



**association of american
medical colleges**

**AGENDA
FOR
COUNCIL OF DEANS**

ADMINISTRATIVE BOARD

**WEDNESDAY, APRIL 15, 1987
6:00 PM - 7:00 PM
MONROE WEST**

**THURSDAY, APRIL 16, 1987
8:00 AM - 12:00 PM
HAMILTON ROOM**

**WASHINGTON HILTON HOTEL
WASHINGTON, DC**

**COUNCIL OF DEANS
ADMINISTRATIVE BOARD MEETING**

Washington Hilton Hotel
Washington, DC

AGENDA

Wednesday, April 15, 1987

6:00 p.m. - 7:00 p.m.

Monroe West

Joint Administrative Boards Session

*Guest Speaker: C. Everett Koop, M.D.

7:00 p.m. - 10:00 p.m.

Monroe East

Reception & Dinner

Thursday, April 16, 1987

8:00 a.m. - 12:00 p.m.

Hamilton

COD Administrative Board Meeting

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C. Membership of AAMC Task Force on Physician Supply
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D. Status of New York Legislative Action On NBME Eligibility Policies
(Oral)

E. NSF Proposed Misconduct in Science Policy
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VII. OSR Report

VIII. Old Business

IX. New Business

X. Adjourn

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

January 22, 1987
8:30 a.m. - 12:00 p.m.
Caucus Room

Washington Hilton Hotel
Washington, D.C.

PRESENT

(Board Members)

L. Thompson Bowles, M.D., Ph.D.
William Butler, M.D.
D. Kay Clawson, M.D.
Robert Daniels, M.D.
William B. Deal, M.D.
Louis J. Kettel, M.D., Chairman
Walter F. Leavell, M.D.
John Naughton, M.D.
Richard Ross, M.D.
Henry Russe, M.D.
W. Donald Weston, M.D.

(Guests)

Vicki Darrow
Kimberly Dunn
Edward J. Stemmler, M.D.*
Virginia Weldon, M.D.*

ABSENT

Hibbard E. Williams, M.D.

(Staff)

David Baime*
James Bentley, Ph.D. *
Janet Bickel
Debra Day
Paul Jolly, Ph.D.
Robert F. Jones, Ph.D.
Thomas J. Kennedy, M.D.*
Joseph A. Keyes, Jr.
Robert G. Petersdorf, M.D.*
James R. Schofield, M.D.
John F. Sherman, Ph.D.*
August Swanson, M.D.*
James Terwilliger*
Kathleen Turner*

*Present for part of meeting

I. CALL TO ORDER

The meeting was called to order at 8:30 a.m. by Louis J. Kettel, M.D., Chairman.

II. CHAIRMAN'S REPORT

Dr. Kettel reported that the Executive Committee had met and received a report from Dr. Petersdorf on the reorganization of AAMC staff and a report on the progress of discussions on the relationship between the AAMC and the AAHC. Dr. Petersdorf was to be available later to discuss these issues with the Board.

Dr. Kettel also reported that the AAMC officer's retreat focused on the results of the constituent survey. It was also decided that the theme for the 1987 Annual Meeting would be physician supply.

III. APPROVAL OF MINUTES

The minutes of the September 10-11, 1986 meeting of the COD Administrative Board were approved as submitted.

IV. REPORT OF THE PRESIDENT

Dr. Petersdorf outlined for the Board his plan for staff reorganization. His intention in developing the plan was to rectify perceived weaknesses in the current organization and areas of dyshomeostasis, as well as to allow the AAMC to branch out into new endeavors. The plan featured a centralized Office of Government Relations within the Office of the President and five separate Divisions of Biomedical Research, Academic Affairs, Clinical Services, Institutional Planning and

Development, and Public Affairs. Vice-presidents to head up the Divisions of Biomedical Research and Public Affairs were to be recruited. The Department of Academic Affairs would assume staffing responsibility for the Council of Deans, and an associate vice president was to be recruited for that division under Dr. Swanson's leadership. Two new groups were to be added to the membership structure including the Group on International Relations and a Group on Practice Plan Administrators. The new plan featured a matrix organization in which there was to be a looser relationship between the functional areas and the Councils such that staff for each functional area could truly be in a position to serve every Council.

V. ACTION ITEMS

A. Establishment of a Joint AAHC/AAMC Forum

Dr. Petersdorf also described for the Board the major features of a document which provided for the establishment of an on-going Forum between the AAMC and the AAHC. The Forum was proposed after it became clear that it was not now possible to structure a merger of the two Associations. Members of the Forum, which would include the chairmen, chairmen-elect and presidents of the two Associations, as well as other appointed members, would meet three times a year in conjunction with one of the two organization's established meetings. The purpose of the Forum was to discuss areas of common interest such that the two organizations could speak on one voice on major policy questions. The Forum was established with a "sunset" clause, providing for a three year life. One outcome of the Forum not to be excluded was the possibility of a formal merger at that time.

Action: On motion, seconded, and unanimously approved, the Board approved the plans for establishment of a joint AAMC/AAHC Forum.

B. Health Manpower Initiative

Dr. Petersdorf also described a staff plan to develop a task force which would be charged with reviewing physician supply and production. It would consider the manpower mix required for providing services in teaching hospitals, facilitating access to health care services, and assuring a sufficient number of appropriately trained researchers in the biomedical and behavioral sciences. This proposal had been discussed at the Officer's Retreat. It was hoped that the work of the task force and its subcommittees might lead the Association to a policy statement on the physician supply question.

The Board expressed its support for the direction of this initiative and advised only that there needed to be appropriate and adequate representation of all interested parties in the work of the task force.

C. AAMC Position on NBME Score Reporting

The Board revisited the actions, taken at its June and September, 1986 Board meetings, endorsing a pass-fail only score reporting system for the NBME examinations. Based on the discussion at the Council business meeting in October which showed that Council members were evenly divided on the question and reports from other Councils and Groups which showed that there was little in the way of consensus on this issue, the Board decided it could no longer support the position taken.

Action: On motion, seconded, and passed unanimously, the Board voted to rescind its previous action that the AAMC should encourage the National Board of Medical Examiners to report its examination scores solely on a pass-fail basis.

Ms. Darrow thanked the Board members for their work in bringing this issue to the fore. She reaffirmed OSR's support for the pass-fail only score reporting system. Board members opined that the NBME score reporting issue will continue to be discussed and debated, and that this particular vote did not preclude the deans from developing a consensus in support of the position in the future.

D. Impending New York Legislation and the NBME

The NBME had been asked by the New York deans to consider a revision of its policy limiting access to the Part I and II examinations to students and graduates of LCME-accredited schools. Legislation likely to be adopted in New York in the current year would prohibit the use of the NBME as a licensure exam unless that limitation was removed. The AAMC had been asked by the NBME to express its view on such a change.

In the discussion, Dr. Stemmler interpreted the NBME's position regarding licensure as recognizing the incompleteness of the examination without the corresponding evaluation by faculties of LCME-accredited schools. He argued that the AAMC must defend as a matter of policy the importance of LCME accreditation in licensure and certification. Dr. Bowles, with Dr. Stemmler a member of the NBME's Executive Board, concurred, stating that it was preliminary sense of the Executive Board that this was a situation in which the principle outweighed any revenue loss potential. Dr. Naughton described the history of negotiations

between the New York deans and legislative staff on this issue and advised that the AAMC avoid becoming involved in what was perceived by many to be a state issue. The Board concluded that it should take no position on the issue at this time.

E. Treatment of Residents and Fellows for GSL

The AAMC's Committee on Student Financial Assistance had asked the Executive Council to issue a strong statement discouraging the practice of treating residents as students for the purpose of deferring payment of GSL loans. The Committee feared that widespread publicity of these activities would reap adverse consequences for students and schools. This advice was countered by a fear that AAMC condemnation of the practice would make the offending schools even more vulnerable and that it was appropriate for each school with the legal advice at its disposal to determine its own policies.

Action: On motion, seconded and passed unanimously, the Board approved a staff recommendation to send the information report prepared by staff on this agenda item to all member schools and medical student financial aid officers.

F. Final Report of Transition Committee

The Board reviewed the final report of the AAMC Committee on Graduate Medical Education and the Transition From Medical School to Residency. Dr. Clawson expressed disappointment that a stronger statement regarding earliest date for the release of deans letters and transcripts could not be made but acknowledged the problems in achieving that consensus. Dr. Swanson express optimism that further discussion toward this end

could take place at the spring meeting. He also noted tht an original recommendation that the LCME monitor the extent to which a school's students take additional electives in a specialty was not in the final report. Dr. Schofield responded that the LCME was currently asking questions and exerting its influence on this issue to the extent it was able.

Action: On motion, seconded and passed unanimously, the Board accepted the Committee report.

VI. DISCUSSION ITEMS

A. Taxation of Unrelated Business Income

Mr. Keyes reviewed the law on taxation of unrelated business income in the context of Rep. Dan Roostenkowski's (D-IL) intention to hold hearings as part of a comprehensive review of the area. He asked the deans to review their own institution's policies and procedures and to provide information to staff on the extent to which the tax-exempt status of their activities required clarification under the law. The Association was reluctant to engage in a formal survey but was interested in the extent to which current activities were a cause of concern. The deans agreed to write to or call Mr. Keyes and Dr. Kennedy with information.

B. Medical Care for the Indigent

The Board considered a position paper adopted by the Midwest deans on the role of academic health centers in the care of the medically indigent. AMA and AHA initiatives with regard to indigent care were also provided. The question to the Board was whether the AAMC should assign

the problem of indigent care a higher priority on its agenda and what role it should play.

Dr. Bentley observed that price competition in health care delivery had made this issue more acute and that a fundamental tension in all discussions of the topic was whether simply funding was needed or a new and better organization of health care delivery. He cautioned that there was some hyperbole in the presentation of data showing an increase in charity care provided, since they were based on charges rather than costs, and emphasized that indigent care must not be viewed as one problem but a series of problems specific to different subpopulations.

An argument in favor of a more pro-active AAMC stance was academic medical center hospitals and clinics may inherit an even greater proportion of this and that an offensive strategy to secure funding for these services, perhaps through the development of model legislation may be wise. A coalition task force, involving the AMA and AHA was also proposed, in acknowledgement of the magnitude of the issue. However, some skepticism was also expressed about the effectiveness of a national initiative on an issue that tended to be local in nature. The Board concluded that there were multiple issues involved, academic medicine's social responsibility, the preservation of a diverse patient base for teaching and research, and concerns about funding and reimbursement. It decided that the Midwest deans had proposed an important agenda item that the Board should consider further, after Dr. Bentley and staff in the Division of Clinical Services provided further analysis.

C. Memberships and Organization of Groups

The Board discussed a concern that the membership expansion of AAMC Groups and proliferation of Group meetings were presenting problems for the deans. Several Board members described the difficulty they had in approving travel requests of all of their staffs who were interested in attending Group meetings and functions. The value of these meetings to those who participate, for professional development and exchange of ideas, was also noted. Dr. Kettel observed that the number of meetings being sponsored had cost and time implications to AAMC staff as well and recommended that as a first step toward further exploration of this issue staff conduct an internal analysis.

D. COD Spring Meeting

The Board reviewed plans for the 1987 spring meeting at the Stouffer Wailea Beach Resort in Maui, Hawaii. The Board rejected proposals for either a private luau theme dinner or participation in the hotel-sponsored guest luau, in favor of a less extravagant private dinner. It also reviewed Board member assignments for discussion groups and the telephone network and suggested that Board members contact those in their groups who had not registered for the meeting to encourage them to attend. Ms. Day would provide this information.

Dr. Bowles suggested that policies regarding payment and reimbursement for recreational activities be clarified and communicated to the members at the beginning of the meeting.

E. 1987 Annual Meeting Social Event

The Board reviewed proposed sites for the COD annual meeting dinner and advised staff to avoid an extravagant affair and search for a private room in a nice restaurant. It was suggested that the "Capitol Steps," a political satire and singing groups, be considered to provide entertainment.

Dr. Kettel described the revised annual meeting format which included an opening session at 4:30, Sunday afternoon, and a plenary session on Monday morning. Monday afternoon would feature a joint Council session on the meeting theme of physician supply, followed by Council business meetings. The COD dinner would take place on Monday evening.

VII. OSR REPORT

Ms. Darrow stated the OSR annual meeting theme would be perspectives on the role of medicine in society. It was working with the GME on being included in that group's computer network and with Dr. Swanson on AAMC initiatives to promote problem-based learning. Students had spent that morning on Capitol Hill to talk with legislative staff on issues of concern. The OSR was quite pleased with the plans for the COD spring meeting.

VIII. ADJOURNMENT

The meeting was adjourned at 11:50 a.m.

ORGANIZING THE GROUP ON FACULTY PRACTICE

Background

The AAMC Division of Clinical Services has been established to serve the needs of teaching hospitals, clinical faculty and faculty practice plans. While the existing Councils of Teaching Hospitals and Academic Societies provide the frameworks for addressing the concerns and problems of hospitals and clinical faculties, no single organization exists within the AAMC to address the needs of faculty practice plans. The AAMC reorganization plan envisions addressing the problem by developing a Group on Faculty Practice as an AAMC membership group for practice plan representatives.

In order to develop a membership group for faculty practices, three questions must be addressed:

- o What should be the institutional role of the individual belonging to the Group on Faculty Practice?
- o How should faculty practice plans be distinguished from general group practices or medical education foundations in teaching hospitals generally?
- o How many individuals from each practice plan should be included in the group?

Discussion

Faculty practice plans may be thought of as having three operational levels: a board of directors, an administrator, and a staff of administrative and clerical personnel. For the AAMC Group on Faculty Practice to function effectively, the membership of the group must share similar organizational perspectives. Therefore, individuals named to the group should have similar roles in the practice plan. The role of the board chairperson for the practice plan is highly varied across medical schools. Some chairs are elected by the plan members or the board; others are appointed to the positions. Still other chairs acquire the role because of another position they hold in the university's administrative structure. The involvement of plan chairpersons is also quite variable. Some chairs have an actively operational interest; others preside at board and annual meetings. Because of the variation in the role of board chairpersons, it is recommended that the Executive Council:

authorize establishing a new membership group, the Group on Faculty Practice, comprised of the administrators (or equivalent) of faculty practices.

Structured plans which bill for physicians' services and which collect and distribute resulting revenues exist in most medical schools and in many teaching hospitals. The physicians involved in these plans may include:

- o full-time faculty,
- o part-time faculty with clinical teaching appointments,
- o voluntary, attending physicians who assign fees for patient services provided in the teaching hospital.

The size, scope and interest of the Group on Faculty Practice will depend upon the number of plans included and the types of physicians involved in the plans. The primary interest of the AAMC is to develop a membership group of plan administrators in academic medicine. This emphasis can be diluted and the usefulness of the group diminished by involving a large number of practice groups consisting primarily of faculty with only clinical appointments or voluntary faculty. The dilution of interest and usefulness can be limited by establishing the Group on Faculty Practice with individuals representing plans composed primarily of full-time faculty. To ensure the emphasis on faculty practice in the Group, it is recommended that the Executive Council:

approve limiting the membership in the Group on Faculty Practice to plans representing full-time faculty.

In many medical schools, the faculty practice plan is either a single plan for all disciplines or a plan of federated disciplinary plans. In other medical schools, each department and perhaps each section has its own freestanding plan with its own staff. The Group on Faculty Practice will have a clear focus addressing the full array of relevant issues if it is comprised of: (1) institutional representatives with responsibility for the organization, committees and programs of the Group and (2) personal members welcome to attend and participate in open meetings of the Group. Therefore, it is recommended that the Executive Council:

approve limiting institutional representatives in the GFP to a single representative per LCME accredited medical school with the dean selecting the GFP representative.

Where an LCME accredited school does not have a practice plan within the framework of the school, a hospital plan may be named by the dean for each hospital in which the majority of the hospital's chiefs of service are chairpersons in the school's clinical departments. When a dean designates a hospital plan in the absence of a school plan, the hospital's chief executive officer would be asked to nominate an institutional representative.

Once the institutional representatives are selected and the Group on Faculty Practice is operational, it is recommended that the Executive Council:

approve allowing deans and hospital CEOs to name additional personal members who -- because of their roles in the medical school, clinical department or hospital -- are actively involved in administering the full-time faculty's clinical practice.

Recommendation

That the Council of Deans' Administrative Board discuss this draft agenda item at the Board's April meeting so that this item, or a revision, is included on the Executive Council agenda in June.

DEANS SOCIAL EVENT AT ANNUAL MEETING

The traditional deans' reception and dinner at the Annual meeting has been scheduled for the evening of Monday, November 9th.

Staff are currently searching for entertainment and a private room in a nice restaurant. The Old Ebbitt Grill, founded in 1856 and Washington's oldest restaurant, is being considered as the site.

Update on AAMC Group on Medical Education
Electronic Conferencing Network on
CONFER Conferencing System

The purposes of the conferencing system (AAMC:GMED) are:

1. To provide timely medical education news items for AAMC.
2. To continue information exchange begun at national/regional meetings.
3. Electronic communication to supplement telephone and letters.
4. To locate "experts" (i.e., experienced) with specific skills and knowledge.
5. To conduct small group meetings.
6. To provide an information resource of work-in-progress.
7. An open forum to discuss medical education issues.

The system features 4 modes of communication:

- 1) private NOTES
- 2) MESSAGES to individuals
- 3) public BULLETINS to every participant
- 4) discussion ITEMS

There are currently 32 ITEMS on the conference, the index of ITEMS follows:

Teaching in ambulatory settings	Questions about CONFER features
Miscellaneous	NGME: Discussion items for Northeast
WGME: Discussion items for Western region	CGME: Discussion items for Central
SGME: Discussion items for Southern region	Medical School Administration
Announcements - CME, Workshops	Multi-Center Proposals
Problem-Based Learning	Program Development
Program Evaluation	NBME
Testing and Grading	Advising and Counseling
Computers in Medical Education	Curriculum Evaluation
Evaluating Faculty Contributions	Student-Centered Learning
Curriculum Change	Faculty Development
Problem Student	Electives
Clerkships	ICM Courses
Basic Sciences	Deleted Items
Retired and Updated Items	

An example of the content of one discussion item is attached.

How is CONFER accessed?

The CONFERENCE is accessed through a local Telenet number. Some cities or towns do not have a local Telenet number and add a long distance call charge to the closest Telenet number or direct dial to Michigan.
The cost is \$.25 per contact minute prime time, telecommunication charges included.

The average costs per month are: frequent user: 30+ minutes per week = \$50.00
moderate user: 15-20 minutes per week = \$21.00
infrequent user: 5-10 minutes per week = \$8.50

There are currently 45 active participants, representing 39 medical schools and the American Board of Internal Medicine. A list of those participants is included.

Since November 10, 1986 there have been:

- o 734 messages sent
- o 752 items displayed
- o 186 responses made
- o 1286 sets of responses seen, and
- o 4597 DO NEXT? prompts issued

Item 29 15:15 Feb06/87 11 lines 4 responses

Michael Ravitch
COURSE SYLLABUS

COURSE SYLLABUS -- means something different to each student and faculty member at our institution. We'd like your help in thinking about what syllabi are for and how to manage syllabi in the educational program.

1. What is a syllabus at your institution?
2. Do you have guidelines regarding:
 - a. the form of the syllabus (length, detail, "objectives", etc.)
 - b. whether courses must have a syllabus
 - c. whether courses must have a syllabus if the course closely follows a text book
3. Who pays for the syllabus? if students, how extensive is the syllabus and how much are they charged?

4 responses

Feb07/87 07:50

29:1) Clyde Tucker: Michael, In typical Colorado "free spirit" we have no restrictions or guidelines! Totally left to the discretion of the Department and course director. Some Departments provide the material free to the students but that decreases in frequency each year as budgets get tighter. Several departments are now selling the syllabi to students through the book store but it is entirely at the discretion of the department as to what they include. Some provide no Syllabus at all.

Feb07/87 15:46

29:2) David Altman: Mike, the syllabus is a source of considerable discussion and controversy here. No guidelines are currently provided, and like Coloradans we Californians are pretty free spirited too. There is no consensus among either faculty or students about what form a syllabus should take. I am working with the courses so that we can avoid the all too easy mistake of having syllabi which simply reproduce lectures. As we reduce lecture hours this should become less of a problem and the purpose of a syllabus should become better defined. One problem here is tied to the evaluation process, as in those courses giving multiple-choice exams. Students are often told that the test will be based on that which is in the syllabus. As for cost, most depts. are selling the syllabus in our book store to defray the production costs. No objection on this from students as the tradition has been established. Finally the dean would like to see all syllabi banned. Not much support on this from course directors.

Feb08/87 12:54

29:3) Alberto Galofre:

Similar situation for us Mike. Syllabi are required by present policy. Quality uneven as judged by students. Given our lecture oriented curriculum students prefer a complete, well written text. Some faculty would prefer abolition of syllabi and note-taking service with more class attendance and reliance on textbook learning.

Feb08/87 14:38

29:4) Michael Ravitch: It seems that we have hit upon problems and issues at Northwestern that have their counterparts at other medical schools. Our students want complete, well organized syllabi, complete with illustrations and tables, identical to the lectures, covering all and only what will be tested, and provided free of charge (of course). I am sure we will develop internal policies within the next year or 2 (even the policy of the Western Territories that departments/courses may do as they please).

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FUTURE MEETING DATES

1987 Meeting Dates:

Executive Council/COD Admin. Board -

June 17-18
September 9-10

AAMC Annual Meeting -

November 7-12
Washington Hilton Hotel
Washington, DC

1988 Meeting Dates:

Executive Council/COD Admin. Board -

January 13-14
April 6-7
June 22-23
September 7-8

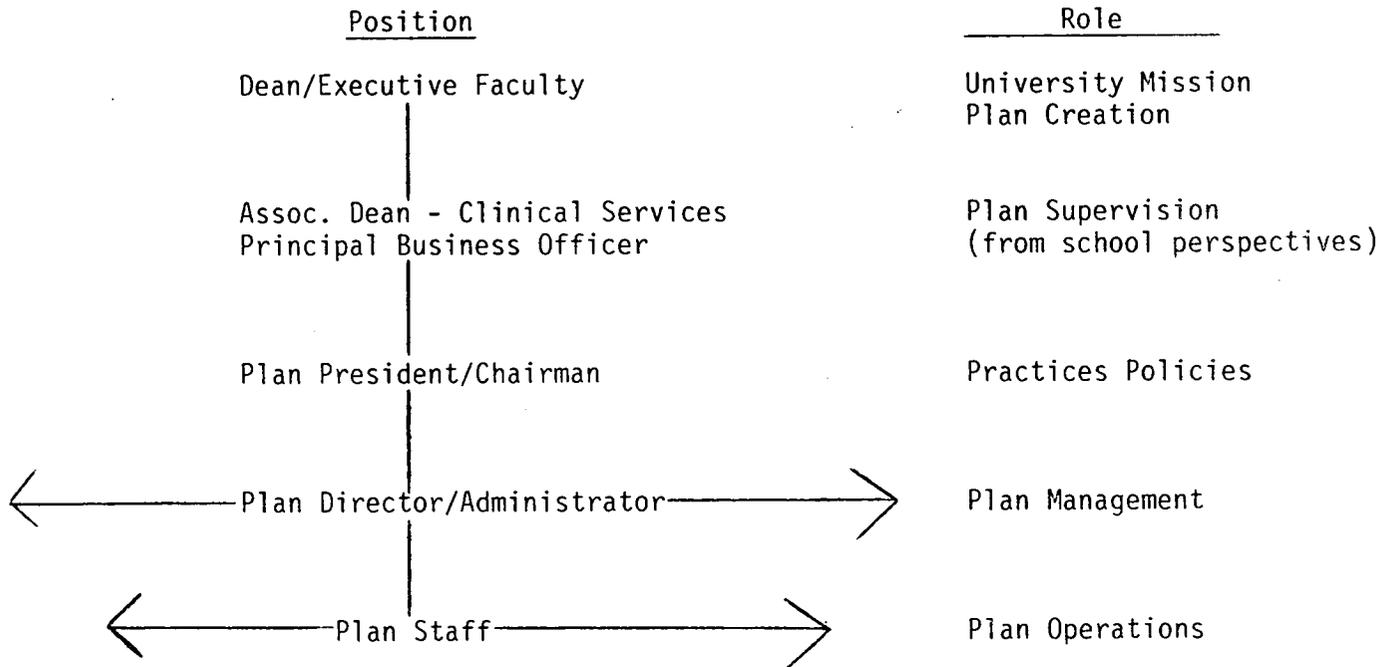
AAMC Annual Meeting -

November 12-17
Hilton Hotel
Chicago, Illinois

COD Spring Meeting -

March 19-23
Inter-Continental Hotel
Hilton Head Island, So. Carolina

Describing Levels of Practice Plan Personnel



Handout
COD Ad Board
April 16, 1987

GOVERNMENT RELATIONS UPDATE

Budget

Significant action has now occurred in both chambers. On April 9, the House approved by a vote of 230-192 H. Con. Res. 95, setting forth the Federal budget for FYs 1988-90. For next fiscal year, spending is cut by \$17.5 billion, with domestic and defense programs bearing an equal share of the reductions. Revenues are increased by \$18 billion. This leaves a deficit of \$107.6 billion, which is lower than the Gramm-Rudman-Hollings (GRH) ceiling if and only if the President's economic assumptions are used. The House budget generally freezes domestic discretionary programs at their current spending levels; however, NIH receives a "full inflation" increase (this would not meet NIH's estimate of its "current services" budget), as does maternal and child health, community health centers, and health education for the disadvantaged. Medicare absorbs unspecified cuts of \$1.5 billion. The Administration's overall cap on the Medicaid program is rejected; an additional \$600 million is provided for initiatives in infant mortality and to improve the services paid for by Medicaid in nursing homes. The House resolution provides an increase in AIDS funding of \$550 million over the FY 1987 funding level of roughly \$420 million. Finally, the Administration's proposed reductions for student financial assistance are rejected.

The Senate Budget Committee approved a budget plan for FYs 1988-91 just before the current Easter recess on a party line vote of 13-11. Like its House counterpart, the budget's deficit is slightly lower than the FY 1988 GRH deficit ceiling if the President's economic and technical assumptions are used; however, the resolution's deficit is \$25.8 billion higher if the assumptions of the Congressional Budget Office are employed. The Senate plan cuts \$6.9 billion from defense programs, \$10.3 billion from domestic programs, and increases revenues by \$18.5 billion. It reduces Medicare spending by \$3.3 billion; the plan also assumes that beneficiary costs will not rise. A Medicaid initiative of \$200 million is provided. Funding for NIH and AIDS research would increase by \$500 million, although no specific assumption is made about the distribution of these funds. Higher education programs also receive a major funding boost.

The Senate resolution will be brought to the floor soon after the recess ends on April 20, at which time a number of alternatives to the Committee plan will be offered, including the President's budget. Congressional rules stipulate that the budget resolution (which does not require Presidential signature) be set in place by April 15.

FY 1988 Labor-HHS-Education Appropriations

FY 1988 appropriations for the Departments of Labor, Health and Human Services, and Education will be marked up first, as is custom, in the House. The timing of the markup and the overall spending ceiling under which both the House and Senate subcommittees must act will be dependent upon the outcome of this year's budget process. It appears extremely unlikely that the House Subcommittee will mark up its bill before mid-May.

The AAMC is currently scheduled to testify before the House Subcommittee on April 27, and the Senate on May 5. Dr. Robin D. Powell, Dean, University of Kentucky College of Medicine, will testify before Rep. Natcher's Subcommittee, and Dr. Petersdorf will testify in the Senate. The AAMC's testimony will advocate the FY 1988 proposal of the Ad Hoc Group for Medical Research Funding, which calls for \$7.69 billion for NIH and \$590 million for ADAMHA research and research training, current services levels of funding for Title VII of the Public Health Service Act, and rejection of the Administration's proposed cuts in student financial assistance. The AAMC will thank the Subcommittees for their roles in turning back the Executive Branch's premature implementation of its "extended availability" proposal for NIH and ADAMHA. The Association will further state its opposition to the Administration's request for "full appropriations" for the total cost, including outyears, of all FY 1988 competing research project grants. It will likely do so on the grounds that this change should receive a more complete airing before it is adopted and that, even if making "full appropriations" for grants is sound as a general policy, the Administration's request is far too low to meet reasonable projected outyear costs of the awards.

FY 1988 Veterans Administration (VA) Appropriations

The Association will present its views on the FY 1988 budget for the VA's Department of Medicine and Surgery (DM&S) in testimony before the House and Senate Appropriations Subcommittee on HUD-Independent Agencies. AAMC President, Dr. Robert G. Petersdorf, will testify before the Senate Subcommittee on May 8, and a yet-to-be determined member of the Association's constituency will come before the House panel on April 29. As in past years, the AAMC's testimony will focus on: the VA's overall medical care account, including funds for house staff positions and residency stipends; funding for medical, rehabilitation, and health services research; and, the VA's major and minor construction programs.

FY 1987 Supplemental Appropriations

On March 25, the House Appropriations Committee reported out a Supplemental Appropriations bill for FY 1987. The bill contains non-binding report language that rejects the Administration's proposal to carry over into FY 1988 \$334 million of funds originally appropriated for NIH for FY 1987. Similar language rejects the proposed carryover into next fiscal year of \$5 million in FY 1987 ADAMHA funds. The Supplemental Appropriations bill also includes \$1.8 million for the National Institute on Aging, mostly for research on Alzheimer's disease.

Earlier this year, the AAMC became aware of a funding shortfall in the General Clinical Research Centers (GCRC) program for the current fiscal year. The shortfall is estimated at about \$16 million and is due to a relatively small appropriations increase in FY 1987 as well as lower than anticipated revenues from individuals receiving treatment through the 93 GCRCs. AAMC staff met last month to discuss this issue with staff from the offices of Senators Chiles (D-Fl.) and Weicker (R-Ct.), as well as Representative Natcher (D-Ky.), and received the response that an FY 1987 supplemental appropriation of the necessary magnitude is fiscally and politically unfeasible. The AAMC was urged to inform all interested parties that the most profitable strategy at this juncture is to request through routine channels an acceptable appropriation for FY 1988.

The full House should act on the supplemental bill soon after the current recess ends on April 20. When this legislation clears that chamber, Senate Committee action will ensue. The Administration opposes the House supplemental bill and it is unclear when, and in what form, the legislation will ultimately be enacted.

Legislation Relating to the Use of Animals in Research

A number of bills have been introduced in the 100th Congress which relate to the use of animals in research. Unfortunately, all of them would serve to limit or eliminate the use of animal models in biomedical research.

- H.R. 778 - the Pet Protection Act (Sponsored by Rep. Robert Mrazek, D-NY)

Similar to legislation introduced during the 99th Congress, H.R. 778 would deny NIH research grant funding to any person obtaining an animal from a shelter for use in research. The legislation has attracted more than 75 cosponsors, and may be debated during hearings on the NIH reauthorization next year.

- H.R. 1770 - (Sponsored by Rep. Charlie Rose, D-NC)

The legislation would grant any citizen the legal right ("standing") to sue the Federal government on his own or on behalf of any animal to compel enforcement of the Animal Welfare Act (AWA). Lack of standing by animals rights activists has led to the dismissal of suits brought by such groups for failure to comply with or compelling enforcement of the provisions of the AWA. This bill is identical to one which Rep. Rose authored in the 99th Congress.

- H.R. 1708 - the Research Accountability Act (Sponsored by Rep. Robert Torricelli, D-NJ)

H.R. 1708 would seek to end what Rep. Torricelli has called unnecessarily duplicative research. This would be accomplished by requiring all Federal research grant proposals which involve the use of live animals to be submitted to the newly-created National Center for Research Accountability for assurances that the research would be non-repetitive. The Center, to be housed within the National Library of Medicine, would be mandated with collecting and storing the full text of all "published research results"; in order to determine if the proposal duplicates prior research efforts, the Center would perform a full-text literature search of all research results published since 1960.

- H.R. 1635 - the Consumer Products Safe Testing Act (Sponsored by Rep. Barbara Boxer, D-Ca.)

This measure would prohibit the use of LD-50 tests for product safety, labeling and transportation as required by Federal law. It would also require Federal regulations to specify that nonanimal toxicity tests be used to comply with Federal laws, unless it is determined that, in certain cases, such tests have less validity than tests using animals.

The bill, which has nearly 50 cosponsors, goes much further than legislation put forth during the last Congress.

Tax Legislation

The following pieces of legislation are identical, in that they would restore the full tax deductibility of interest on educational loans. Although the timetable and legislative vehicle are both uncertain, restoration of the deductibility of student loan interest is a possible candidate for action during the 100th Congress. However, action is unlikely until the second session in 1988.

- H.R. 592 (Schulze, R-Pa.)
- H.R. 603 (Tauke, R-Ia.)
- H.R. 979 (Gaydos, D-Pa.)
- S. 628 (Grassley, R-Ia.)
- Unrelated Business Income Tax (UBIT) Hearings

The House Ways and Means Subcommittee on Oversight hearings on the UBIT issue, originally scheduled for late April, have now been postponed until sometime in June. The ever increasing scope of topics to be examined during the hearings, and the need for Subcommittee staff to expand their organization for the sessions, are the chief causes of the delay.

An area that has been receiving increasing attention in relation to this issue -- and now appears likely to be one of the prime topics of the hearings -- is the operations and practices of non-profit hospitals. Due in no small degree to the attention given an article which appeared in the Harvard Business Review condemning non-profit hospitals as being unworthy of their tax-exempt status, representatives of these institutions will be asked to defend not only certain commercial activities but in some ways the continuation of their tax-exempt status. While this situation may also be true for certain charity organizations, it seems to go beyond the nature of the investigation of the university-based community; there, it appears that the Subcommittee will focus on more narrow commercial activities -- commercially sponsored research, bookstores, sales of university property, travel agencies -- rather than broader philosophical questions of tax status.

S. 79 - High Risk Occupational Disease Notification and Prevention Act of 1987

The intent of this legislation, introduced by Sen. Howard Metzenbaum (D-Oh.), is to create a system to notify workers of exposure to occupational health hazards. Included in the bill, as originally introduced, was a proposal to tie Federal financial aid to medical schools to the offering by these schools of a certain amount of instruction in occupational medicine. The AAMC, as well as the entire higher education community, found such an

approach to solving the problem of a perceived deficiency in education in occupational medicine unacceptable. Subsequently, Sen. Metzenbaum agreed to develop a proposal that would both be acceptable to the academic medical community and achieve his desired goal.

The final product, accepted by Sen. Metzenbaum's Subcommittee on Labor during a mark-up session on April 9, would amend Title VII of the Public Health Service Act by establishing an incentive grant program for training in occupational medicine. Specifically, the bill would offer two options under the grant program. The first is targeted at schools with existing occupational medicine programs, and the other for those without such a program. Both options would provide for faculty development in this area, in addition to the former providing funds for occupational medicine training for residents in internal medicine and family medicine.

Following further action on the bill by the Labor Subcommittee, S. 79 is expected to be taken up by the full Senate Labor and Human Resources Committee in late May or June.

Medicare Budget Reconciliation

The Health Care Financing Administration (HCFA) has modified the administration's original request for a 1.5 percent increase in the Medicare Prospective Payment System (PPS) hospital update factor for fiscal 1988. HCFA Administrator William Roper, testifying before the health subcommittees of both the House Ways and Means Committee and the Senate Finance Committee, said that the appropriate update factor may be as high as 2.0 percent. However, he said that any final recommendation should be deferred until nearer the beginning of fiscal 1988, when more up-to-date data and analysis will be available.

Roper also predicted that the combined effect of changes mandated by the Omnibus Budget Reconciliation Act of 1986, including separate outlier reductions of PPS rates for urban and rural hospitals and computation of PPS rates on a discharge-weighted rather than a hospital-weighted basis, will increase the payment rate to rural hospitals by about 6.0 percent while reducing urban rates by less than 1.0 percent. As a result, HCFA believes that the discrepancy between rural and urban hospital operating margins will almost be eliminated and a higher percentage increase for rural hospitals, as is favored by the Prospective Payment Assessment Commission (ProPAC), is not justified.

With regard to hospital profits under PPS, Roper noted the HHS Inspector General has observed the same 12 percent to 16 percent Medicare operating margins seen in fiscal 1984 in a "statistically representative" sample of hospitals for fiscal 1985. Roper suggested that the fact that 80 percent of hospitals had positive Medicare operating margins during the first two years of PPS is "evidence of the adaptability of hospitals." But he also placed responsibility for the size of these margins on the Congress for granting higher updates than HCFA considered "prudent," including mandating an increase for fiscal 1988 equal to the market-basket rate of increase minus two percentage points. This equals an increase of 2.9 percent, almost a full percentage point higher than what HCFA has set as the upper limit for the increase.

With regard to capital and educational payments and adjustments as well as physician payments, there has been no change in the Administration's position as set forth in the President's budget.

Medicare Designation of Heart Transplant Centers

The Health Care Financing Administration (HCFA) published the final regulations governing hospital designation as a heart transplant center for the purposes of Medicare payments in the Federal Register on April 6, 1987. These regulations provide for Medicare coverage of heart transplants if, and only if, the transplants are provided in designated facilities.

The final regulations contain criteria relating to the institutional commitment to the heart transplant program, the qualifications of the transplant team, the selection of patients, the experience and survival rates within the hospital's transplant population, capabilities for organ procurement, the availability of appropriate laboratory services, and the maintenance of data on heart transplant patients. Facilities must have an established cardiac transplantation program with documented evidence of 12 or more patients in each of the two preceding 12-month periods and 12 patients prior to that but after January 1, 1982. The proposed criteria for one- and two-year actuarial survival rates of 73 and 65 percent, respectively, were retained.

HCFA incorporated a number of public comments into the final regulations, including:

- coverage of immunosuppressive drugs for heart transplant recipients for up to one year following the date of a Medicare covered transplant;
- use of "expert consultants" to review applications for center designation and advise HHS on whether designation is warranted; and
- addition of a limited exceptions process so that certain institutions not meeting all of the specified criteria may still be designated on the advice of the expert consultants.

Suggestions that are not part of the final regulations include:

- eligibility for consortia of hospitals;
- provisional designation for facilities meeting all of the criteria except for the two-year experience requirement; and
- consideration of geographic distribution in the designation process.

Expansion of Medicaid Eligibility

Congress is currently considering a number of proposals to provide catastrophic health insurance coverage for hospital and physician services under Medicare. Concerns have been raised that these proposals have high annual deductibles -- ranging from \$1,500 to \$2,000 -- that must be paid out-of-pocket before the catastrophic protections apply. In addition, these bills do not address the two major sources of catastrophic health expenses for the elderly and disabled: long-term care and prescription drugs.

In response to these concerns, Representatives Henry Waxman (D-Ca) and Pete Stark (D-Ca) introduced on March 23 three bills that they characterized as "catastrophic protection for the low-income elderly and disabled." The

bills: H.R. 1760, H.R. 1761, and H.R. 1762 would largely eliminate welfare status as a condition for Medicaid eligibility.

In the past, Medicaid eligibility has been associated with eligibility for two federal welfare programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). This association has been weakened, however, by measures such as the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), which allowed states to extend Medicaid eligibility to certain families and individuals with incomes too high to qualify for AFDC or SSI, but below the federal poverty level. The Waxman-Stark proposals would allow states for the first time to expand Medicaid coverage to individuals with incomes as high as 150 percent above the poverty line.

These three proposals are:

- H.R. 1760, the "Medicaid Catastrophic Protection Amendments of 1987" - would require states to provide for payment of Medicare premiums, deductibles and cost-sharing for Medicare beneficiaries at or below the poverty level;
- H.R. 1761, the "Low-Income Elderly and Disabled Medicaid Amendments of 1987" - would permit states to provide for payment of Medicare premiums, deductibles, and cost-sharing for Medicare beneficiaries with incomes at or below 150 percent of the poverty level; and
- H.R. 1762, the "Low-Income Elderly Medicaid Drug Coverage Amendments of 1987" - would permit states, at their option, to provide medical assistance for poor elderly individuals in meeting the costs of prescribed drugs.

All three bills have been referred to the House Committee on Energy and Commerce. In introducing this legislation, Waxman, who chairs the Energy and Commerce Subcommittee on Health, noted that he unofficially estimates the cost of these three proposals plus H.R. 1711 -- his "Community Spouse Protection Amendments of 1987" -- will total under \$700 million in additional federal Medicaid outlays in fiscal 1987. Waxman pointed out that this is 2.3 percent of the total \$30 billion that the Congressional Budget Office estimates the Federal government will spend on Medicaid in 1988.

Medicare Catastrophic Health Insurance

The Congress is currently considering a number of proposals to provide catastrophic health insurance coverage under the Medicare program. The following is a brief summary of these proposals.

S. 592/H.R. 1245

The administration's plan, introduced on February 25 by Sen. Bob Dole (R-Ks) and Rep. Robert Michael (R-Il), would cover acute care only. All Part A co-insurance charges for days 61 to 150 would be eliminated. Hospital coverage would be extended to 365 days. Beneficiaries would pay a maximum of two deductibles a year for the first day of each admission. There is a \$2,000 per year limit on Part A cost-sharing and Part B co-insurance. This plan does not cover out-of-pocket expenses for long-term nursing care, outpatient prescription drugs, dental services, home health services, physical exams, and

optical services and supplies. Financing would come from a monthly premium charged to all Medicare beneficiaries who choose Part B coverage.

H.R. 1280 and 1281

A plan that shares many similarities with the administration's proposal, but differs sharply in how it would be financed, was introduced February 26 by Reps. Pete Stark (D-Ca) and Willis Gradison (R-Oh). Financing for this proposal would be "progressive;" the federally subsidized portion of the benefit would be added to the adjusted gross income of taxpaying Medicare beneficiaries. It is estimated that only 35 percent of the eligible beneficiaries would pay for the entire program: 7.4 million would pay an additional \$265 a year in taxes and another 2.4 million elderly would pay an extra \$495 a year.

Other changes include a lower cap for out-of-pocket expenses (\$688 for Part A costs and \$1,000 for Part B expenses in 1988). Beneficiaries would pay only one deductible a year. As with the administration's proposal, the two major out-of-pocket expenditures -- long-term care and prescription drugs -- are not covered.

H.R. 65

This proposal, introduced by Rep. Claude Pepper (D-Fl) in January, includes long term-care, hearing and vision services, and dental care. It would be financed by raising the base for Social Security withholding from the current \$42,000 to "as high as necessary" to cover the increased services. Early hearings on this bill suggest that this represents an unacceptable shift in the underlying philosophy of Social Security.

S. 754

This bill, introduced on March 17 by Republican Senators Dole, John Danforth (Mo), Pete Domenici (NM), Dave Durenberger (Mn), and John Chafee (RI), addresses the cost of prescription drugs. It would allow organ transplant patients to count immunosuppressive drugs toward a \$1,800 a year cap on out-of-pocket costs. The bill also directs HHS to request a study to identify additional prescription drugs that could be counted toward the cap in the future. The bill would be financed through a premium.

Abortion Legislation

There are several legislative proposals before the Congress to address the abortion issue.

S. 264

This bill, introduced by Sens. Humphrey (R-NH), Proxmire (D-Wi), Armstrong (R-Co), Helms (R-NC), Garn (R-Ut), and Gramm (R-Tx) on January 6, would amend the Internal Revenue Code to deny status as a tax-exempt organization, and as a charitable contribution recipient, for organizations that perform, finance, or provide facilities for any abortion, unless the life of the mother was endangered. It was referred to the Committee on Finance.

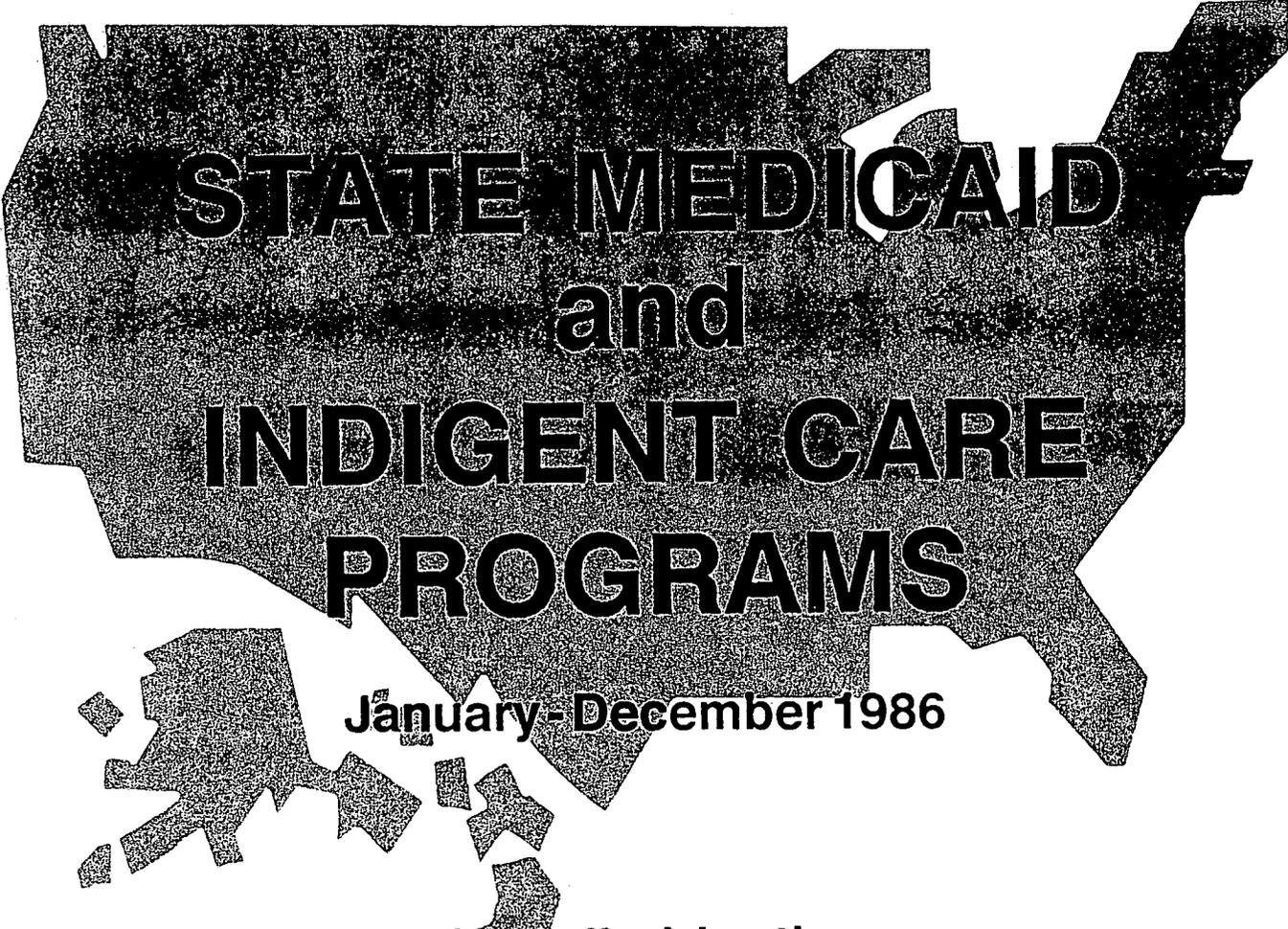
H.R. 1591

This bill, introduced by Rep. Dornan (R-Ca) on March 12, would amend the Internal Revenue Code to deny the deduction of medical expenses incurred during abortions, unless the life of the mother would be endangered by carrying the fetus to term. This bill was referred to the Committee on Ways and Means.

H.R. 1749

Introduced by Rep. Hyde (R-Il) with 60 co-sponsors, this bill would prohibit the use of federal funds for abortions except when the life of the mother would be endangered, and would prohibit the use of Public Health Service Act Title X family planning funds to organizations that perform or refer for abortions. The bill was referred to the Committee on Energy and Commerce.

MAJOR CHANGES
in



**STATE MEDICAID
and
INDIGENT CARE
PROGRAMS**

January - December 1986

Compiled by the
**INTERGOVERNMENTAL HEALTH
POLICY PROJECT**

The George Washington University

HIGHLIGHTS AND TRENDS IN STATE INDIGENT CARE PROGRAMS

Over the past several years, several state legislatures have authorized sweeping changes in their programs to finance indigent or uncompensated care. For example, in 1985, ARKANSAS, SOUTH CAROLINA and TEXAS enacted laws that made major structural changes in eligibility criteria for indigent care programs or in their financing mechanisms. Several other states made more modest modifications to their indigent care programs during 1985. In contrast, most state legislatures took a more cautious approach to indigent care issues in 1986.

EFFECTS OF STATES' BUDGET CRISES

Several energy producing states have been hard hit by the steep decline in oil prices. Although state budgets were cut due to mounting deficits, indigent care programs generally were spared major reductions. For example, in TEXAS, where the state experienced a \$3.5 billion deficit, there were not substantial cuts in the three new indigent care programs enacted by the legislature in 1985 and in the early stages of implementation.

However in ALASKA, where approximately 80% of state revenues depend on oil, the Governor ordered \$550 million in spending cuts resulting in a 45% cut in funds for the general relief medical program. In addition, state funding for the catastrophic health program, which assists those with very high health expenses but limited resources, received no funds for FY 87. However, some essential services in the indigent care program were reinstated through a \$750,000 allocation in FY 87.

Some farm states were also affected by large budget deficits in 1986. In KANSAS, for example, there was a \$14 million cut in the indigent care program. This resulted in the elimination of almost all outpatient services under the so-called MediKan program and a limit on general inpatient hospital services to \$225 per recipient per fiscal year.

CALIFORNIA's budget situation also resulted in a battle over the level of indigent care funding. Governor Deukmejian slashed a total of \$706 million from the state's budget to fulfill his goal of keeping a \$1 billion reserve in the state treasury. In the FY 87 budget act, a \$50 million increase in the indigent care program was vetoed. The legislature then restored the funds but the Governor authorized only half of the money to be spent, leaving the remaining \$25 million to be taken up again when the legislature reconvenes for its 1987 session. Also vetoed were bills that would have provided financial relief to rural hospitals and hospitals caring for a disproportionate share of indigent patients, one that would have established a task force to study uncompensated care, and another that would have established a health insurance risk pool for the medically uninsurable. All will be the subject of continued debate in 1987.

CHANGES IN ELIGIBILITY, SERVICES AND MANAGEMENT

During 1986, legislatures in CONNECTICUT, GEORGIA, INDIANA, IOWA, MICHIGAN, MISSISSIPPI, MONTANA, NEW JERSEY, NEW YORK, SOUTH DAKOTA, and WISCONSIN made some changes in eligibility, services or management of their indigent care programs. However, in general, 1986 state actions do not approach the magnitude of actions taken by other states in recent years.

The MISSISSIPPI legislature abolished its state-funded indigent care program, budgeted at approximately \$3 million per year, and replaced it with an expansion in Medicaid eligibility. The theory behind the legislature's action was that expanding AFDC and Medicaid eligibility from approximately 16% of the federal poverty level to 50% would allow the state to capture federal matching funds for services formerly paid for by state funds. In two separate laws, the MISSISSIPPI legislature also allowed two poor counties to use county funds for medical services provided to indigent residents. These laws were necessary because MISSISSIPPI's counties do not have home rule authority.

In 1985, NEW YORK decided to discontinue its experimental all-payer rate setting mechanism, through which charity care and bad debt expenses were shared by all payers, including Medicare and Medicaid. Under the system adopted by the state to replace the all payer system, Medicare reimbursements were to be made on the basis of DRGs, although Medicare was still to be held indirectly liable for uncompensated care costs through a 4.5% assessment levied on hospitals' Medicare revenues. In April, 1986, the NEW YORK Supreme Court voided this law on the grounds that the U.S. Congress intended that Medicare revenues be used only for Medicare patients and had already enacted a method for dealing with uncompensated care, through the Medicare disproportionate share adjustment.

In response to the court's decision, the NEW YORK legislature revised the stricken statute. S.B. 9477 levied an across the board assessment of 1.9% on all inpatient hospital revenues to replace the \$160 million that would have been generated by the Medicare assessment. The assessment will be 3.8% for the balance of calendar year 1986 to generate the same amount of revenue that would have been collected if the law had been in effect for the full year. The new law's purpose is to replace the lost Medicare revenue; the only significant difference is that it taxes hospitals directly instead of assessing Medicare.

Another all-payer rate setting state, NEW JERSEY, approved a law in January 1987, amending the manner in which hospitals' uncompensated care costs are reimbursed. Before the legislation passed, each hospital's rates reflected the level of uncompensated care through a hospital-specific mark-up on all payers' reimbursement rates. However, urban hospitals with high indigent care caseloads found themselves at a competitive disadvantage in marketing their services to HMOs and PPOs. The legislature set up the NEW JERSEY Uncompensated Care Trust Fund to pool the funds from an across-the-board mark-up of 10.5% (a rate subject to the approval of the state health commissioner) on the rates charged to all payers by all hospitals. Hospitals not providing a certain level of indigent care will owe money to the fund and those providing more than the level will receive additional payments. Medicare continues to participate in this rate-setting system under a federal waiver.

The WISCONSIN Hospital Rate Setting Commission issued a rule that amends hospital's reporting requirements for charity care and bad debt by distinguishing the two based on the patient's ability to pay. It also required hospitals to submit a charity care policy detailing the income criteria to be used in determining ability to pay and describing other procedures that will be used to set a target level or "fair share" capacity to provide charity care. The commission also established incentives in the context of the rate setting process for hospitals to meet and exceed this target level.

MONTANA modified its income eligibility standards for both general relief and general relief medical services. The two programs have different stan-

dards; people with somewhat higher incomes are eligible to receive medical services even though they are not eligible for cash assistance. H.B. 33 XX lowered the income standards for the medical program for one person households but raised them for larger households. For example, the new law permits three person households whose incomes do not exceed \$526 per month to receive medical services necessary to treat serious medical conditions. The corresponding income standard under the old law was \$400.

INDIANA was one of the few states to make substantial changes in its indigent care program. Under previous law, the state set eligibility standards based on AFDC standards, but the program was totally funded and administered by the counties. The law shifts the administration of the program to the Department of Public Welfare and removes the requirement that eligibility standards be pegged to AFDC eligibility criteria. The law sets up temporary financial eligibility criteria, which are to remain in effect until January 1988, after which eligibility is to be set by rule and adjusted at least every two years. The temporary financial eligibility sets the maximum monthly income for a three person household at \$377.40.

The INDIANA law also alters the program's funding and reimbursement structure. It requires counties to levy a property tax to fund the program, and stipulates how much revenue the tax should generate. Some revenues from other county taxes are also made available for use by the indigent care program. The state is permitted, but not required, to appropriate funds. Therefore, liability for funding the program rests with the counties, though the state actually pays the bill. Reimbursement to hospitals is set initially at two thirds of the amount of claims submitted, except that the state and the counties are not liable for payments that can not be covered by funds in the indigent care account. The state may pay more than two thirds of the amount submitted on claims if there are sufficient funds in the account at the end of the year to enable it to do so. H.B. 1085 also changes the scope of services provided by the indigent care program. Under previous law, services were limited to emergency care. The law permits care to be rendered by a hospital if the absence of immediate medical attention would probably result in: placing a person's life in jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily part. Non-hospital based care continues to be a non-covered service. The law also directs the Health Department to establish a statewide data collection system to gather information about patient demographics and types and costs of services provided by hospitals.

GEORGIA made minor revisions in funding programs for the medically indigent. S.B. 56 requires that proceeds from the sale or lease of a publicly owned hospital be placed in a trust to provide care to indigent people residing in the hospital's service area. If proceeds from the sale or lease exceed \$100,000, then only interest from the principal may be used to fund care. If proceeds do not exceed \$100,000, then the principal may also be used.

SOUTH DAKOTA's H.B. 1077 permits county commissioners to adopt standards for the amount, duration and scope of both emergency and non-emergency indigent care services. CONNECTICUT amended the manner in which local communities pay indigent care bills. Rather than paying hospitals directly, towns will forward bills to the state, which will pay hospitals the full amount and then charge the towns 10% of the total bill.

In its FY 87 appropriations act, the MICHIGAN legislature authorized a modest expansion of benefits by covering dentures, hearing aids and eyeglasses

to all people eligible for the indigent care program. Previously, these benefits were made available only to those participating in workfare programs. More significantly, the legislature directed the Department of Social Services to redesign the program by substituting provider-managed ambulatory care plans and other forms of authorized care plans for the current system, which requires written authorization by the local department for recipients to receive services. The new system will take effect no sooner than July, 1987. Similarly most general assistance recipients in OREGON will be required to participate in a primary physician and primary pharmacy lock-in program.

MATERNITY CARE

MICHIGAN joined MASSACHUSETTS in providing the funds to guarantee the availability of prenatal care to any woman unable to afford this care whose income is under 185% of the federal poverty level. In MICHIGAN, this was accomplished by designating prenatal and postpartum care as a basic health service in the state's public health code. As such, it must be made available to all women who are pregnant regardless of income. Funds of \$5 million were allocated to pay for this care. A legislative attempt to make the MASSACHUSETTS "Healthy Start" program an entitlement failed; the program, however, did receive about \$15 million to provide pregnancy-related services to all pregnant women with incomes under 185% of the federal poverty level. And in MARYLAND, \$1.5 million was appropriated to fund the prenatal assistance program to provide maternity care services to pregnant women under age 21 who are below the federal poverty line but ineligible for Medicaid.

IOWA's indigent care program is operated through the University of Iowa's Medical Center, which receives approximately \$25 million in state funds to treat indigents and support health professionals' education and training. Under this system, counties are permitted to refer a certain number of non-obstetrical and non-orthopedic indigent patients and an unlimited number of obstetrical and orthopedic indigent patients to the university's medical center for free treatment. Costs of providing care to patients at the university are financed through a state appropriation; counties are responsible for the costs of caring for indigents treated within their borders. This system results in many pregnant women having to travel a considerable distance to obtain prenatal care and spending the last portion of their pregnancies in close proximity to the university's hospital.

In its FY 87 appropriations act, the legislature decentralized the program somewhat by reallocating \$1.1 million of the funds targeted for obstetrical care at the University of Iowa to the counties. Each county will receive \$1,400 per obstetrical patient for a specified number of patients. The formula for determining how many patients each county is allotted is based on the number of live births in the county, not counting women who deliver babies at the university medical center. However, each county will be given funds for at least four patients regardless of the number of births. The IOWA legislature also signaled its intent to completely decentralize the obstetrical portion of its indigent care program by July, 1988, but implementation of this provision is likely to be controversial. Finally, the legislature authorized the Department of Human Services to seek grant or foundation funds to study and implement alternative methods to improve financial access to medical care for the state's rural, underinsured residents, and approved matching funds of up to \$150,000 if the department succeeds in obtaining a grant.

LIMITS ON TRANSFERRING INDIGENT PATIENTS

Earlier this year, Congress passed a provision requiring hospitals participating in Medicare to provide emergency care to people regardless of their ability to pay, and prohibited hospitals from transferring patients unless their condition has been stabilized or a doctor certified that a transfer would be beneficial to the patient. Fines of up to \$25,000 can be imposed on hospitals or physicians who do not comply with the law's requirements. In addition, six states (FLORIDA, LOUISIANA, MARYLAND, MASSACHUSETTS, PENNSYLVANIA, and TENNESSEE) enacted laws designed to limit the conditions under which hospitals may transfer patients because they do not have insurance and are unable to pay for their care. TEXAS enacted a similar measure last year as part of its overhaul of indigent care funding.

The FLORIDA law, S.B. 1036, prohibits hospitals maintaining full-service emergency rooms from refusing to admit patients based on economic criteria or indigence. In cases where they are unable to render appropriate care, the bill requires that hospitals stabilize patients before transfer, arrange transportation, if necessary, notify the hospital to which the patient is being transferred, and provide available medical records to the receiving hospital.

LOUISIANA's law prohibits hospitals from denying emergency services to people because they are unable to pay, or on account of race, religion, or national ancestry. It also prohibits arbitrary, capricious or unreasonable discrimination based on age, sex, physical condition or economic status. Emergency services are defined as those usually available and that must be provided immediately to stabilize a condition that could reasonably be expected to result in death, serious permanent disfigurement or loss or impairment of function. It also includes care necessary to provide for a woman in active labor, if the hospital provides obstetrical services, or transfer of a woman in active labor.

MARYLAND's new law, S.B. 711, does not specifically prohibit transfers based on patients' economic circumstances. Rather, it directs the Department of Health and Mental Hygiene to develop guidelines, in consultation with the state hospital association, for the transfer of patients. In developing the guidelines, the state must consider factors similar to those spelled out in the FLORIDA law. Similarly, MASSACHUSETTS' law, S.B. 465, does not forbid hospitals from transferring indigent patients, but it spells out conditions that must be met before hospitals can transfer indigent patients.

The PENNSYLVANIA law, S.B. 293, requires hospitals, as a condition of licensure, to provide medically necessary lifesaving and emergency health care services to people regardless of their financial status or ability to pay. It also stipulates that hospitals may transfer patients only when they lack the staff or facilities to "properly render definitive treatment." Finally, TENNESSEE's law, S.B. 1410 requires the Department of Health and the Environment to adopt rules governing the transfer of hospital inpatients, based on specified standards. The law states that patients should not be involuntarily transferred for purely economic reasons.

INDIGENT CARE STUDY COMMISSIONS

Several other states, including GEORGIA, KENTUCKY, NEW MEXICO, PENNSYLVANIA, TENNESSEE, VIRGINIA AND WASHINGTON, grappled with indigent care problems. However, instead of authorizing changes in these programs, they opted to establish a study commission to assess the problem

and make recommendations for legislative consideration next year. This brings the total number of states that have established indigent care task forces over the past three years to thirty one.

The GEORGIA legislature approved two studies. In S.R. 394, the Senate expressed its concern over the sale or lease of public hospitals, which frequently results in reduced access to care for indigents and higher costs for patients receiving care at the now privately-owned facilities. The resolution created the Health Care Supply and Financing Study to look into these problems and recommend solutions by December 1986. The GEORGIA House also registered apprehension over the growing indigent care problem in H.R. 716, through which it asks the governor to establish a Task Force on Funding of Indigent Care Programs. The House wants the task force to study the problem with an eye to maximizing federal funds in its proposed solutions.

In KENTUCKY, the Senate adopted S.C.R. 59, which directs the Legislative Research Commission to identify low income populations most at risk of being uninsured and develop model legislation to improve their access to care. It also requires the commission to apply for funds from the Robert Wood Johnson Foundation's "Health Care for the Uninsured" program to carry out the study. In the event the money is not secured, the commission is to determine whether it can finance the study from its budget. Study results are to be submitted to the legislature by January, 1988.

The NEW MEXICO Senate approved a memorial requesting the association of counties, county commissions, the state hospital association, hospitals and the home health industry to develop model guidelines for administration of the indigent care program as well as develop a comprehensive approach to providing health care for medically indigent patients.

As part of a comprehensive health care cost containment act, the PENNSYLVANIA legislature established an independent health care cost containment council whose powers include collecting and analyzing health cost data and studying indigent care. The law directs the council to conduct a comprehensive study of indigent care and submit a plan for providing ongoing services to the medically indigent to the General Assembly by July 1, 1988. In its study, the council must investigate the demographics of the uninsured population, their access to care, the effects of providing indigent care upon providers, and methods of financing indigent care. An unusual feature of the bill requires the General Assembly to enact an indigent care program within 120 days of the submission of the council's plan. The legislature is given discretion to enact a program based either on the proposal submitted or to design its own plan.

In VIRGINIA, the legislature passed three measures related to indigent care. S.J.R. 32 directed the Governor to establish a Task Force on Indigent Health Care. Governor Baliles announced his appointments to the Task Force in August. The Senate resolution directs the task force to study all aspects of the indigent health care issue, including the feasibility of establishing a special fund to pay for necessary care of indigent mothers and children, identify problems specific to VIRGINIA, and recommend actions to resolve these problems. In addition, the Senate also passed S.J.R. 87, which asks the Joint Legislative Audit and Review Commission to study problems identified in the funding formulas for two programs currently providing care to the indigent, the State/ Local Hospitalization and State/Local Cooperative Health Department Programs. The commission is to make recommendations for formula revisions and submit its results by November 15, 1987.

The VIRGINIA House of Representatives also voiced interest in studying indigent health care programs in H.J.R. 65. The measure creates a joint subcommittee whose primary task will be to study the commonwealth's trauma care system. But the committee is also directed to examine issues concerning the provision of preventive health care services to the indigent and to report its findings by November 15, 1987.

In WASHINGTON, the legislature created a health care project commission to conduct a demographic study of people without health insurance and design a managed care program to provide basic health services for them for an estimated cost of \$50 per month per person. Services provided under the program are to emphasize preventive and primary health care, with special attention paid to prenatal and postnatal care and health care services for children under 18. The commission was directed to establish eligibility criteria, administrative structures, provisions for monitoring quality of care provided to enrollees, and methods of funding the program. Financing mechanisms may include payments by enrollees. The commission submit its report to the legislature in early 1987.

HEALTH INSURANCE RISK POOLS

Prior to 1986, nine states passed laws establishing comprehensive health insurance associations, more frequently called risk pools. Their purpose is to reduce the number of people without health insurance by offering individual insurance policies to people who are considered poor risks because of bad health or pre-existing conditions. Risk pools do not assist many poor people in obtaining insurance because the premiums are too expensive. However, they do help to prevent middle income people in bad health from becoming impoverished through high medical expenses. As such, they can play a valuable, if limited, role in states' strategies to reduce the number of medically indigent people and the amount of uncompensated care costs. This year, two more states, IOWA and TENNESSEE, enacted risk pooling legislation.

PHARMACEUTICAL ASSISTANCE TO THE ELDERLY

After years of political promises and legislative battles, the NEW YORK legislature enacted a program for elderly pharmaceutical insurance coverage to subsidize the drug costs of low-income persons over 65 years of age. Over one million elderly people will be eligible for the program, although only half are expected to qualify for a subsidized drug benefit based on the copayments and deductibles built into the program. Total costs are estimated at approximately \$150 million. The law establishes two types of coverage. Comprehensive coverage will require an annual fee and copayments for each prescription with maximum annual payments equal to 8% of income for individuals with incomes up to \$9,000 (\$12,000 for married couples). Catastrophic coverage will be available to individuals with incomes up to \$15,000 (\$20,000 for couples) under either a premium plan, which requires quarterly premiums to qualify for certain copayment limits, or a deductible option, that would permit copayment limits after the deductible had been paid. A key cost-containment feature of the program promotes generic drugs. Minor changes were made to other pharmaceutical assistance programs in ILLINOIS, MARYLAND and RHODE ISLAND.

ESTABLISHMENT OF A DATE FOR RECEIPT OF DEANS' LETTERS

One of the recommendations of the Ad Hoc Committee on Graduate Medical Education and the transition from Medical School to Residency was that a date be established for release of Deans' letters. Another recommendation was to shorten the period between the NRMP deadline for submission of rank order lists and the announcement of match results. For the 1988 Match the NRMP plans to set February 19 as the deadline date for submission of rank order lists with announcement of the match scheduled for March 23rd. This will advance the deadline date by five weeks and provide more time for both programs and students to make their selections.

Based upon this schedule, both the CAS and COD deliberated upon an optimal date for the release of Deans' letters by the medical schools at their spring meetings. There was a firm consensus that November 1 should be the date adopted. This will provide 16 weeks between the receipt of Deans' letters and the submission of rank order lists.

Recommendation:

That the Executive Council approve November 1 as the date for release of Deans' letters and authorize wide dissemination of this date to residency program directors as the earliest date that complete evaluations of student performance will be available.