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# P/S/R/O Update

Boston University Medical Center

Northeast Edition

Number 9

June 3/75

The  
Medical  
Cost/Quality  
Newsletter

(PSRO Update this month sheds light on the novel and, to date, little known Public Law 93-641, the National Health Planning and Resources Act of 1974, which creates Health Systems Agencies. We begin below with a general overview of health planning since 1946. A separate article discusses HSAs and their relationship with PSROs. Finally, a PSRO Update Special Report provides deep background on HSAs and what they seek to accomplish.--Editor)

## Health planning efforts not new, but power to enforce them is

In 1944, Congress passed the Hill-Burton program to provide monies to the state for hospital bed construction and modernization. In the late '50s, areawide health-facilities planning councils supported by federal funds were established to coordinate and monitor local health-facilities development.

Congress in 1966 passed the Partnership for Health legislation, creating a new fed-  
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## Health Systems Agency network begins to form

The role of the federal government in American health care has been expanding in what is recognized as preparation for the implementation of national health insurance. Current activity centers around the establishment of a network of Health Systems Agencies to oversee the distribution of facilities in their designated Health Service Areas.  
(Continued on page 2)

## Federal PSRO policies bring calls for change, more local autonomy

Nagging issues concerning relationships between the federal government and PSROs emerged in New England during a two-day meeting held in Kennebunkport, Me., May 5 and 6.

In a nutshell, the emotional issues concerned the manner in which the federal government is implementing the PSRO program, with two key problems seen by the PSROs: the lack of administrative flexibility in budgeting; and the lack of local autonomy in

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## Autonomy of local PSROs under stress in conflict with DHEW directives

The inevitable irritations of growing pains enmeshed in the operation of DHEW bureaucracy are annoying PSROs in New York State, with widespread comment that local autonomy is under stress.

One specific source of irritation is the question of slotting; another is reimbursement for physicians' time in actual PSRO work. Some of the PSROs queried by PSRO Update indicated a roll-with-the-punch philosophy, conceding that he who controls the purse-strings calls the tune.

'NO ANSWERS THUS FAR'

Jack Coleman, executive director of the Genessee Region PSRO Inc., regards DHEW as wrong in its prohibition on slotting. "As  
(Continued on page 6)

AT PRESS TIME: FEDERAL JUDGE BARS JULY 1 IMPLEMENTATION  
OF HOSPITAL REVIEW PROGRAM — Story, Page 5

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## Health planning efforts now new, but power is

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eral health planning program to meet the problems of supply, quality and costs of needed health care services. The Comprehensive Health Planning Program made possible a network of voluntary state and regional health planning organizations to plan cooperatively with major health-care providers for future area health services. Later, Regional Medical Programs were developed as brokers to advance technology and skilled manpower at the institutional level for cancer, health and stroke research and treatment. The Experimental Health Services Delivery Program was also created to funnel monies available to underserved, depressed urban and rural areas to provide a basic health-delivery system to local populations.

### MILLIONS FOR 'MODEST EFFECT'

Since 1967, the federal government has invested \$249.1 million, matched by funds from state and local government and contributions from private-interest groups, in an effort to develop solutions to the major problems of health services delivery: prohibitive costs, lack of availability to major segments of the population and quality of services lower than that which is desirable and attainable. However, health planning has had a modest effect on the operation of the nation's health services delivery system.

For the most part, the relative changes that occurred over the 11-year period in areas with planning agencies were not very different from those that occurred in areas without them.

In the past two years, the federal and some state governments, eager to exert control over the rising cost of health service, have seized upon the comprehensive health-planning program as a mechanism for regulating the activities of health-care providers. Thus, while health planning itself is not new, the power of health planning agencies to enforce planning efforts is novel and marks the new hope for the program as it is transformed and reorganized under PL 93-641.

## Health Systems Agency network begins to form

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While PSROs monitor cost and quality of medical care in their regions, HSAs\* will be monitoring use and development of medical facilities under the new National Planning and Resources Development Act (PL 93-641).

Health officials encourage PSROs to work closely with Health Systems Agencies for a unified approach to planning concerning hospitals, nursing homes, home health care, mental health, public health, emergency care and neighborhood health centers.

Mechanisms like HSAs and PSROs must be in working order before any sort of national health care plan can begin. DHEW is trying to avoid repeating the mistakes of the early Medicare/Medicaid era, when the federal government released funds without having an adequate system to monitor their use.

"To assume that the American health-care system is now capable of delivering the additional care that would certainly be demanded if national health insurance were enacted, is, I believe, a dangerous and potentially disastrous mistake," Charles C. Edwards, M.D., former DHEW assistant secretary for Health, wrote in the March 13 New England Journal of Medicine. "The maldistribution of health providers, the excessive reliance on institutional care, and the absence of broadly effective systems of utilization review and quality assurance make it virtually certain that early adoption of national health insurance would be followed by enormous inflationary pressure and would lead to public demands for even more stringent federal control of the cost of health-care services and the manner in which they are provided...Clearly, the United States does not need a repetition of the experience of Medicare and Medicaid, but I have very serious doubts about whether our political leaders have really profited from that experience."

### PROPOSALS FOR BOUNDARIES

On May 3, governors of all the states were required to submit proposals to DHEW for the establishment of Health Service Areas in their states. Delineation of these territories was left to local planning experts. Regional and federal officials of DHEW are to review the proposals and designate the final boundaries of the Health Service Areas August 1.

New York, which has 12 PSROs, has proposed eight HSA areas; Connecticut, with four PSROs, is proposing five HSAs; Massachusetts has five PSROs, seeks six HSAs; Vermont, Maine, New Hampshire and Rhode Island each have a single PSRO and seek one HSA.

In determining the boundaries of Health Service Areas, local planners looked primarily

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# Progress Notes from the Northeast

P/S/R/O  
Update  
New England  
& New York

## New England

As the end of the fiscal year approaches, nine planning PSROs in New England move toward expected designation as conditionals, all hoping that their proposed budgets don't get chopped too heavily in the tough contract negotiations many expect to face.

### TIMETABLE, PROCEDURE

The timetable and procedure are approximately this: by mid-May the Secretary of DHEW had begun public notification that he intended to designate these PSROs as conditionals; doctors had 30 days in which to object to his choice, and if 10 per cent in an area did so, a polling of all eligible physicians had to be taken; if, in the polling, more than 50 per cent of these doctors protested the designation, then the Secretary could not designate the PSRO as conditional.

Since the PSROs in New England have enrolled more than 50 per cent of the doctors, it is unlikely that any PSRO will go to polling.

### CONTRACT NEGOTIATIONS

Assuming all nine PSROs receive designation as conditionals, there remains the problem of a contract between DHEW and each PSRO, not an automatic process, guaranteed by designation. The PSRO and DHEW must sign a contract for a specific amount of money in specific categories before any PSRO can actually become conditional.

If conditional status is achieved by these nine, it will bring the total at that stage to 11 in New England; BAY STATE PSRO in Boston and CHARLES RIVER in Newton, Mass., have already entered the second phase of conditional.

The two remaining PSROs are VERMONT and CENTRAL MASSACHUSETTS (in Worcester); their plans for conditional were submitted after the March 1 deadline, thus virtually eliminating them from consideration as conditionals in this funding cycle.

### Federal PSRO policies bring calls for change

(Continued from page 1)

organizational structure. For many, these spell uniformity and rigidity from Washington in a program that was supposed to be characterized by local responses to local conditions.

### ISSUES ARISING ELSEWHERE

The issues are not unique to New England: very similar complaints over the federal implementation of PSROs have surfaced in California, where the PSROs are talking about forming a confederation, and in the Northern Virginia PSRO, which has sent a scathing letter to Washington complaining of federal policy and methods.

Following the Kennebunkport conference, the New England group sent a telegram to Assistant Secretary for Health Theodore Cooper, M.D., asking for a reply within one week to a request for a meeting with him. Its tone is said to have been moderate, but urgent.

Participants agreed that the meeting was cathartic. Some felt it would produce changes in federal policy; others, more jaded in the ways of the federal government, saw it as useful for venting the spleen, but of little consequence in altering federal policy.

The disbursement of federal funds through contracts instead of grants has provoked the most indignation, since contracts are seen as too constricting for a program of professional peer review. (See separate article on Page 4.)

One specific point of concern has continued to be the lack of direction from Washington on a data policy, the development of which is thought to buttress the entire PSRO system, the lack of which seems to delay other areas of PSRO work.

### QUESTION OF SLOTTING

The question of slotting the boards of directors, to prevent domination by groups of doctors whose clout exceeds their numbers,

has continued to raise objections from PSROs that disagree with federal policy against slotting. Some PSROs would prefer the latitude to allow slotting in order to prevent an imbalance on the boards. The federal policy aims to leave all seats on boards of directors open to eligible members.

Reimbursement continues to be a thorny issue, with the federal government imposing a limit of \$35 an hour for physician work on committees and a total limit of 100 hours during the previous six months of planning status. Most PSROs feel this amount is inadequate for the work doctors must do, for example, on committees on norms, standards and criteria.

Another complaint heard from several PSROs is that DHEW is demanding changes in bylaws which amount to "nit picking"; the fear here is that Washington wants a uniform set of bylaws for the entire country. An example of this is the federal requirement that there be quarterly board meetings; when a New England PSRO board had a corporate resolution stating it would meet monthly, Washington judged it to be inadequate because the bylaws were not explicit.

#### WHENCE THE FUNDING?

A conflict mentioned less openly and less often concerns the relationships between PSROs and statewide support centers. The question of money and power takes the form of whether the support centers receive funding directly from the federal government or from subcontracts from the PSROs. The latter was thought to be the policy, according to a statement from Henry Simmons, M.D., outgoing director of OPSR, but the new mode of direct funding has apparently become policy in action.

This apparent change in policy has caused some difficulty for the Connecticut Medical Institute (CMI), the state support center, for it had not counted on drafting a proposal for direct funding; its support had been written into the proposals of the state's four PSROs. Then, with little notice, CMI had to put together a proposal for funding by May 21 to qualify for direct funding. The Commonwealth Institute of Medicine, the Massachusetts support center, on the other hand, is funded directly, and prefers it that way. Thus, it does not necessarily have to do the bidding of the PSROs.

#### A USEFUL 'VENTING'

The consensus from those who attended

the Kennebunkport meeting (11 of 13 New England PSROs plus two support centers) was that it was a useful meeting, giving PSRO professionals the opportunity to share ideas as well as grievances, without the presence of Washington officials. "It allowed people to vent their spleen," said one participant.

The post-meeting analyses ranged from comments about not having had the problems to begin with, to continued indignation at the way Washington treats the PSROs. One participant felt "schizophrenic" because, on the one hand, PSROs are demanding federal guidance in such areas as data policy, and on the other, are demanding a freer hand than the contracts will allow.

#### Grant or contract?

##### Depends on your goal

When the federal government decides to give money either to private organizations or to state (or lower) levels of government, it chooses one of two methods: the contract or the grant. Usually when there is a definite purpose to be accomplished, one that has identified goals or products, the contract is used. (PSROs are considered to have the definite purpose of keeping the quality of medical care high and the costs low.)

#### SPELLING IT OUT

Through the contract, the federal government can spell out its requirements in some detail and can expect the results to agree with its intentions. There is not much leeway in the contract form of dispensing money. Because of the specificity, the government usually publishes a Request for Proposal (RFP) that details requirements of a potential contract. Often only a single proposal will come in and the contract will be negotiated between the contracting organization and a contract officer.

Grants, on the other hand, are given for more general purposes, ones in which the outcomes may not be anticipated. This type of money will allow the recipient to go off on tangents to pursue a promising idea if the activities of the grant project seem to call for it. Most medical research falls into this category, where the product or outcome is uncertain. The grant allows far greater flexibility than the contract, and thus appeals more to many PSROs, which feel constricted by the specificity of contracts.

## New York

Another important step has been taken in New York State, with DHEW's announcement of its intention to enter into agreements with nine PSROs.

Those approved for conditional designation, subject to completion of negotiation and lack of objection by physicians, include Areas 1 (Buffalo); 2 (Rochester); 5 (Glens Falls); 9 (Westchester-Putnam); 10 (Rockland County); 11 (Manhattan); 13 (Kings County); 15 (Nassau County), and 16 (Bronx).

### MEMOS ON UR ROLE

Meanwhile, PSROs in the state are busy working on a memorandum of understanding on the question of hospital UR\* committees through a subcommittee discussing the matter with State Health Department officials (See PSRO Update, May). The PSROs had complained that the state people were seeking to infringe upon the PSROs' prerogatives in this area. Involved in the problem is the state's "NYSHUR" program, a UR program based on a computerized data system that collects information on Medicaid discharges from every hospital in the state.

Apropos of this, Eugene O'Reilly, project director of the NASSAU PHYSICIANS REVIEW ORGANIZATION, pointed out that the Nassau County Health Department has a health-statistics system developed under a federal grant, which could feed the state's "NYSHUR" program. "If 'NYSHUR' could go along, it could avoid duplication and save money," O'Reilly suggested.

The NASSAU PHYSICIANS REVIEW ORGANIZATION, meanwhile, is preparing to begin the process of evaluating hospitals for delegated utilization-review function. "We'll do it on a hospital-by-hospital basis (there are 16 hospitals in the county), and we'll decide whether the hospitals can handle the function," O'Reilly said.

Similar action is being taken by the KINGS COUNTY HEALTH CARE REVIEW ORGANIZATION. Sheryl Buchholtz, associate director, said that the Kings County organization would like to delegate the utilization review function to as many hospitals as possible.

Buchholtz said that the Kings County group plans next month to appoint to its advisory board a podiatrist, occupational therapist and pharmacist.

AREA 9 PSRO OF NEW YORK STATE will

start an experimental project in July under a Kellogg Foundation Fund grant to test concurrent review, to see if this review will result in better care, according to Michael Maffucci, executive director. "We'll pick five disease categories and monitor the patients from the time they enter the hospital, and will feed back this information against certain criteria," Maffucci said. "Three of the six hospitals involved in the project will serve as controls."

### REIMBURSEMENT ISSUE

In Buffalo, the ERIE REGION PSRO, INC., is contacting hospitals on UR plans, with most of the 38 hospitals desiring to be delegated, according to Warren Mutz, program director. "Reimbursement for the utilization review work is a big problem," Mutz said. "This question of reimbursement for UR has not been delineated by either the federal or state people."

Much to its surprise, the FIVE-COUNTY ORGANIZATION FOR MEDICAL CARE & PSRO found that "quite a few" of the 13 hospitals want the PSRO to handle the UR, according to Russell H. Feltus, managing director. "We were quite surprised," he said.

Feltus said that the PSRO is conducting a pilot study at St. Luke's Memorial Hospital in Utica, to analyze work of nurse-coordinators."

### FEDERAL JUDGE BLOCKS

#### JULY 1 UR IMPLEMENTATION

In a move supporting the American Medical Association's challenge of the constitutionality of new UR regulations, a U.S. district court judge May 27 granted a preliminary injunction blocking the July 1 implementation of the DHEW requirements.

The AMA filed suit--their first against the federal government--last Feb. 20. The plaintiffs questioned the authority of the DHEW Secretary to begin operating UR committees that would conduct admission review of Medicare/Medicaid patients within 24 hours of admission.

The AMA protested the participation of nonphysicians in medical decisions. The group also contended that the regulations would violate the constitutional rights of physicians and patients.

In his ruling, Judge Julius J. Hoffman held that the regulations would "significantly interfere with a patient's right to medical treatment" and that the 24-hour review period would "delay and unnecessarily complicate medical matters and result in perceptible injury to patients."

\* UR--Utilization Review

## Autonomy of local PSROs stressed by conflict with DHEW

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we see it, representation of each county is important," he said. "DHEW doesn't see it that way." Coleman added: "We consider DHEW as strict constructionists. We've appealed two or three things, and have gotten no answers thus far."

Harry Feder, executive director of the Bronx Medical Services Foundation Inc., said that the issue of representation has not been resolved. "We've been told: no slotting," he said. He added, "We don't want any one organization to control any election." Feder pointed out, as a hypothetical illustration, that an organization such as the Committee of Interns and Residents (CIR) in New York City, with more than 3,000 hospital house-staff members, could control an election. He hastened to add, however, that CIR has been quite helpful in aiding the PSRO.

Feder said he had been fortunate in his own relationships with some cooperative DHEW individuals. "We disagree once in a while," he said. "Of course, they pay the dollars, they control it..."

On the other hand, Russell Feltus, managing director of the Five-County Organization for Medical Care & PSRO, said he had had "no problems with DHEW."

Warren Mutz, program director, Erie Region PSRO Inc., declined comment at first on local autonomy, but did say, "Everybody is up in arms about slotting."

## A SORE POINT

Reimbursement is a sore point for the Area 9 PSRO of New York State. "The feeling is that the amount of money for physician reimbursement for doing actual PSRO work--not just coming to meetings, but real work on PSRO guides and criteria, etc.--was not forthcoming," Michael Maffucci, executive director, said. "The point is, the physicians' input is needed, but they're cutting the funds for physicians down to a third of what we asked for. There's a feeling that DHEW wants the physicians to work for nothing."

From the Kings County Health Care Review Organization came the comment that DHEW is "boiler-plating many ideas." DHEW is following a "rigid, bureaucratic line," with everything "being pressed into one form," according to Sheryl Buchholtz, associate director. For example, DHEW wants, as

identifying code numbers, the Social Security numbers of every physician in the PSRO, she said.

Eugene O'Reilly, project director of the Nassau Physicians Review Organization, said that there is a feeling that DHEW seems to be getting into areas of local autonomy and attempting "preemption of local prerogatives...the preemption comes in different ways," he said. It is done through regulations, for example, he added.

## Level of PSRO funding brings question about the intent of Congress

The failure of Congress to appropriate enough money for the needs of PSROs raises questions about the intent of that body, Ernest W. Saward, M.D., chairperson of the National Professional Standards Review Council, declared at the annual health conference of the New York Academy of Medicine. The theme of the conference was "The Professional Responsibility for Quality of Health Care."

"The present main problem has to do with the fundamental dichotomy as to the purpose of the (PSRO) Act," Dr. Saward said. "In its wisdom Congress did not appropriate enough money. If funds had been fully implemented, it was the intent to convert many of the 91 planning PSROs to conditional PSROs and to cover as many as 203 designated areas that wished to apply by 1976.

"The funds appropriated are apparently deliberately calculated not to accomplish this goal. It's a sheer surmise as to what the intent of the Congress really is, but some would see it as an attempt to evaluate what a few PSROs would accomplish before national implementation, despite the original congressional mandate to apply to the entire nation."

Projecting toward the year 2000, Dr. Selma Mushkin, professor of economics and director of the public service laboratory at Georgetown University, said, "Unless care is taken to avoid rigidity, reform will be needed to free the medical market from undue restraints of PSROs."

Dr. Mushkin said that while improved quality of care may be achieved and questionable surgery all but eliminated by the year 2000, advances in therapy, as well as new research, may have been slowed down.

(The proceedings of the conference will be available in September, 1975. Information may be obtained from the Committee on Medicine and Society, New York Academy of Medicine, E. 103rd St., New York, N.Y.

## Health Systems Agency network begins to form

(Continued from Page 2)

ily at the geographical representation of physicians and patients in medical facilities. Other factors studied were total population and standard metropolitan statistical areas (SMSAs). They were to try to avoid splitting SMSAs as well as PSROs, and to include at least half a million people in each Health Service Area.

If a proposal for an Area could not meet those conditions, it went to DHEW with an application for a waiver of requirements. Local planners expect territory delineations in compliance with the National Health Planning and Resources Development Act to meet easy acceptance; they predict DHEW will spend most of the time between May 3 and August 1 considering the waiver applications.

### PROBLEMS: DATA COORDINATION

In Massachusetts, for example, Governor Michael S. Dukakis recommended the establishment of six Health Service Areas, roughly meeting the guidelines set in the Act. All six, however, deviated slightly from the SMSAs, and one includes fewer than 500,000 people. PSRO boundaries, also, could not be respected exactly, but local officials see no serious difficulties in establishing cooperation between PSROs and Health Systems Agencies in overlapping areas. The biggest problem they foresee involves data coordination. Planning would necessitate cooperation between two pairs of PSROs and Health Systems Agencies rather than one.

In making their decision, Massachusetts officials had to weigh the arguments of two concerned groups. One was the West Suburban Hospital Association, which was opposed to the inclusion of Boston's suburbs in the metropolitan Health Service Area. The Association lost its fight when the state decided not to isolate Boston by making it an Area in itself. The other group that eventually lost was the city's teaching hospitals. That group lobbied for fewer, larger Health Service Areas to give what it felt would be a broader base for tertiary-care planning.

### SEEKING HSA DESIGNATION

After DHEW announces the boundaries of the Health Service Areas in August, health-planning groups within the Areas may apply for recognition as Health Systems Agencies. The Agencies, which can be set up as non-profit entities or as branches of local government, will be complex mechanisms for the organization of area, state and federal ac-

tivity in health planning. They will assess needs, develop health plans, and make assignments for future development of facilities. They will review all funding proposals, administer grants and contracts, and make recommendations about the Area's allocation of health-care facilities.

Health Systems Agencies will determine the medical-facility distribution goals for their Areas and regulate the development of resources by individual medical providers. The Act requires that a majority of each Agency's board consist of consumers, the remainder to consist of physicians, medical administrators and health planners.

The next step in the establishment of a successful mechanism for health-facility planning, after Health Service Areas and Health Systems Agencies are designated, is to formulate guidelines and regulations for them. Until that time, the implications of the National Health Planning and Resources Development Act cannot be fully analyzed. The DHEW timetable calls for Health Systems Agencies to be operational by July 1, 1976.

### Federal court ruling upholds PSRO law after AAPS challenge

A decision was handed down by a three-judge federal panel in the U.S. District Court for Northern Illinois upholding the PSRO law as being constitutional. The challenges brought against the law were raised in a suit brought by the American Association of Physicians and Surgeons. The AAPS argued that the PSRO law is unconstitutional in that it deprives physicians of the right to practice their profession, interferes with the physician-patient relationship, and constitutes an invasion of privacy.

The court ruled that the PSRO law "does not bar physicians from practicing their profession but only provides standards for the dispensation of federal funds." Denial of payments are not final but can be pursued through an appellate system, thus ensuring that the concept of procedural due process (as embodied in the Fifth Amendment) is upheld.

The court stated that the law does not infringe upon a physician's right to practice but "it merely provides that if a practitioner wishes to be compensated for his services by the federal government, he is required to comply with certain guidelines and procedures enumerated in the statute."

The AAPS plaintiffs argued that the PSRO system of norms of care, diagnosis

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**Overhaul of OPSR  
appears imminent;  
Fund deadline looms**

WASHINGTON, D.C.--The details are not known yet, but the long-awaited, much-discussed reorganization of the PSRO program's administrative structure will go into effect this month -- maybe.

DHEW's new Assistant Secretary for Health, Theodore Cooper, M.D., hopes the reorganization can be implemented between the departure of Deputy Assistant Secretary Henry E. Simmons, M.D., on June 1, and the beginning of the new fiscal year on July 1.

**CHANGE IS CERTAIN**

Meanwhile, although no details of the reorganization are being released until after Simmons leaves for his new post with the J. Walter Thompson advertising organization, one thing is fairly certain: OPSR will not survive in its present form.

It is not yet known whether OPSR's coordination, evaluation, and oversight functions will be shifted to the Bureau of Quality Assurance in the Health Services Administration or will remain in part within the office of the Assistant Secretary for Health.

Much will depend on the degree of importance the new Assistant Secretary places on the federal government's quality assurance program -- and Dr. Cooper hasn't said very much about that as yet.

He did say that he intends to replace Simmons, but some OPSR staff members question whether that decision will still hold once Simmons has left. Simmons' departure will give Cooper much more latitude for his reorganization plans, and that is thought to be one reason for holding back any announcement.

Until some decisions are announced, there is no way of assessing any effects that reorganization might have on PSROs in the field.

Although OPSR is in a state of organizational limbo, the day-to-day work continues as usual as the program races down to the fiscal wire -- June 30.

One of the worst things that can happen to an agency trying to persuade Congress to increase its appropriations is that it end the fiscal year with money left over.

It happened to OPSR last year, and to

avoid a recurrence of that situation, OPSR has announced FY-1976 funding for 20 new planning PSROs, together with notification of its intention to fund 50 new conditional PSROs.

The problem, as one OPSR staff member told PSRO Update, is that if any of the conditionals have to go into a polling situation, there is no way they can be funded in this fiscal year.

**Federal Court ruling  
upholds PSRO law**

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and treatment would have an adverse effect on the doctor-patient relationship. The court stated that the argument was premature, in that norms had not been developed; it further reasoned that while reducing norms to specific language was a difficult task, it was one that had been accomplished successfully in a number of private medical utilization programs.

**'PRIVACY' ARGUMENT REJECTED**

The court rejected the claim that the requirement in the PSRO law for physicians to supply information concerning their patients is in violation of a constitutional right of privacy. "The challenged legislation in the instant suit seeks information for a legitimate governmental purpose. The manner in which the information is gathered and maintained is reasonable...The legislation contains provisions that properly balance the plaintiffs' right of privacy with the government's interest in maintaining proper health care in an economical manner."

**CONSTITUTIONALITY UNSETTLED**

The theme that underlies the decision is the notion that the PSRO law preserves a proper balance between the interests of physicians and other providers and the government's interest in providing proper medical care to those most in need of it. While the decision upholds the PSRO law on its face, the court ruling does not deal with the constitutionality of the application of this statute. It seems fairly certain that the AAPS will attempt to appeal the decision, perhaps directly to the Supreme Court.

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