M I N U T E S

COMMISSION ON HEALTH CARE COSTS

September 13-14, 1977

Members Present

Frank Lowman, Chairman
Senator Arnold Berman
Sister Caroline Juenemann
Representative Roy M. Ehrlich
John Erickson
Representative Jamie Schwartz
Al Tickwart
Senator Wesley Sowers

Staff Present

Emalene Correll, Kansas Legislative Research Department
Norman Furse, Revisor of Statutes Office

Others Present

Richard Morrissey, Department of Health and Environment, Topeka, Kansas
Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Kathryn Klassen, Department of Social and Rehabilitation Services, Topeka, Kansas
Dr. Robert Harder, Department of Social and Rehabilitation Services, Topeka, Kansas
Ruth C. Dickinson, State Department of Planning and Research, Topeka, Kansas
Nelson Tilden, Kansas Hospital Association, Topeka, Kansas
Frank L. Gentry, Kansas Hospital Association, Topeka, Kansas
James L. Scott, Kansas Hospital Association, Topeka, Kansas
Robert J. O'Brien, Wesley Medical Center, Wichita, Kansas
Connie Rueck, H.I.S., Silver Lake, Kansas
Linda Irwin, H.I.S., Silver Lake, Kansas
Eleanor Smith, League of Women Voters, Lawrence, Kansas
Helen Crockett, League of Women Voters, Lawrence, Kansas
Jack Roberts, Blue Cross-Blue Shield, Topeka, Kansas
Gary A. Lausier, Marion Labs, Inc., Kansas City, Missouri
Jerry Hedrick, Marion Labs, Inc., Kansas City, Missouri
Terry Whelan, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Larry Fischer, Kansas Health Care Association, Coffeyville, Kansas
Dick Hummel, Kansas Health Care Association, Topeka, Kansas
Laurence Bartel, Prairie View Mental Health Center, Newton, Kansas
Jerry Slaughter, Kansas Medical Society, Topeka, Kansas
Lloyd Hall, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Richard Petro, Surgical and Orthopedic Appliances, Topeka, Kansas
Jack Milligan, Kansas Optometric Association, Topeka, Kansas
Gary Robbins, Kansas State Nurses Association, Topeka, Kansas
Joe Harkins, Department of Health and Environment, Topeka, Kansas
Vickie Hurt, Kansas Health Care Association, Horton, Kansas
Ray Briggs, Kansas Health Care Association, Topeka, Kansas
Carl Schmitthenner, Kansas State Dental Association, Topeka, Kansas
Glyndon Hanson, Kansas Chiropractic Association, Topeka, Kansas
John B. Cobb, Lattimore-Fink Labs, Topeka, Kansas
Ronald J. Zoeller, D.C., Kansas Chiropractic Association, Topeka, Kansas
Ellen Francis, Kansas Pharmaceutical Association, Topeka, Kansas
Alfred J. Staab, Ellis County Ambulance Service, Hays, Kansas
Lyle E. Eckhart, B.E.M.S., Topeka, Kansas
Dr. Jack Dunigan, Kansas Psychiatric Association, Topeka, Kansas
Glen Leonardi, Community Addictive Treatment, Inc., Topeka, Kansas
Dr. Franklin A. Donovan, Kansas Podiatry Association, Atchison, Kansas

The meeting was called to order at 10:05 a.m. by the Chairman, Frank Lowman, who noted conferees had been asked to speak to the following points:

1. Services they provide under Title XIX and the time involved in providing these services.
2. Impact of Title XIX on their fees and costs.
3. Measures their profession has taken or could take to contain costs under Title XIX.
4. General steps that could be taken to contain costs under Title XIX.

Kansas Hospital Association*

Frank Gentry, President, presented an introductory statement (Attachment A, pages 1-3) followed by a statement on cost containment efforts and the national perspective on hospital costs by Nelson Tilden, Director of Health Services and Planning (Attachment A, pages 4-8). Robert O'Brien, Assistant Director, Wesley Medical Center, Wichita, Kansas, and Chairman of the Council on Finance, presented a written statement on proposed solutions (Attachment A, pages 9-11). Mr. Gentry also distributed a copy of detailed information prepared for the House Ways and Means Committee during the last legislative session (Attachment B).

In answer to questions, Mr. Gentry stated there are 164 licensed hospitals in Kansas including state institutions and federal hospitals. One hundred fifty-nine belong to the Kansas Hospital Association.

Answering questions relative to putting a cap on hospital costs, Mr. Gentry stated the Association has not tried to determine what affect capping costs would have on supportive personnel outside of the hospital, but capping revenue and not costs would have a great impact on hospitals. Its affect on personnel within the hospital would depend on how each hospital decided to cut its costs to stay within the cap.

Mr. Gentry, in answer to questions, noted that the bills now before Congress all include strict qualifications which must be met before rate review responsibilities would be delegated to a state. The House of Delegates of the American Hospital Association has directed their staff to draft a bill excluding states that can show efforts are being made in state sanctioned rate review.

A Commission member noted that if the present rate of increase curve continues, by 1983 national health care costs will be $280 billion per year, an increase from 9 percent to 14 percent of the gross national product. The curve in Kansas indicates costs will double in five to six years. Therefore, there should be an incentive to do something about health care costs. In response to additional comments, Mr. O'Brien stated the cost of medications varies depending on frequency, how administered and the monitoring required. These are usually added costs but in some instances, such as aspirin, where the cost of running a billing through separately is high, will be a part of the daily charge. Mr. Tilden noted hospital costs may have increased 7 plus percent, as noted, but, in comparing this increase with the percentage increase for energy, a factor which must be considered is that the product offered by hospitals has changed drastically during this period while the energy product has remained the same. Yet the cost of energy to hospitals has increased, i.e., for St. Francis Hospital in Topeka it has increased $100,000. He agreed that hospital costs are increasing at a higher rate than the rate of inflation but he was not sure the rate was 49 percent higher than that for other services. He re-emphasized that what hospitals provide is related to the fact that 90 percent of hospital payments come from third party payments. High coverages and first dollar coverages create a demand which must be met. In answer to a question, Mr. Tilden stated insurance under which the consumer picks up the first dollars is available. For example, Blue Cross has a high quality deductible policy with about 40 percent reduction in premium. However, they cannot sell it because most people are covered by their employer and they bargain for the best coverage they can get. A Commission member noted there is no incentive for an employer to purchase the lower rate plan because health coverage is a fringe benefit he can give which will give him a tax advantage.

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* Because of time limitation, Kansas Hospital Association conferees were asked to return at 3:00 p.m. Testimony given in answer to questions at that time is included in this section of the minutes.

In response to further comments by the Commission, Mr. Tilden stated all hospital admissions, tests and regimens of treatment are controlled by persons licensed to practice medicine and surgery since they must be ordered by them. Hospitals do not advertise. This does not mean that a Professional Standards Review Organization (PSRO), which the Association endorses, is not needed. However, promised federal funding to implement PSRO's has not been forthcoming. He then referred to peer review committees which are functioning.

A Commission member asked what happens if the hospital feels the regimen of treatment prescribed is superfluous. Mr. Tilden asked who in the hospital, other than doctors, is qualified to make this assessment? Mr. O'Brien noted the medical audit procedure would pick up the fact that the prescribed treatment was not standard. This would be an educational process and could be the basis for a sanction against the doctor.

In answer to comments about who determines equipment expenditures in hospitals, Mr. O'Brien gave the following example to illustrate the procedure used: a neurosurgeon requests a CAT scanner which he feels is valuable to his practice; the administrator analyzes the request and submits it to the appropriate clinical departments for comments; the request is submitted to the hospital board; if approved, it is submitted to the HSA for recommendations for certificate-of-need.

In answer to questions, Mr. O'Brien stated that by 1980 there will probably be four CAT scanners, two of which will be whole body scanners, in Wichita which has a population of a hundred and some thousand. The whole body scanner costs about $300,000. A member stated the appropriate ratio for scanners is about 1 per 400,000 population. The cost figure he saw, which he assumed was correct, was $500,000 with an annual operating cost of $200,000. Mr. O'Brien stated the operation figure quoted was high.

A Commission member noted a study indicated that for a heart surgical team to maintain its skill and for the hospital to justify it medically and financially, 2,000 open heart operations per year should be performed in a hospital with such facilities. Probably only one hospital in Kansas would meet this criteria yet more were doing this type surgery.

Mr. Tilden noted the important thing is to focus on what we are going to do about the present situation, not argue about how we got there. Hospitals support planning and are moving away from competitiveness. He noted federal rules will soon require HSA's to carry out appropriateness reviews to determine if every service is needed and will continue to be needed. If not, sanctions will be taken.

In answer to questions, Mr. Gentry stated the Hospital Association is on record as supporting a rate review program. Answering questions about specific states, Association conferees stated Washington's program is barely underway and the Connecticut program has problems. A Commission member noted there may be problems in Connecticut but according to a report from the Council of State Governments, the Connecticut Commission has reduced hospital requests and costs. Mr. Scott stated that 32 of 34 large hospitals in Connecticut have taken the Commission to court. Five cases have been settled and all have been in favor of the hospital. The legal fees of approximately $250,000 to $300,000 per year will add to hospital costs.

Mr. Gentry, in answer to questions, stated rate review in Kansas is just getting underway on a voluntary basis. The program is under Blue Cross-Blue Shield with a rate body composed of subscriber members, all consumers, of Blue Cross. This program has the flexibility of trimming costs through a volunteer program. However, no program produces immediate results. He reiterated the points on page 9 of Attachment A.

A member questioned that hospitals in Kansas which have received Hill-Burton funds are complying with the requirement therein to provide a percentage of free care. Mr. Scott pointed out there are three ways to show unpaid services were rendered. Most Kansas hospitals are county hospitals that are required to have an open door policy, or are operated on this basis by a charitable group. There is no requirement for these hospitals to report the dollar amount of uncompensated care provided. Audit statements would show it has been provided in the form of bad debts. Last year the amount reported as Hill-Burton free care appears to be smaller than free care given and written off as a bad debt. Because of restriction problems, the Association would like the issue explored. Mr. Gentry stated all hospitals receiving Hill-Burton funds are in compliance and the Department of Health and Environment has stated that they are. He suggested the Commission ask a representative of the state agency to appear to answer some of the members questions. Consensus was that this be done.

Staff noted the information provided by the Department of Social and Rehabilitation Services indicated 4,000 hospital beds in Kansas are not being utilized, which would seem to indicate that the certificate-of-need program had not functioned effectively. Mr. Gentry noted the bed utilization figure has been revised by Blue Cross-Blue Shield because of the necessarily wide fluctuations in small hospitals. The point to remember is that a small hospital which usually has a 50 percent occupancy may staff for that rate so it does not add to the cost problem. Staff is increased only during higher occupancy periods. Agreeing that some smaller hospitals are really providing only nursing home care, he stated there is going to be a move toward regionalization in the next few years. Mr. Tilden noted the difficulty of determining which beds are excess beds. Closing a hospital may not always help contain total health care costs. For example, a small hospital, charging $120 per day, close to Hays is closed. People now have to go to the Hays hospital and pay $160 per day plus transportation costs. The number of hospital beds in Topeka and Wichita run high in relation to population. However, if you take the total HSA area served this may not be true.

Mr. Tilden stated one problem with the certificate-of-need program has been the lack of a state plan against which requests could be judged.

A Commission member stated there also needed to be a cost containment plan and suggested imposing a standard accounting procedure on hospitals. Association conferees noted that all hospitals participating in Medicare must conform to the accounting system set out in that law. The Association's recommendation is that, since hospitals are so different, they use their own accounting system but use a uniform reporting system. This would allow classifying hospitals for comparisons.

A Commission member recommended moving in the direction of prospective cost payments noting federal money is available for experimental programs. Mr. Gentry stated this was a good approach if it was done by the state under broad federal guidelines. He did not know the impact state guidelines would have on federal legislation. Mr. Scott noted a number of these experiments are going on. The one in Rhode Island, almost completed, is considered a failure but others show some promise.

A Commission member referred to the concept of baselining and stated this is interfering with cost containment. He suggested establishing a rate based on the rate of five years ago plus an amount based on increased cost of living. Mr. Tilden noted this would leave a deficit someone would have to pick up. Mr. Scott stated there are three issues involved -- cost, access and quality -- which are interdependent. Our society, which has emphasized access and quality, is just now addressing the problem of costs. The suggestion made would have an impact on both access and quality. Also it is really not possible to go back five years because of the technological advances made during this period. The Commission member stated he was not sure per day cost figures quoted by hospitals were accurate since figures could be manipulated. He felt the cost leg of the triangle was inflated. In answer to a question, he stated he thought his suggestion would work fine. There would be an outcry at first but hospitals would rise to the situation.

In answer to a question, Mr. Gentry stated hospital boards are composed almost entirely of persons outside the health care system. Mr. Scott stated county hospital trustees are appointed by the county commissioners; in district hospitals they are elected by people in the district; some city hospital boards are elected on the city ballot. These account for over one-half of the hospitals in Kansas.

A Commission member quoted from a letter to Dr. Harder from Senator Hayden stating that all 81 hospitals reporting received 30 percent to 50 percent of their income from Medicaid. He stated communities may be contributing to the bricks and mortar but the state is carrying the operating costs and should be playing a more vigorous role in the containment of those costs.

Mr. Tilden noted much of the interchange had sounded like an adversary situation and this was not conducive to finding solutions. Also, some agreement as to factors causing increased costs is necessary, if progress toward cost containment is to be made.

At the request of the Commission, the Kansas Hospital Association and Dr. Harder will provide statistics for Kansas which can be compared to national figures used in connection with bills being proposed at the federal level.

Kansas Medical Society

Jerry Slaughter, Executive Director, presented a written statement. (Attachment C)

In answer to questions, Mr. Slaughter stated he thought it was fair to say that the medical profession tended to want each new technological advancement and they do have a decisive voice in the decision to purchase equipment. Staff noted one state determined the number of CAT scanners needed but found this was circumvented by physicians putting them in their offices and clinics which were not covered by certificate-of-need. Mr. Slaughter stated requiring a certificate-of-need for expensive equipment irrespective of the setting in which it is placed should be considered even though physicians would object to having their offices and clinics included. Finding a rational solution, based on need, before the problem grows out of bounds is preferable.

Responding to whether having radiologists function as salaried members of a hospital staff would be preferable to independent practice, Mr. Slaughter stated he was reluctant to say which of the ways services are best. However, if the hospital and radiologist agree, this would be appropriate and it is done.

In answer to questions, Mr. Slaughter stated their organization, with a membership of 2,470, has changed from a fraternal organization to an organization oriented to promoting better health care in Kansas. He stated he did not know what the average physician's income before taxes was but the Department of Economic Development should have these figures.

In response to questions about HMO's, Mr. Slaughter stated he was not sure the Kansas Medical Society had said it was in favor of HMO's, but many physicians do favor such organizations as an alternative to traditional fee for service delivery. However, there is no particular incentive for a group of physicians to develop an HMO. He noted a group of physicians in Wichita had formed an HMO but it was not successful because a need could not be generated. HMO's may hold some promise for holding health care costs down, i.e., it has been noted that HMO's have a lower hospital admission rate.

Speaking to the increased Medicaid and Medicare costs in Kansas, Mr. Slaughter stated he questions whether this is due to increases in fees or services. Information relating to what these programs paid for office calls earlier and what they pay now, seems to indicate the number served and the number of times they are served are a larger factor in total cost.

Responding to the suggestion that Dr. Harder institute a schedule of charges for services, Mr. Slaughter stated physicians would be lukewarm to the idea but would not discount it if it were applied to every service provided. He noted the Kansas Medical Society is working with Dr. Harder to find ways to cut costs.

A Commission member stated he felt steps to determine how much a physician can make or the hours he works was a step toward socialized medicine which he opposed.

In answer to a question, Mr. Slaughter stated the Kansas Medical Society has supported loan and grant programs and has entered into the recruitment process in rural areas. Currently KMS and the Kansas Farm Bureau are cooperating in a loan program specifically for medical students from rural areas. The program provides a low interest loan and a recommendation for admission to medical school in return for an agreement to practice in rural Kansas. A Commission member noted that although all students accepted at the KU School of Medicine are in essence required to state they will practice in Kansas, only a small percentage do. He then asked if the same thing would happen in this program. Mr. Slaughter stated a sharp attorney would not have difficulty finding loopholes in the contract. However, their program is based on the Illinois program which has been in operation for a number of years and has had only two defecters. The program also involves constant contact with the student to establish ties to Kansas.

In answer to specific questions, Mr. Slaughter stated he thought there was a connection between specialization and costs. However, he had not seen any figures supporting this and did not know how direct it was. He did not know if KUMC had engineered the earlier trend toward specialization but both KUMC and KMS support the emphasis on generalists and residencies in family practice.

Mr. Slaughter, responding to questions, stated there is no doubt that doctors control hospital costs to some extent since they decide on admissions, order tests and prescribe treatment. He noted medical students are trained in the best equipped hospitals

with emphasis on testing which tends to develop only the science of medicine and not the art of medicine. KMS has asked the School of Medicine to look at the impact this type of training has on costs. They have suggested that a student be made aware of the cost of a test at the time it is ordered. A joint meeting is being planned with the Kansas Hospital Association on cost awareness and steps that might be taken toward cost containment.

The Kansas Medical Society is also interested in preventive medicine, i.e., the program developed with the American Cancer Society on early warning signs; programs to encourage regular checkups; educating the public about ways to maintain health and prevent illness. There is a need to let the public know they are a part of the problem so they must be a part of the solution.

The Commission recessed for lunch at 12:05 p.m. and reconvened at 1:35 p.m.

Mental Health Centers

Clint Wilsie, Kansas Association of Directors of Community Mental Health Centers, presented a written statement (Attachment D).

In answer to questions, Mr. Wilsie stated the new Title XIX limits effective August 1 limit reimbursement to four individual and four group sessions per month. However, in mental health centers only one modality of treatment is usually used. One month's experience is not enough to determine the impact this limitation will have on centers but some are expecting it to be catastrophic. The number of visits per person before August could be furnished to give an indication of what the impact may be. Alcoholism counseling is included in the totals on the chart. Only four centers have specialized alcoholism and drug programs. Courts can and do send people to a comprehensive center since these centers provide inpatient services. In Sedgwick County only about 20 percent of those committed to the comprehensive center by a court end up at a state hospital.

Mr. Wilsie, responding to questions about charges, stated charges are based on the type of service provided such as inpatient, partial hospitalization, outpatient, and transitional living. There is not a breakdown showing costs per staff hour. Budgets are usually done on a line item basis with staff the largest item. Budgets also include costs for whatever time delineation is appropriate for each type service. Reporting requires a separation of income by souce but does not require a separation of patients. He also noted that charges vary from center to center, i.e., $25.00 to $45.00 per hour for outpatient services. One factor affecting this difference is the number of services provided which are not reimbursable by Medicaid. The need for a more detailed breakdown of costs with a common base such as staff hours was noted.

In answer to a question, Dr. Harder stated that with the limitation effective August 1, the Department expects this program to hold its own. All provider groups have been cut, some more than 16 percent, and some will not be able to stay even.

Medical Equipment and Supplies

Mr. Petro, Petros Surgical Appliances, described the services they offer, including the making and fitting of prostheses, sale of medical supplies and rental and sale of items such as hospital beds, wheelchairs and crutches. He noted that since they are a retailer, they do not control much of the market and under Title XIX demand is created by the doctor who writes the prescription.

Mr. Petro made the following comments and suggestions: changing the regulations to allow physicians to write a prescription for the length of time a device or supply will be needed rather than requiring that prescriptions be rewritten each month would cut down on paper work and the cost of processing and possibly some physician charges, i.e., the physician visits of persons with broken bones and persons with colostomies, purchasing equipment such as a wheelchair or hospital bed in cases requiring long term use; maintaining a central pool to which purchased items are returned to be used by someone else; maintaining people at home at less cost by using rental equipment, i.e., a person in traction for five days if no other treatment is required, or a patient waiting for a special device to be constructed; consolidating and tightening up programs such as happened when the Kansas Crippled Childrens program was put under the Department of Health and Environment. He noted the amounts saved by these suggestions might not be significant compared to total costs but they were the only way he saw for his segment of the health care field to contribute to cost containment.

Mr. Petro stated he saw very little opportunity for relief through pricing since cost to the retailer is determined by factors over which he has no control. Competition among suppliers is limited because in many areas the number of competitors is limited. Cost of labor and other items related to operating a business have also increased. He stated peer review is not very feasible since there are only two or three similar businesses in the state. This type business takes a certain population base so the number is limited.

Mr. Petro stated payment to them under Title XIX is at the 52nd percentile. He did not know how this would affect him since he had only been in the program since July 1 and had not yet received a payment.

In answer to questions, Mr. Petro stated it would be difficult for the state to encourage medical supply companies to take steps to save since Title XIX accounts for less than 20 percent of their business. Medicaid will pay for the purchase of some items, but many have to be rented. He stated he has seen an increase in the use of devices which he feels is at least partially attributable to acceptance of their use.

Mr. Petro, in answer to a question, stated their insurance premiums are about $2,500 which is approximately double what they were a few years ago. He can remember when they were $200. The amount of coverage has not changed significantly.

Kansas Association of Osteopathic Medicine

Lloyd Hall, Executive Director, stated there are some factors affecting cost which are beyond the control of the vendor, this Commission and the agency, i.e., minimum wage requirements, incidental taxes and other inflationary factors. There are other factors over which the state does have some control. One of these is the shortage of doctors. If the requisite number of doctors is available to provide service costs will move downward. The law of supply and demand will work. The state also controls the number of services to be provided and cutting these would cut costs. Effective measures to control use are needed. It is difficult for the doctor to determine that a person does not need to be seen before seeing that person. If he refuses, he is open to medical malpractice; if he sees the person he is subject to nonpayment based on audit review. Requiring the client to pay some frontend cost may help eliminate some unnessary use. Another approach which would not be very feasible would be for the state to protect the doctor refusing to see people from medical malpractice suits. He also suggested that the philosophy that all health care dollars should be spent for illness be changed. Spending dollars on health maintenance and prevention will, in the long run, affect health care costs. He also noted the effect of the destructive pattern of living on costs. He stated that if one assumes people have a right to quality medical care one must accept the fact that a duty must be imposed on someone to cover the cost of this care. It is important to develop cost containment programs and find effective ways of controlling abuse.

In answer to questions relating to the concept of supply and demand, Mr. Hall stated that if a doctor has too many patients, he hires supportive personnel which increases his overhead. Also, if more doctors are available, people will go to a different doctor rather than wait for long periods of time in a doctor's office. This creates competition which lowers prices. More doctors would also affect the number of persons being seen in emergency rooms of hospitals. In answer to a specific question, Mr. Hall stated he would accept the general statement that the ratio of doctors to population is greater in urban areas than in rural areas although there are some exceptions, but he would not accept the statement that the average income of urban doctors is greater than that of rural doctors.

Mr. Hall referred to a study of where doctors are located in Kansas, their age and the extent of their practice. Copies will be forwarded to the Commission when they are available. In answer to a question, he stated they did not attempt to do a breakdown based on type of practice such as family practice. Staff noted a grant application submitted by a family practice group in Topeka indicated that Shawnee County and the surrounding area served by the county has a ratio of 1 to 40,000 for primary care, indicating it is underserved.

In answer to questions, Mr. Hall stated he feels the law of supply and demand also works in hospitals but there are some factors which may interfere with it working as effectively as it does in other areas of health care.

Referring to Mr. Hall's remarks about copayment, staff noted required services under Title XIX cannot be on a copay basis. Mr. Hall stated he was thinking in terms of charging a recipient a frontend charge for visits over an allotted number.

In answer to a question, Mr. Hall stated osteopaths would be willing to help determine which medical procedures would give the most benefit for the dollars expended.

In answer to questions, Mr. Hall stated steps need to be taken to get graduates of the medical school to stay in Kansas. However, he thought there were other approaches than raising tuition and requiring students who do not stay in the state to pay it. He noted the problem created by the Attorney General's ruling on the bill passed last Session relating to money for Kansas students in the School of Osteopathy in Kansas City.

A Commission member noted that a code of ethics speaks to fraud and referred to information received at the last meeting relative to duplicate claims filed by providers. He then asked if persons wilfully taking duplicate payments should lose their license. Mr. Hall stated "yes" and that he felt the Board of Healing Arts would take appropriate action. If the Association of Osteopathic Medicine had clear evidence an osteopath was doing this, they would voluntarily report it to the Board of Healing Arts. Jerry Slaughter, who was also asked to respond, stated he thought fraud was already a legal reason for revoking a license.

Kansas Optometric Association

Jack Milligan, Executive Director presented a written statement (Attachment E).

The meeting was adjourned at 5:00 p.m.

September 14, 1977

The meeting was called to order at 9:05 a.m. by the Chairman, Frank Lowman.

Kansas Health Care Association

Dick Hummel, Executive Director, stated he was also speaking for Health Care Providers, Inc., a legislative task force representing the four associations of nursing homes in Kansas. After introducing Larry Fischer, a nursing home operator, he presented a written statement and distributed four attachments (Attachments F - J).

A Commission member noted it is difficult to accept a cost plus approach after the experience with Blue Cross-Blue Shield. More than just a statement that you do not think there will be collusion is needed when you are saying on one hand that if there are not enough persons wanting your service, there will be a cost problem, and on the other hand you are saying if many persons want your services, you can charge whatever you want because people will pay it.

In answer to a question, Mr. Fischer stated there are four cost centers used in determining payments, with the state as a whole serving as a fifth center. Costs are arrayed in each cost center and the 75th percentile for each is determined. A home is penalized if it is above this percentile in any one cost center even though the total daily charge is below the total daily figure at the 75th percentile. This is a problem.

Mr. Hummel stated the beginning premise needs to be a determination of actual costs on an ongoing basis with payments related to this cost. He noted there will probably always be offenders in this program as in all other programs, but he felt the number would be very small.

A Commission member, noting that full financial disclosure is implicit in the above premise and referring to the Connecticut study which showed that a multiplicity of corporations with interlocking of officers were operating nursing homes, stated he was going to introduce a bill requiring such disclosure. In response to questions, Mr. Fischer stated the industry could not say whether or not they would support such a bill until they had seen the bill.

Responding to the suggestion of payment on a sliding scale based on level of care, Mr. Fischer stated he felt this was being done to some extent now but it should be explored. It was noted such a plan would not mean a flat payment uniform throughout the state because care in the 355 nursing homes would vary.

In answer to a question, Mr. Hummel stated there are about 355 licensed homes in Kansas representing approximately 23,000 beds. Mr. Fischer stated increases and decreases in the number of patients in skilled care homes and intermediate care homes has been influenced by a change in the classification system. What used to be classified as a skilled care home is the intermediate care home now. Homes comparable to today's skilled care home did not exist earlier. However, there has been a growth in the overall number of people going into the equivalent of nursing homes in the last five years.

Concern was expressed over the decrease in the number of skilled care beds. Mr. Fischer stated he predicts a further decrease because of the new requirements in relation to payments. For example, under the new regulations a nursing unit is set at 60 beds. If a unit exceeds this, staff would have to be doubled. There is already a nurse shortage so the home would be forced to enter a bidding war which escalates cost.

In answer to a question, Mr. Fischer stated nursing homes are on a prospective cost basis. They have 90 days after the fiscal year ends to file their fiscal report with SRS. SRS then has 90 days to review the reports and adjust the rates accordingly. In establishing the final rate, SRS makes a percentage adjustment for homes whose fiscal year does not end June 30 and an across the board adjustment for inflation factors. He noted that homes incurring additional costs to comply with regulations may not see any return for 18 to 24 months. He referred to the example noted above relative to the 60 bed nursing unit. He also noted no fiscal impact for this regulation was shown on the impact statement submitted by the Department of Health and Environment. Nursing homes would like to see cost reports filed every three months and rate adjustments made if indicated.

Mr. Fischer, in answer to a question, stated approximately 40 percent of nursing home revenue comes from state payments. On the basis of this percentage, a Commission member challenged the statement made earlier that nursing homes were a vital part of free enterprise. By his definition free enterprise is a competitive business working for profit. He stated the nursing home industry is at least a quasi-public utility and suggested treating it as a public utility so it could be allowed to set its rate based on cost plus a return on the investment as other utilities do. Mr. Fischer stated the industry has discussed this concept but has not taken a position of acceptance or rejection. It is a viable system if consideration is given to the fact the risk factor for this industry is greater than for other utilities and should be considered in rate setting.

In answer to questions, Mr. Hummel stated they are not suggesting there should not be rules and regulations. They are asking a postponement of the effective date for the rules and regulations which became effective on February 15, 1977, while a study of their fiscal impact is done.

A Commission member, referring to statements about how bad business is, asked why people remain in the nursing home business. Mr. Hummel stated the primary reason is that they care and want to provide quality care for people. He noted that about 50 percent of the homes have set a limit on the number of persons they can subsidize in their home in order to stay in business. The fees charged "private patients" are influenced upward in proportion to the number which are subsidized. Responding to a statement by a Commission member, Mr. Hummel stated some states have said that nursing homes cannot make different charges for different types of patients, i.e. private and welfare, but this is being challenged in the courts.

Responding to questions about the peer review process, Mr. Hummel stated they are in the process of informing their members and non-member homes of this program. They have met with the Department of Health and Environment, Department of Social and Rehabilitation Services and the Ombudsman. The next goal is to inform clients. Reviews were started in June and, hopefully, 15 will be done by the end of the month. The first homes to be reviewed are those of members of the review board and the executive committee. The only sanction for noncompliance is loss of membership in the organization. No new member will be admitted until after peer review is completed. In the case of a non-member, all the Association can do is contact them and offer its services. The program is seen as a method of helping to solve problems and complaints before it is necessary for a state agency to intervene or close the home. Hopefully, as credibility is built, the review board will be able to work closely with both state departments involved.

A Commission member noted that under Medicaid, reimbursement can be made for caring for people in their own home. In answer to questions, Mr. Fischer stated there are probably people in nursing homes because there is no other place for them to be cared for. Kathryn Klassen, Department of Social and Rehabilitation Services, stated this program is carried out by home health care agencies and suggested the Commission might want to hear from a representative.

Kansas Pharmaceutical Association

Doug Johnson, Executive Director, presented a written statement with attachments (Attachment K). Elaborating on some of the points and programs presented, Mr. Johnson stated that under drug utilization review, the computer checks the pharmacy claim against a data file giving per unit cost, which is based on a national acceptable publication, for the drug prescribed. If the claim is higher than the price in the data file, the file prevails in terms of payment. This encourages the pharmicist to buy at the best price available. For example, buying direct may be cheaper although buying from a wholesaler is easier. The projected savings for the next year, based on a review of every claim coming through the program, is between $300,000 and $750,000.

Mr. Johnson stated a program has been initiated at the federal level (MAC - Maximum Allowable Cost Program) but it presently includes only 12 drugs. A unit price is established for each of these drugs and pharmacists and doctors are notified that reimbursement cannot be above this unit price. If a physician feels a particular brand which is above this unit price is medically necessary, he may so state and it would be allowable. In answer to a question, Mr. Johnson stated that during the first month there have been only four cases in which this has happened.

Mr. Johnson stated a concern of drug utilization review is whether or not an optium match between diagnosis or condition and prescription has been achieved. However, matching claims from pharmacists with claims from physicians as a basis for looking at this was difficult since a pharmacist sends his claims in every day and the physician may send his in only once a week or once a month. A new type of prescription form which includes the diagnosis or condition being prescribed for is being used on a pilot basis with a few physicians and pharmacists to see if it will solve this problem (Attachment K1). If it works, it will be required for all Medicaid patients receiving prescriptions.

In answer to a question, Mr. Johnson stated that since brand exchange has become legal in 20 states, most pharmaceutical companies have come out with a generic line.

Responding to a question, Mr. Slaughter stated the House of Delegates of the Kansas Medical Society voted not to accept the recommendation of its study committee to support brand exchange last year. There were some concerns about liability and quality. Physicians were used to certain brands and had confidence in them. However, more physicians are supporting brand exchange and many physicians do write prescriptions generically. It is partly a matter of education. This issue will be brought up at the next meeting of the Executive Council of the Medical Society.

Mr. Johnson, in answer to questions, stated that non-profit hospitals may purchase drugs for in-house use only under the Robinson-Patman Act exemption at a lower rate than community pharmacies pay. A Commission member noted information relative to the high cost of drugs in hospitals. Mr. Johnson stated the pharmacy in the hospital has no control over this as charges are determined by the administration office.

Answering a question, Mr. Johnson stated hospital pharmacies come under the general pharmacy regulations and also come under a specific set of regulations pertaining to hospital pharmacies.

Kansas State Dental Association

Carl Schmitthenner, Executive Director of the Association, presented a written statement (Attachment L).

In answer to questions, Mr. Schmitthenner stated he did not think a significant amount of income in most dental practices comes from Title XIX. The percentage of patients under Title XIX per practice varies greatly.

Mr. Schmitthenner, in answer to questions, stated the rise in costs for dental practice is due to increases in the costs of equipment and supplies and number of supportive personnel.

Responding to a question, Mr. Schmitthenner stated there have been a number of changes in dentistry between 1950 and 1970. The most significant of which is the recognition that prevention may make it possible to prevent dentures, etc. The emphasis on prevention may also lead to a decline in overall costs.

Psychiatrists In Private Practice

Jack Dunigan, M.D., Topeka, Kansas, stated there are approximately 40 psychiatrists in private practice in Kansas. This is about 40 percent of the Kansas membership of the Kansas Psychiatric Association. He stated he did not have statistics for all those in private practice so he would use figures from his own practice which he thinks is fairly typical. Medicaid patients account for 16½ percent of the total volume in his group practice; 12¼ percent of monies received; and it takes about 20 percent of their total time to service Medicaid claims. Dr. Dunigan noted he also serves on statewide committees and as a consultant to the claims agency which gives him two different perspectives.

One impact of Medicaid has been to divide private practitioners from practitioners in mental health centers. This is partially due to differences in treatment and philosophy but it is also due to the Department of Social and Rehabilitation's reimbursement policies which are different for the two modes. Billings for mental health centers are showing billings for three or four hours per day. It is all billed as psychotherapy no matter who provides the services, i.e., social worker, nurse, psychologist or psychiatrist.

Dr. Dunigan noted the need for defining "medical necessity" so it can be split off and other symptoms or areas of the problem can be treated by others at a lesser rate. The Department of Social and Rehabilitation Services also needs to define more clearly what constitutes an exception to the restriction on the number of allowable visits per month. This restriction is a good one and fits in well with the nationwide average. However, most exceptions are granted which means the economic saving which was the intent of the limitation is lost. He also noted the problem of the private practitioner in essence subsidizing the Medicaid patient because the reimbursement does not cover total charges.

In answer to questions, Dr. Dunigan stated the four visits per month limitation had had almost no affect on his practice since very few patients are seen over once a week in their group practice. Hospital visits would be an exception to this. They also do group therapy.

Dr. Dunigan noted they have a problem in child placement because SRS will not reimburse for the services of a social worker in private practice. For example, they have a child in a hospital, who needs to go into foster care. If they can use the services of a private social worker, the placement takes about one or two weeks. If they have to wait for a social worker from SRS because payment is not allowed for their social worker, it takes a month or longer because of the SRS worker's caseload. This is not really cost effective since SRS pays for the hospitalization during this period. It is medically necessary for the child to remain in the hospital because there is no other placement available. This is primarily a problem with a child in a private institution.

In answer to a question, Dr. Dunigan stated that social workers, marriage counselors and alcoholism counselors in mental health centers can be reimbursed because it is a part of the cost base.

Dr. Dunigan, in answer to a question, emphasized that a part of the answer to cost containment is delineating what requires medical time and what can be handled competently and effectively by those with lesser education. New treatment modes are also helping control costs, i.e., group and chemotherapy.

Responding to a question, Dr. Dunigan stated hospitals use paramedical personnel in treatment programs but he did not know of any specific training program developed outside of an institution.

Alcoholism Treatment Center

Glen Leonardi, Community Addictive Treatment, Inc., Topeka, described their treatment program. He noted the fact they are a non-profit community based program which utilizes paramedical personnel under the direction of a professional keeps costs down. Quality control lies in the hands of the medical director who assumes complete responsibility for the people in the program.

Approximately 46 percent of their outpatients are on third party payment and of those 35 percent are covered by Medicaid. On the inpatient service, 98 percent are on Medicaid because of the type person they are dealing with. These clients act out in ways which prohibit functioning so they fall into the welfare rolls. Since assuming responsibility for themselves is the goal of the program, efforts are made to have clients assume financial responsibility as soon as possible. Also, the sooner the client picks up financial responsibility the sooner he becomes consistent in his treatment. In the outpatient program the person comes off Title XIX fairly soon. It takes longer for the inpatient.

Answering a question, Mr. Leonardi stated they have had 25 in their inpatient program but they are cutting this back to about 17. The ongoing caseload in the outpatient service is between 50 and 70.

In answer to questions, Mr. Leonardi stated his program is paid at the 75th percentile. In the outpatient program, personnel included in Medicaid billings have to have a masters degree. If a person with lesser qualifications does individual counseling, he does not qualify for billing unless a qualified person is with him. In other modes of treatment this person's cost is included in the hourly cost. If an alcoholism counselor is certified there is some justification for recommending that he be included in billing on the same basis as the social worker. Certification does tend to raise costs and alcoholism counselors are pushing in that direction.

Mr. Leonardi, in answer to questions, stated the maximum length of stay in their outpatient program is about eight months with most people staying four to five months. The optimum time for inpatients is six months but the average stay is two to three months. These times are influenced by the fact the program accepts only those who have failed in a shorter term program. For those who stay four to six months the success rate is about 50 percent.

He noted that closing of the alcoholism program at Topeka State Hospital will send clients to them so from an administrator's point of view it is a positive. However, it will leave a gap in services for the person needing a short term program.

In answer to questions, Mr. Leonardi emphasized that good utilization of supervision by consultants is the biggest factor in keeping costs down although use of trained and skilled counselors also affects it.

Kansas Psychological Association

Clyde Rousey, private practicing psychologist, presented a written statement (Attachment M). He noted that the Colorado Psychological Association and Medicare have begun a study to determine the effect of direct billing by psychologists.

In answer to a question, Dr. Rousey stated his Assocation met with SRS about a year ago to determine services to be reimbursed by Medicaid. These include four individual sessions and four group sessions per month and up to six hours of testing. Any other service provided to the same client is not reimbursed.

Dr. Rousey, in answer to a question stated, with the exception of those grandfathered in, all certified psychologists have a Ph.D.

Responding to questions about peer review procedures, Dr. Rousey agreed that letting patients know of this opportunity is a problem. In his practice he explains the procedure to any person who is dissatisfied but this does not reach those that do not complain. This is a problem shared by all professions.

In response to questions and comments about the Kaiser program, Dr. Rousey stated no psychologists wants to insert themselves into a case prior to a doctor determining there is not a physician problem. Once this is done, a program of this type could be an exciting frontier for both professions. At the request of the Commission, Dr. Rousey will provide copies of the Kaiser study.

In answer to a question, Mr. Slaughter stated this approach is carried out now on a very limited basis in joint practices of psychiatrists and psychologists.

Dr. Rousey, in answer to a question, stated the difference between the 400 certified psychologists and the 200 actually practicing is partially accounted for by those who are teaching but not practicing and those who have moved out of the state.

Responding to a comment, Dr. Rousey stated he was not sure more psychologists were needed. Community mental health centers provide services for a segment of the population and to his knowledge no one who comes to a private practitioner is turned away, unless it is a matter of people not knowing services are available. Most professions still feel some constraints about advertising but they are willing to speak to groups about services which are provided.

Kansas Chiropractic Association

Glydon Hanson, Executive Director, referred to the material given to Commission members (Attachments N-R) and introduced Dr. John Hill, Chairman, Kansas Chiropractic Association, Peer Review Committee, who presented a written statement (Attachment S).

In answer to questions, Dr. Hill stated the initial physical exam, for which they are not reimbursed, would include such things as tests and X-rays and would not be billed just on the basis of an office visit. He stated he thought all health care providers would do a physical exam before initiating treatment. He also noted there is no federal cost sharing under Medicare for a diagnosis that does not result in a referral to another specialty.

Ms. Klassen, Department of Social and Rehabilitation Services, stated they can pay only for manipulation of the spine since under Title XIX chiropractors come under "other type provider."

Responding to questions about their peer review committee, Dr. Hill stated if the committee finds something which is not proper, it is taken to the chiropractor involved. If it involves a matter of ethics, it would be referred to the Board of Healing Arts. Persons having a complaint are told they can take it to this committee but no effort is made to inform all patients about it.

Mr. Hanson, in answer to a question, stated he thought Medicaid payments accounted for about 5 percent of chiropractors' gross billings.

Kansas Podiatry Association

Dr. Franklin A. Donovan, President, presented a written statement (Attachment T).

In answer to a question, Dr. Donovan stated hospital privileges for podiatrists, as for all health care providers, depend on the bylaws of each hospital. Ultimate authority for granting or denying privileges rests with the hospital's board of trustees. He stated he had hospital privileges in the community where he practiced but to his knowledge no podiatrist has hospital privileges in Topeka. He stated he would assume this is because of the number of orthopedic surgeons in Topeka and perhaps this could be construed as economic discrimination against a qualified group who might offer a service at less cost.

Dr. Donovan pointed out that podiatrists in Topeka, as elsewhere, do surgery in their offices which saves the hospital charge.

In answer to a question, Dr. Donovan stated the multiple fee schedule was set up by the Podiatry Association after studying what was being done across the country.

Independent Laboratories

John Cobb, General Manager, Lattimore-Fink Laboratories, Topeka, presented a written statement (Attachment U).

Reference was made to a segment of a "60 Minutes" TV program which dealt with kickbacks to laboratories. Mr. Cobb stated no doubt some abuse goes on in any state. However, he questioned that the extent of abuse was more than minimal.

Attention was called to the fact that Medicaid accounted for 5 percent of this laboratory's billing and only 1.5 percent of their business. In answer to a question, Mr. Cobb stated a consolidated billing system would help lower cost. Billings could then be sent in once a week or once a month on one form rather than sending in a separate form each time a patient comes in for services. Ms. Klassen, SRS, noted that a new federal ruling requires all independent laboratories to do their own billing. A physician can no longer send a sample to a lab and then bill the patient through his own billing.

In answer to a question, Mr. Cobb stated they do Medicaid business in Missouri and the only difference is that they have to be certified by HEW because they are doing business outside of the state in which they are operating.

Mr. Cobb, in answer to a question, stated the cost of doing blood profiles has been reduced significantly in the last five years because of technical advances. He stated he thought savings from reduced costs were passed on to the consumer ultimately and noted the steps California has taken to insure that this happens, i.e., requiring the physician to show the client what he paid for the test.

Mr. Cobb agreed that physicians are ordering more tests today but he could not quantify it because of other changes within their laboratory operation. The medical malpractice situation has no doubt contributed to this.

Ambulance Services

Al Staab, ambulance operator, Hays, stated he operates a Class II service with four ambulances, a high risk transportation system and nine employees. The service provides transportation to and from hospitals and nursing homes, a neonatal and postnatal clinic service and transportation to other areas. The services average 12 to 15 transportation runs per month.

Mr. Staab noted payments are not a problem once you get past the paper work. However, requiring a written "necessity authorization" from a physician does create some problems. If they are called they have to assume the run is necessary and their experience has not shown otherwise. He recommended that a call from a physician or an individual be acceptable authorization and, if a written authorization is needed, the form be returned to the physician not to the ambulance service. He also noted that if the person transported goes only to the emergency room, he may be unable to get a "necessity authorization" from a physician. The present system puts the ambulance personnel in the position of determining necessity which they are not qualified to do. He noted Medicare does not require this justification.

Mr. Staab said he also has problems getting a diagnosis from the physician or the hospital which is required on the Medicaid form. He stated that on claims involving both Medicare and Medicaid the following procedure is required: the form is mailed to Medicare (Blue Cross-Blue Shield) in Topeka which pays their share and returns the form to the ambulance service which sends it to Medicaid (Blue Cross-Blue Shield) in Topeka. He recommended developing a system which would eliminate the need for the extra postage and time.

In answer to a question, Mr. Staab stated he is under a $40,000 annual contract with Ellis County and keeps that revenue he collects. He buys his own equipment and hires his own personnel. The charge for a basic run is $30.00 and for an emergency run it is $35.00. The only additional charge is for oxygen which is $10.00.

Mr. Staab, in answer to a question, stated he would not fall under the state licensing law until 1980 but he did not think licensing of the service will necessarily affect costs much. However, certification of EMT's (Emergency Medical Technicians) does represent an upgrading which affects salaries. If there is competition for EMT's because the supply does not meet the demand salaries will increase.

The meeting was adjourned at 4:00 p.m.

Prepared by Emalene Correll

Approved by Committee on:

Oct. 6, '77

(Date)

Attachment A

KANSAS HOSPITAL ASSOCIATION

STATEMENT BEFORE

GOVERNOR'S COMMISSION ON HEALTH CARE COSTS

Contents

September 12, 1977

Atch. A

Introduction

Mr. Chairman, members of the Commission, we appreciate the opportunity of appearing before you today, representing the 159 hospitals in Kansas, to talk about Title XIX aspects of the health care cost problem. As you will note from the first page, our presentation will be in four parts, and we will be pleased to answer any questions you may have. Please also note that our presentation makes some references to a document we prepared earlier this year for the Kansas House Ways and Means Committee. By referring to that document, we can hold this presentation to a minimum.

Let us first say that we have read the statement provided to you by Secretary Harder at your first meeting. Our respective staffs have met since your last meeting, and we have requested another meeting with Secretary Harder and his staff to discuss in detail some of his statements about hospitals. We think it would be improper to use this forum to air our dispute with some of the data you have been given. We are in the process of analyzing the SRS document and would furnish a copy to the Commission, if desired.

This presentation will concentrate on the positive activities being carried out to effect cost containment in hospitals; will present a larger, more universal view of the circumstances causing hospital cost increases; and lastly, will spell out a positive and potentially far-reaching attempt to reduce hospital cost increases taken by our Board in July, and by the American Hospital Association two weeks ago. First, however, you will find a section entitled "Title XIX Data", which provides a statistical picture of the amount of services rendered by hospitals to Title XIX recipients.

I. Title XIX Data

In the short time we had to prepare this testimony, the Kansas Hospital Association has worked to develop a comprehensive, statistical profile of the impact of the Title XIX program on Kansas hospitals. Although this profile is not finished at this time, there are available to us several general statistics that we believe indicate some significant aspects of the Title XIX program.

In his presentation before this Commission, Secretary Harder noted that Title XIX paid for 49,000 hospital admissions in 1976. During that year, all Kansas hospitals had a total of 459,000 admissions. Our 144 community hospitals accounted for 428,000 admissions. Although we have not yet identified the facilities in which the 49,000 admissions occurred, we can reasonably estimate that Title XIX admissions accounted for between 10.5% and 11.5% of the total hospital admissions in the State of Kansas for 1976.

Other preliminary figures are available that serve to indicate the relationship between charge per patient day for all hospital patients and the charge per day for Title XIX patients. According to the Kansas Hospital Payment Profile System (KHPPS), developed by Kansas Blue Cross, the average charge made by Kansas hospitals for Title XIX patients for the calendar quarter ending March 31, 1977, was $155.64. The National Hospital Panel Survey for the State of Kansas for the month of February, 1977, shows that the revenue per patient day for all hospitals, treating all patients, was $158.08. Although these figures were developed through different processes, we feel that both computations are sufficiently sophisticated to allow us to make the general statement that the average charge per Title XIX inpatient day does not vary significantly from the total charge made to all hospital inpatients.

A final measure for which there is information readily available concerns the average length of stay for all hospital admissions. For the year ending June 30, 1977, the average length of stay for Title XIX patients was 6.8 days. We do not

have overall figures available to us for this time period; however, the Kansas Hospital Association's Patient Origin and Utilization Study indicates that for 1976 the statewide average length of stay for all patients was 7.04 days, and the average length of stay for those patients over 65 years of age was 10.31 days. Again, these figures were developed by different measuring processes, we can reasonably infer that there is not significant difference between the average length of stay of Title XIX patients as compared with other categories of patients.

In summary:

1. There are about 49,000 Title XIX admissions per year to Kansas hospitals.
2. Title XIX accounts for 10-11% of all hospital admissions.
3. Charges per day for Title XIX recipients are approximately the same, or less, than charges to all other patients.
4. The length of stay for Title XIX recipients is as low, or lower, than for all patients.

II. Hospital Cost Containment Efforts

Kansas hospitals, like hospitals everywhere, are under constant bombardment from the media, bureaucrats, legislators, and others concerning the rate of increase in hospital costs. Although much attention is being given this subject lately, Kansas hospitals saw the cost increase problem developing earlier than the critics and voluntarily initiated cost-cutting measures, such as utilization review, well before the government "invented" it. Page 23 of the Ways and Means statement reflects the tremendous progress made in this area. Pages 19 and 23 of that document detail many of the efforts being made currently to restrain costs. Since that document was written, we have strengthened our efforts in the area of shared services -- an area acknowledged by experts as having potential for cost savings through the sharing of expensive equipment and personnel. There has been a statewide seminar on the subject this year, and three new shared service consortia have been initiated which will involve perhaps as many as a hundred hospitals.

Hospital administrators are sensitive to the national criticism about costs, and particularly about many inferences that hospitals are inefficient or wasteful. It is our opinion, and one shared by many highly successful business and community leaders who serve on hospital boards, that hospitals as a group are well run and are acting responsibly by cutting costs wherever possible. As with any industry, weaknesses can be pointed out, but we have heard it said, and we believe that there is absolutely no evidence that the hospital industry operates any less efficiently than others. Nor is there any evidence that private hospitals operate any less efficiently than do public hospitals, or other public institutions and agencies.

We also submit that the very governmental officials who criticize hospitals for the amount of increase in costs are in no position to be critical. Charles Pilliod, chairman of the board of Goodyear Tire and Rubber Company, recently said,

"The best defense of the private sector rests in the 'principle of efficiency.' I know of no situation where the government has a record of greater efficiency than the private sector." He went on to say, "Maintenance of that efficiency cannot be obtained by arbitrary establishment of price controls."

This is not to say that hospital administrators and their local community boards are satisfied with their efforts. Far from it. But as we will point out in the next section, the rise of hospital costs is due to a complex, interrelated set of factors, many of which are beyond the control of the hospital.

III. National Perspective on Hospital Costs

As we have grappled with the whole question of hospital costs, particularly over the past year, it has become more and more clear that the hospital cost problem has a very close parallel in the energy crisis. Let us illustrate.

1. Both problems did not crop up overnight, but resulted from the composite of many private and public decisions made over several decades.
2. Both problems are serious and have a great potential impact on the nation's economy.
3. Both have complex causes involving many facets of society. On the one hand, oil companies, auto makers, the consuming public, and the whole dependence of our technology-oriented society is involved in creating an energy crisis. On the other hand, hospitals, physicians, insurance companies, federal and state governments, the consuming public, and a technology explosion, all play a large role in the creation of hospital costs.
4. Both are problems which are national in scope and are not amenable to single state solutions.

Significantly, neither Congress nor the Administration have said that the energy problem is the fault of any one segment of society. When it comes to the hospital cost problem, however, most of the "solutions" would simply try to force hospitals to bear the entire responsibility for a solution. That approach is no more workable than it would be for the government to demand that the oil companies solve the energy crisis.

If it were in the power of hospitals to effect a short-term solution to the problem, you would find no one quicker to make the effort. But it is important to understand, as few seem to, something of the interrelating economic forces at work contributing to the continuing upward trend in hospital costs. Some of those major forces are these:

1. Inflation in the general economy is acknowledged as contributing roughly half of the total increase in hospital costs.
2. The creation by the government of increasing demands for hospital service through the provision of Medicare and Medicaid coverage to millions of people.
3. The creation of demand because of high-benefit level health insurance coverages of Blue Cross and commercial insurers, and the lack of consumer concern about the cost of care coming from first dollar coverage.
4. Vast expansion of medical technology over the past two decades resulting in new and highly expensive equipment which requires well-trained and highly paid personnel to operate.
5. Pressures from physicians and from the public to have available the highest quality equipment and services.
6. Improvement in salaries and benefits of traditionally underpaid hospital workers, much of it the result of hospitals coming under the minimum wage law in 1967.
7. Extensive use of hospital services by physicians who are caught in the malpractice dilemma, where the failure to practice preventive medicine can result in a lawsuit.
8. Proliferation of federal and state standards for upgrading the physical environment of the hospital.
9. Self-destructive life styles of the American public, resulting in large amounts of unnecessary hospitalization due to accidents, alcohol and drug-related disorders, obestity, and lack of exercise -- to name a few.

Indeed, it becomes easy to see that hospitals have been highly successful in meeting the increasing demands for care; have been successful in keeping up with technological advances; have successfully managed to increase wages to respectable

levels; have successfully met increasing federal standards. And because virtually all of the major third parties have paid the costs as they have been created, the cost have kept escalating. No industry or public agency, we would submit, could have acted differently because of the number of these interacting outside forces.

We think that people like Mr. Pilliod, who, incidentally, was chosen by President Carter to serve on a special advisory committee on national health insurance, understand that the hospital cost problem defies an easy and quick solution, despite the fact that governmental payers keep acting like there is.

Senator Herman Talmadge agrees. Senator Talmadge, chairman of the Subcommittee on Health of the Senate Finance Committee, acknowledges that simple solutions like caps or lids will not work and, indeed, may do more short-run harm to the economic viability of hospitals than the benefits that would derive. Further, exclusive preoccupation with costs, to the detriment of concern for quality and access, is counter to the philosophy espoused by the Congress in many other laws, including P.L. 93-641, the National Health Planning and Resources Development Act of 1974. Senator Talmadge's Medicare and Medicaid Reform Bill (S. 1470), co-sponsored by Senator Dole and over twenty other senators, recognizes the important role of physicians in the process and attempts to deal with this issue on a long-term basis. The bill also provides efficiency incentives not present in any reimbursement program of the government today.

In his key role in the Senate, Senator Talmadge is greatly concerned about hospital costs, but he also knows the problems are too complex for simplistic, quick solutions. One of the provisions of the Talmadge bill promises future potential for the exemption of states with rate review programs. The next section will discuss the KHA/AHA position which deals with the subject of rate review.

IV. Solutions Offered by KHA and AHA

After the great publicity surrounding the announcement of the Carter administration's Cost Containment Act of 1977 (H.R. 6575), we held a series of meetings with hospitals around the state. It was apparent that the Carter proposal could seriously impair the ability of hospitals to serve. Because of that, Kansas hospitals recognized that meaningful alternatives to the Carter plan should be developed. Subsequently, a special ad hoc committee, and then our Board, met to develop realistic alternatives which could be proposed at both the national and state levels. After three days of meetings, our Board concluded that (1) no short-term program could achieve the magnitude of savings desired by the federal government without risking irreparable damage to the hospital system; (2) that even as a short-term transitional measure, a cap is unworkable and impossible to administer equitably; and (3) a longer term alternative must be proposed which has a realistic potential for impacting on the rate of cost increase. They felt that long-range solutions are already in place through provisions of the Professional Standards Review Organization and health planning laws, but that these have not been given proper priority by the government. They further felt that individual hospital budget and rate review by an independent board or commission represented the best hope of achieving savings. Knowing that the rate review proposal would meet with concern by some of our membership, the Board adopted the following positions:

(1) That a federal law should be passed establishing broad, minimal federal guidelines under which states would operate an independent health care commission; and

(2) That as a transitional measure, Kansas hospitals would phase in a prospective rate review program operated by Kansas Blue Cross.

Speaking to the latter recommendation, and to the subject of rate review as a whole, we have carefully observed the rate review program operated by Indiana Blue Cross

over the past several years. Statistics from Indiana indicate that a substantial impact is being made by the program as evidenced by reports that cost increases are 20% less than the national average. We believe similar results can and will be made in Kansas.

Some weeks after our Board took its action, the Board of Trustees and House of Delegates of the American Hospital Association, representing 6,500 hospitals in the U.S., voted to adopt a position identical to our own. This supported our view that rate review represents the best and most realistic alternative the hospital industry can provide, given the variety of forces causing cost increases.

Despite the high quality of care provided in Kansas hospitals, costs here are the 11th lowest in the United States. Even so, the rate of increase in costs must be slowed down. Improvements in the number and distribution of beds and services can be made. In order to assure that Kansans have the proper facilities in the right amounts at the right locations, Kansas hospitals are actively involved in health planning processes across the state. This result cannot occur in a year or two, because the mechanism for making all those decisions are not yet fully developed. The next five years will see a dramatic change in the quality of the health planning process, to the point the public will be assured of cost-effective capital expansion decisions.

In closing, we must reiterate our conviction that the rising cost of the Title XIX program here in Kansas is the composite of many national factors, some sociological and some economic. Our problems here cannot be fully solved until such time as national questions concerning patient demand, quality of services, access to care, and self-destructive life styles are realistically addressed. Until this happens, KHA pledges its full resources to continue to work with the State of Kansas in the further development of programs such as utilization review and health planning. We feel the cooperative efforts of all health institutions in these efforts, in

addition to the BC/KHA cooperative effort in hospital rate review, offer the citizens of the State of Kansas the most realistic hope of dealing with the problem of rising health care costs.

Attachment B

KANSAS HOSPITAL ASSOCIATION

PRESENTATION BEFORE THE KANSAS STATE LEGISLATURE

HOUSE WAYS AND MEANS COMMITTEE

JANUARY 25, 1977
1:30 p.m.

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Donald J. Conroy, Associate Administrator, St. Francis Hospital, Wichita
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James L. Scott, Director of Fiscal Affairs, Kansas Hospital Association
Sister Mary Walter, Administrator, St. Francis Hospital, Topeka

I

INTRODUCTION

Mr. Chairman and members of the Committee:

I am Frank Gentry of the Kansas Hospital Association. We are pleased to have the opportunity to appear before you and to discuss hospital costs. It was a coincidence that on the day I approached your Chairman, asking for an opportunity to appear, you folks had made the decision to invite in several health care providers for just that purpose.

In our presentation we will acknowledge that hospital costs are high, but establish that they are not "out of control", as some are prone to say. We will then describe some of the things hospitals are doing in their effort to contain costs and give an explanation of why hospital costs continue to increase. The letter from your Chairman asked that we be prepared to suggest how savings can be realized, and to provide an assessment how suggested progam changes would affect our industry. We will be making some suggestions but we'll probably turn that question around and ask what kind of hospital care you believe Kansans want and deserve, and further, ask what more you think we could be doing in our efforts.

You're probably going to hear more than you bargained for, but we really don't know how to respond without going into some detail. For that matter, we still haven't received the letter requesting us to appear. I wouldn't have known what your questions were if I hadn't come by and read Mrs. Hartman's copy.

Mentioning that reminds me of a bumper sticker I saw the other day--"If you like the U.S. Postal Service; you'll love National Health Insurance".

Perhaps we're going to take more of your time than we would normally because of a feeling of paranoia. The State Insurance Commission has pre-

vailed on the House Insurance Committee to introduce a bill controlling the quality and cost of medical care.....the Secretary of Health and Environment has declared in a publication that is being widely distributed that medical care cost is the first of the six "most pressing health problems facing Kansans today".....and I hear that the Secretary of Social and Rehabilitation Services told this Committee that hospital costs are too high; that there are too many empty hospital beds in Kansas; that we should be providing more charity care; and that if hospital stays were one day shorter, it would save the State Title XIX money.

He's right on that last point, of course; if the patient wasn't admitted at all, it would save even more. Or, if the patient were declared ineligible, the State would save money. I should point out, however, that there is no such thing as free care. That which is given has to be paid for by some one. If Title XIX reimbursement falls short--and it has historically--the patients with private health insurance or Blue Cross, or those who self insure, simply subsidize that loss. The controller at Stormont-Vail told me his Title XIX payments run between 93 and 94 percent of their costs. We think this is fairly typical. The Sunflower Chapter of the Hospital Financial Management Association has a study underway to compare the rate of payment from a variety of third-party payers. We think the percentage is about the same from Medicare as it is from Medicaid, perhaps a bit better.

We are familiar with some of the suggestions that have been made and will be addressing those suggestions in our presentation. I think that in a nutshell, the issue facing this Committee, and as a matter of fact, the entire Legislature and people over the entire nation, is that with the existing infinite demand for health care, we have but finite resources with

which to purchase them. You have some tough decisions before you, and it is our hope that our presentation will shed some light on the meat of the issue.

Mr. Chairman, with your permission, we would prefer to go through our total presentation and then accept questions. This subject is so complex that if we enter a discussion midway, there's a good chance we won't have an opportunity to complete the presentation.

By the way, we have copies of our papers for distribution a little later.

I have with me several individuals, and I'll take this opportunity, if I may, to introduce them.

II

THE CONSUMER PRICE INDEX FALLACY

First, let us look at the historical trend of hospital costs. The statistic most often used to measure increases in hospital prices is the Hospital Service Charge Index (HSCI), which is a part of the Consumer Price Index (CPI). The Consumer Price Index itself was developed and is employed by the U.S. Bureau of Labor Statistics to measure increases in the nation's cost of living by tracking the historic price experience of selected consumer items. The Hospital Service Charge Index was introduced in 1972. These two statistics are often compared side-by-side to demonstrate that hospital charges are rising at a rate in excess of the rate of inflation in the general economy.

But because of the statistical make-up of the indices, such a comparison is truly invalid. The items included in the Consumer Price Index are, for the most part, sharply defined and the quantities rigidly fixed. Two examples are a pound of whole white bread and a gallon of fresh milk. The price of these items is then compared each month with the price of the item in the base period to determine historic price experience. Thus, the precise specification of the items and their quantities is essential to an accurate comparison. If either the definitions or the quantities of items is changed, it is no longer possible to accurately measure price changes. For example, It is impossible to compare the 1970 price of a gallon of milk with the price of a 1977 gallon of skim milk (in fact, two different items); nor is it possible to compare the 1970 price of one gallon of milk with the 1975 price of two gallons of milk (in fact, two different quantities).

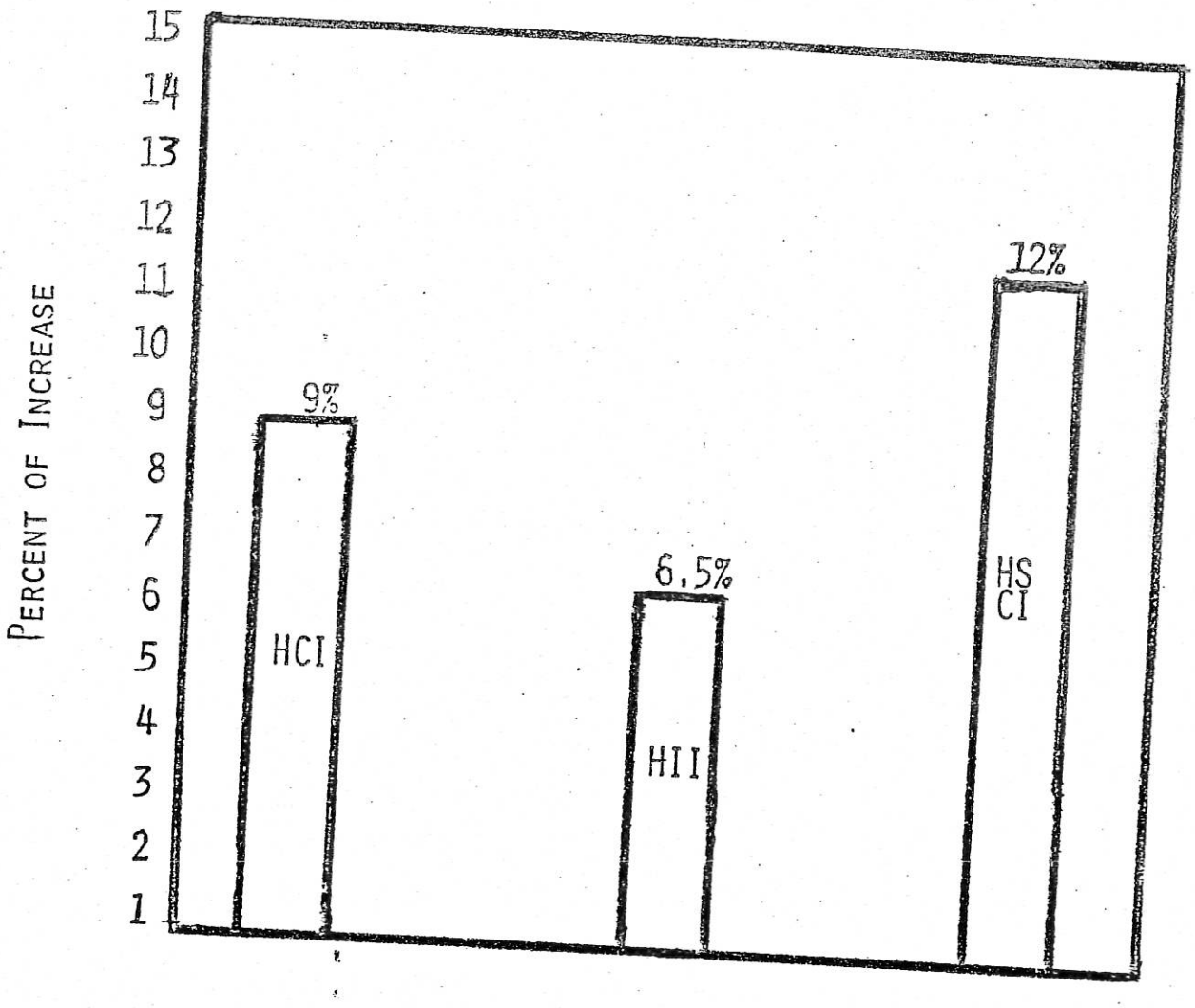
This requirement for precise specification of the items and their quantities has been seriously compromised in the case of the Hospital Service Charge Index. Fifty-two percent of the Hospital Service Charge Index is developed as a result of the charge for a semi-private room. Included in this are the charges for food services, routine nursing care, and minor medical and surgical supplies. A gallon of milk in 1970 compared to a gallon of milk in 1977 discusses basically the same product; this is what the Consumer Price Index wants to do. A hospital semi-private room in 1970 compared to a hospital semi-private room in 1977 is not a comparison of similar items. Statistics indicate that more hours of nursing service per day are given today than previously. It is also evident that routine hospital nursing care is much more complex and sophisticated today than it was only five years ago. Therefore, the HSCI is in reality a measure of three things: (1) the increasing prices for hospital routine care; (2) the increasing intensity (quantity) of services; and (3) the increasing complexity/sophistication of these services. For most other elements of the Consumer Price Index, the only measure is of increasing prices. The HSCI reflects much more than just price increases.

The Consumer Price Index also has a second serious problem; this statistic measures only hospital charges. In Kansas, over 75 percent of a typical hospital's income is based on third-party contractual relationships with Federal agencies, such as the Medicare and Medicaid programs, and private insurers, such as Blue Cross. Medicare and Medicaid both reimburse hospitals on a cost-related basis. In many instances they pay amounts that, although they are cost-related, do not fully reimburse the hospital's total cost of treatment to the beneficiaries of these programs. Therefore, this shortfall of revenue must be transferred to the private-pay and commercial insurance patients. Examples can be developed that show that, for instance, what would initially appear to be a 10% increase in hospital charges might

only be a transferring of legitimate hospital costs from the Federal Government's responsibility to the responsibility of private payers. It is our opinion that if the Federal Government reimbursed hospitals equitably for services to its program beneficiaries, much of the increase in the HSCI would be eliminated.

In an effort to develop more factual data on the trends of hospital cost increases, the American Hospital Association developed two new statistical indices. These two indices, the Hospital Cost Index (HCI) and the Hospital Intensity Index (HII), measure the costs to hospitals for the purchase of goods and services used in rendering hospital care (the HCI) and increases in the intensity of hospital services (the HII). Recently released data from these two new statistical indices support our contention that inflation in the hospital industry is not accurately shown by the Hospital Service Charge Component of the Consumer Price Index. (See Chart 1). Between September, 1975, and September, 1976, the HCI rose 9.0 percent and HII rose 6.5 percent. During the same period, the overall CPI rose 5.5 percent; but the Hospital Service Charge Component of the CPI rose 12 percent. The HII shows that part of the reason patients' prices are rising is that hospitals are providing more and better services. The chart demonstrates the comparison of these figures. A full description of the derivation of these new AHA statistics is available upon request.

PERCENT OF INCREASE IN PRICE INDEXES,
SEPT. 1975-SEPTEMBER 1976



HCI--HOSPITAL COST INDEX

COST TO HOSPITALS OF PURCHASED GOODS & SERVICES

HII--HOSPITAL INTENSITY INDEX

QUANTITIES OF HOSPITAL SERVICES PROVIDED

HSCI--HOSPITAL SERVICE CHARGE INDEX

COST TO PATIENT FOR HOSPITAL SERVICES

CHART 1

III

WHY HOSPITAL COSTS CONTINUE TO RISE

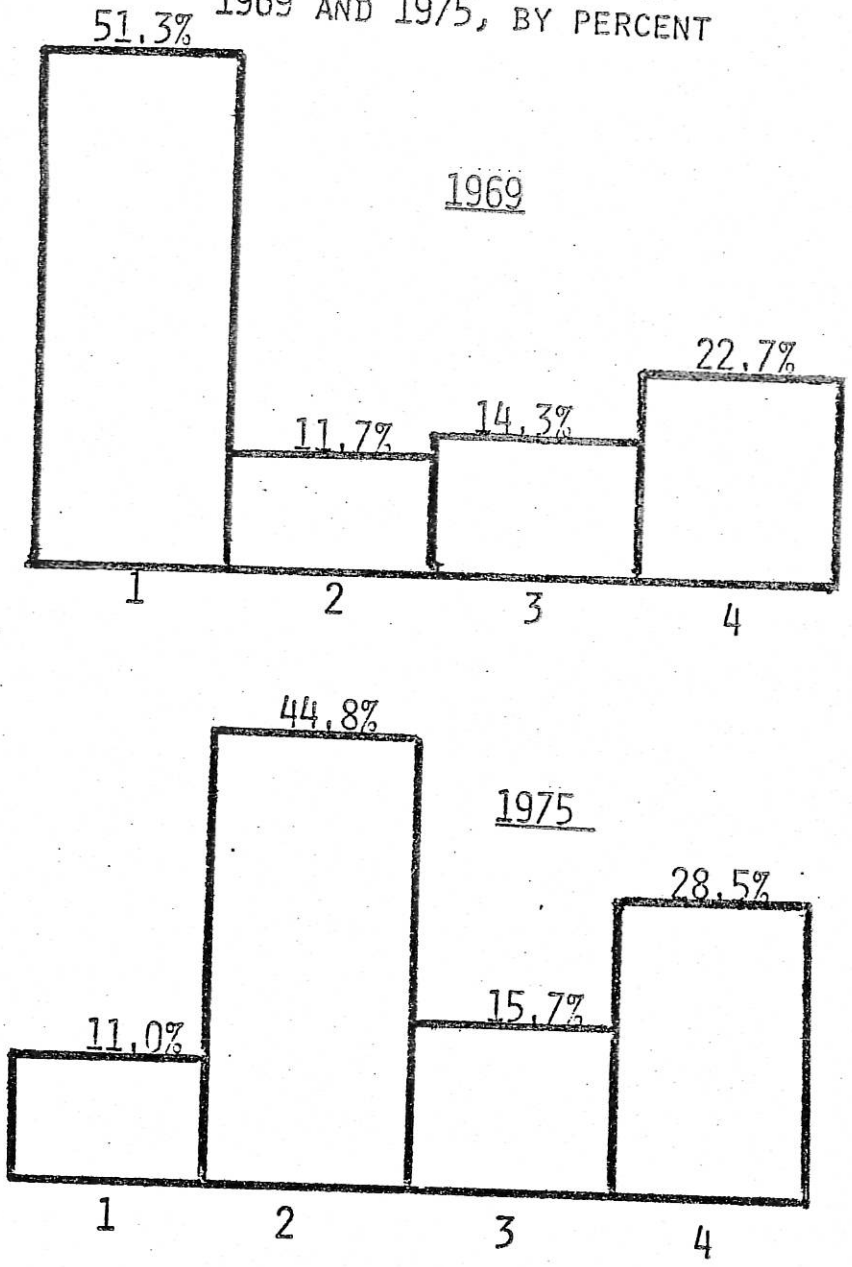
As we will soon demonstrate, Kansas hospitals have made significant efforts to moderate the rate of hospital cost increases. However, many factors conspire to keep the cost moving upward. Many of these factors are, of course, beyond the control of the hospital administrator, and as we have demonstrated earlier, some of the increase in hospital costs is due to the improvement of the intensity of service.

In a 1975 study, the American Hospital Association identified several factors which have combined to contribute to the increase in hospital costs. The four such factors identified were: (See Chart 2)

1. An increase in the number of personnel employed in the hospital
2. An increase in the wages of these personnel
3. An increase in the quantity of goods and services purchased by the hospital
4. An increase in the price of these goods and services

AHA's analysis reveals that the largest single reason (44.8%) for the overall hospital cost increase was the increase in the price of goods and services purchased by the hospital. In other words, 44.8% of the increase in hospital costs was the result of inflation in the general economy. This increase is much higher than the increase in the general consumer price index for the same period because of the particular mix of goods and services that a hospital buys. A hospital is a heavy user of energy, because of its 24-hour operation, and therefore the dramatic rise in utility rates has had a significant effect on hospital costs. Also, many drugs and disposable supplies utilized in today's modern hospital are petroleum-based products. A final and very obvious factor that has

COMPONENTS OF TOTAL HOSPITAL INFLATION, 1969 AND 1975, BY PERCENT



KEY: 1--INCREASES IN THE QUANTITY OF GOODS AND SERVICES PURCHASED
2--INCREASES IN THE COST OF GOODS AND SERVICES PURCHASED
3--INCREASES IN THE QUANTITY OF PERSONNEL EMPLOYED
4--INCREASES IN AVERAGE WAGES

(SOURCE: THE HOSPITAL ECONOMY, 1975. DIVISION OF INFORMATION SERVICES, AMERICAN HOSPITAL ASSOCIATION, 1976)

CHART 2

pushed hospital costs up is the skyrocketing cost of malpractice insurance. The cost of coverage has increased by over 300% in one year in most Kansas hospitals.

The second largest component identified in the AHA study was an increase in the wages of hospital personnel. This component accounted for 28.5% of the overall increase in the hospital's cost. Hospital wages have increased for a variety of reasons, one of which is the voluntary effort by hospitals to adjust the traditionally low salaries in this industry relative to the salaries in other industries. Chart 3 illustrates some of the reasons for the increases in hospital salary levels. While the average salary for a Kansas hospital employee for the period ending December 31, 1974, was $6,592.00; for the same period, the average way for a non-agricultural, non-governmental worker in Kansas was $8,405.00. Thus, even after this effort, hospital workers still earned 27.5% less than do industrial workers.

A third factor related to hospital cost inflation was the increase in the number of personnel in hospitals. This factor accounted for 15.7% of the overall increase. Most of increase in personnel can be attributed to new people being added to the hospital's payroll to provide new and increasingly sophisticated services. (See Chart 4). The addition of separate intensive care units, including cardiac care units and neonatal intensive care units, are new services that require new personnel to be added. The chart now before you summarizes the major new services that have been introduced in the past few years. Although expensive, the addition of these services and the personnel required to run them do improve the overall health care opportunities for our Kansas citizens.

Finally, 11% of the increase in hospital costs results from increased quantity of goods and services purchased, which in turn has resulted from the provision of more services for each patient.

INCREASE IN SALARY LEVELS ARE DUE TO:

NEED TO ADJUST TRADITIONALLY LOW SALARIES RELATIVE TO SALARIES IN OTHER INDUSTRIES

TECHNOLOGICAL ADVANCES REQUIRING MORE SKILLED PERSONNEL

COMPENSATION FOR DECREASING PURCHASING POWER OF THE DOLLAR

ATTEMPT TO ATTRACT MORE PEOPLE INTO FIELD THAT TRADITIONALLY EXPERIENCED A MANPOWER SHORTAGE

COVERAGE OF HOSPITALS UNDER THE MINIMUM WAGE LAW AND ITS OVERTIME PROVISIONS

CHART 3

NEW SERVICES OFFERED

INHALATION THERAPY

INTENSIVE CARE

INTENSIVE CORONARY CARE

OCCUPATIONAL THERAPY

SOCIAL SERVICES

ELECTROENCEPHALOGRAPHY

RADIUM THERAPY

RADIO-ISOTOPES

COBALT THERAPY

OPEN HEART SURGERY

EXTENDED CARE PROGRAMS

ORGAN TRANSPLANTS

HOME CARE PROGRAMS

PSYCHIATRIC SERVICES IN GENERAL HOSPITALS

CHART 4

IV. KANSAS HEALTH CARE COSTS/COMPARATIVE DATA

The fact that hospital costs are going up is a point which, of course, is non-debatable. A question that naturally arises out of this statement is: How do hospital costs compare with the cost increases in other facets of our society?

Chart 5 shows a comparable family budget in 1970 and 1975, both before and after taxes. Between 1970 and 1975, the average family increased their expenditures for medical care from $564 per year to $822, an increase of 45.7%. Alarming you might say, but not really. During that same period of time a person's after-tax income increased by 42.1%. In other words, in 1970 the intermediate family spent 6.5% of its after-tax income on medical care, and in 1975, 6.6% of the family income was spent on medical care. This is scarcely a dramatic surge.

Hospital care in Kansas is a bargain when compared to the cost of care nationwide, and even compared to the cost of care in the bordering states. (See Chart 6) Based upon 1975 data, published by the American Hospital Association's Department of Special Research Studies, the average cost per day in the United States was $133.76. The state with the highest average cost per day was Massacusetts - their cost was $176.04. The state with the lowest cost per day was South Dakota - their cost was $92.00. In Kansas, the average cost per patient day was $102.47. Only ten states had a lower cost per day, at that time, than did Kansas.

In addition to comparing favorably on the national level, Kansas also compares favorably with its bordering states. Chart 7 fully explains this point. The cost per patient day in 1975, from the same study as quoted above, for Colorado was $131.94; for Missouri $116.69; Oklahoma $117.81;

and Nebraska $108.20. Again, in Kansas, the cost per patient day was $102.47.

Another criticism is that an increasing proportion of the Gross National Product is going for health and medical care services. We find this not to be a negative statement, but instead to represent a positive step. Who is going to say that a given percentage of the GNP is too much, when a person's health is perhaps the most important thing he possesses? As our economy continues to grow and less and less of our Gross National Product is required for subsistence activities, such as food and shelter, we feel it only natural and indeed preferable that additional expenditures go toward the improvement of the health of members of society.

Chart 8 shows the increase in the percent of the Gross National Product represented by health and medical services. As you can see, it has increased from 4.6% in 1950 to 7.7% in 1973. By 1975, this percentage had risen to 8.3% and the Federal Government estimates that by 1980, if not sooner, the United States will devote 10% of the value of all goods and services to paying for health care and developing medical resources. Again we would ask, who is to say that this proportion is too high. One might even ask if 10% is sufficient.

IMPACT OF EXPENSES FOR FAMILY OF FOUR

FAMILY BUDGET (FOUR MEMBERS)	1970	1975	PERCENTAGE INCREASE
BEFORE TAXES	$10,664	$15,318	+43.6%
AFTER TAXES (SPENDABLE INCOME)	8,744	12,427	42.1
SPENT FOR...			
FOOD	2,452	3,827	56.1
HOUSING	2,501	3,533	41.3
TRANSPORTATION	912	1,279	40.2
CLOTHING, PERSONAL CARE	1,137	1,433	26.0
OTHER FAMILY SPENDING	639	831	30.0
CHARITY, LIFE INS., ETC.	539	701	30.1
TAXES, ETC.			
SOCIAL SECURITY TAXES	387	834	115.5
INCOME TAXES	1,533	2,057	34.2
MEDICAL CARE	564	822	45.7

6.6% of After Tax

6.5% of After Tax

CHART 5

SOURCE: U.S. BUREAU OF LABOR STATISTICS

AVERAGE COST PER DAY*

1975

NATION'S HIGHEST	MASSACHUSETTS	$176.04
NATION'S LOWEST	SOUTH DAKOTA	92.00
	UNITED STATES	133.76

KANSAS $102.47

ONLY 10 STATES HAVE A LOWER COST PER DAY THAN KANSAS.

SOURCE: AMERICAN HOSPITAL ASSOCIATION
DEPARTMENT OF SOCIAL RESEARCH STUDIES, OCT., 1975

CHART 6

Average Cost Per Day in Kansas and Surrounding States*
1975

Colorado	$131.94
Oklahoma	117.81
Missouri	116.69
Nebraska	108.20
Kansas	102.47

Source: American Hospital Association
Department of Social Research Studies, Oct., 1975

Chart 7

PERCENT OF GROSS NATIONAL PRODUCT

	1950	1960	1970	1973
GOVERNMENT AND GOVERNMENT ENTERPRISES	8.3	10.7	13.2	13.0
SERVICES	8.5	9.9	11.7	11.5
HEALTH AND MEDICAL SERVICES (ALSO A COMPONENT OF SERVICES)	4.6	5.2	7.1	7.7
FINANCE INSURANCE, REAL ESTATE	10.8	13.4	14.1	13.7
MANUFACTURING	29.4	28.7	25.8	25.2
AGRICULTURE, FORESTRY, FISHERIES	7.3	4.3	3.2	4.6

CHART 8

V. HOSPITAL COST CONTAINMENT ACTION PROGRAMS

No one is more acutely aware of the increases in hospital costs, nor is anymore more concerned about these increases, than are hospital administrators. The assurance to the public that hospitals are doing all within their power to best utilize the health care dollar is a primary objective of all hospitals. In Kansas, hospitals are involved in a wide range of programs designed to help conserve their limited operating funds. Chart 9 lists the programs which are described below:

Hospital Administrative Services (HAS) This is a computerized tool which is used by Kansas hospitals to help isolate and identify costs which are significantly different from costs in comparable hospitals. Hospitals now use this administrative tool to compare operating statistics and financial indicators, with hospitals of like size and with their own operation in previous fiscal periods. The number of Kansas hospitals voluntarily using this excellent management tool now exceeds 100, or over two thirds of all hospitals in the state.

AHA Cost Containment Program. Produced by the American Hospital Association for use in hospitals on a departmental level, KHA has introduced this program to over 60 hospitals in Kansas. This educational program is designed to assist department heads carry out cost containment activities and thereby be more cost-effective in the management of their department. It is estimated that more than one-half of Kansas hospitals will be introduced to this program during 1977.

Sharing of Services. KHA has formed a new committee, charged with discovering how the Association can play a coordinating role with several recently developed shared services programs scattered around the state.

Some of these programs consist of larger hospitals providing services for smaller ones, incurring a savings for the larger hospitals, and providing a service which could not otherwise be afforded by the smaller hospitals. Some of the kinds of services shared are: administration, bio-medical engineering, education, and data processing.

Group Purchasing. About 85% of the hospitals in the state are engaged in one of several group purchasing programs. It is KHA's objective to increase the participation and effectiveness of these programs.

Employee Benefit Program. KHA, along with 15 other states, participates in a shared Hospital Employee Benefit Program, through which significant savings are realized through volume purchasing of quality fringe benefits for hospital employees.

Consultation Services. KHA has developed a program through which member hospitals may receive invaluable management assistance from a consultation visit by peers from similar hospitals. Whereas outside consultation services are normally very expensive, this service provides many of the same advantages at only the cost of travel and subsistence of the participants. Hospitals using this service find it very helpful and the consultants have found it very beneficial, as well.

Hospital Planning. KHA helped "invent" health planning well before it was required by law. As a matter of fact, we believe the voluntary effort was more effective than that mandated by law. Hospital experience in the voluntary program served to enhance the process under law. All of the hospitals in the state participate in a KHA-sponsored Patient Origin and Utilization Study, providing valuable data for the planning process. In addition, hospitals and the Association staff are deeply involved in assisting the State Planning Agency and the Health Systems Agencies in

implementing the new planning law.

Continuing Education. In 1976, a record 4,000 hospital employees participated in one or more of the 50 KHA-sponsored educational efforts, programs designed to improve services and efficiency in various departments.

Public Education. KHA has recently initiated a program to help Kansans stay out of hospitals, and to help patients do a better job of self-care after discharge. Watch for the "Childsafe" publicity, an innovative effort on the part of the Hospital Auxiliaries of Kansas to protect our children.

Utilization Review (UR). This is a program designed to insure that hospital patients receive only medically necessary care and assures that patients leave the hospital as soon as they can safely do so. UR activity in Kansas predated requirements by Medicare and Medicaid and therefore greater progress has been made here than elsewhere around the country. Efforts by Kansas hospitals and doctors have shortened the length of stay continually over the past several years, to a point many believe may be optimum, below which a lower length of stay would indicate that patients were being discharged too early. (See Chart 10)

It has been suggested by one critic of hospital costs that a great deal of money could be saved by shortening the length of stay another day. We believe such critics do not understand the rigorous standards hospitals must meet to comply with federal UR requirements, nor the record of accomplishment which has been made to date. We are suggesting that further reducing the overall length of stay may be the result of a continuance of the rigorous system of review in effect, if the optimum length of stay has not already been reached. This is not, however, a process which is amenable to manipulation to cut hospital stays arbitrarily.

HOSPITAL COST CONTAINMENT ACTION PROGRAMS

I. HOSPITAL ADMINISTRATIVE SERVICES

II. AHA COST CONTAINMENT PROGRAM

III. SHARING OF SERVICES

IV. GROUP PURCHASING

V. EMPLOYEE BENEFIT PROGRAM

VI. CONSULTATION SERVICES

VII. HOSPITAL PLANNING

VIII. CONTINUING EDUCATION

IX. PUBLIC EDUCATION

X. UTILIZATION REVIEW

CHART 9

Average Length of Stay (in days) in Kansas Hospitals

	1967	1969	1971	1973	1974	1975
Medicine, Surgery	9.45	9.06	8.20	7.86	7.71	7.54
Obstetrics	4.23	4.15	3.75	3.61	3.60	3.60
Pediatrics	4.49	4.45	4.59	4.23	4.29	4.25
Combined	8.43	8.15	7.38	7.14	7.04	6.89
Nursery	4.84	4.72	4.47	4.64	4.32	4.26
Short term Psychiatric and Rehabilitation	24.33	19.25	17.53	15.00	14.65	15.65

Chart 10

VI. INCREASES IN HOSPITAL PRODUCTIVITY

We have just demonstrated, through the discussion of hospital cost containment activities, that hospitals are committed to stemming the rising tide of hospital cost increases. Hospital productivity data shows that cost containment efforts have borne results. Data is available from the American Hospital Association's Hospital Administrative Services program that illustrates some of the increases in hospital productivity over a period covering 1969 to July 1976. Let us summarize for you some of these productivity gains.

This review of productivity trends is based on seven years of continuous monthly data from 428 HAS subscribers.

Some of these findings for the period covering 1969 to July of 1976 are summarized below and are depicted on Chart 11.

1. The average number of manhours expended for each diagnostic x-ray procedure decreased from 1.13 to 1.08, an increase in productivity of 6.2% in spite of the increasing complexity of such procedures.

2. The number of manhours needed for each 1000 square feet of plant maintenance was reduced from 17.58 to 15.84, a productivity increase of 9.8%.

3. The number of pounds of laundry processed per manhour increased from 34.36 to 39.83, a productivity growth of 13.7%.

4. The number of meals prepared in dietary departments per manhour grew from 2.98 to 3.29, an increase in productivity of 10.4%.

5. The number of manhours utilized by housekeeping departments for each 1000 square feet decreased from 52.31 to 39.86, indicating productivity improvement of 23.8%.

6. Finally, the number of clinical laboratory tests performed per manhour increased from 4.77 to 6.93, a productivity increase of 45.3%.

These data clearly indicate that voluntary efforts have resulted in significant productivity gains in hospitals. Each of the examples cited represents a cost center that is minimally impacted by demands of legislation and regulations and consequently least affected by factors external to hospital management.

Conversely, the study shows that demands created by external forces may result in a requirement for many more manhours in cost centers most directly affected by the demands. Two examples show this clearly:

1. In the medical records department, the number of manhours required per discharge unit has grown from 2.03 to 2.59, representing a 27.6% increase.

2. The number of administrative and fiscal manhours per hospital bed has grown from 32.67 to 41.76, representing an increase of 27.8%. When the fiscal manhours are separated they show a growth from 15.07 manhours per bed in 1972 (first year that data was separated) to 31.95 in 1976. In other words, the number of manhours required for just fiscal services and reporting in 1976 is within 2% of the number of manhours required in 1969 for all administrative and fiscal activities.

There is no question that the advent of Medicare in 1965 and the subsequent increased federal involvement in many aspects of health care delivery have resulted in significant demands for additional paperwork on the part of providers, resulting in many millions of manhours per year. It is not our intent here to debate the merits of such requirements. To the contrary, the KHA has consistently supported legislation and programs to improve the quality and accessibility of health care for all people.

PRODUCTIVITY IN HOSPITALS PERCENT OF CHANGE 1969-1976	
DIAGNOSTIC X-RAY PROCEDURES	+6%
PLANT MAINTENANCE (PER 1,000 FEET)	+10%
LAUNDRY PROCESSED PER MAN HOUR	+14%
MEALS PREPARED PER MAN HOUR	+10%
HOUSEKEEPING	+24%
LABORATORY TESTS PER MAN HOUR	+45%

INCREASED NUMBER OF MAN HOURS NEEDED	
MEDICAL RECORDS (MAN HOURS PER DISCHARGE)	+28%
ADMINISTRATIVE & FISCAL MAN HOURS PER BED	+28%

CHART 11

VII. MEDICALLY NECESSARY CARE

We must understand that health care costs are rising for very complex reasons. We hope that we have demonstrated some of these reasons for you. As a result of the complexity of this issue, it is not readily amenable to simplistic solutions.

The Economic Stabilization Program attempted to apply a simplistic solution to this problem. Disastrous consequences to the financial stability of many institutions proved the danger of this course of action.

Another graphic example of such a proposed simplistic solution is the one that we sometimes hear in reference to the state's Medicaid cost problem. A specific proposal that does not recognize the complexity of the hospital cost issue is that of cutting off Medicaid payments to a hospital at the 50th percentile for length of stay. This would result in the state stopping payment for all care after an automatic cut-off date. Thus, payment would stop whether or not the patient was dismissed or needed further medically necessary care. Let us take a look at one diagnosis and see what the impact on hospitals would be. As you can see from Chart 12, 50% of male patients age 50-64 entering the hospital with a single diagnosis of acute myocardial infarction (heart attack) would expect to get out the hospital on the 16th day. In other words, the 50th percentile for this diagnosis is 16 days. By the 20th day, another 25% of those admitted can expect to be well enough to go home.

This chart means that for a given diagnosis, 50% of the cases can expect to be well enough to leave the hospital on the 16th day. However, 25% more needed another four days to be medically well enough to be discharged, and one percent of these patients were still not discharged on the 32nd day of the stay. The proposal, therefore, to save money for the state

by simply stopping payment at the 50th percentile would leave half the cases with one or more days of necessary hospital care unpaid. Was any money truly saved? Of course not. It costs money to care for these patients and since hospitals have virtually no margin of revenue over expenses, the cost must be recouped from everyone else who pays their bills. We might add at this time that these people would continue to receive the care in Kansas hospitals.

1975

LENGTH OF HOSPITAL STAY FOR HEART ATTACK

(ACUTE MYOCARDIAL INFARCTION)

MALES 50-64 YEARS OF AGE

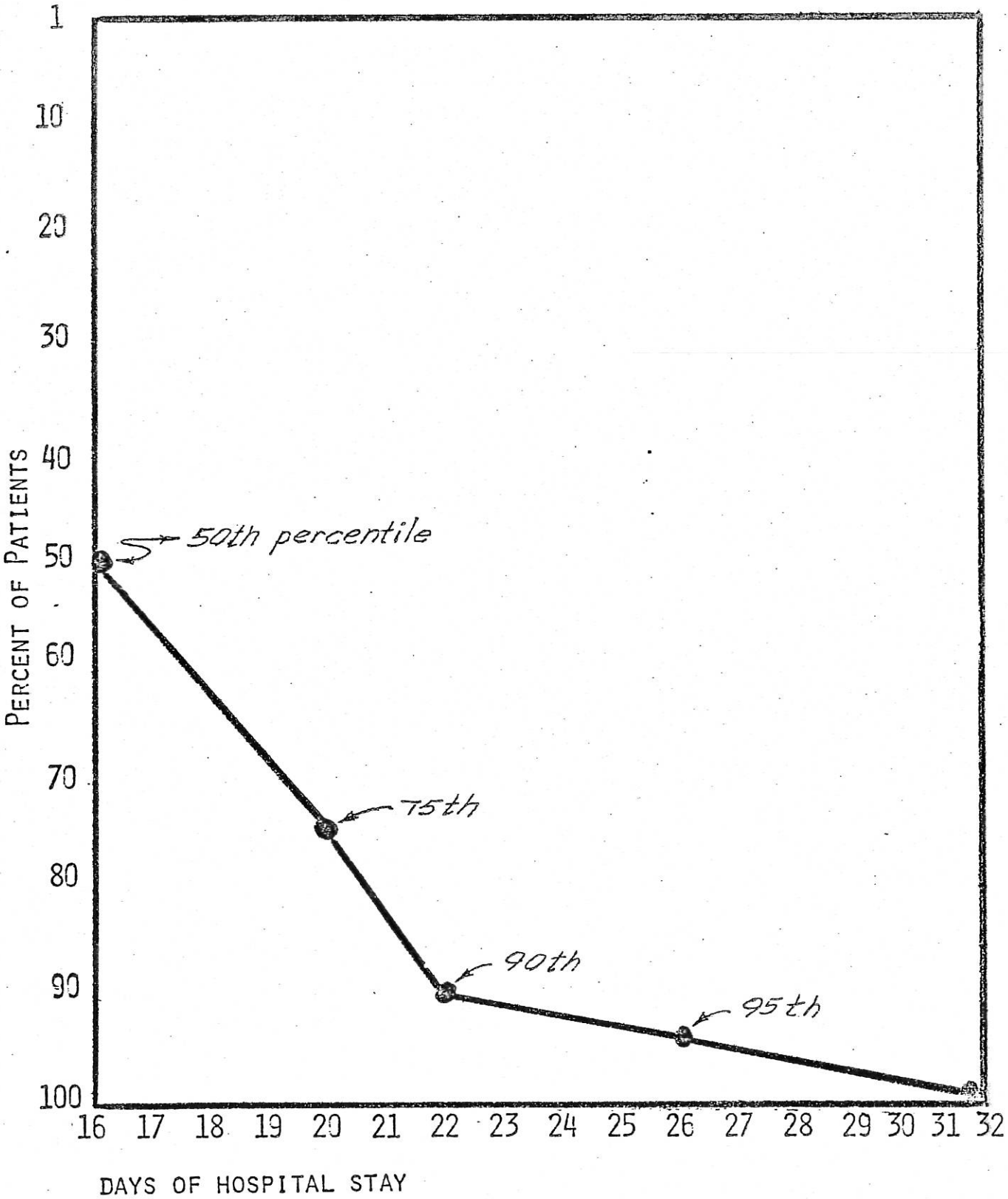


CHART 12

VIII. KHA STUDY OF "EXCESS BEDS"

Statements have been made by various officials of state agencies to the effect that a major reason for escalating costs of health care, both in Kansas and nationally, is the cost of maintaining excess beds in our acute care hospitals. Some individuals have stated they feel there are 4,200 such excess beds in Kansas. The source of the statistical data used by the persons making these statements is not known. However, the figure has probably been derived by use of the statewide annual occupancy rate of 71.1% multiplied by the total number of beds in Kansas. As there are 14,893 beds in the 154 general hospitals in Kansas, a 71.1% occupancy means that on an "average" day, 10,589 of these beds are occupied and 4,304 of these beds are empty. It is these empty beds that are being declared excess. The central question is: Are these unused beds necessary to allow for the variations in the number of patients who require hospitalization on any given day, or are they in fact excess beds?

The Kansas Hospital Association has, for nine years, collected detailed utilization data from all of the acute care hospitals in Kansas. This data includes the number of discharges and patient days by age categories and by type of services utilized (medical, surgical, obstetrical, pediatrics, nursery, psychiatric, rehabilitative). The study also provides patient origin data indicating exactly where Kansas patients obtain their care.

KHA is in a good position, because of this data, to use these statistics in an effort to analyze the claims of over-bedding. KHA recently carried out a special study to shed light on the "4200 excess bed" claim. We constructed a scientific sample of Kansas hospitals representing all bed sizes. As a result of this study, we found that many of the hospitals experienced

very high occupancy rates during some portion of the year, with several hospitals being strained to the point of putting patients in hallway beds.

This study confirms what we have long believed -- that average annual occupancy figures do not bear any relevance to discussions of unnecessary or excess hospital beds. One small northeastern Kansas hospital had a 1976 occupancy rate of around 50%, and yet the study revealed that there were times during the year when medical or surgical patients had to be put in labor rooms in order to receive needed care.

The KHA study included 20 hospitals. If the annual average occupancy rate were applied to those hospitals, one would obtain a figure of 441 beds which might be termed "excess." However, by directly surveying the 20 hospitals, we found that 403 (91.4%) of those beds were in fact required during the year to provide necessary care. If the results of this scientific sample study were applied to all Kansas hospitals, it can be generalized that approximately 3,934 patient beds out of the 4,304 empty beds are needed to allow hospitals to accommodate their peak loads. The need for only 370 beds would then be subject to further investigation.

Another fact needs to be taken into account when considering the "empty bed" problem. Kansans, like the other citizens of the United States, suffer from what has been called the "Dr. Welby Syndrome." Because of improvements in communications media, people have become more and more aware of advances in medical technology. Not only are they aware of the advances, they are expecting their hospitals to offer advanced services. Hospitals have attempted to respond to these demands by installing highly specialized services such as cardiac care units and intensive care units, for example. The beds set aside for these highly specialized services cannot be used for the more routine admissions. A six bed cardiac care unit may only have

two or three patients in it at any given time. The extra three or four beds reduce the average occupancy rate for the hospital. Several of the hospital personnel who were contacted during this study commented that, though their annual average occupancy rate for the entire hospital might be 65 or 70 percent, as often as half the time, all of their medical and surgical beds were filled, forcing elective surgery patients to be turned away. Areas of the hospital must be devoted to specialized services because of pressure from the community to provide these services, even though these beds could be more profitably utilized by providing care to medically or surgically needy patients. This dilemma is not easily resolved. It is unknown at this time how many of the 370 beds that were discussed earlier can be accounted for in this manner.

Hospitals are available to Kansans 24 hours a day, seven days a week, whether you arrive with a broken arm or a heart attack, or along with 15 other victims of a tornado or an automobile accident or an explosion. A statistically "unnecessary" bed becomes very necessary when you or I, or our family or a friend needs to be hospitalized.

Although our study is a simple one, we feel its findings are conclusive enough to thoroughly discredit the contentions that there are 4,200 excess beds in our state.

IX. SUMMARY

We have discussed the current situation with hospital costs and hope we've provided you some historical trend analysis. But what does the future hold in this subject? That truly is the key question. People's expectations of hospitals and the kind of care they receive are very high. This is in part due to the media exposure of TV programs like "Emergency," "Dr. Welby," and "Medical Center," where the general public sees miracles performed regularly. We also are inundated with weekly sections in Time and Newsweek on medicine, and even Parade magazine seems to have an almost weekly feature on some new technological advancement or improvement on health care services. Having seen miracles performed on television and reading about new and wonderful life-saving techniques available, people expect this kind of care for themselves if and when they are sick. This expectation is not lessened by the fact that someone resides in Topeka as compared to New York City and people, when they are sick, want that kind of care and at that time are not truly concerned about the cost. Every hospital administrator has heard the phrase, "I don't care about the cost, just get my mother or my wife well."

This technology that is discussed keeps exploding and there is nothing ahead but bigger and better medical advances. Just last week's Time magazine discussed the changes in burn care; the number of people who would have previously died whose lives are being saved today.

In 1975, the Federal Government spent $2.4 billion dollars for medical research. The results of that research will, of course, eventually improve hospital care, but it is absolutely predictable that the results will be in new and more expensive equipment, and consequently higher hospital costs will result. Do we want to make the social decision to stop the research,

to stop the progress, to freeze medical care at the 1977 level? We truly doubt that the public would be supportive of such a move. But it is obvious that something needs to be done. What courses of action are available to us as representatives of the hospital industry, and what courses of action are available to you as representatives of the consuming public? Before we get into detail on that discussion we need to talk about a few assumptions that need to be made on this subject.

First, self-destructive life styles will not change a great deal. Dwight Metzler, Secretary of Health and Environment, noted in his testimony before the House Public Health and Welfare Committee that this was one of the major health problems in Kansas; we eat too much, smoke too much; drink too much; and exercise too little. It is, however, safe to assume that this tendency on the part of the citizens of our state and our country will continue.

Our second assumption is that people will want medical technology advancements to continue and the people will want the best possible care to be available to them when they need it.

The third assumption is that people will expect to stay in the hospital only as long as is medically necessary.

Our final assumption will be that the federal and state standards for hospital care will continue to increase.

Based on these assumptions, what more can we do? There is no doubt that the hospitals are becoming increasingly sensitive to the need for more and stronger efforts to contain costs. This is a major effort on the part of our Association and we feel is one of the major objectives of each and every hospital in Kansas. The data that we presented earlier - the increased HAS participation, the growing number of hospitals participating in the American Hospital Association's Cost Containment Program -- are all indicative

of this commitment. We also feel that many efforts have been started which have not yet had a chance to make an impact on hospital costs. We feel that two pieces of legislation passed by the Congress in recent years have set the stage for a significant impact on health care costs.

The capital expenditures control under the National Health Planning and Resources Act (P.L. 93-641) will do much to prevent the construction of unnecessary facilities and services. The HSAs in Kansas are still in the formative stage, but they, working within the framework of our State Certificate of Need legislation (K.S.A. 1976 Supp. 65-4801, et seq.) should be able to adequately control this aspect of health care costs.

The other federal law to which I have reference is the 1972 amendment to the Social Security Act (P.L. 92-603). It made provision for Professional Standards Review Organizations that now are in varying stages of development throughout the country.

I'm sure you will hear more about the PSRO here in Kansas from representatives of the Medical Society. For now, then, I'll simply state that the corporate mechanism is in place and awaits further federal funding. Not only will it be geared to continue our current utilization review, but to increase the effectiveness in the monitoring of hospital admissions; to review the ancillary services provided for each patient; to develop a profile of each physician to identify those doing an inordinate amount of any given procedure; and so forth. It is our opinion that PSROs have the potential of making the most significant impact on the cost of health care of any effort to date.

Rate regulation is being touted as a possible means of controlling costs. Experiments in some 18 states are currently underway, authorized by the two laws to which I've just made reference. We here in Kansas have

an experiment just starting, without the "benefit" of federal funding. It's too early to predict the success of these programs. Implementation is complex and expensive. We here in Kansas are maintaining surveillance on all of the experiments, some of which seem to be doomed to stifle medical progress. The Office of Research and Statistics of the Social Security Administration recently held a panel discussion on the subject, and concluded that rate regulation had demonstrated little, if any, impact on health care costs. As I indicated earlier, I think it's too early to say.

Mr. Chairman and members of the Committee, we appreciate your patience. We realize we've taken much of the Committee's time and hope our presentation will be of value. I suspect we've touched on some points that have raised questions. We will do our best to handle them. Thank you very much.

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Attachment C

COMMISSION ON HEALTH CARE COSTS

September 13, 1977

Kansas Medical Society

Mr. Chairman and members of the committee, I appreciate the opportunity to appear today as you continue your study and deliberations on the complex issue of the escalating costs of health care. There is no single solution to this problem. Health care costs are increasing as a result of many factors, and consequently the solution to the problem lies in a well thought out, rational approach that encompasses many fronts.

The demand for health care services, unlike almost any other service, is insatiable. It is this demand for care that provides incentives to build more hospital beds, buy more equipment, train more personnel, conduct more research, develop more drugs and lab tests, and do all the other things that ultimately result in increased health costs. It is clearly evident that there is only one way to truly cut costs effectively, and that is to reduce the number of services delivered. That objective will undoubtedly be one of the most difficult to achieve as time goes on.

Everyone must bear part of the blame for the rising costs of health care. Physicians, hospitals, the public, government, and advancing technology all are part of the problem. In most places, technological advance cuts costs; in health care it usually increases total costs. In 1976 Medicare spent $450 million dialyzing the kidneys of 18,000 patients. Only a few years ago expensive treatments and therapies such as this did not exist or were not readily available to the public. On the other hand, certain technological advances, such as the discovery of new vaccines, have directly saved millions of dollars by

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preventing diseases. By increasing the survival rate for previously untreatable diseases, modern technology in an indirect way also contributes to increasing health costs, as those people saved from early death live longer to contract other illnesses in later life. Up to now there have not been many incentives to weigh the marginal benefits of some treatments against the costs.

In many ways the public is a major contributor to the high cost of health care. On one end of the spectrum is the patient who never sees a doctor for regular, maintenance care, and so generally his first entry to the health care system is when he has developed some serious malady that is expensive to treat, and which could probably have been prevented with regular care. On the other end is the "worried well" who over-utilizes the system and ties up valuable health care dollars in unneeded office and emergency room visits. In addition, the lifestyle of the average American is not particularly conducive to the maintenance of good health. Estimates of the annual cost of caring for lung cancer, respiratory ailments, and cardiovascular disease attributable to smoking are as high as $5 billion and climbing. Better diet, no smoking, and less alcohol would cut health costs by billions of dollars nationwide. In fact, in the long run, we would best spend our health dollars in the area of health education, emphasizing and encouraging good preventive health habits, good diet, and discouraging the use of tobacco, alcohol and other drugs.

Health insurance programs, both government and private, could do much in the way of holding down costs. Instead of providing incentives for

treating patients in the expensive hospital setting, programs could encourage more outpatient laboratory testing and contain reimbursement incentives to do certain simple medical and surgical procedures in the office instead of the hospital.

The current medical malpractice problem has contributed significantly to the rising cost of health care. Not only have malpractice premiums skyrocketed - and it is the patient who ultimately pays for increasing insurance costs - but the fear of lawsuit causes many physicians to order more laboratory tests and x-rays than are medically necessary. It is hard to estimate the actual financial impact of the practice of defensive medicine, but it is safe to say that the cost is significant.

Today almost 2 out of every 3 dollars expended for health care is paid for by a third party, whether it be government or the private health insurance industry. When the bill is paid by someone else, a third party, there is a tendency to not give much concern to the cost of the services delivered, since "someone else is paying for it." This illusion is costly. Eliminating first dollar coverage or enacting co-payment features could help reduce health cost because of the slowdown in utilization of services it might encourage as people begin to take a greater and more direct financial responsibility for their health care.

Physicians, other health professionals, and hospitals need to do more to help reduce health costs. Physicians can order laboratory work-ups on and outpatient basis, and where appropriate do minor or routine procedures

in the office instead of in the hospital. Health care services which are not medically necessary should be eliminated from government-financed programs. A committee of our association has been meeting with Secretary Harder for the past several years on a regular basis, and we presently are ready to begin an analysis of ways we can reduce costs to the Medicaid program by eliminating certain medical services that are not absolutely essential.

In summary, there is no easy way to reduce health care costs. Many areas should be explored: providing incentives for outpatient care versus hospital care, establishing deductibles or co-pay features in health insurance programs, eliminating all services that are not medically necessary from government-financed programs, promoting good preventive health habits in the population, making the public more aware of their responsibility in recognizing and dealing with the problem, encouraging the development of alternative delivery systems such as HMO's, and strengthening the health planning process so that expensive equipment and resources in a community can be shared, not duplicated. Finally, some hard decisions need to be made as to what level of services is appropriate and economically feasible to deliver in order to fill the almost unending demand for health care. Thank you.

Jerry Slaughter
Kansas Medical Society

Attachment D

REVIEW OF TITLE XIX PROVIDER VENDORSHIP

OF KANSAS COMMUNITY MENTAL HEALTH CENTERS

Community Mental Health Center Report
to Kansas Health Care Cost Commission

For over 10 years, Kansas Mental Health Centers have been approved vendors for Title XIX funds, and the amounts of those services provided have increased markedly, as have the total services of Community Mental Health Centers throughout the State. Not only have several new Centers been established during that period, but also existing Centers have taken advantage of construction and staffing grants provided by HEW and have expanded their services to include five basic elements which has allowed them to become classified as Comprehensive Community Mental Health Centers.

These five elements are as follows: Outpatient, Inpatient, Partial Hospitalization, Emergency Services, Consultation and Education. In addition, most of the Comprehensive Centers are currently expanding services to new programs through HEW to include seven additional elements, which are: Alcohol, Drug, Children, Elderly, Precare, Aftercare, and Transitional Living.

Currently, the residents of the entire State of Kansas have access to local mental health services through 31 Community Mental Health Centers, and over 75% of the population of the State receive services through 11 of those that are Comprehensive Mental Health Centers.

The enclosed attachment indicates that during 1976 Medicaid funds that went to Mental Health Centers totaled $1,878,073, and amounted to an average of 15.05% of the budgets of the Centers. This percentage figure also represents the same approximate number of patients covered by Medicaid as compared to non Title XIX patients treated in Mental Health Centers. The total Title XIX expenditure that is directed to Mental Health Centers amounts to less than 2% of all of the Title XIX funds expended throughout the State to all other provider groups.

Mental Health Centers have traditionally served in the role of the aftercare resources in the community for those patients who were released from state hospitals. This has been based on the expectations of each respective community in that follow-up of state hospital patients be made available locally through Mental Health Centers, and has also been promulgated in the State Plan and subsequent planning efforts of SRS in "Project Interweave."

More recently, other efforts have been placed on precare or screening by Mental Health Centers so that patients who formerly would have been referred to state hospitals are now maintained in the community and placed in treatment situations locally that are structured to their symptom needs. Hence, the populations of patient clientele in the Mental Health Centers are quite different from those of the private psychiatric providers who deal more often with shorter term, non-chronic patients or more transient situational disorders. The Mental Health Centers

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have treated the more socially and economically deprived groups which not infrequently are recipients of Title XIX.

The results of the impact of Mental Health Centers have been formidable in that the populations of state hospitals have rapidly declined over those 10 years and the majority of patients who have been residents in state hospitals are now treated and rehabilitated in their home communities so that neither dependence on complete institutionalization is fostered and family ties are not disrupted. Without Title XIX, much of this care for the 8,617 patients listed in the attachment would not have been possible.

Finally, Mental Health Centers have been subjected to the most rigorous controls and have welcomed this, as this near constant surveillance has enabled them to maintain their full creditability. Not only are the individual Centers closely scrutinized by a multitude of interested groups within the community, i.e., their own respective Boards, County Commissioners who levy local funds, local Mental Health Associations, local health planning groups and health systems agencies, other community social agencies, etc., but they also made themselves available for very close and continuous scrutiny on the part of the State Department of Social and Rehabilitation Services. This scrutiny comes in the form of the following:

1. Medicaid fees are determined by an annual audit of the SRS fiscal staff and the amount of the fee is set so that it does not exceed the actual Center's cost for services. If a fee is determined through audit to be in excess of the customary and prevailing maximum charges levied to private paying patients of a particular Center, the addition is disallowed, and only the top Center fee or the audited Medicaid rate (whichever is less) may then be reimbursed.

2. Each Center receives an annual program audit for both inpatient and outpatient services. This audit assures that no Medicaid patients are allowed to over-utilize Center services.

3. Another safeguard directed toward over-utilization is the peer review requirement that all Centers have the patient charts reviewed by staff not involved in the individual's treatment, and as a part of that team there is also a physician who may not even be on the Center's staff. This review is required to occur after every 13 therapy sessions. No other service provider for Title XIX is required to develop a utilization and review process for those clients who are seen only on an outpatient basis.

4. A more recent ruling requires that Centers can no longer provide therapy for patients more frequently than four hours per month, or 12 sessions in any 90-day period. For all practical purposes, this regulation eliminates reimbursement for psychological evaluations for all those patients whose treatment requirements demand that they are seen weekly for hourly sessions for therapeutic purposes. If they utilized all of their eligibility in therapeutic intervention, they would have no additional hours left for psychological evaluation, medication checks, etc. These

new regulations also require that a medical necessity review over and above those reviews listed in Nos. 2 and 3 also take place at the end of 90 days for all those patients requiring treatment beyond that time span. These requirements became effective August 1, but as they in no way fit the treatment needs of the patient clientele that characteristically avail themselves of community mental health services, and more closely follow the private practice model, debate with SRS continues toward alleviating the very restrictive aspects of the regulations.

Clinton D. Willsie, President
Association of Directors of Community
Mental Health Centers of Kansas

September 13, 1977

1976 . Kansas Mental Health Centers

Center	Medicaid Fees	No. Clients	% of Budget	Remarks
Leavenworth/ Atchison	$ 42,322	400	25%	Patients represent 50% of caseload
Concordia	14,858	126	10%	
ElDorado	36,757	214	12%	
Emporia	32,343	385	7%	
Garden City	92,661	421	18%	
Great Bend	17,677	111	9%	
Greensburg	5,985	26	6%	
Hays	115,817	482	15%	"If we lost this, we could not maintain our federal grants and would lose $190,0 in grant money. This would be end of comprehensive pro gram and probably the loss of some of our supporting counties." Julius Cohen
Hiawatha	18,630	84	19%	
	"Average of $221 per patient". -Dave Cowan			
Humboldt	59,245	290	29.2%	
Hutchinson	70,612	500	18%	
Sekan	171,741	800	23.5%	
Kansas City, Ks.	104,043	500	10%	down from usual amount due to change of medical director
Lawrence	53.516	164	20%	
Liberal	3,604	55	2.49%	

hattan	$ 27,826	112	9%	number of clients presen 15% of caseload
Johnson Co., Mission	37,618	183	5.2%	
Johnson Co., Olathe	47,557	204	12.7%	
Newton	243,728	640	9.4%	includes outpatient only
Ottawa	15,049	112	23.3%	
Pittsburg	102,373	421	27%	
Salina	46,329	346	21%	
Topeka, Shawnee	89,644	452	8.9%	
Wichita/ FCS	21,914	117	14%	
Wichita/ WGC	49,500	349	19%	
Wichita/ Sedg. Co. DMH	335,386	1025	18%	
Winfield	21,338	98	14.75%	
Louisburg	Operation of Center began in 1976			
Totals	$1,878,073	8,617	15.05% average	

Attachment E

TESTIMONY ON TITLE XIX

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KANSAS OPTOMETRIC ASSOCIATION

September 13, 1977

Mr. Chairman and Members of the Committee:

My name is Jack Milligan, I am the Executive Director of the Kansas Optometric Association.

I appear today representing approximately 1¼% of the total Medicaid budget.

The optometric portion of the Medicaid program is comprised of 2 parts: optometric examination and optometric services. These two portions of the program are further broken down into two categories, 0 through 20 years of age and 21 years of age and above. From this point on to avoid any confusion, when referring to the optometric portion of the Medicaid program I will refer to vision examination and services for those patients 20 years of age and under and 21 years of age and above.

Vision Examinations

Eligible Recipients 20 Years and Under

Effective July 8, 1977, Title XIX will pay for one vision evaluation every 12 months.

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Eligible Recipients Age
21 and Over

Effective July 8, 1977, Title XIX will pay for one vision evaluation every 48 months for recipients age 21 and over. When symptoms are such that an exam is required to rule out ocular pathology, payment will be made if documented by the provider listing such symptoms.

Exceptions to the above will be only by prior authorization with adequate documentation.

Optical Services

Eligible Recipients
20 Years and Under

Effective July 8, 1977, Title XIX continued to cover the dispensing of eyeglasses and repairs.

Payment for frames is limited to $9.20. (More expensive frames will require prior authorization, as will second and subsequent sets of eyeglasses).

When both lenses require replacement, prior authorization must be obtained.

Glasses prescribed by a new examination are not considered "subsequent sets", provided the new prescription meets

minimum change requirements. Trimmed, ornamental, jewelled, foreign, gold filled, and wire frames are excluded from coverage.

Eligible Recipients Age 21 and Over

Effective July 8, 1977 there will be no Title XIX coverage for optical services (i.e. eyeglasses, contact lenses or repairs) for these recipients.

The optometric portion of the Medicaid program has a peer review mechanism that we feel is working extremely well. This mechanism consists of a committee comprised of 5 optometrists and is chaired by Dr. Larry Harris, an optometrist practicing in Topeka, and who also serves as the optometric consultant to SRS. Dr. Harris personally screens 10% of all paid claims. If he then discovers any questionable claims, he requests that the committee immediately place that provider on a "100% Watch-List" and then screens 100% of the claims submitted by that provider. It is important to note that the members of the committee are not aware of which provider's claim they are screening at the time they vote to accept or reject it, thus eliminating any possibility of bias or prejudice on the part of the committee members.

It's difficult to imagine how any additional reduction in the optometric portion of the Medicaid program could be warranted. It is obvious from the Table attached that optometric fees have been controlled by the Department of SRS and thus hopefully disqualifying any additional reduction in that area.

However; there has been a consistent cost increase in one aspect of the optical program, and that is the cost of materials. Prior to the July 1, 1977 Emergency Rules and Regulations the Title XIX program always reimbursed the dispensers of glasses, be it optometrist, physician, or optical dispenser for the actual laboratory cost of frames and lenses, and these costs have increased considerably.

When the program started in fiscal year 1968, single vision lenses cost an average of $4.50 and today's average exceeds $10.00. Two dollars of this increase is directly attributed to a U.S. Food and Drug Administration regulation that requires all lenses to be impact resistant.

Frames have also increased dramatically in cost. Within the last 2 or 3 years the maximum in the program on frames has risen from approximately $5.00 to $9.20.

Last January 26, 1977 my predecessor James Clark, made some cost cutting suggestions before the House Ways and Means Committee, those suggestions were as follows:

1) A bid on materials by the optical laboratories. This was considered previously, but because of considerable delay in the delivery of materials, it was not implemented.

2) A co-pay formula on materials for recipients over 21 years of age, such as paying the first $5.00 on any materials involved.

3) Restrict those recipients over 21 to one pair of glasses per year.

However, suggestions 2 and 3 above are now no longer pertinent because of the recent reductions in Title XIX Optical Services which no longer pays for any eyeglasses for recipients 21 years of age and older.

I think it is evident that the optometric portion of the program has already been reduced to the minimum. For example, prior to the July 8, 1977 Emergency Rules and Regulations those recipients 0 - 21 years and over 40 years of age received a set of eyeglasses every 12 months, and recipients 22 through 39 years of age received one set of eyeglasses every 24 months.

Under vision examinations, recipients 0 - 21 years and over 40 years of age received one eye examination every 12 months, and recipients 22 through 39 years of age received one eye examination every 24 months. After visiting with numerous optometrists throughout the state, we have concluded that there has

been a large reduction of Title XIX recipients for vision examinations and optical services. This reduction clearly reveals many individuals are unable to receive badly needed optometric care.

Mr. Chairman, I respectfully submit that the optometric portion of the Medicaid program has been whittled and reduced to the absolute minimum. I repeat that the optometric portion of the program currently represents only 1¼% of the entire Medicaid budget. With the promulgation of the July 8, 1977 Emergency Rules and Regulations, the Department of SRS estimated that 30,000 Medicaid recipients would be affected and an annual savings of $890,000 and state savings of $489,500 would occur.

Needless to say, any additional cuts in the optometric portion of the Medicaid program would render it almost useless.

I would certainly hope that such a small percentage of the Medicaid program can remain intact and continue its very valuable and needed services to the Title XIX recipients.

OPTOMETRIC DIAGNOSTIC PROCEDURES

RANGE MAXIMUMS

Procedure	Fy '69 90th %tile	Fy '70 75th	Fy '71 50th	Present 50th
* Visual Acuity Testing	3.00	3.00	3.00	2.25
* External Examination	3.00	3.00	3.00	2.25
* Refractions	6.00	5.00	5.00	5.00
* Coordination Testing	5.00	5.00	5.00	4.50
* Ophthalmoscopy Examination	5.00	5.00	5.00	4.50
* Keratometry	3.00	3.00	3.00	2.25
Biomicroscopy Examination	3.00	3.00	3.00	2.50
Tonometry	4.00	3.00	3.00	2.50
Multiple Pattern Fields	3.00	3.00	3.00	2.75
Plotted Fields	6.00	5.00	5.00	5.00
* Total	25.00	24.00	24.00	20.75

* Routine procedures in 1970

Attachment F

HEALTH CARE PROVIDERS, INC.
1301 Topeka Boulevard
Topeka, Kansas 66612

DATE: September 14, 1977

TO: Chairman, Commission on Health Care Costs

FROM: Health Care Providers, Inc.

SUBJECT: Health Care Costs and Nursing Homes

Mr. Chairman:

As spokesman for an organization that represents 93% of the licensed Adult Care Homes in Kansas, both proprietary and non-proprietary, we welcome this opportunity to discuss nursing home costs.

A central thesis of this presentation is that nursing homes should be evaluated as a separate component within the health care sector for purposes of drawing any conclusions about price behavior, cost escalation or public expenditures. There are fundamental differences which must be understood and go a long way toward explaining why nursing home costs have risen at a rate comparable to the Consumer Price Index, based upon available data.

TYPES OF SERVICES: "Nursing Home" is a broad generic term used to describe several types of long term care facilities. It is sometimes applied to extended care facilities, convalescent hospitals/homes, skilled nursing care homes, intermediate care facilities and even boarding/residential care homes. More explanatory are the three types of services offered in a nursing home.

NURSING CARE: Nursing procedures requiring the professional skills of a registered nurse of Licensed Practical Nurse. These skills include administering medications, injections, catheterization, and similar procedures ordered by the attending physician. Post-hospital stroke, heart or orthopedic care is available with such related services as physical therapy, occupational therapy, dental services, dietary consultation, social services, laboratory and x-ray services.

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ERSONAL CARE: Services such as help in walking, getting in and out of bed, bathing, dressing, and preparation of special diets as prescribed by a physician.

RESIDENTIAL CARE: General supervision in a protective environment, including room and board and social services as needed.

CATEGORIES OF NURSING CARE

The Kansas Department of Health and Environment has the established authority for the licensure and inspections of nursing homes in Kansas, and has since 1963. Following are the categories of Adult Care Homes as of February 15, 1977.

A. Skilled Nursing Home: Provides continuous skilled nursing care on a 24 hour basis. Registered nurses, LPNs and trained aides provide services prescribed by attending physician. Emphasis is on nursing care with rehabilitative therapy, physical therapy, occupational therapy, and other needed medical services. Facility is eligible for both Medicare and Medicaid Programs, if meets Federal Conditions of Participation.

TYPICAL SERVICES OFFERED IN A STATE SKILLED NURSING HOME (SNF)

* Round the clock nursing care. Licensed personnel on all tours of duty.
* Room and Board
* Advisory Committee (consists of a physician, nurse, religious advisor, and local citizens to advise and counsel the administrator).
* Full or Part-time Medical Director (Physician) responsible for over-all coordination of medical care in the facility.
* Physician's Services (Federal): Physician visit at least once every 30 days for the first 90 days; subsequent visits based upon physician recommendations, but cannot exceed every 60 days.
* Director of Nursing Services; Full time.
* Dietitian Full time or Dietetic Services Supervisor.
* Specialized Rehabilitative Services, such as O.T., P.T., Audiology.
* Pharmaceutical Services - under general supervision of Pharmacist.
* Laboratory and Radiology Services Provided or Arranged.
* Dental Services
* Social Services - Licensed Social Worker or consultation with.
* Medical Records Practicioner or Supervisor.
* Infection Control Committee
* Housekeeping and Maintenance
* Licensed Administrator (Except for long-term care units of hospitals).
* Activity Director
* Trained Nursing Home Aides

NUMBER OF SKILLED NURSING HOMES IN KANSAS AS OF 8-1-77 = 49

CAPACITY: 5,131 Beds

KANSAS PUBLIC ASSISTANCE, TABLE IIC: NURSING HOME RECIPIENTS AND EXPENDITURES BY MONTH:

	PERSONS	AVG./PERSON	AVG./DAY	MAXIMUM RATES 6-1-77:
MAY 1976	739	400.79	13.36	
MAY 1977	523	421.16	14.04	$ 24.23 day

B. Intermediate Care Home: Provides basic medical, nursing and social services in addition to room and board for persons not capable of fully independent living. This type of facility may participate in the Medicaid Program.

TYPICAL SERVICES PROVIDED IN THE INTERMEDIATE CARE FACILITY (ICF)

* Supervised nursing care 8 hours a day, 7 days a week.
* Room and Board.
* Laundry-Housekeeping.
* Advisory Committee.
* Arrangements for Lab and x-ray services when needed.
* Medical Director
* Dental Services if provided
* Rehabilitative Services when provided
* Social Services - Full time staff person with consultation from Licensed Social Worker.
* Activity Director - Full time.
* Health Services Supervisor - registered nurse or LPN employed full time on day tour of duty.
* Trained Nursing Home Aides.
* Dietetic Supervisor with consultation of qualified dietitian.
* Pharmaceutical Services - Consultant.
* Medical Records Practioner or Supervisor.
* Infection Control Committee.
* Physician's visit every 60 days unless otherwise documented.

NUMBER OF INTERMEDIATE CARE FACILITIES IN KANSAS AS OF 8-1-77: = 261

CAPACITY: 16,860 Beds

KANSAS PUBLIC ASSISTANCE, TABLE ICC: NURSING HOME RECIPIENTS AND EXPENDITURES BY MONTH:

	PERSONS	AVG./PERSON	AVG./DAY	MAXIMUM RATE 6-1-77:
MAY 1976	10,107	308.30	10.27	
MAY 1977	10,647	339.55	11.32	$15.93 Day

C. Personal Care Home: Provides simple nursing care and domiciliary care. Not eligible for federal programs. TOTAL NUMBER OF HOMES: 44, BEDS: 2,158.

SERVICES OFFERED:

* Medical-Dental Services. Transportations arrangement for emergencies.
* Residential Consultation Services: Personal health, home health care, social services.
* Trained Nursing Home Aides.
* Room and Board
* Resident Activities-recreation, religious services.
* Dietetic Services - nutrition and meal planning.

CONCLUSION: Approximately one-half of the nursing home beds are occupied by Medicaid recipients.

The preponderance of nursing home revenues are not received in the form of actual cost reimbursement. Although the Federal statutes require the largest payor, Medicaid, to reimburse facilities on a "reasonable cost related basis", considerable flexability has been given to the states to set up rates on a prospective basis with ceilings.

Currently approximately 57% of the nursing homes in Kansas are not receiving actual costs for the Medicaid residents. The difference is being made up by the private paying residents and families. In essence there is a Co-Pay imposed upon them with but one objectionable option -- the rapid depletion of personal funds leading to public assistance.

Cost containment can be injurious when unjustly applies to providers of health care. This is the situation now in Kansas nursing homes, and has been for the past ten years. A recent Finding of Fact by a District Court judge has affirmed this with his ruling that the first sixteen homes in the class action, Seneca, et. al., are due monies in excess of $650,000.00.

CORRECTIVE STEPS AND RECOMMENDATIONS

THE MAJOR CAUSES OF HIGHER EXPENDITURES FOR NURSING HOME CARE ARE INCREASED NUMBER OF AGED RECIPIENTS AND THE EXPANSION OF AVAILABLE COVERED SERVICES.

PREMISE: Per diem nursing home costs can be contained in two ways:

1.) Delivering the service more efficiently.

2.) Reducing the level of service.

Since no one will publicly espouse #2, let us consider how the services can be delivered more efficiently. We can suggest the following possibilities:

I. Regulatory Reform:

Nursing homes face an endless web of regulations emanating from all levels of government. While many of these rules are sound and basic to the assurance of quality care, many are duplicative and unnecessary and levied without any notes of fiscal impact. Such is the case in Kansas. For too long, the standard setting functions (Department of Health and Environment) have been carried out with little coordination with the paying agencies (Social and Rehabilitative Services). We need to decide simultaneously, and in advance what services will be purchased for what price. At least then decisions which are made to increase costs will be affirmed in full recognition of those costs. We seriously recommend that the Adult Care Home Rules and Regulations effected February 15, 1977 be nullified until substantial studies be made of their fiscal impact to Kansans.
We highly endorse the statement made by Dr. Robert Harder, Secretary, Kansas Department of Social and Rehabilitative Services, that "planning and financing be closely tied".

II. Tightening Utilization in Existing Programs:

Government officials contend that significant savings can be achieved through more rigid utilization controls in Medicare, Medicaid and private health plans.

There is no question that expensive services are being used when less expensive alternatives are available. The most glaring example is the utilization of hospitals by persons for convalescent purposes, when nursing homes could be utilized for about 75% less cost.

Legislation which would substantially change the requirements of Utilization Review, medical review and independent professional review imposed by Section 1903(g) of the Social Security Act is being considered by Congress at this time.

Representative Paul Rogers (D-Fla.) has introduced legislation entitled the Utilization Control Amendments of 1977 (H.R. 8095). The bill would delete from the Medicaid program extensive requirements for State Medicaid agencies to carry out these reviews. Instead, the state agency that certifies facility compliance for Federal eligibility would assume this responsibility as part of the facility's certification process.

This appears to be a sound concept worthy of support.

III. Other Alternatives to Nursing Homes:

Current interest is to seek out alternatives and investments in home health care, residential/custodial care, incentives to families to care for their infirm elderly members as viable options. However, as a recent option paper pointed out "realistically...it is likely that the total amount paid for long term care would not decrease as many elderly not in nursing homes and presently receiving no care could benefit from supportive services not now available."

RECOMMENDATIONS: Expanded roles for nursing homes. Capability of providing many services on other than a full time basis. Day Care, Meals-on-wheels, outpatient therapy services, preventative health services, home health services and home-makers services are examples of services which homes could provide, barring legal and licensure prohibitions.

IV. Tighten Medicaid Eligibility Enforcement:

Medicaid eligibility controls vary widely from state to state. There are undoubtly ineligible persons receiving services in Kansas. Caseload control, can in some areas, be an important factor in controlling costs.

V. Cost Task Force Study Group:

We encourage this concept be pursued and a determination be made of actual costs incurred by nursing homes. Rates for similar service vary from state to state and from one home to the next. In turn, homes should receive their cost

plus a profit factor.

A recently completed two year study of nursing homes in Los Angeles, California surprised even it's authors. One dramatic finding was that the best care is given in homes that receive a profit. (A copy of this report is submitted for the record.)

Also, we would encourage realistic ceilings and reasonable limits when exploring nursing home costs and rates.

VII. Voluntary Steps Taken By Nursing Homes To Control Costs:

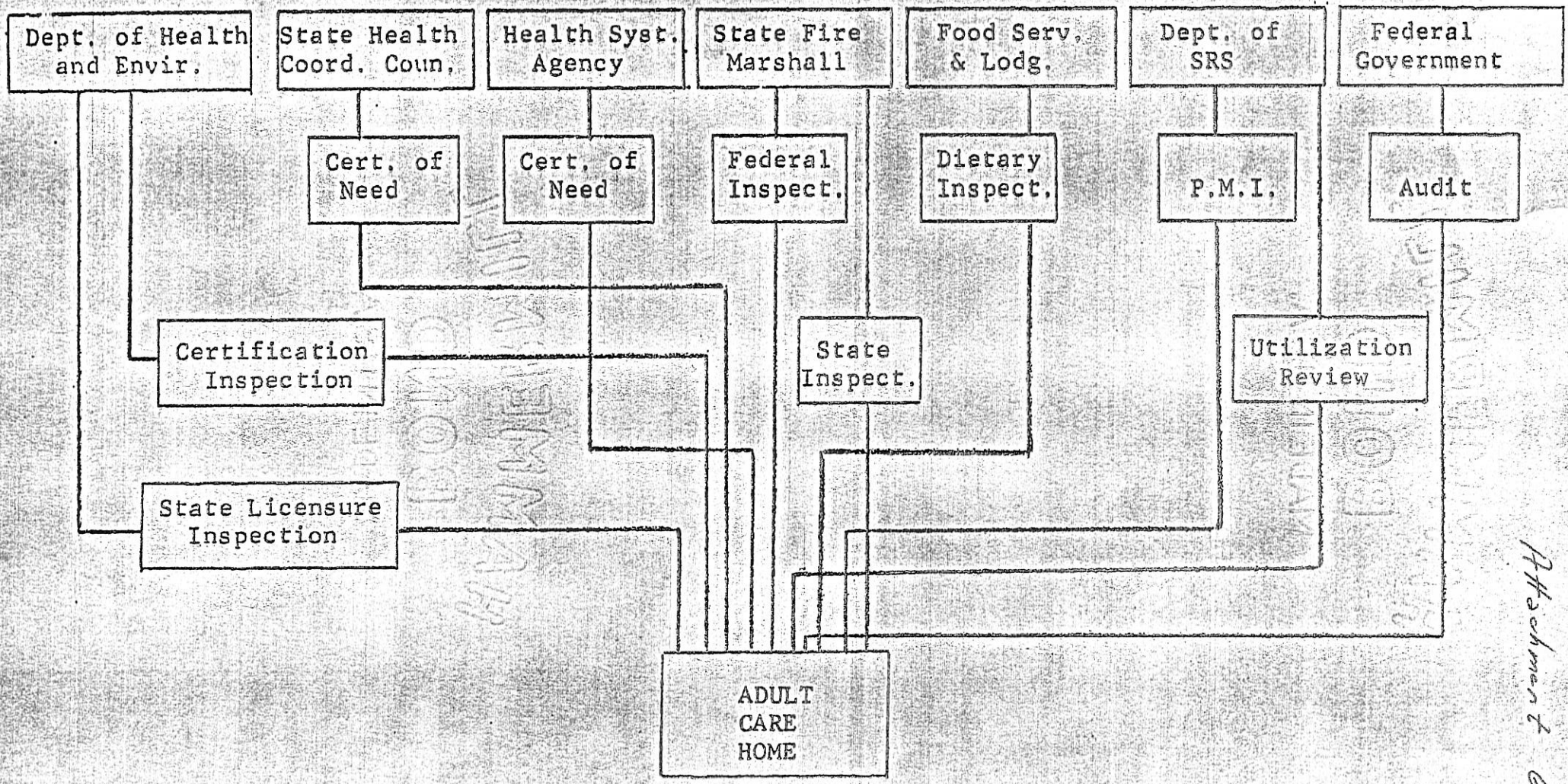
* Peer Review (self-evaluation) is operational.
* Energy Conservation Workshops.
* Cost Related Workshops Co-Sponsored with the Department of Social and Rehabilitative Services.
* Association Delivery of the Medication Aide Training Program with the Approval of the Kansas Department of Health and Environment.

Mr. Chairman, we appreciate this opportunity to discuss the various aspects of Adult Care Homes in Kansas.

Sincerely,

Dick Hummel,
Legislative Laison,
Health Care Providers, Inc.

REGULATION OF ADULT CARE HOMES IN THE STATE OF KANSAS



Attachment 6

Attachment H

Los Angeles Times

HARRISON GRAY OTIS, 1882-1917
HARRY CHANDLER, 1917-1944
NORMAN CHANDLER, 1944-1960

Caring for the Aged—With Care

A sweeping and ambitious two-year study of nursing homes in Los Angeles County has produced a report that should serve the interests of elderly patients everywhere. The study is the first of its kind. Its intriguing conclusions should foster sharp changes in public attitudes toward nursing homes and the challenge of caring for America's aged.

The effort was launched in 1975 after several scandals heightened concern over lapses and abuses in the nursing-home business. The County Board of Supervisors directed a task force to audit the industry, define what determines the difference between good and bad care, and recommend changes in licensing, regulation and government payments for the care of poor patients.

The resulting report surprised even its authors. They started their study with grave concerns about private nursing homes. They concluded, with the persuasively documented finding that the most profitable facilities are the ones delivering the best care. They also suspected excessive profits, but found instead an average profit of 3.3% of revenues.

Among the report's other significant findings:

—Patients are generally better off in a small facility managed by the owner.

—The key ingredients of success are the skill and motivation of the nursing staff.

—Most nursing homes' pay scales are too low. The resulting staff turnover erodes morale and patient care.

—Medi-Cal reimbursement rates of $21 to $24 a day per patient are too low.

—Physicians tend to shirk their responsibilities toward their nursing-home patients by skipping the regular visits demanded by Medi-Cal rules and professional standards.

—Good care requires competent supervision, usually by a registered nurse. Too many facilities are short of supervisors, and the patient suffers accordingly.

It would be encouraging to think that this report might cause a dramatic improvement in patient care, but the challenge is massive, and the changes are likely to be slow. There are about 40,000 patients in nursing homes in Los Angeles County alone, and the numbers are just as imposing elsewhere. Even a small increase in Medi-Cal reimbursement rates translates into tens of millions of dollars a year in each major metropolitan area.

Better care for the aged will require more than regular bed checks and better medical training for nurses' aides. Geriatric specialists say patients thrive more if a nursing home feels as much as possible like a home, not a hospital. Patients should have things to do, things to talk about. Those who are able should have assigned responsibilities.

These ideas point in a healthy new direction. Carrying them out will require more resources than society now provides. The county report should help make more resources available.

This editorial appeared in the Los Angeles Times on Monday, June 28, 1977. The Association's Los Angeles Regional office has been in constant contact recently with the Times, along with assistance from the Public Relations Department in Sacramento. Follow-up letters have been sent to the editor by several CAHF members urging continued support of this campaign. Many more "letters to the editor" from facilities and employees would certainly enhance our position with this important media source.

Atch. H

County Nursing Home Industry Rapped in Study

BY FRANK DEL OLMO
Times Staff Writer

A largely critical report on the local nursing home industry has concluded, surprisingly, that privately run, profit-making nursing homes tend to provide their patients with the best care.

The study group that prepared the report, which was commissioned two years ago in the wake of local nursing home scandals, started with a negative attitude toward privately run nursing homes, according to one county official who worked on the project.

The study, which was made public Wednesday, is particularly critical of the way some doctors handle their patients in nursing homes. Researchers found that many patients suffered from "a lack of attention by the attending physician."

Noting that 68% of the patients in nursing homes are Medi-Cal recipients, the report also suggests that the low return many nursing homes get from the Medi-Cal system "contributes substantially to the financial inability of nursing homes to improve patient care . . ."

It recommends that the state reevaluate its Medi-Cal rate structure to provide "for a reasonable rate of return" for nursing home operators.

The study is the work of a special task force of auditors from the county auditor-controller's office and health professionals from the Department of Health Services.

Lance Brisson, an assistant county public administrator/public guardian, who also was a member of the task force, said that when he first began working with the task force, it was with a critical view toward private nursing homes that were run as profit-making enterprises.

Contrary to Brisson's expectations, he said the report concluded that "it does not appear that the quality of patient care provided by the nursing home industry is being diminished by the allocation of operating funds to profit instead of patient care."

Nursing Homes Hit in County Report

Continued from First Page

This conclusion and many other findings in the report are based on mathematical computations in which county auditors tried to quantify the quality of medical care provided in local nursing homes.

Brisson said this unique statistical approach was necessary because county researchers found that no public or private body had ever tried to evaluate nursing home care in the detail demanded by county supervisors when the study was begun.

While conceding that some of the language and statistics in the report are dry and technical, Brisson said this is because the study was not so much intended for public consumption as it was designed to influence state and federal legislation in the area of nursing home care.

The dry statistics, Brisson said, "translate into the food the patients are given, how often their bed sheets are changed and the floors are cleaned."

To gauge the quality of medical care, task force researchers visited 48 randomly selected nursing homes and evaluated the care received by 712 patients.

Among the study's key recommendations:

—Governmental agencies should emphasize the placement of nursing home patients in small, owner-operated facilities.

Researchers found that those nursing homes with fewer than 100 beds tended to provide better patient care than larger homes, and that owner-operated facilities, or "mom and pop businesses" as Brisson called them, appeared to be run more efficiently.

—Physicians personally should evaluate their patients on a regular basis (30 to 60 days) to monitor their condition, identify new problems and modify treatment plans.

The report states that the "traditional physician leadership in matters of patient care, so visible in the hospital setting, seemed diminished or totally lacking" in the nursing homes that were surveyed.

The report criticizes those physicians who place patients in nursing homes, then fail to follow up adequately. Federal regulations require that every nursing home patient's treatment program be evaluated by an attending physician every 30 days, according to the report.

However, the report states, for 110 of the 712 patients surveyed, researchers found "no documented evidence that . . . patients received the monthly physician visits."

"Some facilities even reported that medical charts were carried to physicians' offices to obtain written progress notes in the absence of actually visiting the patient," the report states.

—The state should increase the Medi-Cal reimbursement rate "to cover all Medi-Cal patients costs and provide a reasonable rate of return" for operators, primarily by making key changes in the method by which the reimbursement rate is computed.

The report recommends that the state adjust Medi-Cal reimbursement rates on a quarterly, rather than annual basis, to reflect the impact of inflation on nursing home expenses and that reimbursement rates be varied in different regions of the state.

—The nursing home system should be reorganized so that patients with differing needs and dependency levels can no longer be thrown together in the same facility.

The study recommends four different kinds of homes, ranging from rehabilitation facilities for patients who have a potential for improvement to closed facilities for those patients with severe mental disorders who require a protected environment.

The study makes 21 other recommendations for changes by the nursing home industry and the government agencies that work with it or regulate it.

Los Angeles County
Nursing Home Study
1975-77

Prepared for:

Los Angeles County
Board of Supervisors

Pete F. Schabarum

Kenneth Hahn

Edmund D. Edelman

James A. Hayes

Baxter Ward

Prepared by:

Mark H. Bloodgood
Auditor-Controller
Los Angeles County

PREFACE

On April 22, 1975, at the request of the Los Angeles County Board of Supervisors, the Los Angeles County Nursing Home Task Force, under the Chairmanship of Los Angeles County Auditor-Controller Mark H. Bloodgood, was formed to study the operations of nursing homes in Los Angeles County.

The Task Force was composed of members of the Auditor-Controller's staff and the staffs of the Chief Administrative Officer and the Departments of Health Services (DHS), Personnel, and Public Administrator-Public Guardian.

The principal objective of the Task Force was to gather factual financial, statistical, and medical data on a cross-section of nursing homes operating within Los Angeles County for the purpose of determining their financial condition and the possible relationship between their financial condition and the quality of care provided. Secondary objectives included determining: (1) the present financial capability of nursing homes to improve patient care through paying higher wages, employing more skilled personnel, and sponsoring better recreation programs; (2) whether facilities follow a uniform system of accounts for identifying costs; (3) the cost of providing legally and medically acceptable levels of care by type of patients; (4) the minimum standards for staffing and services; (5) whether objective bases exist by which quality of care provided can be measured; and (6) if there is a correlation between the sources of payments to nursing homes and the kind of care patients receive.

The results of the study are presented in this report. The County wishes to extend its appreciation for the interest and cooperation received from the California Association of Health Facilities and the Los Angeles County Council of Nursing Home Associations and to the owners and employees of the nursing homes who participated in the study and made possible this report.

Also, we wish to express our sincere thanks to the members of the Technical Advisory Committee.

COUNTY OF LOS ANGELES

NURSING HOME TASK FORCE MEMBERS

Task Force Members	Designated Representatives
Mark H. Bloodgood Auditor-Controller Task Force Chairman	Daniel O. Ikemoto Assistant Auditor-Controller
	J. Tyler McCauley Chief, Audit Division
	Gary W. Wells Principal Accountant-Auditor
	Wayne S. Tada Senior Accountant-Auditor
	Thomas J. Garcia Intermediate Accountant-Auditor
	Stephen J. Kane Intermediate Accountant-Auditor
Harry L. Hufford Chief Administrative Officer/ Acting Director Department of Personnel	Vincent Terry Chief Analyst
	Karen Doms Chief Personnel Analyst
Liston A. Witherill Director of Health Services	Larry Gonzales, Chief, Logistics and Systems Management Division
	Loren G. MacKinney, M.D. Office of Quality Assurance
	Clyde Johnson Administrative Assistant Office of Quality Assurance
	Patricia Bingham, R.N. Office of Quality Assurance
	Bonnie Norman, R.N. Nursing Programs Coordinator
Bruce Altman Public Administrator/ Public Guardian	Lance Brisson Assistant Public Administrator/ Public Guardian

TECHNICAL ADVISORY COMMITTEE

The Office of Quality Assurance, Department of Health Services, appointed a Technical Advisory Committee to provide expert and impartial guidance for the health care component of the study. This Committee was consulted during the development of the study methodology, throughout the data analysis, and in the formulation of conclusions and recommendations.

Committee Members

Everett J. Carmody, M.D.	Medical Director, Long Beach General Hospital
Elsie Giorgi, M.D.	Associate Clinical Professor of Medicine, UCLA School of Medicine
George Griffith, M.D. (Deceased)	Professor of Cardiology, USC School of Medicine
Bernard Hanes, Ph.D. (Statistical Advisor)	Professor, Health Science, California State University, Northridge
Lawrence Hart, M.D., M.P.H.	Director, Health Care Services, County of Santa Barbara
Carl Hopkins, Ph.D., M.P.H. (Chairman of Committee - Statistical Advisor)	Professor of Health Services Research, School of Public Health, UCLA
Robert Karns, M.D.	Immediate Past Chairman of Mental Health Advisory Board
Paul Kerschner, Ph.D.	Director, Community Projects, USC Gerontology Center
Clayton Loosli, M.D. (Deceased)	Hastings Professor of Medicine & Pathology, USC School of Medicine
Edward Shapiro, M.D.	Clinical Professor of Medicine, Emeritus, USC School of Medicine
Paul Torrens, M.D., M.P.H.	Professor & Chairman, Division of Health Services & Hospital Administration, School of Public Health, UCLA

NURSING HOME ASSOCIATIONS

The County sought and received an endorsement for the Nursing Home study from the Los Angeles County Council of Nursing Home Associations (LACCNHA) (see Appendix C). Representatives of LACCNHA and the California Association of Health Facilities (CAHF), while not participating in the sample selection procedures or data gathering phase of the survey, did provide expert advice throughout the study. In addition, LACCNHA and CAHF representatives reviewed and commented on the survey findings.

Nursing Home Associations Representatives

Irene Bowerman	Regional Director - California Association of Health Facilities (CAHF)
Arnold Freed	Third Vice-President (CAHF)
Ardelle Patterson	President - Los Angeles County Council of Nursing Home Associations (LACCNHA)

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INTRODUCTION

Authority for Study

On April 22, 1975, on motion of Los Angeles County Supervisor Baxter Ward, unanimously carried, the Los Angeles County Auditor-Controller was instructed to organize a task force for the purpose of conducting an audit of a cross-section of County nursing homes to ascertain accurately their financial condition (see Appendix A). The Auditor-Controller was to report to the Board on all aspects of nursing home operations, including his determination of the following:

Correlation between profitability of nursing home operations and quality of care provided;

Present financial capability of nursing homes to improve patient care through paying higher wages, employing more skilled personnel, and sponsoring better recreation programs;

Whether local nursing homes follow a uniform system of accounts for identifying costs;

Cost of providing legally and medically acceptable levels of care by type of patients, including allocation of reasonable overhead charges;

Minimum standards prescribed for staffing and services; and

Whether objective bases exist by which quality of care provided can be measured, and if there is a correlation between the sources of payments to nursing homes and the kind of care patients receive.

As the Task Force had no licensing or enforcement responsibilities and no legal or subpoena authority, facility and patient participation was completely voluntary. Each facility agreed to participate before any data collection was initiated. Also, each patient who participated (or their representative) signed a consent before their records were reviewed.

Historical Background

Interest in measuring the quality of medical care was documented at least 100 years ago. Yet today, despite much study in this area, measurement of the quality of care remains an elusive concept.

Quality of care in the long-term care field (nursing home care) has increasingly become the focus of Congressional investigations and studies by consumer and other special interest groups, as well as frequent examinations by regulatory agencies.

In some cases, the outcome of this increased scrutiny has been exposure of illegal financial arrangements (e.g., kickbacks for ancillary services provided by vendors, fictitious or exhorbitant charges to federal and state medical assistance programs, etc.) and/or unconscionable treatment of patients. The notoriety resulting from such findings has precipitated numerous changes in laws and regulations governing nursing home operations.

Quite naturally, out of this atmosphere has come considerable debate between the owners and operators of nursing homes and the regulatory agencies regarding the need for the new regulations and the cost of conforming with the regulations. This issue has become particularly acute in California in the area of the State administered Medi-Cal Program where cost reimbursement is based on a flat per diem rate. The per diem rate is only periodically adjusted, and most nursing homes maintain the rate is not sufficient to meet the inflating costs of health care coupled with the cost of implementing new regulations.

The most significant recent legislation affecting State nursing home operations was California SB413 and AB1600 which became effective January 1, 1974 with the corresponding regulations being implemented on July 13, 1975. These bills served to modify or increase the existing legal requirements for Skilled Nursing Facilities (SNFs) as specified in Title 22, Division 5 of the California Administrative Code.

Additional requirements included increased annual licensing fees, provision for an advisory dentist, additional nursing staff, increased dietary service, in-service training of various personnel, employment of a medical records consultant and medical director and various other items.

At the time this report is being written, considerable debate is continuing related to the rate of reimbursement for nursing home care and the need for, and costs of, implementing the new Title 22 requirements. One fact has become evident - there is little relative financial and medical data available to aid in making an accurate determination of this kind. An objective of this study is to attempt to provide this type of data.

PREVIEW TO THE REPORT PRESENTATION

The findings of this report are presented in the following order:

Task Force Recommendations

A summary of the Task Force's recommendations is presented first. The recommendations are presented without explanatory comments.

Scope and Methodology of Survey

The scope and methodology of the survey are presented following the Task Force recommendations. All limitations to scope and methodology are discussed in the scope section. Sample selection procedures and analytical techniques are discussed in the methodology section.

Questions of Los Angeles County Board of Supervisors

The questions raised by the Board of Supervisors in their request of April 22, 1975 are presented following the Task Force recommendations. The answers and/or conclusions and recommendations relative to the specific questions are presented following each question and are based on the findings of the Task Force.

Other Findings and Conclusions

Other findings, conclusions and/or recommendations of the Task Force are presented at the end of the report. The conclusions and recommendations are based upon the Task Force's analysis of the financial and medical data gathered during the survey.

TASK FORCE RECOMMENDATIONS

1. The State reduce the rate differentials used for the various size facilities. (pp.18-20)

2. The State monitor the occupancy levels in the nursing home industry and regulate the supply of nursing home beds to ensure optimum occupancy levels throughout the industry. (pp. 20-21)

   Note

   With the passage and implementation of PL 93-641 and AB 4001, the Health Systems Agency (HSA) and the State's Certificate of Need Program, it can be anticipated that occupancy rates for SNFs will be monitored by the State Department of Health. The impact of these mechanisms should also coincide with the expansion of Professional Standards Review Organization (PSRO) into long-term care facilities. The PSRO reviews, among other things, the appropriateness of the level of care provided to federally funded patients in acute care, Skilled Nursing and Intermediate care facilities.

3. Special services be increasingly emphasized in the current monitoring efforts of SNFs and in the development of new, care-oriented SNF regulations. (p. 21)

4. The Nursing Home Industry consider directing future increases in nursing expenses towards the Registered Nurse component. (pp. 21-22)

5. The State re-evaluate the Medi-Cal rate and adjust it to cover all Medi-Cal patient costs and provide for a reasonable rate of return. (pp. 23-24)

   Note

   It was not within the scope of this study to determine what a "reasonable rate of return" for SNFs should be. (According to the most recent available data from Standard and Poor's Industry Surveys, the average rate of return on revenue for selected hospital chains in the health care industry for 1975 is 7.7%.) Perhaps, this topic would best be addressed by some future study group from the investment community with the expertise necessary to resolve this issue. We would, however, caution any such future study group to recognize that "rate of return" is a dynamic rather than static concept. All rates of return fluctuate continually in the marketplace in response to a variety of changing economic conditions. One possible approach to dealing with the dynamic nature of rates of return may be to have these rates adjusted periodically by an independent arbitrator mutually selected by the State and Nursing Home Industry. This would provide for the establishment of an unbiased rate of return which would be periodically adjusted to reflect current conditions in the marketplace.

6. The State ensure that Medi-Cal reimbursement rates cover the cost of a legally acceptable level of care for geriatric patients in all SNFs. (p. 26)

Task Force Recommendations (Contd.)

7. The State advise SNFs of the benefits for improved care and profit through efficient scheduling of nursing aide staff. (pp. 29-31)

8. A Problem Oriented Medical Record System be mandated for all SNFs. (pp. 32-33)

9. Governmental agencies emphasize the placement of SNF patients in smaller (less than 100 beds), owner-operated facilities. (p. 35)

10. The State increase the Medi-Cal reimbursement rate to provide for competitive nursing staff wages. (pp. 36-37)

11. Governmental agencies exercise due caution in justifying cost based medical reimbursement programs on the basis of increased care expectations. (pp. 40-41)

12. The State: -stratify reimbursement rates by geographic region.

-adjust reimbursement rates quarterly to reflect the impact of inflation on the SNFs' costs.

-base the property related cost component of the Medi-Cal reimbursement rate on actual facility occupancy. (pp. 41-43)

13. Patients be placed, according to the assessment of their functional limitations and resultant dependency levels, in various specialized facilities under a reorganized nursing home system which includes facilities specializing in sub-acute/rehabilitation care and affiliated with an acute hospital, long-term skilled nursing care, intermediate care, and skilled nursing care of the mentally disordered. (pp. 47-50)

Assessment of patients' functional limitations be an integral part of the admission process to determine placement and continue on a regular periodic basis throughout the care and discharge planning process. (pp. 47-50)

The education and training of the staff be directed to the specialized needs of their respective patient population. (pp. 47-50)

14. Closed facilities be licensed and regulated separately by the State to admit and treat only patients with diagnosed mental disorders. (These are patients who are known to be aggressively dangerous to themselves, others, or property.) (pp. 50-51)

15. Licensing agencies report deficiencies in physician visits and medical record documentation to the respective physician and the Board of Medical Quality Assurance for appropriate action. (p. 52)

16. Physicians personally evaluate their patients on a regular basis (30 to 60 days) to monitor their condition, identify new problems, and appropriately modify treatment plans. (pp. 52-53)

The status of the patients' problems and their management be noted in the progress notes at the conclusion of each evaluation. (pp. 52-53)

Task Force Recommendations (Contd.)

17. The Advisory Physician or Medical Director perform internal chart audits as a control measure over the quality of physician care provided. (pp. 53-55)

The use of nurse practitioners in SNFs and the possibility of a related reimbursement mechanism for their services be considered by the State Legislature as an alternative to increased, direct physician involvement. (pp. 53-55)

Continuing medical education in gerontology be increasingly stressed for physicians practicing in SNFs. (pp. 53-55)

18. Regular chart audits be instituted by SNFs. (pp. 56-57)

19. Increased emphasis be given to the dietary services area by licensing surveyors. (pp. 57-59)

Dietitian-prepared menus be altered only with nutritional equivalents and evaluations of meal alterations be conducted and recorded by the dietitian consultant at the next visit. (pp. 57-59)

SNFs provide complete and attractive dining areas. (pp. 57-59)

20. The State Legislature consider the designation and licensure of separate sub-acute/rehabilitation facilities. (pp. 60-61)

21. Internal chart audits be performed by medical records personnel. (pp. 61-62)

Review and follow-up of deficiencies identified be done by the Medical Director and appropriate medical care policies developed to correct these deficiencies. (pp. 61-62)

22. The discharging health facilities and physicians be held responsible when adequate transfer records have not been forwarded to the admitting facility within 48 hours of the respective patient's admission. (pp. 62-63)

23. Licensing inspectors place increased emphasis on patients' protection and safety. (pp. 63-64)

24. Standardized educational and training programs for SNF personnel be developed, including appropriate testing mechanisms, with proper attention given to the psycho-social-emotional as well as technical aspects of geriatric care. (pp. 65-67)

The educational system, particularly the medical and nursing schools, be encouraged to promote and support formal and continuing educational programs for geriatric care. (pp. 65-67)

Note

Required educational programs for nurse assistants have been legislated by Assembly Bill No. 3619.

25. The State Legislature seriously consider the proposal made by the California Public Interest Research Group regarding ombudsman and volunteer services for nursing homes. (pp. 68-69)

Note

In May 1974, the County of Los Angeles Board of Supervisors initiated the HALO Volunteer Program"...to bring recreational/ socialization activities and intellectual stimulation to residents of out-of-home care facilities." This volunteer program is coordinated by the Los Angeles County's Department of Public Social Services and is implemented through the combined efforts of various County Departments, Schools and other community agencies. As of February 1977, almost 500 volunteers had been assigned to nursing homes under the Program. Further, six colleges are participating in the HALO Program and provide academic credit for volunteer services.

RESPONSE TO QUESTIONS OF THE LOS ANGELES COUNTY BOARD OF SUPERVISORS

As previously indicated, the Auditor-Controller was instructed to respond to seven specific questions relating to nursing home operations. The questions and the Task Force's responses are presented below.

Question 1

Is there a correlation between the profitability of nursing home operations and the quality of care provided?

Task Force Response

According to our correlational analysis, facility pre-tax profit per patient day correlates positively with the quality of patient care as measured by the health care index (.29). While we were unable to identify the cause-effect relationship between profit and care from this correlation, it does not appear that the quality of patient care provided by the nursing home industry is being diminished by the allocation of operating funds to profit instead of patient care.

Assuming that at least some profit is essential for the continued existence of most SNFs and that improved care is currently the primary concern of governmental regulatory agencies, we attempted to identify those factors (variables) most positively associated with quality of care and profit. In addition, we attempted to identify factors positively associated with either the quality of care or profit, but having a minimal or zero effect on the other variable. This identification process was accomplished using a statistical technique known as "regression analysis".

Using the same variables included in the correlation table at Appendix L we were able to derive meaningful regression equations on both pre-tax profit per patient day and the health care index. The variables included in these equations were chosen on the basis of both statistical significance and professional judgment. Professional judgment was required to ensure inclusion of only those variables which could provide meaningful information regarding the significant components of profit and care. These variables are defined as follows:

- A1 - Medi-Cal Reimbursement Rate
- A3 - Average Private Pay Reimbursement Rate
- A8 - Special Services Expense Per Patient Day
- A21 - Medi-Cal Patient Mix
- A26 - Number of Beds (Licensed)
- A31 - Number of Years Business Owned
- A33 - Occupancy Percentage
- A41 - Indirect Expense Per Patient Day
- A45 - Registered Nurse Expense Per Patient Day
- A47 - Aide Expense Per Patient Day
- A72 - Facility Classification Per Licensing Survey(s).

Question I (Contd.)

The resultant regression equations are:

$$\text{Pre-tax Profit Per Patient Day} = -21.417 + .083A33 + .954A1 - .995A72 + .072A31 + 1.147A45 - .472A47$$

$$\text{Health Care Index} = -.327 + .007A33 + .009A3 + .046A41 + .002A21 + .042A8 + .005A31 - .001A26$$

The -21.417 in the pre-tax profit per patient day equation and the -.327 in the health care index equation represent mathematical constants common to all linear equations. These constants are commonly known as "y-intercepts" when used in conjunction with a simple, two-dimensional x-y graph.

Before any meaningful conclusions could be drawn from the equations, the percentage contributions of each independent variable to the dependent variables (pre-tax profit per patient day and health care index) had to be considered. These percentages were derived by combining various statistical factors provided in the regression analysis. The resulting percentage contributions of the independent (cause) variables to the dependent (effect) variables are shown in the table below:

Variable	% Contribution to Pre-tax Profit Per Patient Day	% Contribution to Health Care Index
Medi-Cal Reimbursement Rate	12	*
Average Private Pay Reimbursement Rate	*	2
Special Services Expense Per Patient Day	*	13
Medi-Cal Patient Mix	*	13
Number of Beds (Licensed)	*	6
Number of Years Business Owned	11	5
Occupancy Percentage	32	36
Indirect Expense Per Patient Day	*	*
Registered Nurse Expense Per Patient Day	8	*
Aide Expense Per Patient Day	4	*
Facility Classification Per Licensing Survey(s)	22	*
Total Contribution	89	75

From the preceding, it can be seen that 89% of the components of pre-tax profit per patient day and 75% of the components of patient care (as measured by the health care index) are explained in these eleven variables.

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* Insignificant contribution

Question 1 (Contd.)

Our interpretation of these variables is presented below.

1. The number of licensed beds in a facility appears to contribute somewhat to the quality of care provided (6%). Profit is also affected by the number of beds in a facility as reflected in the 12% contribution of the Medi-Cal rate to profit. To understand the relationship between profit and a facility's number of beds, it is necessary to understand that Medi-Cal patients comprise 68% of nursing home patients as well as to understand the Medi-Cal reimbursement rate structure.

   The Medi-Cal rate paid to facilities varies depending upon the number of beds a facility has as shown below:

Size of Facility	Medi-Cal Reimbursement Rate 10/31/76
1-59 beds	$24.18
60-99	22.34
100+	21.41

   The rate decreases as the number of beds increases under the theory that there are inherent economies achieved as the size of the facility increases. For example, it would seem that a facility with more beds could spread its fixed costs over a larger base (e.g., 59 vs. 100 beds), and therefore, the costs per bed would be lower. Our study showed, however, that there are only minimal operating cost differentials related to the size of a facility. Therefore, the Medi-Cal reimbursement rate differential contributed to a higher average profit per patient day in smaller facilities. To equalize Medi-Cal program profits per patient day, the State should reduce the rate differentials used for the various size facilities.

   Recommendation 1

   The State reduce the rate differentials used for the various size facilities.

2. Occupancy percentage, as would be expected, is the single largest contributor to pre-tax profit per patient day. Higher occupancy reduces the fixed cost component of a facility's total costs per patient day and, therefore, results in higher pre-tax profit per patient day.

   Since our regression analysis indicates that higher occupancy also contributes substantially to better care, the State should monitor the occupancy level in the nursing home industry and regulate the supply of nursing home beds to ensure optimum occupancy levels throughout the industry.

Question 1 (Contd.)

Recommendation 2

The State monitor the occupancy levels in the nursing home industry and regulate the supply of nursing home beds to ensure optimum occupancy levels throughout the industry.

Note

With the passage and implementation of PL 93-641 and AB 4001, the Health Systems Agency (HSA) and the State's Certificate of Need Program, it can be anticipated that occupancy rates for SNFs will be monitored by the State Department of Health. The impact of these mechanisms should also coincide with the expansion of Professional Standards Review Organization (PSRO) into long-term care facilities. The PSRO reviews, among other things, the appropriateness of the level of care provided to Federally funded patients in acute care, Skilled Nursing and Intermediate care facilities.

3. Special services expense contributes 13% to the quality of patient health care provided by SNFs. Special services are generally considered to be such items as physical and occupational therapy, and physician prescribed medical equipment and prosthetic and orthotic medical devices. Since it appears that special services are an important component of care, they should be increasingly emphasized in the current monitoring efforts of SNFs and in the development of new, care-oriented SNF regulations.

Recommendation 3

Special services be increasingly emphasized in the current monitoring efforts of SNFs and in the development of new, care-oriented SNF regulations.

4. The 13% contribution of the Medi-Cal patient mix to patient health care appears to be merely a reflection of the higher occupancy in the facilities with high Medi-Cal patient mixes. (The Medi-Cal patient mix is the percentage of Medi-Cal funded patient days to a facility's total number of patient days.)

Recommendation

None

5. The relative contributions of Registered Nurse (RN) and Nurse's Aide (NA) expenses (positive 8% and negative 4%, respectively) and the apparent lack of impact these expenses have on care, suggest that facilities could increase their profits through operational efficiencies by directing future increases in nursing expenses towards the RN component rather than the NA component. This makes sense when one considers that the RN's role in nursing homes is primarily administrative in nature and the aide's productivity depends upon this administrative ability. Thus, the RN's role is crucial for efficient operation. Therefore, the Nursing Home Industry should consider directing future increases in nursing expenses towards the RN component.

Question 1 (Contd.)

Recommendation 4

The Nursing Home Industry consider directing future increases in nursing expenses towards the Registered Nurse component.

6. The number of years a SNF business is owned appears to be an important factor in both facility profit and health care. The average length of ownership for the 24 facilities surveyed was seven years. One way to increase the average length of ownership would be to provide increased opportunities for profits. Profitability could be significantly enhanced by the State monitoring industry occupancy levels and regulating the supply of nursing home beds available as previously discussed.

Recommendation

See Recommendation 2

7. SNFs are categorized by the Health Facilities Division of DHS commensurate with SNFs' respective degrees of compliance with licensing regulations. (For detailed criteria used to group SNFs, see Appendix P.) According to our regression analysis, the extent to which a SNF is in compliance with licensing regulations contributes 22% to profit. Thus, perhaps contrary to popular opinion, it appears that the extent of a SNFs' compliance with licensing regulations is consistent with increased profit.

Recommendation

None

Question 2

What is the present financial capability of nursing homes to improve patient care through paying higher wages, employing more skilled personnel and sponsoring better recreation programs?

Task Force Response

Two basic assumptions are implied in this question. The first is that patient care can be improved through paying higher wages, employing more skilled personnel and sponsoring better recreation programs. The second is that more skilled personnel and better recreation programs cost more.

The financial data gathered on 24 geriatric facilities shows the weighted average profit per patient day (pre-tax) was $.57 for the year ended March 31, 1975. Pertinent data regarding this $.57 is given below:

Average Revenue and Expenses per Patient Day

	Industry Average	Range for Individual Facilities
Revenue	$18.59	$17.21 to $24.64
Expense	18.02	15.74 to 23.16
Profit	.57	-2.67 to 3.18

Based on this $.57 profit per patient day, the average sized geriatric nursing facility in Los Angeles County made only $17,248 pre-tax profit for the year ended March 31, 1975. This amount is computed using a 91 bed facility at 91.1% occupancy. (Ninety-one beds was the average size of the 24 facilities surveyed. 91.1% was the average occupancy of the 24 facilities surveyed.)

On a rate of return basis, the weighted average return on revenue for the 24 facilities was 3.05% for the year ended March 31, 1975. This rate of return does not appear excessive when compared to the most comparable data available regarding the average rate of return for selected hospital chains in the health care industry. According to Standard and Poor's Industry Surveys, the pre-tax rate of return on revenue for 1974 was 8.7%.

It appears that the financial capability of nursing homes to improve patient care through paying higher wages, employing more skilled personnel, sponsoring better recreation programs, etc., is minimal.

The most significant finding in the area of nursing home profitability relates to the Medi-Cal rate. It was previously mentioned that 68% of nursing home patients are Medi-Cal patients. The Task Force findings show that the nursing home industry is losing money on Medi-Cal patients.

Question 2 (Contd.)

The average revenue per patient day received from Medi-Cal patients for the year ended March 31, 1975, was $17.70. The related per patient day expenses were $18.02.

When these per patient day expenses are adjusted for inflation and the incremental costs of recent changes in Title 22 requirements through October 31, 1976, the comparison of per patient day revenue vs. expense for Medi-Cal patients by size of facility is:

Size of Facility	Adjusted Per Patient Day Expense, 10/31/76	Medi-Cal Reimbursement Rate, 10/31/76	Profit (Loss) Per Patient Day
1-59 beds	$22.28	$24.18	$1.90
60-99	22.59	22.34	(.25)
100+	22.00	21.41	(.59)

It appears from this analysis that Medi-Cal patients placed in Los Angeles County nursing homes are being subsidized by other payors (e.g., private pay patients, etc.). This contributes substantially to the financial inability of nursing homes to improve patient care through paying higher wages, employing more skilled personnel and sponsoring better recreation programs. Therefore, the State should re-evaluate the Medi-Cal rate and adjust it to cover all Medi-Cal patient costs and provide for a reasonable rate of return.

Recommendation 5

The State re-evaluate the Medi-Cal rate and adjust it to cover all Medi-Cal patient costs and provide for a reasonable rate of return.

Note

It was not within the scope of this study to determine what a "reasonable rate of return" for SNFs should be. (According to the most recent available data from Standard and Poor's Industry Surveys, the average rate of return on revenue for selected hospital chains in the health care industry for 1975 is 7.7%.) Perhaps, this topic would best be addressed by some future study group from the investment community with the expertise necessary to resolve this issue. We would, however, caution any such future study group to recognize that "rate of return" is a dynamic rather than static concept. All rates of return fluctuate continually in the marketplace in response to a variety of changing economic conditions. One possible approach to dealing with the dynamic nature of rates of return may be to have these rates adjusted periodically by an independent arbitrator mutually selected by the State and Nursing Home Industry. This would provide for the establishment of an unbiased rate of return which would be periodically adjusted to reflect current conditions in the marketplace.

Question 3

Do local nursing facilities follow a uniform system of accounts for identifying costs?

Task Force Response

Although a uniform system of accounts for identifying costs was not in use during our survey period, such a system was scheduled for implementation January 1, 1977 by the California Health Facilities Commission. The implementation of this system should significantly improve the comparability of revenues and expenses among facilities.

Question 4

What is the cost of providing legally and medically acceptable levels of care by type of patients, including allocation of reasonable overhead charges?

Task Force Response

A. Cost of Providing a Legally Acceptable Level of Care

The cost of providing a legally acceptable level of care at October 31, 1976 for geriatric skilled nursing facility patients was computed by the financial survey team to be:

Size of Facility	Cost	Medi-Cal Reimbursement Rate	Profit (Loss)
1-59 beds	$21.90	$24.18	$2.28
60-99	22.20	22.34	.14
100+	21.65	21.41	(.24)

These costs include an allocation of reasonable facility overhead charges but are net of any profit component.

Our approach for determining the minimum cost of providing a legally acceptable level of care was to use the financial information on the homes surveyed to determine the average cost of operating nursing homes that were determined to be in compliance with existing laws and regulations. (For detailed procedures used in computing these costs, see Appendix I.) The determination of compliance was made by the County Department of Health Services' Division of Health Facilities. (For a detailed description of the criteria used for this determination, see Appendix P.)

The costs of providing a legally acceptable level of care determined above, when compared to the Medi-Cal rates in effect, show that the 100+ bed size facilities were losing $.24 per patient day on Medi-Cal patients while facilities in 1-59 bed range were making $2.28 per patient day. Facilities in the 60-99 bed group were making $.14 per patient day (pre-tax) on Medi-Cal patients.

As previously recommended, the State should reduce the rate differentials used for the various sizes of facilities. Further, the State should ensure that Medi-Cal reimbursement rates cover the cost of a legally acceptable level of care for geriatric patients in all SNFs.

Recommendation 6

The State ensure that Medi-Cal reimbursement rates cover the cost of a legally acceptable level of care for geriatric patients in all SNFs.

B. Cost of Providing a Medically Acceptable Level of Care

The cost of providing a medically acceptable level of care at October 31, 1976 for geriatric skilled nursing facility patients was computed by the financial survey team on the basis of medical criteria provided by the County Department of Health Services and financial data gathered during the survey. (For detailed procedures used in computation see Appendix I.)

The criteria selected for determining a medically acceptable level of care provided by a Skilled Nursing Facility consist of a combination of health care and psycho-social-activity factors. These factors were incorporated into two quality of care measurement indices: the HC and PSA indices (see Appendix H). While the criteria are basic and apply to all patients, they are not all inclusive of the individual needs of each patient which may include physician or other care needs outside the scope of the SNF's direct responsibility.

While the Task Force is in general agreement that any determination of medically acceptable SNF care must include both health care and psycho-social-activity factors, some qualification is necessary regarding the extent to which psycho-social-activity care could be adequately measured. The problem stems from the use of the patient medical record as the basis for psycho-social-activity care measurement. Although the patient medical record constituted the study's only objective basis for care measurement, it was not believed to be sufficient for adequate measurement of the actual level of psycho-social-activity care provided. This problem is of particular concern since no objective basis has been developed to measure the presence or absence of the caring and concern that is shown in the staff-patient relationship. Both the Task Force and TAC believe that a primary goal of some future study should be the development of such an objective basis.

As a result of this problem, the Task Force decided to delete the PSA index from the correlation and regression analyses segments of this study. However, despite the preceding problem, it was decided to use the PSA Index as one essential criterion in determining the cost of providing a medically acceptable level of care for comparison with the Medi-Cal reimbursement rates. In addition, it was decided to present the costs of an acceptable level of care based on the HC and PSA indices individually for comparison with the Medi-Cal reimbursement rates. The approach used by the Task Force for this determination was to use surveyed facilities meeting the determined criteria for acceptability and to determine the average cost expended by those facilities per patient day.

The costs, by size of facility, of providing a medically acceptable level of care at October 31, 1976, and a comparison of those costs

Cost of Providing a Medically Acceptable Level of Care (Contd.)

to the Medi-Cal reimbursement rates, is:

Based on HC and PSA Indices Combined

Size of Facility	Cost	Medi-Cal Reimbursement Rate	Profit (Loss)
1-59 beds	$21.25	$24.18	$2.93
60-99	21.56	22.34	.78
100+	21.01	21.41	.40

The costs, by size of facility, of providing acceptable levels of care at October 31, 1976, on the basis of the HC and PSA indices individually, and a comparison of those costs to the Medi-Cal reimbursement rates are presented below:

Based on HC Index Only

Size of Facility	Cost	Medi-Cal Reimbursement Rate	Profit (Loss)
1-59 beds	$22.33	$24.18	$1.85
60-99	22.63	22.34	(.29)
100+	22.08	21.41	(.67)

Based on PSA Index Only

Size of Facility	Cost	Medi-Cal Reimbursement Rate	Profit (Loss)
1-59 beds	$21.10	$24.18	$3.08
60-99	21.41	22.34	.93
100+	20.86	21.41	.55

These costs include an allocation of reasonable facility overhead charges but are net of any profit component.

As can be seen from the above tables, the Medi-Cal reimbursement rate is generally sufficient to meet the costs of providing an acceptable level of care except in the case of the 100+ bed size facilities. This is consistent with our previous finding that the current disparity by size of facility among the Medi-Cal reimbursement rates is too large and should be narrowed to equalize SNF per patient day profits among all nursing homes regardless of size.

Recommendation

See Recommendation 1.

Question 5

What are the minimum standards prescribed for staffing and services?

Task Force Response

A. Staffing

The staffing patterns of the 24 facilities were reviewed by the medical survey team. Only members of the staff available for "hands-on" patient care were included in the review (e.g., Registered Nurses, Licensed Vocational Nurses and Nursing Aides). In general, the Registered Nurse's duties revolve around supervision and nursing administration. The Licensed Vocational Nurse (LVN) usually administers medications and treatments while the aides perform most of the direct patient care. Based on observation and inquiry, it is apparent that productivity and efficiency are dependent upon the supervision of the Registered Nurse. The following table indicates the average nursing staff ratios.

NURSING STAFF RATIOS

	Average Staff Ratios			Average Nursing Hour Ratio (Hours)		
Shift	Patient/ Aides	Patient/ Licensed Staff	Total Staff	Aide	Licensed Staff	Total Staff
Day	9.58	42.91	7.78	.86	.20	1.05
Evening	15.95	49.02	11.87	.51	.18	.69
Night	26.66	78.33	18.90	.33	.12	.44
24 hour	4.81	16.94	3.73	1.69	.49	2.18

The patient/staff ratio indicates the number of patients assigned to each staff member during a work shift while the nursing hour ratio* (N.H.R.) is the average allocation of staff time for individual patient care. The average nursing hour ratios, when translated into an allocation of time per individual patient, show that, in a 24 hour period, a patient averages 101 (1.69 x 60 minutes) minutes of the aide time and 29 (.49 x 60 minutes) minutes of licensed staff care or supervision. It should be noted that this time may be spent in non-contact duties such as charting of medical data.

A high nursing hour ratio implies more care per patient. While the availability of nursing staff does not assure quality care, it does make it possible to provide the service. It was evident from our survey that the quantity of the nursing personnel did not necessarily ensure quality care. This observation was supported by the minimal correlation between the health care index and the total nursing staff N.H.R. (-.20).

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* N.H.R. formula: $\frac{\text{total hours worked}}{\text{patient census}}$ = nursing hour ratio

Question 5 (Contd.)

Therefore, it is concluded that it is the skill, ability and motivation of the staff members that result in quality care. Since it appears that increasing staffing levels (standards) would not necessarily improve the quality of care provided, it would be more appropriate to concentrate on the improvement of the current nursing staff.

Nursing staff could potentially be improved by increasing wages which would attract more qualified personnel (see Recommendation 10) and implementing additional training programs with proper attention given to the social-emotional as well as the technical aspects of geriatric care. (For a detailed discussion of nursing staff training programs, see Other Findings and Conclusions - Medical.)

Although the 24 hour nursing hour ratio for all nursing staff does not correlate significantly with the quality of patient care, the following correlations of the aide nursing hour ratios with the profit and care indices provide some information regarding efficient allocation of aide staff to various hourly shifts.

Aide Nursing Hour Ratios Correlated with Profit per Patient Day and the Health Care Index - 24 Facilities

Shift	Health Care Index	Profit
7-3	.18	.40
3-11	-.36	-.20
11-7	-.15	.09
24 hour	-.11	.19

The table above indicates that those facilities which allocate a greater portion of their total aide nursing hours to the morning shift (7-3) experience both better overall care and increased profit. Conversely, it appears that facilities with a larger percentage of their aide hours allocated to the evening shift (3-11) sustain losses in both the overall quality of care provided and profit. These correlations show that even though 24-hour staffing ratios do not significantly affect care, staffing patterns by individual shift can appreciably impact not only care, but profit also.

To improve SNF operations, the State should advise SNFs of the benefits for improved care and profit through efficient scheduling of nursing aide staff.

Question 5 (Contd.)

Recommendation 7

The State advise SNFs of the benefits for improved care and profit through efficient scheduling of nursing aide staff.

B. Services

The standards for SNF services as stipulated in Title 22 of the California Administrative Code are generally sufficient to provide for an acceptable level of SNF care. However, we did identify some significant deficiencies in the actual services provided by the facilities surveyed. These included inadequate patient admission assessments by physicians, irregular physician visits, lack of physician attention to patients, numerous charting errors of physician orders, inadequate transfer records, alteration of planned meals, inadequate feeding assistance, unpleasant dining areas and lack of coordinated rehabilitation programs. Our detailed analyses of these deficiencies in SNF services and the corresponding recommendations to alleviate the conditions are contained in the Other Findings and Conclusions - Medical section of this report.

Question 6

Do objective bases exist by which quality of care provided can be measured?

Task Force Response

Interest in the measurement of quality of care was documented at least 100 years ago, yet, even today, it remains an elusive concept. The expression "quality care" generally denotes a degree of concern and excellence in providing nursing care, social and emotional support and appropriate individualized and group activities. Several recent studies have been made in an attempt to define and evaluate the quality of long-term nursing home care. Each study reports limitations of evaluative instruments and results.

We evaluated the quality of care based on three criteria: process criteria, outcome of care criteria and structural criteria.

Process criteria are related to the actions of the licensed nurses, nurse's aides and physicians towards the patients. Process criteria were evaluated largely through the use of extensive questionnaires derived primarily from a Department of Health, Education and Welfare study.

The outcome of care criteria reflect what happened to the patient as a result of medical intervention and were evaluated by direct observation of the patient.

Structural criteria relate to the physical facility, staff and administrative policies and procedures. These criteria were evaluated through the use of questionnaires. These latter criteria, structural criteria, are not as closely related to direct patient care. Structural criteria relate to environmental factors rather than direct patient care considerations. For this reason, our evaluation of quality of care focused on the process and outcome of care criteria with primary emphasis on process criteria.

The only available objective source of information for measuring process care in our study was the medical records of the patients included in our survey. Therefore, our examination of the quality of care provided focused on the patients' medical records.

The adequacy of the medical records as a basis for the assessment of patient care actually provided is largely dependent upon: (1) the conscientiousness of the SNF staff in documenting such care, and (2) the relevance of the documentation in relation to the patients' needs, problems, etc. The medical records in the facilities surveyed were often deficient. Documentation was inaccurate, poorly organized, and lacking in coordinated plans for delivery of care.

Question 6 (Contd.)

Our findings indicate that although medical records exist as an objective basis for measuring the quality of care provided by SNFs, they are not maintained adequately enough to properly accomplish this purpose. While a new medical record system is not a panacea for the problem of objectively measuring quality of care, a Problem Oriented Medical Record System (POMRS) would provide a more objective basis for measuring patient care by: (1) defining patient problems, and (2) providing a means for recording the identification and provision of services necessary for the resolution of those problems. (See Appendix Q for supplemental information regarding the POMRS.)

Also, a POMRS would provide valuable objective data for ongoing chart audits by the SNF staff, the Professional Standards Review Organization, or other agencies responsible for assessing the quality of patient care in nursing homes.

Recommendation 8

A Problem Oriented Medical Record System be mandated for all SNFs.

Question 7

Is there a correlation between the sources of payment to nursing homes and the kind of care a patient receives?

Task Force Response

It appears that only the governmental sources of payment affect the quality of care provided by skilled nursing facilities.

The correlation coefficients showing the relationships between the major sources of payment and the Health Care index are shown in the table below:

Source of Payment	Health Care Index	Average Reimbursement Rate
Medi-Cal	.35	$17.70
Private Pay	-.11	19.80
Intermediate	-.47	14.17
Medicare	.17	17.68

Both the Medi-Cal and Medicare sources of payment correlated somewhat positively with the Health Care index. The positive influence of these governmental revenue sources is not readily explainable. Some possible explanations include increased inspection reviews by licensing and/or funding agencies and increased occupancy in facilities with large Medi-Cal patient mixes. In contrast, the intermediate care source of payment (also funded by the government) correlates negatively with the quality of care. This highly negative correlation is probably indicative of the tendency for unprofitable, low occupancy homes (and thus more likely providers of poorer quality medical care as shown previously) to accept Intermediate patients in an attempt to more fully cover their fixed expenses. This is supported by the negative correlation of Intermediate patient percentage with total facility occupancy (-.71) and the positive correlation of indirect (fixed) expenses with the Intermediate patient percentage (.37).

It should be noted that, historically, the intermediate care reimbursement rate has been substantially below the SNF rate due to the decreased severity of the Intermediate patient needs. Therefore, Intermediate patients tend to be "less desirable" from a fiscal standpoint and, thus, are only sought by low occupancy facilities in an attempt to cover their fixed expenses.

There was no significant correlation between the percentage of private pay patients and the quality of care provided.

OTHER FINDINGS AND CONCLUSIONS

In addition to the analyses and conclusions previously cited in response to the Los Angeles County Board of Supervisors' questions, supplemental analyses of the data gathered were performed and conclusions drawn by the financial and medical survey teams. While some of the conclusions developed from these supplemental analyses are identical to those previously discussed, these analyses involved a separate analytical approach. The separate analyses provide additional support to further reinforce the conclusions already made. Other conclusions from these separate data analyses address areas not previously evaluated.

Financial

A. Facility Characteristics

It is commonly assumed by the nursing home industry that the following facility characteristics significantly affect nursing home profits, costs and quality of care provided. The facility characteristics were correlated with various components of profit, costs and quality of care in an attempt to determine their affect on these components. The following are our analyses of the relationships indicated by the correlations.

1. Owner vs. Non-Owner-Operated

Owner-operated facilities appear to be more efficient. They provided at least the same level of health care (.14) as non-owner-operated facilities but at less cost per patient day. Therefore, our findings indicate governmental agencies could reduce the costs of long term SNF care by emphasizing placement of patients in owner-operated facilities.

Recommendation

See following Recommendation

2. Facility Size

Facilities with smaller numbers of licensed beds (less than 100 beds) tend to provide better patient care as measured by the health care index (.27). They also appear to generate superior profits per patient day (.29). These superior profits are due primarily to the higher Medi-Cal reimbursement rate paid to smaller facilities. Smaller facilities also appear to be more efficient as they are able to provide better care with no significant increase in expenses (.04). This increased efficiency appears to be due to the tendency for smaller facilities to be owner-operated (.29). Therefore, to maximize the use of taxpayer funds, governmental agencies should emphasize placement of SNF patients in smaller, owner-operated facilities.

Recommendation 9

Governmental agencies emphasize the placement of SNF patients in smaller (less than 100 beds), owner-operated facilities.

Facility Characteristics (Contd.)

3. Occupancy Percentage

Facilities with high patient occupancy generate increased profits (.71), reflecting better "coverage" of indirect costs (.55), especially property related expenses (.56). Also, as has been previously shown, higher occupancy results in the provision of better patient care as measured by the health care index (.50). These relationships are consistent with previously cited findings based on regression analysis of the data gathered.

Recommendation

See Recommendation 2

4. Employee Turnover Percentage

The nursing home industry's 200% average annual employee turnover rate (per our survey) adversely affects patient care (-.43) and also results in increased facility nursing expenses (.49), especially in the Licensed Vocational Nurse (.33) and Nursing Aide (.23) categories. This high turnover is probably the result of inadequate nursing staff wages.

According to a study done by the California Association of Health Facilities, the average wages paid nursing personnel by Skilled Nursing Facilities were substantially below those paid by State and private hospitals. For example, during 1975-76, the average hourly wage paid to an RN by a SNF was $4.87 compared with $7.12 by a State hospital. A nurse's aide was paid $3.78 by the State but only $2.29 by the SNF.

Since high employee turnover appears to be consistent with both low nursing wages and high nursing expense, it is apparent that the high nursing expense must be caused by a larger number of nursing personnel, rather than higher wages. This seems to indicate that in facilities with high employee turnover, more employees of lesser quality are needed to accomplish the same amount of work that is being performed by a given number of higher quality nursing staff in a home with lower employee turnover.

To enable SNFs to compete with other health care providers for quality nursing staff, the State should increase the Medi-Cal reimbursement rate to provide for competitive nursing staff wages. Competitive nursing staff wages would be helpful in reducing the industry's high employee turnover rate which adversely affects care.

Employee Turnover Percentage (Contd.)

Recommendation 10

The State increase the Medi-Cal reimbursement rate to provide for competitive nursing staff wages.

5. Management Fees

Facility management fees appear to have little impact on SNF financial operations and the quality of care provided. Although homes without management fees are more profitable ($.92 per patient day) and provide at least the same level of care (.12) as facilities with management fees, their increased profitability is due to their smaller size (.44) and, thus, higher Medi-Cal reimbursement rate, not the fact that they do not have a management fee. Further, total expenses for homes without management fees vary little with those homes with management fees, indicating that management fees do not affect operational efficiency.

Recommendation

None

6. Profit or Loss

Facilities generating superior profits also provide better care (.46) probably because of their higher occupancy (.72). Profit facilities also tend to generate more revenue per patient day than the loss facilities (.23) primarily due to their tendency to have less beds (.44) which results in a higher Medi-Cal rate (.36). Profit facilities also appear to be more efficient probably because they tend to be owner-operated (.41). Profit facilities provide better care for less cost as both the direct care and indirect cost components per patient day are less for the profit facilities than for the loss facilities ($11.88 vs. $12.44 and $5.81 vs. $6.55). Therefore, occupancy, size and owner-operation of a facility are again shown to significantly impact on profit, care and efficiency of nursing home operations.

Recommendation

See Recommendations 2, and 9.

Facility Characteristics (Contd.)

7. Leased vs. Owned Property

Owned facilities generate superior profits per patient day primarily due to reduced indirect expenses per patient day ($5.58 vs. $6.17 for leased facilities), especially property related ($2.30 vs. $3.15).

Since profit is assumed to be essential for the continued existence of SNFs, the State may want to consider subsidizing leased facilities by reimbursing for indirect expenses on a facility-by-facility basis. This could increase the profits in those facilities with high indirect expenses. However, it should be noted that our study indicates that higher indirect expenses do not significantly impact on the quality of care provided (.01). Also, reimbursement of indirect costs on a facility-by-facility basis would reduce these facilities' incentive to contain indirect costs through operating and purchasing efficiencies. Further, under such a system, the State and the SNFs would incur increased administrative costs for the preparation and audit of provider cost reports. For these reasons, the Task Force feels that reimbursement of indirect costs on a facility-by-facility basis is not a practicable alternative to the present flat-rate system.

Recommendation

None

8. Age of Facility

It has been suggested by the Nursing Home Industry that older facilities are more profitable due to decreased property related expenses. However, we found that these costs tended to be offset by increased plant operation and maintenance expenses in the older homes. In fact, newer facilities appeared to be more efficient. Newer homes provided relatively the same level of care with less revenue per patient day and less total expenses per patient day, especially the direct cost component. We believe this increased efficiency was primarily the result of the tendency for newer facilities to be owner-operated (.43). Therefore, it appears that the age of a facility does not significantly affect profitability.

Recommendation

None

Facility Characteristics (Contd.)

9. Number of Years Business Owned

Businesses which have been owned for longer periods of time generate superior profits primarily resulting from increased efficiency (provision of equal or better care at less cost).

This is probably due to the increased expertise of management. Total expenses per patient day decline as the number of years a business is owned increases. This is a function of the decline in both the direct care and indirect cost components. The quality of care provided remains relatively constant.

As was previously discussed in the answer to Board question 1, the number of years a business is owned appears to be an important factor of both facility profit and health care, and thus, ownership turnover in SNFs should be discouraged by providing increased opportunities for profits in the industry. Profitability could be significantly enhanced by the State monitoring of industry occupancy levels and regulating of the supply of nursing home beds.

Recommendation

See Recommendation 2

10. Revenue Mix

Facilities with a large percentage of Medi-Cal patients appear to generate greater profits per patient day (.29) and provide better care as measured by the Health Care index (.35).

The increased profit is generated despite the tendency for total revenue per patient day to decline as a facility's percentage of Medi-Cal patients increases (.56) because total expenses per patient day decline even more (.69), especially the direct care components (.64). This increased profit and care is probably due primarily to increased occupancy (.41) (as previously shown) and the tendency for these homes to be owner-operated (.44) and, therefore, more efficient.

Recommendation

None

B. Correlation Analysis

The following correlation tables are presented here for analysis of the inter-relationships among the industry's revenues, expenses

Correlation Analysis (Contd.)

and profits and the overall impact of these factors on health care provided.

Revenue Per Patient Day	Correlation Coefficients: Pre-Tax Profit Per Patient Day	Health Care Index	Average Reimbursement Rate
Medi-Cal	.44	.08	$17.70
Medicare	-.43	.06	17.68
Private	-.23	.06	19.80
Intermediate	-.38	-.35	14.17
V.A.	-.02	-.07	18.96
Ancillary Services & Other	.11	.17	.69
Total Revenue	.23	.19	18.59

Observation

The Medi-Cal rate per patient day, which is a function of a facility's size, is the single largest revenue determinant of pre-tax profit per patient day. Therefore, if profit is to be improved through increased revenues, increasing the Medi-Cal revenue component will have the most significant impact.

Expense Per Patient Day	Correlation Coefficients: Total Expense Per Patient Day	Pre-Tax Profit Per Patient Day	Health Care Index
Special Services	.69	-.05	.26
Nursing	.51	-.27	-.26
Dietary	.57	-.04	-.03
Social Services	-.07	-.32	.09
Housekeeping	.36	-.36	-.35
Laundry & Linen	.51	-.29	.05
Direct Care	.87	-.30	-.06
Plant Operation & Maintenance	.30	-.18	.19
General & Administrative	.19	.05	.04
Property Related	.22	-.68	-.07
Other	.10	.04	-.10
Indirect Care	.37	-.53	.01
Total	1.00	-.55	-.06

Observations

The direct care expense component of total expense per patient day is by far the most significant determinant of total expenses per patient day. However, the indirect expense component, especially property related expenses, correlates negatively (more strongly) with pre-tax profit. The State may want to consider increasing facility profits by reimbursing for indirect expenses on a facility-by-facility basis (See previous discussion of Facility Characteristics - Leased vs. Owned Property).

Correlation Analysis (Contd.)

Perhaps one of the most significant findings of this study is that there is little correlation between cost and quality of care provided by SNFs. Therefore, governmental agencies should exercise due caution in justifying cost based medical reimbursement programs on the basis of increased care expectations.

Recommendation 11

Governmental agencies exercise due caution in justifying cost based medical reimbursement programs on the basis of increased care expectations.

C. Alternatives to the Medi-Cal Reimbursement System

The current Medi-Cal reimbursement system functions on the basis of state-wide flat rates stratified by bed size to reflect economies inherent in larger scale operations. These flat rates are developed from a cost study of financial data submitted by the California Association of Health Facilities for a sample of SNFs. Audit verification is performed by the State on a sub-sample of the facilities for which data has been submitted, adjustments are made and the median costs of the study are used to set the rate. This method appears to be consistent with federal law which requires Medicaid (Medi-Cal in California) SNF rates to be "reasonably cost related".

Alternatives to the State's current reimbursement system basically fall into two categories:

1. "Cost plus profit" - Similar to the reimbursement system currently employed by the federal Medicare program; and
2. "Incentive based" - Similar to a plan used in Connecticut until recently, whereby providers of nursing care were "financially rewarded" for giving increased levels of care as determined by regular monitoring surveys.

Both of these alternatives offer the advantage of reimbursement on a facility-by-facility basis. Also, method #1 provides recognition of the impact of inflation over time and increased care requirements. The latter method, however, does not appear to be consistent with the recent federal law requiring Medicaid reimbursement systems to be "reasonably cost related". For this reason, Connecticut discontinued their "incentive-based" reimbursement system.

The disadvantages of the "cost plus profit" system when compared with the current flat rate system include the following:

1. The SNFs would have no incentive to contain costs through operating and purchasing efficiencies except, perhaps, if maximum reimbursement ceilings were set.

Alternatives to the Medi-Cal Reimbursement System (Contd.)

2. The State would incur increased administrative costs for field and desk audits of provider cost reports, start-up costs of a new reimbursement program and record-keeping of provisional payments to providers for use in year-end cost settlements.

3. The system would impair the State's ability to forecast budgetary requirements since estimates of program costs would not only vary by the volume of patients but also by the fluctuating costs of individual facilities.

4. Provider costs would be increased for preparation of, and audit responses to, facility cost reports.

In addition to these disadvantages of the "cost plus profit" system, both alternative reimbursement systems are based on the premise that cost is positively correlated with quality of care. As previously mentioned, this study does not support this assumption. In fact, those facilities which have the largest percentage of "flat-rate" reimbursement Medi-Cal patients also spend the least per patient day and provide care equal in quality to those facilities having less "flat-rate" reimbursement patients.

For these reasons, we believe that the State's current reimbursement system, with a few modifications, is best suited to meet both the "care" requirements of the patient and the fiscal constraints of the governmental agencies which reimburse these costs. Modifications to the current system should include:

1. Stratification of reimbursement rates by geographical regions

Although the facilities surveyed in this study were confined to Los Angeles County, recent cost data accumulated by accounting representatives of the California Association of Health Facilities indicate that the cost of operating a Skilled Nursing Facility in Los Angeles County differs significantly from the cost in other regions of the State (See Appendix K for regional cost breakdown).

2. Adjustment of reimbursement rates to compensate for spiraling costs

Traditionally, the State has not recognized increases in facility costs due to inflation until an industry cost study was completed. The time lag between the increase in a facility's costs and an increase in the reimbursement of those costs created by this system forces facilities to absorb inflationary costs which eventually could affect patient care.

To alleviate this problem, reimbursement rates should be adjusted quarterly to reflect the impact of inflation on the costs which are the basis for the reimbursement rate. Periodic cost studies should be completed to ensure the accuracy of the quarterly rate adjustments.

Alternatives to the Medi-Cal Reimbursement System (Contd.)

3. The property related cost component of the Medi-Cal reimbursement rate should be based on actual facility occupancy rather than on an arbitrarily determined 90% occupancy rate

Historically, the State has computed the property related cost component of the Medi-Cal reimbursement rate on a 90% occupancy basis. This results in over-reimbursement for those facilities with greater than a 90% occupancy rate and under-reimbursement for those with less than the 90% rate.

Recommendation 12

The State: -stratify reimbursement rates by geographic region.

-adjust reimbursement rates quarterly to reflect the impact of inflation on the SNFs' costs.

-base the property related cost component of the Medi-Cal reimbursement rate on actual facility occupancy.

Att B

Attachment I

Appendix B

Administrator Self-Evaluation Form

	Excellent	Adequate	Needs Attention	Comments
Administration				
Meaningful Policies				
Structure/Organization/Communication				
Patients/Families/Community Relations				
Nursing				
Quality of Nursing Care				
Quality of Nursing Supervision				
Dietary				
Resident Satisfaction with Meals				
Dietary Department Supervision				
Therapeutic Diet Management				
Housekeeping, Maintenance, Laundry				
General Cleanliness & Appearance of Facility				
Safe Environment				
Department Supervision				
Facility Linen Service				
Patients' Personal Laundry				
Recreation, Social Services				
Meaningful Social Activities				
Patient participation & involvement				
Management & supervision				
Staff support of Activities Program				
Supportive Services				
Availability & Utilization of:				
Physical Therapy				
Dental Therapy				
Podiatry				
Speech Pathology				
Occupational Therapy				

Att. I

Attachment I

August 22, 1977

TO: Members of the Governor's Advisory Council

We believe the nursing home industry to be a vital part of the free enterprise system and should not be expected or mandated to assist in the funding of the Medicaid program to the extent that the State has expected in past years.

In order to support our position, we direct your attention to the Seneca Manor lawsuit that has found the State Department of Social and Rehabilitation Services to be in violation of the statutes and the findings were upheld by the Tenth Circuit Court of Appeals and a hearing before the U. S. Supreme Court was denied. At the present time, judgments and interest on 16 claims have been rendered by the Federal District Court in an amount slightly under one million dollars ($1,000,000). The judgments are presently being appealed to the Tenth Circuit Court of Appeals.

It is our opinion that the best solution to the items you are charged with is to eliminate the source of the problem--this being the present reimbursement method.

As the program exists today, there is nothing reasonable about its framework or results in delivery of quality care to the nursing home resident. How can a program that provides no profit factor and pays 42.46 percent of the providers for cost of services delivered and the remaining facilities receive an amount less than cost be classified as a reasonable program.

A quick recap of the 325 providers of adult care services using the Kansas Department of Social and Rehabilitation Services' reimbursement data reflects the following:

	ICF FACILITIES	SKILLED FACILITIES	TOTAL FACILITIES
Facilities Listed	279 - 85.85%	46 - 14.15%	325 - 100.00%
Reimbursed - Full Cost	114 - 35.08%	24 - 7.38%	138 - 42.46%
Reimbursed - Less Than Cost	165 - 50.77%	22 - 6.77%	187 - 57.54%
Reimbursed - Cost & Profit	0 - 00.00%	0 - 00.00%	0 - 00.00%

For your review we have attached 3 pages of Compilation of Cost Centers and Statistical Data - Skilled - 07-05-77 - Schedule B and 8 pages of Compilation of Cost Centers and Statistical Data - ICF - 07-05-77 - Schedule B as prepared by the Kansas State Department of Social and Rehabilitation Services.

Atch. J

The penciled numbers in the extreme right-hand column indicated the allowed cost for each facility utilizing the present complex system of the 75th percentile of four (4) cost centers and an additional percentile limitation on the total to the 75th percentile. We definitely feel the committee must understand how the lack of an adequate reimbursement system creates the problem you are assigned to solve.

COMPILATION OF COST CENTERS AND STATISTICAL DATA - SKILLED 07-05-77 SCHEDULE B

PROJ NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN. (4.03)	PROPRTY (4.25)	RM & BD (6.51)	HLTH. CR (10.31)	TOTAL (24.23)	
0515	18	90.4	2.07	2.33	5.86	7.78	18.04	5.60	4.00	2.18	2.48	6.23	8.09	18.98	
0516	104	88.9	1.99	2.14	10.60	10.71	25.44	13.80	4.00	2.12	2.42	12.42	11.30	28.26	21.36
0526	70	85.0>	6.55	4.32	6.78	10.09	27.74	5.60	4.00	6.99	4.53	7.20	10.53	29.25	24.23
0528	38	94.0	6.71	3.33	7.98	9.26	27.28	5.60	4.00	7.20	3.45	8.47	9.70	28.82	23.69
0529	36	94.4	4.71	3.28	7.18	9.86	25.03	5.60	4.00	5.03	3.47	7.66	10.31	26.47	24.23
0534	21	96.7	4.21	2.42	5.91	10.19	22.73	11.80	4.00	4.54	2.60	6.42	10.67	24.23	23.36
0535	33	95.5	4.21	2.78	6.78	10.33	24.10	13.80	4.00	4.60	2.99	7.49	10.84	25.92	23.84
0541	36	96.7	3.91	3.50	6.31	7.58	21.30	7.20	4.00	4.21	3.68	6.75	7.92	22.56	22.14
0549	20	92.5	5.16	3.60	6.81	11.69	27.26	13.80	4.00	5.83	3.79	7.43	12.29	29.34	24.23
0550	28	98.5	3.75	3.61	5.96	8.45	21.77	13.80	4.00	4.22	3.84	6.51	8.84	23.41	23.82
0551	40	95.6	3.62	4.00	6.84	10.64	25.10	13.80	4.00	3.95	4.25	7.51	11.20	26.91	24.23
0556	33	85.0>	2.23	3.63	6.14	8.99	20.99	5.60	4.00	2.35	3.76	6.53	9.36	22.00	21.93
0557	132	98.7	3.58	7.01	4.91	10.00	25.50	13.80	4.00	4.03	7.30	5.46	10.75	27.54	24.05
0564	27	86.5	7.19	5.39	9.14	14.36	36.08	5.60	4.00	7.63	5.57	9.76	15.01	37.97	24.23
0566	174	85.0>	3.84	5.70	5.55	13.88	28.97	13.80	4.00	4.30	5.96	6.19	15.03	31.48	24.23
1000	59	94.8	2.26	2.44	3.19	5.61	13.50	13.80	4.00	2.49	2.62	3.61	5.90	14.62	
1009	196	85.0>	2.18	3.82	4.62	6.94	17.56	13.80	4.00	2.31	3.98	5.16	7.25	18.70	
1010	88	97.4	2.89	3.47	3.24	5.39	14.99	11.80	4.00	3.11	3.62	3.58	5.64	15.95	
1012	200	85.0>	2.17	5.25	3.61	7.70	18.73	5.60	4.00	2.31	5.36	3.88	8.13	19.68	18.57
1013	300	97.2	1.57	3.18	3.26	7.01	15.02	13.80	4.00	1.75	3.32	3.65	7.33	16.05	
1014	200	99.0	2.77	3.61	3.89	7.02	17.29	6.80	4.00	2.97	3.73	4.21	7.37	18.28	
1016	125	94.8	2.42	2.05	3.94	7.02	15.43	5.60	4.00	2.53	2.15	4.24	7.31	16.23	
1023	150	89.6	1.88	3.04	3.09	5.48	13.49	13.80	4.00	2.00	3.22	3.46	5.82	14.50	
1024	50	97.5	2.97	3.88	3.77	5.04	15.66	5.60	4.00	3.12	4.01	4.04	5.24	16.41	
1025	284	97.9	2.14	2.95	3.91	5.83	14.83	6.80	4.00	2.30	3.04	4.20	6.10	15.64	
1027	100	86.5	3.38	4.65	4.70	8.12	20.85	6.80	4.00	3.64	4.80	5.05	8.56	22.05	21.50
1028	92	98.9	2.28	2.88	3.53	5.48	14.17	13.80	4.00	2.44	3.05	3.95	5.76	15.20	
1030	100	93.6	3.51	2.09	3.54	7.44	16.58	11.80	4.00	3.78	2.25	3.92	7.80	17.75	
1031	41	85.0>	2.21	1.90	3.88	12.51	20.50	13.80	4.00	2.42	2.04	4.32	13.25	22.03	19.08
1033	100	95.9	3.16	3.60	3.76	7.27	17.79	13.80	4.00	3.54	3.78	4.19	7.75	19.26	
1034	167	89.1	1.64	3.69	5.02	5.89	16.24	13.80	4.00	1.83	3.91	5.54	6.16	17.44	
1039	136	97.2	3.45	1.65	5.51	8.38	18.99	5.60	4.00	3.67	1.74	5.86	8.74	20.01	
1043	200	97.6	2.42	3.72	3.12	6.59	15.85	6.80	4.00	2.59	3.85	3.36	6.90	16.70	
1045	68	97.5	2.30	2.98	3.39	5.29	13.96	13.80	4.00	2.51	3.15	3.79	5.53	14.98	
1047	100	85.0>	3.76	3.90	4.97	8.37	21.00	5.60	4.00	3.91	3.99	5.33	8.77	22.00	
1048	100	91.2	2.15	4.05	4.05	6.01	16.26	13.80	4.00	2.30	4.17	4.52	6.32	17.31	
1052	119	98.6	2.92	3.80	3.40	5.07	15.19	13.80	4.00	3.13	3.99	3.79	5.28	16.19	
5	100	97.8	1.98	5.30	3.58	4.41	15.27	13.80	4.00	2.13	5.56	4.01	4.62	16.32	15.01
7	66	96.1	1.71	3.81	4.91	6.57	17.00	5.60	4.00	1.82	3.94	5.25	6.85	17.85	
1058	199	97.6	2.34	3.51	4.69	6.88	17.42	5.60	4.00	2.48	3.58	5.01	7.20	18.27	
1059	200	92.7	2.77	4.58	4.61	7.54	19.50	6.80	4.00	2.98	4.69	4.95	7.90	20.52	20.08
1060	150	88.3	2.70	4.01	4.29	5.80	16.80	5.60	4.00	2.83	4.09	4.58	6.08	17.58	

COMPILATION OF COST LIMITS AND ESTIMATE DATA - MEDICAID - SCHEDULE B

(2)

R P G J	ME NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	
R	1061	100	88.9	3.63	4.66	4.57	6.54	19.40	5.60	4.00	3.89	4.75	4.86	6.83	20.33	19.83
R	1213	126	85.0	7.14	5.99	6.02	15.47	34.62	13.20	4.00	7.77	6.42	6.60	16.75	37.54	24.23
R	1666	107	88.9	3.13	6.71	4.99	5.18	20.01	13.80	4.00	3.41	6.97	5.51	5.42	21.31	18.21
R	1733	108	93.4	1.79	3.28	3.55	4.61	13.23	13.80	4.00	1.95	3.42	3.96	4.83	14.16	

" " " " 22.41

R G	HOME NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL
	HIGH	300	99.0	7.19	7.01	10.60	15.47	36.08			7.77	7.30	12.42	16.75	37.97
	99TH	300	99.0	7.19	7.01	10.60	15.47	36.08			7.77	7.30	12.42	16.75	37.97
	95TH	200	98.7	6.71	5.99	7.98	13.88	28.97			7.20	6.42	8.47	15.01	31.48
	90TH	200	97.9	4.71	5.30	6.81	10.71	27.28			5.03	5.56	7.49	11.30	28.82
	85TH	196	97.6	4.21	4.66	6.78	10.33	25.44			4.54	4.80	7.20	10.84	27.54
	80TH	167	97.5	3.84	4.58	6.14	10.09	25.03			4.22	4.69	6.60	10.67	26.47
	75TH	150	97.4	3.75	4.05	5.96	9.86	22.73			4.03	4.25	6.51	10.31	24.23
	70TH	126	96.7	3.58	3.90	5.55	8.45	21.00			3.89	4.01	6.19	8.84	22.05
	65TH	119	96.1	3.45	3.82	5.02	8.37	20.85			3.67	3.99	5.54	8.74	22.00
	60TH	107	95.6	3.16	3.80	4.97	7.78	20.01			3.54	3.94	5.46	8.13	21.31
	55TH	100	94.8	2.92	3.63	4.70	7.54	18.99			3.12	3.84	5.16	7.90	20.01
	50TH	100	94.0	2.77	3.61	4.62	7.27	18.04			2.98	3.78	5.01	7.75	19.26
	40TH	88	91.2	2.34	3.47	3.94	6.88	17.00			2.51	3.58	4.32	7.20	17.86
	30TH	59	88.9	2.23	3.18	3.77	6.01	16.24			2.42	3.32	4.19	6.32	17.31
	20TH	36	86.5	2.14	2.78	3.54	5.48	15.19			2.30	2.99	3.92	5.82	16.19
	10TH	28	85.0	1.88	2.14	3.26	5.18	14.17			2.00	2.42	3.65	5.42	15.20
	1ST														
	LOW	18	85.0	1.57	1.65	3.09	4.41	13.23			1.75	1.74	3.36	4.62	14.16
	MEAN	107	92.8	3.20	3.73	4.99	7.96	19.88			3.46	3.90	5.44	8.37	21.17
	WTMN	136	92.7	2.91	3.92	4.52	7.53	18.88			3.14	4.08	4.95	7.94	20.12
	HOMS	46	46	46	46	46	46	46			46	46	46	46	46

NUMBER OF BEDS

	UNDR 20	20 - 50	51 - 75	76 - 100	OVR 100
HIGH	18.98	37.97	29.25	22.05	37.54
LOW	18.98	16.41	14.62	15.20	14.16
MEAN	18.98	25.50	19.17	18.46	20.30
WTMN		24.58	19.11	18.42	20.05
HOMS	1	12	4	9	20

COMPILATION OF COST CENTERS AND STATISTICAL DATA - ICF — 07-05-77 — SCHEDULE B — (1)

HOME NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	
0504	46	95.0	2.56	2.50	5.76	7.49	18.31	5.60	4.00	2.67	2.52	5.11	7.73	17.83	15.45
0505	26	90.9	4.34	1.35	8.36	9.41	23.46	5.60	4.00	4.33	1.45	8.32	9.30	23.39	14.52
0506	22	101.1	4.59	4.77	6.41	7.08	22.85	11.80	4.00	4.95	5.21	7.24	7.41	24.81	15.12
0508	49	96.9	2.17	2.63	5.65	6.63	17.08	11.80	4.00	2.40	2.82	6.21	6.94	18.37	15.60
0519	16	95.2	3.45	2.32	5.88	6.75	18.40	7.20	4.00	3.68	2.44	6.27	7.05	19.44	15.55
0523	62	90.6	3.55	1.66	6.06	9.80	21.07	13.80	4.00	3.81	1.85	6.71	10.29	22.66	14.67
0524	26	96.4	2.77	4.79	6.82	6.60	20.98	5.60	4.00	2.93	5.09	7.25	6.91	22.18	15.73
0536	20	85.0>	2.32	2.69	6.81	11.23	23.05	5.60	4.00	2.42	2.88	7.26	11.69	24.25	15.47
0537	32	89.2	3.78	2.13	4.44	4.29	14.64	11.80	4.00	4.22	2.29	4.86	4.48	15.85	14.06
0543	125	85.0>	2.30	3.85	5.73	7.99	19.87	13.80	4.00	2.50	4.00	6.44	8.34	21.28	15.71
0552	28	85.0>	2.62	3.16	9.74	14.31	29.83	13.80	4.00	2.83	3.39	10.80	15.13	32.15	15.23
0558	85	98.8	1.57	2.63	3.78	5.50	13.48	11.80	4.00	1.74	2.74	4.39	5.72	14.59	14.42
0559	67	98.1	1.34	2.99	5.40	3.66	13.39	13.80	4.00	1.41	3.23	6.01	3.83	14.48	15.04
0561	34	93.7	3.46	3.77	6.24	8.04	21.51	5.60	4.00	3.66	3.98	6.60	8.37	22.61	15.73
0563	38	92.6	4.25	3.00	7.17	9.91	24.33	5.60	4.00	4.49	3.11	7.61	10.32	25.53	15.73
0565	30	89.4	5.96	3.35	7.81	9.14	26.26	7.20	4.00	6.34	3.48	8.37	9.52	27.71	15.15
1002	105	95.8	2.01	1.83	4.45	8.07	16.36	13.80	4.00	2.18	2.05	4.88	8.42	17.53	14.37
1005	67	95.6	2.47	2.08	4.81	6.78	16.14	5.60	4.00	2.61	2.18	5.23	7.06	17.08	14.93
1006	185	96.6	2.07	2.95	3.55	4.55	13.12	11.80	4.00	2.18	3.10	3.89	4.79	13.96	
1011	100	98.0	1.28	2.95	4.23	4.64	13.10	5.60	4.00	1.36	3.08	4.52	4.84	13.80	
1020	100	95.7	2.91	1.87	5.87	9.24	19.89	5.60	4.00	3.08	1.96	6.23	9.71	20.98	14.80
1044	50	85.0>	2.93	4.27	3.79	4.00	14.99	13.80	4.00	3.16	4.47	4.13	4.22	15.98	14.81
1046	53	95.0	2.16	1.76	3.31	4.81	12.04	13.80	4.00	2.38	1.86	3.65	5.03	12.92	
1049	100	97.5	2.64	3.50	4.02	4.49	14.65	5.60	4.00	2.80	3.59	4.31	4.68	15.38	15.28
1050	50	99.2	2.37	3.58	3.31	4.72	13.98	5.60	4.00	2.45	3.67	3.54	4.92	14.58	
1054	70	85.0>	2.43	3.91	3.32	3.66	13.32	13.80	4.00	2.67	4.04	3.70	3.84	14.25	13.97
1500	60	97.4	1.75	4.19	2.96	5.46	14.36	5.60	4.00	1.80	4.29	3.18	5.70	14.97	14.27
1501	45	95.6	1.74	2.23	2.96	4.24	11.17	5.60	4.00	1.85	2.31	3.16	4.43	11.75	
1502	50	98.9	1.88	1.81	5.30	6.51	15.50	5.60	4.00	1.94	1.93	5.69	6.80	16.36	14.01
1504	144	85.0>	1.93	3.32	2.63	4.01	11.89	6.80	4.00	2.07	3.42	2.81	4.18	12.48	
1505	40	97.4	1.80	3.66	3.46	3.40	12.32	11.80	4.00	1.85	3.80	3.80	3.56	13.01	12.97
1507	60	95.9	1.54	3.87	3.42	5.02	13.85	5.60	4.00	1.58	3.96	3.65	5.25	14.44	14.24
1508	49	93.8	2.47	3.56	1.99	5.13	13.15	11.80	4.00	2.66	3.74	2.26	5.36	14.02	
1510	50	98.0	2.46	2.33	3.85	4.99	13.63	5.60	4.00	2.57	2.48	4.10	5.20	14.35	
1511	50	97.6	2.32	2.28	3.90	5.29	13.79	5.60	4.00	2.41	2.41	4.18	5.52	14.52	
1512	73	91.6	2.40	3.02	3.71	5.31	14.44	13.80	4.00	2.63	3.18	4.14	5.56	15.51	15.50
1515	36	85.0>	2.52	2.64	5.35	7.69	18.20	5.60	4.00	2.65	2.78	5.67	8.03	19.13	15.57
1516	25	92.0	2.70	4.15	5.50	4.61	16.96	13.80	4.00	2.94	4.41	6.01	4.80	18.16	15.25
1519	61	99.4	1.92	2.23	3.41	5.02	12.58	5.60	4.00	2.01	2.32	3.64	5.23	13.20	
1520	48	98.3	1.67	1.71	2.98	4.15	10.51	13.80	4.00	1.81	1.84	3.29	4.32	11.26	
1521	32	99.6	1.87	1.96	3.82	4.91	12.56	6.80	4.00	1.96	2.09	4.11	5.12	13.28	
1522	76	99.8	2.24	1.60	4.26	4.96	13.06	13.80	4.00	2.44	1.73	4.63	5.20	14.00	13.96

HOME NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	
1527	92	90.3	2.07	2.26	3.32	5.22	12.87	6.80	4.00	2.21	2.34	3.57	5.45	13.57	
1530	116	92.0	2.42	3.63	2.98	3.73	12.76	13.80	4.00	2.60	3.83 •	3.34	3.89	13.66	13.59
1531	100	92.0	1.95	3.59	2.71	4.60	12.85	13.80	4.00	2.07	3.78 •	3.04	4.88	13.77	13.75
1534	100	85.0>	1.94	3.76	3.95	4.88	14.53	11.80	4.00	2.07	4.11 •	4.30	5.12	15.60	15.55
1535	50	91.9	2.71	3.65	3.91	4.66	14.93	13.80	4.00	2.87 •	3.87 •	4.38	4.85	15.97	15.89
1536	48	94.3	2.12	2.69	4.79	4.72	14.32	11.80	4.00	2.26	2.84	5.22 •	4.93	15.25	14.62
1537	100	86.7	1.81	3.04	4.67	4.26	13.78	13.80	4.00	1.96	3.28	5.18 •	4.45	14.87	14.28
1539	50	92.0	1.90	1.91	5.07	5.14	14.02	5.60	4.00	1.98	2.00	5.41 •	5.36	14.75	13.93
1541	68	95.8	2.53	2.89	5.35	6.17	16.94	5.60	4.00	2.66	2.97	5.70 •	6.44 •	17.77	15.77
1542	50	96.7	1.93	1.59	3.91	4.67	12.10	11.80	4.00	2.05	1.71	4.31	4.89	12.96	
1543	49	106.7	1.63	2.40	4.02	4.32	12.37	13.80	4.00	1.76	2.59	4.49	4.52	13.36	
1544	50	98.4	2.54	2.20	4.40	4.05	13.19	11.80	4.00	2.74 •	2.32	4.91 •	4.29	14.26	13.90
1545	64	100.4	1.71	2.04	3.61	3.96	11.32	11.80	4.00	1.85	2.17	4.03	4.14	12.19	
1546	50	85.0>	3.05	3.25	5.95	6.43	18.68	5.60	4.00	3.19 •	3.40	6.33 •	6.72 •	19.64	15.71
1547	51	99.0	1.43	1.07	2.86	4.64	10.00	13.80	4.00	1.51	1.19	3.16	4.86	10.72	
1548	50	99.4	1.54	2.91	3.85	5.78	14.08	13.80	4.00	1.68	3.10	4.25	6.04 •	15.07	14.58
1549	46	99.4	2.54	2.64	3.39	5.30	13.87	5.60	4.00	2.65	2.75	3.62	5.52	14.54	
1550	44	93.5	2.26	2.23	2.53	2.66	9.68	11.80	4.00	2.36	2.37	2.77	2.82	10.32	
1551	50	96.2	2.65	1.76	6.21	9.06	19.68	5.60	4.00	2.76 •	1.90	6.60 •	9.46 •	20.72	14.74
1552	51	90.6	2.45	1.58	6.79	7.87	18.69	5.60	4.00	2.53	1.69	7.22 •	8.20 •	19.64	14.36
1553	50	85.0>	2.37	1.85	3.54	4.47	12.23	11.80	4.00	2.53	1.97	3.90	4.68	13.08	
1554	32	96.8	1.83	1.61	3.14	3.29	9.87	5.60	4.00	1.88	1.69	3.33	3.43	10.38	
1555	50	95.3	2.00	1.80	2.58	4.34	10.72	7.20	4.00	2.07	1.88	2.80	4.55	11.30	
1556	60	85.0>	1.85	2.62	2.59	4.21	11.27	5.60	4.00	1.91	2.72	2.77	4.40	11.80	
1557	115	89.2	3.75	3.72	3.92	5.01	16.40	11.80	4.00	4.10 •	3.92 •	4.27	5.26	17.55	15.93
1558	110	85.0>	3.07	3.33	6.15	6.03	18.58	13.80	4.00	3.34 •	3.60	6.76 •	6.33 •	20.03	15.85
1560	40	98.2	2.73	1.20	3.12	4.86	11.91	13.80	4.00	2.94 •	1.29	3.50	5.08	12.81	12.57
1561	50	99.3	1.92	2.51	3.21	5.16	12.80	5.60	4.00	1.97	2.59	3.45	5.38	13.39	
1563	50	95.7	1.75	2.96	3.38	3.96	12.05	13.80	4.00	1.90	3.20	3.74	4.14	12.98	
1565	162	99.5	2.20	2.70	3.27	6.46	14.63	13.80	4.00	2.40	2.86	3.59	6.78 •	15.63	14.40
1567	100	95.0	1.37	2.15	4.56	4.60	12.68	11.80	4.00	1.43	2.33	4.98 •	4.85	13.59	13.20
1571	50	85.3	2.31	3.03	3.73	5.09	14.16	5.60	4.00	2.42	3.19	4.02	5.30	14.93	
1574	46	89.4	1.58	1.86	3.31	4.74	11.49	5.60	4.00	1.64	1.95	3.52	4.94	12.05	
1575	39	86.6	2.80	1.54	3.20	5.75	13.29	5.60	4.00	2.92 •	1.60	3.42	5.99 •	13.93	13.27
1578	41	88.3	2.40	2.83	4.08	5.21	14.52	5.60	4.00	2.49	2.97	4.38	5.43	15.27	
1579	79	92.7	2.32	3.49	4.32	5.18	15.31	7.80	4.00	2.50	3.64	4.64 •	5.42	16.20	15.93
1583	50	89.6	2.25	2.05	3.69	4.97	12.96	13.80	4.00	2.39	2.21	4.08	5.23	13.91	
1584	56	98.1	2.15	3.03	3.82	4.68	13.68	13.80	4.00	2.32	3.19	4.26	4.93	14.70	
1585	46	85.1	2.86	2.50	3.30	4.72	13.38	11.80	4.00	3.15 •	2.66	3.63	4.91	14.35	13.90
8	50	99.7	2.21	2.46	2.71	4.09	11.47	5.60	4.00	2.30	2.56	2.89	4.27	12.02	
9	132	86.0	1.72	2.26	4.11	4.03	12.12	5.60	4.00	1.81	2.38	4.37	4.20	12.76	
1590	42	99.8	1.26	1.47	4.22	3.42	10.37	7.20	4.00	1.31	1.58	4.51	3.56	10.96	

P J	ZONE NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	
	1591	60	97.8	1.94	3.62	4.21	4.54	14.31	5.60	4.00	2.01	3.76	4.49	4.75	15.01	
	1594	94	98.0	2.31	2.78	3.45	3.65	12.19	13.80	4.00	2.45	2.95	3.81	3.82	13.03	
	1596	24	94.4	2.95	2.67	4.39	6.74	16.75	5.60	4.00	3.02	2.77	4.69	7.05	17.53	15.41
	1597	50	92.4	2.27	3.70	4.10	4.69	14.76	13.80	4.00	2.40	3.94	4.65	4.94	15.93	15.69
	1599	44	96.3	2.02	2.29	3.46	4.91	12.68	6.80	4.00	2.15	2.40	3.73	5.12	13.40	
	1601	50	93.8	1.88	2.79	3.64	4.90	13.21	5.60	4.00	1.97	2.91	3.90	5.11	13.89	
	1602	100	99.6	1.75	3.06	4.00	4.86	13.67	13.80	4.00	1.87	3.18	4.37	5.08	14.50	
	1603	50	97.7	1.61	2.55	3.23	3.03	10.42	11.80	4.00	1.67	2.65	3.57	3.16	11.05	
	1604	60	99.2	2.19	2.00	3.30	5.91	13.40	13.80	4.00	2.32	2.13	3.66	6.17	14.28	13.4
	1605	53	95.9	1.82	4.08	2.87	4.26	13.03	11.80	4.00	1.94	4.26	3.17	4.44	13.81	13.31
	1610	94	98.5	1.83	1.84	4.62	5.35	13.64	5.60	4.00	1.90	1.92	4.93	5.58	14.33	13.96
	1612	54	98.6	1.79	2.24	3.85	4.66	12.54	7.20	4.00	1.87	2.37	4.16	4.86	13.26	
	1615	34	97.7	1.69	1.41	4.05	4.83	11.98	13.80	4.00	1.78	1.57	4.53	5.05	12.93	
	1617	75	94.8	2.03	1.66	3.13	5.06	11.88	5.60	4.00	2.08	1.72	3.35	5.27	12.42	
	1618	50	97.6	1.80	2.23	4.09	4.74	12.86	5.60	4.00	1.87	2.31	4.38	4.94	13.50	
	1619	23	99.0	2.77	1.38	2.34	4.97	11.46	5.60	4.00	2.83	1.46	2.50	5.17	11.96	11.85
	1620	96	86.9	2.08	2.06	3.15	4.13	11.42	7.20	4.00	2.16	2.15	3.40	4.33	12.04	
	1621	84	92.4	1.52	1.71	2.08	2.64	7.95	7.20	4.00	1.56	1.78	2.29	2.75	8.38	
	1624	100	95.0	2.98	2.65	3.06	3.87	12.56	6.80	4.00	3.20	2.73	3.30	4.02	13.25	12.75
	1626	50	97.5	2.21	2.71	3.14	5.83	13.89	5.60	4.00	2.31	2.83	3.35	6.09	14.58	14.04
	1628	50	97.8	2.57	2.06	3.57	4.96	13.16	7.20	4.00	2.70	2.14	3.86	5.18	13.88	
	1629	50	93.4	2.15	2.53	3.69	5.38	13.75	5.60	4.00	2.26	2.58	3.94	5.61	14.39	14.33
	1630	50	96.3	1.60	2.79	2.84	3.63	10.86	13.80	4.00	1.74	2.98	3.18	3.78	11.68	
	1631	46	97.9	1.97	3.45	3.54	5.26	14.22	11.80	4.00	2.07	3.59	3.92	5.50	15.08	
	1632	53	98.9	3.22	2.89	4.98	5.18	16.27	6.80	4.00	3.36	3.07	5.31	5.42	17.16	15.72
	1633	50	99.5	3.31	3.22	4.48	5.80	16.81	11.80	4.00	3.62	3.38	4.88	6.07	17.95	15.34
	1635	48	91.9	2.04	1.66	4.36	6.21	14.27	13.80	4.00	2.18	1.79	4.81	6.48	15.26	14.11
	1639	57	96.2	2.08	2.70	3.23	4.67	12.68	7.20	4.00	2.19	2.79	3.48	4.88	13.34	
	1640	48	96.5	2.60	2.11	2.91	4.81	12.43	13.80	4.00	2.81	2.32	3.24	5.00	13.37	13.26
	1641	50	98.9	2.10	3.24	3.94	5.12	14.40	5.60	4.00	2.20	3.35	4.22	5.34	15.11	
	1648	49	98.4	1.95	3.27	3.49	4.66	13.37	7.20	4.00	2.04	3.43	3.82	4.88	14.17	
	1649	100	91.6	2.60	3.22	5.06	9.09	19.97	13.80	4.00	2.82	3.44	5.58	9.65	21.49	15.73
	1650	77	98.0	2.94	2.07	3.69	5.12	13.82	6.10	4.00	3.08	2.16	3.93	5.33	14.50	14.12
	1652	60	93.3	2.46	3.25	4.55	4.16	14.42	11.80	4.00	2.64	3.45	4.99	4.36	15.44	15.04
	1654	50	96.4	2.27	2.70	3.85	4.96	13.78	13.80	4.00	2.50	2.84	4.28	5.21	14.83	
	1655	50	95.7	2.12	2.99	3.73	4.71	13.55	13.80	4.00	2.27	3.17	4.13	4.93	14.50	
	1656	51	94.5	1.85	2.67	3.71	5.32	13.55	7.20	4.00	1.93	2.77	3.98	5.55	14.23	
	1657	100	98.0	1.51	2.90	3.25	3.41	11.07	13.00	4.00	1.62	2.99	3.41	3.58	11.80	
	58	66	92.8	2.12	3.13	4.38	4.68	14.33	6.80	4.00	2.22	3.30	4.72	4.88	15.12	14.94
	59	50	87.7	1.79	2.55	2.70	5.18	12.22	5.60	4.00	1.86	2.66	2.89	5.40	12.81	
	1660	30	99.4	2.75	3.20	5.90	7.56	19.41	5.60	4.00	2.88	3.38	6.32	7.09	20.47	15.81
	1663	50	88.8	1.76	2.79	3.49	3.95	11.99	13.80	4.00	1.91	2.95	3.87	4.14	12.87	

P	HOME NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM. & BD	HLTH CR	TOTAL	S
	1664	50	85.0>	3.45	1.80	3.72	4.14	13.11	13.80	4.00	3.72	1.92	4.11	4.37	14.12	13.10
	1665	75	94.8	2.50	3.91	4.32	5.70	16.43	6.80	4.00	2.67	4.07	4.66	5.96	17.36	15.23
	1667	108	94.5	1.46	3.97	4.07	5.13	14.63	7.20	4.00	1.55	4.11	4.42	5.37	15.45	15.10
	1668	51	96.2	3.07	2.39	5.29	6.27	17.02	13.80	4.00	3.24	2.58	5.71	6.58	18.11	15.72
	1669	52	97.4	2.02	1.10	4.55	4.80	12.47	5.60	4.00	2.08	1.17	4.87	5.01	13.13	12.85
	1671	69	86.8	2.45	4.35	4.02	4.95	15.77	13.80	4.00	2.71	4.54	4.46	5.17	16.88	15.23
	1672	117	97.7	2.06	2.06	3.35	4.15	11.62	13.80	4.00	2.20	2.23	3.73	4.35	12.51	
	1674	68	93.9	2.36	3.31	3.40	4.41	13.48	5.60	4.00	2.46	3.40	3.65	4.60	14.11	
	1675	104	97.6	1.86	3.20	3.58	3.97	12.61	13.80	4.00	2.04	3.34	3.98	4.17	13.53	
	1678	115	95.0	2.16	2.51	3.29	4.40	12.36	6.80	4.00	2.31	2.67	3.54	4.57	13.09	
	1680	50	95.0	1.96	3.64	3.08	4.45	13.13	7.20	4.00	2.03	3.75	3.34	4.64	13.76	
	1681	100	96.9	2.67	2.07	4.25	6.14	15.13	5.60	4.00	2.80	2.15	4.55	6.40	15.90	14.90
	1683	150	85.0>	2.01	3.85	3.69	6.06	15.61	5.60	4.00	2.15	3.93	3.96	6.35	16.39	15.42
	1684	50	98.6	2.28	3.81	3.46	5.01	14.56	13.80	4.00	2.49	3.99	3.86	5.33	15.67	15.44
	1687	54	97.7	1.81	3.24	3.03	3.84	11.92	13.80	4.00	1.98	3.40	3.35	4.00	12.73	
	1688	50	98.5	1.64	2.76	3.17	3.46	11.03	13.80	4.00	1.78	2.89	3.52	3.61	11.80	
	1689	100	95.7	3.45	5.66	2.66	4.66	16.45	13.80	4.00	3.73	5.88	2.96	4.87	17.44	14.27
	1690	57	85.0>	1.33	3.35	4.51	5.31	14.50	13.80	4.00	1.41	3.52	4.94	5.55	15.42	15.01
	1692	67	99.4	2.76	3.69	3.17	3.65	13.27	6.10	4.00	2.89	3.80	3.39	3.79	13.87	13.47
	1695	60	98.0	3.12	3.69	4.01	4.96	15.78	13.80	4.00	3.37	3.86	4.44	5.18	16.85	15.23
	1697	100	97.7	1.60	3.25	3.52	4.00	12.37	13.80	4.00	1.73	3.44	3.92	4.17	13.26	
	1699	100	86.3	3.37	2.39	3.43	4.43	13.62	6.80	4.00	3.65	2.47	3.68	4.64	14.44	13.49
	1702	55	96.4	2.33	3.31	3.85	5.27	14.76	5.60	4.00	2.41	3.40	4.12	5.50	15.43	
	1704	100	95.5	2.91	3.09	3.09	3.57	12.66	6.80	4.00	3.16	3.17	3.31	3.72	13.36	12.90
	1705	47	85.0>	2.53	1.19	4.77	4.95	13.44	5.60	4.00	2.65	1.29	5.10	5.17	14.21	13.70
	1706	33	88.4	2.65	2.04	4.09	4.58	13.36	5.60	4.00	2.74	2.16	4.40	4.79	14.09	14.05
	1707	50	97.8	1.47	2.86	3.26	4.85	12.44	5.60	4.00	1.54	2.97	3.47	5.07	13.05	
	1708	100	93.3	1.82	3.15	3.69	4.51	13.17	13.80	4.00	2.00	3.32	4.13	4.75	14.20	
	1709	75	88.9	1.73	2.57	3.76	5.99	14.05	5.60	4.00	1.82	2.63	4.03	6.25	14.73	14.05
	1713	45	98.4	1.61	1.80	4.60	4.33	12.34	11.80	4.00	1.70	1.93	5.00	4.56	13.19	12.78
	1714	90	92.6	2.46	4.84	4.11	6.27	17.68	5.60	4.00	2.60	4.95	4.36	6.53	18.44	15.23
	1715	50	96.5	1.81	1.56	3.47	4.64	11.48	7.20	4.00	1.86	1.64	3.78	4.82	12.10	
	1716	50	100.0	2.40	4.79	3.45	3.82	14.46	13.80	4.00	2.55	5.08	3.86	4.00	15.49	14.17
	1726	82	99.0	2.11	2.17	1.71	2.14	8.13	11.80	4.00	2.23	2.35	1.88	2.22	8.68	
	1727	60	99.4	2.42	3.69	2.72	3.55	12.38	5.60	4.00	2.50	3.73	2.94	3.71	12.88	
	1729	38	97.0	2.90	.75	4.71	5.81	14.17	5.60	4.00	3.04	.82	5.01	6.05	14.92	13.55
	1732	50	93.5	1.85	2.60	4.34	4.57	13.36	13.80	4.00	1.95	2.75	4.77	4.78	14.25	14.01
	1734	50	100.0	1.94	3.81	3.53	4.71	13.99	13.80	4.00	2.09	3.98	3.91	4.93	14.89	14.67
	1735	50	93.7	2.39	3.59	2.80	5.44	14.22	5.60	4.00	2.50	3.69	3.00	5.66	14.85	14.74
	1737	50	98.8	2.21	2.45	3.73	5.18	13.57	13.80	4.00	2.36	2.53	4.14	5.39	14.42	
	1738	85	92.7	1.94	2.90	3.94	4.43	13.21	11.80	4.00	2.10	3.02	4.38	4.64	14.14	
	1741	50	98.6	1.82	3.45	3.37	5.17	13.81	5.60	4.00	1.90	3.53	3.59	5.39	14.41	

HOME	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	(16)
1744	50	96.4	2.05	4.11	3.33	4.04	13.53	13.80	4.00	2.23	4.29 ▲	3.74	4.23	14.49	13.96
1745	73	98.3	2.18	3.05	3.40	4.23	12.86	13.80	4.00	2.41	3.22	3.74	4.46	13.83	
1746	50	95.7	1.36	2.57	3.69	4.50	12.12	13.80	4.00	1.46	2.74	4.11	4.72	13.03	
1748	98	96.8	2.21	3.59	3.94	5.33	15.07	5.60	4.00	2.34	3.67	4.21	5.55	15.77	
1749	100	94.3	2.10	2.94	3.57	5.33	13.94	5.60	4.00	2.22	3.00	3.81	5.57 ▲	14.60	14.58
1750	100	93.2	2.19	3.10	3.62	5.77	14.68	5.60	4.00	2.32	3.17	3.86	6.01 ▲	15.36	14.90
1752	61	95.0	2.61	3.17	4.60	4.81	15.19	5.60	4.00	2.68	3.24	4.90 ▲	5.01	15.83	15.52
1754	60	96.7	2.64	4.08	3.81	5.43	15.96	5.60	4.00	2.79 ▲	4.13 ▲	4.07	5.66 ▲	16.65	15.72
1755	60	98.8	2.56	5.52	4.05	4.54	16.67	5.60	4.00	2.70	5.64 ▲	4.32	4.74	17.40	15.52
1756	62	96.0	2.63	3.25	3.50	3.86	13.24	13.80	4.00	2.91 ▲	3.34	3.94	4.04	14.23	14.02
1757	73	96.3	1.81	2.41	3.26	4.01	11.49	13.80	4.00	1.99	2.53	3.62	4.21	12.35	
1758	50	85.0>	1.01	2.40	2.31	3.29	9.01	11.80	4.00	1.08	2.47	2.54	3.44	9.53	
1759	50	96.8	2.11	4.65	4.28	6.22	17.26	7.20	4.00	2.22	4.86 ▲	4.64 ▲	6.50 ▲	18.22	15.78
1760	50	97.7	1.62	3.71	3.81	4.78	13.92	13.80	4.00	1.73	3.87 ▲	4.28	5.01	14.89	14.78
1761	50	97.6	1.99	3.82	3.49	4.61	13.91	13.80	4.00	2.16	4.06 ▲	3.86	4.80	14.88	14.58
1762	64	92.7	2.17	1.87	3.01	5.09	12.14	5.60	4.00	2.27	1.92	3.20	5.31	12.70	
1763	80	87.7	1.99	4.44	3.19	4.13	13.75	11.80	4.00	2.11	4.58 ▲	3.56	4.30	14.55	13.73
1764	50	98.3	1.69	3.95	3.51	3.68	12.83	13.80	4.00	1.84	4.10 ▲	3.89	3.83	13.66	13.32
1765	50	98.1	2.00	3.31	4.03	5.09	14.43	13.80	4.00	2.15	3.41	4.48	5.39	15.43	
1767	70	94.9	2.11	4.10	3.50	4.35	14.06	13.80	4.00	2.31	4.25 ▲	3.90	4.58	15.05	14.55
1768	100	92.0	2.63	4.62	3.88	4.63	15.76	13.80	4.00	2.89 ▲	4.82 ▲	4.29	4.85	16.85	15.60
1769	50	99.2	2.80	3.61	4.31	4.95	15.67	7.20	4.00	2.91 ▲	3.79 ▲	4.63 ▲	5.18	16.51	15.75
1771	100	55.7	4.96	6.50	3.57	4.29	19.32	13.80	4.00	5.60 ▲	6.74 ▲	3.96	4.47	20.77	14.84
1772	50	99.1	2.35	3.93	3.33	4.32	13.93	13.80	4.00	2.52	4.10 ▲	3.75	4.53	14.90	14.56
1773	100	98.3	2.31	3.68	3.49	5.25	14.73	5.60	4.00	2.45	3.77 ▲	3.73	5.48	15.43	15.42
1774	43	97.4	2.18	2.80	3.41	5.27	13.66	5.60	4.00	2.24	2.89	3.64	5.51	14.28	
1775	82	85.3	2.63	4.74	3.56	4.27	15.20	5.60	4.00	2.73 ▲	4.84 ▲	3.80	4.46	15.83	14.72
1776	50	99.1	1.82	3.62	4.86	4.94	15.24	5.60	4.00	1.89	3.71	5.21 ▲	5.17	15.98	15.36
1777	50	99.5	2.16	3.57	3.39	4.23	13.37	11.80	4.00	2.29	3.68	3.71	4.44	14.12	
1778	74	94.4	1.91	4.42	3.50	4.88	14.71	5.60	4.00	2.00	4.56 ▲	3.75	5.09	15.40	14.60
1779	50	97.8	1.96	3.75	4.02	5.83	15.56	5.60	4.00	2.04	3.80 ▲	4.30	6.08 ▲	16.22	15.45
1780	50	88.7	2.10	5.06	4.07	4.73	15.96	13.80	4.00	2.29	5.23 ▲	4.51	4.94	16.97	15.50
1781	50	94.6	2.26	3.63	4.18	5.72	15.79	5.60	4.00	2.36	3.71	4.45	5.95 ▲	16.47	16.07
1782	100	86.3	3.64	3.80	3.72	4.05	15.21	6.80	4.00	3.93 ▲	3.90 ▲	4.02	4.24	16.09	14.72
1783	64	86.1	3.08	3.82	4.30	6.17	17.37	13.80	4.00	3.46 ▲	3.97 ▲	4.79 ▲	6.46 ▲	18.68	15.75
1784	60	91.5	2.10	3.93	3.88	4.55	14.46	7.20	4.00	2.26	4.04 ▲	4.18	4.75	15.23	14.85
1785	33	90.5	2.91	4.44	3.84	6.70	17.89	13.80	4.00	3.21 ▲	4.75 ▲	4.27	7.00 ▲	19.23	15.48
1786	100	38.3	6.86	11.27	5.00	6.19	29.32	13.80	4.00	7.76 ▲	11.57 ▲	5.51 ▲	6.47 ▲	31.31	15.89
1787	100	86.8	2.69	4.51	4.26	6.24	17.70	6.80	4.00	2.89 ▲	4.60 ▲	4.59	6.52 ▲	18.60	15.11
98	50	97.4	1.60	4.27	3.01	4.91	13.79	13.80	4.00	1.69	4.46 ▲	3.29	5.11	14.55	13.85
9	41	96.2	2.14	1.89	3.95	4.44	12.42	13.80	4.00	2.37	2.05	4.37	4.64	13.43	
1790	50	96.3	2.53	1.63	3.59	5.45	13.20	12.70	4.00	2.73 ▲	1.73	3.96	5.75 ▲	14.17	13.91

HOME NO.	NO. BEDS	% OCCUP	*** BEFORE INFLATION *** ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	INFLT	INFLT							
1791	50	96.0	2.40	4.58	4.10	5.03	16.11	5.60	4.00	2.49	4.69	4.41	5.25	16.84	15.91	
1792	100	93.9	3.21	4.02	3.14	4.94	15.31	6.80	4.00	3.47	4.11	3.38	5.18	16.14	15.02	
1793	60	74.5	2.03	5.21	4.21	5.25	16.70	7.20	4.00	2.16	5.33	4.52	5.51	17.52	15.95	
1794	50	85.0>	2.33	1.69	4.04	7.16	15.22	5.60	4.00	2.41	1.78	4.30	7.50	15.99	14.04	
1795	100	52.8	2.16	5.39	3.82	4.97	16.34	6.80	4.00	2.26	5.49	4.12	5.21	17.09	15.05	
1797	60	66.7	2.55	7.12	4.19	6.02	19.88	5.60	4.00	2.68	7.35	4.49	6.32	20.84	18.32	
1798	50	90.3	1.99	5.55	3.35	4.23	15.12	5.60	4.00	2.09	5.69	3.58	4.40	15.76	13.73	
1799	100	95.1	2.20	4.11	3.59	4.52	14.42	6.80	4.00	2.28	4.21	3.86	4.73	15.08	14.63	
1800	50	98.7	3.39	4.08	3.81	4.55	15.83	5.60	4.00	3.51	4.19	4.07	4.74	16.51	15.37	
1803	50	59.8	2.55	5.59	6.25	7.26	21.65	5.60	4.00	2.69	5.67	6.64	7.59	22.59	15.53	
1804	100	85.0>	3.64	4.48	3.79	4.82	16.73	5.60	4.00	3.81	4.56	4.05	5.02	17.44	15.53	
1808	46	99.8	2.50	3.05	2.83	3.70	12.08	13.80	4.00	2.64	3.21	3.20	3.88	12.93		
1811	58	79.0	4.84	1.15	4.74	4.58	15.31	6.80	4.00	5.25	1.24	5.11	4.79	16.39	13.32	
1813	50	99.0	1.86	3.89	4.51	5.46	15.72	13.80	4.00	1.98	4.03	5.06	5.73	16.80	15.88	
2013	84	93.0	2.72	1.60	4.29	4.40	13.01	5.60	4.00	2.84	1.67	4.59	4.59	13.69	13.55	
2501	49	98.0	1.67	2.94	3.63	4.64	12.88	5.60	4.00	1.72	3.02	3.88	4.85	13.47		
2502	42	85.0>	2.47	2.84	3.81	4.07	13.19	13.80	4.00	2.73	2.99	4.22	4.26	14.20	14.17	
2504	50	98.1	1.93	1.53	3.41	4.35	11.22	7.20	4.00	2.03	1.60	3.66	4.53	11.82		
2505	54	97.4	1.96	1.55	2.65	4.34	10.50	7.20	4.00	2.03	1.69	2.89	4.56	11.17		
2515	50	85.0>	.85	2.75	2.53	3.63	9.76	11.80	4.00	.93	2.91	2.82	3.78	10.44		
2518	36	95.0	1.69	1.37	3.82	3.97	10.85	5.60	4.00	1.74	1.44	4.11	4.14	11.43		
2520	59	87.1	2.97	2.04	4.06	4.97	14.04	5.60	4.00	3.11	2.11	4.32	5.18	14.72	14.31	
2523	32	99.3	2.04	2.14	2.87	5.94	12.99	5.60	4.00	2.09	2.27	3.14	6.19	13.69	13.05	
2525	52	87.2	1.80	1.64	3.30	4.22	10.96	13.80	4.00	1.91	1.76	3.68	4.41	11.76		
2539	79	94.2	2.10	1.09	3.81	4.97	11.97	5.60	4.00	2.22	1.17	4.06	5.18	12.63		
2545	36	96.2	2.84	2.57	3.90	4.75	14.06	6.80	4.00	2.96	2.69	4.25	4.99	14.89	14.63	
2547	41	97.2	2.50	1.68	4.36	4.56	13.10	5.60	4.00	2.65	1.78	4.67	4.77	13.87	13.79	
2548	49	99.6	2.47	1.89	4.01	5.04	13.41	5.60	4.00	2.60	1.97	4.27	5.26	14.10		
2553	56	99.1	1.48	1.04	3.86	4.55	10.93	13.80	4.00	1.55	1.21	4.44	4.74	11.94		
2555	48	97.3	1.80	1.47	3.38	4.18	10.83	13.80	4.00	1.95	1.60	3.76	4.37	11.88		
2557	71	97.5	2.04	1.67	3.53	5.09	12.33	5.60	4.00	2.13	1.79	3.77	5.31	13.00		
2558	21	85.0>	2.88	1.29	4.94	9.67	18.78	5.60	4.00	2.99	1.40	5.26	10.07	19.72	14.24	
2572	96	85.0>	1.55	2.17	3.18	4.00	10.90	7.20	4.00	1.60	2.23	3.43	4.18	11.44		
2573	69	92.6	2.04	4.15	2.77	5.07	14.03	5.60	4.00	2.15	4.25	2.96	5.30	14.66	14.17	
2580	36	95.5	2.36	2.40	3.65	5.80	14.21	5.60	4.00	2.46	2.49	3.91	6.05	14.91	14.41	
2582	46	94.5	1.75	2.07	3.54	4.09	11.45	13.80	4.00	1.89	2.30	3.93	4.28	12.40		
2584	60	94.9	1.30	3.65	3.80	3.56	12.31	13.80	4.00	1.36	3.85	4.24	3.73	13.18	13.07	
2591	87	98.7	1.50	2.54	3.48	3.28	10.80	5.60	4.00	1.55	2.61	3.70	3.43	11.29		
2593	52	97.2	2.15	2.68	4.81	3.73	13.37	13.80	4.00	2.33	2.92	5.28	3.91	14.44	13.75	
2598	56	96.4	2.08	1.09	3.13	4.89	11.19	5.60	4.00	2.17	1.15	3.33	5.08	11.73		
2610	23	96.7	2.46	5.70	2.31	.17	10.64	5.60	4.00	2.51	5.97	2.52	.19	11.19	8.9	
2612	46	95.2	1.69	1.31	3.13	3.96	10.09	13.80	4.00	1.83	1.47	3.48	4.15	10.93		

P J	HOME NO.	NO. BEDS	% OCCUP	**** BEFORE INFLATION ***** ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	***** AFTER INFLATION ****** ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	
	13	44	96.3	2.31	2.41	3.23	4.55	12.50	5.60	4.00	2.39	2.51	3.47	4.74	13.11	
	2620	51	88.0	.96	1.14	2.12	3.41	7.63	11.80	4.00	1.03	1.24	2.39	3.55	8.21	
	2623	36	98.4	1.56	1.15	4.39	4.56	11.66	13.80	4.00	1.63	1.24	4.73	4.74	12.34	12.20
	2628	52	93.4	1.85	3.52	2.99	4.66	13.02	11.80	4.00	1.98	3.70	3.30	4.84	13.82	
	2636	59	92.4	2.53	1.51	3.91	4.43	12.38	5.60	4.00	2.60	1.58	4.16	4.62	12.96	
	2640	31	99.5	1.24	.81	3.32	5.03	10.20	11.80	4.00	1.31	.71	3.70	5.24	10.96	
	2642	34	95.2	1.94	2.06	3.89	5.46	13.35	5.60	4.00	2.01	2.19	4.18	5.70	14.08	13.93
	2644	50	97.2	2.80	3.47	4.86	6.04	17.17	5.60	4.00	2.95	3.64	5.19	6.29	18.07	15.89
	2646	54	85.0>	2.51	1.34	4.26	4.92	13.03	11.80	4.00	2.68	1.47	4.71	5.19	14.05	13.95
	2652	33	99.4	1.43	1.33	4.10	3.40	10.26	11.80	4.00	1.48	1.47	4.44	3.56	10.95	
	2656	50	95.8	1.70	1.34	3.04	2.89	8.97	13.80	4.00	1.79	1.47	3.32	3.01	9.59	
	2662	55	95.8	2.90	3.03	5.31	5.15	16.39	13.80	4.00	3.17	3.21	5.79	5.39	17.56	15.89
	2666	52	99.5	2.13	1.39	4.43	5.40	13.35	5.60	4.00	2.19	1.46	4.70	5.61	13.96	13.79
	2683	47	96.2	2.02	2.71	3.28	4.40	12.41	13.80	4.00	2.12	2.86	3.69	4.60	13.27	
	2716	50	97.1	2.50	1.75	4.17	3.22	11.64	6.10	4.00	2.61	1.80	4.50	3.35	12.26	
	2719	56	97.4	2.96	2.03	5.79	6.39	17.17	5.60	4.00	3.10	2.15	6.17	6.67	13.09	14.99
	2721	47	93.4	2.66	1.48	2.82	4.90	11.86	13.80	4.00	2.96	1.61	3.19	5.13	12.89	12.63
	2726	28	93.6	2.68	1.21	3.86	5.75	13.50	5.60	4.00	2.75	1.30	4.12	6.01	14.18	13.67
	2727	50	94.2	1.66	1.66	2.74	3.63	9.69	13.80	4.00	1.80	1.78	3.03	3.80	10.41	
	2735	50	100.1	2.07	2.51	3.64	4.07	12.29	13.80	4.00	2.32	2.60	4.04	4.26	13.22	
	2743	50	98.0	2.04	4.97	2.52	3.23	12.76	5.60	4.00	2.11	5.09	2.70	3.38	13.28	11.95
	2749	50	93.5	1.73	2.14	3.48	3.95	11.30	13.80	4.00	1.87	2.30	3.86	4.13	12.16	
	2755	50	99.4	1.78	2.69	4.51	4.16	13.14	6.80	4.00	1.88	2.77	4.82	4.34	13.81	13.58
	2756	50	94.9	.76	3.05	3.67	6.63	14.11	13.80	4.00	.79	3.17	4.12	6.93	15.01	13.63
	2757	67	98.1	2.30	2.82	3.50	4.18	12.80	6.10	4.00	2.40	2.90	3.74	4.36	13.40	
	2758	50	96.0	1.88	4.12	2.93	3.72	12.65	11.80	4.00	2.02	4.25	3.27	3.89	13.43	12.94
	2760	80	95.4	2.34	4.19	3.74	3.40	13.67	5.60	4.00	2.41	4.27	4.00	3.55	14.23	13.72

COMPILATION OF COST CENTERS AND STATISTICAL DATA - ICF 07-05-77 SCHEDULE B (8)

HOME NO.	NO. BEDS	% OCCUP	BEFORE INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL	HSTRC INFLT	PROSP INFLT	AFTER INFLATION ADMIN.	PROPRTY	RM & BD	HLTH CR	TOTAL
HIGH	185	106.7	6.86	11.27	9.74	14.31	29.83			7.76	11.57	10.80	15.13	32.15
99TH	144	100.1	4.84	5.70	7.17	9.80	24.33			5.25	5.97	7.61	10.29	25.53
95TH	100	99.5	3.45	4.79	5.90	7.69	19.87			3.68	5.08	6.33	8.03	20.84
90TH	100	99.2	2.96	4.19	5.07	6.46	17.37			3.17	4.41	5.58	6.78	18.44
85TH	100	98.8	2.80	3.93	4.62	6.03	16.43			2.94	4.10	5.01	6.32	17.44
80TH	82	98.3	2.65	3.76	4.39	5.72	15.76			2.82	3.93	4.79	5.96	16.51
75TH	71	98.0	2.55	3.63	4.26	5.32	15.13			2.70	3.76	4.59	5.55	15.93
70TH	64	97.7	2.47	3.45	4.09	5.18	14.56			2.64	3.59	4.45	5.40	15.43
65TH	60	97.4	2.40	3.24	4.01	5.07	14.31			2.51	3.40	4.37	5.30	15.08
60TH	55	96.7	2.31	3.05	3.89	4.97	14.02			2.44	3.21	4.27	5.19	14.87
55TH	51	96.3	2.21	2.94	3.82	4.90	13.78			2.38	3.07	4.14	5.12	14.54
50TH	50	95.8	2.16	2.79	3.73	4.80	13.55			2.31	2.91	4.08	5.01	14.35
40TH	50	94.8	2.04	2.53	3.54	4.60	13.15			2.16	2.63	3.89	4.80	13.96
30TH	50	92.8	1.93	2.17	3.40	4.35	12.65			2.02	2.31	3.70	4.57	13.37
20TH	47	89.4	1.80	1.84	3.21	4.09	12.10			1.88	1.93	3.48	4.28	12.92
10TH	36	85.0	1.60	1.53	2.87	3.66	11.07			1.70	1.60	3.18	3.83	11.80
1ST	21	55.7	.96	1.04	2.08	2.64	8.13			1.03	1.15	2.29	2.75	8.68
LOW	16	38.3	.76	.61	1.71	.17	7.63			.79	.71	1.88	.19	8.21
MEAN	61	93.7	2.28	2.90	3.91	5.02	14.10			2.42	3.03	4.25	5.24	14.95
WTMN	71	93.8	2.25	2.95	3.83	4.94	13.97			2.39	3.09	4.16	5.16	14.80
HOMS	279	279	279	279	279	279	279			279	279	279	279	279

NUMBER OF BEDS

	UNDR 20	20 - 50	51 - 75	76 - 100	OVR 100
HIGH	19.44	32.15	22.66	31.31	21.28
LOW	19.44	9.53	8.21	8.38	12.48
MEAN	19.44	14.88	14.74	15.17	15.41
WTMN		14.62	14.70	14.96	15.30
HOMS	1	147	68	49	14

Attachment K

THE KANSAS PHARMACEUTICAL ASSOCIATION
1308 WEST 10TH
P. O. BOX 4218, GAGE CENTER STATION
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

DOUGLAS P. JOHNSON, R. PH.
EXECUTIVE DIRECTOR

TO: Commission on Health Care Costs

RE: Medicaid Drug Program

DATE: Wednesday, September 14, 1977

Mr. Chairman and members of the committee, my name is Doug Johnson, Executive Director of the Kansas Pharmaceutical Association, representing pharmacists in the state. We appreciate the opportunity to appear before the commission on this subject and congratulate the commission for calling upon health care provider organizations to provide input.

The pharmacy service component of the Medicaid Program, commonly called the "Drug Program" is an optional program.

For the purpose of discussion, the following sections will be covered:

1) History of the Drug Program
2) Comparison FY76 (6 mo) - FY77 (6 mo)
3) Recipients vs. Drug Claims
4) Cost Containment Measures
5) Fees
6) Recommendations

1) History of the Program

Addendum I was prepared to give a graphic as well as narrative analysis of the Medicaid Drug Program. We strongly suggest that you all take the time to read that analysis as it points out a very interesting, yet to us, shocking story.

The last paragraph points out that a computer report had been approved by Dr. Harder to show the fiscal impact at the 90th percentile of cost. The fiscal impact of reimbursement at the 90th percentile of cost is estimated by the state to be $260,315 or a 7.6% increase over the current 44th percentile.

2) Comparison of FY 76 (6 mo) - FY 77 (6 mo)

The chart below illustrates a comparison between the first 6 months of FY 1976 and the first 6 months of FY 1977. It shows the percentage increase in expenditures for drugs and also the increase in persons receiving medical services. I am aware that data is now available from SRS that would compare the full twelve month period; however, I have not yet received that information.

	FY 1976	FY 1977	% Change	Persons receiving medical services
July	$ 372,263	$ 389,117	+ 4.5	- 130
Aug.	1,270,027	1,295,851	+ 2.0	+ 6,532
Sept.	2,020,766	2,173,206	+ 7.5	+ 15,133
Oct.	2,729,586	3,212,165	+17.7	+ 33,223
Nov.	3,608,226	3,940,933	+ 9.2	+ 31,332
Dec.	4,673,499	4,730,896	+ 1.2	+ 25,563

3) Recipients vs. Drug Claims

If you spend time on Addendum II, the data is self-explanatory. However, allow me to list some highlights.

a) Persons receiving Medical Services have increased while for the first 6-month period Drug Claims Paid (prescriptions) have decreased 5.3%.
b) Drug claims per person receiving Medical Services has decreased 10%.
c) For the first 6 months, there was an actual 0.5% decrease in drug payments.

The chart which follows adds additional insight into the Drug Program.

Month 1975	Recipients of Pharmacy Services	FY 76 1 # of Rx's	Rx per Recipient
July	28,463	76,231	2.68
Aug.	45,167	180,963	4.01
Sept.	41,263	149,316	3.62
Oct.	41,589	140,674	3.38
Nov.	47,257	174,130	3.68
Dec.	50,561	205,965	4.07
TOTAL	254,300	927,279	3.65

Month 1976	FY 77 Recipients of Pharmacy Services	# of Rx's	Rx per Recipient
July*	28,071	71,603	2.55
Aug.	47,269	172,724	3.65
Sept.	48,239	165,941	3.44
Oct.	53,487	196,976	3.68
Nov.	44,624	138,877	3.11
Dec.	47,345	149,735	3.16
TOTAL	269,035	895,856	3.33

It is interesting to note that recipients of pharmacy services are up 5.8% for the first 6 month of FY 77 compared to a 6.3% increase in persons receiving medical services. There was a 3.4% reduction in the number of prescriptions for the comparison period. A more pertinent fact is that the number of prescriptions received per recipient has decreased 8.8% during FY 77, from 3.65 Rx's to 3.33 Rx's per recipient.

4) Cost Containment Measures

The Drug Program has historically had the smallest percentage of increase of all categories. One reason is that our services are dependent on the action of other health care providers. However, we also believe our experience is good because of the procedure we have developed with the Department of Social and Rehabilitation Services. A committee of our Association meets almost monthly with the Medical Services Section of SRS in addition to meeting twice annually with Dr. Harder. While these monthly meetings are not totally responsible for the 3 major areas below, we have saved thousands of dollars by eliminating drugs that were being abused, such as weight control drugs, vitamins, etc.

The 3 areas below do reflect major areas of cost containment.

a. The Co-Pay on drugs which went into effect on July 1, 1976, is a large factor in the 6 month increase of only 1.2%. The Co-Pay, which still is a heated topic with a few people, has cut down on the unnecessary utilization of drugs. Our Association has recommended this concept for years and we are glad it is in effect.

b. Drug Utilization Review
Because of our concern for the Medicaid recipients, we developed a program called Drug Utilization Review. This program is currently being funded by the State Department

of Social and Rehabilitation Services. Attached as Addendum III is an outline of the program. Basically the program is aimed at providing the best possible care in the most cost effective manner. It will address such things as provider abuse, recipient abuse, program inadequacies, prescribing habits and many more. Several states have started similar programs for a few counties. However, Kansas is the first to implement a DUR program statewide. We are convinced that the project will not only save money, but more importantly, we believe the recipients will receive better care.

c. Counseling Regulation

Kansas is one of the first states to require pharmacists to counsel with their patients on their drug regimen. This regulation was adopted not only for the Medicaid program but for all Kansans. One of the largest problems in drug care is non-compliance with a medication regimen. Estimates range from 4% for a group of tuberculosis out patients, to 92% for a group of pediatric patients being treated for streptococcal infections.

Our Association, in an attempt to reduce non-compliance, requested the counseling regulation and we have developed a continuing series of instruction sheets to help educate patients about their drug regimen. Attached as Addendum IV is a sample of that material.

We have also recommended passage of Brand Exchange legislation which we believe will cut costs. SB108 dealing with brand exchange did pass the 1977 Senate and is sitting in the House Public Health and Welfare Committee. Addendum V provides some background on Brand Exchange.

5) Fees

Addendum I does a very good job about illustrating fees in the Kansas Medicaid Drug Program.

We believe we have done, or are currently working on all areas we know of for cost containment. However unless SRS, the Governor, the Legislature, and this Commission do something to increase fees, all of these efforts could well be in vain.

The profession of pharmacy in Kansas has taken pride in the fact that we developed a variable fee system based on cost. A copy of the detailed survey which must be completed by Kansas

pharmacies every year is attached as Addendum VI. HEW now requires that states must do a similar survey to justify reimbursement.

While we take pride in the variable fee concept, we are also aware that currently it is virtually worthless because the state has chosen to neglect their own data.

You all heard Dr. Harder last month say that physicians, dentists, etc., were reimbursed at the 50th percentile of submitted charges, nursing homes are reimbursed at the 75th percentile of cost. Pharmacies are currently being reimbursed at the 44th percentile of cost or their usual and customary whichever is less.

Pharmacy fees for 1977-78 which are by law scheduled to go into effect on July 1 of each year have not yet been settled for 1977-78. We met just 2 days ago to discuss the new fee data with Dr. Harder. The data presented to us reflects the following.

a) If the state reimbursed at the same total cost as last year, the cost would reflect reimbursement at the 34th percentile. (1976-77, it was the 44th percentile)

b) Even if the state increased that total cost allowed by 10¢, which they have suggested by their printouts, cost reimbursement would be at the same level, i.e., the 44th percentile of cost.

It is simple mathematics that most pharmacies cannot continue to operate if they must fill prescriptions at below their cost as certified by the state survey and printouts.

6) Recommendations

a) Continuation of the Co-Pay on Drugs

b) Continued involvement in the joint pharmacy - SRS - Drug Utilization Review Program

c) Passage of a workable Brand Exchange bill, such as SB108.

**d) Increase in the level of reimbursement to pharmacies based on the 90th percentile of cost or usual and customary, whichever is less.

We appreciate the opportunity to appear and would be glad to answer any questions you might have.

KANSAS MEDICAID DRUG PROGRAM

An Analysis

Kansas Pharmaceutical Association P.O. Box 4218 Topeka, Kansas 66604

The purpose of this report is to provide an analysis of how the variable fee system of reimbursement to pharmacy providers under the Medicaid program (Title XIX) started in 1969 and its progression through Fiscal Year 1977.

Reimbursement to pharmacy providers on a variable fee *based on cost* is a unique system of reimbursement to health care providers in Kansas and throughout the country. The basic premise of a variable fee system is to individualize fees paid based on individual costs of filling a prescription. The concept is a good one as fees paid to each pharmacy can be justified. Traditionally, most other providers are reimbursed at an established percentile of submitted charges. The variable fee system again is not based on submitted charges but rather on actual cost.

One of the major problems with any fee system based on cost is that if the program does not reimburse those costs the system and time spent by all cannot be justified. It is fortunate to a degree that cost data is compiled as it is easy to illustrate when changes occur. However, unless appropriate changes are made to reimburse these costs, we find ourselves in the situation of provider subsidy of a program.

Chart I reflects a history of the variable fee system in Kansas from its inception through the early years until the state took over cost analysis in 1972. The chart reflects a very interesting story when compared to the statistics below.

Current law in Kansas states that pharmacy providers shall be reimbursed their cost plus a reasonable profit. For Fiscal Year 1977 the state has determined that cost is no greater than $2.05 and a reasonable profit is $0.30. We could question whether 30 cents is a reasonable profit. However, our major concern is that the system pay based on their own data of cost.

Chart II gives an illustration of what has happened for the past three years. Pharmacy costs have risen. However, pharmacy costs allowed by the state have decreased from the 65th percentile of cost to the 44th percentile of cost. It should be emphasized again that we are not talking about profit, which has remained constant for the past three years.

We were able to convince SRS this past year that costs allowed had to be increased. We accepted a ten cent increase in cost as a stop gap measure only, until we could go to the Kansas Legislature and point out this discrep-

Chart I

	1971	1970	1969
Low fee	1.08	1.16	0.93
High fee	2.12	2.49	2.45
Selling Price	4.47	4.37	4.23
Average	1.67	1.87	1.87
Cost of goods	2.31	2.23	2.17
Profit	5%	10.5%	10.5%

*In the spring of 1969, Hugh Cotton and the Kansas Pharmaceutical Association conducted a pilot study of Kansas pharmacies to determine the cost of filling a prescription. This was a concept of Hugh Cotton's known today as the variable fee.

Based on the pilot study, Mr. Cotton and KPhA were awarded a grant from HEW to do another survey on cost of filling a prescription for fee determination in the Medicaid drug program. Based on that survey, fees were determined for each pharmacy on a variable basis. The chart above reflects the results of fees paid in 1969, 1970, and 1971.

Chart II
State Limitations

Fiscal Year	Cost/Rx	Profit/Rx	Total Fee/Rx	Percentile of Cost/Rx
1975 (1)*	$1.95	$0.30	$2.25	65th
1976 (2)*	$1.95	$0.30	$2.25	46th
1977 (3)*	$2.05	$0.30	$2.35	44th

*(1) Fiscal Year 1975 fees are for the year July 1, 1974-June 30, 1975 and are based on January 1, 1973-December 31, 1973 cost.

*(2) Fiscal Year 1976 fees are for the year July 1, 1975-June 30, 1976 and are based on January 1, 1974-December 31, 1974 costs.

*(3) Fiscal Year 1977 fees are for the year July 1, 1976-June 30, 1977 and are based on January 1, 1975-December 31, 1975 costs.

ancy. The ten cent increase in cost, in the final analysis, is still a reduction of 2 percentile in cost over Fiscal Year 1976. We are therefore facing a current situation where 56 per cent of the pharmacies participating in the program have a reported cost per prescription of $2.05 or more. However, the state has set the limit at $2.05. It must also be emphasized that the cost data for Fiscal Year 1977 fees is based on historical data from January 1, 1975-December 31, 1975 costs.

There is a protection mechanism built into the program that assures that the Medicaid program is not being charged more than the pharmacy provider's usual and customary charge on the average. An example is as follows: If a pharmacy *cost survey* showed a cost of $2.00 per prescription, and we add the $0.30 profit, the fee would be $2.30. However, if the *usual and customary survey* showed an average fee of $2.00, the fee assigned to the pharmacy would be $2.00, *not* $2.30. This illustrates that even though 56 per cent of the pharmacies had a reported cost of $2.05 or more, some may have been limited by their usual and customary fee. The state reports that in fact, 15 per cent were limited by usual and customary which reduces the percentage at the maximum cost to 41 per cent.

Chart IV does show a 42 per cent increase in drug expenditures. However, a breakdown of those expenditures is necessary. Drug costs accounted for 26 per cent of the increase. This increased drug cost reflects increases in the prices manufacturers charge the pharmacists for the drugs. Increase in claims due to increases in patients on welfare accounted for 10% of the increase. Taking into account the increased drug costs reflected by increased claims (1.1 x 1.26 = 1.39), 39 per cent of the 42 per cent increase is totally out of the hands of the pharmacists. The other 3 per cent does not relate to increases in fees as the cost and total fees allowed remained the same for Fiscal Year '75 and Fiscal Year '76. The 3 per cent does relate to increased payments to pharmacists as more pharmacists were receiving the maximum fee. Referral back to Chart II illustrates this very clearly. It shows that in Fiscal Year '75, 35 per cent of participating pharmacy providers had a cost of $1.95 or more, while in Fiscal Year '76, 54 per cent had a cost of $1.95 or more. Again the $1.95 is the maximum cost allowed by the state.

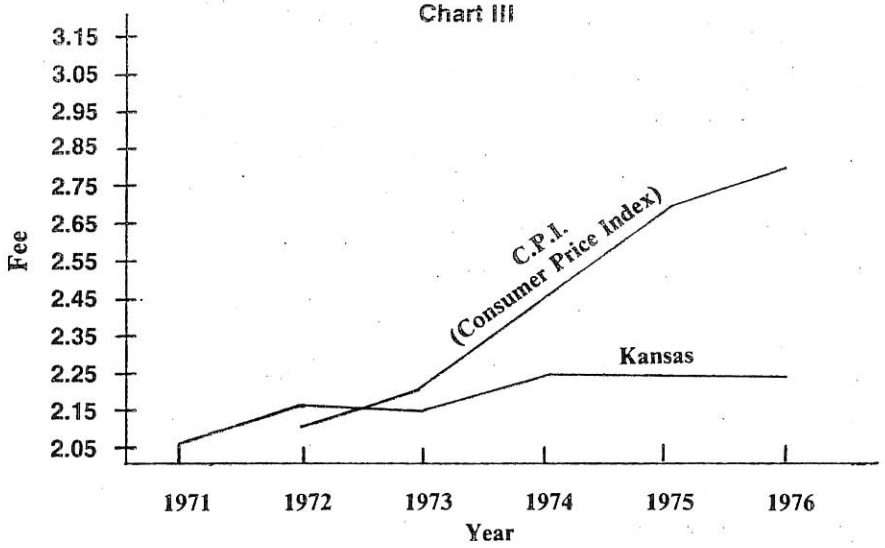
The change above shows very clearly that from Fiscal Year '75 to Fiscal Year '76 we have actually changed from the variable fee to a flat fee, as far as reported costs are concerned, as in Fiscal Year '76. Fifty-four per cent of the providers were at the maximum allowed. In Fiscal Year '77, 56 per cent of the providers are at the maximum allowed.

Recommendation

We recommend that pharmacists be reimbursed at the 90th percentile of cost plus a reasonable profit. Reimbursement at this level will not eliminate those extremely high costs but will return the program to a variable fee based on cost.

We have attempted to estimate what reimbursement at the 90th percentile would cost the program. However, without an additional computer run of data submitted to the state, we are unable to come up with a figure. We have requested this computer run from Dr. Harder and he has agreed to have it done. As soon as the data is available, it will be distributed.

Chart III



Year	Maximum Kansas Fee	CPI	CPI Fee
1971	2.05	121.3	—
1972	2.15	125.3	2.11
1973	2.15	133.1	2.21
1974	2.15	147.7	2.49
1975	2.25	161.2	2.72
1976*	2.25	167.5	2.82

*1976—Through March, 1976

The above chart illustrates a comparison between the consumer price index (CPI) and the Kansas variable fee. There is a 38% difference between the CPI from 1971 through March of 1976. If this 38% were applied to the $2.05 Kansas fee in 1976 the fee for Fiscal Year 1976 would have been $2.82.

Chart IV
Medical Provider Payment Costs

	Fiscal Year '75	Fiscal Year '76	% Change
Drugs	6,775,692	9,631,334	+42.1
Optometrists	868,211	1,311,816	+51.1
Physicians	8,468,794	12,668,364	+49.6
Podiatrists	21,713	33,396	+53.8
Lab. and Radiology	1,441,728	2,432,491	+68.7
Dental	2,675,738	4,420,574	+65.2
Chiropractors	179,707	303,997	+69.2

Month	Persons Receiving Medical Services	# ** Drug Claims	Drug Claims Per Person Receiving Med. Services	Drug Payment[1] Payment[2]	Drug Payment Per Claim
FY 76					
1975					
July	46,808	78,069	1.67	$ 380,320	$4.87
August	71,987	185,006	2.57	$ 915,863	$4.95
September	66,531	152,734	2.30	$ 765,999	$5.01
October	67,446	143,766	2.13	$ 722,680	$5.03
November	75,369	177,685	2.36	$ 894,675	$5.04
December	80,080	210,602	2.63	$1,086,527	$5.16
July-Dec. Total	408,221	947,862	2.32	$4,766,064	$5.03
1976					
January	67,231	146,059	2.17	$ 759,444	$5.20
July-Jan. Total	475,452	1,093,921	2.30	$5,525,508	$5.05

Month	Persons Receiving Medical Services	# ** Drug Claims	Drug Claims Per Person Receiving Med. Services	Drug Payment[1] Payment[3]	Drug Payment Per Claim
FY 77					
1976					
July	46,678	71,766	1.54	$ 389,956	$5.43
August	78,649	173,120	2.20	$ 908,525	$5.25
September	75,132	166,371	2.21	$ 879,328	$5.29
October	85,536	197,403	2.31	$1,041,043	$5.27
November	73,478	139,219	1.89	$ 730,391	$5.25
December	74,311	150,058	2.02	$ 791,499	$5.28
July-Dec. Total	433,784	897,937	2.07	$4,740,742	$5.28
1977*					
January	101,118 (est.)	208,139	2.06	$1,105,223	$5.31
July-Jan. Total	534,902	1,106,076	2.07	$5,848,965	$5.29

[1]Payments include family planning drugs which are not reflected in drug payments on the report "Summary of Medical Assistance Costs".

[2]Co-pay not in effect during FY 76

[3]Co-pay in effect in FY 77 and co-pay deductions are reflected by payment shown

*The persons receiving count has been estimated while the number of drug claims and payment figures are actual.

**Family planning prescriptions are included

Kansas Pharmacy Foundation
1308 W Tenth Street, P.O. Box 4218, Topeka, Kansas 66604 • 913-232-5654

PURPOSE & FUNCTION OF DRUG UTILIZATION REVIEW IN THE KANSAS MEDICAID PROGRAM

I. INTRODUCTION

Drug utilization review (DUR) is aimed at optimal and efficient drug usage by encouraging rational drug therapy. Rational drug therapy includes the concept of "prescribing the right drug for the right patient, at the right time, in the right amounts, and with due consideration for relative cost plus the option of prescribing no drug when a drug is not needed."

Of central concern to drug utilization review is whether or not an optimum match between some definite and identified disease condition and some drug indicated for that condition has been achieved. Only if the particular drug used was indicated will a review of drug usage conclude that therapy was correct.

The HEW Task Force on Prescription Drugs summarized these considerations in the following manner:

> In any drug program, utilization review is a dynamic process aimed first at rational prescribing and consequent improvement of the quality of health care, and second at minimizing needless expenditures . . .
>
> . . . the implementation--the establishment and improvement of guidelines, the provision of acceptable deviations, the limitations of irrational prescribing, the prevention of fraudulent practices, and other professional judgements--should be mainly the responsibility of clinicians, pharmacologists, and pharmacists, who are widely respected as objective, well informed, and appreciative of the needs of physicians, pharmacists, and patients, and who would work with their colleagues at the state or local level.

> . . . there is an evident need for further research to develop and test various approaches to effective (drug) utilization review - approaches which should be most acceptable to physicians, pharmacists, consumers and others, and which would obtain their effective support.

II. PROJECT OBJECTIVES

The establishment of the Kansas Pharmacy Foundation as the Drug Utilization Review mechanism for the State Medicaid Program serves to accomplish the following objectives:

1. Establish criteria and standards for the rational use of drugs which represent sound therapy and good medical practice.
2. Review the drug consuming habits of recipients
3. Review the drug dispensing practices of pharmacists
4. Review the drug prescribing behavior of physicians
5. Provide credible information that can be used for educational and enforcement purposes

Through a monthly review of prescription claims data, the information generated will be used to establish normal or customary levels of drug use which are appropriate to those circumstances where drug therapy is vital to sound medical treatment.

III. PROJECT GOALS

Through the monthly review process, and the application of the information obtained, the following goals will be met:

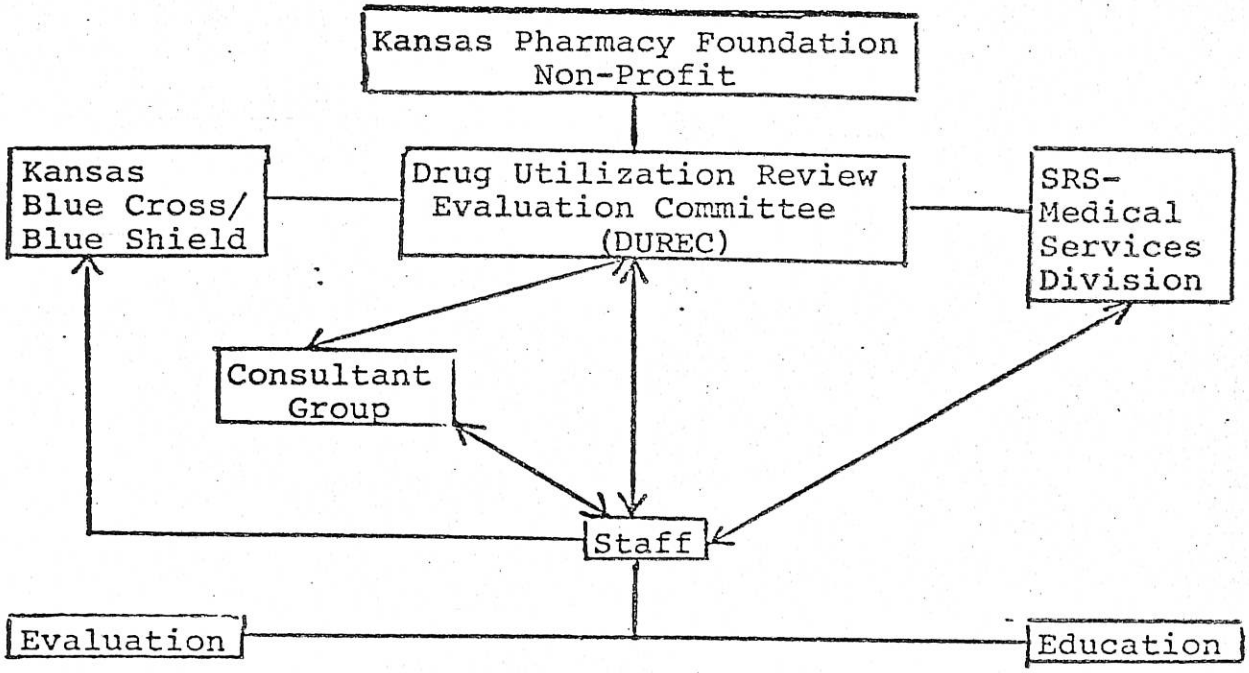
1. Documentation of those instances where drug use is inappropriate.
2. Identification of those situations where improper or inadequate drug therapy is employed.

3. Provision of aggregated information useful to groups interested in improving provider education.

4. Indirectly provide for the reduction of drug costs by providing educational information needed to improve the rationale of drug therapy.

The ultimate purpose of the ongoing drug utilization review program is to assure that the right drug is prescribed for the right patient, at the right time, in the right amounts, with due consideration for relative cost; plus the option of assuring that no drug is prescribed when it is not needed.

IV. ORGANIZATIONAL STRUCTURE



V. MECHANISM & RESPONSIBILITIES

The primary activities of the groups are coordinated with responsibilities divided in the following manner:

1. SRS - MEDICAL SERVICES DIVISION, STATE OF KANSAS

   a. Investigate the activity of patients, pharmacists, and physicians, in those cases where fraud or misutilization of drugs occur.

   b. Apply the educational information provided by the Kansas Pharmacy Foundation.

   c. Serve on the DUR Evaluation Committee.

   d. Provide funding for the DUR activity.

   e. Continue all administrative and enforcement activity currently within the domain of that agency.

2. KANSAS BLUE CROSS/BLUE SHIELD

   a. Generate reports as specified by the DUR Evaluation Committee (with SRS approval) that are needed for the monthly review process.

   b. Serve on the DUR Evaluation Committee.

   c. Act as the fiscal intermediary for Medicaid claims processing; continuing all current operational functions.

3. KANSAS PHARMACY FOUNDATION

   a. Working through SRS, develop specifications for Blue Cross/Blue Shield needed to generate data on patients, physicians, pharmacies, and drug use.

   b. Provide for the staff screening of monthly generated reports based on criteria and standards developed by the DUR Evaluation Committee.

   c. Provide for the review of staff-generated cases and reports by the DUR Evaluation Committee.

   d. Assure that recommendations and reports provided to SRS-Medical Services Division receive follow-up action.

   e. Assist in the development of criteria and standards that will be used for educational purposes.

4. DRUG UTILIZATION REVIEW EVALUATION COMMITTEE

a. Working in conjunction with a medical specialty consultant group, develop a series of criteria for those drugs having a high volume of utilization.

b. Make recommendations to SRS - Medical Services Division for changes in the computer report generating portion of the physician and pharmacist claims processing system.

c. Perform a monthly review of staff-generated cases and reports.

d. Recommend to SRS mechanisms which should be used to achieve a more rational state of drug prescribing, dispensing, and use.

e. Provide recommendations to the Kansas Pharmacy Foundation which can be used as supportative material in the evaluation of provider educational standards.

f. Evaluation Committee Members (multidisciplinary)

Medicine:
Wayne Wallace, Jr., M.D. - Chairman
-family practice, Atchison, Kansas
Ernie Chaney, M.D.
-family practice, Belleville, Kansas

Pharmacy:
David Henry, R.Ph.
-clinical instructor, KU Med Center
Max Heidrick, R.Ph.
-community pharmacist, Beloit, Kansas

Pharmacologists:
Edward Walaszek, Ph.D.
-chairman, Dept. of Pharmacology, KU Med. Center
Charles Rutledge, Ph.D.
-chairman, Dept. of Pharmacology & Taxicology, KU School of Pharmacy

Lay Public:
Joan Hurst
-instructor, KU School of Liberal Arts

SRS: State of Kansas
Gene Hotchkiss, R.Ph.
-pharmacy consultant, Medical Services Section

Blue Cross/Blue Shield of Kansas
Bill Gloy
-director of Professional Utilization Review

Kansas Pharmacy Foundation
Roger Miller, R.Ph. (ex officio)
-community pharmacist, Bonner Springs, Kansas

VI. LONG RANGE BENEFITS

The benefits of an on-going Drug Utilization Review mechanism are as follows:

1. Guarantee a utilization review/peer review activity in order to eliminate Medicaid program abuse by recipients and/or providers of health care services in Kansas.

2. Provide for cost savings in the Medicaid program by actively assuring low provider/recipient abuse by re-inforcing educational objectives.

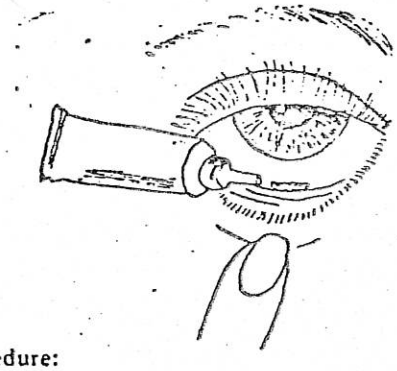
3. Provide for an approved "quality assurance" mechanism, that can be incorporated into the State's PSRO activity.

4. Provide for the dissemination of quantitative information to the State's HSA such that the goals and objectives of each are met through mutual cooperation of provider organizations and State agencies.

5. Provide a formal mechanism for receiving and researching complaints from providers &/or recipients.

PGM:mj

TILLATION OF AN EYE OINTMENT

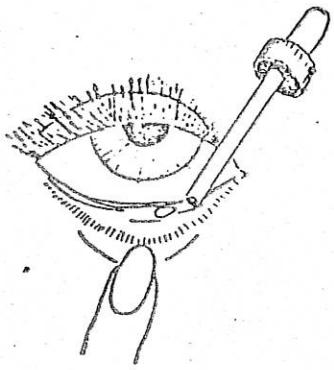


Procedure:

1. Wash hands before and after instillation.
2. You should lie down or sit with your head tilted back.
3. Draw the lower eyelid down; then look up.
4. Place the ointment about ½ inch along the inside margin of the lower eyelid.
5. Do not touch the eye or the eyelid with the tip of the ointment tube.
6. You should close your eye; then with a tissue gently remove any excess ointment from the eyelid lashes.

This information is provided by:

ADMINISTRATION OF EYE DROPS

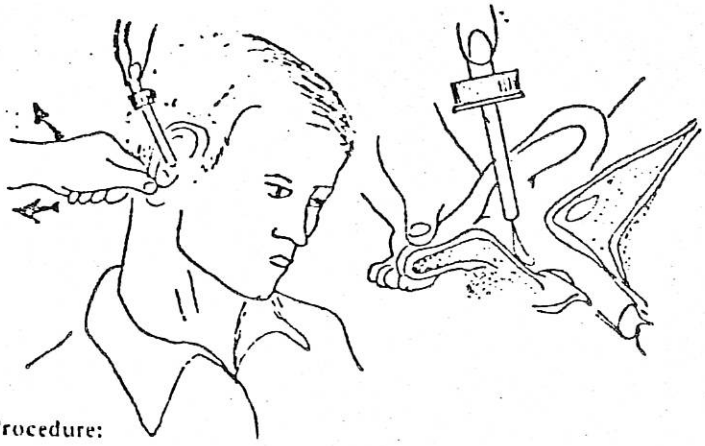


Procedure:

1. Wash hands before and after administration.
2. You should lie down or sit with your head tilted back with chin up.
3. Draw the medication into the dropper. The dropper should be held with the tip down.
4. You should open both eyes and look up, with one finger draw the lower eyelid down.
5. With the dropper in the other hand, hold it as near as possible to the eyelid without touching it and drop the prescribed number of drops behind lower eyelid. THE SOLUTION SHOULD NOT FALL ON THE SENSITIVE CORNEA which will cause stinging.
6. DO NOT TOUCH THE EYE OR THE EYELID WITH THE TIP OF THE DROPPER. The dropper should not be cracked or chipped.
7. You should close your eye; then with a tissue gently remove any excess solution from the eyelid and lashes.

This information is provided by:

ADMINISTRATION OF EAR DROPS

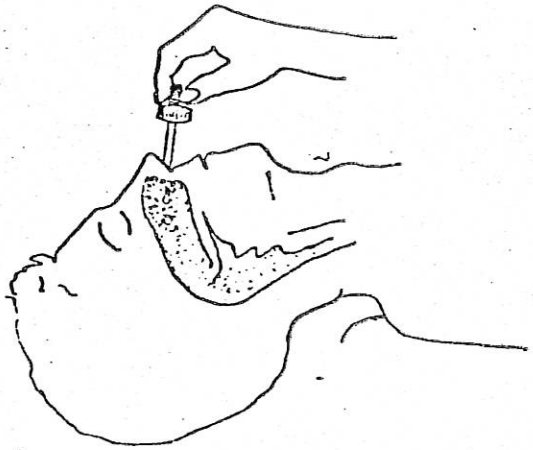


Procedure:

1. You should tilt your head away from the affected ear.
2. Draw the medication into the dropper. The dropper should be held with the tip end down.
3. Straighten your ear canal as follows:
   Adult — Hold the external ear flap upward and backward.
   Children — Hold the ear flap downward and backward.
4. After checking the tip of the dropper to see it is not chipped or cracked, instill the prescribed number of drops into the ear. Direct the medication toward the wall of the ear canal and avoid touching the ear canal with the medicine dropper.

This information is provided by:

ADMINISTRATION OF NOSE DROPS



Procedure:

1. You should lie down or sit with your head tilted back.
2. After checking the tip of the dropper to see it is not chipped or cracked, you should breath through your mouth and place the prescribed number of drops into the nose.
3. Do not touch the sides of the nasal openings with the dropper.
4. You should remain in this position for several minutes so the medication can spread through the nasal cavity.

This information is provided by:

SUPPOSITORIES

positories may be given rectally or vaginally.
thod to follow for rectal suppository to stimulate bowel
ment:
move foil wrapper from suppository, then put on rubber
ves.
rn on your left side and insert suppository, pointed end first,
h into rectum, so that it will not slip out.
sh the bottom end of the suppository sideways to make sure
t some part of it touches the bowel wall as this stimulates a
rmal movement.
u should have results in 20 to 30 minutes. If you did not retain
e suppository, it was not inserted high enough and should be
shed higher. It is often advisable to hold cheeks of buttocks
gether for a short while.
oat suppository well with petroleum jelly if you have
morrhoids.
her rectal suppositories should be administered with the same
dure as for bowel movements, and may be ordered for:
emperature elevation
ausea
yspnea (difficult breathing)
emorrhoids
ginal medication is usually for local effect and may be given in
orm of a suppository, a paint, powder, or a cream. Vaginal
ication has rapid absorption.

his information is provided by:

HOT & COLD APPLICATIONS

I. MOIST HEAT is used to ease pain, supply moisture and promote circulation, muscle relaxation or wound drainage.
   A. Types:
      1. Soaks
      2. Compresses (cotton, gauze, flannel or towels)
         a. One can keep desired temperature by enclosing area in plastic and loosely tying in place with gauze.
         b. DO NOT use electric pads—danger of shock and burning.

II. DRY HEAT is used to ease pain, promote circulation, and muscle relaxation.
   A. Types:
      1. Hot water bottles
      2. Aqua-K pads
   B. Hot objects must never be applied to persons who are asleep or unconscious.

III. Cold applications are used for decreasing blood supply, relieving congestion and swelling, controlling hemorrhage, and to reduce fever.
   A. Types:
      1. Ice cap
      2. Ice collar
      3. Cold water soaks

This information is provided by:

Medication Guide and Drug Information

The use of modern drug therapy often necessitates that certain
ections be followed while you are taking your medications. It is
o necessary that you be aware of some of the effects that the drug
y have so you will know what to expect.

Below you will find those items checked that are appropriate to
scription _____ dispensed on _____.

[ ] Take this medication on an empty stomach; 1 hour before or 2 to 3 hours after a meal.

[ ] Do not use milk, juice, or antacids to swallow this medication, and avoid drinking any of these liquids for 1 hour before to 2 hours after each dose.

[ ] Do not consume dairy products, antacids or iron for 1 hour before to 2 hours after taking a dose of this medication.

[ ] Drink a large glass of water with each dose of this medication.

[ ] Do not drink alcoholic beverages while taking this medication.

[ ] Do not take any medication other than that prescribed for you by your physician while you are taking this particular drug.

[ ] Take each dose with either food or milk.

[ ] Dilute this medication in fruit juice or water before taking.

[ ] These tablets must be chewed before swallowing them.

[ ] Take your dose of this medication at the same time every day to avoid forgetting to take it.

[ ] Do not take aspirin or aspirin-containing products without the knowledge and consent of your physician.

12. [ ] This medication contains a dose of (aspirin) (acetaminophen). Avoid taking additional quantities of (aspirin) (acetaminophen) or non-prescription products containing this ingredient unless instructed to do so by your physician.

13. [ ] The quantity of medication prescribed constitutes a course of treatment. Use until all medication is gone or your physician has instructed you to stop.

14. [ ] These tablets must not be chewed before swallowing them.

15. [ ] While taking this medication do not take non-prescription cold, cough or sinus medication without consulting your physician or pharmacist.

16. [ ] Apply sparingly.

17. [ ] This medication should be taken "around the clock", at the hourly intervals specified.

18. [ ] May cause drowsiness in some persons. If you must drive a car or operate dangerous machinery, use caution.

19. [ ] This medication may cause discoloration of the urine or feces.

20. [ ] Avoid prolonged exposure to sunlight while taking this medication. You may sunburn more easily while taking this medication.

21. [ ] This medication may cause dryness of the mouth and nose but this is to be expected and is not harmful.

22. [ ] Additional special comments:

_____ R.Ph

PHYSICIAN CONTROLLED BRAND EXCHANGE

Background

Approximately five years ago no state had enacted any form of Brand Exchange legislation; however, in the past 5 years, 20 states have now passed and signed into law some form of the legislation.

The basic intent of all the legislation is the same, i.e., to save consumers money by dispensing a lower cost generically equivalent drug product. The attached document labeled "A" illustrates very clearly what has happened in the prescription drug market in the past several years. One manufacturer will manufacture a particular product (in the finished dosage form) for other companies large and small who distribute it under their own name. Until this was recently disclosed, neither pharmacists nor physicians were aware of this practice, and therefore, many put their trust in the larger company's product--which is, in most cases, more expensive.

The primary opposition to Brand Exchange legislation comes from the manufacturers of prescription drugs. They have built up name recognition for their branded products while they were covered by patent; and after the 17-year patent law is lifted, they continue to promote the brand product at the same price. Two documents attached (B & C) are ones which have led the way for brand exchange passage in most states.

Document B is a resolution passed by the Drug Research Board of the National Research Council endorsing Brand Exchange. This resolution is landmark, as it contained endorsements of physicians, researchers, pharmacologists, and industry representatives.

Document C is an article written by an attorney with the Federal Trade Commission analyzing all forms of Brand Exchange legislation.

Document D is a report of the Kansas Medical Society's Ad Hoc Committee on Brand Exchange. That report was submitted to the Medical Society's House of Delegates on November 7, 1976; and after 3 votes, the resolution endorsing Document D failed. The primary problem is one of education. If every physician voting had spent the time to study the issue as the 3 physicians had, there is no doubt in our minds that it would have passed.

An attempt has been made to keep this background as short as possible. However, there is such a wealth of material in support of this concept, it is hard to only select a few items. Additional information will be presented upon request.

Manufacturer Disclosure — PMA Concedes

A requirement that the name of the actual manufacturer of a drug appear on its label, in addition to that of the distributor, has finally been agreed to by the Pharmaceutical Manufacturers Association (PMA). This move has long been favored by APhA and NARD.

PMA has indicated that this change in position is related to the legislative activity by several state Pharmaceutical Associations. The states of Kansas, Florida and California have already been successful in placing the label requirement on the books.

The PMA Board of Directors voted to lend their Association's support to national legislation regarding laws considering the almost impossible situation that would result if the various states adopted different and possibly even conflicting laws.

The Kansas law (KSA 65-669b) can be satisfied "*by either stating such information on the label of the drug or by filing a statement with such information with the Board of Health.*" A staff review of the information filed with the Board of Health revealed that most manufacturers were not complying with the law. A review of the information that was available and supplementing it with a thorough search conducted by the California Pharmaceutical Association proved very informative. Two examples are as follows:

Chloral Hydrate 500 Milligram Capsules

Manufacturer	Distributor	AWP*
	Squibb	$5.00/100
	Lemmon Pharmacal	$2.90/100
R.P. Scherer	Stanlabs	$2.15/100
	Alliance Labs	$1.75/100
	McKesson	$1.75/100
	Pure Pac	$1.48/100

*AWP-Average Wholesale Price

Tetracycline Hcl 250 Milligram Capsules

Manufacturer	Distributor	AWP*
	A.H. Robins	$3.25/100
	Smith, Kline & French	$3.40/100
Milan	Wyeth	$2.06/100
	Towne Paulsen	$1.50/100
	Alliance Labs	$2.50/100
	Central Pharmacal	$2.50/100

*AWP-Average Wholesale Price

This evidence not only supports the contention that the pharmacist can save the patient considerable amounts of money, if he knows which firm manufactures which product, but it supports the contention that drug product selection by the pharmacist is not a radical or dangerous precedent, rather it is the most intelligent method of selecting the drug product which the consumer will ultimately receive.

News from the NATIONAL RESEARCH COUNCIL

The National Research Council was organized by the National Academy of Sciences in 1916 in order to [illegible] for a broader participation by American scientists and engineers in the work of the Academy. The Academy was [illegible]ered by Congress in 1863 as a private organization with a responsibility for advising the Federal Government in science and technology. Since this responsibility is now shared with the National Academy of Engineering, organized in 1964 under the original NAS charter, the Research Council serves, in effect, as an operating agency for both academies.

2101 CONSTITUTION AVENUE, N.W., WASHINGTON, D.C. 20418 AREA CODE 202 EX 3-8190

For further information call
Harry Weiss, (202) 389-6511

DRUG BOARD URGES CHANGE IN DRUG SUBSTITUTION LAWS

FOR RELEASE: P.M.'s, Tuesday, January 21, 1975

WASHINGTON--A physician should be required to give to, or explicitly withhold from, the pharmacist the option of substituting one brand of a drug he prescribes for another brand of the same drug--an option which could in many cases provide the same treatment at lower cost--according to a resolution of the National Research Council's Drug Research Board (DRB).

This "substitution" option is allowed by law in only two states--Florida and Michigan. In all others it is illegal for a pharmacist, without checking with the prescribing physician, to replace one brand with another even if both brands are known by the pharmacist to have been made in the same laboratory and even if one costs substantially less than the other, the DRB said in a background statement accompanying its resolution.

The DRB pointed out that "no inherent reason" exists for choosing the more expensive drug product simply because of brand-name familiarity. In the absence of any data indicating the substituted drug is not equivalent, then the pharmacist is "in the best position" to make the final choice, the Board said, with cost an element in the decision.

Following are the resolution and the background statement:

Resolution

WHEREAS, The patient's welfare should be the ultimate goal of statutes and regulations concerning drug product selection, which in operational terms means the best product for the lowest cost, and

WHEREAS, The physician must have the ultimate responsibility and authority in drug product selection, since he has the fullest knowledge of the patient's needs and responses with attendant obligation to be held accountable for his selection of particular drug products, and

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WHEREAS, The pharmacist may, in some situations, have greater knowledge of drug products than other health professionals, including knowledge of both quality and costs, and

WHEREAS, It is appropriate that decisions with regard to the choice of drug products be made by the health professional possessing the greatest amount of information involved in the particular selection in question, with the attendant accountability, therefore be it

RESOLVED, That the physician, having selected the chemical entity to be used for therapy, should be required to delegate to the pharmacist, or explicitly to retain to himself, selection of the particular drug product to be dispensed and received by the patient.

Background Statement

Early in 1973, the DRB became interested in the question of the appropriateness of existing drug antisubstitution legislation and its relation to the final application of knowledge concerning drugs. Initially, the DRB considered that the antisubstitution laws which have existed in almost all of the states for several decades remain appropriate at the present time and protect the consumer from inferior products. At that time (early 1973), a resolution strongly endorsing continuation of antisubstitution legislation was considered by the DRB. However, subsequent meetings with representatives of various groups, especially the American Pharmaceutical Association (APhA), brought out important facts with which the DRB had not previously been familiar and which it believes most of the American public and American physicians are not aware of.

Perhaps most important is the fact that it is currently illegal for a pharmacist, often the last health professional to have contact with a patient prior to the latter's taking a prescribed drug, to substitute one brand of a given chemical entity for another (e.g., on the basis of lesser cost to the patient) even if both brands were manufactured in the same laboratory, when only the former brand is specified by the physician on the prescription. The DRB discussions concentrated on the knowledge or information, which goes into such decisions; and many of the discussions focused on how one is to deal with an absence of data on bioavailability and bioequivalence. The DRB did not consider that the cheaper of two drug products of the same chemical entity is necessarily the more desirable. However, in the absence of information to the contrary, it is unreasonable to assume that the less expensive is less desirab In essence, the resolution finally adopted unanimously by the DRB asserts that, in the absence of data to the contrary, there is no inherent reason for choosi the more expensive drug product simply because of the familiarity of the physi or pharmacist with the brand name. It further asserts that the pharmacist may the health professional most familiar with the details of cost, the one who has deal with inventory and similar problems, and because of these, the physician should either delegate to the pharmacist the right to make the choice or expli citly reserve that right for himself.

-MORE-

The DRB resolution, in addition, emphasizes accountability of the health professionals involved--the physician and the pharmacist--for their decisions. For the physician, he must be prepared to defend his decision to restrict the dispensed drug product to the specific brand named in his prescription, should he choose to require such a restriction. For the pharmacist, he must be prepared to defend his substitution of a cheaper drug product than a brand named in the prescription, should substitution be permitted by the physician.

The DRB is aware that it changed its position during the calendar year 1973, so that the final position is almost exactly opposite to that it initially considered taking on this issue. The main reasons for this change were (1) learning that amendment of antisubstitution laws does not mean removing from the physician the prerogative of requiring a particular brand; (2) becoming aware of the data on source manufacturer of a number of different brands of some chemical entities (e.g., tetracycline and chloral hydrate, as recorded in the "Hearings before the Subcommittee on Small Business of the U.S. Senate, 93rd Congress, Second Session, etc., etc.," Part 24, February 20, 21, March 5, and 6, 1974); (3) examining the relative laws recently passed by the states of Florida and Michigan. An important unstated aspect of this issue, however, is the conspicuous absence of data or information of any sort for use by the health professionals in making such decisions, other than cost data. As stated above, however, the DRB decided that, in the absence of data indicating inequivalence, cost would often be the deciding factor; and the pharmacist is often in the best position to make this final choice.

The resolution was passed unanimously by the members of the DRB with one abstention, that of J. Richard Crout, director, Bureau of Drugs, Food and Drug Administration, whose agency has not taken an official stand on the issue. Chairman of the DRB is Frederick E. Shideman, head, department of pharmacology, University of Minnesota. Other members are Daniel L. Azarnoff, professor of medicine and pharmacology, University of Kans Medical Center; James A. Bain, director, division of basic health sciences, Emory University; Mitchell B. Balter, chief, special studies section, psychopharmacology research branch, National Institute of Mental Health; Allan D. Bass, associate dean for biomedical sciences, Vanderbilt University School of Medicine; Paul Calabresi, physician-in-chief, Roger Williams General Hospital, Brown University; J. Richard Crout, director, Bureau of Drugs, Food and Drug Administration; Victor A. Drill, director, scientific and professiona affairs, G.D. Searle & Co., Skokie, Illinois; Robert M. Hodges, vice president, research and development, Parke, Davis & Company, Ann Arbor, Michigan; Hugh H. Hussey, editor emeritus, American Medical Association, Chicago, Illinois; Werner Kalow, chairman, department of pharmacology, University of Toronto; Thomas D. Kinney, professor of pathology, Duke University Medical Center; Kenneth G. Kohlstaedt, professor of medicine, Indiana

-MORE-

iversity; Emanuel M. Papper, dean, University of Miami School of Medicine; James A. ttman, Jr., dean, School of Medicine, University of Alabama; James M. Price, vice esident, corporate research and experimental therapy, Abbott Laboratories, North icago, Illinois; David P. Rall, director, National Institute of Environmental Health iences, Research Triangle Park, North Carolina; and George W. Thorn, physician-in-ief, emeritus, Peter Bent Brigham Hospital, Boston, Massachusetts.

# # #

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Physician Controlled Source Selection —A Suggested Approach to Substitution

Bruce M. Chadwick

(Remarks made before the Cleveland Clinic Educational Foundation, Cleveland, Ohio, September 8, 1975.

I greatly appreciate this opportunity to discuss "drug substitution" before your prestigious organization. I must disclaim at the outset that my remarks today are my personal views. They are not intended to be and should not be considered to be the official position of the Federal Trade Commission.

With that understood, I will state my position very clearly. I am against drug substitution; but, with equal vigor, I am also in favor of drug substitution. "Did I hear that correctly?" you may be asking, "Is he both for and against drug substitution?" The answer is yes. Let me explain.

Substitution—A Study of Clear Intentions and Ambiguous Arguments

The literature concerning "substitution" is confused and confusing. Seldom do protagonists and antagonists define their terms, let alone define them similarly. Even when a definition is established, the arguments for and against are often emotional, diversionary and question begging.

There are no less than seven types of "substitution." Only the first two that I will mention are defensible from my perspective. Only the second one appears truly workable. That is why I can claim to be both for and against substitution.

This continued confusion and emotionalism in the literature of substitution is, I venture, considerable testament to the zealous determination of the principal manufacturers and distributors to maintain their economically advantageous status quo.

That status quo is market power. Market power, the ability of a firm to maintain simultaneously high prices and market domination against firms with lower prices for equivalent products, is obtained by an initial distributor of a prescription drug through the patent system. It is subsequently maintained through trade name (brand) promotion, the effect of which is reinforced and increased by economically self-interested state regulations—the so-called antisubstitution and anti-advertising laws. Prices to consumers remain considerably higher than those which should occur under more aggressive price competition. The consumer injury associated with the unnecessary maintenance of this market power is normally estimated to be millions and hundreds of millions of dollars.[1] It will continue to increase as a large number of patents expire over the next ten years. At the least, consumer injury appears substantial and warrants serious concern by appropriate regulators.

Before discussing solutions, let us establish some common ground by reviewing and defining the various types of "substitution." Hopefully, it will help to avoid the traditional ambiguity and diversionary potential of this issue. In highlighting the various types of substitution, the concept of source selection comes up repeatedly. It warrants definition: source selection occurs when a dispenser or prescriber selects among more than one manufacturing or distributional source[2] (that is, company) which each sells the same basic drug, or therapeutic moiety to be more technical. It is a selection of the brands or unbranded generics of the same drug.

Authorized Formulary Selection

The first medically defensible but generally unworkable type of substitution is what I call the "authorized formulary selection." This occurs when an appropriate regulatory body or individual physicians establish a list of drugs from which source selection, if it occurs at all, must occur. Sometimes substitution is optional; sometimes it is required. The prescriber is given veto power to prohibit selection from this formulary as appropriate. Although this approach is useful in an institutional setting (e.g., hospitals), and among individual pharmacists and physicians by specific agreement, it appears to be generally unworkable when applied across the board to retail pharmacies. I understand that Kentucky, Maryland, and Massachusetts have versions of this system. The experience does not appear to have been satisfactory.[3]

Physician Controlled Source Selection

The next type of substitution is, I believe, medically defensible, workable, and desirable. I call it "physician controlled source selection." This occurs when an appropriate regulatory body specifically permits pharmacist source selection except when a prescriber communicates contrary instructions by means other than brand designation. Thus, for example, unless a prescriber instructs "Do not substitute", or "This source only", the prescriber implicitly authorizes the dispensing pharmacist to choose an appropriate source *just as he would do were he to have written the prescription generically.* The only difference with a generic prescription is that the prescriber explicitly authorizes pharmacist source selection by *requiring* the pharmacist to make the selection. Also, with a generic prescription, of course, there is technically no "substitution", since no source was originally specified. In any event, with "physician controlled source selection" the prescriber is on notice that source selection will occur unless he instructs otherwise. Arkansas, Michigan, Minnesota, Oregon, and California have recently enacted this type provision. Actually, California and Arkansas have hybrid systems, combining physician controlled source selection with a "negative formulary" a list of drugs which are not to be substituted even if a prescriber fails to instruct "Do not substitute". Apparently this is designed to reduce potential physician errors. More on this later.

The remaining five types of substitution are, to me, medically indefensible. They are often used by opponents of "substitution" to discredit all types of source selection.

Implicitly Unauthorized or Ambiguous Source Selection

The first of these may be called "implicitly unauthorized or ambiguous source selection."

This occurs when no prohibition exists against source substitution *but also* when no positive regulatory permission is given to substitute. Prescribers are not on notice as to whether brand specification will be binding

(over)

Nor are pharmacists on notice as to whether brand specification was meant to be binding. The District of Columbia and Vermont (as to narcotic drugs)—and until recently, Alaska—have had this arrangement. It is not surprising that little source selection takes place. The ambiguity of this situation makes it tantamount to an antisubstitution law, absent the legal assurance of no substitution.

Explicitly Unauthorized or Unrestrained Source Selection

Another type of indefensible substitution can be characterized as "explicitly unauthorized or unrestrained source selection". This would occur if a dispensing pharmacist could override the physician's prerogative for a particular source. A pharmacist could ignore a physician's instructions not to substitute any other source of the prescribed drug. No state has this system. Nor am I aware of this system ever being presented by pro-substitution spokesmen. Nonetheless, it is one of the principal diversionary "models" which is usually set up by those who wish to attack pro-substitution systems.[4] Later, I discuss this as the "physician supremacy smokescreen."

Therapeutic Selection

Another potentially troublesome type of substitution can be called "therapeutic selection". This would occur under a system in which the prescriber diagnoses an ailment, explains the desired type of treatment and isolates any potential risks to the relevant patient. The physician then defers to a drug dispenser the decision of which therapeutic agent(s) to use in treatment. In this system, the pharmacist writes *and* dispenses the traditional prescription. The physician merely tells what he wants to accomplish. This system occurs in none of our states, but it is probably being advanced by some pharmacists as their future, long-range aspiration. I assume that it is the spector of this system which frightens some physicians into opposing even limited source selection. They may envision a flood-gate phenomenon—give a pharmacist a source selection and he will eventually make a therapeutic selection. The logical nexus is unpersuasive.

Fraudulent Counterfeit Selection

Now we come to the great counterfeit conspiracy. This involves a type of substitution that I call "fraudulent counterfeit selection". This system would never occur with any official blessing. It involves a pharmacist knowingly or unwittingly passing off a look-alike but often not a chemically equivalent product for that which was prescribed. Both the physician and consumer are duped. Sometimes the pharmacist is duped. This counterfeit or passing off problem was early adjudged to be unfair competition. The problem developed in rather epidemic proportions during the 1930's and 50's when new unpatented and patented drugs suddenly flooded the market as a result of the extraordinary drug research and development breakthroughs of that era. Shyster companies tried to take an elicit piece of this burgeoning prescription drug market. All responsible members of the health care team as well as the general public were outraged. Trading on this emotionalism, the major drug manufacturers pushed a regulatory program that was ostensibly designed to rid the country of the counterfeit menace.[5] In addition to private actions for unfair competition, the great authority of state criminal and licensing law would come to the rescue. However, the new antisubstitution laws were much broader than necessary to assure their anti-counterfeit aims. In apparent appreciation of the impending patent expirations of the 1960's and 70's, and probably in legitimate fear that manufacturers were not closely enough policed by FDA for quality, the drug manufacturers secured support and passage for brand-specific antisubstitution laws in nearly every state of the union.

"Substitution" became synonymous with "counterfeiting" and "gross immorality".[6] Such overtones are still encouraged by opponents of source selection in an ingenuous attempt to establish guilt by association.

Mistaken Product Selection

The last type of substitution I wish to mention can be called "mistaken product selection". As with "fraudulent counterfeit selection", this will never occur with official blessings. A mistaken product selection occurs, for example, when a pharmacist dispenses a mild tranquilizer instead of prescribed birth control pills or a skin tanning drug instead of gall bladder medicine.[7] Negligent errors such as these—not even related to source selection—are nonetheless used to point to apparent horrors of physician controlled source selection. The connection is absurd.

Physician Controlled Source Selection—Safe and Salutary

As mentioned above, physician controlled source selection is both defensible and workable as a technique by which an appropriate regulator can reduce unnecessarily high prescription drug prices to consumers. Its impact would primarily be felt by manufacturers and distributors rather than pharmacists. Several states have recently adopted this technique. When used, it should be structured in such a way to assure that the regulator avoids practicing medicine, interfering with ultimate physician control of the prescribed drug product, interfering with pharmacists' independent selection of a drug product source, or encouraging the dispensing of therapeutically inequivalent drugs. Such a system should also, to the extent consistent with the above features, be designed to encourage the dispensing of low-priced drugs in which pharmacists and physicians have confidence and encourage the passing on of such price savings to consumers.

I believe that the approach that I will outline in the remainder of these remarks accomplishes all of the above, especially when used in conjunction with readily available consumer price information. Were I a state regulator concerned with the problem of "antisubstitution laws", the most important thing that I could do would be to remove the antisubstitution law to conform with what I earlier described as "physician controlled source selection", or if you like, implicitly authorized substitution. I would permit the pharmacist to select the drug product source unless the physician explicitly instructed otherwise.

In discussing this approach, I will attempt to remove several smokescreens and fears which enshroud proposals for physician controlled source selection. The first is what I call "the therapeutic equivalency smokescreen".

The Therapeutic Equivalency Smokescreen

There are three types of "equivalencies" relevant to prescription drugs. For clarity, it is desirable to avoid the ambiguous term "generic equivalency" and, instead, to use one of the following as warranted. Because these or related concepts are used so extensively in the source selection literature, it is important to understand them.

Chemical equivalency exists between two sources when the active ingredient(s) are essentially identical in type and amount. Thus, Lederle's brand or source of tetracycline hydrochloride (Achromycin V) is chemically equivalent to Squibb's brand (Sumycin), Sherry's product (an unbranded generic), and approximately 62 other sources of tetracycline, which, by the way, range in price to the pharmacist from $4.12 to $50.60 per 1000 capsules of 250 mg. doses.[8] The Food and Drug Administration refers to this concept as "pharmaceutical equivalency".[9]

Biological equivalency exists between two chemically equivalent drug products when the active ingredients are absorbed in the body and reach their intended location (i.e., they are biologically available) in essentially the same time and the same concentration. Theoretically, it seems, all chemically equivalent drugs should be biologically equivalent in the same patient. However, due to such things as the packing density of pills, the crystalline form or particle size of active ingredients, and the biological effects of certain so-called inert or inactive fillers and binders, some "chemically equivalent" drug products will become available to the body in different concentrations and over different time periods. This may or may not interfere with proper therapy. In any event, such drug products are considered biologically inequivalent.

Therapeutical equivalency exists between two chemically equivalent drug products, whether or not they are biologically equivalent, when they in fact produce the same therapy or clinical results for example, when they cure an ailment with essentially identical success in the same time period. The Food and Drug Administration appears to combine what I refer to as biological equivalency and therapeutical equivalency into a single concept of "bioequivalence".[10]

selection is the fact that for a variety of reasons, one can have no (or little) assurance that ch[illegible]lly equivalent sources of a drug are in [illegible]herapeutically equivalent. The statement suffers seriously from exaggeration.[13] *But even if it were totally true, it is irrelevant to deciding whether physician controlled source selection is inferior, healthwise, to the present antisubstitution system.* It is relevant only for formulary systems which selections and for reimbursement programs such as HEW's new Maximum Allowable Cost component of Medicaid.

Even in states with antisubstitution laws, physicians are now given two unrestrained prescribing options: they may prescribe generically—that is, require source selection by the pharmacist—or specify a drug product source. I am aware of no one arguing that physicians be prohibited from prescribing generically. Hence, everyone is now willing at least to trust in physicians' prescribing habits and pharmacists' source selection as relates to generically written prescriptions. The system of physician controlled source selection in no way changes this arrangement. It simply assures that a physician's source selection (*i.e.*, a prescription naming a brand) is a deliberate selection and not a shorthand for a generic prescription. The physician retains just as much *authority* to specify by the source or generically as he presently has. Thus, unless we now reverse the hypothesis that physicians can be trusted, the proposal designed to establish physician controlled source selection has at least as many safeguards as our present system.

As I mentioned above, the recent California and Arkansas "negative formularies" do seem to challenge the hypothesis that physicians can be trusted. However, it is of interest that neither state prohibits *generic* prescriptions for the same "troublesome" drugs. This notable paradox may suggest that the negative formulary is more a political expedient than an important health measure.

I stated that physician controlled source selection has "*at least*" as many safeguards as present antisubstitution systems. It is noteworthy that considerable literature exists suggesting that pharmacists may be even more capable than physicians (both because of specialized training and available time) to engage in authorized source selection.[14]

Although physicians will retain their *authority* to insist upon a particular source selection, it appears fairly clear that they will often decide not to do so.[15] This is precisely what worries the larger manufacturers - they will immediately lose sales, just as they would, for example, if physicians would generically prescribe "propoxyphene hydrochloride" instead of "Darvon."[16] Due to the relative ease of writing "Darvon" and other leading brands of other drugs vis-a-vis their usually complex generic or established names, the prospect of "generic prescribing" is not of much concern to the manufacturers.

Perhaps the second argument most vigorously advanced by opponents of the various types of source selection is the awful spector that physicians will lose their authority to dictate source selection even if they believe it desirable or necessary for therapy. I call this the "physician supremacy smokescreen." As explained above, under the limited type of substitution that I am proposing (and which is usually proposed), these fears are groundless. Physicians retain the same authority they now have to insist upon a particular source.

The Reluctant Pharmacist Fallacy

We now come to the "reluctant pharmacist fallacy." There is considerable concern, not entirely unwaranted I suspect, that even if pharmacists were simply permitted to substitute many would not.[17] And further, of those who would substitute, some (presumably those using a percentage mark-up) would select higher priced sources in order to exact higher profits while others would fail to pass their cost savings on to consumers.[18]

Several approaches could be used to help ameliorate these potential problems, depending upon how serious they seem to be.

At least one reason that some pharmacists may be reluctant to engage in very low-priced generic source selections (as opposed to moderately low priced brand selections) is that they (as well as doctors) do not have easy access to useful, comparative source information. Continued FDA vigilence in dealing with manufacturers should continuously reduce the need for this information. Nevertheless, an appropriate regulator may wish to require manufacturers or distributors to provide pharmacists (and physicians) with greater information related to source selection criteria. In addition to identification of the actual manufacturer of a distributor's bulk and final form drugs,[19] the relevant manufacturing and quality control specifications may be useful information.[20]

To assure that pharmacists pass on to consumers a healthy portion of the cost savings of selecting less expensive sources, regulators should assure that consumers have adequate comparative price information, or, as the American Pharmaceutical Association calls it, "enhanced consumer awareness of the opportunity to save money on prescription medication."[21] Price disclosures should put price competitive pressures upon pharmacists to pass on m[illegible]st of the cost savings from low priced generic sources to consumers.[22] This will be especially so in states which require pharmacists to "post" prices of various sources of multisourced drugs or to present a point-of-purchase sign indicating the potential option and benefits of source selection.[23]

If all else fails, the final and least desirable way to ameliorate the "reluctant pharmacist fallacy" would be to require a pharmacist to charge no more for a substitutable prescription than he would charge if he in fact dis-*in stock for dispensing.* The pharmacist should be in no way required to stock or dispense any product. But, if in his pr[illegible]n-al wisdom he decides to stock and i[illegible]as in stock a particular source which he sells for less than his other source(s), under this type requirement he could not charge more for the substitutable prescription than he would for the low priced product unless the consumer agrees. He would not be concerned about the therapeutic inequivalence of the lower priced product since he has it in stock with the intent to dispense it. Although this provision would not require him to dispense the lowest priced source he stocks, he is left with three choices:

First, he may dispense it and charge accordingly.

Second, he may dispense a higher cost source so long as he prices it as he would the lower cost source.

Third, he should be able to get the consumer's consent to dispense other than his lowest priced source and charge whatever they agree upon.

Hopefully, however, this rather drastic regulatory intrusion into the pharmacist's management prerogatives may be avoided by the earlier suggestions related to manufacturing information and consumer price disclosures.

To briefly recap, I think that a system of "physician controlled source selection" is safe and salutary. It will result in very substantial consumer economic benefits and significant, although less substantial, pharmacist savings. But not everyone will come out victorious under this system. Certain large manufacturers will be the exception. And this leads to an important issue concerning pharmaceutical research and development.

The Research and Development Dilemma

Industry representatives and a small number of writers outside the industry[24] maintain that prescription drug manufacturers' profits are really not as large as they seem and, in any event, need to be rather substantial to continue important and expensive research and new drug development. Patent monopolies, the argument goes, may not be sufficient. In this unique industry, we should permit post-patent market power which would normally be considered anticompetitive in order to assure sufficient profits to continue attracting research and development capital.

I am unpersuaded that the major drug companies are impoverished. I am also unpersuaded that we should help to artificially extend the 17-year patent monopoly. Our basic bias should be in favor of free competition - not against it. The argument does not appear too qualitatively different from that of pharmacists arguing to be immunized from price competition so that they can continue offering consumers certain desirable services. The pharmacists don't even have the decade and a half of monopoly profits to soften their views on competition.

Professional Legal Liability—he Last Big Scare

One [illegible] problem warrants attention, although it will be fully discussed elsewhere in your program. It is, I think, the last big scare: professional legal liability. By calling it the "last big scare" I do not mean to imply that it is no cause for concern. It clearly is. Nevertheless, it is no cause for alarm.

I prefer to distinguish between "legal responsibility," "legal exposure," and "legal expense." Legal responsibility occurs when legal consequences attach to certain conduct. For example, legal consequences attach to a physician specifying a particular brand of a multisource drug. If he should have known that the brand was ineffective or hazardous he may be legally negligent. On the other hand, there are probably not any legal consequences if he prescribes the same therapeutic moiety by established name, assuming there are multiple sources, some of which are safe and efficacious.

"Legal exposure," the second concept, refers to how frequently one engages in conduct for which he is legally responsible. Thus, the more times a physician prescribes by brand (or source), the greater his legal exposure.

The third concept, "legal expense," refers to legal exposure which results in a lawsuit and damages. Logically, the greater one's legal exposure, the greater the *probability* of incurring legal expense. Whether that probability becomes an *actuality* depends upon the degree of care with which one exercises his legal responsibilities.

Although I don't pretend to be an expert in this area, I would conjecture that a physician's legal responsibility in prescribing a multisource drug will always take the form of "tort" law—intentional or, more likely, negligence.[25] If this is so, the physician would probably reduce his legal exposure by permitting pharmacists to make source selections.[26]

What about the pharmacist's liability? Unlike the physician, the pharmacist must be concerned with two types of legal responsibility—tort law and warranty law. When a pharmacist makes a source selection, either under physician controlled substitution or when a prescription is written generically, he has a "tort" responsibility to exercise professional due care in his selection. If he should have known the source was somehow bad, he will be negligent. As a pharmacist is allowed to make more source selections, his tort responsibility and exposure will increase. However, his legal *expense* will only increase if he fails to exercise professional competence. That is the way it should be. And that is the way it is whenever physicians now prescribe generically.[27]

A pharmacist, as mentioned, must also contend with warranty liability. Under the Uniform Commercial Code, it seems clear that a pharmacist is a "merchant" selling "goods" for purpose of warranty law.[28] Hence, he has warranty responsibility for every drug source he dispenses, whether or not prescribed by brand.[29] Under [illegible]physician controlled source selection [illegible] his warranty responsibility doesn't ch[illegible]. His exposure, however, will increase to the extent he inadvertently selects harmful or ineffective sources. Nonetheless legal *expense*, even in the latter circumstance, should remain minimal because he will be able to hold responsible the distributor and, in turn, the culpable manufacturer for having breached their warranties to him.

Potential administrative liability under federal or state Food, Drug and Cosmetics Acts should be irrelevant to physician controlled source selection, assuming appropriate disclosures are made. Likewise, the "unfair competition" theories properly used by manufacturers to stop fraudulent counterfeit selection are irrelevant to physician controlled source selection, assuming again that appropriate disclosures are made.[30]

In sum, the professional's legal *expense* should be essentially unchanged under the system I propose, despite the potentially important differences in tort and warranty *exposure*.

As a final conclusion, I simply ask that you focus on what I have described as "physician controlled source selection." Don't be sidetracked by ingenuous, diversionary arguments which relate to other admittedly indefensible systems of substitution.

(Editor's note—References to Mr. Chadwick's article are available upon request from the editor.)

BRAND EXCHANGE - Fall House of Delegates - Nov. 7, 1976

(As authorized by Resolution 76-17)

Resolution 76-17 directed the Pharmacy Liaison Committee to meet with representatives of the Kansas Pharmaceutical Association to continue examining a proposed brand exchange program. The committee subsequently met with representatives of KPhA and has prepared their recommendations to the Fall House of Delegates (see Resolution and attachment A-F76).

During the committee's deliberations, a wealth of literature on the subject of physician-controlled brand exchange was reviewed, and the committee attempted to assess the impact the enactment of a brand exchange law would have on physician's prescribing practices and patient care in Kansas. It was learned that over 20 states currently have brand exchange laws in effect, and that with the impending implementation of the Maximum Allowable Cost regulations, all federal programs would in effect embrace a "brand exchange" concept for future reimbursement. The committee also found that brand exchange is currently being utilized extensively throughout many Kansas hospitals, and ever-increasingly by private physicians in their practices.

The potential benefits of a physician-controlled brand exchange program lie primarily in possible cost savings to patients, a point which carries considerable merit with state legislators. Additionally, the enactment of such a law would allow pharmacies across the state to reduce their vast inventory of multi-source drug products in favor of more cost-effective stock.

The committee raised the question of a physician's potential liability when a brand exchange is made that results in an untoward reaction. The bulk of legal literature reviewed indicates that a physician's liability is not substantially affected either way by virtue of a brand exchange. If a pharmacist, however, knowingly stocked and exchanged a vastly inferior drug product that resulted in adverse reactions, he undoubtedly would have an increased liability.

In summary, based upon the literature reviewed and the discussions undertaken, the committee could find no inherent, compelling objections to the enactment of a physician-controlled brand exchange program such as the one outlined in the enclosed resolution. A program such as this could have a substantial cost savings benefit to the patient population of the state as a whole. The committee recommends adoption of the resolution and accompanying draft legislative proposal.

John Huff, M.D.
Richard Beach, M.D.
John P. Brockhouse, M.D.

STATE OF KANSAS

ROBERT F. BENNETT, *Governor*

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

State Office Building

TOPEKA, KANSAS 66612

ROBERT C. HARDER, *Secretary*

Division of Vocational Rehabilitation

Division of Social Services

Division of Mental Health and Retardation

Division of Children and Youth

Division of Administrative Services

Alcohol and Drug Abuse Section

State Office Economic Opportunity

February 9, 1977

Re: Cost Studies to Determine Professional Fees

To: Pharmacies Participating in the Kansas Medical Assistance Program, Title XIX
Area Directors Code 1

Enclosed are three copies of a cost statement for your completion which will serve as the basis of your professional fee in fiscal year 1978. All Kansas pharmacies, except hospital pharmacies and those community pharmacies operating for less than six months during 1976, are required to file cost studies. All those not required to file and new stores opened in 1977 will be assigned a statewide fee. In addition, out-of-state pharmacies that experienced an annual volume of Title XIX payments for calendar 1976 in excess of $500 are required to file cost studies. All other out-of-state providers will be assigned a fee not greater than the Kansas statewide dispensing fee. Those providers who fail to file cost studies as required or by the date due, will be assigned a professional fee equal to the lowest of all computed fees filed by Kansas pharmacies.

Please prepare the drug cost study in triplicate and the drug survey in duplicate and retain one copy of each for your files. One set should be submitted in the following page order: Pages 1-4, Cost Studies; Page 5, Drug Survey Summary; Pages 6-11, Drug Survey Sampling (pages not numbered). The second set will include only Pages 1-4, Cost Studies; and Page 5, Drug Survey Sampling. Send both sets to the State Department of Social and Rehabilitation Services, Attention: Medical Services Section, State Office Building, Topeka, Kansas, 66612. The deadline for filing is April 15, 1977. However, it would expedite our processing if we received them prior to that date. All information reported in these schedules will be kept confidential.

The computation to determine the individual provider's computed fee will involve separate calculations of labor cost and other overhead costs and, if necessary, individually reported labor and other overhead costs will be reduced to a reasonable percentile of all such figures reported.

The effective date of change of professional fees will be July 1, 1977. Those pharmacies utilizing accounting periods other than a calendar year must use as their reporting period the fiscal year which ended during 1976. The State Department of Social and Rehabilitation Services will notify each pharmacy of the assigned professional fee to be used when filing claims for drugs dispensed under the Kansas Medical Assistance Program, beginning July 1, 1977.

The professional fee assigned to the individual provider will be the lower of the provider's average gross margin per prescription as reflected by the prescription survey or the computed fee as derived from the allowable labor and allowable overhead costs plus a minimum uniform profit allowance of at least 30 cents.

Upon receipt of notice of the assigned professional fee, a pharmacy may request an explanation of the computation involved providing the request is supported by reasonable justification. Providers continuing to feel that the assigned fee has been incorrectly determined, may file an appeal with the Director of Medical Services, State Department of Social and Rehabilitation Services, State Office Building, Topeka, Kansas, 66612.

Payment for drugs dispensed under the Kansas Medical Assistance Program is subject to reimbursement at reasonable rates commensurate with the budgeted resources of the agency to provide such Medical Assistance.

Cost studies are subject to audit to confirm accuracy of reported information. Any such audit will be performed within two years of the period in which the fee is applicable. If the audit discloses the assigned fee to be in error, the amount of change in the reimbursable amount may be subject to a retroactive adjustment to the beginning of the audited periods.

Blank cost studies are also being mailed to those not presently required to file so they will be familiar with the forms when they are required to file. Your cooperation in this eighth year of the professional fee reimbursement system is greatly appreciated.

Sincerely yours,

William E. Richards

William E. Richards, Sr.
Director of Social Services

WER:rdh
Enclosures

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
State Office Building Topeka, Kansas 66612

GENERAL INSTRUCTIONS FOR PHARMACY COST STUDY

The information requested in this year's cost study is similar to the information contained in last year's study. Some alterations were made to the forms, partly in response to recommendations received from individual pharmacists.

The forms are designed to follow the expenses recorded on your federal income tax return. Line numbers of various federal income tax forms have been indicated in the left margin of page 3 for individual expenses. For example, if you are an individual proprietor, depreciation expense requested on line 43, page 3, may be found on Internal Revenue Service Form 1040, Schedule C, line 6. Likewise, if you are organized as a partnership, depreciation expense may be found on Form 1065, line 20. For corporations, the same item is found on line 21 of Forms 1120 or 1120S. The balance of page 3 can be completed in a similar manner.

Individual line item expenses per tax return and cost study will agree in most cases, since you should report all ordinary and necessary expenses actually incurred by the business on both the study and the return. Budgeted or expected costs should not be reported. All major differences regarding the treatment of expenses between the cost study and your federal income tax return have been noted in these instructions. If a question arises as to the treatment of a specific expense item the provider should assume tax treatment. It is suggested that the person who normally prepares your income tax returns also prepare this cost study.

The purpose of the Reconciliation on page 4, is to insure that all expenses are included on the cost study and to insure that none are duplicated. You must reconcile total expenses per cost study (page 3, line 68) to either total expenses per Books of the particular store or operation for which this study is being filed or to total expenses from the related federal income tax return whichever is more convenient for you. The Reconciliation must be completed on every cost study even if you have no reconciling items. For items that are being reconciled it is important to indicate by line number where the reconciling items are found on the cost study. It is not intended that you should have to reveal any outside or unrelated activities.

Information on pages 2 and 3 will be keypunched so the forms should be neatly filled in. Round all dollar amounts to the nearest whole dollar, omitting all cents, except for the average gross profit per prescription from your survey, line 71, page 3, and last year's professional fee (the fee now in effect), line 72, page 3. For example, if advertising expense was $132.59 on your federal return, report 133 on line 64, page 3. Do not report it as 132.59 or 133.00. If questions arise as to the interpretation or use of the instructions or forms, please write to us for assistance.

INSTRUCTIONS FOR PRESCRIPTION SUMMARY AND SUPPLEMENTAL INFORMATION ON PAGE 2

ITEMS 1-17 Check no more than one box in each category and supply the requested information as it applies to your operation. See detailed instructions that follow.

ITEMS 9, 10, 11 Ownership Affiliation Those that are not members of a chain (as defined) should check item 9. A chain is defined, for this purpose, as two or more stores or units located anywhere in the United States, under one ownership or management group that has significant influence or control over buying, pricing or other management functions. This definition does not include units that have membership in voluntary chains, buying cooperatives, or other such buying groups. As an example, a chain with three units in Kansas and seven or more units in other states would check item 11, since the chain consists of 10 or more units.

ITEM 12 Zip Code Report the zip code of the physical location of this store. This is usually the same as your mailing address except when using a post office box or a home office for mailing purposes. This information is needed to perform statistical analysis that should be beneficial to all pharmacists.

ITEMS 18-20 Prescriptions Dispensed Indicate the total number of prescriptions (new and refill) dispensed, including Title XIX prescriptions, for your cost study fiscal period. If you provide medication through a unit-dose medication delivery system, the original prescription should be counted as a new prescription and each subsequent billing period is to be considered a refill of that prescription. The accuracy of information relevant to the total number of prescriptions dispensed is of the utmost importance.

ITEM 21 Fiscal Year Indicate month, day and year which ends the fiscal period of your business. This must be the same fiscal year used for your tax return. It must end on or before 12-31-76.

LINES 22-25 Cost Allocation Information Provide the requested information for prescriptions and total store, including prescriptions. Insert under column 1, Prescription, lines 22, 23, and 24, only the dollar amounts that are directly attributed to a transaction involving prescription items included in line 20 above. Non-prescription OTC items, cosmetics, feminine hygiene products, vitamins, beauty aids, prophylactics, etc., should not be included as prescription sales. The amounts for total store sales and total store cost of goods sold may be found on lines 1 and 2 of your tax return.

LINE 25 Area, Floor Space The accuracy of this information is extremely important. Do not include storage area in either column 1 or 2. Storage area is described as area primarily used for storage such as basement, attic, off-the-premises areas, and freight in-out area. Prescription shelf space is not defined as storage area and, therefore, is included in prescription area. Report prescription area and total store area according to their exact dimensions. Do not include patient waiting area with prescription area. An additional 50% of the reported prescription area (subject to limitation) will be added by us for patient waiting area and prescription-related office area in determining the ratio of prescription area to total store area. This ratio will, of course, be limited to 100%.

INSTRUCTIONS FOR SALARIES, WAGES, PAYROLL TAXES & EMPLOYEE BENEFITS ON PAGE 2

LINES 26-39 General Instructions Each line (except line 39) is intended to contain information for only one individual employee or owner. If your operation has more individuals than lines provided, please attach a detailed schedule containing the requested information and bring the totals foward to the form. Also, note that line 26 can be used only by individual proprietors, and lines 27 through 30 can be used by both partnerships and corporations but not by individual proprietors.

LINES 26-34, Column 1, Individual's Social Security Number Report the social security number of each owner and professional listed.

LINES 26-34, Column 2 Check if individual is a registered pharmacist.

LINE 26, Column 3, Drawings (Individual Proprietor) Enter total salary or drawings in the box provided. Do not, however, include this amount when totaling column 3 on line 40 since drawings of an individual proprietor are not deductible for tax purposes. The amount of drawings in the box, within limits, will be included in calculating your fee.

LINES 27-30, Column 3, Drawings/Salaries (Partners/Stockholders) Enter drawings/salaries for each partner/stockholder with prescription time. (Those without prescription time should be entered in line 39). Federal references: 1065, line 14; 1120 and 1120S, line 12.

LINES 31-39, Column 3, Salaries and Wages (Employees) Enter salary and wages paid to each individual employee, except those employees who have no prescription time in which case it is entered in total on line 39. Individual proprietors will find these expenses on line 10 of IRS Form 1040, Schedule C; partnerships on line 13 of IRS Form 1065; corporations on line 13 of IRS Form 1120 or 1120S.

LINES 27-30, Column 4, Payroll Taxes on Stockholders' Salaries (Corporation Only) Enter employer's share of payroll taxes in column 4, lines 27-30. In order to afford equal treatment to all businesses regardless of type of ownership, this amount will not be an allowable cost for purposes of calculating your professional fee. Note: Self-employment taxes will not be recorded anywhere on this cost study.

LINES 31-39, Column 4, Payroll Taxes (Employees) Enter only the employer's share of payroll taxes for each employee. Payroll taxes include federal and state unemployment taxes, employer's share of FICA taxes, and Workmen's Compensation premiums.

LINES 26-39, Column 5 Enter cost of employer's contribution to profit sharing plans, pension plans, and employee benefits (employer's contribution to medical insurance, etc.) that are identifiable with the individuals entered on lines 26 through 38. Any costs not traceable to such individuals should be entered on line 39, column 5. Federal Reference: 1040C, lines 15(a) and (b); 1065, lines 23(a) and (b); 1120 and 1120S, lines 24 and 25.

LINES 26-38, Column 6 Indicate the number of weeks an individual was employed during the year.

LINES 26-38, Columns 7 and 8, Average Weekly Hours Indicate average hours worked per week both in total, and duty hours in the prescription department. Duty hours are limited to the compounding, dispensing, and performing other tasks that are directly related to the filling of prescriptions included in line 20 above. Certain administrative time may be included in duty hours to the extent that they relate to prescriptions included in line 20. These administrative duties may include discussion of and purchasing of pharmaceuticals, taking inventory, preparing drug reports required by state and federal laws, maintenance of prescription files, and personnel matters. It is recognized that some duty hours may be incurred after the close of normal business hours.

LINE 39, Columns 3, 4, and 5 Enter all payroll expenses not identifiable with individuals listed on lines 26-38.

LINE 40 Total columns 3, 4, and 5. Do not include line 26 in the totaling of column 3.

LINE 41 Combine the amounts on line 40, columns 3, 4, and 5, and transfer this total to page 3, line 53.

LINE 42 Rx Delivery Expense, Labor Indicate the amount of line 41 that represents salaries, payroll taxes, cost of employer contributions to profit sharing and pension plans of sub-professionals employed for delivery of prescriptions. If an individual performs services other than delivery, an allocation of his total remuneration should be made based on time spent at each duty. It is important that you make a reasonable attempt to estimate this amount.

INSTRUCTIONS FOR EXPENSE STATEMENT ON PAGE 3

LINES 43-51, Columns 1-5 The total expense items in column 5 must be allocated where applicable to the first four columns: (1) prescription delivery equipment, (2) land and building at store premises, (3) store equipment and (4) other. Column 2, land and building, should only include expenses on land and building related to the store premises.

LINE 45 Personal Property Taxes Include taxes only on business related personal property, not taxes on such property as a personal automobile.

LINE 46 A line is provided for corporations to record state income taxes. This item will not be allowed as a cost item in determining the provider fee. It is included so that the corporate user of these forms can more conveniently reconcile the total expenses to their Books or federal return.

LINE 47 Other Taxes Specify the type of tax. Do not include payroll taxes. Payroll taxes will be entered on the Salaries Schedule, page 2. Also, do not enter income or sales taxes since these items are not allowable costs.

LINE 48 Rent on Business Property Include only rent that applies to the store. For example, a pharmacy located in a medical arts center would include only the rent applicable to the pharmacy area. An appropriate reconciliation would be made on page 4.

LINE 49 Repairs are allowed in the same manner as for federal tax purposes. Expenditures that should properly be capitalized are not entered here.

LINE 53 Salaries, Wages, Payroll Taxes, and Employee Benefits This amount is transferred from line 41, page 2.

LINE 57 Contributions (Corporations Only) Enter charitable contributions on this line. They, however, will not be allowed as a cost item in computing fees and are included here only as a means of reconciling with the federal return. In this way different forms of business ownership will be afforded equal treatment.

LINES 58-67 Record on these lines the detail of expenses included in the section "Other Deductions" or "Other Business Expenses" of your federal return.

LINE 58 Rx Delivery Expenses Record Rx delivery expenses not previously recorded, such as the cost of contracting out Rx delivery. This line should not contain any labor. All labor is contained on page 2.

LINE 59 Rx Containers and Labels Expense of prescription containers and labels should be included here if separately identified as an "Other Expense" on your federal return. If claimed in the cost of goods sold schedule of your federal return, go to line 69. If you did not claim this as a separate deduction on your federal return and if your accounting records are such that this figure is difficult to determine, leave this line blank. You will be allowed a reasonable amount for Rx containers and labels based on your prescription volume.

LINE 61 Direct Physician Line Record the portion of total telephone expense identifiable as charges for a direct physician line or for a line whose telephone number is available only to physicians and not to the public or customers.

LINE 62 All other business telephone expenses are recorded here.

LINE 63 Operating and Office Supplies Do not include expenses incurred for prescription containers and labels.

LINES 65-67 Space is provided for other expenses that have not been previously identified. Specify the nature of these expenses.

LINE 68 Total This should agree with total expenses per Books or federal return. The total is in any case transferred to page 4, line B, column 2, where any differences are explained.

LINES 69-70 Most pharmacies will have no entries on these lines. They are provided for those who may have recorded some prescription expenses in their cost of goods sold schedule of their federal return.

LINE 69 Rx Containers and Labels If prescription containers and labels were claimed in the cost of goods sold schedule, record their cost here. If you did not claim this as a separate deduction on your federal return and if your accounting records are such that this figure is difficult to determine, leave this line blank. You will be allowed a reasonable amount for prescription containers and labels based on your prescription volume.

LINE 70 Enter other prescription expenses included in the cost of goods sold schedule. Do not record cost of drugs purchased as standard purchase price is allowed by the Kansas Department of Social and Rehabilitation Services in calculating the reimbursement amount.

LINE 71 Enter your average gross profit per Rx from Survey Summary.

LINE 72 Enter your current professional fee per Rx.

LINE 73 Enter the provider number assigned this store by the Kansas Department of Social and Rehabilitation Services.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
State Office Building Topeka, Kansas 66612

PHARMACY COST STUDY

NOTE: SEE INSTRUCTIONS BEFORE COMPLETING FORMS. It is suggested that the person who normally prepares your income tax returns also prepare this cost study.

Name of Pharmacy _____ Provider No. _____

Street Address _____ Zip Code _____

City _____ Population _____ County _____

Employer's Federal Identification Number _____ Telephone _____

Please list below all owners (all individuals, all partners, and stockholders with 5% or more ownership interest):

Name	City and State	Social Security Number

DECLARATION BY OWNER AND PREPARER

I declare that I have examined this cost study, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the related Books or Federal Income Tax Return except as explained in the Reconciliation on page 4 of this cost study. Declaration of preparer (other than owner) is based on all information of which preparer has any knowledge.

Your Signature _____ Title/Position _____ Date _____

Preparer's Signature (Other than owner) _____ Title/Position _____ Date _____

Preparer's Street Address _____ City and State _____ Zip _____

Provider Number [ ]

Type of Ownership: 1 ☐ Individual 2 ☐ Partnership 3 ☐ Corporation
4 ☐ Other--specify _____

Location of Pharmacy:
5 ☐ Downtown Business
6 ☐ Neighborhood
7 ☐ Shopping Center
8 ☐ Medical Office Building

Ownership Affiliation:
9 ☐ Independent (1 unit only)
10 ☐ Chain Unit (2-9 units)
11 ☐ Chain Unit (10 or more units)
Zip Code of Store (12) _____

Accounting Method: 13 ☐ Cash 14 ☐ Accrual 15 ☐ Other--specify _____

Check if Building is Rented 16 ☐ No. of hours pharmacy open per week (17) _____

No. of prescriptions dispensed: (18) New _____ (19) Refill _____ (20) Total _____

Fiscal Year Ending: (21) Month _____ Day _____ Year _____

Cost Allocation Information: (Round to Nearest Dollar)		Prescription (1)	Total Store (2)
Sales	(22)		
Cost of Goods Sold	(23)		
Cost of Ending Inventory	(24)		
Area--Square Feet (Do not include storage area)	(25)		

SALARIES, WAGES, PAYROLL TAXES AND EMPLOYEE BENEFITS (Round to the nearest dollar)

	Owner's and Professional's Social Security Number (1)	Line No.	Check if R Ph (2)	Salaries & Drawings (3)	Payroll Taxes (4)	Cost of Employee Benefits (5)	No. Wks Emp (6)	Avg Weekly Hrs Total (7)	Avg Weekly Hrs Rx (8)
Owner(s) Ind. Prop.		26			xxxxxxxxxx				
Partners & Stockholders (with time in Rx Dept)		27							
		28							
		29							
		30							
Professional & Interns Only		31							
		32							
		33							
		34							
Sub-Prof. (those with time in Rx Dept)	xxxxxxxxxxx	35	xxxx						
	xxxxxxxxxxx	36	xxxx						
	xxxxxxxxxxx	37	xxxx						
	xxxxxxxxxxx	38	xxxx						
All Others	xxxxxxxxxxx	39	xxxx				xxx	xxxxx	xxxxx
TOTALS		40							

GRAND TOTAL (sum of columns 3, 4, and 5 of line 40) Transfer to page 3, line 53 (41) ☐

Amount of Line 41 representing delivery expense (see instructions) (42) ☐

Federal Reference

EXPENSE STATEMENT (Round to Nearest Dollar)

1040C	1065	1120 & 1120S		RxDlvy Equip (1)	Land, Bldg (2)	Store Equip (3)	Other (4)	Line No	Total (5)	Agency Use Only
6	20	21	Depreciation					43		
7	17	17	Taxes (See instructions):							
			Real Estate	xxxxxx				44		
			Personal Property		xxxxx			45		
			State Income (Corp Only)	xxxxxx	xxxxx	xxxxx	xxxxx	46		
			Other (Not Payroll) Specify _____					47		
8	15	16	Rent on Business Property					48		
9	19	14	Repairs					49		
11	24	26	Insurance					50		
14	21	10	Amortization					51		
16	16	18	Interest					52		
			Total of Salaries, Wages, Payroll Taxes & Employee Benefits, from page 2, Line 41 (see instructions)					53		
12	24	26	Legal & Professional Fees:							
			Accounting and Legal					54		
			Rx Department Fees, Dues, and Licenses					55		
17	18	15	Bad Debts Arising from Sales					56		
		19	Contributions (corporations only--see instructions)					57		
19	24	26	Other Business Expenses not included elsewhere:							
			Rx Delivery Expenses					58		
			Rx Containers & Labels (see instructions)					59		
			Heat, Water, Lights					60		
			Telephone--Direct Physician Line (see instructions)					61		
			Telephone--All Other					62		
			Operating & Office Supplies (see instructions)					63		
			Advertising					64		
			Specify _____					65		
			Specify _____					66		
			Specify _____					67		
20	25	27	TOTAL--Transfer to page 4, line B, column 2					68		
			Rx expenses included in cost of goods sold schedule of Federal return:							
			Rx containers and labels (see instructions)					69		
			Other expenses--specify _____					70		
			Average gross profit per Rx from survey (dollars & cents)					71		
			Last year's professional fee (dollars & cents)					72		

Provider Number 73

RECONCILIATION

See page I of instructions. It is not intended that you should have to reveal any outside or unrelated activities.

Please check to which you are reconciling:	Line No	Books or Federal Return (1)	Cost Study (2)
Total Expenses per Books ☐ or Federal Return ☐	A		xxxxxxxxxxxxx
Total Expenses per Cost Study (Page 3, Line 68)	B	xxxxxxxxxxxxxxxx	
Expenses on Books or Federal Return not on Cost Study:			
Specify _____	C	xxxxxxxxxxxxxxxx	
Specify _____	C	xxxxxxxxxxxxxxxx	
Expenses on Cost Study not on Books or Federal Return:			
Specify* _____	D		xxxxxxxxxxxxx
Specify* _____	D		xxxxxxxxxxxxx
TOTAL (should be equal)	E		

*Specify the nature of the expense and indicate the line number on the cost study where the expense is included.

OTHER INFORMATION

Please describe any unusual or pertinent information about your operation during the reporting period that may be helpful in analyzing your cost figures. For example, reasons for sizable increase or decrease in number of prescriptions, change in size of drug area, or the nature of expenses recorded on lines 43-51, column 4.

Remarks: _____

RELATED PHARMACY INFORMATION

Do any of the owners (any individual, any partner, and any stockholder with 5% or more ownership interest) or employees have an interest, directly or indirectly, as an employee or owner in any other pharmacy located in Kansas? (Except stock ownership as a passive investment in publicly held corporations).

☐ Yes ☐ No

If your answer is no, do not complete the rest of this page. If your answer is yes, be sure you have listed the person's social security number in the appropriate space(s) in column 1, of lines 26-38 on page 2.

Also, list below all pharmacies under common control or ownership located in Kansas such as a parent firm and its chain units. Attach schedule if necessary. This information is necessary in order to correctly analyze your cost study, particularly the salaries and employee benefits schedule on page 2. We need this listing on only one study. On the other related studies simply indicate the provider number on which this information was contained and return all related studies in one envelope.

Federal I.D. Number	Related Pharmacy Provider No.	Cost Study Filed? Yes	No	Comments

KANSAS DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES
STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

Instructions for the Completion of Drug Survey

Complete one original and one copy of the form, REPORT OF GROSS PROFIT ON PRESCRIPTIONS IN SURVEY, recording data for new prescriptions filled on or the first working day after each date indicated on the survey form. The dates specified should be within the respective fiscal period of your cost study report. Prescriptions to be EXCLUDED from this survey are Title XIX prescriptions, OTC prescriptions, and prescriptions priced at reduced rates for physicians and employees. Prescriptions priced at special rates due to competitive and other circumstances must be INCLUDED on the survey. Such prescriptions would include those for oral contraceptives and medications used as loss leaders, prescriptions with senior citizens or special group discount prices, etc. The prescription number, quantity dispensed, product dispensed, medication strength, acquisition cost and selling price before tax should be included on the gross profit survey.

The actual acquisition cost of the item is the net cost to you which includes all discounts, quantity and cost. Submit the original copy of each prescription survey with your cost study report and keep the copy for your records.

The summary of the gross profit on your sampled prescriptions provides for the computation to determine the average gross profit per prescription. If the sample is less than 300 prescriptions change the denominator at the bottom of the page to agree with the total sample.

SUMMARY OF GROSS PROFIT ON PRESCRIPTIONS SAMPLED

Period _____ Year	Total Acquisition Costs	Total Selling Price
January 1 (50 Rx's)	$ _____	$ _____
March 10 "	_____	_____
May 20 "	_____	_____
July 1 "	_____	_____
September 10 "	_____	_____
November 20 "	_____	_____
Grand Total	$ _____	_____
Subtract Grand Total Acquisition Costs		_____
Gross Profit on Surveyed Prescriptions		$ _____ (a)

Computation of Average Gross Profit per Rx:

$ _____ (a) = $ _____ *
300

*This figure is the average gross profit per prescription of the 300 prescriptions included in the survey. Transfer this amount to Line 71, page 3.

Provider Number [ ]

REPORT OF GROSS PROFIT ON PRESCRIPTIONS IN SURVEY

Please list below the first 50 new prescriptions filled on and after _____ (Indicate Date).

Six copies of this survey are required for the periods beginning January 1, March 10, May 20, July 1, September 10, and November 20.

Line Number	Rx Number	Quantity, Item, Strength	Actual Acquisition Cost	Selling Price Before Tax
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
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35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
		Totals		

STATE DEPT. OF SOCIAL AND REHABILITATION SERVICES

Attach. K1

PHYSICIAN: Detach at the perforated edge. Retain this portion for your files or discard.

Patient Name _____ Date _____

Drug Name, Strength, Quantity

DIAGNOSIS OR CONDITION

DIAGNOSIS OR CONDITION	DIAGNOSIS CODE #
Acne	706 ☐
Anxiety	300 ☐
Arthritis, rheumatoid	712 ☐
Arthritis, osteo-	713 ☐
Asthma	493 ☐
Bronchitis	490 ☐
Congestive Heart Failure	427 ☐
Depression	298 ☐
Headache	791 ☐
Hypertension	401 ☐
Infection, skin	686 ☐
Infection, upper resp, viral	465 ☐
Infection, urinary tract	599 ☐
Insomnia	306 ☐
Menopausal symptoms	627 ☐
Myocardial infarction	410 ☐
Nutrition/Vitamin deficiency	269 ☐
Otitis Media	381 ☐
Pain	305 ☐
Pharyngitis/Tonsilitis, strep	034 ☐
Pneumonia	483 ☐
Psychoneurotic disorder	296 ☐
Psychosis	299 ☐
Seizure disorder	345 ☐
Ulcer disease, stomach	531 ☐
Vaginitis/Cervicitis, non-venereal	620 ☐
Venereal Disease	097 ☐
Other, not elsewhere classified	999 ☐

TITLE XIX
PRESECRIPTION
ORDER

Attachment K1

(Physician name, address)

DATE

PATIENT NAME ADDRESS CITY

RX

VOID

SIG:

REFILL PHYSICIAN SIGNATURE DEA NUMBER

Attachment 4

Kansas State Dental Association

August 19, 1977

TESTIMONY
by
Carl C. Schmitthenner, Jr.
Executive Director
Kansas State Dental Association

KANSAS COMMISSION ON HEALTH CARE COSTS

Mr. Chairman & Members of the Commission:

For 105 years the Kansas State Dental Association has stood for the highest ideals in public service. Our Constitution states, "The objects of this Association shall be to promote public health and health service, especially in the State of Kansas, to advance the art and science of dentistry, and to foster an awareness of the obligations and responsibilities of the Dental Profession to society."

Toward these ends our Association is proud not only of the words, but also of the deeds. For many years we have promoted fluoridation, a proven method of reducing dental disease. We led the way in the addition of a lay representative on the Kansas Dental Board, seeking the input of those who receive our care. Our peer review system is a proven method of assuring Kansas citizens of proper and appropriate care.

With more specific reference to Title XIX and the cost of dental care, we have been equally concerned. Our own members have brought situations of poor care and fraud to the attention of the Department of Social and Rehabilitative Services. Peer review has been just as available to SRS and medicaid recipients as others in our state.

Dentists can be proud of their responsible restraint of the fee increases during an inflationary economy. According to the U. S. Bureau of Labor Statistics dental fees have risen only slightly more than the value of all goods and services. During the last ten years dental fees have risen 4.7% less than all services and 6.7% less than the cost of medical care.

This is particularly impressive when you consider the fact that expenses of dental practice have risen 132% in the same ten years, more than twice the rate at which dental fees increased. In considering increasing health costs it should be remembered that a recent Federal study found the effect of health insurance and government programs has been the greatest single cause in the inflation of health care costs.

The Kansas State Dental Association a year and a half ago became so concerned with cost of this program that our members authorized a special task force to study the Medicaid Program.

4301 Huntoon, Topeka, Kansas 66604 • 913-272-7360

Atch. 4

We found one of the most comprehensive dental programs anywhere. In fact, the Kansas Medicaid Program is the largest dental prepayment plan in Kansas. The Program provided 165,000 Kansans every dental service they needed without cost until recent changes that eliminated dentures and bridges.

The average American spends $41 yearly for dental care. Under this program for persons who are generally considered to have greater need for care, the cost of dental service averages $30 per person. Our members spend many hours of volunteer time reviewing proposed treatment and recommending to SRS whether the cost of that care should be reimbursed.

Reimbursements made under the Medicare Program are based on data that is often two years old and at levels below Federal guidelines. The low reimbursement levels force dentists to make up losses on care provided under Title XIX by higher fees to their other patients. These higher fees become a hidden tax that is a particular hardship on our working poor, brought about by a failure of SRS to accept responsibility for paying for the care they expect recipients to receive.

Our task force suggested some remedies. In meetings with Dr. Harder we suggested predetermination for many more services than were previously reviewed and the inclusion of a co-payment which would require the recipient to pay a small portion of the cost of care, thereby eliminating unwarranted demands for service. Several other cost containment measures we suggested are currently under study by SRS.

The task force was constantly frustrated by a lack of data. We feel that establishing data that would evaluate the actual fee increases, the number of persons receiving each type of care, and the number and types of services provided is essential to an insurance type program. It is the only method by which valid judgments can be made.

This data may show dentistry has been unjustly increasing fees and if so, we will cooperate in efforts to reduce these costs. We don't think this will be the case. No data on national or local levels shows dental fees to be inflationary. The costs of this program closely match the increases in the number of eligible recipients.

The Kansas State Dental Association has been a constructive and responsible provider in dealing with health care for the disadvantaged. We hope some of the concepts that have proven valuable in the dental program can be applied to other areas of the Medicaid Program.

Expenditures and prices for dental and other health care, 1935 to 1972

Bureau of Economic Research and Statistics

Every second year since 1959, the Bureau has published an analysis of the US Department of Commerce estimates of consumer expenditures for dental and other health care and the US Department of Labor price indexes for health care. The continuity of this series is preserved by this report covering the period through 1972.

It should be pointed out, however, that the Department of Commerce estimates of expenditures for dental care for 1971 and 1972 appear to be unduly low. For calendar 1972, the Department of Commerce estimate is $4,639,000,000. For fiscal year 1972 (ending at midyear), the Social Security Administration estimated consumer expenditures for dental care at $4,771,000,000. On the basis of interviews of a cross section of the population, the National Center for Health Statistics of the US Department of Health, Education, and Welfare estimated 1970 per capita "out-of-pocket" expenditures for dental care at $29; the population included 200,856,000 persons, leading to an estimate of $5.8 billion in consumer expenditures for dental care in 1970. On the basis of gross incomes of dentists reported in the "1971 Survey of Dental Practice," the Bureau of Economic Research and Statistics estimated 1970 consumer expenditures for dental care at $4.8 billion.

Table 1 shows the Department of Commerce estimates of the steady increase in amount spent for dental care since 1935. Of the $57,431,000,000 spent for health care in the United States in 1972, $4,639,000,000 was spent for dental care. Total expenditures for dental care since 1968 exceed the total health care bill in 1935 and 1940 and total expenditures to physicians in 1954.

Dentistry's portion of the health dollar has steadily declined since 1940 (Table 2). Dental services accounted for 13.9% of total expenditures for health care in 1940, 9.1% in 1970, and 8.1% in 1972. Physicians received 27.3% and 27.4% in 1970 and 1971, respectively, but the percentage declined to 26.8% in 1972. Small decreases during the 1970-1972 period occurred for all other items of health care with the exception of health insurance and hospitals. Health insur-

Table 1 ■ Consumer expenditures for health care, 1935 to 1972 (millions of dollars).

Item	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1956	1954	1952	1950	1940	1935
Dentists	4,639	4,339	4,293	3,921	3,461	2,970	2,623	2,265	2,007	1,876	1,645	1,428	1,110	962	419	302
Physicians	15,409	14,268	12,943	11,468	10,047	8,382	7,044	5,992	5,292	4,574	3,773	3,351	2,849	2,568	913	731
Other professional services	2,319	2,209	2,059	1,857	1,822	1,565	1,245	1,066	968	832	680	609	518	472	173	151
Drug preparations and sundries	7,870	7,267	6,945	6,429	5,873	5,133	4,331	4,012	3,607	3,195	2,661	2,163	2,058	1,719	635	474
Ophthalmic products and orthopedic appliances	1,822	1,673	1,745	1,729	1,700	1,563	1,056	895	769	663	655	595	580	486	186	131
Privately controlled hospitals and sanitariums	21,316	18,988	16,851	14,540	12,323	9,294	7,729	6,100	5,096	4,202	3,426	2,878	2,406	1,979	527	406
Health insurance*	4,056	3,271	2,565	2,770	2,541	2,215	1,775	1,672	1,377	1,130	1,013	1,022	704	602	165	93
Total	57,431	52,015	47,401	42,814	37,767	31,142	25,803	22,002	19,116	16,472	13,853	12,046	10,225	8,788	3,018	2,288

*Premiums minus claims paid

Source: *Survey of Current Business*, US Department of Commerce (various issues)

Table 2 ■ Percentage distribution of the health dollar, 1935 to 1972.

Item	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1956	1954	1952	1950	1940	1935
Dentists	8.1	8.3	9.1	9.2	9.2	9.5	10.2	10.3	10.5	11.4	11.9	11.8	10.8	10.9	13.9	13.2
Physicians	26.8	27.4	27.3	26.8	26.6	26.9	27.3	27.2	27.7	27.8	27.3	27.8	27.9	29.2	30.2	32.0
Other professional services	4.0	4.3	4.3	4.3	4.8	5.0	4.8	4.9	5.1	5.0	4.9	5.1	5.1	5.4	5.7	6.6
Drug preparations and sundries	13.7	14.0	14.7	15.0	15.6	16.5	16.8	18.2	18.9	19.4	19.2	18.0	20.1	19.6	21.0	20.7
Ophthalmic products and orthopedic appliances	3.2	3.2	3.7	4.0	4.5	5.1	4.1	4.1	4.0	4.0	4.7	4.9	5.7	5.5	6.2	5.7
Privately controlled hospitals and sanitariums	37.1	36.5	35.5	34.2	32.6	29.9	29.9	27.7	26.6	25.5	24.7	23.9	23.5	22.5	17.5	17.7
Health insurance	7.1	6.3	5.4	6.5	6.7	7.1	6.9	7.6	7.2	6.9	7.3	8.5	6.9	6.9	5.5	4.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Calculated by Bureau of Economic Research and Statistics from data in Table 1

Table 3 ■ Percentage of total consumer expenditures spent for specified items of health care, 1935 to 1972.

Item	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1956	1954	1952	1950	1940	1935
Dentists	0.64	0.65	0.70	0.68	0.65	0.65	0.65	0.64	0.62	0.64	0.62	0.60	0.51	0.50	0.59	0.54
Physicians	2.12	2.14	2.10	1.98	1.87	1.80	1.76	1.69	1.63	1.58	1.41	1.42	1.31	1.34	1.29	1.31
Other professional services	0.32	0.33	0.33	0.32	0.34	0.34	0.31	0.30	0.30	0.29	0.25	0.26	0.24	0.25	0.25	0.27
Drug preparations and sundries	1.08	1.09	1.12	1.11	1.09	1.10	1.08	1.13	1.11	1.10	1.00	0.91	0.95	0.90	0.90	0.85
Ophthalmic products and orthopedic appliances	0.25	0.25	0.28	0.30	0.32	0.34	0.26	0.25	0.23	0.23	0.25	0.25	0.27	0.25	0.26	0.24
Privately controlled hospitals and sanitariums	2.93	2.85	2.73	2.53	2.30	1.99	1.93	1.72	1.57	1.45	1.28	1.22	1.11	1.04	0.74	0.73
Health insurance	0.56	0.49	0.42	0.48	0.47	0.47	0.44	0.47	0.42	0.39	0.38	0.43	0.33	0.32	0.23	0.17
Total	7.90	7.80	7.68	7.39	7.04	6.68	6.43	6.20	5.88	5.68	5.19	5.09	4.72	4.60	4.26	4.11

Source: Calculated by Bureau of Economic Research and Statistics from data published in *Survey of Current Business*, US Department of Commerce (various issues)

ance increased from 5.4% in 1970 to 7.1% in 1972, and hospitals from 35.5% to 37.1%.

Items of health care as a percentage of total consumer expenditures are presented in Table 3. Dentistry's percentage of total expenditures increased from 0.50% in 1950 to 0.70% in 1970. During 1971 and 1972, a slight decrease occurred, the figures being 0.65% and 0.64%. In 1940, physicians' fees accounted for 1.29% and steadily increased to 2.14% in 1971. The item of health care receiving the highest percentage of total expenditures since 1962 was hospitals. During the 1962-1972 period, consumer expenditures to hospitals increased from 1.72% to 2.93%. All items of health care increased from 4.11% in 1935 to 7.90% in 1972.

Tables 4 and 5 show price indexes for items of medical care and their percent of change during specified periods. In 1972, the price index for dentists' fees was slightly lower than the indexes for physicians' fees and "all medical care." During the 1958-1972 period, the price index for dentists' fees increased 68.3% compared to 97.6% for physicians' fees, 241.5% for hospitals, and 81.0% for "all medical care." The corresponding figures for the 1935-72 period were 224.3%, 241.3%, 1,331.9%, and 267.0%.

In 1972, Americans spent 2.7 times as much for tobacco products as for dental care, and 4.4 times as much for alcoholic beverages. Expenditures for health care accounted for 7.19% of total consumer expenditures in 1968, 7.67% in 1970, and 7.90% in 1972 (Table 6). Per capita expenditures for dental care and amount of den-

Table 4 ■ Price indexes for items of "medical care" and Consumer Price Index, 1935 to 1972 (1967=100).

Item	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1956	1954	1952	1950	1940	1935
Dentists' fees*	132.3	127.0	119.4	112.9	105.5	95.2	89.4	84.7	82.1	78.6	74.4	72.3	67.8	63.9	42.0	40.8
Fillings, adult, amalgam, one surface	133.8	128.0	120.3	113.1	105.4	94.7	88.8	84.3	81.9	78.2	73.9	72.0	67.7	63.9	42.1	40.4
Extractions, adult	132.3	126.9	118.6	112.9	105.2	96.7	90.4	85.0	82.0	79.0	75.2	72.6	66.6	62.8	40.3	39.5
Physicians' fees†	133.8	129.8	121.4	112.9	105.6	93.4	85.2	81.3	77.0	67.7	67.4	63.2	59.8	55.2	39.6	39.2
Family doctor, office visits	134.8	131.4	122.6	113.3	105.8	92.7	84.1	80.0	75.9	72.1	67.2	63.7	59.2	54.9	39.1	38.8
Family doctor, house visits	136.7	131.0	122.4	114.5	106.5	93.5	84.1	79.7	75.0	70.1	63.5	58.8	56.3	52.9	39.6	39.1
Obstetrical cases	133.8	129.0	121.8	113.5	105.2	93.0	87.1	83.7	79.4	75.5	70.9	64.4	60.2	51.2	33.0	32.1
Tonsillectomy and adenoidectomy	129.9	125.2	117.1	110.3	104.9	94.9	88.4	83.8	80.3	74.3	69.5	67.4	64.3	60.7	41.5	41.8
Examination, prescription, and dispensing of eyeglasses	124.9	120.3	113.5	107.6	103.2	95.3	90.9	89.2	85.1	82.1	78.2	75.9	77.8	73.5	58.1	56.6
Hospital daily service charges‡	170.4	160.8	143.9	127.9	113.2	84.0	72.4	64.0	56.3	49.9	43.7	39.6	35.2	28.9	12.7	11.9
Semiprivate room	173.9	163.1	145.4	128.8	113.6	83.5	71.9	65.3	57.3	51.2	44.9	40.6	36.6	30.3	13.7	12.8
Drugs and prescriptions	105.6	105.4	103.6	101.3	100.2	100.5	100.5	101.7	104.5	102.8	96.7	93.7	91.8	88.5	70.8	70.7
Prescriptions	100.9	101.3	101.2	99.6	98.3	101.8	103.1	107.1	114.9	113.1	104.7	100.2	98.3	92.6	66.2	65.4
All "medical care"	132.5	128.4	120.6	113.4	106.1	93.4	87.3	83.5	79.1	73.2	67.2	63.4	59.3	53.7	36.8	36.1
Consumer Price Index	125.3	121.3	116.3	109.8	104.2	97.2	92.9	90.7	88.6	86.6	81.4	80.5	79.5	72.1	42.0	41.1

*Indexes since 1963 include complete upper dentures.
†Included "appendectomy" before 1963
‡Formerly listed as "hospital rates" (before 1963) and included "men's pay ward."
Source: Consumer Price Index (various reports), Bureau of Labor Statistics, US Department of Labor.

Table 5 ■ Percentage change in price indexes for items of "medical care" and for Consumer Price Index for specified periods.

Item	1970-1972	1958-1972	1950-1972	1935-1972
Dentists' fees*	10.8	68.3	107.0	224.3
Fillings, adult, amalgam, one surface	11.2	71.1	109.4	231.2
Extractions, adult	11.6	67.5	110.7	234.9
Physicians' fees†	10.2	97.6	142.4	241.3
Family doctor, office visits	10.0	87.0	145.5	247.4
Family doctor, house visits	11.7	95.0	158.4	249.6
Obstetrical cases	9.9	77.2	161.3	316.8
Tonsillectomy and adenoidectomy	10.9	74.8	114.0	210.8
Examination, prescription, and dispensing of eyeglasses	10.0	52.1	69.9	120.7
Hospital daily service charges‡	18.4	241.5	489.6	1331.9
Semiprivate room	19.6	239.6	473.9	1258.6
Drugs and prescriptions	1.9	2.7	19.3	49.4
Prescriptions	-0.3	-10.8	9.0	54.3
All "medical care"	9.9	81.0	146.7	267.0
Consumer Price Index	7.7	44.7	73.8	234.9

*Indexes since 1963 include complete upper dentures.
†Included "appendectomy" before 1963.
‡Formerly listed as "hospital rates" (before 1963) and included "men's pay ward."
Source: Calculated by Bureau of Economic Research and Statistics from data in Table 4.

Table 6 ■ Consumer expenditures for selected items, 1972.

Item	Amount (millions of dollars)	% total consumer expenditures
Tobacco products	12,593	1.73
Alcoholic beverages	20,291	2.79
Recreation	47,826	6.58
Radio and television receivers, records, and musical instruments	11,406	1.57
Admissions to spectator amusements	2,631	0.36
Pari-mutuel net receipts	1,207	0.17
Personal care	11,119	1.53
Toilet articles and preparations	6,714	0.92
Barbershops, beauty parlors, and baths	4,405	0.61
Jewelry and watches	4,566	0.63
User-operated transportation	93,949	12.93
New cars and net purchases of used cars	45,745	6.30
Gasoline and oil	25,523	3.51
Funeral and burial expenses	2,393	0.33
Health care	57,431	7.90
Physicians	15,409	2.12
Dentists	4,639	0.64
Hospitals and sanitariums	21,316	2.93

Sources: Amounts from *Survey of Current Business*, July 1973, US Department of Commerce, p 29
Percentages calculated by Bureau of Economic Research and Statistics.

Table 7 ■ Expenditures and price index for dental care and measure of relative amount of dental service received per capita, 1935 to 1972.

Year	Estimated civilian population, July 1	Consumer expenditures for dental care (millions of dollars)	(A) Per capita expenditures for dental care	(B) Dental care price index (1967 = 100)	Amount of dental care per capita (A) ÷ (B)/100
1972	206,457,000	4,639	22.47	132.3	16.98
1971	204,250,000	4,339	21.24	127.0	16.72
1970	201,722,000	4,293	21.28	119.4	17.82
1969	199,145,000	3,921	19.69	112.9	17.44
1968	197,113,000	3,461	17.56	105.5	16.64
1966	193,420,000	2,970	15.36	95.2	16.13
1964	189,141,000	2,623	13.87	89.4	15.51
1962	183,677,000	2,265	12.33	84.7	14.56
1960	178,136,000	2,007	11.27	82.1	13.73
1958	172,226,000	1,876	10.89	78.6	13.85
1956	166,055,000	1,645	9.91	74.4	13.32
1954	159,695,000	1,428	8.94	72.3	12.36
1952	153,892,000	1,110	7.21	67.8	10.63
1950	150,790,000	962	6.38	63.9	9.98
1940	131,658,000	419	3.18	42.0	7.57
1935	127,099,000	302	2.38	40.8	5.83

Note: Alaska and Hawaii included beginning in 1960.
Source: Population figures are from Current Population Reports, Series P-25, Bureau of the Census, US Department of Commerce.
Estimates of consumer expenditures are from *Survey of Current Business*, US Department of Commerce. Dental care price indexes are from various reports on the Consumer Price Index, Bureau of Labor Statistics, US Department of Labor.

tal care per capita are presented in Table 7. Per capita expenditure divided by the dental care price index provides a measure of the amount of dental care received. The amount of dental care per capita steadily increased from 5.83 in 1935 to 17.82 in 1970. This figure declined to 16.72 in 1971, then increased slightly to 16.98 in 1972.

The Department of Commerce has revised its dental expenditures in the past, and may well do so for 1971 and 1972. Throughout the 1935-1972 period an increase of 191.2% occurred, meaning the amount of care received by the average person in 1972 was nearly three times as much as that received in 1935.

REPORTS OF COUNCILS AND BUREAUS

Dentists' fees and inflation

Joint report of the Bureau of Economic Research and Statistics and the Bureau of Public Information

This report places in perspective the trend of dental fees in recent years by using the Consumer Price Index and similar indexes as statistical measures of the general trend in prices.

Dentists' fees, as measured by the Consumer Price Index (CPI), have been remarkably stable in relation to the rest of the economy during the past decade.

The 1975 average index of dentists' fees was 161.9, measured by the CPI's 1967 base of 100. The 1975 average for all items in the CPI was 161.2. Thus, from 1967 to 1975, dentists' fees increased 61.9%, compared with a 61.2% increase in average prices of goods and services.

To determine what relationship exists between fees charged by dentists and dentists' expenses, an index of dentists' professional expenses, by item, was constructed. This index is based on data from biannual surveys of dental practice conducted by the ADA Bureau of Economic Research and Statistics. These data are, in turn, compared with the dental fee portion of the CPI.

Description of Consumer Price Index

The CPI is issued monthly by the Bureau of Labor Statistics, US Department of Labor. It is the only index compiled by the US government that is designed to measure changes in the purchasing power of the urban consumer's dollar. Possibly half the people in America find their incomes affected by it. Among these are more than 5 million workers covered by wage contracts and pensions with escalator clauses tied to rises in the CPI. About 44 million other persons now find their incomes affected by the index, largely as a result of statutory action. These include social security beneficiaries, retired military and federal civil service employees and their survivors, postal employees, and food stamp recipients.

The official name of the index is Consumer Price Index for Urban Wage Earners and Clerical Workers. It is a statistical measure of changes in prices of goods (commodities) and services bought by urban wage earners and clerical workers, including families and single persons. Price information is gathered on about 400 items from approximately 18,000 stores and establishments in 56 cities. Prices are collected monthly in New York, Chicago, Los Angeles, Detroit, and Philadelphia, and quarterly on a staggered basis in 51 other cities.

The list of commodities and services priced is called the "market basket." The content of the

Table 1 ■ Relative importance of selected items in Consumer Price Index, December 1974.

Item	Relative importance	
All items		100.000
Commodities		63.762
Food	24.785	
Apparel commodities	8.273	
Services		36.238
Housing	33.766	
Transportation	12.715	
Health and recreation	18.723	
Medical care	6.241	
Personal care	2.519	
Reading and recreation	5.222	
Other goods and services	4.742	

"Housing" consists of items that are partly under services and partly under commodities.

Table 2 ■ Relative importance of selected items under medical care in Consumer Price Index, December 1973.

Item	Relative importance
Drugs and prescriptions	0.806
Professional services	2.787
Dentists' fees	0.896
General physician—office visit	0.900
General physician—house visit	0.137
Other physician services	0.572
Health insurance	2.026
Hospital services	1.057

list is kept essentially unchanged between major revisions of the CPI to make sure that any index change is caused by prices alone.

The CPI represents price changes for everything people buy for living—food, clothing, automobiles, homes, furnishings, household supplies, fuel, drugs, and recreational goods; dentists', physicians', and lawyers' fees; the cost of haircuts, rent, repairs, transportation fares, public utility rates, and so forth. Prices include all taxes directly associated with the purchase of an item, including sales and excise taxes. The CPI also includes real estate taxes on owned homes as part of the price of home ownership. It does not include income and other taxes not associated with prices of specific goods and services.

■ *Weighting structure:* The "market basket" concept means that the CPI is a weighted aggregative index with fixed or constant annual weights. Each item is weighted according to its relative importance in the family budget of urban wage earners. The relative importance (weights) for items in the current CPI was established in 1960–1961, on the basis of extensive studies of family expenditure patterns. The relative importance of selected items in December 1974 is shown in Table 1.

Relative importance of selected items under medical care in December 1973 is shown in Table 2.

■ *Dental fee component:* The items priced in the CPI are the fees charged for three representative dental services, obtained from a sample of dentists: one-surface amalgam restoration, in adults; simple extractions in adults, including local anesthetic and radiographs; and complete maxillary denture. As shown in Table 2, dentists' fees had a relative importance of 0.896 in December 1973. In December 1972, the weight was 0.939, distributed among the three component services: restoration, adult—0.478; extraction, adult—0.236; and denture, complete maxillary, adult—0.225.

According to the Bureau of Labor Statistics these services were selected as probable representation of the universe of dental services. In other words, fee increases for these services would very likely indicate the extent to which fees are increased for other dental services.

The Bureau of Labor Statistics samples 434 dentists for the CPI. In accordance with sampling procedures, fee data are collected from the same group of representative dentists as much as possible. The Bureau of Labor Statistics indicates that the turnover among dentists reporting fee data is low, averaging less than one replacement each month. The percentage distribution by census region of dentists reporting fee information is: Northeast, 21%; North Central, 35%; South, 23%; and West, 21%.

■ *Dentists' fees and prices in 1975:* Table 3 shows the 1975 average annual indexes for the medical care component of the CPI. The medical care index contains two major subgroups: drugs and prescriptions (not shown in detail in Table 3)

Table 3 ■ Average annual indexes for medical care and selected components, Consumer Price Index, United States, 1975.

Item	Index (1967=100)
Medical care	168.6
Drugs and prescriptions	118.8
Professional services	
Dentists' fees	161.9
Restorations, adult, amalgam, one-surface	166.7
Extractions, adult	160.9
Dentures, complete maxillary	153.0
Physicians' fees	169.4
General physician, office visit	173.9
General physician, house visit	170.5
Obstetrical cases	167.2
Pediatric care, office visit	172.5
Psychiatric care, office visit	153.0
Herniorrhaphy, adult	152.3
Tonsillectomy and adenoidectomy	163.3
Other professional services	
Eyeglasses, including examination	149.6
Routine lab tests	151.4
Hospital service charges	
Semiprivate room rates	236.1
Operating room charges	239.4
X-ray diagnostic tests, upper GI	156.2

Source: US Bureau of Labor Statistics.

and professional services.

Table 3 shows the 1975 average indexes for all subgroups under dentists' fees, physicians' fees, and other professional services. For hospital service charges, only three of ten subgroups are shown in Table 3. (These are the only hospital items for which data were published for the entire eight-year period. The hospital index was expanded from three to ten items in 1972, using that year as the base year.)

The 1975 average index of dentists' fees, 161.9, is a weighted average of indexes of the three dental subgroups. In 1975, the index for a one-surface amalgam restoration averaged 166.7, extraction, 160.9; and maxillary denture, 153.0.

The index for dentists' fees was lower than the general index for medical care, which averaged 168.6, and for physicians' fees, which averaged 169.4. Of the items composing the general index for medical care, drugs and prescriptions were lowest with 118.8. Among professional services comparable to dentistry, only psychiatrist office visits and eye care services had indexes of commodities and services, the two major components of the CPI. Approximately 64% of urban working families' after-tax-income is spent on commodities and 36% on services. In ponents in the cost of hospital care had more than doubled in eight years.

Table 4 shows a comparison of dentists' fees with CPI indexes for items other than medical care. The most important of these are the indexes of commodities and services, the two major components of the CPI. Approximately 64% of urban working families' after-tax-income is spent on commodities and 36% on services. In 1975, the price index for commodities averaged 158.4, which was 3.5 index points below the dentists' fee index. This means that the total increase in dentists' fees since 1967 was about 2% above the increase in retail commodity prices. Food is the largest subgroup under commodities, accounting for about a fourth of urban working families' expenditures. The 1975 index for food prices at the supermarket was 175.4, about 8% higher than the dentists' fee index. Among commodities with increases higher than dentists' fees were fuel oil and coal (index of 235.3 in 1975) and gasoline (170.8). Commodities with smaller increases than dental fees included clothing (141.2) and household appliances (128.1).

Table 4 ■ Average annual index for selected items, Consumer Price Index, United States, 1975.

Item	Index (1967-100)
Dentists' fees	161.9
All items	161.2
Medical care	168.6
Physicians' fees	169.4
Hospital semiprivate room rates	236.1
Commodities	158.4
Services	166.6
Food	175.4
Clothing	141.2
Housing	166.8
Home ownership costs	181.7
Maintenance and repair services	187.6
Transportation	150.6
Auto repairs and maintenance	176.6
Gasoline	170.8
Fuel oil and coal	235.3
Household appliances	128.1
Insurance and finance	180.4
Legal services, short will form	187.8
Daily newspapers	174.5
Postal charges	175.4

Source: US Bureau of Labor Statistics.

The cost of services in 1975 was 166.6 on the CPI, indicating total increases of about 3% above dental fee increases since 1967. Among services with higher price increases than dentists' fees were home ownership costs (index of 181.7 in 1975), home maintenance and repair services (187.6), auto repairs and maintenance (176.6), insurance and finance (180.4), daily newspapers (174.5), postal charges (175.4), and fees for routine legal services (187.8).

Dentists' fees and price trends, 1967–1975

Table 5 shows the CPI annual averages for the past eight years for dentists' fees, physicians'

Table 5 ■ US averages for selected items, 1967-1975, Consumer Price Index. (Average annual index, 1967=100.)

Yr	Dentists' fees	Physicians' fees	Medical care	Hospital semiprivate room rates	Services	All items
1967	100.0	100.0	100.0	100.0	100.0	100.0
1968	105.5	105.6	106.1	113.6	105.2	104.2
1969	112.9	112.9	113.4	128.8	112.5	109.8
1970	119.4	121.4	120.6	145.4	121.6	116.3
1971	127.0	129.8	128.4	163.1	128.4	121.3
1972	132.3	133.6	132.5	173.9	133.3	125.3
1973	136.4	138.2	137.7	182.1	139.1	133.1
1974	146.8	150.9	150.5	201.5	152.0	147.7
1975	161.9	169.4	168.6	236.1	166.6	161.2

Source: US Bureau of Labor Statistics.

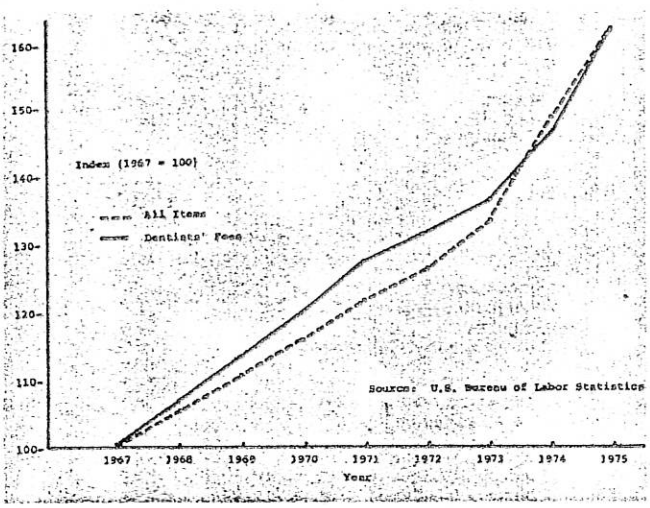


Fig 1 ■ Annual US averages for dentists' fees and all items, 1967–1975, Consumer Price Index.

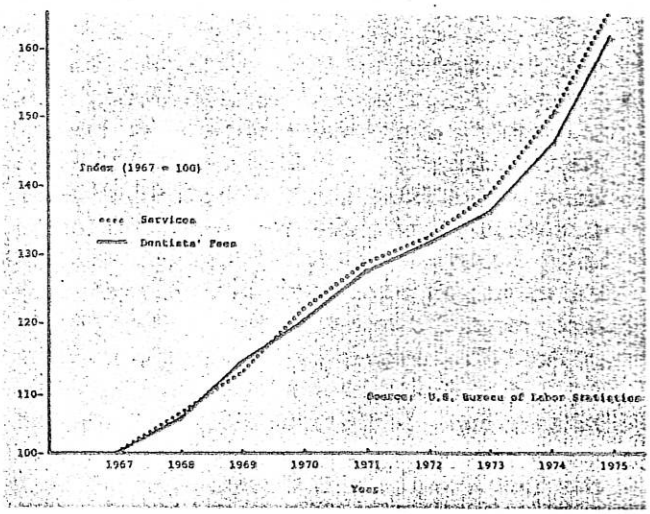


Fig 2 ■ Annual US averages for dentists' fees and services, 1967–1975, Consumer Price Index.

fees, medical care, hospital semiprivate room rates, services, and all items. From the late 1960s to 1972, dentists' fees were rising at a rate slightly higher than that for average prices in the economy as a whole. The cost of dental care, however, was rising at a slightly lower rate than the cost of other health care services, and services in general. By 1972, the increase in dentists' fees was nearly the same as in medical care, whereas hospital room rates were about 30% higher. Since 1972, during the Phase III controls, dental fees rose at a lower rate than the average of other prices in the economy and also at a lower rate than other health care services.

These trends for the years 1967 to 1975 are shown in Figures 1 through 3.

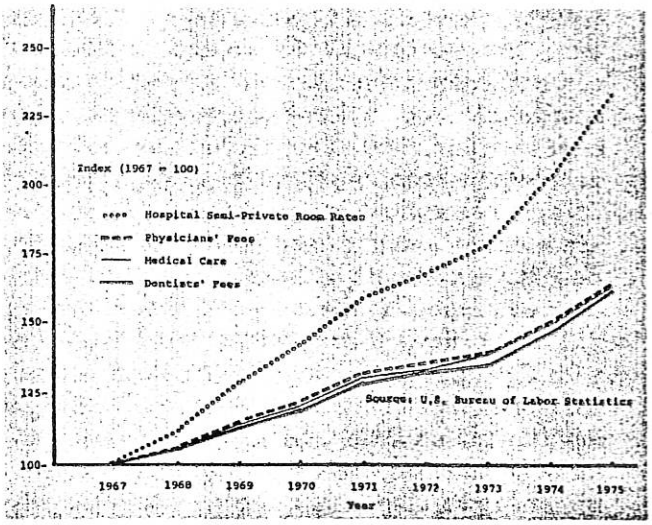


Fig 3 ■ Annual US averages for dentists' fees, physicians' fees, hospital semiprivate room rates, and medical care, 1967–1975, Consumer Price Index.

Cost of conducting a dental practice

In the years since 1967, dentists' expenses for materials and services needed to operate a practice increased more than twice as fast as the increase in dental fees. Average expenses for operating a dental practice more than doubled between 1967 and 1975, whereas fees were raised an average of 62%. The substantial cost increases were partly the result of price rises of consumable supplies and services. Some of these increases were inflationary, and some reflected the cost of quality improvements of new dental products introduced in the market every year. Such expenses included new equipment purchases, new operatories constructed, and greatly increased utilization of auxiliary personnel. Among items of smaller cost, the price of alloy in 1975 was about double the 1970 price. In the five years from 1970 to 1975, prices of dentists' hand instruments such as amalgam carvers increased about 100%, the price of endodontic files increased more than 60%, and forceps about 55%. The price of a prophylaxis angle increased more than 50% in the past five years, model plaster increased more than 60% in price, radiographic film about 30%, and paper and cotton products about 30%.

Data from ADA surveys of dental practice are shown in Tables 6 and 7 and Figure 4. Table 6 shows the index of dental fees from the CPI compared with indexes of dentists' professional

Table 6 ■ Index of dentists' fees, professional expenses and salary expenses, 1967-1975. (Average annual index, 1967=100.)

Yr	Dentists' fees*	Dentists' professional expenses†	Dentists' salary expenses†
1967	100.0	100.0	100.0
1968	105.5	110.3	112.5
1969	112.9	121.1	126.6
1970	119.4	131.9	143.4
1971	127.0	149.3	159.9
1972	132.3	166.8	179.2
1973	136.4	186.3	199.8
1974	146.8	208.1	222.7
1975	161.9	232.5	248.3

* Source, Consumer Price Index, US Bureau of Labor Statistics.
† Source, ADA Survey of Dental Practice. Data compiled for years 1967, 1970, and 1972; estimated for other years.

expenses and salary expenses. In 1975, the index of dentists' total expenses (with 1967=100) was estimated at 232.5. Salaries paid to employees was the largest expense item for dentists, amounting to almost a third of total expenses. Salary expenses stood at 248.3 on the index in 1975. The cost of fringe benefits for employees (health accident, disability and life insurance, and retirement plans, paid vacations, holidays, and sick leave) although only a small portion of total expenses, increased more than threefold since 1967. Overhead for such items as laundry, office supplies, and office maintenance more than doubled during the eight years and increased to over 12% of total expenses. Table 7 shows the 1975 index of dentists' professional expenses and percent of total expenses for various items. Figure 4 shows the trend in dentists' fees, salary expenses, and total professional expenses from 1967 to 1975.

Summary

Dentists' fees, as measured by the Consumer Price Index, increased at about the same rate in the past eight years as average prices in the economy. Between 1967 and 1975, dentists' fees increased 61.9% compared with a 61.2% increase in average prices of all goods and services measured in the index.

In the years since 1967, the cost of conducting a dental practice has steadily increased. Dentists' expenses for materials and services increased approximately twice as fast as the increase in dental fees. On the basis of ADA survey data,[1-3] dentists' professional expenses increased 133% and dentists' salary expenses for auxiliaries increased 148% between 1967 and 1975, whereas dentists' fees increased only 62%.

Table 7 ■ Estimated index of dentists' professional expenses, by item, 1975, and items as percentage of total expenses.

Item	Estimated 1975 index (1967=100)	% of total expenses
Office rent and utilities	204.8	12.3
Salaries (including commissions)	248.3	32.4
Fringe benefits (not included in salaries)	357.7	1.8
Dental supplies and equipment (excluding office supplies)	195.7	17.6
Commercial dental laboratory charges	187.4	19.9
Insurance, depreciation, travel, subscriptions, professional fees, and so forth	177.8	3.4
All other overhead (laundry, office supplies, postage, collection expenses, office management, and so forth)	253.9	12.6
Total expenses	232.5	100.0

Source: ADA surveys of dental practice.

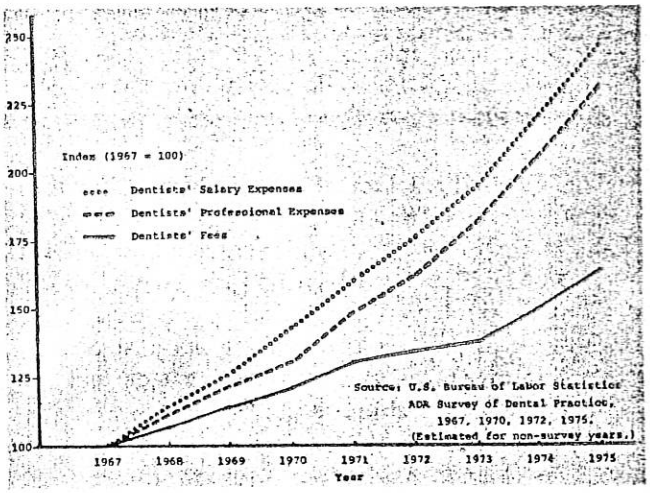


Fig 4 ■ Index of dentists' fees, dentists' professional expenses and salary expenses, annual US averages, 1967–1975.

This article was prepared by Sheldon Loewy, MA, and Karen Schaid, BS, ADA Bureau of Economic Research and Statistics.

1. 1968 Survey of dental practice. Chicago, American Dental Association, 1969.
2. 1971 survey of dental practice. Chicago, American Dental Association 1972.
3. 1973 Survey of dental practice. Chicago, American Dental Association, 1974.

Attachment M

TESTIMONY PRESENTED TO THE
COMMISSION ON HEALTH CARE COSTS
September 14, 1977

My name is Dr. Clyde Rousey. I am a psychologist in private practice in Topeka. I am certified by the state of Kansas as a psychologist as well as recognized by the Council for the National Register of Health Service Providers in Psychology. Currently I serve as a member of the Shawnee County Subarea Council of the Northeast Kansas Health Systems Agency. As such, I have a personal committment to the study of health care, health care facilities and the attendent costs. It is my understanding that your focus is on cost containment for health care services and the contributions to this goal of the various health care professions. As a resident of the state of Kansas for the past sixteen years, a fellow taxpayer, a consumer of health care services myself as well as a provider of psychological services, I welcome the opportunity to discuss the role of psychology and suggest ways in which I believe psychology can and is making significant contributions towards the containment of health care costs. In so doing, I will discuss three areas.

1. What is a psychologist and what does he or she do?
2. The role of psychologists in providing health care for Title XIX and Medicare recipients and for persons covered by other third party payment plans.
3. What psychology is doing to contain the costs of health care. Pursuant to this last point, I will review some innovations now being attempted by psychologists.

What is a psychologist? By law effective July 1, 1967, no one offering psychological services to the public can be called a psychologist unless they are certified by the Kansas Board of Examiners in Psychology. The current requirements for certification require individuals to have a Ph.D. from an accredited Psychology Department, have two years of experience--one of which must have been Postdoctoral and pass a written examination. There are now close to 400 certified psychologists in Kansas with approximately 200 of these supplying health care service in the mental health area on a full or part-time basis. There are numerous areas of practice of psychology including pure research, study of how individuals learn, study of the interelationship between physiological and psychological factors, study of growth and development in a psychological and educational sense and finally, individuals whose interest is primarily in clinical work with humans who in some way show maladaptive interpersonal relationships. It is to the clinical psychologist that the average citizen most often turns for health care. A clinical psychologist is especially trained to administer diagnostic tests which evaluate individual intelligence, his ability to get along with people, and think in rational and appropriate ways. Equally important, a clinical psychologist also provides

Atch. M

psychotherapy for such troublesome human problems as depression, the control and expression of feelings, illogical thinking, confusion over their role as men or women and so on. A psychiatrist and psychologist are still often confused by the general public. Perhaps the most important basic distinction between the two is the medical training of the psychiatrist and the research training of the psychologist. This distinction should not obscure the unique and overlapping contributions of both groups. The psychiatrist by virtue of his medical training integrates physical and psychological findings, prescribes medication as indicated and does psychotherapy. A psychologist performs formal diagnostic testing, integrates clinical and pure research for the benefit of the patient and also provides psychotherapy where appropriate.

The role of psychologists in Title XIX and other Health Care Programs: Until July of this year, it was impossible for recipients of Title XIX benefits to receive services from a psychologist except by going through a physician. Thus, all individuals receiving psychological services had to have a physician--preferably a psychiatrist, assume the role of a primary provider and bill SRS for any charges. Administrative costs involved in billing by the middle man were often and appropriately paid. This form of constraint allowed for confusion in record keeping as to just how much service was being performed by psychologists since anyone could bill for "psychotherapy" through sponsorship of a physician. While the costs for psychotherapy have always been similar between psychologists and psychiatrists, diagnostic studies performed by psychologists for the Title XIX program have been reimbursed at $25 per hour. Although there are no definite figures available for the specific average costs for psychological services, it is certain that the level of reimbursement has been less than the prevailing rates charged private patients. Thus, Title XIX has always had its own cost containment by limiting the amount to be paid. In the past legislative session, psychologists acquired the status of primary providers for Title XIX patients. As such, Kansas is one of 17 states who encompass 41% of the United States population. In addition, Kansas is one of 26 states mandating what has been called "Freedom of Choice" for individuals in choosing whom they turn to for psychological treatment. Only Medicare still insists that while psychologists can provide diagnostic psychological examinations, when providing psychotherapy they must be under the direct supervision of a physician. The obvious added expense to health care costs involved in tying up the time of two professionals for one patient is obvious and deserves change. In the case of CHAMPUS, FEP Insurance and numerous other third party private insurance, psychologists are able to provide service for any claimant who has this benefit as part of their health care policy.

How psychologists contribute to cost containment: There are at least two facets to cost containment. The first is the obvious containment to costs for a specific service while the second is containment of overall health care costs. Probably the latter of these two is the real bottom line of the ledger in the area of cost containment.

With respect to the first area, psychologists monitor carefully who can offer, or represent as offering, psychological services. The Board of Examiners has no authority to control the psychological services offered by medical disciplines or community mental health centers since these groups are assumed as responsible groups in their own right. As a result of psychologists becoming primary providers, the overall costs billed specifically by psychologists for Title XIX recipients will be available for the first time. This will provide SRS with specific figures to use in their cost containment efforts.

Another way in which the cost of psychological care is addressed is by the Professional Standards Review Committee of the Kansas Psychological Association. This committee is available to both consumers and providers of psychological services. In addition to the professional members who comprise this committee, there are also two lay members. If any individual considers costs or services out of line, this person can appeal to this committee for help in resolving the issue. Psychologists in the state of Kansas know that their peers are available to monitor their practice in all areas. The PSRC of the Kansas Psychological Association has been active in reviewing and recommending disposition of numerous disputes.

Yet another kind of attempt to hold down costs in an agency is being studied by one of my colleagues in private practice. As we all know, agencies and groups often start programs which persist long after their usefulness by virtue of the paperwork and bureaucracy. His effort represents one of the virtues of the private segment, for he provides psychological services to agencies and is paid only so long as patient need exists.

We come now to how psychologists contribute to cost containment of health care costs in general. This area is to my mind the bottom line of the health care cost ledger and is thus most important of all. In the major push to reduce the size of state mental hospitals, there has been an increasing trend to having patients with psychological difficulties return to their home communities and be cared for on an outpatient basis by a community mental health center. Unfortunately, not all individuals in Kansas have ready access to community mental health centers and, in many cases, there are more persons needing this service than the available community mental health centers can serve. In these cases, psychologists in private practice

provide the psychological services necessary to keep individuals out of state mental hospitals, thereby reducing the necessity for expensive state institutions. A psychologist is readily available in all counties in Kansas. The potential costs saved by this process are difficult to estimate, but in this instance, the idea of cost containment is expanded beyond the notion of one single discipline and translated into cost containment for all the many health services which would be utilized if the patient had to go back to a hospital. Finally, I would like to tell you about a rather exciting effort in cost containment for total health care which was completed in California. One of my colleagues, Dr. Donald Tiffany of the High Plains Comprehensive Community Mental Health Center presented a paper at the Kansas Psychological Association meeting in April of 1977 which was entitled "The Sore Thumb Syndrome" or "Mental Health Planning at the State Level". He described the work of a psychologist and psychiatrist of the Kaiser Foundation Hospital and the Permanent Medical Group in San Francisco. Doctor Tiffany wrote:

> "The outpatient and inpatient medical utilization for the year prior to the initial interview in the Department of Psychiatry as well as for the five years following were studied for three groups of psychotherapy patients, one interview only, brief therapy ($\bar{x}$=6.2 interviews), and long-term therapy ($\bar{x}$=33.9 interviews), and a control group of matched patients demonstrating similar criteria of distress but not, in the six years under study, seen in psychotherapy. The three psychotherapy groups as well as the control (non-psychotherapy) group were high utilizers of medical facilities, with an average utilization significantly higher than that of the (Kaiser Foundation) Health Plan participants average. Results of the study....showed significant declines in medical utilization in the psychotherapy groups when compared to the control group, whose inpatient and outpatient utilization remained relatively constant throughout the six years. The finding that one session only, with no repeat psychological visits, could reduce medical utilization by 60% over the following five years, was surprising and totally unexpected. Equally surprising was the 75% reduction in medical utilization over a five year period in those patients initially receiving two to eight psychotherapy sessions (brief therapy). In addition, they found that the combined psychiatric and medical utilization for the long-term therapy group showed no overall decline in outpatient utilization -- inasmuch as psychotherapy visits seemed to supplant medical visits. However, there was a significant decline in inpatient utilization. This highly significant decline in hospitalization rate tended to occur within the first year after the initial interview and remained generally comparable to the Health Plan subscribers average for the remaining five years of the study."

A similar effort could be made within our state with chronic users of Title XIX medical services. Such an effort would offer a new and inventive way towards cost containment for total health care costs.

Finally, may I express my appreciation for the opportunity to present this material to you on behalf of the Kansas Psychological Association and Dr. Henry Remple, President. It is our desire and wish to cooperate in any way that is possible to meet the desirable and necessary goal of cost containment while providing appropriate health care for the citizens of Kansas.

Attachment N

HEALTH CARE COST CONTAINMENT: POLICY ALTERNATIVES

A report by

The Kansas Chiropractic Association

Prepared for

The Commission on Health Care Costs

September 14, 1977

Att. N

The growing crisis of health care costs is undeniable and rapidly is becoming one of the primary public policy issues confronting the federal and state governments.

While this report will focus on Title XIX, it is our view that the real problem is not the design or administration of the Medicaid program.

That the Medicaid program is on the brink of collapse in other states is simply a symptom of the far larger problem of the cost of health care delivery in this nation.

We endorse the proposition that the poor and dependent people in Kansas must have access to quality health care services.

We believe in a Medicaid program which is oriented toward health preservation, rather than toward crisis management, and early detection of, followed by elimination or control of, health problems.

We believe that all health care providers should be paid in full for their services, subject to stringent justification based on medical necessity.

An analysis of the Kansas Medicaid program should be based on the following factors:

1. The amount, duration, and scope of the services covered.

2. The number of persons eligible for program benefits that actually participate in the program.

3. The rate at which covered services are utilized by those eligible.

4. The price that the state pays for each of the covered services.

The most expedient approach to the Medicaid problem is to cut back on the scope of services and the number of those eligible to receive them. We believe that is the wrong approach and, in the long run, is a disservice to the taxpayers, the dependent people, and the providers of health care services.

The proper focal point is the cost and utilization of services.

The most recent national data available (1974) indicates that only something more than a dime of every Medicaid dollar was paid to healing arts practitioners, i.e., doctors. About 36 cents of each dollar went to nursing homes. About 30 cents of each dollar went to hospitals. Of the remaining 24 cents of each dollar, seven cents went for prescription drugs, with the rest divided among out-patient hospital services, clinics, and dentists.

About two-thirds of the expenditures under Medicaid, therefore, were for institutional services. Cost containment policies directed at individual doctors would miss most of the dollar flow.

Indeed, policies directed at restricting patient access to the healing arts practitioner of their choice seem to have the effect of encouraging patients to delay getting attention for their health care problem until hospitalization or emergency room care becomes mandatory, at very high cost.

Before the Commission can deal substantively with the issue before it, we suggest some pointed questions should be asked:

1. How does the Attorney General's office respond to complaints in the area of health care costs, and what results have been obtained?

2. Whether the Attorney General would consider overutilization to be fraud, making the provider subject to prosecution under provisions of consumer protection laws?

3. Whether the Kansas State Board of Healing Arts perceives over-utilization as fraud, and subject to discipline?

4. How does the Kansas State Board of Healing Arts respond to complaints about health care costs?

5. What steps have been taken by the Blues to contain the costs of the Medicaid program?

6. What incentives do the Blues provide for cost containment?

7. Does SRS consider either the New Mexico PSRO program for prescriptions or the New York surgery (second opinion) program as valid cost-containment approaches?

8. How do Kansas Medicaid provider charges compare with cost rates nationally and in comparable states?

9. What steps has SRS taken to utilize Medicare coverage where applicable and to pursue alternate sources of payment, e.g., Worker's Compensation or tort claims of beneficiaries.

10. What is the administrative cost of processing claims and what steps are being taken to reduce those costs?

11. Is the announced intention of the Blues to review hospital rate increases likely to slow down such increases or merely slow down government action to deal with rate increases?

12. What collection procedures are utilized by hospitals, as well as the percentage and actual dollar amounts of write-offs.

13. How do write-offs affect subsequent hospital charges?

In addition, the Commission might inquire of both labor and industry as to the impact of health care costs on employers and the impact of health care benefit costs on wages.

Policy Alternatives

The following is a list of policy alternatives which have been gleaned from the increasing abundant literature on health care costs containment policies.

We do not necessarily endorse any or all of them. Indeed, we might resist implementation of some of them.

However, we feel a moral responsibility to the public and to this Commission to bring to your attention even those ideas with which we might disagree.

1. Consideration could be given, in the Medicaid program, to a freeze on the individual profiles of all institutional health care providers (the individual profile, in conjunction with the level of percentile, determines the reimbursement to the provider).

2. State government should request voluntary price controls among health care providers while the Legislature gives this issue thorough study. The publicity attendant to this jaw-boning approach will let the providers know state government is serious about this issue.

3. Consideration could be given to a state-imposed fee schedule, nailing down maximum third-party reimbursement, similar to the effect of KSA 44-510 in Workmen's Compensation.

4. Consider the imposition of wage and price controls on the state's health care industry.

5. Consider public utility-type regulation of institutional provider charges, as in Massachusetts and New Jersey. At least 90 percent of all hospital charges are paid by third-parties--and most often that third party is the government. The public interest requires some mechanism for imposing accountability on those institutions. Just as it would be unthinkable to appoint the presidents of the three largest utilities in the state to the Kansas Corporation Commission, so should any health care-oriented regulatory commission also be controlled by consumers.

6. Since about half the state's population is covered by some Blue Cross/Blue Shield program, stringent regulation of the Blues by state government would be proper.

7. Consider imposing a disciplinary tie-in with the licensing authority in over-utilization cases.

8. Consider extension of tax-incentives to employers and employes (rather than to providers) to encourage the creation of HMOs.

9. Consider reguiring health care insurance policies to make reimbursement for physical examinations, nutritional consultation, and other health-preserving mechanisms.

10. Educate consumers to seek out less costly health care alternatives.

11. A careful review of KSA 40-1801 and KSA 40-1902, state laws relating to the control of the Blues in Kansas, should be undertaken. We believe that their boards of directors should clearly be controlled by consumers--the purchasers of services--rather than by providers.

At most, we believe some minority representation might be allowed medical doctors and hospital administrators, but no more than that.

Conclusion

This report, in the main, is based on "Medicaid Cutbacks," a handbook published by the National Clearinghouse For Legal Services, 500 N. Michigan Avenue, Suite 2220, Chicago, Illinois 60611. The Kansas Chiropractic Association would be pleased to provide copies of the handbook upon request from any member of the Commission or its staff. Another valuable publication is "Advocate's Guide to Cost Containment" by Diane Rowland, now a member of the Office of Research and Statistics, SSA, HEW. The KCA will provide copies upon request.

Attachment O

FACT SHEET ON CHIROPRACTIC

This Fact Sheet briefly describes the position of chiropractic in the health-care delivery system of the United States.

I. State Licensing and Authorization
- A. All 50 states, plus the District of Columbia and Puerto Rico, license and officially recognize chiropractic as a health profession.
- B. All 50 states authorize chiropractic services as part of their workmen's compensation program.
- C. Over three-fifths of the states representing some 70% of the nation's population, require inclusion of chiropractic services under all commercial health and accident policies written in those states.
- D. The National Conference of Insurance Legislators adopted a model bill for state health insurance programs, which defines "physician" to include doctor of chiropractic.

II. Federal Authorization and Recognition
- A. For all Americans
  1. Medicare
  2. Medicaid
  3. Vocational rehabilitation program
  4. Under the Internal Revenue Code, chiropractic health care is a "medical" deduction
- B. Specifically for Federal employees
  1. in federal employee health benefit programs,
  2. in federal employee workmen's compensation,
  3. in leave approvals for civil service excuse of illness.
- C. Chiropractic Education
  1. The U.S. Office of Education, HEW, officially recognized a chiropractic accrediting agency for chiropractic colleges.
  2. To obtain a diploma as a Doctor of Chiropractic, a candidate must have two years of pre-professional college education and 4 years of resident instruction at a chiropractic college.
  3. In almost three-fifths of the states, candidates for a chiropractic licensure must qualify under the same basic science exams as required for MDs.
- D. Specifically for Veterans
  GI Bill of Rights covers education in chiropractic colleges.
- E. Research
  As a result of Congressional action and funding of research in chiropractic, the National Institute of Neurological Disease and Stroke held a Workshop on "The Research Status of Spinal Manipulative Therapy," February 2-4, 1975, opened by Dr. Donald B. Tower, Director of NINDS, and directed by Dr. Murray Goldstein, Director, Extramural Programs and Associate Director of NINDS. Papers were read by leading MDs, DOs, DCs and PhDs.
- F. Miscellaneous
  1. Under the immigration law, aliens are admitted as students in order to study in chiropractic colleges.
  2. The U.S. Public Health Service.
     a. classifies doctors of chiropractic among "medical specialists and practitioners," and
     b. includes DCs in its Health Manpower Source Book.

III. Private Sector
- A. Virtually all major commercial health insurance carriers include chiropractic in their private policies.
- B. Major industrial employers, such as General Motors, have included chiropractic in the health plan for *all* their own employees.
- C. Substantial numbers of major international, national and local unions include chiropractic in their own health and welfare plans (including the railroad and rubber unions, for example).

Atch. O

Attachment P

COMPARATIVE COST

Studies of Industrial Back Injuries

Studies of workmen's compensation records provide objective evidence of the efficacy of chiropractic care in the treatment of industrial injuries. From data supplied by Workmen's Compensation Commissions, comparisons of D.C. and M.D. treatment of industrial injuries have demonstrated dramatically that those cases under chiropractic care showed reduced treatment costs, compensation costs, work-time losses, and workman disability and suffering.

1. ***Florida.*** A Florida study (First Research Corporation, "A Survey and Analysis of the Treatment of Sprain and Strain Injuries in Industrial Cases," 1961) indicates that treatment costs for substantially identical cases were 27.5 percent less for cases handled by D.C.'s than for cases handled by M.D.'s. The study further indicated that when a back or neck injury case was handled by an M.D. rather than a D.C. that (a) compensation costs averaged 311 percent more (under care by an M.D. and (b) worktime losses averaged 300 percent more (under care by an M.D.).

2. ***Oregon.*** The medical director of the Workmen's Compensation Board of the State of Oregon released the results of a similar study, "A Study of Time Loss Back Claims, 1971," which showed that of claimants treated by no other physicians than a chiropractor, 82 percent of these workmen resumed work after one week of time loss. These claims were closed without a disability award. However, claimants treated by M.D.'s in which the diagnosis seems comparable to the type of injury suffered by the workmen treated by the D.C., 41 percent of these workmen resumed work after one week of time loss.

In a separate study of statistical information furnished by the Oregon Workmen's Compensation Board in 1971, a 24-month study limited to back-injury cases involving sprains and strains only found (a) $298.52 average total cost under care of M.D., as compared to (b) $72.92 average total cost under care of D.C. These average total costs include doctor and hospital costs plus compensable time loss.

3. *Kansas.* A survey of Kansas workmen's compensation records of 1971 shows (a) $102.53 average total cost under care by an M.D., as compared to (b) $65.69 average total cost under care of a D.C. These average total costs include doctor and hospital costs plus compensable time loss. This survey was also limited to back injury cases involving sprains and strains only.

4. *Iowa.* A comparison of the cost of D.C. vs. M.D. treatment is found in two Iowa studies covering the years 1966 and 1969. Average cost per case for M.D. treatment in 1966 was $210.86, as compared to average cost per case for D.C. care in 1966 of $68.24 and in 1969 of $79.28.

5. ***California.*** In December 1972, C. Richard Wolf, M.D., completed a study which was designed to compare time loss due to industrial back injury when treated by either a D.C. or an M.D., using the records of the Division of Labor Statistics and Research (Doctor's First Report of Work Injury). In summary, 1,000 employees with industrial back injuries were questioned about the time lost and residual pain from injuries suffered. On the injuries reported, one-half had been treated by M.D. and one-half by D.C. physicians. Of the 1,000 employees surveyed, 629 responded to the questionnaire. No degree of bias in study design could be determined, and there were no apparent major identifiable differences in the two groups with regard to age of employee categories. The major differences determined were:

	Employees Treated by M.D.'s	Employees Treated by D.C.'s
Average lost time per employee	32 days	15.6 days
Employees reporting no lost time	21.0%	47.9%
Employees reporting lost time in excess of 60 days	13.2%	6.7%
Employees reporting complete recovery	34.8%	51.0%

Att. P

Attachment Q

CHIROPRACTIC SERVICES HANDBOOK

KANSAS MEDICAID ASSISTANCE PROGRAM

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

Revised -- January, 1975

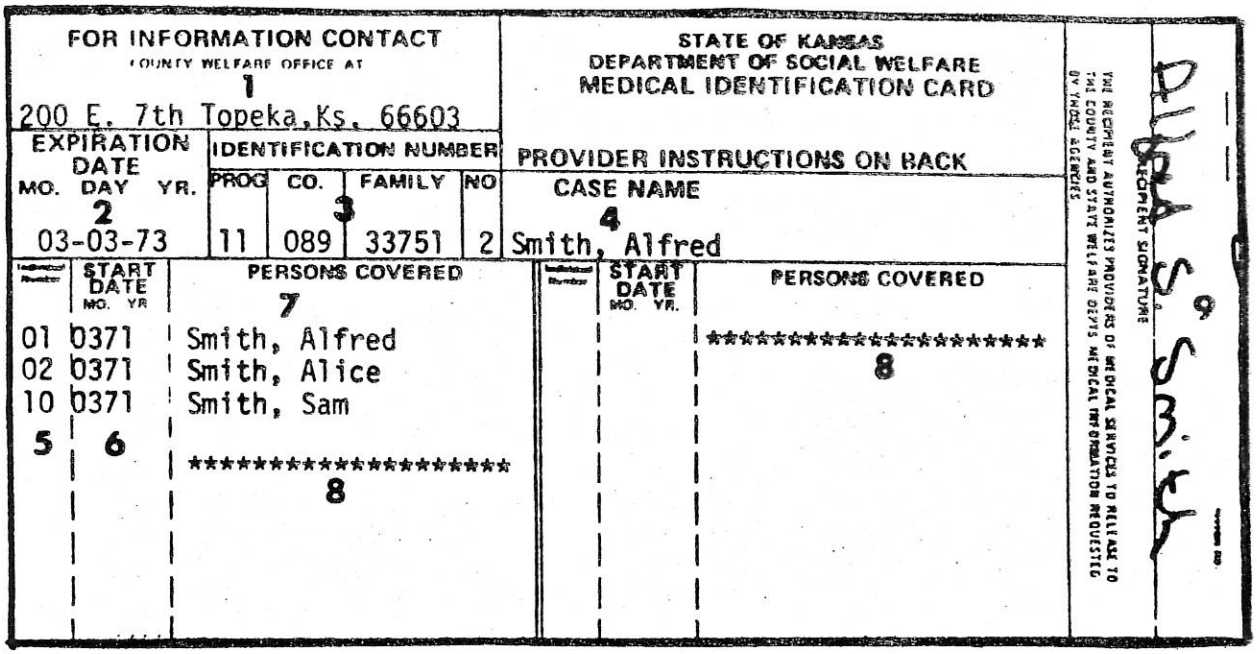
Atch. 9

TABLE OF CONTENTS

THE TITLE XIX IDENTIFICATION CARD -- WHO IS ELIGIBLE

The State Department of Social and Rehabilitation Services began issuing monthly Medical I.D. Cards as of January, 1973. Each month, persons eligible for medical assistance under the Title XIX Program will receive a new I.D. Card. A Recipient who does not receive an I.D. card to cover the coming monthly time period will not be eligible for medical assistance after the expiration date on his present Card. THEREFORE, IT IS IMPORTANT TO CHECK THE I.D. CARDS EACH TIME A SERVICE IS PROVIDED TO BE SURE IT COVERS THE CURRENT MONTH.

The face of this Medical I.D. Card will appear as shown below:



FOR INFORMATION CONTACT COUNTY WELFARE OFFICE AT
1
200 E. 7th Topeka,Ks. 66603

STATE OF KANSAS
DEPARTMENT OF SOCIAL WELFARE
MEDICAL IDENTIFICATION CARD

PROVIDER INSTRUCTIONS ON BACK

THE RECIPIENT AUTHORIZES PROVIDERS OF MEDICAL SERVICES TO RELEASE TO THIS COUNTY AND STATE WELFARE DEPTS MEDICAL INFORMATION REQUESTED BY THESE AGENCIES

RECIPIENT SIGNATURE
9
Alfred S. Smith

EXPIRATION DATE MO. DAY YR.	IDENTIFICATION NUMBER PROG	CO.	FAMILY	NO	CASE NAME
2 03-03-73	11	089	33751	2	4 Smith, Alfred

	START DATE MO. YR	PERSONS COVERED
		7
01	0371	Smith, Alfred
02	0371	Smith, Alice
10	0371	Smith, Sam
5	6	**********
		8

	START DATE MO. YR.	PERSONS COVERED
		**********
		8

1. Address of County Social and Rehabilitation Services Office.
2. Date of eligibility expires until next Card is issued.
3. First 11 digits of I.D. Number.
4. Case Name.
   a. All eligible Title XIX family members are specifically shown on this card. Any family member not shown is not eligible.
   b. BE SURE TO NOTICE DATE OF MEDICAL ELIGIBILITY. Any services provided prior to this date are not covered under this case number.
   c. Be sure the Title XIX beneficiary is carrying a current I.D. card.
   d. Should you have any questions about eligibility contact the County Social and Rehabilitation Services Office who issued this card.
5. Individual Number (Last two digits of I.D. Number).
6. Date eligibility began under Title XIX.
7. Persons covered.
8. Asterisks conclude list of persons eligible.
9. Recipient's signature.

THE TITLE XIX IDENTIFICATION CARD

You will notice that the face of the I. D. Card has changed. The back of the I.D. Card has also changed. See below:

Information needed on claims and eligibility.

Card must be signed.

Names appearing below the asterisk should be verified by County Social and Rehabilitation Services.

Title XIX liability.

ATTENTION: MEDICAL SERVICE PROVIDERS

All claims must have complete Identification number, Individual number, Case name and patient's name. Check the client's Card on each visit. Persons listed are eligible from start date shown until expiration date. Do not bill the Kansas Department of Social and Rehabilitation Services for services after the expiration date shown.

- - - - - - - - - - - - - FOLD - - - - - - - - - - - - - - - -

The recipient's signature must be on the right margin of the Card.

If names appear below the row of asterisks (***) on the face of the Card, contact the Local SRS Office regarding eligibility.

- - - - - - - - - - - - - FOLD - - - - - - - - - - - - - - - -

Kansas Medical Assistance is not liable for payment of services to which the client is entitled through veterans benefits or private insurance.* All non-emergency out-of-state medical services, except those historically obtained in border areas, are subject to prior authorization by the Medical Services Section.

*Check with patient.

TITLE XIX COVERS . . .

PROFESSIONAL SERVICES wherever provided are covered at individually established, usual and customary professional charge if these charges fall within Prevailing Charge Ranges for Kansas. This includes:

-Diagnostic services

-Therapeutic services

-Rehabilitative services

-Palliative services

-Preventive services

EXCEPT: Services rendered primarily for cosmetic purposes OR services not considered necessary in relation to the condition for which care is required.

THREE THINGS TO REMEMBER:

1. All other insurance or public/community programs should provide their benefits first. If there is a balance, Title XIX will pay the remaining amount.

2. If there is a payment pending from private insurance or other sources, do not file your claim until the other source payment is received.

3. Always show the amount of payment from other sources on the Title XIX claim when other payment sources are involved.

LIMITATIONS TO REMEMBER . . .

Title XIX payment for Chiropractic Services is limited to

- Doctors of Chiropractic Licensed to practice in the state where Chiropractic services are rendered.

- Manual manipulation of the spine and covered modalities listed below:

Hot or cold packs	Paraffin bath
Traction, mechanical	Microwave
Electrical stimulation (unattended)	Whirlpool
Ultrasound	Diathermy
Vasopneumatic devices	Infra-red
Ultraviolet	Med-co-son
Microtherm	Ultratherm

The following types of modalities are non covered under Title XIX:

Diapulse
Spectrowave
Superpulse

- X-rays

- Doctors of Chiropractic Currently Active in practice who have registered their fees with the State Department of Social and Rehabilitation Services prior to July 1, 1968. Chiropractors who did not register by July 1, 1968, need to make written application for participation in the Title XIX program expressing intent to participate, providing date of license, school from which graduated, and length of time in practice. This application needs to be addressed to:

Medical Services Division
State Department of Social and Rehabilitation Services
State Office Building
Topeka, Kansas 66612

- ONE Practitioner's care for a given diagnosis of a Title XIX patient.

- Code 0018 should be used for nursing home visits when only one patient is seen and code 0021 should be used when seeing more than one patient.

County of Assistance payments only:

- Orthopedic Appliances are payable only through the patient's county of residence Social and Rehabilitation Services Office (Shown on the I.D. Card).

- Claims for Orthopedic Appliances must be acceptable by the County Social and Rehabilitation Services Office and accompanied by a copy of the supplier's invoice.

- Reimbursement for Orthopedic Appliances is the acquisition cost shown on the invoice and does not cover sales tax. When supplied by a practitioner, the item will be paid by invoice central payment procedure 400-403.

Prior Authorization Required For:

THERAPY ANTICIPATED TO COVER 90 DAYS or longer must be submitted to the Chiropractic Review Committee for prior authorization. The request must be submitted in narrative form giving the diagnosis and sufficient information concerning the medical necessity of prolonged therapy. Submit your request for prior authorization by the 60th day of the course of treatment.

The anticipated number of visits required per month should also be indicated.

HOW TO FILE FOR PRIOR AUTHORIZATION

1. Complete items 1 - 8 and item 13 of the Title XIX Chiropractic claim form (shown on page 7). If services have already been provided, you may bill for the services by completing items 9 - 12 and 14 - 18.

2. The original green copy of the Title XIX Chiropractic claim form should be sent to:

   Blue Cross and Blue Shield of Kansas
   Title XIX
   P.O. Box 675
   Topeka, Kansas 66601

NOTE: Routing through the County or State Department of Social and Rehabilitation Services is unnecessary and only delays processing.

3. After the Chiropractor receives approval from Blue Shield of Kansas for the treatment plan, if names appear below the row of asterisks on the front of the I.D. Card, contact the County Social and Rehabilitation Services Office regarding eligibility. Then Blue Shield of Kansas will provide the Chiropractor written notification approving or denying the service. Approval applies only to performance of the proposed service. It does not constitute agreement to pay the charge in its entirety nor does it confirm current eligibility of the recipient. The recipient's eligibility card should be checked prior to the performance of each service (office visit).

4. After the services are provided, the completed Title XIX Chiropractic claim form should be sent to Blue Shield of Kansas at the address shown in #2, above.

REMEMBER: When filing a claim for prior authorization, the bottom portion must be completed and the entire claim form sent to Blue Shield of Kansas at the address shown in #2, above.

IF PRIOR AUTHORIZATION IS DENIED

If prior authorization is denied, this does not always imply that no treatment at all is necessary but simply that the plan of service as presented is unacceptable. Treatment that does not need prior approval may be rendered and a claim may be submitted for payment.

EXAMPLES OF SERVICES SUBJECT TO CHIROPRACTIC REVIEW COMMITTEE REVIEW OR REVIEW BY THE CHIROPRACTIC CONSULTANT

- Multiple visits in one day
- An unusual number of visits in one week
- More than one treatment per visit
- Family Group Treatments
- Any claim manifesting an unusual pattern of practice
- X-rays
- More than four office visits per month--information substantiating the medical necessity of the additional visits must be included on the claim form IF prior authorization was not obtained.
- More than one home or nursing home call per month--information substantiating the medical necessity of the additional visits must be included on the claim form IF prior authorization was not obtained.

HOW TO COMPLETE THE TITLE XIX CHIROPRACTIC CLAIM FORM (See page 8 for an explanation of numbered items)

TITLE XIX CHIROPRACTIC CLAIM

STATE OF KANSAS — DEPARTMENT OF SOCIAL WELFARE

1013479

COUNTY OF ASSISTANCE (1) | CASE IDENTIFICATION NUMBER (13 DIGITS) (2)

CASE NAME (3) | PATIENT'S NAME (4) | AGE (5) | AMOUNT BILLED MEDICARE

CHIROPRACTOR'S NAME AND ADDRESS (6) | CHIROPRACTOR NO. (7) | HEALTH INSURANCE CLAIM NO. (8)

NAME AND ADDRESS OF LABORATORY

Description of Services (Please Itemize)	Date	POS	NO. OF VISITS	Proc. Code	Charge	For Agency Use
(9)	(10)			(11)	(12)	

DIAGNOSIS (13)

DEDUCT PAYMENT RECEIVED FROM OTHER SOURCES (14)

GRAND TOTAL (15)

I hereby certify that the material or services listed hereon have been delivered or performed; that the original invoice is correct, just and remains unpaid; that the amount for services indicated is actually due according to law, is subject to welfare regulations, is not in excess of regular fees and constitutes full and complete payment and satisfaction for these services; and that the goods and services provided by me are available without discrimination as to race, color or national origin. Further, I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under the applicable federal or state laws. DFA 38-158 1/73

(16) Date

(17) Signature of Chiropractor

(18)

TITLE XIX CHIROPRACTIC PRIOR AUTHORIZATION FORM

STATE OF KANSAS — DEPARTMENT OF SOCIAL WELFARE
(Detach if Prior Authorization not applicable)

1013479

PATIENT'S NAME | CASE IDENTIFICATION NUMBER (13 DIGITS)

(COMPLETE DETAILED DESCRIPTION OF SERVICE)

DESCRIPTION OF THE CLAIM FORM

1. Enter here the name of the county which is shown on the patient's I.D. Card.

2. Enter here the 13 digit Case Identification Number found on the patient's I.D. Card.

   REMEMBER: The 11 digit Case Number plus the 2 digit Individual Number makes up the patient's 13 digit Title XIX Identification Number.

3. Enter here the Case Name found on the patient's I.D. Card.

4. Enter here the patient's name since it may differ from the Case Name. If the patient's name and Case Name are the same, write "same" in this space.

5. Enter here the age of the patient.

6. Enter here the Chiropractor's name and address.

7. Enter here the Chiropractor's Blue Shield provider code number. Inaccurate information may result in payment to the wrong Chiropractor or an extended delay in payment.

8. Give the Medicare number for your patients who are eligible for Medicare.

9. Enter here an itemization and description of services rendered.

10. Enter here the date each service was rendered.

11. Enter here the correct Blue Shield Procedure Code for each service rendered (as shown on page 11).

12. Enter here the charge for each service rendered.

13. Always include "Diagnosis", "Symptomatology", or "Condition Suspected" and the subluxation complex in the diagnosis box at the lower left of the claim form. On x-ray claims specify view, e.g. A-P, lateral, oblique and area viewed and film size.

14. Enter here the amount of payment received from other sources.

15. Enter here the total charges for the services shown on this claim.

16. Enter here the date the claim form was signed by the Chiropractor.

17. The Chiropractor's signature must be put here.

18. The bottom portion of the Title XIX Chiropractic Claim form is to be used ONLY when prior authorization, or Special Consideration, is being requested. (See page 5 regarding prior authorization.)

    REMEMBER: Bill only one month of services per patient per claim form. DO NOT bill several months together on ONE claim form.

HOW TO FILE FOR JOINT TITLE XIX/MEDICARE PATIENTS

For those patients who also have Medicare Part B you should use the SSA 1490-W claim form. Bill only Medicare covered services (code 0045 or 0046) on the top copy of SSA 1490-W claim form and send it to Medicare Claims. After you receive the EOMB from Medicare which explains how the claim was handled, type Title XIX covered services on the yellow copy of the claim form and send it to Title XIX Claims along with a copy of the EOMB (Explanation of Medicare Benefits). Please staple the EOMB to the back of the 1490-W form to save time in processing.

TIPS ABOUT "SPECIAL" CLAIMS:

If an unusual case requires departure from customary charges, attach a narrative with explanatory information and send it to Title XIX Claims. Sufficient information must be given to support the charges made.

To call this to Blue Shield's attention, add phrase "Individual Consideration requested."

If multiple diagnoses are involved, indicate primary diagnosis and list all secondary diagnoses and/or complicating factors.

WHEN BILLING HOME AND OFFICE SERVICES:

- Give the date of each visit.
- Itemize the place of each service, number of services, and the charge for each service.
- Indicate initial office calls (0038) as separate line items whenever there is a different charge made.
- Use code 0051 for modalities (a list of covered modalities is given on page 4) WHEN PERFORMED IN ADDITION TO A CHIROPRACTIC ADJUSTMENT BY MANUAL MANIPULATION OF THE SPINE (codes 0014, 0018, 0021, 0044, 0045, and 0046). Do not "LUMP" modality charges with your charge for an office, home, or nursing home visit.
- Nursing home visits should be billed under code 0018 WHEN ONLY ONE PATIENT IS SEEN or code 0021 WHEN MORE THAN ONE PATIENT IS SEEN.

TIMELY FILING OF CLAIMS

If a patient's application for Title XIX benefits is delayed because of determination of eligibility, your office may go ahead and file a claim for the services provided. In this situation, the case identification number would be left blank on the claim form. In this way, Title XIX Claims Department can date stamp the claim to indicate it was received within the six-month filing period.

In the case of a Medicare/Title XIX related claim, it is necessary that Medicare receive the claim within six months of the service date.

Contact the Title XIX Correspondent Unit, 1133 Topeka Boulevard, Topeka, Kansas, 66601, if you have any questions regarding this information.

CODE NUMBER	VISITS
0014	Home Visit
0018	Nursing home visit
0021	Multiple calls during one nursing home visit
[0038	Initial office call, patient referred to other provider for treatment
0044	Office Visit - routine, including chiropractic adjustment
*0045	Office visit, Chiropractic treatment, solely by manual manipulation of the spine (supported by x-ray as to necessity)
*0046	Home visit, Chiropractic treatment, solely by manual manipulation of the spine (supported by x-rays as to necessity)
[0051	Modality only
9070	Mileage - one way beyond a radius of 10 miles

*These are the only codes payable under the Medicare Program.

CODE NUMBER	X-RAYS
	Necessary Films for Diagnosis
Spinal	
7101	Chest, 2 views (originally lungs)
7110	Ribs, unilateral (Originally Thoracic Cage)
7204	Cervical, A-P and Lateral (2 views)
[7205	Spine, cervical, minimum of 3 views including odontoid projection
[7206	Spine, cervical, complete, including oblique and/or flexion extension studies
7207	Spine, Thoracic, minimum of 2 views
[7209	Full spine, 14 X 36 (1 view)
7210	Spine, lumbo-sacral, A-P and Lateral (2 views)
[7211	Spine, complete lumbo-sacral, minimum 5 views
[7212	Spine, lumbo-sacral, bending views only, minimum 4 views
7217	Pelvis, A-P only
Upper Extremities	
7245	Clavicle
7246	Scapula
7248	Shoulder, complete study
7250	Humerus, including 1 joint
7252	Elbow, A-P and Lateral
7255	Forearm including 1 joint, (original survey Ulna-Radius)
7257	Wrist, A-P and Lateral
7259	Hand
Lower Extremities	
7300	Hip, complete study
7303	Femur (thigh) including 1 joint
7304	Knee, 2 views
7306	Tibia and fibula (leg) including 1 joint
7308	Ankle, complete study, minimum 3 views
7310	Foot, complete study, minimum 3 views
Skull	
7025	Partial Study, less than 4 views with or without stereo
7026	Complete Study, minimum of 4 views with or without stereo

NOTE: If you can't find the proper code, please describe fully the services and leave the code are blank.

WHO TO CONTACT AND WHEN

1. WHO TO CONTACT

Should you have any question about a payment, non-payment, or policy interpretations of services, please direct your question to:

Blue Shield of Kansas
Government Claims Department
1133 Topeka Boulevard
Topeka, Kansas 66601

OR

Call:
Area Code 913-232-1000
and ask for Government Claims
Correspondence Department

2. WHEN TO CONTACT

It normally takes three months to process Title XIX claims for payment. However, on Special Consideration cases or when the Title XIX beneficiary's eligibility is in doubt it could take longer.

DO NOT resubmit duplicate copies of claims. Any inquiry regarding unpaid claims should be sent to the Government Claims Correspondence Department as shown above in #1.

3. WHEN YOU NEED CLAIM FORMS

A supply of Title XIX Claim forms may be ordered from:

Supply Department
Blue Cross and Blue Shield of Kansas
1133 Topeka Boulevard
Topeka, Kansas 66601

BE SURE to order the forms by form number. Regular Title XIX Chiropractic Claim Forms are #DFA 38-158. The claim form to use when filing for joint Medicare/Title XIX patients is SSA 1490-W.

INSTRUCTIONS FOR USING "TITLE XIX REJECT LISTING FOR PROVIDERS"

The Title XIX Reject Listing identifies claims which are not payable for one or more of the reasons listed below. The entries in the column headed "DISP CODE" identify why the particular service was not payable. The following are the procedures to follow for each code:

353 NO CASE MASTER RECORD WAS FOUND FOR THIS CLAIM. From your records, insert the patient's name on the reject listing. Write or stamp your name and address in the top right corner of each document and forward to the county Social and Rehabilitation Services Office for confirmation of the case number and eligibility. This addition of your name and address will aid the county SRS in returning the documents to you.

354 MEDICAL ELIGIBILITY CODE IS "0". Forward the computer report to the District or Branch Welfare Office for eligibility confirmation.

355 DATE OF SERVICE IS NOT WITHIN MEDICAL ELIGIBILITY PERIOD. Write or stamp your name and address in the top right corner of each document and forward to the county Social and Rehabilitation Services Office for validation of eligibility.

356 VALID LINE ITEM WILL PAY, IF 355 LINE ITEM WERE DELETED. Items shown with this code are payable. However, other items on the claim were not eligible for payment. Consequently, none of the claim was paid. Write or stamp your name and address in the top right corner of each document and forward to the county Social and Rehabilitation Services Office for validation of eligibility on those lines with disposition code 355, OR cross off the line items with disposition code 355 and return document to Title XIX for payment of remaining line items.

The county SRS office is authorized to sign the documents, making corrections to case numbers and/or periods of eligibility for medical services.

When the county SRS office returns these documents to you, promptly forward them to the Title XIX Claims Department who will handle each sheet as a claim and will process those marked eligible by the county SRS office for appropriate payments. NOTE: Please return only the Reject Listings. DO NOT resubmit on a new claim form.

It is suggested that eligibility information be verified by the recipient's Medical Information Card, which is now issued on a month-to-month basis, before services are provided. This will reduce the number of cases rejected.

HOW TITLE XIX PAYMENTS FOR PROFESSIONAL SERVICES ARE DETERMINED

Title XIX intends to pay providers their "customary" charges up to a maximum that would cover in full the charges of at least half of the doctors providing a given professional service.

Each provider is paid HIS customary charge in full IF it is below, or the same as, the 50th Percentile of all individual doctors' "customary charges". A doctor is paid only the "50th Percentile maximum" IF his "customary charge" is more than that figure.

FOR LESS FREQUENTLY PERFORMED PROCEDURES:

The provider's customary charge is paid UP TO a maximum figure that results from the "average conversion factor" for providers against their respective professional relative value schedules.

The "average conversion factor" is obtained from computing the "50th Percentile Maximums" conversion factors of the frequently performed procedures.

FOR NEW PROCEDURES

Temporary payment guidelines are recommended to Title XIX. Approved guidelines are used to allow charges for the first year.

After a year's experience, providers' "customary" charges and "50th Percentile Maximums" are developed from actual claims records as earlier described.

FOR "UNUSUAL CHARGE" PROCEDURES:

Providers with unusual cases wanting to make unusual charges ask for special consideration.

SPECIAL TITLE XIX PROVISIONS . . .

A. Reimbursement Rates for Service:

Payments to all providers are subject to the limitations of funds budgeted for the Medical Assistance Program. Should funds for the fiscal year prove inadequate to meet all costs on the basis of fees and charges provided in this contract, payment to providers will be made on the basis of funds available and a payment plan as determined by the State Board of Social and Rehabilitation Services. If an adjustment in the rate of reimbursements is necessitated by a shortage of state funds, each provider will be informed. Reduced reimbursements will be applicable to all providers.

B. The State's Right to Terminate Relationship with a Provider:

Providers of services and supplies to medical assistance recipients in order to qualify as a participant in the program must comply with all laws of Kansas policies or rules and regulations of the State Board of Social and Rehabilitation Services and the standards or ethics of their business or profession. The State Board of Social and Rehabilitation Services may, after notification and after hearing if one be requested as hereinafter provided, withdraw payment liability for goods and services upon determination that the provider has failed to comply with this regulation or for other good cause.

Upon notification of intent to withdraw payment liability by the State Board of Social and Rehabilitation Services, the provider of such services and supplies may within five (5) days after the receipt of such notice file a written request for a hearing before the state board. Such hearing shall follow the procedures and be conducted in the manner as far as possible as is provided in K.S.A. 75-3306. If no timely request for hearing is requested by the provider or if the board after the hearing shall determine that good cause exists the board may withdraw the provider's name from the eligible list of participants in the program and no further payments shall be made to such provider until the State Board of Social and Rehabilitation Services shall determine that the provider is eligible to participate in the program.

C. Out of State Providers:

If the provider is located in another state and services are rendered in that state, the provider must be licensed and otherwise certified by the proper agencies in his state of residence as qualified to render the services for which the charge is made. Out-of-state services require prior authorization.

Attachment

K.C.A. PEER REVIEW COMMITTEE

STANDARDS FOR PROFESSIONAL EXCELLENCE

I. Commitment to Peer Review

The Kansas Chiropractors Association, at its annual 1973 spring convention, established by resolution a Peer Review Committee program.

Accordingly, the profession's peer review goals were established:

(1) To assure high quality health services at reasonable cost;

(2) To assure high standards of professional conduct and ethics by objective evaluation of chiropractic peers;

(3) To provide educational assistance to the doctor of chiropractic in rendering his service;

(4) To assure that chiropractic review procedures remain the responsibility and the privilege of the profession.

Manifestly, therefore, the K.C.A. underscored its response to society's real need for professional peer review programs. Indeed, the K.C.A. viewed such a program for chiropractic--in its service to the public--as a necessity. Moreover, the K.C.A. took note of the transitory state of contemporary health care and health care delivery systems.

Of primary concern to the profession and others, of course, is the nature of peer review. The function of peer review is educational--to assure quality chiropractic care. Peer review is not intended to be disciplinary, but rather evaluative, analytical and consultative.

Traditionally, for the past several years, the K.C.A. has maintained a continuing program and process of claims review for third-party payors, specifically, insurance carriers and the Medicaid (Title XIX) program of the State Department of Social Welfare.

Peer review, however, is more than claims review, which generally considers cost and utilization factors. Indeed, peer review encompasses the total of the practitioner's responsibility to his patients, the public and the profession.

Of course, the K.C.A. peer review program must and will continue to include elements of claims review for third-party payors.

Atch. 8

An acceptable definition, therefore, of peer review as adopted by the K.C.A. is "an objective evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other physicians in the same discipline."

Accordingly, since peer review must strive for an objective evaluation of the individual doctor's professional performance, it is clear that certain professional standards are essential. (Otherwise, no objective evaluation is possible.)

It is essential, moreover, that the K.C.A. peer review program provide for a constant monitoring of the profession--by and through chiropractic peers--to see that such standards are both understood and practiced.

Such standards, as implemented by the K.C.A. Peer Review Committee, must be consistent with the profession's contemporary academic and clinical education and training, all of which must be based on the reservoir of scientific knowledge available.

Such is the thrust of the K.C.A. Peer Review Committee program, which will focus--at the outset--on third-party reimbursement matters.

II. Organization

The K.C.A. Peer Review Committee consists of a state chairman and four members who serve as chairmen of the following respective sub-committees:

(a) Cost and Utilization--to determine whether procedures (diagnostic & therapeutic) performed or ordered by the attending doctor of chiropractic on a specific review matter were necessary and justifiable; further, to determine whether said procedures were within approved cost guidelines, viz., the Relative Value Schedule adopted by the K.C.A. in convention.

(b) Quality--to determine whether procedures (diagnostic & therapeutic) performed or ordered by the attending physician were reasonably performed and conformed to proper standards, i.e., academic and clinical training based on scientific knowledge.

(c) Goverment-Sponsored Programs--to determine whether matters submitted are in compliance with pertinent government requirements, as well as to determine whether cost, utilization and quality standards are met by the attending doctor.

(d) Education--to prepare and to implement a program of education for the profession to assure the highest professional standards of ethics and patient care.

Each sub-committee is comprised of its chairman and seven other members representing different K.C.A. districts. Said members

serve two-year terms, except certain members initially serving one-year terms to ensure both rotation and continuity, upon the appointment of the K.C.A. President.

The Peer Review Committee, as well as each of its sub-committees, meets monthly, unless the state chairman determines, at his discretion, that a particular monthly meeting is unnecessary.

The Peer Review Committee has full responsibility and authority, from the K.C.A. in convention, to implement the peer review program and to develop and to adopt professional standards therefor.

III. Jurisdiction

The K.C.A. Peer Review Committee will review any matter relative to the quality and efficiency of services rendered by any doctor of chiropractic duly licensed by the Kansas State Board of Healing Arts.

Three parties may submit such matters for review:

(a) a third-party payor;

(b) a chiropractic patient (limited to third-party reimbursement matters);

(c) an individual doctor of chiropractic.

The K.C.A. Peer Review Committee and its sub-committees are not, however, adjudicatory or arbitration bodies. Their specific and singular task is to render a professional opinion on matters properly submitted thereto.

Generally, any third-party reimbursement matter will be reviewed, except medico-legal questions, e.g., workman's compensation. However, only cases when the claim has not been settled or paid by the third-party reimbursement organization will be eligible for submission.

In such claims review matters, the K.C.A. Peer Review Committee and its sub-committees will render a professional opinion thereon; moreover, they will recommend appropriate reimbursement amount limits consistent with such opinions.

If any ethics question is noted in the Peer Review Committee processes, the specific matter will be forwarded to the K.C.A. Ethics Committee for appropriate consideration.

If a matter submitted for review involved a chiropractic specialist (and therefore a higher standard of academic and clinical education and training), e.g., a certified roentgenologist, said matter will be forwarded to an appropriate chiropractic specialty council for review.

IV. Procedure

A. Submission of matters for review

1. All claims and communications relating to peer review matters should be submitted to:

John H. Hill, D.C., Chairman
Peer Review Committee
Kansas Chiropractors Association
3320 Harrison
Topeka, Kansas 66611

2. Any third-party insurance carrier claims submitted for review must be accompanied by a check in the amount of $10.00 made payable to the Kansas Chiropractors Association to defer clerical and administrative expenses of the review process. (A similar requirement is applicable to individual doctors of chiropractic who are non-members of the K.C.A.)

3. Any party submitting a matter for review must indicate in writing the specific question(s) (not merely a complaint) to which the committee should address itself.

Examples of such questions are:

*Whether the type and frequency of treatment were necessary.

*Whether the itemized charges for specific services rendered were reasonable and customary.

*Whether x-ray and laboratory procedures utilized were necessary.

4. Any third-party insurance carrier claim submitted for review shall be accompanied by (in addition to the specific questions addressed to the committee) the following:

(a) Copies of all forms, letters and communications received from and sent to the doctor (and patient) relative to the claim to be reviewed;

(b) A written statement from the carrier indicating that it has contacted the doctor relating to the particular claim in question; further, that it has requested said doctor to provide appropriate justification relative to any questions thereon. (To improve communications with doctors of chiropractic, it is suggested the carrier explain briefly the patient's insurance coverage and its need for additional information in order to determine proper benefit payment.)

(c) A written statement from the carrier indicating that the claim has not been settled or paid.

5. Individual doctors of chiropractic whose claims are to be reviewed shall furnish, when requested, the following information:

(a) A written statement, e.g., a substantiating or narrative report, setting forth all pertinent data the doctor deems will aid the committee and sub-committee members in making a fair and responsible decision, including case history, chief complaints, pre-existing conditions, full description of physical examination, including tests conducted and results therefrom, differential diagnosis (initial, working and final) and prognosis; such a statement should include mention of any and all extenuating circumstances.

(b) All radiographs and records, including, but not limited to, examination records, laboratory reports and records of each individual visit including the patient's condition, response, treatment rendered, advice given and itemized billing.

6. Chiropractic patients requesting a review shall furnish the following information:

(a) A written statement regarding his impression of treatment and services rendered;

(b) A written statement regarding his symptomatic response;

(c) A written statement indicating whether or not he agreed to the doctor's fees at the beginning of his case and specifics pertaining thereto.

7. Treating doctors of chiropractic, before submitting individual cases for review consideration and recommendation, shall have made a reasonable effort to the matter through courteous written inquiry with the third-party carrier. (This provision is not intended to suggest that doctors of chiropractic should become negotiators for the patient, whose contract insurance benefits are in question; indeed, the doctor should remember he is not a party to the contract and should merely provide justification for payment to the carrier.)

(a) Treating doctors shall submit one (1) copy of the complete case file including all correspondence and written resumes of telephone communications with the third-party reimbursement organization.

B. Review of matters submitted

1. The K.C.A. Peer Review Committee state chairman is responsible for determining whether a matter submitted is appropriate for review and for assigning a case review number thereto.

2. If the state chairman determines that a matter submitted is appropriate for review, and all pertinent information has been submitted by the party requesting the review, he shall provide notice thereof to the specified doctor of chiropractic (by certified mail, return receipt requested); further, he shall notify the party requesting the review that the matter is properly before the K.C.A. Peer Review Committee.

3. Upon receipt of an appropriate inquiry for review, the state chairman shall, in his notice thereof to the specified doctor of chiropractic, allow said doctor 14 days from receipt of said notice to provide pertinent information, if requested, to the Peer Review Committee. (The state chairman may, however, for good cause, extend such time not to exceed an additional 14 days; any additional extension, for good cause, must be approved by a majority of the K.C.A. Peer Review Committee members.)

4. Each doctor of chiropractic whose particular services are submitted for review may, if he wishes, request that any and all name references to himself and to his patient be deleted from all documents submitted. Upon timely receipt of such a request, such name reference shall be deleted from all documents submitted. (Otherwise, name references--if appearing on documents submitted--will not be deleted from said documents.)

5. Following receipt of the hereinabove specified information, or following the lapse of the time allotted for submitting said information, the state chairman shall submit the review matter to the appropriate sub-committee(s) for an opinion thereon and, if applicable, a recommendation relative to third-party reimbursement. (Each sub-committee member shall receive a copy of all documents pertinent thereto; the state chairman shall be responsible for the submission of review matters, if possible, by form presentation.)

6. Each matter submitted for review and referred to an appropriate sub-committee(s) shall be scheduled for consideration at said body's next regular meeting(s). Each sub-committee may continue its deliberations at its discretion; however, in the event of such a continuance, pertinent parties shall be notified thereof by the state chairman.

7. Each sub-committee may, at its discretion, refer any matter submitted to another sub-committee for evaluative, consultative or educational purposes.

8. Each sub-committee, in its deliberations upon any matter submitted for review, shall consider only such evidence as is presented to it in writing and/or documentary form.

9. Each sub-committee chairman shall, following deliberations by his sub-committee, provide findings, opinions, conclusions and recommendations relative to the particular matter reviewed to the state peer review chairman.

10. If a majority of sub-committee members present and voting cannot agree on appropriate findings, opinions, conclusions and recommendations on the particular matter submitted for review, then said matter shall be submitted to the K.C.A. Peer Review Committee for de novo review.

11. The state chairman shall be responsible for the preparation of a detailed report of said findings, opinions, conclusions and recommendations and for the submission of said report to the party requesting the review.

12. The state chairman shall be responsible for submitting a copy of said report to the individual doctor involved; he shall also be responsible for submitting a copy of any other evaluative, consultative and educational report pertinent to the specific matter before the Peer Review Committee.

13. The Peer Review Sub-committee on Government-Sponsored Programs may accept for review any matter submitted to it by the aforementioned parties without notice thereof to the treating doctor. (This guideline is applicable to the review of claims submitted to the committee by the State Department of Social and Rehabilitation Services or its agent, Kansas Blue Cross/Blue Shield, relative to the Title XIX [Medicaid] program, and by either Kansas Medicare carrier, Kansas Blue Shield or Kansas City Blue Shield, relative to the Title XVIII [Medicare] program.)

C. Appeal of Sub-committee Determination

1. Any party aggrieved with the pertinent findings, opinions, conclusions and recommendations as set forth in the detailed report thereof and as hereinabove provided may appeal the same to the K.C.A. Peer Review Committee by submitting written notice of appeal with the state chairman (by registered mail, return receipt requested) within fourteen (14) days from the date of mailing of said report.

2. Upon receipt of any notice of appeal, the state chairman shall schedule an appeal hearing at the next regular meeting of the K.C.A. Peer Review Committee, unless at his discretion, the matter should be continued to said committee's subsequent regular meeting.

3. The state chairman shall notify pertinent parties of any notice of appeal and shall further notify pertinent parties of any scheduled hearing thereon, which said parties may attend, present evidence, and argument, subject to reasonable time limitations designated by the state chairman, subject to approval of the K.C.A. Peer Review Committee.

4. Any party providing notice of appeal of an appropriate sub-committee determination shall attend and appear at said hearing or said appeal will be ineffectual.

5. Following any appeal hearing, the state chairman shall be responsible for the preparation of a detailed report relative to the Peer Review Committee's findings, opinions, conclusions and recommendations on the matter submitted and for the submission of said report to the party requesting the review and to the individual doctor involved.

D. General Procedural Guidelines

1. No Peer Review Committee or sub-committee member shall participate in making a committee or sub-committee determination on a claim submitted for review relative to himself or a professional colleague and with whom he is professionally associated.

2. Robert's Rules of Order, Revised, shall prevail at all meetings of the Peer Review Committee and sub-committees, consistent with the By-Laws of the Kansas Chiropractors Association.

3. No member of the K.C.A. Peer Review Committee or sub-committees shall receive compensation for services therein rendered, which shall be deemed a service to the public and the chiropractic profession.

4. All records shall be maintained at the discretion of the state chairman.

5. The K.C.A. Peer Review Committee, at its discretion, subject to the approval of the K.C.A. Board of Directors, shall establish and maintain communications with the American Chiropractic Association and the International Chiropractors Association, their respective specialty councils, and other appropriate institutions in the government and in the private economic sector, e.g., Director of Workman's Compensation, various consumer groups, etc.

6. No member of the K.C.A. Peer Review or sub-committees shall disclose any information to any person on particular matters submitted thereto, said information to be held in confidence, except (1) to the extent that may be necessary to carry out the purposes of the K.C.A. Peer Review Committee program, or (2) in such cases and under such circumstances as the state chairman shall provide to assure adequate protection of the rights and interests of patients, doctors of chiropractic and third-party payors.

E. Committee Procedure for Review of Claims

1. Information Necessary for Review and Evaluation

(a) Patient's name, age, sex

(b) Date and diagnosis of initial examination

(c) History, immediate and prior, of original treating doctor

(d) Examination procedures followed:

(1) X-rays -- how many? When? What areas? What size?
(2) Other laboratory procedures
(3) Physical examination (orthopedic, neurological, spinal, etc.)

(e) Procedure charges (x-ray, laboratory, tests, etc.)

(f) Reports submitted to insurance company:

(1) Were they well done?
(2) Were they typed?
(3) Were periodic progress reports submitted to the insurance company?
(4) Was there a reevaluation of condition?

(g) Treatment:

(1) Length of treatment
(2) Number of treatments
(3) Frequency of treatments

2. Concluding Questions

(a) Was diagnosis compatible and consistent with information?

(b) Were x-ray and other examination procedures adequate or were they insufficient or nonrelated to history of diagnosis?

(c) Were reports adequate, complete, and of sufficient frequency?

(d) Was treatment consistent with diagnosis?

(e) Was treatment program consistent with scientific knowledge and academic and clinical training in accredited chiropractic colleges?

(f) Were charges reasonable and customary for the area?

(1) Charge per call
(2) Other procedural charges

(g) Were total charges compatible with diagnosis and results?

3. Recommendations to the Third Party Reimbursement Organization

(a) The Insurance Review Committee should recommend that the claim be allowed <u>if it is justified</u>.

(b) If treatment and/or procedure charges are excessive, the committee should recommend that only that percentage of the charges which is consistent with good practice be allowed.

(c) If the insurance company is concerned with malingering or over-extension of treatment, the Committee should recommend that the patient be referred to a chiropractic specialist, either an orthopedist or a roentgenologist, for evaluation before further treatment is authorized. It is suggested that the Committee recommend graduates of ACA approved post-graduate courses in orthopedics or in roentgenology, where available, for consultation and evaluation of problem cases requiring long-term care.

(d) Recommendations should be based on:

(1) Practices and procedures consistent with scientific knowledge and as taught in accredited chiropractic colleges;

(2) Differentiation and justification as outlined in "Responsibilities of the Chiropractic Physician Where Third Party Payors are Involved."

V. Definitions: Professional Fees and Terminology

A. RVS: The K.C.A. Peer Review Committee shall utilize the profession's Relative Value Schedule, as adopted by the K.C.A. in convention, as an applicable standard for fee review matters. (See Relative Value Schedule.)

The following rules are applicable thereto:

1. Examine the patient according to history and symptomatology with services sufficient to arrive at a conclusion.

2. Use only procedures necessary and as are consistent with academic and clinical training in chiropractic colleges.

3. Provide sufficient substantiation of your procedures whether it be examination or treatment. This is your responsibility to the third party and the patient. Failure to do so will not only reflect on your personal reputation, but also on the professional stature of chiropractic.

4. Make all reports concise and as complete as necessary to be consistent with professional excellence. They are judged entirely on the content--not the length. Superfluous information is undesirable and unacceptable.

5. Fees structured here are considered adequate to reimburse, for time, knowledge, and skill representative of professional excellence. These are maximum fees for reimbursable cases.

6. Fees should be consistent with your usual charge for non-insurance cases unless such exceed the RVS. You then charge the lesser fee for the services.

7. Any differential between the physician's fee and a reimbursable fee is a matter to be resolved between physician and patient prior to the initiation of treatment.

The $7.00 per unit conversion factor, as adopted by the K.C.A. in convention therefor, shall be applicable for K.C.A. Peer Review Committee purposes.

B. Fee Definitions

The following fee definitions shall be utilized by the K.C.A. Peer Review Committee in its discussion and delineation of fee review matters:

Usual - the usual fee charged by a doctor for his services to a patient, i.e., the usual fee his patients agree to pay in return for his services.

Customary - the average fee charged among doctors for particular services in the same general economic and geographic area.

Reasonable - the fee determined by actuarial statistics to be within the customary range and acceptable for reimbursement (generally analogous to customary fee).

C. Terminology

The K.C.A. Peer Review Committee shall utilize, in addition to the K.C.A. RVS, the following standard terminology publications:

1. Current Medical Information and Terminology, published by the American Medical Association, for the naming and describing of diseases and conditions.

2. Current Procedural Terminology, published by the American Medical Association, for naming and codifying diagnostic and therapeutic procedures.

3. International Classification of Diseases, Adapted, published by the United States Public Health Service.

4. Dorland's Illustrated Medical Dictionary, published by W.B. Saunders Co.

In keeping with such standards, the Committee recognizes that the chiropractic use of the term "subluxation," in reporting, is usually valid as an objective description, but is not acceptable as a diagnostic term unless demonstrable as a scientifically acceptable and classified entity.

VI. Standards for Utilization, Quality and Costs

A. General

The K.C.A. Peer Review Committee shall utilize as a guideline and hereby incorporates by reference, as though fully set forth herein, the following professional standard publications:

1. Basic Chiropractic Procedural Manual, published by the American Chiropractic Association (1973).

2. Peer Review Guidelines, As Amended, Volumes I & II, published by the American Chiropractic Association (1973).

Specific standards therein shall be utilized except insofar as they conflict with standards adopted and published by the K.C.A. Peer Review Committee.

B. Quality of Facilities

1. Physical plant:

The recommendations take for granted that the facilities comply with local building, sanitary and health codes. Decor, stylization, patient flow factors, and other personal and subjective items are not considered. The recommendations enumerate the physical facilities that should be available in order to conduct the interviews, consultations, examinations and therapies necessary to perform in a competent, ethical manner. It is obvious that a single room may function for more than one purpose. The test, it would seem, is--can the needed functions be performed in the installation?

Necessary rooms or facilities for the following:

(a) Reception or waiting area

(b) Interview and/or consultation area

(c) Clerical and records area

(d) Examination area--sufficient at least to perform non-laboratory (x-ray and clinical lab) functions

(1) If x-ray facilities are not reasonably close at hand, the installation should have a proper, adequate x-ray unit and x-ray area conforming to radiological health regulations.

(2) If clinical laboratory facilities or mail arrangements are not available, a basic laboratory area should be at the installation.

(e) Dressing area

(f) Therapeutic area

(1) For adjustive and manipulative procedures

(2) For physiotherapy--elective

(3) For taping, splinting, etc.--elective

(4) For special procedures--elective

(g) Storage area

(h) Washroom

(i) Lavatories should be appropriately placed

(j) Signs used to designate chiropractic offices and clinics shall be of the size and fashion utilized by the other professions in the area or community, and shall conform to all the requirements of the laws of the jurisdiction and those specifications of the state and local chiropractic associations involved.

2. Equipment:

(a) Equipment and furnishings necessary to proper utilization of areas listed above.

(b) Equipment used for analytical and/or diagnostic purposes must be acceptable to, and consistent with, scientific knowledge.

C. Quality of Examination (initial and follow-up--basic and comprehensive)

1. General:

Examination form is that designed by the clinic directors of the colleges and used in the college clinics as a reporting form. Other examination forms may well be considered for use as a guide.

General examination should correlate history, subjective complaint and objective findings sufficient to arrive at a clinical conclusion, and should be consistent with academic and clinical standards as taught in accredited chiropractic colleges.

Specialty examinations must be consistent with standards established by specialty councils of the ACA.

Examinations should be differentiated according to initial and follow-up, basic, and comprehensive, depending on complaint and the evaluation of the attending physician.

2. Orthopedic:

All information recommended has been supplied by the Council on Orthopedics.

3. Neurology:

All information recommended has been supplied by the Council on Neurology.

4. Roentgenologic:

All information recommended has been supplied by the Council on Roentgenology.

5. Laboratory:

Information recommended has been supplied by the Associates Diagnostic Research Center.

Laboratory examinations, as indicated by evaluation findings, should be consistent with accepted scientific standards.

D. Quality of Patient Records

Records should be sufficiently complete and detailed to justify diagnoses and patient management, or referral, consistent with academic and clinical standards.

Records should include and list the following:

1. Case history

2. Diagnosis

The following conforms to Federal recommendations and is accepted by the insurance industry.

(a) Acute (3 months maximum)

(b) Chronic (over 3 months)

As applied to initial, therapeutic and/or final with consideration of the condition as acute or chronic.

Differential diagnosis is considered essential to the determination of case management.

3. Treatment and management

Records should show any changes in diagnosis or prognosis as well as progress and procedures of case management.

E. Quality of Therapeutics

1. Chiropractic case management--should include procedures directed at prevention, therapy, rehabilitation and maintenance.

(a) Adjustive procedures must be acceptable to the Council on Chiropractic Technic of the ACA and the Council on Chiropractic Education.

(b) Nutrition management should be primarily directed to, or determined by, a need for nutritional change in:

(1) diet

(2) supplements

Additional consideration must be given to the difference between:

(1) rehabilitation

(2) maintenance

(c) Supportive measures

There are procedures and appliances which may be:

(1) stabilizing

(2) mobilizing

(3) immobilizing

(4) assisting

These may be applied directly, such as plaster or tape bandaging, or ancillary such as crutches or walkers. Such procedures and appliances should meet the approval of the specialty councils of the ACA and the Council on Chiropractic Education.

2. Chiropractic physiotherapy--procedures must be acceptable to the Council on Physiotherapy of ACA and the Council on Chiropractic Education.

F. Quality of Reports

It is agreed that chiropractic physicians should routinely maintain written reports on all patients minimally as physical examination and x-ray. Such reports should be standard to maintain adequate record keeping; and assist the physician in his responsibility to provide adequate reports where third parties are involved, and/or the patient desires a written report for his files or a consulting physician.

Minimal reports, the responsibility of the chiropractic physician, should be:

1. initial

2. substantiating

3. re-evaluation

4. final

Other reports, as required, will be:

1. consultation (physical evaluation or roentgenological)

2. narrative

G. Specific Responsibilities of the Doctor of Chiropractic Where Third Parties Are Involved

1. To give accurate diagnosis or diagnostic impression based on a complete examination of pertinent body systems and evaluated data.

2. Reasonable prognosis which shall include:

(a) Estimated time loss;

(b) Estimated impairment and/or disability (partial, complete or permanent;

(c) Estimated number of visits and/or time involved.

3. All of the above should be included on recommended insurance forms or personal stationery--typed and duplicated, when necessary.

4. Patient re-evaluation required after twenty (20) visits or two (2) months time, whichever comes first, should result in refiling of original insurance report with appropriate comments to:

(a) Substantiate continued short term care (10-15 visits);

(b) Preparation of more comprehensive narrative report to substantiate continued extensive care (20 or more visits);

(c) Consideration of examination by peer (D.C. specialist or M.D. specialist) under the following conditions:

(1) if prognosis is not established;

(2) if attending D.C. desires another opinion;

(3) if insurance company requests consultation examination;

(4) if patient requests consultation examination.

5. Differentiate between therapeutic, rehabilitation and health maintenance care.

THERAPEUTIC CARE - May mean any therapeutic or corrective treatment necessary to return the patient to a stationary or pre-clinical status.

PRE-CLINICAL STATUS - May be defined as the condition of the patient prior to sudden onset of symptoms or signs.

CLINICAL STATUS - May be defined as the condition of the patient when there is exhibition of a definitive syndrome or symptom complex.

REHABILITATION - May be defined as re-education or functional restoration of a disabled body system or part.

HEALTH MAINTENANCE - May be defined as a regime designed to provide for the patient's continued well-being, or for maintaining the optimum state of health, while minimizing reoccurance of the clinical status.

STATIONARY STATUS - May be defined as a point where little or no improvement is effectuated despite therapy.

6. Completion of necessary forms to assist the patient in obtaining reimbursement for necessary and reasonable health care costs. Completion of one set of forms without fee is usual and customary, however, additional sets of forms may necessitate additional clerical fee. Any and all clerical fees should accrue to the patient, <u>not</u> third party payors.

7. Cooperation with Review Boards.

8. All report communications with third parties should include an up-to-date bill.

Attachment S

Kansas Chiropractic Association

Mr. Chairman and Members of the Commission:

Thank you for this opportunity to appear and present the views of the Kansas Chiropractic Association on the role of Peer Review in the Medicaid program and the participation of chiropractors in the Medicaid program.

Chiropractic services have been included in the Kansas Medicaid program since its inception in 1967.

Utilization of chiropractic services by Medicaid patients has grown over the years, much as there has been a growth in utilization of chiropractic health care by the general public. In fiscal 1976, the Department of Social and Rehabilitation Services reported that there were 10,417 chiropractic office calls which were made by Medicaid patients. In fiscal 1977, there were 13,014 office calls, according to SRS.

Chiropractic services which are covered by Medicaid include:

1. Manual manipulation of the spine
2. A variety of physiotherapeutic modalities such as mechanical traction, ultrasound, diathermy, etc.
3. Diagnostic x-rays
4. Nursing home visits
5. Orthopedic appliances, such as braces, etc.

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Atch. S

Chiropractors are not reimbursed for two fundamental services: the initial physical examination and nutritional consultation.

Obviously, a doctor cannot undertake a treatment program without first conducting a physical examination. It is that examination, along with other diagnostic procedures, which forms the basis for the diagnosis. Diagnosis is the only rational basis for treatment.

If corners are cut and a thorough physical examination is not conducted, we are open to malpractice. If an examination is not conducted, it is malpractice.

Evaluation and redesign of a patient's nutritional program many times is the key to resolving the patient's health problem, or the prevention of additional health problems. There is, however, no reimbursement for nutritional consultation.

Therefore, doctors of chiropractic are compelled to provide those two basic services free of charge in order to attend to the health care needs of Medicaid patients.

The only exception to this policy is that the chiropractor, as a portal of entry to the health care system, is reimbursed for conducting a physical examination when that examination results in a referral to another category of provider.

The KCA has had some kind of peer review program since the mid-1960s, to examine insurance claims or claims under government-sponsored programs, i.e., Medicare and Medicaid.

The present KCA Peer Review Committee was established in 1973 with

the following objectives:

1. To assure high quality health services at reasonable cost.
2. To assure high standards of professional conduct and ethics by objective evaluation of chiropractic peers.
3. To provide educational assistance to the doctor of chiropractic in rendering his service.

Peer review is not intended to be disciplinary--which is a function of the KCA Ethics Committee and the Kansas State Board of Healing Arts--but rather evaluative, analytical, and consultative.

The Peer Review committee consists of myself, as chairman, and four other doctors, each of whom is chairman of a Peer Review Subcommittee. The subcommittees are Government-Sponsored Programs, Cost and Utilization, Education, and Quality.

It is the subcommittee on Government-Sponsored Programs which reviews both Medicaid and Medicare claims. A request for review may be initiated under two circumstances: When the administrator of the Medicaid program believes a review would be appropriate or when a doctor disagrees with a decision by the administrator of Medicaid to deny or limit a claim.

Of those claims which the administrator submits for review, about 10 percent are denied or limited.

The 33 members of the KCA Peer Review Committee and its subcommittees serve without compensation in any form, and review Medicaid and Medicare claims without charge as a public service of the Association.

The members are appointed by officers and directors of the Association and confirmed by its board of directors for two-year terms. The chairman and subcommittee chairmen are required to participate in educational workshops conducted by the national association on an annual basis, and subcommittee members also attend such workshops on a less regular basis.

This then, very briefly, outlines the participation of the chiropractic profession in the Medicaid program.

John Hill, D.C.
Chairman
KCA Peer Review Committee

Sept. 14, 1977

Attachment 4

KANSAS PODIATRY ASSOCIATION

708 MERCHANTS TOWERS, TOPEKA, KANSAS 66612 354-7611

WAYNE PROBASCO, *Executive Secretary*

OFFICERS

Dr. Franklin A. Donovan, *President*, A[illegible]

Dr. William P. Carpino, *Vice-President*, Pittsburg

Dr. Charles A. Hepford, *Secretary-Tres.*, Topeka

DIRECTORS

Dr. Donald Mahrle, *Topeka*
Dr. William Teasdale, *Great Bend*
Dr. John D. Thompson, *Colleyville*
Dr. Harold J. Sauder, *Independence*

Honorable Senators, Representatives, Ladies and Gentlemen of this Committee.

I am Doctor Frank Donovan, a Podiatrist from Atchison, Kansas representing the Kansas Podiatry Association. It has been our experience in the past that not everyone is aquainted with our profession. Kansas Law defines a Podiatrist as a physician of the foot. A Doctor of Podiatric Medicine is licenses to diagnosis and treat diseases of the foot by medical and surgical means including physical therapy, xray, blood test, and drugs which may be necessary to arrive at a favorable prognosis or for good preventive medicine. As an active member of the health team, the Podiatrist works and consults with all other medical specialty and refers to other medical specialists for concurrent care if necessary. As one of the partners of the health team, the Podiatrist is intimately concern with the need for improvment in the delivery of health care in the United States and Kansas.

There are approximately nine thousand Podiatrist in the United States with fifty of them being located in the State of Kansas. The majority of Podiatrist are in private pratices but they also serve on hospital staffs, faculty in health schools, in goverment institutions, and in the armed forces as commission officers. Educational requirments for Podiatrist are at least six years of higher education, which includes a minimum of two years pre-medical study. Today more than seventy-five per cent of the students entering Podiatry College have a four year degree. Most states as does the State of Kansas, has a Continuing Educational Program which is required for a renewal of a license each year. The Podiatry profession feels this is essential in maintaining and increasing the professional knowledge and skill of the practitioner so that he may better serve his patients.

It has been estimated that ailments of the feet afflict well over half the United States population, in the State of Kansas the fifty Podiatrist each treat approximately four thousand patients visit per year. He also provides comprehensive foot care to hospital in-patient and out-patient communities. He is represented on the State Board of Healing Arts. Kansas Podiatrist are also providing treatments for patients in civil and goverment hospitals, clinics, nursing homes, and in state institutions.

HOW IMPORTANT ARE THE FEET; In industry, one man in ten is absent for about five days a month because of foot pain. The loss from slowed production, absenteeism, and accidents due to foot problems have been estimated to cost over two hundred million dollars a year. In stores, and factories where ever people have to work standing or walking, foot problems cut into the productivity in the earnings of the workers as well as affecting their happiness and their health.

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A woman doing her house work walks at least eight and one half miles a day. The average person walks sixty five thousand miles in his life time. Millions and millions of dollars are spent for over the counter foot remedies as long ago as nineteen-seventy it was estimated at least one hundred and twenty million dollars was spent on over the counter preprations.

It is estimated eight out of ten foot problems are probably preventable with early and proper treatment. When a baby is born his feet has all the parts they will ever have and it takes twenty years to complete the full growth. Therefore you can see why children that need foot care and have foot treatment will someday be productive citizens in our society. Even grown-ups that have trouble with feet from childhood can be helped by proper care and professional treatment. For the working adult, painful foot conditions can lead to decreased efficientcy, loss of income and inability to become employed in many occupations. Therefore you can see how necessary it is that we try to educate all people to take care of their feet as well as their general health. If we can prevent problems we may save the state considerable money. If the case workers and anyone who comes in contact with these recipients of medical care can educate them alone on the benefit of good hygiene and cleanliness of their personal body as well as their homes and their environments. They can do much to start to prevent some problems. We must attempt to have the patient assume some responsibility as the old saying "God helps them that helps themselves" I feel this can help prevent many health problmes as the years go by.

Recent technical advances in Podiatry have been especially striking in the field of foot surgery. Today, the Podiatrist does considerable rehabilative foot treatment, including a substantial amount of surgery to correct foot deformities and to try to keep the patient walking without pain. Many new foot surgery techniques are being developed yearly, which are being preformed in the hospital by the Podiatrist today. Surgery sometimes may keep many of these people working as well as preventing them from becoming nursing home victims later in life due to poor feet, which often lead to knee problems, hip problems and back problems later in life.

The fees for surgery paid by Title XIX may be one of the biggest problems that I can submit to this committee. Many times the fee paid for the surgery for Title XIX recipients is approximately sixty per cent of the normal and customary charge of the practitioner. For example if a practitioner has a surgical fee of approximately two-hundred-seventy-dollars and receives only one-hundred-forty-dollars he is hesitant to do surgery on these type of patients.

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708 MERCHANTS TOWERS, TOPEKA, KANSAS 66612 354-7611

WAYNE PROBASCO, *Executive Secretary*

OFFICERS

Dr. Franklin A. Donovan, *President, At*
Dr. William P. Carpino, *Vice-President, Pittsburg*
Dr. Charles A. Hepford, *Secretary-Tres., Topeka*

DIRECTORS

Dr. Donald Mahrle, *Topeka*
Dr. William Teasdale, *Great Bend*
Dr. John D. Thompson, *Coffeyville*
Dr. Harold J. Sauder, *Independence*

Usually the surgery fee includes all post operative calls and the risk involved in doing the surgery is not worth the amount of money received. You have to realize when you do surgery on a Title XIX patient you still run all the risk of malpratice problems, etc. and sometimes sorry to say many of them can be more demanding than a private patient. Consequently I have the feeling in talking with colleagues across the state that many of them may hesitate to do surgery on welfare patients sometimes even when it might be indicated and be advantageous and save the state money, due to the risk involved and the small amount of payment received. I wouldn't say this is true in each case for some surgical procedures they seem to pay much better than they do others. Nail surgery for instance sometimes only pays about fifty per cent of what you would get from a private patient. I think it's the opinion of the entire Kansas group that surgical fees for Title XIX recipients are one group of payments that might be discussed with the Welfare Department. Some Podiatrist see many children in their pratice. Many of the foot problems are deformity which are seen in infancy can sometimes be corrected at an early age by various methods, casting or foot appliances or shoes. In adolescence most patients are treated by means of shoe therapy, thats the alteration of shoes to correct certain condition or a special type of shoe, or special made orthotics which are similar to certain type of arch supports. Also in adolescence we see numerous cases of ingrown nails, skin diseases and some bone cartridge of inflammatory ailments. In the adult age numerous foot problems arise and as you may be or may not be aware Title XIX only pays for those office visits which are considered to be a medical necessity which I don't think anyone has any complaints about. They will pay up to four visits per month and if in certain cases the indivual patient may need or may have an infectious type disease or ailment for something that would require more office visits, the doctor can write in and ask for indivual consideration in this case. Nursing Home visits I believe are limited to one per month per patient.

I personally feel and I think I'm speaking for our association as a whole that these are good guide lines and I'm sure that this has saved the state numerous dollars over a period of years. Another rule that is good and was implemented by Dr. Harder and his staff is that no one can enter the hospital on Friday or the weekend and not have surgery until the following week. I feel Dr. Harder and his staff is to be complimented for their efforts for trying to work out these type of guide lines which will save the tax payers money over a period of years. One area of confusion seems to be in those cases where a practitioner must get prior authorization before dispensing a special type of shoe or orthotic (which is a form of a arch support). Prior authorization is good, but there should be a specific place to call or write and receive the authorization.

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708 MERCHANTS TOWERS, TOPEKA, KANSAS 66612 354-7611

WAYNE PROBASCO, *Executive Secretary*

OFFICERS

Dr. Franklin A. Donovan, *President, Atc*
Dr. William P. Carpino, *Vice-President, Pittsburg*
Dr. Charles A. Hepford, *Secretary-Tres., Topeka*

DIRECTORS

Dr. Donald Mahrle, *Topeka*
Dr. William Teasdale, *Great Bend*
Dr. John D. Thompson, *Colleyville*
Dr. Harold J. Sauder, *Independence*

We are told to call the county welfare office and get permission from the case worker before making or dispensing any type of a special shoe or orthotic. I might say that these shoes are sometimes used in cases where people have Diabetic ulcers or Perpherial Vascular ulcers. and Sometimes when your bill is sent to the county office they inform you that it has to go to the state office - here again it may be a lack of communication. The way it is now your not quite sure rather you are going to get paid for what you do. Sometimes the Lab fees are sixty or seventy per cent of the device you are dispensing which you have to go ahead and pay, while you may wait six, nine or ten months for payment. Here again I'm afraid there may be cases where the practitioner may neglect to dispense or use what might be considered the best treatment due to a fear of not being paid for his services or the appliances he may be using. Another area that gets kind of cloudy at times is in the case of where a patient may need a pair of shoes, I understand that Title XIX or the Welfare Department will pay for the shoes if they are by Doctors prescription. I have had no problems myself, but it has been brought to my attention that some Practitioners have had problems with patients coming in and wanting a prescription for a ordinary pain of shoes so that the State Department of Social Welfare will pay for the shoes. I realize that it's the Doctors responsibility to decide rather he should give the patient a prescription or not, but this does become a problem in a busy office. Some of these patients can come in and argue with a busy Doctor demanding that he give them a prescription for a good pair of oxfords which he normally would have to buy anyway - here again may be an area that should be looked at and discussed. It's my understanding that the department does pay for corrective children shoes and usually if they are of a corrective nature there's no great problem on this.

Elderly people have had years in which to accumulate troubles including foot problems. Many older people suffer from bad feet. Many elderly people have bad feet simply because of years of abuse and neglect and they let themselves get worst through inactivites because of the pain and discomfort. Because of poor circulation and other infirmities of old age - good foot care for the elderly becomes more and more necessary. Some of the more common problems that affect the feet and usually requires professional attention in the elderly are Diabetes, Flat Feet, Weak Arches, Corns and Callous, Ingrown Nails, Hypertrophied nails (thick heavy nails) which due to pressure from shoes and bed sheets often causes ulceration and infection of the toe., Dermatitis, and Athletes Foot, Bunions, Deformed or Hammer Toes, Warts, Chilblain or Frost Bite as well as numerous circulatory problems. The Podiatrist treating these patients tries to work in close cooperation at all times with the primary physician of the patients.

If you ever had the opportunity to visit a nursing home and examine the feet of many of the patients, you can understand why Podiatric Services may save millions of dollars by preventing hospitalization, for many of these older people.

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708 MERCHANTS TOWERS, TOPEKA, KANSAS 66612 354-7611

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OFFICERS

Dr. Franklin A. Donovan, *President, Atchison*
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If many of these foot problems are neglected they may lead to infection and often times amputation. The cost of several amputations or and hospitalizations would easily cost more than what the entire Podiatric Profession was paid in the State of Kansas last year.

According to the State Department of Social Welfare and Rehabilitation the total sum paid to all Podiatrist in the State of Kansas was somewhat less that three-hundred-thousand-dollars. If we can keep the elderly persons on his feet and able to take care of himself rather than being confined to a bed in a hospital or in a nursing home due to infection or ulcers thousands of dollars can be saved. I'm sure you are aware that it is much cheaper to maintain an ambulatory patient (one who can take care of himself) in a nursing home opposed to one who has to be confined to bed and have special nursing care. I don't believe anyone will argue with fact that proper care of the feet by the Podiatrist and by the nursing home personnel is a most important phase in preventive medicine that we can provide to alleviate suffering and save thousands of dollars. In a quick survey and taking a cross section of the Podiatry profession from various parts of the state the income from Title XIX for Podiatrist varies from zero in come cases to as high as twenty per cent of gross income for two practitioners who practice together. It appears that the average Podiatrist in the State of Kansas receive on an average eight per cent of his gross income from Title XIX.

I would say that most Podiatrist are receiving a large portion of Title XIX funds as a supplemental payment of Medicare. Most of the Title XIX recipients he sees are over sixty-five and consequently are eilgible for Medicare and Title XIX is picking up the difference. How often does a Podiatrist see Title XIX recipients? This is rather difficult to say because as you can see the funds received by most Podiatrist are anywhere from one to twenty per cent of their gross income and in many cases the largest amount of these are supplemental payments of Medicare. We do have some Podiatrist that do a great deal of Nursing Home work, but the majority of Title XIX patients are seen in the office from what I can determine. I'm not sure all you members of this committee are aware of the fact that the federal goverment requires that there be a Podiatrist as a Consultant on most nursing home staffs.

We have received many request in our Executive Secetary office asking if a Podiatrist would be available to come to their nursing home and take care of people when they are unable to care for their problems with their feet. In all cases we have tried to forward the name of a Podiatrist close to the nursing home area.

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708 MERCHANTS TOWERS, TOPEKA, KANSAS 66612 354-7611

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Some of the questions Mrs. Collier has given to us, we have already answered. She said this committee was concerned about the paper work in Title XIX. I would strongly suggest that one way to solve some of these problems would be for a committee from each provider group to meet with Dr. Harder and his staff plus the people from Blue Shield. I think after a general discussion with all provider groups and a consolidation oftheir suggestions and ideals that some of the paper work and red tape could be eliminated or made easier. Our association has always found Dr. Harder and his staff as well as the people from Blue Shield to be most cooperative I think he is to be complemented on the fine job he is trying to do. The committee may wonder why some - and I would say a very few Podiatrist do not accept Title XIX recipients, the reason for this I would say is because they have all the private patients they can take care of. Title XIX pays approximately sixty to seventy per cent of their normal customary fees and in some cases less. The average over head of the Podiatrist office runs forty to fifty per cent subsequently if he is receiving on an average sixty per cent fee it is a small margin of profit.

Has Title XIX cost Podiatry money? The only cost to our association would be in the form of trying to keep abreast of all rule changes. Has it cost the individual practitioner money? I think you would have to say it would depend upon what type of pratice the individual has. I would say no, as long as most practitioners can still conduct their practice the way they wish without govermental interference. If a Doctor has a choice to see those patients who he wishes to see then it should not interfer with his practice. I feel almost anyone in the Healing Arts, in any of the professions is more than happy to help those that need help. We know of numerous instances where Doctors treat patients for nothing because they think the patient is deserving and has no funds to pay. Has Title XIX increased or decreased the Podiatrist income? I would say in some busy practices it has probably caused a decreased since the practitioner is turning away private patients, for a patient whos payment would be lower than his usual and customary fee. Most of the Podiatrist I know do not feel they are being compensated for the time spent, but do feel that these people need help. I'm sure we do have areas where Title XIX has caused an increased in the income of the Doctor depending upon how busy his practice is.

Does the Profession of Podiatry in the State of Kansas have any way of cutting the cost of this program? Our state association over the years have tried to educate and encourage all of its members not to abuse any third party payment. We have asked Blue Shield and the Department of Social Welfare on different occasions to please inform our Peer Review Committee if they feel that any one member of our profession may be abusing this program. We have gone so far as to ask them to check profile on all members from time to time to be sure there is no abuse. We have a Peer Review Committee composed of three Podiatrist who meet quarterly to review all unusual claims.

KANSAS PODIATRY ASSOCIATION

708 MERCHANTS TOWERS, TOPEKA, KANSAS 66612 354-7611

WAYNE PROBASCO, *Executive Secretary*

OFFICERS
Dr. Franklin A. Donovan, *President*,
Dr. William P. Carpino, *Vice-Presider... ittsburg*
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Dr. Harold J. Sauder, *Independence*

I would hope that each provider group would do the same. The Podiatry profession as a group feels that if it appears that any one member is abusing the program he should be called before the Review Committee and given the opportunity to answer charges. If he is committing out right fraud and this can be proven without a doubt he should be made to repay all fees collected plus I do not feel he should be eligible for futher participation in the program.

What does Podiatry do to cut health care cost? One thing we did several years ago was set up a Multiple Fee Schedule. If a Doctor does surgery for instance on three toes on one foot he receives one hundred per cent for the first toe, fifty per cent for the second toe, and twenty five for the third toe. If a procedure is done on the opposite foot he receives sixty seven per cent for that procedure. In some instances the individual Podiatrist have tried to educate the nurses in the nursing homes to do routine foot care on people who has no circulatory or diabetic problems. Many personnel of the nursing home can be trained to take care of small minor problems with the feet and consquently prevent calling a Podiatrist or a Doctor therefore saving thousands of dollars over a period of years. One thing this committee might consider would be a Sur-Charge to every patient under sixty five or not on Medicare but receiving Title XIX medical payments. People who are receiving Medicare benefits have to pay a deductable. We feel that this same type of thing could be done with Title XIX recipients. If the recipient had to pay a small fee of one or two dollars or a small per cent of each charge each time he visited any Doctor's office I think we would see a reduction in office visits. A small per centage of the fee should not work a hardship on most recipients, but it would make him much more responsive to what his physician tells him and to his cooperation with the physician. The deductable type of insurance has worked well in Medicare and I can see no reason why it would not work in most cases of Title XIX. We feel that there should be a massive educational program in all stages of Social Welfare Programs to better educate the recipients how to prepare and buy food, how to cut cost in living expenses and how to budget their money. They need to be taught fundamental basic of good preventive health practice.

In Summation Podiatry feels that it is necessary that we have good communication between the provider and the Department of Social Welfare and committees, such as this to try to get suggestions and ideals to make all programs better for everyone. The one providing the services has to be motivated to do all he can in the preventive field of medicine to prevent more serious health problems that could cost considerable amount of money. The Title XIX recipitents has to be motivated to become more responsible and educated to use the services that are provided wisely and economically.

Thank you again for this opportunity of being here today with you and I would be most happy to answer any questions you may have.

Dr Franklin A. Donovan

DR. FRANKLIN A. DONOVAN
710 Commercial
Atchison, Kansas 66022

Attachment 4

Lattimore-Fink Laboratories is a wholly owned subsidiary company of Damon Corporation which is a NYSE company providing a broad base of medical services throughout its national network of 26 clinical laboratories. Established some 55 years ago in Topeka, Lattimore-Fink is one of the largest clinical laboratories operating in the state of Kansas capable of performing a full range of laboraotry services to physicians, clinics, and hospitals throughout the state of Kansas and Missouri. Human blood specimens and other substances are collected daily from these clients and tested in our laboratory to determine a patients' general state of health or to assist the clinician in the diagnosis of a specific disease state. We offer a complete range of testing services in the disciplines of Hematology, Chemistry, Toxicology, Cytology, Pathology, Microbiology and Serology.

Specimens for diagnosis are collected in three ways:

1. By the laboratory courier who schedules daily stops at our physician and hospital clients' offices.
2. At-home service is available to the elderly, disabled or handicapped patient through personal visits by one of our medical technologists.
3. Many of our patient samples are collected on site at either of the two Lattimore-Fink locations in Topeka.

I've been asked by Mrs. Collier to address five topics representing major areas of concern to the committee. They are:

1. A description of the services provided by Lattimore-Fink to Title 19 recepients.
2. A comment on the magnatude of these services within our organization and how this relates to the total administrative work load of the laboratory.

Atch. 4

3. The impact of Title 19 structured fees on the overall laboratory pricing structure.
4. Experience with Title 19 reimbursement practices and finally.....
5. For a comment on what we as a company are able to do to share the burden of cost containment within the health care industry.

1) Services provided to Title 19 recepients are no different than those extended to other users of our lab service, actually, Lattimore-Fink has only an "arms length" relationship with Medicaid patients in that we only perform work as ordered by our physician clients. We do not create the "work order" for the patient; we simply honor the physician's request. Our primary relationship is with the physician rather than the patient.

2) Of the total number of tests processed by our laboratory, only 1.5% are attributable to welfare patient requests. While this 1.5% of the clinical workload is devoted to Title 19, we estimate that a full 5% of our total clerical function is required to process these billings. Several things account for this additional administrative effort:

A. Many welfare claims are returned to us for forwarding to the patients' County Welfare Office for an interim approval before filing with the State for processing again.
B. Co-insurance with Medicare creates additional steps within the billing cycle - almost to the point of "double handling".
C. Actual payments from Title 19 refer to claim numbers rather than patient names, necessitating additional processing to reconcile the accounts.

D. Completion of Health Insurance Claim Forms represents a significant deviation from the standard laboratory billing practice. Normally, a statement is generated by our computer and is automatically forwarded to either the patient or physician for payment. Medicaid requires that a Health Insurance Claim form be completed for all patient services.

E. In order to complete these forms, certain pertinent patient information must be obtained from the physician or the patient himself. Often this information is either not furnished or incomplete necessitating lengthy telephone inquiries to retrieve the data.

F. Separate financial accounting for welfare related revenues also creates additional administrative duties for us.

This process is obviously cumbersome but is typical of "third-party" billing protocol. Actually, the laboratory would prefer not to involve itself on a direct billing basis but does so strictly as a service to its clients. The usual practice of issuing a monthly itemized statement to a physician; billing him for as many as 50 to 100 patient referrals rather than generating an invoice on each individual patient, is much simpler and more economical.

3) Since Title 19 billing within our system represents such a small amount in relationship to the total, it's fee structure is not adversly impacted by the additional administrative burdens required to service it's subscribers.

4) Reimbursement from Title 19 claims is usually prompt once the appropriate paper work has been submitted. A problem does exist however in terms of

lead time involved between the original date of service and the time when final payment is effected. This delay is customarily caused by a misunderstanding on the part of the patient. When the patient fails to advise the laboratory of his or her insurance status they may in fact be billed directly by the lab. It's only after receiving this bill that they bring their welfare status to our attention. We have attempted to reduce the frequency of these incidents by asking each patient for this information in advance of rendering services. The only other notable problem we have with reimbursement practices is due to the dispairity between the State maximum allowable charges and the amount billed by the laboratory. It usually amounts to a 30% differential.

5) As a "for profit" charter, Lattimore-Fink is concerned with expense reduction and resultatnt cost containment for the consumer of clinical laboratory services.

Two factors combine to make this goal both realistic and achievable:

1. Our company is committed to automation and centralization of the testing process wherever practical. Automation assists in reducing labor expenses which ultimately impacts the consumer health care dollar. Centralization of laboratory funcitons through the use of Damon's reference laboratory network also lends itself to cost containment by preventing costly duplications of testing services and captial expenditures. This simply means that certain tests are performed so infrequently in some laboratories that it becomes more economical to refer the specimen to another more specialized lab which may perform the procedure on a more routine basis. In other words, the higher the frequency of testing, the lower the test cost.
2. The clinical laboratory industry has become a highly competitive

business within the past few years. Even to the extent that many prominent companies have divested themselves of their laboratory subsidiaries due to the lack of profitability. As such, it becomes important for an independent clinical laboratory to not indiscriminately raise prices. We operate in a price sensitive market and maintain a very responsible attitude towards the structure of our fees. Our cost of rendering services to Title 19 recepients is high and I think it has been demonstrated that our laboratory absorbs the lions share of these costs without refelcting them in its fee structure.