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# Health Planning

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*President's Message – Spring 2005*

## **A Tale of Two Cities Redux**

by Dean Montgomery

As the crow flies, Fairfax, Virginia, lies 9.36 miles south-southwest of Bethesda, Maryland. Though separated by history, politics and the purifying waters of the Potomac River, these communities are united by much more powerful forces: namely, unbounded patriotism, economic orthodoxy, psychological equanimity, and noble sentiments. It is in this idyllic setting that our mis-adventure took place.

In the last decade of the 20<sup>th</sup> century, three life-saving and tissue-sparing dermatological surgeons, (Blades<sup>3</sup>) observed this scene, found it good, and set up shop in Bethesda, Maryland. Blades<sup>3</sup> specializes in Mohs micrographic surgery (MMS), a skin cancer surgical technique that maximizes excision of malignant tissue and minimizes the loss of healthy tissue. The technique involves the progressive, systematic removal of small tissue samples and, thus, is time-consuming. It does not require a hospital surgical suite. As with most

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## Health Planning TODAY

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**Donna Schuessler, Editor**



### *A Tale of Two Cities Redux* *Cont'd. from page 1:*

dermatological procedures, MMS is an office-based surgical procedure. Only in exceptional cases do patients have to be transferred to a hospital, or surgery center, for more extensive surgery or wound closure.

Blades<sup>3</sup>'s choice of location was serendipitous. Ever hospitable, Maryland does not regulate the establishment of small (one operating room and any number of "procedure" rooms) surgery centers. As in most states today, it issues a license to all of those meeting minimal licensure standards, thereby permitting them to qualify for Medicare reimbursement and receive what amounts to a facility fee (commonly referred to as a "technical component") in addition to a professional surgical fee. This practice has succeeded beyond all expectation. The free state is now blessed with 324 licensed surgery centers, the most in the nation, more than 225 of which have fewer than two operating rooms. Blades<sup>3</sup> quickly obtained a license and Medicare

certification, effectively converting office surgical practice into a freestanding outpatient surgery center (FOSC).

Life is good but, alas, not fair. Virginians are not as fortunate as their Maryland neighbors. With a population nearly a third larger than Maryland, Virginia gets by with fewer than 40 legal FOSCs. Observing this injustice, and the suffering of Virginians of all rank, Blades<sup>3</sup> opened an office in Falls Church, Virginia. Blades<sup>3</sup> joined several other providers of office-based MMS in Fairfax County, Virginia, all of whom were doing both well and good.

Blades<sup>3</sup> prospered in Virginia. Its MMS caseload rose rapidly, soon equaling, and then exceeding, its Maryland caseload. But in only two years, Blades<sup>3</sup> discovered another great inequity. Although its Virginia and Maryland costs were similar, and its profits in both locations were impressive, Blades<sup>3</sup> profits in Virginia lagged consistently and woefully behind those in Maryland. It soon became apparent that the economic differential between Blades<sup>3</sup>'s Virginia and Maryland operations derived almost entirely from the higher payments, largely from Medicare, but also from Medicaid and from medical insurance companies, that came from the Maryland office being a Medicare-certified surgery center. Blades<sup>3</sup> saw that was not good, and chose to redress this problem by obtaining licensure and certification of its Virginia office as a FOSC. Unlike in Maryland, this necessarily entailed applying for a Certificate of Need (CON).

The ensuing CON review of the Blades<sup>3</sup>'s proposal revealed that converting its Virginia office to a FOSC would:

- Be entirely a paper transaction, requiring no physical changes of any kind;
- Entail no capital expense and no increase in operating costs;
- Not affect quality or access to care;
- Result in no change in operations, service, or caseloads; and
- Result in an increase in Medicare revenue of about \$238 per case.

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*A Tale of Two Cities Redux*  
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Though opposed by benighted local planners as an unnecessary and wasteful raid on the Medicare Trust Fund and, to a lesser extent, on Virginia's beleaguered Medicaid budget, and as an unwholesome precedent, the Blades<sup>3</sup> proposal won state approval. Blades<sup>3</sup> now enjoys an estimated annual windfall of more than \$250,000 in enhanced Medicare payments, as well as enhanced payments from Medicaid and other payers.

Although there was substantial evidence to the contrary, state officials proclaimed that the Blades<sup>3</sup> proposal was by its nature exceptional and, therefore, neither replicable nor a problematic precedent. Unfortunately, reality intervened. The dermatology group (Blades<sup>1</sup>) that provided MMS in their Fairfax County, Virginia, office long before the arrival of Blades<sup>3</sup>, detecting disparities and inequalities of another kind, decided that they, too, could do better, and more good, with higher Medicare payments. Citing the Blades<sup>3</sup> precedent, Blades<sup>1</sup> soon obtained CON approval, and now enjoys an even larger, and more comforting, annual windfall.

The good citizens of Fairfax are pleased that more than \$0.5 million has been added to the local economy, that they now contribute to the depletion of the runaway Medicare Trust Fund, and that the return on investment for both Blades<sup>3</sup> and Blades<sup>1</sup> approaches infinity. They agree with Dr. Pangloss "there is a concatenation of all events in the best of possible worlds."

Of course, there is more good work to be done. Orthopedists, urologists, ophthalmologists, gastroenterologists, podiatrists, and chiropractors wish to combat inequalities and disparities wherever they find them, to be better citizens, to do more good, and to participate fully in the new order. Moreover, Virginians recognized that they have yet to contribute a full measure. With nearly ten times as many surgery centers per capita as Virginia, Maryland reaps millions more in Medicare dollars each year than Virginia. It may take Virginia a full generation to catch up. Then, of course, there are unapproachable new hauls taken annually by California, Texas, and Florida.

When next you examine your paycheck, take satisfaction in your Medicare tax contribution. Blades<sup>3</sup> and Blades<sup>1</sup> thank you. California thanks you. Texas thanks you. Florida thanks you. And, now, Virginia thanks you.

Let Mr. Dickens worry about "the best of times," "the worst of times," and "the age of foolishness". Combating foolishness is a full-time job. Rather, let us join Candide, congratulate Dr. Pangloss on a principle "excellently observed," and get on with cultivating our gardens. A perpetual harvest beckons. 🍷

## Challenges in Collecting Data on the Un-insured

Richard K. Thomas, Ph.D.

An important consideration for health planners, especially in the current environment, is the level of health insurance coverage characterizing a given population. Of particular concern is the extent to which the population lacks health insurance of any type. The level of insurance coverage obviously has important implications not only for health services utilization, but ultimately for health status itself. One challenge for health planners is the specification of the level of un-insurance within the population. A number of on-going efforts are underway nationwide to establish prevalence rates for un-insurance but these efforts face a number of difficulties each of which are discussed below.

The method chosen for data collection on the un-insured will have a substantial impact on the type and quality of data elicited. The telephone survey appears to be the method of choice for a variety of reasons. A sampling frame (i.e., those with telephones) is readily available and telephone interviewing can be done efficiently with the use of computer-assisted interview capabilities. This approach is less-costly than personal interviews conducted on a sample of community households, and more effective than the less-costly method of personal interviews by means of a

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## Policy Perspective

by John Steen, Consultant, Health Planning and Health Policy

On March 8, the long-awaited Medicare Payment Advisory Commission (MedPAC) *Report to the Congress: Physician-Owned Specialty Hospitals*, was issued. It is accessible at [http://www.medpac.gov/publications/congressional\\_reports/Mar05\\_SpecHospitals.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_SpecHospitals.pdf).

Congress ordered the MedPAC report as part of its Stark Law amendments in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In an apparent response to complaints that physician-owned specialty hospitals threaten the continued viability of traditional hospitals, the Stark Law amendments placed a moratorium on new physician investments in specialty hospitals for a period of 18 months, expiring on June 8, 2005. Congress ordered MedPAC and Health and Human Services (HHS) to use the moratorium period to conduct studies of the efficiency, cost and outcomes of specialty hospitals and to submit reports, along with recommendations for any needed legislative or regulatory changes, to Congress. The HHS study on specialty hospital quality is not yet completed.

In its principal recommendation, MedPAC recommends that the specialty hospital moratorium be extended for an additional 18 months, until January 1, 2007. This will give Congress time to review further studies on specialty hospital quality and admission rates and to determine whether to make the moratorium permanent, or to take the more drastic measure of abolishing the Stark whole hospital exception altogether.

In producing its report, MedPAC found 48 hospitals that met its criteria for physician-owned specialty hospitals: 12 heart hospitals, 25 orthopedic hospitals, and 11 surgical hospitals. It found that almost all community hospitals (93% have emergency departments [ED]). Specialty hospitals on average are about half as likely to have EDs, but 8 of the 12 heart hospitals it examined have EDs, compared with only 1 of the 11 surgical hospitals. All of the physician-owned specialty hospitals are for-profit, compared with fewer than 20% of all inpatient prospective payment system (IPPS) hospitals. In some cases, community hospitals have ownership interests in the specialty hospitals. In others, the specialty hospital is owned in part by a national chain. Eight of the 12 heart hospitals are owned in part by the MedCath Corporation.

Medicaid's share of hospital discharges was 15% for community hospitals, 4% for surgical specialty hospitals, and 1% for orthopedic specialty hospitals. Almost 60% of the specialty hospitals it studied were located in four states: South Dakota, Kansas, Oklahoma, and Texas.

Among its principal findings:

- Physician-owned heart, orthopedic, and some surgical hospitals tended to treat fewer Medicaid patients than peer hospitals and community hospitals in the same market. Heart hospitals treated primarily Medicare patients, while orthopedic and surgical hospitals treated primarily privately-insured patients.

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**Policy Perspective**

*Policy Perspective*

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- The increases in cardiac surgery rates associated with the opening of physician-owned heart hospitals were small enough to be statistically insignificant for most types of cardiac surgery. So it appears that specialty hospitals obtained most of their patients by capturing market share from community hospitals.
- Coronary artery bypass graft (CABG) surgeries declined everywhere due to the substitution of angioplasties for this procedure (Wennberg et al. 2004). However, the rate of CABG surgeries per 1,000 beneficiaries declined more slowly in heart hospital markets than in other markets. The difference is statistically significant.
- Though the opening of heart hospitals was associated with slower growth in Medicare inpatient revenue at community hospitals, most community hospitals competing with physician-owned heart hospitals did not experience unusual declines in their all-payer profit margin.

The report also said that, relative to full-service hospitals, specialty hospitals generally treat healthier patients, focus on higher-cost procedures, treat fewer Medicaid beneficiaries, and do not have lower costs. Evidence is not yet in on whether specialty hospitals provide higher quality patient care – that is a question to be addressed by the HHS report yet to come.

MedPAC further recommended that Congress should re-calculate its reimbursement rates under Medicare so the rates more accurately reflect the costs of care. The adjustment would often make it less profitable to treat the types of patients treated by specialty hospitals, such as heart patients, and more profitable to treat patients that tend to generate losses for general hospitals, such as those with pneumonia. MedPAC also favors “gainsharing,” or allowing physicians and hospitals to share savings from more efficient practices. That could reduce the incentive for more specialty hospitals.

At the same Senate Finance Committee hearing in which MedPAC presented its report, the Center for Medicare and Medicaid Services (CMS) unexpectedly released its own preliminary report on specialty hospitals. Thomas Gustafson, deputy director of the CMS

Center for Medicare Management, said the CMS study shows “measures of quality at [physician-owned] cardiac hospitals were generally at least as good, and in some cases better, than the local community hospitals.”

In addition, “complication and mortality rates were lower at cardiac specialty hospitals even when adjusted” for patient-sickness levels, he testified. CMS conducted its study by examining six markets, which represent 11 of the 59 cardiac, surgery and orthopedic specialty hospitals approved in 2003 as Medicare providers. The CMS report also found that doctors who have invested in specialty facilities do not refer patients exclusively to the specialty hospitals, but they do refer a greater share of patients to specialty facilities than to full-service hospitals.

Key committee members called the CMS report “disturbing,” and questioned whether CMS had an “ulterior motive” in conducting the study. Congress is not obligated to follow MedPAC’s recommendations. It remains to be seen whether Congress will implement any of MedPAC’s recommendations in the near future or whether it will wait for the HHS report on specialty hospital quality before taking legislative action. In light of the negative findings in the MedPAC report, the specialty hospital industry needs a favorable quality finding from HHS to counter the growing political climate against physician-owned specialty hospitals. 🍅



# Hospice Care Changes

by Sherry Crockett, Chief Operations Officer  
Serenity Hospice, LLC

Hospice care has been a Medicare benefit for those with a terminal illness since 1983. The Conditions of Participation (COP) for those hospice programs wishing to be Medicare-certified have not been changed since their initial approval. In August 1996, a draft of the new regulations was released by the Centers for Medicare and Medicaid Services (CMS). To date, there are no new COPs; however, the draft is still being reviewed and suggested changes have been offered.

Although changes may not be immediately coming in regard to the COPs, there are changes coming for hospice in relation to the Medicare Modernization Act (MMA) of 2003. The specific changes that this article relates to are Medical Review and Appeals. In the past, if your Fiscal Intermediary (FI) requested additional information, you had 35 days to respond. Should you receive a denial from the FI, you then had to respond with a request for reconsideration within 60 days. If the FI upheld the denial, you could appeal if it was more than \$100 to the Administrative Law Judge. With the MMA of 2003, the process has changed somewhat to make both Part A and Part B of the Medicare benefit regarding this issue look alike.

The new process is as follows:

Following denial of a Part A claim, the party is entitled to a reconsideration if the request is made in writing within 120 days following the receipt of the initial determination. FIs must process 75% of the reconsiderations within 60 days and 90% within 90 days (Reconsideration requests received on or after October 1, 2004 will be called "redeterminations." The new timeliness standard for completing redeterminations is 60 days. 100% of redeterminations received on or after October 1, 2004 must be completed in 60 days of receipt.)

The FI bases the reconsideration decision upon information in its possession when the initial determination was made including statements

or information submitted by the party or parties, plus the medical and other records acquired during the reconsideration. A reconsideration constitutes the FI's final review of its earlier determination. It is in the interests of all parties that all relevant information be available to the FI. It will urge the provider to submit documentation on a timely basis. The provider is responsible for providing the information needed to support its reconsideration request. The FI will develop information that is in its files, or in CMS or SSA files. The FI will inform providers of the processing time limits that are in effect and why it benefits all concerned parties when supporting documentation is submitted timely. If the party is unsuccessful in securing the information from another provider, the FI will assist the party. If necessary, it will remind the uncooperative provider of its responsibilities under its Provider Agreement.

Effective January 10, 2005, the federal rules includes a description of the following processes:

- Full denial;
- Partial denial;
- Alternative methods in full or partial allowance cases; and
- Late date of receipt.

The information you submit is what the FI will utilize to review your claims. If no information is submitted, and then you will receive a denial of services and in the case of a post pay audit, money will be recouped. The FI Palmetto GBA has stated in January 2005 that the greatest denial reason for hospice services is that the FI did not receive the medical record that had been requested. CMS has made an obvious attempt to make it easier for providers to comply with this requirement by extending the time period for response and providing education. It is better for the agency and the industry if a response is provided to any requests of this kind.

For additional information, contact Sherry Crockett at 870-773-2621, or email her at [scrockett0816@juno.com](mailto:scrockett0816@juno.com) 🍏

# When Planning Becomes Reality-Based

James G. Easter, FAAMA, President EMhc and Chair,  
American Academy of Medical Administrators (AAMA)

During recent email correspondence with Tom Piper, I spoke about the American Academy of Medical Administrators (AAMA) and the long-standing relationships I've had with the American Health Planning Association (AHPA) and the evolving world of healthcare planning. The AAMA is a sister organization to AHPA, and we hope to build on the "common threads" of service delivery, education and planning ([www.aameda.org](http://www.aameda.org)). My roots are solidly planted in the facility and asset planning areas, but I worked for years with the Texas programs in the tumultuous 70s and 80s (appointee to the State Health Planning and Development Agency Board and Planning Committee Member before CON programs ceased in Texas). Following those awareness years, I moved to Tennessee and learned some more about this healthcare delivery process; first with Quorum Health Resources, and now for a decade as head of the EMhc Corp. The question on the table is: *When does planning become a reality?*

These thoughts are excerpted from a presentation I'm doing later in March to the American Society of Healthcare Engineers (ASHE) on the Politics of Planning here in Nashville. In an ideal setting, the hospital would establish a formal "strategic planning" process which would become the primary guiding force in the definition of operational priorities, delegated responsibilities, key actions and "measured" results. The process should include clearly defined purposes (limit to a manageable number): goals, objectives, strategies and tactics integrated into the overall mission, vision and the hospital code of ethics (see exhibit below). The awareness that these "formal" components make up the culture of the organization is a high priority concern. Acceptance of the mission, vision and strategic planning process is mandatory for effective outcomes.

## Illustrative Strategic Purpose

Purpose: To ensure that facilities and technology are up to date and continuously improved to remain competitive in the market and attract physicians, patients, and employees to the communities we serve.			1st Quarter		2nd Quarter			3rd Quarter			4th Quarter			
			Accountable: CFO and CEO						2004			2005		
Goals	Accountable	Support	J	A	S	O	N	D	J	F	M	A	M	J
1. Begin implementing any actions identified in facility master plan with quarterly reporting on progress.	Engineer	CEO												
		Board			X				X		X			X
		Consultant												
2. Request and receive proposals for computer system necessary to implement technology plan by December 31, 2004.	CFO	Mgmt. Team	X	X	X	X	X	X						
3. Continue to monitor adequacy of hospital/nursing home technology, the effectiveness with which current technology is used by staff, and the appropriateness of the technology plan as expected needs change, with reporting in January and June, 2005.	MIS/HIS	Ryan												
		Board Consultant								X				
4. Develop capital financing plan to complement facility and technology master plans by November 15, 2004.	CFO	CIO Engineer CEO Full Team	X	X	X	X	X							

*"To ensure that facilities and technology are up to date and continuously improved to remain competitive in the market and attract physicians, patients and employees to the communities we serve."*

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*When Planning Becomes Reality-Based  
Cont'd. from page 7:*

This “purpose” illustration, excerpted from a Quorum-managed hospital, is an excellent example of how the strategic objectives can lead into some very precise and relevant actions. Out of this initiative the following occurred:

1. The board became aware of the facility and technology needs;
2. A campus master plan (MP) was initiated and completed on schedule;
3. Funding and support for new programs occurred (geropsychiatry, clinical services, assisted living);
4. Expanded community partnerships (YMCA and Physician Care Partners);
5. Funding for obsolete infrastructure and impact on facility users;
6. Attitude enhancements for staff and leadership; and
7. Better understanding of the impact of facility image on consumers.

Not every Strategic Plan (SP) leads to a campus MP and evolves as naturally as this MP effort did. The building may not be the highest priority, but it certainly can be a formidable barrier to effective healthcare delivery! The true value of the strategic planning process is the “interactive and consensus-driven” involvement of senior hospital leadership, departmental directors and board members. As you will note in the exhibit above, senior leadership, board members and consultants became a part of the overall development team with both “support” and “accountability” roles and responsibilities.

The need to measure results, define the accountability factors and seek out efficiency opportunities is of paramount importance today as our healthcare system struggles to compete in a rapidly changing environment. The building, and supporting infrastructure, combined with both fixed and moveable equipment, remain a major cost center requiring maintenance and upgrade on a routine basis. Unbundling the building and moving strategically into the region with outpatient clinics is a key concept to consider seriously. From a facility perspective, and a very pragmatic level, the following are key strategic and asset questions that must be answered:

- ✓ What is our service area, market composition and consumer base?

- ✓ Do we really know and understand our competition?
- ✓ Do we have the right physicians supporting our service area?
- ✓ How should we structure our service delivery program to respond to realistic needs?
- ✓ What are our capital asset needs and priorities?
- ✓ Are we in the right location?
- ✓ Can we improve access, quality and cost by changing the treatment site?
- ✓ How do we define realistic needs in a prudent and effective manner?

Moving from the strategy side into the capital asset and budgeting cycle is often one of the most frustrating parts of hospital operations. The ability to “package” budgeted components and prioritize strategically is often a continuous “moving target”. The highest priority is staying in business within your own departmental area while investing wisely to permit rational programmatic growth. The traditional hospital has been arranged in departments and/or service centers with each area representing both expenses and revenues.

All departments are “cost centers” but not all are revenue generating. The non-revenue generating departments are often the ones that impact users the most; for example, engineering, maintenance, materials handling and environmental services. One effective method to assess the true capital costs is the development of a Campus Master Plan. This management tool converts existing assets, programs and facilities into longer term stages of appropriate change. The campus master plan does reach closure on the management of assets. The what, where, how, when, why and how much questions are answered with a clear “road map” for staged actions. The change can be realized in both short term and long term phases contingent upon financial resources and a measurable return on investment (ROI factor). 🍎



# Wizard's Corner

## Sage Advice

*Your wizard is away, temporarily preoccupied with selecting culturally sensitive martial ensembles for C. Rice and designing continental lambs wool suits for P. Wolfowitz. In gratitude, their mentor, a respected Texas sage, advises on a number of pressing health matters.*

### **International Epidemiology:**

"Africa is a nation that suffers from incredible disease." Gothenburg, Sweden, 6/2001

### **Domestic Epidemiology:**

"We're concerned about AIDS in our White House, make no mistake about it."  
Washington, D.C., 2/2001

### **Species-specific Epidemiology:**

"Just remember it's the bird that's supposed to suffer, not the hunter." Roswell,  
NM, 1/2004

### **Age-specific Bovine Epidemiology:**

"I believe that, as quickly as possible, young cows ought to be allowed to go across our  
border." Ottawa, Canada, 11/2004

### **ENT Emergencies:**

"If I'm the president, we're going to have emergency-room care, we're going to have gag  
orders." St. Louis, MO, 10/2000

### **Environmental Harmony:**

"I know the human being and fish can coexist peacefully." Saginaw, MI, 9/2000

### **Pharmacology Explained:**

I don't think we need to be subliminal about the differences between our views on  
prescription drugs." Orlando, FL, 9/2000

### **Pharmacology Clarified:**

"Drug therapies are replacing a lot of medicines as we used to know it."  
Washington, D.C., 10/2000

### **Women's Health:**

"I'm for the fight against the war on breast cancer." NBC TV Interview

### **Mental Health:**

"This is still a dangerous world. It's a world of madmen and uncertainty and potential  
mental losses." South Carolina, 1/2000

### **Psychic Surgery:**

"I'm honored to shake the hand of a brave Iraqi citizen who had his hand cut off by  
Saddam Hussein." Washington, D.C., 5/2004

### **Physician Shortages and Disappointments:**

"Too many good docs are getting out of the business. Too many OB-GYNs aren't able to  
practice their love with women all across this country." Poplar Bluff, MO, 9/2004

### **Medical Records:**

"We need to have our medical records put on the I.T." Collinsville, IL, 1/2005

### **Death Tax Incidence:**

"I'm not sure 80 percent of the people get the death tax. I know this: 100 percent will get  
it if I'm the president." St. Louis, MO, 10/2000

### **Death Tax Prevalence:**

"I firmly believe the death tax is good for people from all walks of life all throughout our  
society." Waco, TX, 8/2002

### **Political Science:**

"It would be a mistake for the United States Senate to allow any kind of human cloning  
to come out of that chamber." Washington, D.C., 4/2002 🍎

*Challenges in Collecting Data on the un-insured  
Cont'd. from page 3:*

convenience sample within the community. This approach is considered more effective, although considerably more costly, than the use of mail-out questionnaires. The downside of telephone interviewing today relates to the current situation with regard to telephone ownership and usage.

First, a small number of households do not have traditional land-line telephone service. Although the numbers are small, these households are also more likely to be those that do not have health insurance coverage.

Second, a growing number of households have unpublished phone numbers. This reflects the desire for privacy and an attempt to reduce nuisance calls.

Third, a growing number of households have telephone sets that include caller ID capabilities or can otherwise block calls. Thus, a certain portion of the population self-selects itself out of the sample by placing their phones "off limits" to telesurveyers.

Fourth, an increasing number of individuals refuse to participate in telephone surveys. This trend reflects the nuisance factor associated with unsolicited sales calls and led to the establishment of a national "no call" database. In all of these situations, it is felt that those who opt out of the pool one way or another have characteristics that are distinct from the general population thereby biasing the sample of those who do participate.

Another phenomenon affecting this situation is the widespread use of cellular phones. The use of cell phones has become so ubiquitous that the number of households with these mobile phones is approaching the number with standard land-lines. Many households have both land-lines and cell phones and, increasingly, individuals are using cell phones to replace land-lines. Research that took place at the time of the presidential election found that those who use cell phones exclusively have characteristics distinct from the rest of the population.

Sampling frames for telephone surveys may be developed using random digit dialing of the exchanges in a particular locality. While this approach reduces any sampling bias and assures that essentially all residential phones will have an equal chance for selection, it does not overcome the problems associated with individuals who have blocks on their phones or simply refuse to participate. The other option is to draw a sample from a listing of the universe of residences within the target area. The household inventory utilized by the Census Bureau or one of the published city directories would be sources of such a listing of residences. Here, again, some numbers may be unlisted or, if listed, blocked to unwanted callers. Another drawback of city directories is that, by the time they are published, many of their numbers may be out of date. This frequently switching of phone numbers is likely to characterize residents of urban areas who are also likely to lack health insurance.

Although the telephone survey is considered more effective for this type of research than other forms of survey research, the use of a telephone survey on a project that targets the disadvantaged population is problematic. This population is less likely to have telephones than the population as a whole. Further, cellular phones are rapidly displacing traditional landline telephones, effectively eliminating many households from the sampling frame. Although this has not been fully documented, some feel that telephone surveys are likely to result in an undercount of the un-insured.

A second deficiency of most surveys of insurance coverage is their sample size. While virtually all such surveys are large enough to yield relatively accurate estimates at the state level, they are seldom large enough to allow for accurate estimates for smaller areas of geography. While it may be possible to generate reasonable estimates for regions within a state, it is not possible to produce county-level estimates. Given the variation likely to exist in most states with regard to level of insurance coverage, substate estimates are essential.

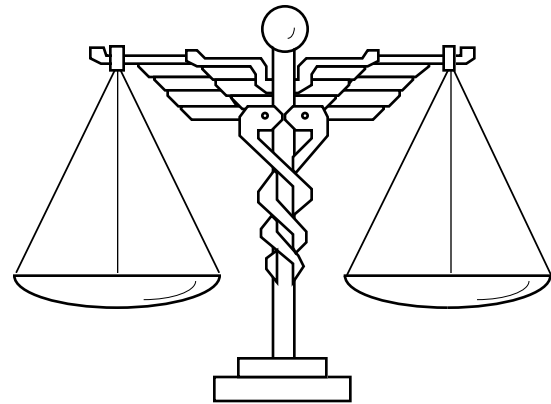
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*Challenges in Collecting Data on the un-insured  
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A third factor that limits the effectiveness of existing surveys on health insurance coverage is the differences in the time frames measured. Some studies determine the lack of health insurance at a single point in time (e.g., the date of the interview), while others may measure the lack of insurance at any point during some previous time period (e.g., anytime during the previous twelve months) or in terms of duration of un-insurance (e.g., number of months without insurance). These variations make the interpretation of survey results problematic and limit the opportunities for comparative assessments.

A final consideration related to the timing of surveys has to do with their frequency of implementation. Given the volatility of the insurance situation in many areas, the level of insurance coverage may change fairly rapidly. Survey data more than one year old may be considered seriously dated. Further, unless a survey is conducted over an extended period of time, trends in insurance coverage are not likely to be identified.

Because of these deficiencies, there are few reliable sources of information on the lack of insurance coverage at the state level and virtually none at the substate level. Given the importance of this issue for health planning, some more effective method of determining the level of insurance clearly needs to be developed. 🍎



## Seeking Balance: Public Interest vs. Private Investment

by Tom Piper, Missouri CON Director

The dicotomy of public perception amazes me . . . while complaining about the out-of-control escalation in health care costs, witnessing the collapse of businesses, experiencing the gutting of state budgets, and allowing the safety net for the uninsured to vanish, the conservative majority complacently stands by and claims that competition between providers will save money, increase access and improve quality. This “commodity” attitude is frightening at best, and destruction at its worst.

Health care should always be in the public interest, where we scrutinize carefully and demand high accountability and long-term investment. Instead, we seem to be rewarding short-term investment and profit-generating motives. The discipline and integrity of charitable institutions seems to be giving way to the greed and self-gratification of privatization, with notable exceptions.

As a consequence, community health planning and regulation is being constricted and strangled into ineffectiveness. Not only is public oversight being cut back, the data systems needed to monitor progress are diminishing. We are asked to trust in competition, but we can't measure their impact.

TRUST, BUT VERIFY . . . an old term used in the Cold War days to describe how we should watch other countries in the nuclear arms race. We need to restore cooperation and balance to our health delivery systems, and reinvest in our community support systems. 🍎