HEALTH CARE CONSUMER

NEWSLETTER of the Champaign County Health Care Consumers

Spring 1982

State Fails to Monitor Medical Profession

In November of 1981 a complaint against a local physician was filed by a Consumer Health Hotline Advocate with the Department of Registration and Education. No response was ever received. According to a recent series of articles in the Chicago Tribune, this is not an isolated incident. They found that, "hundreds of doctors accused of incompetence and unethical practices never have been called to account for their conduct by the Illinois Department of Registration and Education. Despite concerned doctors' and patients' pleas for action, some cases languish for years in department files."

The Department of Registration and Education is the state agency charged with licensing and regulating 29 professions —including most of the health professions. It was established to set standards and to monitor compliance so as to protect consumers from incompetence and unethical practices within the professions. The Department is empowered to investigate and sanction medical practitioners on a wide range of grounds, including: gross or repeated malpractice; dishonorable, unethical, or unprofessional conduct; alcohol or drug abuse; and overcharging patients. They may "revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license" of a medical practitioner.

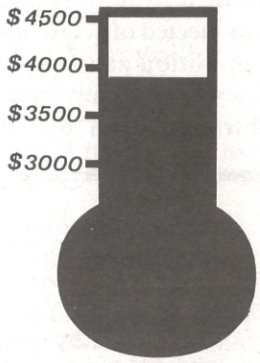
The Department works in conjunction with the Illinois Medical Disciplinary Board which is composed of 5 physicians, 1 chiropractor, and 1 osteopath. Although final rulings on complaints are decided by the Director of the Department of R & E, the recommendations given by the Medical Disciplinary Board are usually upheld.

There are a number of other means through which the activities of health care practitioners are monitored and regulated. The most common of these include: the revocation of staff privileges for a physician by a hospital, malpractice suits filed by individual consumers, and disbarment by the Medicaid program. In Illinois, this valuable information is virtually ignored by the Dept. of R. & E. Since 1976 the Dept. of Public Aid has barred 42 health care providers from participation in the Medicaid program—only six of these providers were ever disciplined by the Dept. of R. & E. for Medicaid related charges. The Illinois Dept. of R. & E. makes no attempt to monitor malpractice suits. The

continued on page 10

CCHCC Board Member Barry Checkoway takes notes at public hearing on Reaganomics sponsored by Committee on Local Initiatives (story on page 2).

Have You Made a Membership Contribution?



Nearly $2500 has been collected in membership dues and donations during the past three months, pushing us over $3800 so far this fiscal year. Although we surpassed last year's $3200, we are still about $700 short of our goal to raise $4500 by June 30, 1982.

If you support the work of the Health Care Consumers, but haven't sent in your membership dues this year, please send it in today. A membership coupon is on the back page of this issue and a return envelope is included for your convenience. Please don't wait, send in a contribution now!

Committee Addresses Reaganomics Locally

An ad hoc group of citizens calling themselves the Committee on Local Initiatives held a public hearing on May 13th attended by nearly 100 persons and formed several task forces to explore ways in which citizens can respond locally to Reaganomics. The public hearing, which was convened by several local ministers, focused on the impact new federal policies (i.e. cutbacks) are having in our community. A poster announcing the hearing stated that, "President Reagan says that well being is a responsibility of the local community. He proposes cutbacks that are already affecting education, environment, food stamps, housing, legal services, medicaid, medicare, job and employment training, and many others. Now is the time to come together to speak out on community needs and local action."

Testimony was presented by over 30 persons in what seemed to be an endless listing of how Reaganomics was already affecting the neediest residents of our community. Testifiers represented or reported on human needs such as: unemployed workers unable to find jobs or training programs, individuals walking the streets searching for shelter and food, children and infants facing cuts in school lunch programs, legal aid clients unable to afford representation in the legal system, community health centers threatened with cuts in services to medically underserved people, minorities confronting racism and new assaults on civil rights legislation and civil liberties, families in public housing facing closures of units and sharp increases in rents and utilities.

Because of the length of the testimony a discussion of strategies for addressing the problems was scheduled for a follow-up meeting two weeks later. Over 30 residents attended this second meeting which was much more upbeat. Four major strategies were identified and Task Forces were formed to develop plans of action in each area. The four strategies included: Focusing on the Private Sector—many persons were concerned that Mr. Reagan's cutbacks were passed with the understanding that the private sector would fill the gap. Yet despite huge tax cuts, the private sector has paid little attention to the growing community needs resulting from Reaganomics. (2) Improving Lifestyle—several persons testifying felt that everyone should try to sacrifice a little more to help those in need. (3) Political Action—a common theme at the hearing was that we needed to place more pressure on our elected officials and take more time to communicate our opposition about Reaganomics, and (4) Taxes and Defense Spending—many people at the follow-up meeting were intrigued with the idea of using our taxes as a way of protesting the unwarranted build-up of weapons and bombs at the expenses of human needs.

Organizers are unsure of what will come of each of these Task Forces but are glad that residents have begun meeting to take matters into their own hands. If you are interested in participating in one of the activities of the Committee on Local Initiatives, please contact Charlie Sweitzer at the McKinley Foundation, 344-0297. Your input is welcomed and needed.

HEALTH CARE CONSUMER is the quarterly newsletter of the Champaign County Health Care Consumers, 124 N. Neil, Champaign, Illinois 61820, (217) 352-6533. It is produced as a voluntary effort of community residents to help consumers stay abreast of health consumer problems and emerging solutions. Comments and contributions are invited and should be directed to the above address. HEALTH CARE CONSUMER is supported through tax-deductible donations from readers and local community residents.

IN THIS ISSUE

HSA Plans Unclear

By law, local health planning agencies called Health System Agencies (HSAs) must publish a plan for health services in their area. Consumers are supposed to be involved since they pay the health bills. The plan is called a Health Systems Plan (HSP).

The state of Illinois is divided up into 11 HSAs and each has its own HSP. Before final publication the HSP must be made known to the public for review and comment. A public hearing must also be held. So far so good.

Now for the bad news. Two researchers at the University of Illinois, including CCHCC Board member Tom O'Rourke, have reviewed each HSP and measured its readability—the amount of education required to be able to read the HSP. The results are alarming. In all HSAs, including the one serving Champaign County, it was found that the readability is ridiculously high. Only those who have college degrees are able to read them—or less than 16% of the U.S. population.

The researchers cited several factors for their findings. While plans are supposed to reflect consumers' wishes and needs, as well as institutional needs, the fact is that HSPs are written by HSA staff members with professional training in health planning. "Planners are known to have problems in communicating with the public, in part because of their use of technical jargon." As a result of the way health plans are written, consumers defer to health care providers who generally are better educated and able to understand the complicated language. The report concludes that "Since the planning documents are incomprehensible to the majority of the public, it should not be surprising that the public rarely participates in the planning process."

Government Study Finds
Hospitals Overpaid Millions in Medicaid/Medicare

A study by the U.S. Department of Health and Human Services and the Illinois Department of Public Aid of 34 Illinois hospitals found that "major deficiencies in enforcement of current (Medicaid/Medicare) policy requirements" results in the overpayment of millions of dollars. The study notes that the findings are not "new to federal health regulators" and "many have been noted in federal reports throughout the last 15 years" but "the problems remain uncorrected." The findings and lack of government action are shocking in themselves but absolutely shameful considering the drastic cuts in benefits to the poor and elderly Americans served by these programs.

A summary of the major findings of the study are divided into four major issues:

- **Patient charges.** The study "found substantive errors in patient charges at 92% of the hospitals reviewed. The fiscal intermediary (an agency responsible for monitoring and reimbursing hospitals) has not adequately tested hospital charge records, and has not identified or corrected errors. At the 13 hospitals reviewed in this area, overcharges and undercharges were identified that resulted in a net overcharge to Medicare and Medicaid patients of $533,389."

  In addition, hospitals are reimbursed for the reasonable costs of providing necessary services to Medicaid and Medicare patients. To determine how much a hospital gets, total hospital costs are allocated between Medicaid/Medicare patients and other patients. The study states that "accurate and complete records are essential for proper calculation of Medicaid/Medicare costs." Yet, 46% of the hospitals reviewed didn't even maintain Medicaid and/or Medicare charge logs and reimbursement was based on "unverified" claims.
- **Hospital based physicians.** At 79% of the hospitals reviewed significant errors were found in the reimbursement of hospital based physicians. At 2 hospitals, reviewers found significant errors that if corrected, would have saved an estimated $306,035. The study went on to state that proper enforcement could result in "a program savings of approximately $16,444,716 in Illinois alone."
- **Third party liability.** "Federal regulations stipulate that the Medicaid program will pay to hospitals the reasonable cost of providing necessary services to eligible needy patients only to the extent that such costs are not covered by other third party sources. Payment made by Medicare, by other insurance, or in cash should be deducted from the total liability of the Medicaid program. The findings in this review identify problems both with hospital procedures and with policy of the state agency.

  "Deficiencies in identifying, billing and reporting receipts from other third party payers were noted at 100% of the hospitals reviewed in this area. Recordkeeping was not adequate and control procedures were insufficient. Regulatory requirements have not been consistently applied to outpatients. All hospitals have been audited in this area by either the fiscal intermediary or by the state agency. These auditors have failed to identify problems or enforce compliance with regulatory requirements."

  The study estimated that if payments could be received from liable third party sources, "the Medicaid program in Illinois could recognize savings of approximately $2,936,293 for one year alone."
- **Grants and gifts.** Federal regulations state that donor restricted gifts, grants and endowment income should be deducted from the allowable costs charged to Medicaid/Medicare, otherwise "hospitals will be reimbursed twice for the same expense."

  Yet, the study found that "at 76% of the hospitals reviewed in this area, auditors noted that either contributed income was incorrectly treated in accounting records or that records were not adequate to document that the hospital's reporting was correct. The fiscal intermediary has not performed adequate audits in this area and has not enforced regulatory requirements."

  The study notes that over a half billion dollars

continued on page 10

CCHCC Opposes Adler Closing

On June 2, the Champaign County Health Care Consumers' Board of Directors voted unanimously to oppose plans to close the Adler Mental Health Center in Champaign. Earlier this year, Governor Thompson proposed closing the Center which provides intensive residential treatment for severely emotionally disturbed and developmentally disabled children.

The governor has argued that closing Adler would save the state money. However, critics contend that without the highly successful short term intensive care given by Adler, many children may end up in state institutions for many years at a greater cost to taxpayers. Speaking in favor of Adler, CCHCC Chair Henrietta DeBoer noted that closing the Center would also result in the loss of more jobs in the community.

Under Thompson's proposal, services at Adler would be transferred to the Adolph Meyer Mental Health Center in Decatur. However, according to CCHCC Board Member Tom O'Rourke, "Any cost reduction would not be due to greater efficiency but rather reduced services."

CCHCC is one of a growing number of organizations opposing the closing of Adler. The night before CCHCC took action, the Champaign County Mental Health Board voted unanimously in favor of keeping Adler open. The following night, the Subarea Board of the Health Systems Agency also recommended that Adler remain open. In response to this growing support, the Illinois Senate approved an amendment to restore funding for Adler, using money Thompson allocated to Decatur's Adolph Meyer Center and general revenue funds. Thompson lost a similar battle last year when he originally proposed closing Adler.

Legislative Updates

Past issues of *Health Care Consumer* have mentioned various legislation introduced in Springfield that affects health care consumers throughout Illinois. The following is an update on that legislation:

- **HB 2379**
  SB 1586 Right-to-Know. Republicans in the Illinois House of Representatives have killed Right-to-Know legislation for this session, while sending out to the floor bills to cut workers' compensation benefits. And the State Senate Rules Committee has also blocked any consideration of Right-to-Know this year by failing to act on Senate Bill 1586. The Committee ignored letters from concerned union members and other supporters who had urged legislators to recognize that workers exposed to toxic chemicals on the job are facing an emergency situation.

  The Right-to-Know campaign is supported by a variety of labor and community groups including CCHCC, the Illinois AFL-CIO, UAW Region 4, The League of Women Voters and Citizens for a Better Environment.

On May 12, CCHCC members joined hundreds of other Illinois residents who met with their state legislators as part of Illinois Public Action Council's Lobby Day in Springfield. Above, Helen Satterthwaite explains that attacks on the Nursing Home Reform Act died in committee . . .

- **HB 662 Nursing Act Reforms.** This bill was defeated after failing to receive a majority vote on April 27 in the House Health and Family Service Committee. The legislation was introduced by the Illinois Nurses Association (INA) to close a loophole in the Illinois Nursing Act that state bureaucrats are suing to challenge the licensure and practice of nurse specialists such as nurse midwives and nurse practitioners. CCHCC testified in favor of HB 662 at a March 4th public hearing, citing cost benefits and expanded consumer choices. Mike Doyle, CCHCC executive Director argued, "It is a disservice to deny consumers the right to choose the type of health care delivery they prefer, and to deny nurses the right to pursue their careers as they desire."

  The only opposition to the legislation came from the Illinois State Medical Society. The INA had been working hard on the legislation for 2 years but fell one vote shy in committee. INA had recently participated in several meetings with the state Medical Society in the hope of reaching an agreement. However, sources close to these discussions indicate the doctors demanded that the nurses support state regulations that would prohibit nurses from establishing their own practices, something the Nurses Association was unwilling to do.

- **HB 2474 Illinois Health Finance Authority.** The Illinois House of Representatives passed this legislation which renews the Illinois Health Finance Authority (IHFA). The bill now moves over to the Senate for consideration where it still faces opposition from the hospital industry.

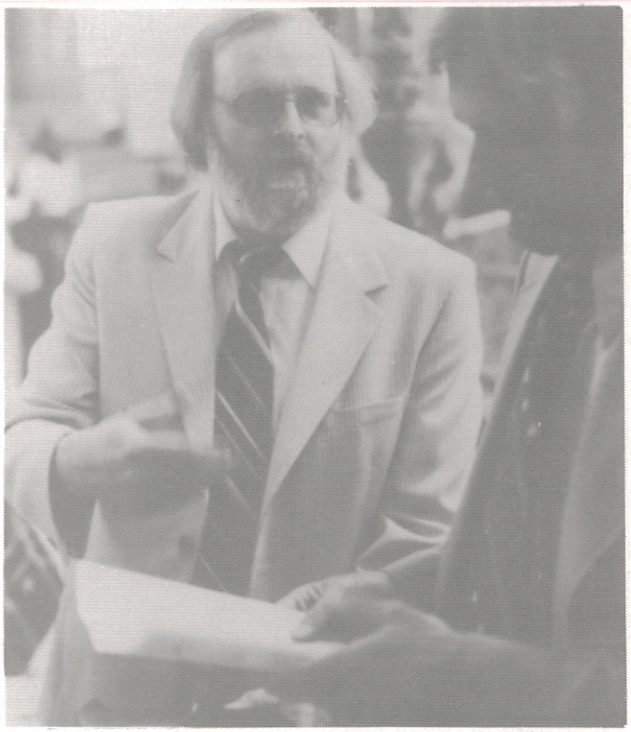
  The Health Finance Authority, an independent State agency, was established by the Illinois General Assembly and has been developing its program for controlling hospital rate increases since early 1979.

  According to Martin J. Koldyke, a Chicago businessman and chairman of the Health Finance Authority, the prevailing system offers little or no incentive to a hospital to control its costs.

  "From a cost standpoint, the current system is counter productive," Koldyke said. "It rewards greater expenditures with higher revenues. It's not that hospitals necessarily have poor management but rather that the system doesn't offer hospitals the kind of incentives to increase efficiency faced by other businessmen."

  A study by the Association of Health Care Con-

continued on page 11



. . . While CCHCC member Joe Ahearn presents the case for Right-To-Know legislation to Representative Tim Johnson.

Program Reports

Health Hotline

The Hotline continues to monitor efforts by Carle Clinic to comply with the Illinois Mental Health Confidentiality Act. Acting upon complaints filed by the Hotline, the Illinois Guardianship and Advocacy Commission voted to investigate Carle and its practice of filing notes from psychiatric sessions in a patient's general medical record. The Commission's Human Rights Authority is expected to discuss the case at its June meeting with a final decision scheduled for July.

The Consumer Health Hotline, which had been receiving about 40-50 calls per month, has been receiving an increasing number of calls since mid-May. In an effort to handle the growing number of calls, a mid-June training session is being planned for persons interested in becoming Hotline Volunteers.

Finally, the Hotline has begun developing a Health Services Evaluation Form for local consumers. The questionnaire which addresses the quality of care received is to be completed by local consumers and filed at the CCHCC office. The file would be available to anyone wanting to know the level of consumer satisfaction with specific health care services and providers.

Women's Health

This summer CCHCC will have a student intern, Nancy Mickenbecker, who will be working with women in the community interested in addressing the issue of midwifery. The concern about birth alternatives in the area, particularly the lack of midwifery services, has been brought to CCHCC's attention on numerous occasions. Representatives of the Women's Health Task Force testified on March 4th at a hearing before state legislators and expressed support for HB 662, which would have legally clarified the role of nurse specialists including midwives. This project is an outgrowth of those activities. If you know someone you think might be interested, help spread the word.

Medicare Task Force

An ever increasing number of calls received by the Consumer Health Hotline are from senior citizens who have questions or complaints about their Medicare coverage. In response to this growing concern, CCHCC will establish a Medicare Task Force this summer. The project is still in the planning stages with interested CCHCC Board Members meeting to discuss the initial parameters of the Task Force. An intensive outreach campaign is expected in late summer to solicit as much input from senior citizens as possible. If you are interested in working on this project, please contact Henrietta DeBoer at 367-5134.

Forums

CCHCC presented a series of spring community forums on a wide range of health care topics. In February over sixty people gathered to learn about sensible alternatives for weight reduction at "The Weight Reduction Maze—How to Get Through It." Representatives from area weight loss centers as well as a University nutritionist and a fitness expert discussed weight loss programs, fad diets, nutrition and exercise needs during weight loss and weight maintenance methods. Several formerly overweight people discussed their weight loss experiences and with the help of photographs, amazed the audience by their former and present appearances.

In March, the community forum focused on "Medicaid: Bringing it All Back Home," a proposal for reforming the Medicaid program through decentralization. The proposal was developed by the Health & Medicine Policy Research Group, a newly formed organization headed by Quentin Young. In short, the plan (featured in the last issue of *Health Care Consumer*) proposes to allocate Medicaid dollars to county governments. In turn, county boards would negotiate HMO type contracts with local providers to serve Medicaid recipients. Although the proposal includes several mechanisms to ensure consumer participation and accountability, some members of the audience expressed skepticism about local officials controlling welfare programs. In response to these and other comments, Policy Research Group member Mike Gelder explained, "This plan isn't set in stone. This kind of feedback is extremely useful. The important thing is to begin exploring alternatives to Reaganomics."

Our April forum examined self-care, a consumer dominated movement which has rapidly expanded and come to the forefront of American health care consciousness in the last decade. "An Ounce of Prevention . . . Wellness Through Self-Care" examined natural foods, stress management, and women's health as areas in which individuals and groups can monitor their health. As a national policy, the concept of self-care can be harmful to those who need better access to health care today and to those who do not have the resources to practice preventative care. But, on an individual and group level, self-care can prevent and cure some ailments as well as strengthen the body to resist disease and stress. Most importantly, the self-care concept demands an active posture and mindset on the part of the consumer in assuming responsibility for one's health and in taking charge of one's body.

Hill-Burton Task Force

After nearly a year and a half of organizing around Hill-Burton, CCHCC's Hill-Burton Task Force is on the verge of a major announcement about the status of local Hill-Burton programs. During the past 18 months there has been a local public hearing; two investigations, one by the local HSA and one by federal officials; accusations of a "witchhunt" by the President of Carle Hospital; findings of local hospital non-compliance with Hill-Burton regulations by both federal and local investigators; and finally discussions between Task Force members and hospital administrators about the future of free and low cost care in our community. According to Task Force member Mamie Smith, each of the hospitals responded very differently to the problem of access facing low-income consumers, "It was very clear which institutions cared and which ones didn't. We plan to issue a report later this summer."

Doctors Directory

The Doctors Directory continues to be a hot item locally. A mid-May check of local stores found that nearly half of the thirty local stores selling the Directory had sold out, and many others with just one or two copies left. A second shipment of over 400 copies to the local distributor has temporarily replenished the shelves at local stores. However, if you notice only one or two copies left at a store, please call the office so we can avoid future shortages.

Self-Care is Not Enough

Barry Checkoway and Stephen Blum

There is widespread dissatisfaction with the existing medical care system. Critics agree that costs are too high; that high technology and curative medicine are often emphasized at the expense of health education, prevention, and promotion; and that many services are unavailable or inaccessible to those who need them most. This "system" is said to operate as a form of economic triage, providing quality care for those with money or insurance, and higher mortality and morbidity for those unable to pay the price. Critics charge that the medical system itself has become a threat to health, as doctors and medical institutions cause illness or make people feel ignorant, dependent, and thus unable to actively attend to their own well-being.

In response, many people are turning to alternative health movements. These include holistic health, emphasizing principles such as nutritional awareness, physical fitness, and environmental sensitivity; community health planning, establishing local agencies to expand citizen participation and produce health systems plans; and self-care, expanding individual responsibility for health through measures such as personal hygiene, exercise, stress control, weight reduction, aerobics, and health foods. These various movements have grown rapidly in the past decade. While holism encourages us to experience more deeply and wholly, health planning invites us to participate in policy decisions, and self-care urges us to help ourselves.

Alternative health movements do more than react against mainstream medicine; they also have a scientific basis of their own. Studies repeatedly show that many major correlates of health have little to do with medicine and much to do with "living a good life," including not smoking, controlling one's weight, eating a balanced diet, exercising regularly, getting a reasonable amount of sleep, driving safely, and wearing automobile seat belts. There are many cases of individuals and groups helping themselves to be more healthy.

Self-care today is getting a big boost as national policy. Ronald Reagan says that well-being is a responsibility of individuals, not federal programs, and that self-help is a necessary alternative to "government intervention." Secretary Schweiker proclaims administration philosophy and defends budget cuts in Medicaid, Medicare, community health centers, food stamps, and public and environmental health programs. Self-care is brilliant politics, seemingly shared by antigovernment conservatives and decentralist progressives, corporate giants and grassroots community groups. Who could oppose such a notion?

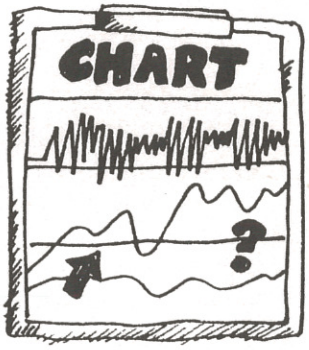
It *is* important to increase individual participation and responsibility in health. But there are dangers in self-care as national policy, dangers which could intensify, even worsen, the health care problems facing the nation. For example:

Hurting the poor and minorities. Many federal health programs were originated in response to the special problems facing the poor and minorities who are the least healthy Americans. The ideology of self-care as national policy assumes that individuals have the ability to "pull themselves up by their bootstraps." But what value is such ideology for those without "boots"? The benefits of self-care are all to be praised. But they are a dream or cruel joke for those without resources, knowledge, and power. Furthermore, for those poor who *do* participate in self-care as an approach to social change, self-care may operate as a subtle form of "regulating the poor," diverting attention away from more powerful methods of social change.

Retreat from social responsibility. In a society fueled largely by privatism and competition, the ideas of "social responsibility" and "community" have fallen on hard times. Self-care as national policy drives us further from these ideas. It stresses the importance of *personal* responsibility and *individual* symptoms and fragments the community as a vehicle for social cohesion and mutual obligation. Self-care as national policy is an antisocial idea: it is the opposite of a caring civilization and may be adopted only at risk to ourselves as social beings.

Blaming the victim. The shift in responsibility from the group to the individual places the burden on the individual to modify his or her behavior rather than on society to modify the conditions which create the problems. By singling out the individual, present policy-makers are implicitly stating that the individual is the problem rather than the victim of the problem. This is bad social science and inept social policy: the major forces operating on individual health are *not* individual but are largely social, political, economic, occupational, and environmental. At its worst, self-care as national policy could become a form of blaming the victim and a rationalization for the status quo.

This is not intended to deny the importance of individual participation and responsibility as means to health. Nor is it intended to dissuade self-care groups from forming, helping themselves, and becoming conscious of the whole social picture. But self-care as national policy is not enough. There is dissatisfaction with mainstream medicine, and alternatives are needed. But self-care, when it becomes an ideology wed to national policy, is an antisocial idea, and a retreat from social responsibility.



ASK THE DOCTOR TO TALK YOUR LANGUAGE!

You have the right to know as much as he or she knows about what's wrong and what can be done.

Local Control No Solution to Medicaid Problems

by Mark Kleiman
Executive Director, Consumer Coalition for Health

A recent issue of this newsletter contained a "modest proposal" from the Chicago-based Health & Medicine Policy Research Group to give control of the Medicaid program over to local governments. The HMPRG proposal demonstrates that any situation, however bad, may always be made infinitely worse. Medicaid is a tremendously complex program, and it would be impossible to fully detail all of the serious problems with the proposal. Here are some of the bigger ones:

I. Local Control Strengthens the Hands of Local Providers

Although the HMPRG proposal would involve local consumers, the local providers would wind up running the show. If you like the way Champaign County Health Care Consumers (CCHCC) was pushed around in the East Central Illinois HSA, you'll *love* local control of the Medicaid program. One of the main reasons CCHCC stopped organizing around HSA elections was that the heavyweight doctors and hospital leaders demonstrated that they had enough money and troops to subvert what *should* have been democratic elections. The mid-state Medical Mafia has a much stronger grip on local politicos than does CCHCC, and there is no doubt of the clout of their campaign contributions. An ancient provider proverb, the Golden Rule, summed it up: "Those who have the gold make the rules."

How would they use such control? In an era of declining Medicaid payments, the heavyweights at Carle and Christie Clinics might just decide to keep all the Medicaid business for themselves. What would then happen to the Frances Nelson Health Center, which is heavily dependent on Medicaid payments?

Farfetched? Hardly. In Missouri, all Medicaid beneficiaries who receive general assistance welfare grants are already required to bypass community clinics and use only city-operated hospitals and clinics. The Missouri legislature is considering a bill which would give the city hospitals total control over *all* Medicaid patients in St. Louis. Community clinic administrators report being hit with the double whammy of severe federal funding cuts and declining Medicaid revenues all at the same time.

II. Local Control Means Local Prejudice

Local governments would be under tremendous pressure to refuse to pay (or drastically under-pay) for unpopular services. The anti-choice, forced pregnancy lobby would surely try to cut payments for family planning, just as they have opposed family planning projects in block grant hearings and health planning agency reviews.

There is also a tremendous danger that open or covert racism would "tailor" benefits and services in ways that discriminated against minorities, welfare families, and other unpopular groups. Many southern states do exactly that already—and they would doubtless be joined by many rural counties in Illinois. It is *precisely* this kind of problem which drove the federal government to establish certain minimum standards in the first place.

Migrant farm workers and their families would also be jeopardized. Because migrants almost always lack a political base in those areas in which they temporarily reside, their needs have quite often been ignored by local governments. That is why the federal government was forced to establish a national program of migrant health centers. Counties controlling their own Medicaid programs would be sorely tempted to ignore the needs of temporary laborers in favor of permanent residents who are capable of organizing and voting.

III. Prepayment is a Two-Edged Sword. Whose Costs Will be Contained?

The HMPRG proposal implicitly relies on the cost savings inherent in prepaid contracts with individual providers or provider groups. This is *precisely* what Reagan did to over half a million California Medicaid beneficiaries when he was Governor.

It is important to remember that prepayment plans do not remove the profit motive—they merely reverse it. When a doctor (or group) is paid on a capitation, or prepaid basis, they will make a profit by providing as little care as possible. In California, doctors were allowed to establish prepaid health plans, or PHPs, with no regulation or consumer protection. Hundreds of thousands were tricked into joining the PHPs by false promises of easy referral to specialists, free transportation to clinic sites, and child care. In reality, many of the clinics were not even open on evenings or weekends. Many people suffered serious illness and injury at the hands of the phony health plans. By encouraging local governments to establish such plans without arming local consumers with protective regulations, the HMPRG proposal opens the door to the same kind of fraud and abuse Reagan tolerated in California.

IV. Centralizing Medicaid Dollars in Public Hospitals Would Dangerously Erode Political Support for Medicaid.

Many of HMPRG's leaders have been heroically involved in the ongoing battle to save Cook County Hospital in Chicago. They hope that local governments in big cities would direct the flow of Medicaid patients to the public hospitals—thus bolstering their critical financial condi-

Continued on page 8

Madigan Reverses Position

Hill-Burton Advocates Win Victory!

Despite an initial scare, the continuation of Hill-Burton seems to be safe for now. Retention of Title XVI, the Hill-Burton enforcement statute looks good after the April 30th hearing before the House Subcommittee on Health and the Environment. One of the keys to the turnaround was that Congressman Madigan, who was one of the regional sponsors of HR 4554 which would repeal Title XVI, has effectively withdrawn his support for repealing Hill-Burton. Madigan has introduced his own bill H.R. 6173 which would make no change in Hill-Burton but would repeal health planning.

In what came as an unexpected but pleasant surprise, *the Administration also supported retention of Title XVI.* Dr. Edward Brandt, HHS's Assistant Secretary for Health, testified that the Administration wanted to continue enforcing Hill-Burton. The National Health Law Program (NHeLP) and the Leadership Conference on Civil Rights, a coalition of over 150 organizations, also testified in support of Title XVI and the need for vigorous Hill-Burton enforcement. Both emphasized that Hill-Burton provides important civil rights protections for low-income persons and minorities and that our nation's goal of equal access to health care could not be achieved if Title XVI was repealed.

The findings of a General Accounting Office report on Hill-Burton enforcement were also presented to the Committee. The GAO concluded that "the Department of Health and Human Services (HHS)," seven years after Title XVI was enacted "continues to have difficulty monitoring compliance data from facilities, and investigating and resolving complaints in a timely manner." Facility non-compliance was widespread and GAO identified many enforcement inadequacies, most of which concerned uncompensated care. However, despite HHS's shortcomings, GAO recommended against any substantial increase in Departmental staffing.

The GAO was particularly critical of the Bureau for Health Facilities (BHF) which is responsible for encouraging the free care part of Hill-Burton. According to the GAO report, BHF officials "assume that the facilities are voluntarily complying with the assurances unless subsequent report information proves otherwise."

However, when the GAO conducted site visits at 14 facilities they found that:

- One facility was still operating under the prior regulations.
- Several facilities did not make timely eligibility determinations, provide individual notice to all patients as required, publish the required newspaper notice, or post the required signs.
- Some facilities were unaware of the compliance reporting requirements.

When it came to complaints, the GAO explained why so little has been done with the complaints such as submitted by CCHCC against local hospitals. According to the report:

"BHF has not effectively implemented its procedures for investigating complaints. Specifically,

- the complaint system has not been timely or responsive,
- decisions to investigate complaints were not based on BHF's priority ranking system,
- systematic followup seldom took place to insure that facilities corrected violations."

BHF has been unable to keep up with the number of complaints and continues to fall further and further behind. On Sept. 1, 1979, there were 315 pending complaints; two years later, there were 690 pending complaints. Of these, 242 had been pending for over two years.

During the last two years, *BHF has decided only 17 complaints.* Of these, 8 or almost half took over two years to

continued on page 12

KNOW WHAT YOU'RE AGREEING TO!

Ask what each of those papers means that you are asked to sign.

It's smart to find out what hospital rules apply to you, too.

Medicaid *from page 7*

tions. This short-sighted strategy may work in the short run—but would jeopardize the entire Medicaid program within a few short years. The blunt truth is that public hospitals and consumer groups have not been the key forces that have saved the Medicaid program. The heaviest (and most effective) support has come from the many private hospitals and doctors who profit from Medicaid dollars, and would be in deep trouble if the program were drastically reduced.

Centralizing Medicaid money in public facilities will merely surrender our private sector "hostages" who are presently the most effective advocates for Medicaid. If there were some mass movement on the horizon which will swoop down and rescue the program, we could easily dispense with these hostages. That movement is not there right now. That is why cash or cash-like benefits (welfare, food stamps, and the like) are cut. Those benefits which are a major source of income for the private sector are the benefits with the greatest chance of survival.

HMPRG wants to politicize health care fights and make it easier to do local community organizing around health issues. They propose to do this by threatening people with the loss of their benefits unless they mobilize to defend them. This is wrong. The CCHCC experience shows that you can organize around a *positive* program of *increasing* people's rights and benefits (Hill-Burton, access to information, etc.). The HMPRG proposal is unintentionally Reaganesque, and is a great leap backwards. It shows, once again, that the greatest single cause of problems are solutions.

1982 Walk for Change

Walk For Change Continues to Grow, Adds New Groups

For the fourth year in a row, nature provided a beautiful sunny Saturday in May for the 10 kilometer Walk-For-Change, an annual community fundraiser sponsored by the Champaign County Health Care Consumers. This year's event saw a moderate increase in the number of walkers and the amount pledged over last year, but may realize a significant jump in actual income. "Even though we had only a 10% increase in both the number of walkers and amount pledged," explained Debbie Doyle, the chair of this year's event, "we expect to see a drastic improvement in the percent of pledge money collected." The reason is that this year walkers didn't receive T-shirts and other prizes until after they turned in their pledge money. As a result over 70% of the amount pledged was collected in the first three weeks compared to 30% last year. "Last year we only collected 77% of the money pledged. This year we are aiming for 100%, but would be happy with anything over 90%," according to Doyle.

There were several new organizations that participated this year replacing some groups who decided not to participate. The new participating organizations included: Bread for the World, Champaign County Americans for Democratic Action, C/U Coalition Against the Apartheid, Developmental Services Center, Democratic Socialist Organizing Committee, and the Illinois Coalition Against Reagan Economics. Several of the new groups did rather well especially Bread for the World which raised the most among them with 9 walkers worth $71.05/km. CCHCC had 14 walkers who had pledges totaling $98.35/km.

Final figures for the Walk indicate that 97 walkers worth $5,947 participated in this year's walk which was co-sponsored with WEFT radio station. CCHCC congratulates all participating organizations and individuals who made the Walk a tremendous success.

Medical Disciplinary Board

from page 1

Tribune found numerous cases where physicians were sued time and again and yet were never investigated by R. & E.

The Tribune reports, "A doctor, sued 14 times, lost a $9 million suit brought by a woman who had become a quadriplegic when he performed plastic surgery on her nose. The state has not held a hearing on his case."

In Illinois, unlike most other states, there is no law mandating that hospitals report to the state when a physician's privileges have been revoked, restricted, or denied. The Illinois law goes so far as to protect physicians by *barring* hospitals from disclosing the grounds for revocation of privileges. Without an effective state-wide regulatory system, doctors denied staff privileges at one hospital are free to move to another hospital within the state and set up practice.

In one such case, an obstetrician practicing at Alexander Brothers Medical Center was charged with "ripping off" a baby's nose during a delivery. A member of the hospital's medical executive committee further charged the physician with inappropriate use of forcepts that led to the mental retardation of a child. The physician's privileges at Alexander Brothers were revoked. He currently practices in Elgin.

In the few cases where investigations are initiated by the Dept. of R. & E., there are still grave doubts as to the effectiveness of their actions. The Tribune reports, "In a study of disciplinary measures imposed by the Dept. over the last five years, the Tribune found that only a small number of doctors ever have been called to account by the Department and that the punishment meted out in those cases amounted to a 'slap on the wrist.'"

The Dept. is allowed by state law to utilize "consent orders"—similar to plea-bargaining. The Tribune found the Department has made frequent use of this regulatory mechanism to avoid "protracted, costly, and time-consuming hearings." Through consent orders, the Department negotiates a settlement whereby the physician will agree not to practice in Illinois for a set period of time and the Department will not record any of the charges brought against him/her. This leaves the physician with a "clean bill of health."

The former coordinator of the Department's medical investigation division, Dr. John M. Fultz, Jr., is critical of the Department's actions. He places some of the blame on the Illinois State Medical Society, which he said was of little help society has regained control of the Dept. and its Medical Disciplinary Board. A current member of the Board, supported by the society, was a staunch backer of the society's "Physician Bill of Rights," a plan designed to keep "meddlers" out of medicine.

Dr. Robert Derbyshire, former head of the Federation of State Medical Boards, states, "The (Medical Disciplinary) Board's true function is the protection of the public against incompetent, unscrupulous, sick and dishonest physicians. . . . A lot of legislators and physicians don't seem to feel that way, though. They think the function of the board is to protect the physician."

In other states the story is often very different. In 37 states there are mandatory reporting statutes. The total number of practitioners investigated is higher, as are the number of license suspensions. In California, for example, there were 22.3 disciplinary actions per 1000 medical doctors by state licensing agencies in 1981, as compared to 6.98 actions in Illinois. The budget for medical investigations in California was $10 million this year. Illinois spends $695,000 for investigations. According to the Federation of State Medical Boards, Illinois ranks 45th among the states in the number of disciplinary actions against doctors.

In response to the Tribune article, Governor Thompson has stated he'll seek an additional $221,000 to beef up the investigation staff. However, consumer advocates have expressed skepticism that more money alone would not improve the situation and have suggested stronger legislation for disciplining unethical or incompetent doctors. State Representative Jill Swick has introduced legislation that would require the Department to look at malpractice cases but it is given little chance for passage.

Without adequate regulation, consumers are left with little protection for incompetent physicians. To fill this void locally, CCHCC Consumer Health Hotline has begun work on developing a Health Service Evaluation Form. According to Hotline Coordinator Cynthia Ward, "The idea is to provide consumers with qualitative information about local medical providers." The form would be filled out by local consumers who want to share their experience with other patients. "If we can't depend on the government to do its job, consumers need to work together to protect themselves," explains Ward. The Health Services Evaluation Form is expected to be completed later this summer. For more information, call Cynthia Ward—352-6533.

EXPECT RESPECT!

You are Somebody, and your dignity is as important as your health.

Medical people owe you the same respect and attention you owe them.

Hospitals Overpaid

from page 3

were donated to Illinois hospitals in 1978. "If only 1% of this estimate were identified as restricted and offset against provider cost, this would result in Medicare/Medicaid program savings of $2,045,523."

The study made three major recommendations: "First, HCFA should require that intermediaries and state agencies strictly enforce federal policy and regulations. Second, HCFA policy staff should review and clarify policy regarding each of the areas covered in this review. Third, since audit is the only available method for controlling Medicare/Medicaid expenditures for hospital costs, the audit function must be strengthened."

Unfortunately, a spokesman for DHHS said he knew of no plans to collect overpayments made in the past and was unaware of any specific changes made as a result of the study.

Seniors Attack Reagan's Proposed Medicare Cuts

Senior Citizens are hardest hit by rising medical costs because they experience the dual pressures of high utilization and limited income. Despite the Medicare program, senior citizens pay more for health care today ($2,026) than they did in 1965 when Medicare was enacted ($412). Recent proposals by the Reagan administration would further increase the amount senior citizens would pay for medical services. The following information is taken from the testimony of Jacob Clayman, President of the National Council of Senior Citizens before a congressional subcommittee:

The National Council of Senior Citizens believes the following 1983 budget proposals are potentially the most harmful to the elderly.

- **Physician fee schedule**

  The Administration proposes to postpone the 1982 update, due in July, until October. In addition, the Administration would limit the annual fee increase.

  Currently, only about one-half of all physicians accept Medicare Part B assignment. That is, half do not accept the rates which Medicare considers customary and reasonable for their services. Instead, the physicians bill the patient directly and at higher fees. The patient receives reimbursement from Medicare and is responsible for paying the physician this amount plus 100 percent of the charge which exceeds the Medicare allowed rate.

  This proposal could decrease the number of physicians who are willing to accept Medicare assignment, resulting in an increase in the beneficiaries' out-of-pocket costs as physicians pass the excess fees on to their patients.

- **Part B deductible**

  The Administration would index this deductible to the CPI. The deductible, now $75 per year, was increased by 25 percent, effective January 1, 1982, as part of the Omnibus Reconciliation Act of 1981.

  To increase the deductible again would further erode the elderly's capability to pay for health care and would potentially discourage them from receiving needed services.

  This proposal can also be counterproductive. The Administration hopes to save money. However, since meeting the Part B deductible gives the elderly access to physicians' services, the size of the deductible may cause beneficiaries to postpone or neglect seeing their physician until they are very ill requiring hospitalization. Such an outcome is undesirable both to those who care about the well-being of the elderly and to those who are concerned about the federal budget.

- **Home health reimbursement**

  In FY 1983, the Administration would require Medicare beneficiaries to pay part of their home health care which is now reimbursed fully for unlimited visits.

  The Administration states that this co-payment is a way to reduce unnecessary visits. NCSC believes that the outcome of this proposal will be a reduction of necessary visits for those who cannot afford the co-payment, a loss of benefit for all beneficiaries, an impediment to receiving needed services, and a potential for unnecessary use of covered services, such as hospital care. It might also increase the length of hospital or skilled nursing facility stays.

Through its Medicare proposals, the Administration is attempting to address the very serious problem of increasing cost for our nation's health care. However, these proposals would not institute reimbursement reform to reduce or control costs; they would not change benefit coverage to better meet the elderly's needs; they would not improve access for the elderly, or anyone else. Instead, the proposals would shift financial responsibility elsewhere for the same troubled health care system which now plagues us and our economy.

We believe that these proposals carry this message: "Health care costs too much; the federal government is spending too much money on the elderly's health care; therefore, to save the government money, someone else will have to pay." In most cases the "someone else" will be the Medicare beneficiary. This is no solution to the problem.

UPDATE: Medicare Victory!

After three days of deliberation and debate, the House of Representatives has rejected *all* of the fiscal year 1983 budget proposals under its consideration. Last night the final votes turned back the most destructive and objectionable budget, the Michel/Latta (R-OH) substitute endorsed by the President, as well as the "Coalition" budget sponsored by Rep. Aspin (D-WI) and the Budget Committee substitute sponsored by Rep. James Jones (D-OK).

The process which ended in defeat of the budgets brought victory for senior citizens, thanks to your hard work and diligence. An amendment (introduced by Mary Rose Oakar, D-OH) to eliminate the Medicare cuts in all three budgets was adopted. In addition, the Michel/Latta budget, with its drastic cuts in domestic spending, including an $18.5 billion cut in Medicare in spite of the Oakar amendment, was solidly defeated.

Legislation from page 4

sumers predicted that the Authority would save Illinois consumers about $65 to $130 million in a year. The Association also noted that the Authority "enhances" financial stability by "offering incentives for efficiency in order to avoid losses, achieve surpluses and greater operating margins."

The Authority, which adopted rules for hospital rate reviews last October, recently postponed implementation of their program of hospital rate review until after the upcoming legislative session. The Authority had originally scheduled its first rate reviews to be effective May 1, but took the action of postponing implementation because of problems which could arise from approving rates for only a few hospitals if the system were not continued by the Legislature. "It's not clear what the legal status of those rates would be," Koldyke said.

Hill-Burton *from page 8*

decide.

When the BHF did conduct assessments, the findings revealed "widespread non-compliance with the current regulations. 64 of the 72 preliminary assessments found facilities in violation of the uncompensated care requirements: 27 of the 29 monitoring assessments found violations; and 52 of the 72 closeout assessments also found facilities in non-compliance."

As far as the compliance reports filed by hospitals, numerous problems were experienced. Many of the reports

> "contained mathematical errors or omissions; BHF and the regional offices spent an inordinate amount of time reviewing the reports for completeness. Worse, the Bureau appears unable to obtain the required data at least once every three years from each facility. Worst of all, the reported data is accepted as accurate unless clerical mistakes are obvious. GAO did not consider whether the reported data is trustworthy, which is especially important in terms of facilities claiming excess compliance.
>
> Only 657 facilities were scheduled to report to BHF by Jan. 1, 1982. And, only 57% submitted reports that were complete and mathematically correct.
>
> Of these 377 reports, 26% or 98 facilities reported deficits—failure to reach their annual compliance level. 6 reported providing zero dollars of uncompensated care and 34 others reported providing less than 60% of the required amount.
>
> Another 136 facilities reported on an unscheduled basis. Of these, 97 also reported deficits—16 of which provided zero dollars and 46 others provided less than 60% of the required amount."

In summary, it is apparent that many hospitals are not doing what they are legally required to do. Also, it is obvious that the governmental agencies responsible for monitoring hospital compliance are not doing their job. However, extension of the law requiring Hill-Burton enforcement is critical if community organizations such as CCHCC are to have any leverage to ensure hospitals in their communities meet the needs of low-income residents.

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CHAMPAIGN COUNTY HEALTH CARE CONSUMERS

WHO WE ARE.....

Champaign County Health Care Consumers is an organization of local citizens concerned with improving health care delivery to all residents of our area. We are community-based and include representatives of women and minority groups, religious bodies and local elected officials, local businesses, labor unions and progressive provider organizations. We believe that health care is too important a matter of public concern to be left solely to those who provide it, and that major improvements will come only with the real involvement of consumers. Champaign County Health Care Consumers is funded largely through tax-deductible contributions of members and other local community residents. It is a not-for-profit, tax-exempt organization. For more information on becoming a member write CCHCC, 124 N. Neil, Champaign, IL 61820 or call (217) 352-6533.

WHAT WE DO.....

We focus on consumer participation, education, and action. Our public forums educate the general public on consumer health issues. Our leadership training workshops provide consumer leaders with knowledge and skills to carry out their responsibilities. Our newsletter helps keep consumers abreast of health care problems and emerging solutions. We work for responsible health planning and administration in accordance with federal regulations. We form Consumer Task Forces to address community health problems, currently emphasizing the problems facing low-income consumers and women. We have established a Consumer Health Hotline for residents who have questions, concerns or complaints about the local health care system. Finally, we publish The Doctors Directory for Champaign County.

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