. Scope of services

As discussed briefly above, the RMCN would be responsible for providing or arranging for the normal scope of Medicare covered services for all beneficiaries residing within the defined market area. In addition, Medicare beneficiaries seeking care from providers under contract with the RMCN ("network providers") would receive an expanded package of preventive services currently covered by the Federally Qualified Health Center (FQHC) Program. These services include a significant number of preventive health services, such as medical social services, nutritional assessment, preventive health education, influenza vaccinations, vision and hearing screening, and mammography. Including FQHC services in the service package should have the additional effect of assuring that networking efforts encompass the infrastructure containing public health expertise.

As discussed above, some RMCNs may develop EPOs as a local option for Medicare beneficiaries willing to commit to using network providers exclusively. Although coordinated care is assured for all Medicare beneficiaries, care for EPO enrollees would be carefully managed by primary care gatekeepers.

In addition, RMCNs may offer, at their local option, incentives such as enhanced services, or discounts or vouchers for services not covered by Medicare (e.g., eyeglasses, hearing aids, or dentures).

In addition to direct health care services, the RMCNs would provide administrative services to beneficiaries, including:

- Administrative coordination to promote efficiency and network cohesion. Rural providers frequently duplicate administrative services, and larger providers often have services or areas of administrative specialty available that are unattainable by small providers individually. A recent study in West Virginia documented that even a relatively small rural network could save between $1 million and $1.5 million annually by sharing administrative functions such as data processing and service and maintenance contracting.

- Clinical coordination to assure a seamless system of clinical care. Although there are many notable exceptions in rural America, in many communities clinical providers are in separate locations and are not well integrated. In their efforts to assure access and quality, rural providers frequently duplicate clinical support services such as utilization review, infection control, biomedical engineering and discharge planning. Increased networking of providers offers new opportunities to overcome duplication and improve quality.

- Shared information systems to facilitate coordination of clinical and administrative systems.
  As a means of achieving both clinical and administrative coordination, a compatible unified medical outcomes data systems among network members will be a necessity. By developing more elaborate data systems and participating in their implementation, RMCNs should also provide an additional tool for smaller and larger providers, alike, to establish network-based continuous quality improvement (CQI) processes for administrative and clinical services. The Risk Management Cooperative discussed in the "Governance" section of this paper will help facilitate CQI for the RMCNs.

In some rural areas, the telecommunications infrastructure will have to be upgraded in order for data systems to operate efficiently. Many rural areas are served by small, independent telephone systems that do not have the capacity to upgrade their facilities to allow transmission of digitized information. This capacity is essential for transmitting both administrative and clinical information.

- Coordinated emergency and non-emergency transportation.
  RMCNs will have to provide or arrange for ambulance service, which is a covered Medicare service. Since many network organizers are involved in at least emergency transportation, this demonstration will offer new opportunities for collaboration between emergency and non-emergency transportation and to develop improved linkages with existing rural transportation systems.

- Collaborative quality assurance, utilization review, and medical staff credentialling.
  Small rural providers often struggle to develop strong quality assurance programs in facilities with small numbers of providers. The RMCNs, by developing networks and shared information systems, will also be able to extend quality assurance and quality improvement programs throughout the network, thereby enhancing service quality.

d. Rational market areas

Because the RRC or other network organizer will be given a payment franchise within its market area, the rational definition of the market becomes critical. However, arriving at such a definition is difficult, given the great variations in geography, health service resources, and demographics in rural America. It is beyond the scope of this paper to define a rational market area for the RMCN demonstration program. The Study Group is currently seeking support from the Robert Wood Johnson Foundation to conduct research to assist in this definition.

While this proposal does not yet define the market areas, several factors should be taken into consideration in developing the definition, including:

- The definition of a market or service area for RMCNs probably should rest on the definition of a geographic area within which it has a "natural monopoly." Federal anti-trust standards of creating a natural monopoly use a market analysis which scores markets based in terms of Little In From Outside (LIFO) and Little Out From Inside (LOFI). In other words, LIFO scores would identify that most of the people using the network's facilities are residents of the areas and LOFI scores rate the degree to which the residents of the area use services within the area exclusively. It is possible that some variation of this methodology will prove useful in identifying market areas for potential RMCNs.

- The network organizer should be reasonably proximate to the other providers with which they are networking. The definition of "reasonable proximity" will vary among network organizers according to local terrain, population, weather and other variables. Proximity is necessary not only for referral relationships, but also so that providers are within the sphere of influence of the network organizer and its medical staff. "Sphere of influence" should not be construed to mean that the RRC or other organizer has the power to direct events within a given territory, but rather, that by its size, scope, expertise, and quality, the network organizer is the local benchmark for care within a region that affects other providers in the area in regard to their clinical and operating behavior.

- The notion of confining markets (or spheres of influence) to existing administrative-political boundaries should be dismissed. In most cases, a county is too small of a geographical unit to represent a market. In some cases, markets cross state borders. It is clear that existing administrative-political boundaries have no relationship to markets and referral patterns and that they should therefore play no role in defining them.

- The use of fixed radius definition of market should also be dismissed. HCFA has used the fix radius approach to define types of providers in the

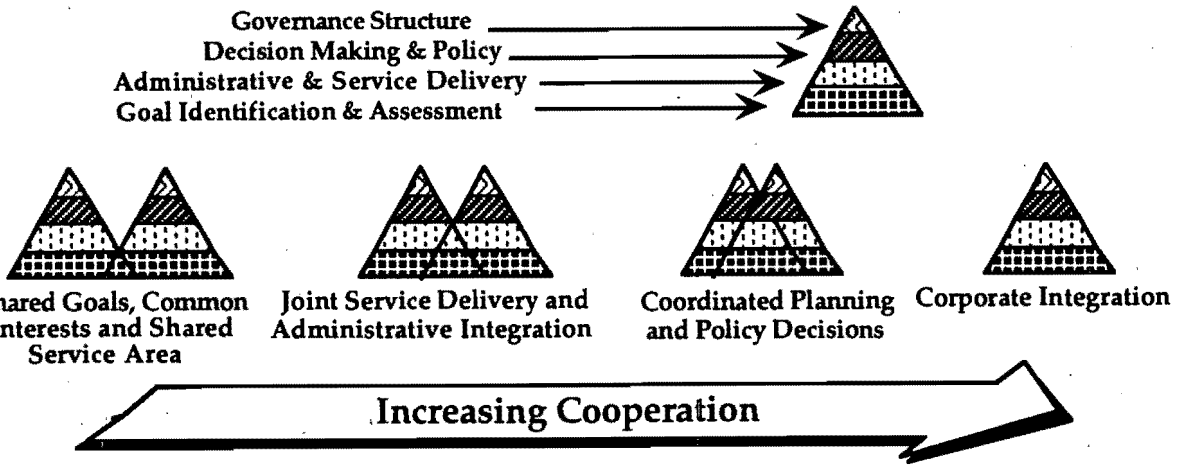
past (e.g., Sole Community Providers, Essential Access Community Hospitals). A 25, 35, or 50 mile circle around an RRC does not appropriately define its sphere of influence. In some cases, even a 75 mile radius may be too confining as a definition of market. In other cases, a market may extend only 25 miles in one direction but 100 miles in the opposite direction. Study Group participants agreed that whatever the true shape of a market, it likely is not a circle, and that certainly a nationally applied radius standard would not accurately define the markets of all RRCs or other network organizers. Markets are irregularly shaped, and the definition of their sphere of influence should reflect local circumstances.

- With the advent of interactive video, teleradiology, and other telecommunications-munitions applications to rural medicine, the accepted concepts of service or market areas become even more difficult to determine. With the use of this sophisticated telecommunications technology, physicians in any RRC or urban medical center can consult with the rural primary care practitioner. This consultation can include clinical supervision as the rural provider performs procedures as directed by the specialist physician. If appropriately and vigorously employed, this technology should contribute toward reducing the need for rural patients to be transported to the RRC or to university teaching facilities for routine progress checks of chronic illnesses or even for sophisticated diagnostic testing.

2. Rural Managed Care Network Development:

As currently configured, rural health networks differ in the degree to which they are integrated. As the following diagram illustrates, increasing cooperation brings increasing levels of integration:

TYPES OF PROVIDER NETWORK INTEGRATION



Very few existing rural health networks function beyond the second level of integration, and most are at the first level. On the other hand, the RMCNs proposed in this demonstration will function at the third level of integration, sharing goal identification and assessment; administrative and service delivery; and decision making and policy. However, governance will remain with the local provider of care.

One of the key features of an integrated network is the creation or recognition of an organization that serves the role of a "network organizer" to whom network members surrender partial autonomy, allowing the network organizer to perform certain agreed upon functions on behalf of the network. In this demonstration program, the RRC or other large rural provider would assume the role of network organizer. If one thinks of the network organizer as the center of a circle through which all network member communications and transactions pass, the network organizer resembles the hub of a wheel of networked services.

The single most important feature of rural health networks suggested by this diagram is that health care is a local product. This fact cannot be emphasized enough. It is critically important that this national demonstration project has maximum flexibility to respond to the ways that local networks are developed and organized. A "cookie-cutter" approach will fail to address the idiosyncratic nature of rural areas and will generate resistance from medical staffs, administrators, governing boards, communities and beneficiaries.

Federal health planning law (P.L. 93-641) provides an important policy precedent for granting geographic franchises. This law allows states to develop Certificate of Need (CON) programs, which in effect grant a service franchise for an applicant provider within a service or market area. The State CON programs grant this franchise by ruling on which provider gets or does not get a piece of technology (such as an MRI) or who gets to provide a new or expanded service.

Similarly, the proposed demonstration will be asking for exclusive geographic payment franchises for RMCNs. In effect, this request is simply an extension of existing policy offered in P.L. 93-641. The essential difference is that this demonstration is seeking a payment franchise, rather than a service franchise. This demonstration will not be an exclusive service provider in the market area, because non-network providers will be able to stay outside of the network in the normal Medicare fee-for-service system. Also, beneficiaries (except those choosing an EPO option, where available) will have freedom of choice, both within and outside of the defined market area.

Instead of regulating services and facilities directly, the project seeks to demonstrate how allowing a large service provider (network organizer) to determine payment rates and mechanisms offered to Medicare providers effectively organizes the market so as to maintain or expand access, contain costs, rationalize the delivery system and provide measures of quality outcomes. Because network organizers are closely related to the system they are developing, they will be likely to be inclusive of other network providers and others in their planning. This method should provide for a much more participative local planning process with considerably less cost than an externally regulated system.

a. Risk assumption and mitigation

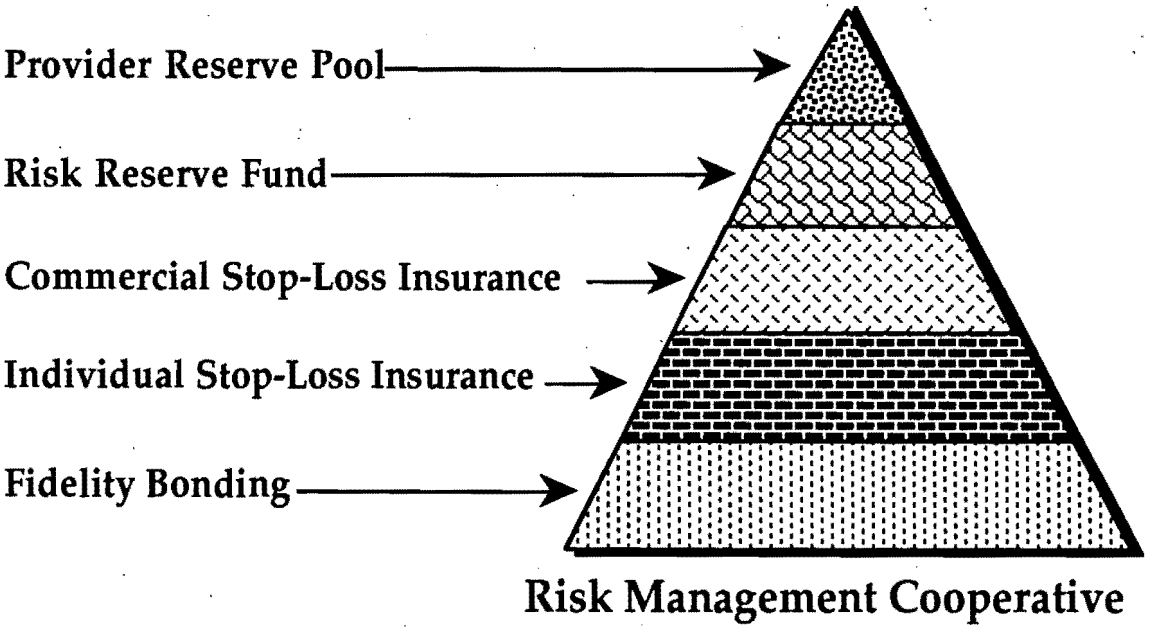
It is critically important to the demonstration program that network organizers assume some measure of risk for the care of the Medicare beneficiaries in their market areas. Risk assures the accountability of the health plan and provides a powerful incentive to contain costs and rationalize services within the market area. At the same time, both the Medicare program and its beneficiaries must be protected against disruptions or degradations of service in this demonstration through a carefully planned risk mitigation strategy.

Although RRCs and other likely network organizers are large by rural standards, they are small by the standards used for insurance underwriting and for the regulation of managed care plans. The risk mitigation strategy will need to be strenuous enough to cover a variety of circumstances. For example, the plan must insure against losses due to beneficiaries' extraordinary costs of medical care, as well as bond indebtedness forfeitures by network organizers or other protected providers within the network. An additional layer of protection in the latter example will be provided by the stringent criteria for accepting network organizers into the demonstration as are described in the following section of this paper on "Network participation and roles."

To address these challenges, the demonstration project will establish a complex combination of risk pooling and stop-loss coverage to assure that risk is sufficiently mitigated for network organizers and RMCNs in the face of unforeseen financial occurrences. Much of the strategy employed by this demonstration is similar to the requirements States apply to health maintenance organizations (HMOs). However, because the demonstration project's risk mitigation strategy is so aggressive, it may not be necessary for RMCNs to comply with state HMO licensure laws, and exemptions may be sought as discussed in the "Legal issues" section below.

The demonstration will develop a risk mitigation strategy based on a "blended" risk pool, which is illustrated in the following diagram:

Risk Mitigation Strategy



The various components of the risk mitigation strategy are as follows:

- The network organizer will make an annual contribution to a provider reserve pool of an unspecified, but substantial amount, with additional responsibility for 150 – 200 percent of that amount. The amount of contribution by network organizers may be a variable one based on the degree of network risk management discipline (i.e., economic credentialling, effective utilization review, targeted provider education, etc.). The amount of the contribution will be set by the Risk Management Cooperative described below.

  This reserve pool would be maintained for the all networks in the demonstration project, for state or regional subsets, or for individual networks. This component of the blended risk pool scheme will put networks at risk for their own performance, or it may, subject to the approval of the Risk Management Cooperative, spread the risk across larger units of the project according whether the program chooses to group networks.

- A risk reserve fund will be raised as a "program related investment loan" from a private foundation or foundations. This component will be used to provide a second layer of coverage over the provider risk pool. This fund will be use to cover losses that exceed the coverage of the provider risk pool, but fall short of the deductible level for the next level of coverage. This will provide a substantial pool of cash reserves to cover network failures and will reduce the cost of commercially-acquired coverage by raising the deductible. The subject of governance and administration of risk reserve fund and other aspects of risk mitigation are discussed below.

- Commercial stop-loss reinsurance of approximately $50 million will be secured for the next level of coverage for all of the networks in the demonstration program by the risk administration entity described below.

- Additional mitigation of risk will be assured by network organizers (or a combination thereof) purchasing individual stop loss insurance coverage on all covered beneficiaries. Again, this coverage could be secured through a joint purchasing arrangement.

- Network organizers will also be required to have in force a fidelity bond or insurance on employees, officers and directors having fiduciary responsibility in the amount of $250,000 for each network.

b. Governance and risk management

Governance of the risk mitigation program will be by a "risk management co-operative" established for the express purpose of developing and administering the program. The risk management cooperative (RMC) will be composed of the network organizers, who will be required to join and pay dues as a condition of participation in the program. The RMC will be incorporated as a cooperative and will be governed in a cooperative manner, on a one-provider/one-vote basis. In addition, the RMC may establish a 501 (c) (3) foundation to enable the receipt of private foundation and governmental grant funding for educational and charitable purposes.

The RMC will provide for an increased level of cooperation among RMCNs in a manner similar to the way RMCNs will offer increased integration among providers within their market areas. The RMC will provide an additional resource for goal identification and assessment; administrative and service delivery; and decision making and policy, as depicted in the third level of integration in the figure at beginning of this section on network development.

It is envisioned that the RMC will be responsible for:

- establishing the rules and procedures for use of and the amount of the network organizers' contributions to the provider risk pool;

- securing the program related investment loan from a private foundation to establish the risk reserve fund, the second level of risk mitigation;

- developing or acquiring expertise in risk management and managed care for member network organizers;

- providing administrative leadership for the demonstration project; and

- establishing joint purchasing programs for commercial stop-loss reinsurance for the networks and for individual Medicare beneficiaries in the plan, as well as for information system hardware and software to provide common data systems for quality outcome assurance.

The Health Care Financing Administration (HCFA) will be the party responsible for making decisions about network participation and providing demonstration project oversight. HCFA's previous experience with similar managed care demonstrations suggests that oversight responsibility should be shared by the Office of Research and Demonstration (ORD) and the Office of Coordinated Care (OCC). The RMC will be able to assist in helping networks comply with HCFA's programmatic guidance and will serve as an "early warning signal" about networks that are having trouble. The RMC will provide an important educational and technical assistance resource to the demonstration project, but it will not have management authority except as delegated by the RMCNs within the scope of the demonstration project.

c. Network organizers' participation and roles

For the purposes of this demonstration, participation may not exceed 10 states. RMCNs may be developed by an individual RRC, by a group of RRCs (or hospitals that have ever been RRCs) and/or other providers within a state or geographic region.

Criteria for selecting RMCN demonstration program participants will include:

- Accreditation
  In the event the network organizer is a hospital, it must meet accreditation standards of either the Joint Commission on Health Care Organization or the American Osteopathic Hospital Association.

- Financial ability to go at risk
  The network organizer must be large enough and financially sound enough to assume the risk involved as measured by such criteria as:
  a. a balance sheet net worth of the higher of $1,000,000 or an amount equal to 8 percent of the projected annual AAPCC payments for service area;

  b. commonly employed financial ratios consistent with industry norms as calculated from audited financial statements; and

  c. cash reserves or an established line of credit, obtained from local sources or through the RMC, in excess of 8 percent of the aggregate annual AAPCC payments for the service area.

Additionally, network organizers may be required to submit audited financial statements annually as a condition of continuing participation.

- Sufficient service and provider mix
  RMCNs should have in place arrangements to assure seamless access to all covered services for Medicare beneficiaries. The network organizer should have on its medical staff and under contract to the network, primary medical providers (family and general practice, pediatrics, general internal medicine and obstetric and gynecology) and most secondary clinical specialty services (such as general surgical services, endoscopy, urologic services, ophtho-

mologic services, radiology, anesthesiology, and pathology). At least one-third of the physicians on the network organizer's medical staff should be actively engaged in primary care practice.

The network organizer should in their panel of network providers, other medical services (such as orthopedic surgery, psychiatry, oncology, non-invasive cardiology, and neurology). Providers in this category should be board certified or eligible for certification.

In addition, the network organizer should have available through contracts or other explicit arrangements (though not necessarily on their medical staffs) other specialty services such as neurosurgery, open heart surgery, pediatric subspecialty services, nephrology, endocrinology, gastroenterology, burn unit service, transplants, pulmonology, and radiation oncology. All providers in this category must be board certified in their appropriate medical specialty.

- Comprehensiveness of services

  The network organizer should have a diverse range of inpatient and outpatient preventive and support services available internally or readily available within the network for Medicare-covered and FQHC services. In addition to acute and chronic medical treatment services, these services should include: advanced medical laboratory and radiology services; medical social services and psychological services; nutritional services; health education; audiology; physical and speech therapy; home health care; and hospice care.

- Appropriateness or rationality of service area

  The network organizer must be able to define a rational service area in which it has a natural monopoly or powerful sphere of influence. Specific criteria for this factor will be defined by further research as discussed above. It is probable that the final criteria will involve some application of anti-trust definitions of "Little In From Outside (LIFO)" and "Little Out From Inside (LOFI)".

- Administrative capacity and/or prior experience with managed care
  The network organizer should demonstrate clinical and administrative capacity to operate in a managed care framework. This factor will involve assessing the network organizer's demonstrated expertise in managed care or its ability to obtain it from external sources. One of the external sources may be the RMC discussed above. The network organizer will be expected to provide a framework for managed care consistent with that of other plans, including: plan structure; enrollment procedures and reports; claims system, procedures and reports; complaint and grievance procedures; marketing plan; quality assurance and utilization review process and procedures; and operational data collection system.

- Structure and willingness of other providers to participate
  The plan for the organizational structure of the RMCN should be clearly identified and have a high potential to be implemented and managed. A health care plan should be developed for the service area based on data obtained on health care resources, patient utilization, health status, and epidemiology.

d. Payments to network organizers

Network organizers will be paid on a capitation basis for each Medicare beneficiary residing in the market area. The network organizer will use the capitation payment to pay for all Medicare covered services. The rate will be based on 100 percent of the Average Area Per Capita Costs (AAPCC) for the area. While this differs from the 95 percent of AAPCC rate paid under the Medicare HMO program, it will be necessary to compensate for the expanded scope of services (including the FQHC preventive services described above) and for the additional cost of network development and coping with large geographic distances.

The AAPCC rates will be based on the most recent available year. The payment rate will be updated each year of the project upon conclusion of the calendar year by a rate of 75 percent of the Medical Expenditure Inflation (MEI) index.

An alternative to developing a network-specific AAPCC rate would be to determine a single AAPCC rate for all of the areas in the demonstration project. This alternative may be considered prior to submission of the final Medicare waiver request.

In addition to the basic capitation payments, network organizers would also be paid an administrative fee of 10 percent of the aggregate AAPCC payments. This administrative fee would compensate the network organizer for assuming all intermediary functions from existing fiscal intermediaries, as well as for coordination of beneficiary care.

e. Provider participation in the RMCN

It will be important to the success of the RMCNs that they enlist the participation of providers as necessary to provide the full range of Medicare covered services. Again, however, beneficiaries (except those enrolled in an EPO option) may choose either network or non-network providers, and the RMCN will still be required to pay for covered services. The organizational structure and payment methodologies that RMCNs adopt will be important incentives to recruiting providers into the network.

For the purposes of this demonstration, the RMCN would be required initially to accept all "participating" Medicare providers within the defined market area into the program. Participating physicians, however, would not be required to sign up with the RMCN if they choose not to be a part of the network. This provision encourages more physicians to join as the Medicare program as participating providers. The RMCN can choose to accept or reject Medicare non-participating physicians within criteria they develop.

As currently envisioned, there are four criteria for accepting physicians into the network: 1) Willingness to participate in the network; 2) Clinical competence demonstrated through credentialling procedures; 3) Ability to meet basic standard for economic credentialling; and 4) Medical liability insurance coverage.

It is likely that the RMCNs will add additional quality requirements for providers as practice parameters evolve from "care-mapping" and other processes that will evolve with the assistance of the RMC. The establishment of practice parameters and guidelines at a level above the RMCN level will be important to provide a buffer against provider resistance. The RMCN may remove physicians from its panel that fail to meet acceptable standards of quality within criteria they will establish in conjunction with the Quality Assurance Councils described below in the section on "Quality".

In order to assure that costs are contained or reduced, an important part of the demonstration is that RMCNs may sanction or terminate providers for economic reasons, as well. RMCNs will be required to phase-in this type of "economic credentialling" by the third year of the demonstration, and it is possible that a network could be required to pay more into risk pools if it has not implemented a strict economic monitoring and control system.

Under this demonstration, too, network organizers would offer network membership to special types of providers that have payment protections under their current programs, i.e., specifically Rural Health Clinics, Federally Qualified Health Centers and Sole Community Hospitals. These facilities have the option to be paid at negotiate rates or at rates set by their current programs for the same scope of services. Protected providers, as here defined, must meet the same standards of quality and participate in quality assurance processes as other providers in the network.

f. Contracting with and paying for other providers

As mentioned above, payments to the network organizer will come in the form of capitated payments for the Medicare beneficiaries residing in the market area. How the network organizer pays the network providers is a local option, and the demonstration offers creative opportunities for risk-sharing. Also, the network organizer would have the flexibility to contract for claims administration with another entity.

Network organizers may contract with providers to provide services to the network participants based on a pre-negotiated fee. The basis for the negotiated fee should be determined by the network organizer and the potential contracting provider.

The Network organizer will include in contracts with providers the expectations of the network in terms of quality of services provided and cost-effectiveness of services provided, as well as minimal requirements for patient/client outcomes. All contracts with other providers must include: a) hold harmless provisions to protect beneficiaries from claims by the provider of sums owed by the RMCN; b) assurances that the provider will treat all beneficiaries under the rules of the demonstration without regard to age, sex, color, creed, national origin, ancestry, religion, marital status, lawful occupation, or frequency of utilization of any beneficiary; c) agreement to actively participate in network quality assurance and utilization review processes and to share administrative and clinical information; and d) to participate in joint purchasing activities of the network, when appropriate.

As described above, there are a number of "specially-protected providers" that receive unique cost-based federal payment protections because they are essential to maintain as viable rural providers. RMCNs' contracts with Rural Health Clinics, Federally Qualified Health Centers and Sole Community Hospitals will extend the current payment protections of these programs, paying them at agreed-upon negotiated rates or under the methodology set by their current programs. These protected programs will be required to submit their current cost and utilization reports to the network organizer if they wish to retain cost-based payments as in their current payment programs. Protected programs will be subject to the same quality assurance, utilization review, and economic credentialling requirements as other providers in the network.

g. Quality assurance

Obviously, entities that are given a geographic payment franchise are going to be required to meet acceptable standards of quality, although the fact that the network organizer is being paid on a capitation basis will require a slightly

different approach than that of standard fee-for-service providers. This demonstration proposes that Professional Review Organization (PRO) functions with respect to RMCNs remain the same, except that the claims denial function will be delegated to the RMCN.

Internally, RMCNs will be required to meet quality assurance program standards similar to those required of health maintenance organizations, including: a) a written quality assurance plan; b) documentation of meetings; c) appropriate protection of confidentiality; and d) a patient data system to document and allow retrieval of information to evaluate continuity, coordination, quality and outcomes of care.

An important new component of the demonstration is the creation of Quality Assurance Councils (QAC) within each RMCN. The QAC will be composed of both network providers and consumers (Medicare beneficiaries). A similar model utilizing providers and employers has been successfully employed in several rural areas. The QAC will develop and establish local standards of quality for use by the RMCN. The QAC also would perform quality assurance and utilization reviews to assure that service quality meets acceptable local and national standards. The RMC will use the QACs' input to assume a leadership role in establishing or identifying practice parameters for use by the QAC.

In order to develop the type and extent of data needed, RMCNs will be required to participate in an outcome measurement data system that focuses on process, severity, and outcome measures of quality. The participating networks could negotiate a single vendor system with real time modem connections for the entire demonstration through the risk management cooperative discussed above.

g. Legal Issues

Formation of the RMCNs probably can proceed without the need for exemptions, or at least significant exemptions, from federal or state antitrust laws. This would be true assuming that the service areas of each network will be allocated either by statute or by a cooperative effort between the at-risk entity and either the federal or state government; and further assuming that statutory

language delegates to the network organizer the ability to determine which provider in the network provides which service. As long as providers within the network do not allocate the service area among themselves, it would appear that network service area allocation could proceed in keeping with existing antitrust laws. Also, as the at-risk entities proceed to contract with or employ other providers, they should be able to work within existing antitrust parameters as long as their actions do not involve collusion or exclude competitors for anticompetitive reasons. It is possible that some limited exemption from monopolization claims would be appropriate to ensure that at-risk entities could select network participants in good faith without the threat of litigation.

In order to provide the financial incentive of waiving Medicare copayments for beneficiaries using in-network services, the demonstration project will seek appropriate fraud and abuse law exemptions that will allow RMCNs to attract beneficiaries. In addition fraud and abuse law protection will be sought for arrangements that RMCNs might offer as provider incentives for in-network referrals.

The RMCN demonstration project's progressive strategy of risk assumption and risk mitigation was described in an earlier section of this paper. The strategy includes four or more layers of risk mitigation, which taken together provide an exceptional degree of protection for the Medicare program and its beneficiaries. In addition, it has been suggested that overall federal project oversight would include HCFA's Office of Coordinated Care. The blended risk pool strategy will be defined in law for the demonstration. For purposes of this demonstration, RMCNs will request exemption from state HMO licensure laws, to the extent that these activities may be seen as applicable and cannot be met by the program.

The Office of Inspector General of the Department of Health and Human Services, in a 1991 report on Emergency Medical Services, identified state corporate practice of medicine statutes as a significant barrier to the development of rural systems of health care. Some institutional providers within RMCNs may find it desirable to employ physicians as a way of rationalizing the health care system in their service area. In many states RMCNs employing physicians or

other health care providers would violate existing corporate practice statutes. It will be important to explore ways for the law authorizing the demonstration to preempt state prohibitions against the corporate practice of medicine.

h. Roles of state and federal governments

Network development can (and has) occurred outside of the purview of state and federal government. However, developing networks with an exclusive geographic payment franchise will require active participation and oversight of state and federal governments for the following reasons:

1. While the proposed demonstration provides some access protection by requiring that network organizers hold harmless RHCs, FQHCs and SCHs, an additional level of local planning and oversight is needed to assure that the networks maintain (and hopefully increase) access.

2. As the networks organize services within their markets for services like EMS, they will clearly be interfacing with state responsibilities and functions. States have an appropriate role at the table to assure that the market organization is consistent with their plans.

3. Ongoing research on alternative rural delivery models (being conducted by Rosenberg and Associates with support from the Robert Wood Johnson Foundation) shows that a substantive state role is a necessary criterion for effective change in the rural delivery system.

Under the RMCN demonstration, states will assume a role similar to the one they perform in the EACH/RPCH Program. Under the design for that program, state governments, in cooperation with state hospital associations, develop state rural health plans. Under the current demonstration, state plans will be required to specify the goals, criteria, and process for designating rural health networks and for granting the payment franchise within designated markets. The state rural health plan will be indicative of a state's active interest in the coordination of health services in rural areas. The designation process indicates that

states are willing to forgo competition in favor of higher public policy goals. This process will likely be as important to potential health care reform plans for rural areas as it will be with the current demonstration.

As we have learned from the EACH/RPCH Program, networks often cross state lines. Similarly, it is likely that some RMCNs will have market areas that extend beyond state boundaries. In those instances, the state role described above will reside with the state in which the network organizer is located, rather than in the state or states in which other providers in the network are located. It is also likely in these instances that states will cooperate in their planning.

Once again, the EACH/RPCH Program suggests a model for federal government involvement. The federal government will establish a demonstration program in which RRCs (or designated facilities who meet "hub-of-the-wheel" criteria) choosing to develop delivery networks would receive a combination of grants and payment incentives. Project oversight from the federal level will be a join effort of two HCFA entities: The Office of Research and Demonstration (which administers the EACH/RPCH Program) and the Office of Coordinated Care.

3. Network Development Grant Program

Similar to the EACH/RPCH Program, under this demonstration the federal government would provide grants to aid in the formation of networks. Grants would cover the expenses of communication, information, and transportation system development; community and provider education on the desirability and mechanics of networking; technical assistance in creating linkages among providers; capital expenses associated with forming linkages (e.g., buying practices, retro-fitting hospitals to consolidate community health services); and all other one-time expenses that are necessary and proper to the formation of networks. The federal government would also make grants to the state to assist in financing the development of rural health plans.

This proposal includes provisions for a Developmental Grant Program with five parts:

a. Grants for up to ten states to participate in developing coordinated networks within the states' health planning processes. These grants can be up to $200,000 per year for two years with a ten percent match required.

b. Grants of up to $50,000 to potential RMCNs to conduct feasibility and market studies.

c. Grants of up to $50,000 to acquire consultative technical assistance to facilitate the process of network formation and facilitation.

d. Grants of up to $250,000 per network to subsidize about 50 percent of the acquisition cost of a comprehensive clinical and administrative data system that will be required for participation.

e. Grants of up to $250,000 per network to assist in the development or expansion of telecommunications within the network, such as teleradiology, slow-scan interactive video, etc.

Conclusion

Regardless of the shape of the final health care reform package, rural health care providers will be required to develop or participate in rational delivery systems to an increasing degree. This proposed Medicare demonstration program can prove to be an important precursor to health care reform and provide useful models now and for the future.

2

Innovation and the Policies of Limits in A Changing Health Care Economy

John E. Wennberg

The U.S. health care sector is the target of a massive social struggle over its reform. The strategies of the past have failed to establish access and contain costs. Indeed, the trend today is toward less access for the poor and many in the middle class, with more care for those who remain "entitled." Thirty-three million Americans are without health insurance. For those with insurance, the rates of utilization of physician services and expensive diagnostic techniques and the number of invasive procedures being performed continue to spiral. If these trends are not altered, the United States will be spending more than 15 percent of its gross national product (GNP) on health by the year 2000. The message of the 1992 presidential debates is that this situation must change. The systems for financing care must be fixed; to do this costs must be contained. Improvements in access must be accompanied by policies of limits.

The way the politics and policies of limits are fashioned will depend on assumptions about the relationship between the utilization of care and the benefits of care—that is, on the shape of the "benefit-utilization curve." One popular interpretation is that the shape of this curve is such that the nation needs to ration effective care. Patient demand and medical progress now make the health care system so expensive that it can no longer be available on equal terms to everyone; moreover, the nation simply cannot afford to pay for everything that works and that patients want. This predicament arises because of the successes of biomedical research, the resulting

efficacy of clinical science, and the efficiency of practicing physicians in translating medical knowledge into beneficial medical interventions. As utilization increases, benefits also increase, but at a declining rate of return as the level of invested resources increase. Somewhere along the curve, society finds itself in a zone in which the benefits can no longer be afforded: the costs of further transfers of GNP toward health care and away from national priorities such as education and housing are simply too great. As a consequence, society must learn to make explicit judgments about the value of specific services as they apply to an individual patient's case. Some experts advocate rationing by age; others recommend using detailed algorithms for specific patient subgroups defined on the basis of "cost-effectiveness."[1] The intent, however, is the same. Policies are needed to set limits on specific services, to develop explicit methods to ration effective care that brings less than socially acceptable marginal returns. The effect of such policies is to deny access to care that works and that patients want on the basis that it is not cost-effective. In the opinion of many, this denial of access inevitably produces a two-tiered system of care, one for the affluent and another for those whose access to care must be underwritten by policies of entitlement.

An alternative interpretation emphasizes that the inadequacies of clinical science and flaws in the role of the physician as the decision-making "agent" of the patient make it impossible to determine the shape of the benefit-utilization curve in medicine. Although investments in basic biomedical science have greatly increased the power of technology to intervene in the natural history of disease, efforts to evaluate the outcomes of these interventions—the effects of medical technology and theories of efficacy in the specific situations of everyday practice—have substantially failed. The risks and benefits of most medical care are poorly understood. Moreover, the agency role of the physician is flawed by professional dominance. This role, which depends on the capacity of physicians to make vicarious judgments about what patients want, has created a market in which the preferences of patients are entangled with those of the physician. In short, in medicine, too little is known about what works and what patients want.

This interpretation emphasizes the major role played by supplier-induced demand, in which the weaknesses in the scientific and ethical status of clinical medicine ensure that available resources are utilized without evidence that more is necessarily better or that patients necessarily want

[1]The most sophisticated articulation of this argument is made by Aaron and Schwartz (1984); for a recent update, see Aaron and Schwartz (1990). Among those advancing arguments for age-based rationing are Callahan (1987) and Lamm (1987). For a description of Oregon's approach to rationing, see Fox and Leichter (1991) and Brown (1991); both reports appear in an issue of *Health Affairs* that focuses on Oregon's priority setting.

more. Medicine's untested and often conflicting theories of efficacy justify—and the dominance of professional preferences ensures—the full deployment of resources, no matter how many or in what quantities. Indeed, medical theory is often implicit and closely associated with per-capita quantities of supply such as hospital beds and physician subspecialists. The crisis in costs is the inevitable consequence of the policies of growth that have prevailed in the U.S. health care sector: the open-ended financing of entitlement services based on funding of utilization; the accelerated production of manpower based on perceptions during the 1960s and 1970s of a "shortage" in medical manpower; the specialization of the physician work force and its division into technology-driven subspecialties whose workloads have uncertain impacts on the health status and satisfaction of patients; easy access to capital markets for the construction of facilities and the purchase of technology; and a willingness of payers to reimburse for services involving underevaluated technology. The end result of these policies has been quantities of supply that are well in excess of the amount required to produce and deliver services that are known to work or that patients are known to want. Under this interpretation, policies of health care limits should concentrate on global restrictions on growth and the promotion of strategies to learn what works and what patients want.

As one familiar with the patterns of use of medical care and the strengths and weaknesses of the scientific status of clinical medicine, I find a good deal of evidence in favor of the supplier-induced theory of demand.[2] This paper seeks to explain this point of view in more detail. It examines alternative interpretations of the shape of the benefit-utilization curve to raise the "which rate is right?" question; that is, what is the rate of service use (and the amount of resources required) when supplier-induced demand is reduced—when patients are informed of the state of medical progress (what is known and not known about the results of care) and when patients are free to choose according to their own preferences? It then looks at the struggle between two competing models for reforming the doctor-patient relationship. One is based on the assumption that the agency role of the physician can be essentially replaced by the guardianship of the third-party payer through micromanaged care and that the delegated decision model inherent in the agency role can be preserved by prescriptive rules of practice developed by competing health care organizations or the state. The

[2]The theoretical basis of this argument was developed in Wennberg and colleagues (1982). Archie Cochrane's *Effectiveness and Efficiency* (1972) provides a thorough introduction to the problems of physicians in understanding the outcomes of care; Eddy and Billings (1988) provide a more recent example. Much of the epidemiological evidence concerning the problem of supplier-induced demand is summarized in "Small Area Analysis and the Medical Care Outcome Problem" (Wennberg, 1990a).

other is based on replacing the delegated decision model with shared decision making, a new partnership between the patient and the physician and the profession and the public. The target in this approach is to reform the ethical status of the doctor-patient relationship so that what is known and not known are explicitly shared and so that patient preferences become dominant in the choice of treatment from among reasonable and available plans of care. The paper also examines why neither micromanaged care nor the shared decision model are sufficient to achieve the goal of rationalizing utilization and containing costs. The implicit nature of much of medical theory keeps most of clinical practice outside of their influences. The paper thus argues that to contain costs it is necessary to limit capacity directly, and it sets out several principles to guide debate about strategies for developing limits. The paper concludes with a discussion of the implications for innovation of policies of limits in medicine.

THE SHAPE OF MEDICINE'S BENEFIT-UTILIZATION CURVE

Different assumptions about the relationship between the utilization of care and the benefits of care are reflected in different assumptions about the shape of the benefit-utilization curve in medicine. The assumption that it is necessary to ration specific services that work and that patients want but that society cannot afford is based on two ideas. One is the notion of "expected value" or benefit now obtained from the resources invested in health care. The doctor-patient relationship efficiently distributes care in such a way that patients benefit from the care they now use more than they would if the care were not received or if it were replaced by a less costly item or service. The other idea is that the "marginal returns" can be rationalized; that is, the benefits are sufficiently well understood that they can be ranked in terms of expected benefit per unit of service (or dollars) utilized.

The diminishing marginal returns that occur in an economy in which utilization is the result of patient demand and biomedical progress are illustrated in Figure 2-1. To achieve such a curve, physicians must be remarkably successful in the sorting of medical problems and in diagnosing and ranking them according to the expected outcomes of treatments. Indeed, they must be perfect in the execution of their agency role to interpret clinical science and understand the values their patients assign to alternative treatments, including the value of no treatment at all. They must thus possess something that clinical science does not now provide: knowledge about the outcomes that matter to patients. The problem the physician faces, however, is not simply to know the outcomes but to weight them according to the individual patient's attitudes toward them. Under delegated decision making, which has been the dominant medical decision model

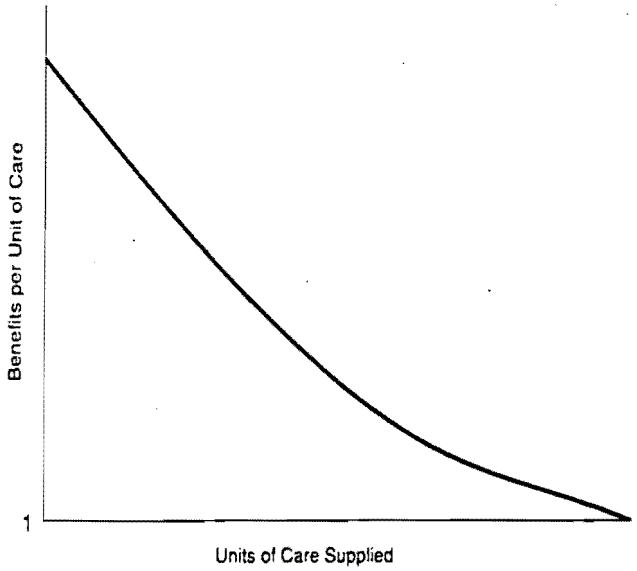


FIGURE 2-1 Example of benefit-utilization curve where medical progress and patient demand drive utilization with diminishing marginal returns. The curve is adapted from Aaron and Schwartz *The Painful Prescription: Rationing Hospital Care*, p. 11.

since the time of Hippocrates,[3] physicians make the choices. They intuit what patients would choose if patients had full information about choices and could do the weighting themselves. In this model, prescriptions for treatment are based on clinical experience, that is, on the "case series" of patients that the individual physician has treated and whose values and preferences have somehow become known.

At the level of the population, the situation is even more complex. For the curve to take its hypothesized shape of decreasing marginal social return, physicians must, collectively, make ordered choices; that is, the patient who receives the first unit of service is the one who gains the most benefit from it, the second patient the one who gains the second most benefit, and so on, with the patient who receives the last unit gaining the least. For this to occur, however, physicians must know and respond to decisions their colleagues have made. There is no feedback loop currently operating in health care markets that would make this feasible; indeed, it is difficult to conceive what such a mechanism would look like.

[3]See *The Silent World of Doctor and Patient* by Jay Katz (1984) for an excellent history of the doctor-patient relationship.

Outcomes and preference research provide empirical evidence that demonstrates the weaknesses of the assumption that the benefit-utilization curves in medicine correspond to Figure 2-1. Over the past few years, my colleagues and I have been involved in an in-depth investigation of the fine structure of a clinical decision problem: the choices that face men with a common form of prostate disease called benign prostatic hyperplasia, or BPH. The inquiry was motivated by small area variation studies showing that the chances that a man would undergo a prostate operation by the time he reached age 85 varied from about 15 percent in some communities to more than 50 percent in others. We asked a group of Maine urologists, some of whom lived in areas with low rates, others of whom lived in high-rate communities, if they could explain these variations.

The urologists differed in their assumptions about the benefits to be derived from prostate operations and about the shape of the curve relating benefits to utilization. Some held a pessimistic attitude toward prostate disease. These physicians believed that BPH usually progressed to a life-threatening obstruction of the bladder or kidney and that it was best to operate early in the course of the disease to prevent future bad outcomes. We called this the preventive theory of surgery. Their clinical decisions were dominated by a hypothesized benefit-utilization curve in which the chief benefit of surgery was improvement in life expectancy. Their reasoning was that if surgery were postponed until evidence of life-threatening obstruction appeared, the patient would be older, sicker, and more likely to die when surgery finally became unavoidable. By operating early, one avoided the higher death rates that occurred when the operation was postponed. Because most men who exhibit early disease will progress to the point where surgery is inevitable, and because the death rate from surgery increases with age, BPH patients will live longer if they have the operation earlier. Because most men eventually develop BPH symptoms, the population captured under the benefit curve of preventive theory (Figure 2-2) encompasses the majority of older men.

Other urologists were more optimistic about untreated BPH and argued for the quality of life theory of surgery. This theory posits that the benefit of surgery for men without obstruction of the bladder or kidneys is its ability to reduce symptoms and improve the quality of life. In the opinion of these urologists, BPH does not usually progress to the point where it threatens life; accordingly, surgery does not play a preventive role in avoiding early death. They estimated that a patient's "utility" for surgery—that is, the "expected value" the patient would gain if the surgeon prescribed surgery—was greatest for those with severe symptoms, whereas those with mild symptoms benefited little. The benefit-utilization curve suggested by these physicians (Figure 2-3) thus has a different parameter of benefit as well as a more rapid decline in value.

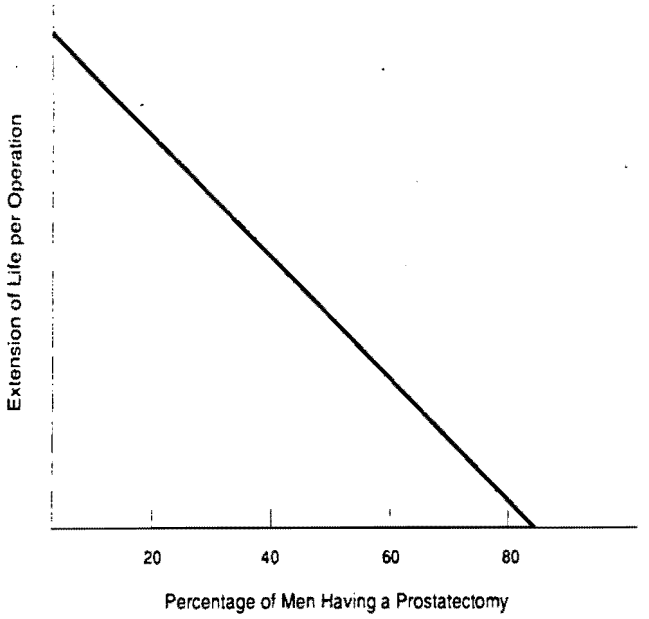


FIGURE 2-2 Benefit-utilization curve under the theory that prostate surgery increases life expectancy.

The unresolved competition between the preventive and the quality of life theories (and their corresponding benefit-utilization curves) reflects indeterminacy rooted in poor clinical science. The outcomes research we undertook showed that the preventive theory was incorrect.[4] Early surgery appeared to lead to a slight decrease in life expectancy because for most men BPH does not progress to life-threatening obstruction. Those without evidence of such obstruction were better off with watchful waiting if the expected value of treatment was an increase in life expectancy. The curve in Figure 2-2 thus is incorrect. If prostate surgery has a place for men with symptoms, it lies in accordance with the quality of life theory.

But the uncertainty about the shape of the benefit-utilization curve is more profound than the failure to define and measure the outcomes that matter to patients. Most urologists who believed in the quality of life hypothesis also practiced within the delegated decision tradition. They understood that they bore a responsibility as the patient's agent to interpret

[4]The findings of this research project have been widely reported. For examples, see Wennberg et al. (1988); Fowler et al. (1988); and Barry et al. (1988).

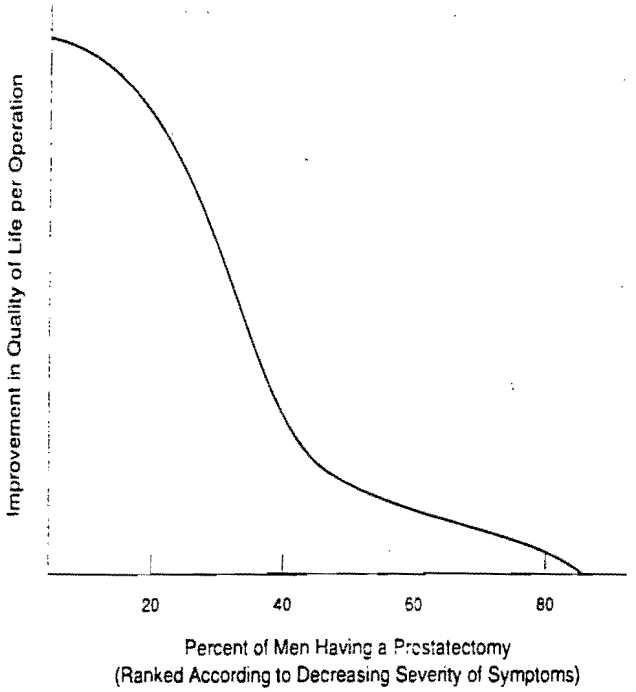


FIGURE 2-3 Benefit-utilization curve under the theory that prostate surgery improves quality of life.

for him what he needed and to convince him, for reasons of his own best interest, to accept their prescription. Yet our preference research showed that what patients want cannot be predicted from objective information available to the physician—that is, from data gained during the physical examination, from laboratory tests measuring such factors as urine flow, or even from answers to questions about the severity of symptoms or impairment of quality of life. Patients who by all such objective measures are similar may still differ in their preferences for treatment. Indeed, as it turned out, when they were informed about the alternatives and offered a choice, nearly 80 percent of men with severe symptoms choose watchful waiting, at least initially. Preferences for outcomes and level of aversion to risk cannot be intuited reliably by physicians based on objective knowledge; to know what patients want, physicians must ask them.

When patient preferences are neglected or misunderstood, the benefit-utilization curve is erratic, without evidence of rational sorting, and the net expected value can actually be negative. For example, if 16 severely symptomatic men were ranked according to impairment of urine flow (a common

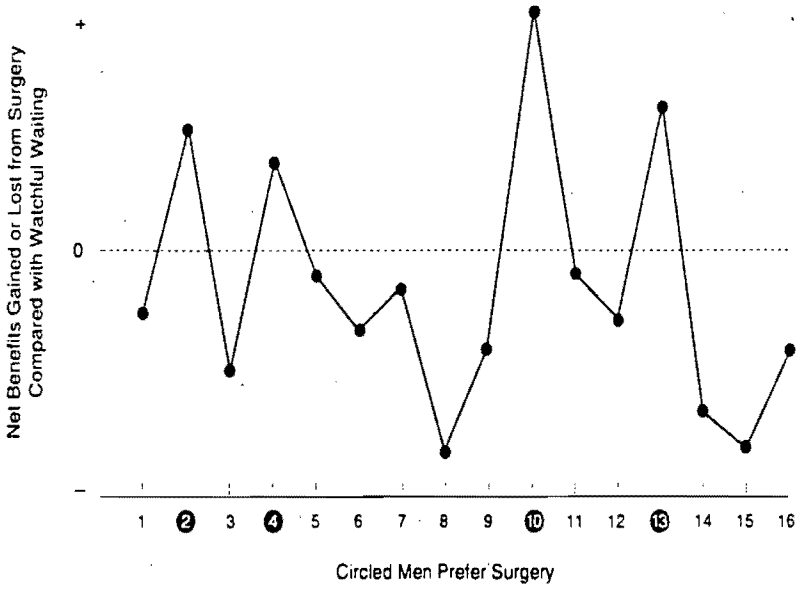


FIGURE 2-4 Benefit-utilization curve for 16 men with severe prostate symptoms who were prescribed surgery under the delegated decision making model.

diagnostic tool), our studies predict that only 4 would want surgery and that the 4 choosing surgery would not be correlated with urine flow impairment. If surgery were prescribed for all 16 men on the basis of the delegated decision model—that is, without informing patients about their options and asking them what they wanted—most patients would receive care they did not want. Whereas the patients ranked second, fourth, tenth, and thirteenth may want surgery, the majority do not. For these patients, the expected value of surgery is actually negative, compared with the benefit they would have obtained from the watchful waiting option they wanted (Figure 2-4).

WHICH RATE IS RIGHT?

What is the rate of service (and resource) use when patients are informed about the state of medical progress—about what is known and not known about the relationship between treatment options and the outcomes that matter to patients—and are free to choose among options according to their own preferences? What are their attitudes toward the benefits and risks of the expected outcomes?

Preference research gives a tentative answer. When patients with BPH are fully informed about their treatment options and asked to participate in

clinical decisions, they choose less invasive treatments more often than they do when decision making follows the delegated model; their choice of treatment is strongly influenced by the degree to which they are bothered by their symptoms and their fear of impotence. Moreover, the population-based rates of surgery decline. For this condition, the trend toward conservative (nonsurgical) treatment choice is evident even in prepaid group practices in which the rates of surgery were already relatively low (and where patients faced no cost barriers at the point of delivery). The results of our preference research thus indicate the likelihood of significant negative returns on current patterns of resource deployment under the delegated decision model.

For the vast majority of illnesses and conditions, the pattern of variation in treatment choice is similar to or even greater than the variation seen for prostate disease. Most conditions do not have a single best treatment. For most conditions for which there is one or more "appropriate" surgical treatments there is also one or more nonsurgical options that are feasible within current scientific understanding. Surgical options for nine conditions—angina, arthritis of the hip and knee, silent gallstones, menopausal conditions affecting the uterus, peripheral vascular disease, back pain due to disc disease, atherosclerosis of the arteries of the neck, and BPH—account for well over half of the major surgery performed in the United States (Table 2-1). For these, the shape of the benefit-utilization curve is un-

TABLE 2-1 Common Conditions for Which the Shape of the Benefit-Utilization Curve Is Unknown

Condition	Major Treatment Controversies
Noncancerous condition of the uterus	Surgery (by type) vs. hormone treatment vs. drugs vs. watchful waiting
Angina pectoris	Bypass surgery vs. angioplasty vs. drugs
Gallstones	Surgery vs. stone crushing vs. medical management vs. watchful waiting
Peripheral vascular disease	Bypass surgery vs. angioplasty vs. medical management
Cataracts	Lens extraction (by type) vs. watchful waiting
Arthritis of hip and knee	Surgery (by type) vs. medical management
Prostatism (BPH—benign prostatic hyperplasia)	Surgery (by type) vs. balloon dilation vs. drugs vs. microwave diathermy vs. watchful waiting
Herniated disc	Surgery (by type) vs. various medical management strategies
Atherosclerosis of carotid artery with threat of stroke	Carotid endarterectomy vs. aspirin

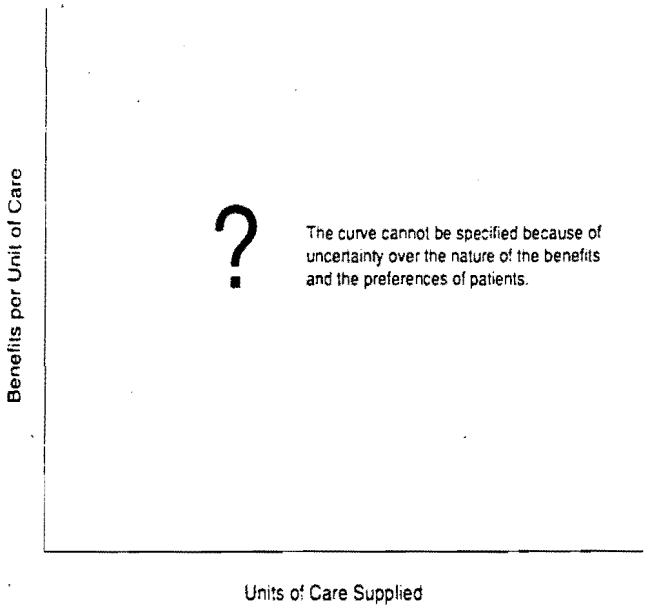


FIGURE 2-5 Status of the current understanding of the benefit-utilization relationship for most medical treatment theories.

known (see Figure 2-5). Through outcomes research, however, and the distinguishing of patient preferences from those of the physician, it will be possible to create islands of rationality in a sea of uncertainty and supplier-induced demand.

REFORM OF THE DOCTOR-PATIENT RELATIONSHIP

The flaws in the role of the physician as a decision-making agent for the patient are now widely apparent, and reform of the doctor-patient relationship is under way. The question now is, which model will replace it? In the United States, ambitious programs have been implemented to check the autonomy of the physician by imposing the use of clinical policy managers to micromanage the choices doctors make for their patients. Unlike the classic staff-model health maintenance organization (HMO) in which cost containment is achieved through global restrictions on the quantity of supply, the strategy of micromanaged care is to force efficiency by setting parameters of practice to define the available options and to guide a myriad of everyday clinical decisions. Acting as agents for third-party payers, the micromanagers develop rules of practice and use them to patrol the deci-

sions of physicians. Virtually all major insurance companies offer micromanaged care programs that invade the traditional decision-making authority of physicians, subjecting their prescribing authority to the discipline of rules developed and administered by third parties. The strategy is not limited to private payers: the state of Oregon, while setting an overall budget, administers constraints not through global budgeting or overall limits on resources but through an ambitious program to micromanage benefits (services) based on estimates of relative cost-effectiveness.

This author's criticism of the micromanaged care model is based in part on its failure to understand the limitations of clinical science. The strategy assumes that the shape of the benefit-utilization curve is known and that this knowledge can be codified by the committees of experts convened to write the rules of practice. Inevitably, because of defects in the knowledge base of medicine which were discussed earlier, virtually none of the rules that emerge from this process can be based on an understanding of the structure of the decision problem over which they claim authority. Because the process is decentralized—there seem to be well over a hundred parties engaged in rule setting—the results are a plethora of varying prescriptive or advisory codifications of the rules of practice, some that directly conflict with one another. In an unfortunate number of examples, the rules are secret or proprietary, the property of the managed care company.

This critique is also based on the ethical weakness of micromanaged care—that is, its tendency to preserve the delegated decision-making model by substituting the guardianship of the third party for the benevolent authoritarianism of the physician. There is little pretense that this model of reform concerns itself with the preferences of individual patients. The imposition of third-party rule often occurs through telephone conversations over an 800 number involving the physician and the agent of the third party. Patients are not involved. The irony is obvious: if physicians do not know what works and what patients want, how can the third party claim such knowledge? The substitution, however, is not simply that of one imperfect agent for another. The micromanagers are agents of the payer, not the patient. The intrusion opens the doctor-patient relationship to the free play of various interests in setting and enforcing clinical rules, a circumstance that offers numerous opportunities for irrationally and arbitrarily rationing care and otherwise perverting the struggle to base clinical choice on the preferences of patients.

The opposing model for reform centers on what would be required to facilitate the sharing of decision making by patients and physicians. It depends on a program of outcomes and preference research and on philosophical inquiry to build the scientific and ethical base for helping patients make decisions that reflect their preferences. It depends on a new relationship between doctors and patients, based on open communication and the

development of new styles of discourse and trust. Shared decision making competes for authority with micromanaged care. Each model seeks to influence clinical choice in specific nonemergency situations such as those listed in Table 2-1, situations in which options exist and time is available to reach a decision. Most commonly, these choices involve the elective use of surgery, but the participants in the conversation are different from those in the managed care model. There, the conversation takes place between the payer and the physician; in shared decision making, discourse is between the physician and the patient.

Because of its explicitly ethical basis, the shared decision-making model is preferable when fateful choices must be made between elective treatment options that entail differing risks and benefits. In these situations, rational choice depends on finding out what the patient wants. As noted earlier, preferences cannot be diagnosed by physical examination, laboratory tests, or questionnaires about symptoms or quality of life. A patient who meets the managed care criteria of eligibility based on these objective features of "appropriate care" may be prescribed a treatment he or she does not want. The benefit-utilization curves that result under micromanaged care look like those shown in Figures 2-4 and 2-5. It is doubtful that effective communication with a patient can occur over an 800 number, no matter how interested the micromanager may be in patient preferences. The shared decision-making model is therefore appropriate for choosing treatments for patients with such common conditions as angina, gallstones, uterine bleeding, benign hypertrophy of the prostate, cataracts, back pain caused by herniated discs, and arthritis of the hip.

LINKAGE BETWEEN THE SUPPLY OF RESOURCES AND MEDICINE'S IMPLICIT THEORIES OF EFFICACY

The critique of third-party micromanaged care presented here also rests on the likely futility of such an approach in effectively limiting undisciplined growth of the health care system. This is a weakness of the shared decision-making model as well. Neither approach is likely to produce systemwide containment of costs, which requires a macroeconomic policy; reforms targeted at the microeconomy of the doctor-patient relationship are insufficient tools for disciplining the macroeconomy. The reason is that most of medicine's resources are not used to execute discrete treatment options specified by well-developed medical discourse. Condition-treatment options such as those listed in Table 2-1 are the exception; most medical resources are allocated implicitly in varying patterns or cascades of acts undertaken to solve medical problems. The theoretical reasons for one pattern of allocation compared with another are often implicit and inaccessible to precise rules of practice. Indeed, medical theories are often so

closely associated with the supply of medical resources that physicians do not even recognize them as explicit theories.

The effect of the supply of beds on the clinical thresholds for hospitalizing patients is a good example. The supply of hospital resources varies remarkably across geographic areas, and the amount allocated is unrelated to illness rates or to explicit theories about the numbers of beds required to treat most diseases. When more beds become available, they are allocated across a broad range of medical conditions for which the clinical policies governing admission and readmission rates are correlated with the supply of beds. In areas with fewer beds, patients with these conditions are more often treated outside of the hospital. For only a few medical conditions are the clinical thresholds such that illness rates determine the probability of hospitalization.

Let us consider the example of Boston, Massachusetts, and New Haven, Connecticut. Residents of Boston have about 4.5 hospital beds per 1,000 persons whereas New Havenites have only 2.9. Explicit rules of practice, codified in medical texts, dictate hospitalization for all patients with heart attacks or strokes, for those who need major surgery to treat their cancers, and for those who suffer from major trauma such as a hip fracture. Diagnostic criteria for these conditions are explicit, and the technologies for distinguishing the presence or absence of the condition are well advanced. But hospitalization for patients with these conditions requires less than 20 percent of the available medical beds, even in low-bed-rate areas. Most of the beds are used for conditions that exhibit highly variable patterns of admission. Hospitalizations for low back pain are the single most important reason for the difference in bed use between Boston and New Haven. Gastroenteritis is the second, followed by chronic bronchitis and pneumonia. The implicit rules of practice in Boston, which have been adapted to the greater supply of beds, result in a larger proportion of the population being admitted, with more frequent readmissions and shorter intervals between admissions.

The mechanism underneath the association between beds and admission and readmission thresholds centers on the decision making of physicians who must decide what to do with sick people. Imagine someone who is faced with the task of watching a conveyor belt that presents, in seemingly random order, a series of balls—some black, some white, some in varying shades of grey. The rules require that all black balls be picked up and put on a shelf and that white balls be left on the conveyor belt. The sorting task is to examine each of the grey balls and decide whether they should be put on the shelf—but at the same time to save room for all the black balls that must be put there.

The conveyor belt simulates the flow of patients through the emergency room or the doctor's office. The black balls are the conditions that all

physicians agree require hospitalization; regardless of how sick the patient may appear, he or she must be admitted. The white balls are those conditions that are treated outside of the hospital. The task is to decide which grey balls should be "admitted"—placed on the shelf. Each must be evaluated as to its degree of greyness (relative illness). There are always more grey balls (more sick people) than there is room on the shelf. The sorter must find a way to deal with the problems presented by all of the grey balls.

Making judgments about degrees of illness and finding safe alternatives for patients are difficult tasks and involve a great deal of uncertainty. If beds are available, it is much easier to rely on others—the ward physicians and nurses—to sort out the problems. It is far easier to admit a patient to the hospital (put a grey ball on the shelf) than to search out alternatives.

Small area analysis reveals something that the sorters do not know. There are fewer beds per capita in New Haven; consequently, the shelf there is much smaller than the shelf in Boston—about half its size. In New Haven, the sorter must spend more time evaluating shades of grey and finding safe alternatives by making calls to the patient's private physician, eliciting the help of home health agencies, or arranging transportation to nursing homes, hospices, or departments of social services.

Small area studies reveal another curious feature: about the same amount of space on the shelf is held in reserve in the low-rate areas as in the high-rate ones. Despite the greatly reduced size of their shelves, there is no evidence that physicians in areas with low per-capita bed rates believe that they are rationing effective services. They do not even use all of the beds available to them. Clinicians in New Haven, like their counterparts in Boston, tend to hold about 15 percent of beds in reserve. They seem unaware of scarcity and are satisfied that their theories of how hospital resources should be deployed are appropriate. The chiefs of service at Yale's teaching hospital in New Haven, when asked whether they were aware that treatments were being withheld because of the area's per-capita bed supply, could identify no examples of explicit rationing. Indeed, as is so often the case when the facts of variation are presented, the chiefs were not even aware that hospital resources were relatively scarce in their community.

In the upside-down economy of medical care, supply comes first and theory follows, in virtual equilibrium as practice style adjusts to ensure the utilization of available resources. Thus, treatment theories governing the use of hospital beds are sufficiently flexible to allow the use of available beds, no matter what the per-capita level of supply; theories that establish the legitimacy of the use of particular procedures justify professional workloads, virtually without regard for the number of specialists; and undervaluated medical treatment theory is sufficiently rich to permit the employment of internists and family practitioners virtually without regard to how many there may be per capita. As clinical problem solvers, it is in the

nature of physicians to deploy available resources, including themselves, close to the point of scarcity. They do this in pursuit of treatment theories that seem reasonable and that might just prove to be effective. This behavior is not the result of simple self-interest: it arises from physicians' perceptions of their role as healers, their faith in plausible theories of efficacy, and their willingness to work to find solutions to the endless stream of problems their patients present.

It is quite possible that higher per-capita rates of investment in health care produce no net benefit over what is achieved in areas with lower per-capita rates. Consider the evidence regarding bed supply. Much of the additional pool of resources in Boston is invested in more frequent readmissions of the chronically ill and in the care of terminal patients. In spite of the 70 percent greater per-capita expenditure for Bostonians compared with New Havenites, the mortality rates are the same, as predicted by the similarities in demographic characteristics. In addition, the more than twofold variation in expenditures for hospitalization among the 185 hospital service areas of New England is not correlated with mortality rates.

Indeed, why should greater spending bring better results? In formulating an expectation about whether more should be better, it is well to recall the contingencies that determine the capacity of the health care system. Capacity is not fashioned according to explicit theories about what works in medicine. The optimal number of beds is unknown, and the number that is actually built or supplied has no theoretical or empirical basis. (One looks in vain to medical texts to learn how many beds are needed for treating a population's burden of illness for such conditions as back pain, pneumonia, and gastroenteritis.) The number of beds is the result of the way the hospital industry has grown. Per-capita rates are arbitrary, the product of the opportunities and desires of institutions and communities—not of the needs or preferences of patients, shaped by the possibilities articulated by medical science.

This is easily seen in case studies that reveal the history of the planning and construction of hospital beds. The populations of Waterville and Augusta in Maine are about the same in size, but Waterville has nearly twice as many beds per capita. The reason is that Waterville hospitals were constructed according to the dictates of religious and professional orthodoxies, a set of dynamics that resulted in three hospitals: a Catholic and a Protestant hospital, each used by allopathic physicians, and a third hospital reserved for osteopaths. In Augusta, only one hospital was built, an ecumenical institution shared by all religious and professional persuasions. The medical care landscape in the United States is contoured by the jagged profiles of resource allocation exemplified by Boston, New Haven, Waterville, and Augusta. In each example, the intensity of construction is determined by dynamics that are indifferent to theories of efficacy or even to

simple rules about the necessary numbers of beds in relation to the size of the population.

The number of physicians who are trained is governed by equally arbitrary policies, many of which were formulated in the 1960s, a period of great concern about medical scarcity. The number of physicians trained for each specialty is the product of administrative and political choices rather than a response to the resources required to produce services dictated by an answer to the "which rate is right?" question. In the case of procedure-oriented specialties, supply is well in excess of the number of practitioners needed to produce treatments that physicians agree are efficacious. For example, when neurosurgeons enter medical markets, they almost invariably find that the available supply has already taken care of the demand for surgical management of brain tumors and head trauma, which are the procedures that all physicians agree are needed. Neurosurgeons thus must invest most of their efforts in treating conditions for which there are valid nonsurgical options. The most common are two condition-treatment options listed in Table 2-1: back operations and carotid artery surgery. Although it is reasonable to conjecture that more of such surgeries might produce some benefit, the studies noted earlier suggest that the amount of neurosurgery now being supplied under the delegated decision model could well exceed the amount patients want when they choose according to well-informed preferences.

SEEKING LIMITS

It is quite possible that the current crisis in health care in this country may stem from the excesses of an economic sector dominated by supplier-induced demand and professional uncertainty about the value of medical care—and not from patient demand based on medical progress. The excesses arise because of errors in the assumption of neoclassic economic policy that capacity would be limited and the quality of care maintained by medical efficacy and patient demand, mediated through the physician who serves as the rational agent for patient and society. The effects of these errors are now increasingly apparent:

- *Quality is poor.* Patient values are not paramount in the decision to use care; information on options (and on the state of medical progress) is not freely communicated; and services (whether wanted or not) are produced with varying efficiency in regard to outcomes.
- *Costs are out of control.* The supplies of resources are created (in increasing amounts) without regard to explicit theories of efficacy and without knowledge of the shape of the benefit-utilization curves for medical interventions and of the amount of resources needed to produce the services patients want.

- *Access is diminished.* The decentralized structures that have financed care through insurance are increasingly unable to provide products that are affordable to business or to individuals without employment-based insurance.

It seems very likely that the 1990s will bring policy decisions that place explicit limits on the medical care system in the United States, although no model of governance has emerged as an odds-on favorite. It may well be impossible to reach a national consensus on what to do, in which case the initiative will fall to the states. If so, several models may evolve, but their shapes should be governed by certain principles and guidelines that find their empirical justification in the epidemiology of medical care and in ethics.

The first principle concerns the general welfare: *it is safe for patients and in the public interest to place global restrictions on growth in the capacity to provide medical care.* Studies of geographic variation in services in this country provide solid evidence that the capacity of the hospital industry and of the physician work force is now well in excess of that required to provide services that are efficacious and that patients actually want. Most medical resources are allocated to treatments for which the theoretical basis for allocation is implicitly associated with the supply of resources and for which there is no empirical evidence that more is better. The nation can and should deal directly with the forces of inflationary growth in the health care sector—with the policies that determine the numbers and distribution of manpower, the size of the hospital industry, and the quantities of technology. The excess in capacity means that the amount spent on health care (as a percentage of GNP) can be directly limited and a health care system achieved that is in equilibrium with other sectors of the national economy—without fear that valuable services must necessarily be rationed.

The second principle concerns the welfare of those who do not now have access to care because they lack insurance: *full entitlement of all Americans to health care can be instituted without increases in the proportion of GNP invested in health and without a loss of welfare to those now insured.* The fear that policies that extend health care entitlement to all citizens will exacerbate the cost crisis is unwarranted; the dynamics that determine the capacity and costs of health care markets are to a large extent independent of illness rates and the demands of patients. To see why this is so, let us return to the analogy of the person sorting the black, white, and grey balls. Physicians are unaware of the relative size of the resource shelf—that is, of the per-capita quantities of "supply" invested in their markets; put another way, they are unaware of the relative size of the population they are serving. For example, two-thirds of the population of Vermont could move to Boston before the relative size of the Boston hospital

resource shelf approaches that of New Haven. The testimony of physicians in New Haven—and the statistical evidence that resources are held in reserve equally in all medical markets, regardless of the relative per-capita rate of resource investment—tells us that if the increase in population size occurred gradually, no one in the medical care industry serving Bostonians would notice the difference. The major change in practice style would be a change in the threshold for hospitalization—a more careful sorting of grey balls. The biggest change in the rates of use of hospitals would be for back pain, gastroenteritis, and chronic bronchitis.

Fewer than 15 percent of Americans are completely uninsured. An understanding of the epidemiology of medical care leads to the prediction that their entitlement would permit them to be absorbed into the health care system without loss of benefit to those now in the system and without any special increase in aggregate expenditures. The capacity to treat the uninsured is already there; what is needed is to make it possible for them to compete for the attention of the health care system on an equal basis with the insured. In a steady-state situation, the increases in costs for treating the uninsured will be offset by the savings realized by reducing utilization among those now insured.

The third principle concerns the interests of patients for whom expensive medical care is effective in a system characterized by excess capacity: *the resources required to meet unmet needs (e.g., prenatal care, bone marrow transplants, long-term care) should be obtained by reallocation of excess capacity and not by rationing effective care.* From the point of view of patients with costly diseases, the reallocation of excess capacity is a more humane way to meet unmet needs than is the deliberate withholding of expensive, effective care on the grounds that the benefits are too costly. If the people of Oregon decide that total resources for health care should be limited, then resources to meet unmet needs should be reallocated from areas of excess capacity. Oregon has its own Bostons and New Havens. Rather than withholding specific treatments such as bone marrow transplants, which are known to increase the expectation for life (and that patients are known to want), this principle recommends the reallocation of resources now invested in excess supplies of hospital beds. Large quantities of resources are thus available for reallocation. If the practice patterns of Boston were more like those of New Haven, 700 hospital beds would be unused, and in 1982 dollars, $300 million would be available for reallocation to other medical needs (Culp et al., 1987).

INNOVATION AND THE POLICIES OF LIMITS

Policies of limits that emphasize the rationing of care through prescriptive rules of practice, that is, through the micromanagement of the doctor-

patient relationship, have very different implications for innovation than policies that set limits that have been developed in accordance with the principles set out in the previous section. The differences are key. At the level of the microeconomy—the doctor-patient relationship—the latter policies emphasize the underdevelopment of clinical science, the entanglement of preferences, and the implicit nature of much of medical theory. At the level of the macroeconomy, they emphasize the opportunities for meeting unmet needs that global limits and strategies for reallocating excess capacity open up. These opportunities also include the development of the necessary professional infrastructure to deal with the weaknesses in the scientific and ethical status of the doctor-patient relationship. A successful policy of global limits has the immediate consequence of buying time to learn what works in medicine and to sort out the many conflicting, explicit theories governing resource deployment in the treatment of discrete conditions such as those listed in Table 2-1. But the several European and the Canadian models for managing the macroeconomy show clearly that setting global limits does not of itself lead to improvement in clinical science or to the development of models for clinical decision making that emphasize patient preferences. For innovation along these lines to prosper, policies to achieve global limits must be linked to a science policy that builds the infrastructure for evaluating medical theory and promotes new models of the doctor-patient relationship.

The introduction suggests some of the characteristics of a science policy that would promote "rational" innovation under both policies of global limits and of managed care. Such policies would encourage the development of new ideas and technologies and their systematic evaluation in a context that fosters the progressive growth of a more fully rationalized microeconomy, namely, a doctor-patient relationship in which decisions are based on information about outcomes and on the preferences of patients. This chapter also draws attention to the sources of medical ideas and the current processes of evaluation to highlight the importance of problem solving in everyday practice as a source of medical theory. In addition, it emphasizes the lack of standardization in innovative processes when they occur in the context of the daily practice of medicine.

The varying sources of medical ideas and the complexity of the innovative processes of medicine have an important implication for science policy: evaluative research must be closely linked to daily practice. They also suggest two goals and two processes of evaluation:

1. the goal of theory evaluation, by which alternative treatments for common conditions are tested in a comprehensive, systematic approach; and
2. the goal of process evaluation, by which the various configurations for packaging technologies and organizing human resources and levels of skill are explicated and evaluated.

The first goal involves outcomes research, the second involves quality management, and their linkage is the relationship between their ends and the means for achieving them.

Let us briefly consider the requirements for building an infrastructure for the evaluative sciences in medicine. The first volume in this series discussed the various disciplines that constitute the evaluative sciences and the rationale for their introduction into mainstream thinking in medical schools (Wennberg, 1990b). It also discussed the policy basis for outcomes research and an organizational strategy, the patient outcome research team approach, for meeting the ongoing requirements for evaluation of established treatment theories, as well as innovations as they emerge. These teams—PORTs, as they are becoming known in the United States—are part of the infrastructure being developed by the Agency for Health Care Policy and Research, a new federal agency that represents the first explicit effort on the part of government to articulate science policy for the evaluative sciences.

There is a certain irony that public policy to rationalize health care should develop in the one nation among Western democracies that Brian Abel-Smith (1985) labels the "odd man out," the single example of a nation that has failed to establish policies of global limits on expenditures. The need for rational reallocation is most acute in systems of care in which marginal spending on innovation is inhibited by policies of global limits. Strategies for avoiding explicit health care rationing by reallocating excess capacity to meet unmet needs for effective medical care depends on the successes of the evaluative sciences in identifying examples of excess capacity and establishing evidence that care is, indeed, effective. It should be much easier to build the necessary infrastructure in systems of care in which the societal commitment to set limits is in place—once the problem of professional uncertainty and excess capacity is understood by policymakers. At least in principle, systems of care governed by policies that rationalize the deployment of manpower and budgets can redefine professional tasks much more easily than is now possible in the United States, with the important exception of prepaid staff-model HMOs such as the Kaiser Permanente Plan or Group Health Cooperative of Puget Sound.

The reallocation of professional time and talent toward the two goals of outcomes research and quality management is a clear example of a potential advantage that Canadian or European models have over the United States. For the sake of argument, let us assume that the health care industry, like any other high-technology industry, should allocate 10 percent of its earnings to the development and testing of its products. In the health care field, investments of this order of magnitude are now made only by well-capitalized pharmaceutical and medical device industries, and as the example of off-label uses of drugs such as prazosin shows, this does not lead to full

rationalization of even drug-related clinical theory. The problem is the vast undercapitalization of the evaluative function within the ongoing practice of medicine. Resources to evaluate innovations arising in clinical practice or to undertake the quality management tasks that in most industries are part of the production process have not traditionally been made available by government or the private sector. One of the most constructive steps consistent with the principles outlined in the previous section would be to allocate a substantial proportion of the health care budget to the task of building the necessary professional infrastructure in the evaluative sciences.

Canada offers an example of what could be done in a system with global limits in place. Canadian physicians are currently paid much less on a per-procedure basis than their counterparts in the United States, resulting in longer work hours and greater productivity in terms of the numbers of procedures performed per physician; as a consequence, the rates of use of many common surgical procedures (and probably a good number of diagnostic procedures) in Canada rival those in the United States, even though the supply of specialists is considerably less. Some of the excess capacity that Canadians now allocate to such procedures could be safely allocated to conduct outcomes research and build the professional infrastructure for management of quality. Leading physicians who are interested in these tasks could be safely recruited from active practice without fear that the reduction in services would harm patients. (This could be done on a half-time basis to allow these physicians to remain clinically active.) Such an effort would not require a reorganization of the fee-for-service financial structure but only the willingness of the provincial government to negotiate salaries for physicians who chose to invest part of their professional time in this manner. Networks of recruited, professional talent linked to centers for the evaluative sciences, would form the infrastructure for a variety of evaluative tasks as well as the dissemination of results. Presumably, such a strategy would also be cost saving, because the total cost of care per active physician—the stream of medical acts he or she initiates or sustains—is very likely to be much greater than the total cost of research per physician-investigator. A commitment to evaluation along these lines holds the promise of rationalizing a spectrum of current inefficiencies, particularly in the management of quality and the explication of as yet unrecognized variations in the processes of production.

An all-payer or single-payer model also offers another opportunity for rapidly increasing the level of sophistication of practicing physicians in the evaluative sciences, in particular their understanding of the relevance of evaluation for the everyday practice of medicine. Medical education has been primarily geared to the production of medical students and the training of medical residents; in situations of perceived manpower scarcity, this focus is quite natural. The current situation of excess capacity presents a

new challenge and opportunity for medical education: to pay attention to ongoing learning requirements in a field with rapid technological change and to commit to a mission of lifetime learning in which skills are reshaped, knowledge rebuilt, and careers refashioned to meet changing needs. Again, in Canada, these policies are within reach. Just as the existence of excess capacity justifies the redeployment of professional talent to build capacity for the evaluative sciences, it also justifies periodic salaried sabbaticals from clinical practice for all professionals, including physicians, nurses, administrators and others.

In theory, the British National Health Service provides similar flexibility for the reallocation of professional workloads. Moreover, the special role of the British general practitioner, the unique responsibility he or she bears for initiating referrals, offers a splendid opportunity for development of the new model for the doctor-patient relationship based on shared decision making. Rationalization of treatment patterns for specific conditions such as BPH ultimately depends on rationalization of referrals from primary care to specialty care—on the development of what in the United States is called the cognitive role of the physician.

It is no coincidence that governmental policy encouraging the evaluative sciences developed first in the United States. The issue of practice variations and the need to improve the scientific basis of clinical decision making have been prominently discussed in professional journals as well as in the lay press. The linkage of practice guidelines to outcomes research and the growth of the idea that micromanaged care will contain costs brought together the critical support needed for a new federal initiative, the Agency for Health Care Policy and Research, at a time of budget deficit and reluctance by Congress to take on new tasks. The tensions between the trend toward cost containment based on micromanaged care and the needs and requirements for rational innovation continue to grow. The implications of micromanaged care for the innovative processes of the pharmaceutical and medical device industry, as well as for surgical innovation, are now being widely discussed. In some cases, the emphasis on cost-effectiveness and reallocation will seem commensurate with the goals outlined here. But in other cases, the restrictions operate in the other direction and affect the weakest link in the evaluative process: the assessment of innovation within the context of everyday practice. At a time when the expansion of practice-based infrastructure to support innovation is needed, rules that restrict the funding of "experimental" technologies are being more rigidly enforced. Moreover, the increasing sensitivity to cost shifting, that is, the effort on the part of the purchaser to get the "right price," penalizes most the academic medical centers that traditionally have been the most productive sources of medical innovation. This is unfortunate, given that the health care system's situation of excess and professional uncertainty requires just the opposite.

Nevertheless, things are changing. Whatever the shape of the new American health care economy, the policies of reform, if they are to promote rather than retard medical innovation, must assume the obligation to build the scientific and ethical basis of clinical medicine and contain resource consumption within limits acceptable to the wider society. The obligation to reform the scientific and ethical basis of clinical medicine can be summarized in four guiding principles:

1. knowledge about relevant treatment options should be freely communicated to patients;
2. the choice of intervention from among options that work and that society is willing to provide should be based on the patient's preference;
3. the production of treatments should be continuously improved; and,
4. new as well as conventional treatment theories should be continuously assessed and reassessed.

The opportunity to build a productive microeconomy, to keep the doctor-patient relationship free from intrusions by the state or by third-party micromanagement, depends, in turn, on a public policy for health that deals with the problem of limits and innovation. The challenge to the policies and politics of reform is to (a) set limits on the growth of supply; (b) reallocate excess capacity to productive purposes; (c) support the lifetime learning requirements of the profession; and (d) build the professional infrastructure required to learn what works in medicine and to produce services efficiently, free of supplier-induced demand.

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