ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
ANNUAL BUSINESS MEETING

Monday, October 29, 1984
Williford A & B
Conrad Hilton Hotel
Chicago, Illinois

AGENDA

IX. Old Business

X. New Business

XI. OSR Report

XII. Installation of Chairman

XIII. Adjournment

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Information Items

A. Matching Medical Students for Advanced Residency Positions

B. Relationships with Investor-Owned Organizations

C. Status of Research Facilities and Instrumentation

D. Correspondence with the Ad Hoc Steering Committee on Animal Issues

E. Letters to the NIH Office for Protection from Research Risks on Proposed PHS Policy on Humane Care and Use of Animals

F. Follow-up on Lengthening of Training Requirements by Specialty Certifying Boards

G. Low-Level Radioactive Waste Disposal

H. Paying Capital Costs in COTH Hospitals

I. Modifying the Medicare Payment System

J. Resident Tracking Project

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS

SPRING BUSINESS MEETING

Wednesday, April 4, 1984
8:30 am - 12:00 pm

WILLOW ROOM
CALLAWAY GARDENS
PINE MOUNTAIN, GEORGIA

Minutes

I. Call to Order

The business meeting was called to order at 8:30 am by Edward J. Stemmler, M.D., chairman.

II. Report of the Chairman

Dr. Stemmler conveyed Dr. Roger's invitation to the Council to hold its 1986 Spring Meeting in Hawaii. He promised that the Administrative Board would consider the invitation and solicited expressions of preference from Council members.

He then reported on the most recent Board meeting which was intended to provide the basis for the discussion at this meeting on the relationship between the Administrative Board and the Council. One outcome of that meeting was a sense, which seemed to be shared by many, that the activities of this Council should recognize the talent which exists in its membership, and the importance of the utilization of that talent in the affairs of the Association. He noted that the deans take great pride in how their association represents them, and in the form in which it has developed under the leadership of John Cooper. The issue is, how do we position ourselves from here on so that we can use our membership most effectively.

As chairman, he concluded that it would be useful to take a look at how the Council's elected representatives are expected, in the membership's eyes, to serve the Council, and how the Board and the Council could work together more in a collegium.

A derivative of those discussions had to do with how the Council accepted new members into the group. The Board made a special effort this year to extend its hospitality. He judged that it worked reasonably effectively for this meeting and expressed the hope that that kind of pattern can be maintained in the future.

There was a perception by the Administrative Board that the COD membership did not have enough time to exchange views and talk to each other in an informal and unstructured way. There was a serious question raised whether one meeting a year of the Spring Meeting format was enough. The Administrative Board felt that it would be sensible to look to developing a session with less business to conduct and more of an opportunity to exchange views tied to the national meeting. This should be arranged in some way that would not extend in any significant way the time commitment that deans would have to make. The general pattern of attendance at the national meeting has been for the deans to come on Sunday, to stay through the Monday Business Meeting, and then to begin to depart thereafter. And so, if the Council's direction were to explore this more seriously, the plan would be to arrange a programmatic meeting scheduled for Sunday afternoon and Sunday evening in Chicago.

Dr. Stemmler then opened the topic for discussion from the floor. In response to suggestions from the membership, he stated his intention to appoint a program planing committee to develop an agenda. The meeting itself would be a kind of private meeting for deans.

III. Council of Deans--Administrative Board Relationship

Dr. Stemmler asked the members of the Board to join him on the podium to participate in the discussion. He pointed out that there is no protocol that governs membership on the Administrative Board. Administrative Board members are nominated by a nominating committee, which has paid a lot of attention to a variety of factors such as regional representation, other factors that could be identified to be important in the governance of the Council and of the Association.

The AAMC in its organization has groups that are brought together by geography and by shared interests. Many have been impressed with the cordial arrangement that the southern deans have evolved. They work very effectively together, have programs which serve their interests, and their group has become both a social as well as a business organization. No other grouping around the country has a comparable arrangement

although the midwest deans at one point pursued an ambitious meeting pattern. There are other groupings, e.g., the deans of private-freestanding schools and of community based schools who choose to meet to discuss issues that are of importance to them. There is a consortium of schools, principally in the northeast, the old Ivy consortium, which meets from time to time. That group has not had any major significance in the governance of the COD.

The Board's discussion, which ranged over all of these sub-arrangements in the Association, ended with a conclusion that it was better not to have an elected delegate kind of governance. The nominating committee has been discharging its reponsibilities in a thoughtful way and with an understanding of the nature of the Association. There was no evidence that there had been an insensitivity to the kind of representation that ought to exist.

Nevertheless, the Board is aware of a sense of detachment between what happens on the Administrative Board and the Council. As a very small organization, there is no absolute reason why there should be such a detachment. The Council of Deans is unique in the AAMC in that it is the sole professional organization serving the interest and needs of deans. Therefore, the deans all have a stake in making this organization work as effectively as possible to serve their purposes. With this background, Dr. Stemmler opened the discussion to the Council.

In the discussion which followed:

- There was a suggestion that the COD ought to be more proactive and less reactive than it is sometimes viewed. In response, it was noted that the COD issues paper was an effort to be significantly proactive. The opinion was also offered that while many of the actions were initiated because of a need to mount a defense of some sort, they often resulted in forward looking positions or programs of the AAMC.

- The deans were exhorted to put their best talents and efforts forward on behalf of the AAMC for their own benefit and that of their colleagues.

- The AAMC position on physician strikes ("The Withholding of Services by Physicians") was pointed to with pride as a principled and proactive stand.

- The deans' roster was identified as a mechanism by which deans' contributions to the AAMC could be noted by colleagues and taken into account in the nominating process.

- The purpose and function of the advisory ballot was questioned and explained.

- The extent of response to the nominating committee's solicitation of the deans was noted as characteristically sparse, in the neighborhood of one fourth of the membership.

- There was a suggestion that an effective way to bring out the best and recognize the diversity of the group is to form more task forces and small committees responsible for researching particular issues and reporting to the Board.

- The addition of additional members-at-large on the Administrative Board was identified as a recent action designed to create more turnover and to permit additional people to serve.

- There was at least one proponent of the position that an elected representative from various identifiable interest groups would enforce a sense of accountability on the part of the Board members and create a better recognition of the need for two-way communications between the Board and the membership. On behalf of the Board, the chairman reported that the Board members recognized that they had been remiss in these areas and planned to develop more effective means of communication.

- It was suggested that the entire Council be alerted to the major issues to be considered by the Board, in advance of each meeting, with the invitation to those interested to contact Board members with their own views.

- There was the suggestion that the AAMC explore the utilization of modern communications technology, e.g., electronic mail, as a means of enhancing both the communication between the AAMC and the members, and permitting communication among the members.

- Several deans provided testimonials to the effect that they felt highly successful in raising and having considered, items of importance to themselves or their institutions.

- Several deans provided suggestions for enhancing the utility of the COD roster: 1) that it include each deans' specialty, 2) that deans be given an opportunity to list organizations and activities of interest to his colleagues, 3) that each dean be permitted to identify areas of experience or expertise, and 4) that the AAMC keep track of expressions of interest of deans in serving on AAMC endeavors. Two purposes would be served by better identification of talent and experience: recognition of expertise for AMMC purposes, and a resevoir of potential assistance for colleagues to call on.

Dr. Stemmler ended this section of the discussion with three conclusions that he had reached on the basis of the comments. First, he detected little sentiment or need to modify the current nominating structure. Second, that the chairman and the Board should look for ways to provide more effective communications on the day-to-day business of the Board. Third, that we look to find ways to permit more members to participate in the formulation of ideas that might become positions of the Council and the Association. Finally, that the discussion reinforced the need to identify and recognize the talent available.

IV. Discussion of COD Issues Paper

Dr. Stemmler opened the discussion by noting the leadership of the Council of Teaching Hospitals in initiating this kind of process. The COD Administrative Board judged that the Council of Deans could profit by the example set by the development and discussion of the paper, "New Challenges for the Council and Department of Teaching Hospitals." It was considered important for the deans to identify those areas on the horizon that deans perceive as being central to their interests and important to defend; areas which should emerge as priority for the Association.

The paper in the Council's agenda book represented a staff distilation of the discussion which took place at the Philadelphia Board meeting. Dr. Stemmler asked the Council members to suggest additional areas which should be given attention.

The discussion which followed noted the comprehensiveness of the initial draft of the paper and suggested the difficulty of commenting productively on it in a meeting of this format. Members were encouraged to write their thoughts to the chairman and staff for consideration in the further development of the paper. They were encouraged to take a long-term perspective on the project and to contribute their ideas on issues which would take on increasing significance to the AAMC.

V. The Project on the General Professional Education of the Physician

This item was unlisted on the published agenda but added to the amended agenda which was presented by the chairman on Sunday night. It dealt with identifying the posture of the Council of Deans with respect to GPEP. While the deans seemed to feel very strongly that this was an important undertaking by the Association, that this was time for the Association to take a major national position on the important area of medical education, there seemed to be a sense of detachment on the part of the deans toward the Project.

Dr. Stemmler wanted to insure that the deans were familiar with the time table and the plans for finishing and publishing the report. He called upon Dr. Swanson to lay out these matters. Dr. Swanson expressed the hope that the 18 members of the panel would be satisfied with a draft no later than the first of June. The plan was to present the report to the Executive Council in June at its meeting, and to release a general summation of the report in a booklet (which will be approximately 75 pages) sometime in mid-September. There will be an additional journal supplement published--planned for the November issue of the Journal of Medical Education--which will include the booklet material as well as some appendices describing the state of medical education at this time and containing the working groups' reports to the panel.

Dr. Cooper noted that the need for a study of contemporary medical education was identified by the Executive Council and discussed at two of the Officers' Retreats. The Executive Council decided that the Association should go forward with the study which would follow the work previously done on continuing medical education and graduate medical education. The Executive Council then appointed a very distinguished panel of people charged with making the study recommendations. The project is made possible by very generous support from the Kaiser Family Foundation.

The ordinary way that these things are handled in the Association is for the panel to present its report to the chairman of the Executive Council. There will then be time for commentary by the membership. The Executive Council will review whatever input it has received and will take its action on the document. It may adopt the recommendations as AAMC policy, or it may not. But the report itself would remain the panel's report and would not be subject to modification by the Executive Council.

Dr. Stemmler responded that Dr. Cooper's review illustrated the point that the Council, either through its Administrative Board alone or as a Council, will be faced with a position of responding to the question of whether the panel's recommendations should become an AAMC policy. He also pointed out that with the publicity of the GPEP report when it hits the press, each dean is going to be put into a position requiring that he respond in some way. Everyone anticipated broad national coverage and that the press would naturally turn to the deans for comment. He expressed the need for deans to receive the report from the Association with enough lead time to be able to digest the report and be prepared to respond before it goes public.

VI. Specialty Residency (PGY-2) Match of Medical Students

Dr. Stemmler pointed out that the material in the agenda book included minutes of a meeting with representatives of specialty societies which match medical students to PGY-2 positions and a page that described the issues. He stated his satisfaction that the Association is positioning itself appropriately to deal with this very complex problem.

VII. Draft of "Functions and Structure of a Medical School"

Dr. Stemmler simply pointed out that each member had received a copy of the document. He asked that they read it carefully and send comments to Drs. Schofield and Peterson.

VIII. Medical Education and International Relations

Dr. David Greer elaborated on some of the points made in a letter included in the agenda book. He reported on student exchange relationships between Brown and the Karolinska, transfers of students with an English school, potential relationships with young faculty from South Korea, contacts with a school in Columbia, and a 12 year old relationship between Brown University and an East German University.

Dr. Greer's question to the AAMC was, "does the AAMC have a role in international relations?" Dr. Cooper responded that the Association once did, but that support for the enterprise dried up. It was his view that the State Department, the AID, and foundations were more interested in supporting the universities directly than in providing assistance to the AAMC to contribute to those efforts.

Dr. Greer suggested that the AAMC might be losing opportunities to become much more visible and possibly influential on the national level. He reported that several European countries now have national programs for their medical graduates to spend three, four or five years in African nations. That decompresses the glut of physicians while it acts as Peace Corps type service to the countries. In the U.S. we are also faced with an overcapacity while much of the world is in great need.

There are many things done on an individual school level; there may also be opportunities for activities at a national level.

IX. National Earthquake Conference

Dr. Moy reported that in the first week of June there would be a National Earthquake Conference in St. Louis, hosted by the Central United States Earthquake Consortium. Official invitations would be sent to the 40 states that do have earthquake problems, existent or potential, as well as other related organizations.

One fourth of the major presentations will be related to the need for a medical response in the event of a catastrophic earthquake. It was possible to anticipate that some of the representatives will come back to their states and contact deans, describing concerns about a coordinated medical response in the event of a disastrous earthquake. Dr. Moy's purpose was to bring this briefly to the deans' attention so that if contacted, that they would have a context to start considering an institutional response.

He then described the New Madrick Fault and the prospect for a repeat of the quake along the faultline which occured in 1811-1812. The quake would have serious nationwide ramifications and would create medical emergencies to which the medical schools would be called upon to respond.

X. Clinical Evaluation Program

Dr. Xenia Tonesk reported that the purpose of the clinical evaluation program is to assist clinical faculty in evaluating medical students and residents. The major focus in this program at present is the self-assessment of clinical evaluation systems. It is an attempt to put into the hands of faculty a set of guidelines and self-assessment materials to assess the strengths and weaknesses within those systems, make decisions as to the desired changes, and regarding the implementation of these changes.

At the present moment, there are 120 U.S. medical schools and 15 Canadian medical schools represented in the program. In 75 schools somebody from the dean's office or the dean himself has expressed an interest. The program also received responses from 335 clinical departments and 64 hospitals.

The self-assessment materials are now being piloted with six schools. At the Annual Meeting, six schools will report on their experiences of having participated in the self-assessment exercise. By December, 1984, a package of self-assessment materials are expected to be available. In the spring of 1985, the AAMC will conduct workshops to train project coordinators to use these materials effectively, and to train individual faculty to develop or sharpen their skills in terms of just backing up their subjective judgements and bringing in the appropriate evaluation tools.

XI. Defending the Use of Animals in Research

Dr. Sherman reported on one of the most useful and cost-effective public relations efforts made by any group within the country, directed toward the objective of creating a better understanding of the need for animals as research subjects. The California schools, some associations and other groups there have banded together in an educational effort through a newly formed California Biomedical Research Association to tackle this problem at the level where the most serious threat in many areas seems to be occurring; namely, at the state or local level.

He pointed out that the persistance and the commitment of our opposition is singularly long, effective and deep. We can probably never match that commitment of financial resources available to them. Therefore, we have got to find more cost-effective ways of targeting our efforts and our resources to the battle. He commended for other schools' consideration and use, the very effective job of the California organization, done with relatively little in the way of resources.

The head of this organization shared brochures with us and urged us to utilize them in any fashion that seemed productive, either by purchasing additional quantities for distribution, or by plagiarizing the content for adaptation at the local level.

The CBRA intends eventually to come out with a series of about 15, single page resumes on various diseases and the relationship of animal models to successful prosecution of research in those areas.

It is a very well thought out and a very cost-effective way of educating the public about this important subject.

XII. Adjournment

There being no other business to conduct, the meeting was adjourned at 11:25 am.

REPORT OF THE NOMINATING COMMITTEE

The reports of the COD and the AAMC nominating committees appear on the following pages. They report that Dr. Rudi Schmid, Dean of the University of California, San Francisco, was nominated to fill the vacancy created by Dr. Goodale's resignation from the Executive Council. After due consideration, Dr. Schmid has declined to accept the nomination, citing competing demands on his time and energy. The nominating committee will be reconstituted to provide a new nomination, but as of this printing it has not complete this task.

WAKE FOREST
UNIVERSITY

The Bowman Gray
School of Medicine

Department of Medicine

September 28, 1984

John A. D. Cooper, M.D.
President
Association of American Medical Colleges
One Dupont Circle, NW
Washington, DC 20036

Dear John:

The AAMC Nominating Committee met by conference call on September 28, 1984. As you know, the nominating committee consists of:

Joseph E. Johnson, III, Chairman
Robert Hill, CAS Nominating Committee Chairman
Richard Reynolds, COD Nominating Committee Chairman
Earl Frederick, COTH Nominating Committee Chairman
William Luginbuhl, Representative-at-Large

The committee considered candidates for the position of AAMC Chairman-Elect for 1985, three representatives to the AAMC Executive Council from the Council of Deans and one representative to the Executive Council from the Council of Teaching Hospitals. After due consideration, the committee has agreed on the following candidates and hereby submit their names:

AAMC Chairman-Elect:	Virginia V. Weldon Washington University School of Medicine
COD Representatives: (2 vacancies for 3-year terms)	1) William Butler Baylor College of Medicine 2) Robert S. Daniels Cincinnati College of Medicine
COD Representative: (1 vacancy for 1-year term)	Rudi Schmid UCSF School of Medicine

300 South Hawthorne Road, Winston-Salem, North Carolina 27103
TELEX 806449 BGSM WSL

COTH Representative: (1 vacancy for 3-year term)	William Kerr University of California Hospitals San Francisco

I will be prepared to present this slate to the assembly on Tuesday, October 3, 1984.

Sincerely yours,

Joseph E. Johnson, III, M.D.
Professor and Chairman

JEJ:ds

July 11, 1984

Edward J. Stemmler, M.D., Dean
University of Pennsylvania
School of Medicine
36th and Hamilton Walk
Philadelphia, PA 19104

Dear Ed:

This letter constitutes my report as Chairman of the Council of Deans' Nominating Committe to you as Chairman of the Council of Deans. The committee met at 3:30 p.m. EST on June 4, 1984, by telephone conference call. At that time, we had available to us the tallies of the advisory ballots submitted by members of the Council.

The Nominating Committee was cognizant of the COD rules and regulations as well as the AAMC Bylaws. For the offices to be filled by vote of the Council of Deans, your Nominating Committee proposes the following slate:

Chairman-Elect of the Council of Deans

D. Kay Clawson, M.D.
Exec. Vice Chancellor and Exec. Dean
University of Kansas
School of Medicine

Members-at-Large of the Council of Deans

Walter F. Leavell, M.D.
Dean
Meharry Medical College
School of Medicine

Thomas H. Meikle, Jr., M.D.
Dean
Cornell University Medical College

Henry P. Russe, M.D.
Dean
Rush Medical College

Other offices are filled by election of the Assembly. A slate will be proposed for the Assembly's consideration by the AAMC Nominating Committee of which I am a member. The committee that I chair has been asked to submit names in the form of recommendations to that committee. On the basis of our deliberations, our committee will recommend as follows:

Council of Deans Representatives to the Executive Council
William T. Butler, M.D.
President
Baylor College of Medicine

Robert S. Daniels, M.D.
Dean
University of Cincinnati College of Medicine
School of Medicine

Chairman-Elect of the Assembly
Virginia V. Weldon, M.D.
Deputy Vice Chancellor for Medical Affairs
Washington University School of Medicine

These nominations, I believe, accurately reflect the wishes of the members of the Council of Deans. I have called each of these nominees and they have agreed to serve.

The Nominating Committee was also apprised of Dr. Goodale's resignation and noted that this left a vacant position in that Dr. Goodale's term extended through the academic year 1984-85. The committee recognizes that the Executive Council has the option of appointing a person to fill out the remainder of the term or permitting the position to be filled by election at the next Annual Meeting. Should the Executive Council select the latter option, the Nominating Committee will propose that the AAMC Nominating Committee select Rudi Schmid, M.D., Dean, University of California, San Francisco, College of Medicine, to serve in that position for the one year remaining of Dr. Goodale's term. I am confident that we have a slate which will contribute to the work of the association.

Thank you for the opportunity to serve as chairman of this committee.

Sincerely,

Richard C. Reynolds, M.D.
Dean
UMDNJ-Rutgers Medical School

cc: John M. Dennis, M.D.
John W. Eckstein, M.D.
David C. Dale, M.D.
Arthur C. Christakos, M.D.
Joseph A. Keyes, Jr.

ELECTION OF INSTITUTIONAL MEMBER

The following school has received full accreditation on probation by the Liaison Committee on Medical Education and is eligible for Full Institutional Membership in the AAMC:

Universidad Central del Caribe
Escuela de Medicina de Cayey

RECOMMENDATION: That the Council of Deans approve the election of this school to Full Institutional Membership.

MATCHING MEDICAL STUDENTS FOR ADVANCED RESIDENCY POSITIONS

During the past year the Councils of the AAMC have examined the current practices for selection of medical students to specialty residency positions commencing at least one year after graduation (PGY-2). They have reviewed the interdigitation of advanced residency selection with the medical school curriculum and intern selection. The views of faculty, Deans of Students, students, and specialty residency program directors have been sought. In December the Executive Committee met with the leaders of the professional societies of five disciplines currently seeking to match future residents early in the senior year of medical school. After due consideration, the following resolution was adopted by the AAMC Executive Council in September 1984:

> The educational needs of medical students are best served if they are not forced to make premature decisions about career specialization. Their time in medical school should be devoted, as much as possible, to completing their general professional education, obtaining in-depth training in basic disciplines and breadth in elective experiences.
>
> To achieve these educational goals and contain the pressures toward premature specialization, medical schools should release their summary reports of student achievement (Deans' letters, transcripts) as late as possible in the senior year as recommended by the AAMC Task Force on Graduate Medical Education in 1981. Specialty program directors should moderate their pressures for early specialty selection, and students should support efforts to conduct residency selection as late in the senior year as possible. This timing allows students to complete the basic clerkship cycle as well as some elective experiences before chosing a post-graduate career track and affords time for the school to evaluate and summarize the achievements of that senior class.
>
> Optimal career selection is further enhanced by coordinating applications and interview trips, integrating selection of internship and residency programs which require dual applications, and maximizing the ability of medical student couples to obtain desired residency choices in the same geographic area. All of these desired outcomes are achieved by the National Resident Matching Program which has a long and distinguished record in coordinating the yearly placement of the majority of American medical students in residency programs. We propose that all internship (PGY-1) and residency (PGY-2 and beyond) positions offered to medical students be offered only through NRMP.

RELATIONSHIPS WITH INVESTOR-OWNED ORGANIZATIONS

At the COD Spring Meeting, there was a discussion of medical school relationships with investor-owned hospitals. In response to a question regarding the number having some level of contact or involvement with for-profit organizations in the health field, approximately half of those present raised a hand. In order to acquire more information as to the nature and extent of these relationships, a questionnaire was sent to each dean (attached). This memorandum provides a synopsis of the responses.

Seventy deans returned the questionnaire, of which forty reported that there had been a contact regarding affiliation relationships with an investor-owned organization. Twelve are presently affiliated with a hospital owned or managed by a for-profit corporation and four of these have an agreement they would be willing to share. Among the four is the University of Louisville-Humana Hospital University relationship which has been described at the AAMC Annual Meeting and the COTH Spring Meeting by Dean Kmetz. One affiliation involves a simple agreement for rotation of residents in orthopedic surgery. Another involves a less than 200-bed hospital owned by a 90 +/- physician multi-specialty group used for both students and housestaff rotations. The fourth involves a hospital proposed for establishment which is desired by the school to permit greater access to capital.

One dean has concluded an agreement with a for-profit HMO which he would be willing to share. Another dean willing to share an agreement is not now affiliated with a for-profit organization, but was once engaged in negotiations regarding a psychiatric hospital.

The eight remaining affiliated hospitals are:

- a regional hospital owned by a major chain used by the school for limited internal medicine rotations and limited elective rotations,
- a major chain hospital used by the school as a means of gaining access to patients for faculty and students,
- an eye hospital managed by a for-profit corporation,
- a psychiatric hospital,
- a women's hospital,
- a small, new hospital,
- a hospital owned by a chain
- a university hospital managed by a for-profit concern.

The above paragraphs summarize the responses to questions 1, 9, and 10. Responses to questions 2 through 8 are tabulated below:

(2) The activity which is the subject of the contact is a:

Hospital	28
Nursing Home	3
Ambulatory Surgery Center	3
HMO	3
Psychiatric Hospital	3
Psychiatric Service	1
Ambulatory Care Center	1
Building for Ambulatory Care	1
Imaging Center	1
Substance Abuse Program	1
Proprietary Hospital (sic)	1
Diagnostic Center Funded by Business	1
Radiation Therapy	1
Clinical Laboratory	1
Rehabilitation Center	1

(3) The activity was already in being in 15 cases and proposed for establishment in 28 cases.

(4) Contact was initiated by the for-profit organization 33
by the school 10

In only three instances did the school clearly initiate contact involving an activity already in being; in two of the three, the other responses make clear that it was a hospital already in the community to which the school desired to send residents (2) or students (1). In each case, an agreement has been reached. The subject of the third school-initiated contact is a hospital, but the context does not make clear whether it is a for-profit hospital or a university-owned hospital; no agreement was reached and discussions have been discontinued.

In three instances, the contact appears to have been initiated by the school and hospital simultaneously (or ambiguously) in that both options to question four are selected. In each instance, an agreement has been concluded.

(5) Eight report negotiations are concluded, while 23 report that they are underway--nine casually and 14 seriously. Seventeen, who have had a contact, are not now negotiating.

(6) The motivation of the school was access to capital 18
access to patients for faculty in 11
access to patients for students in 9
Five deans listed other:

Housestaff	2
Efficiency and broader consultation base	1
Legislature	1
Faculty Support	1

(7) Ten deans responded to the question regarding the profitability of the university hospital being considered for sale; of those 4 said yes (it was currently profitable) and 6 said it was not.

(8) Of those contemplating the sale of a currently owned facility, five respondents reported that the plan involved undergraduate medical education, six--residency training, four--sponsored research, five--patient care to indigents, and four--medical center sharing in any profits.

RELATIONSHIPS WITH INVESTOR OWNED ORGANIZATIONS

At the Spring Meeting of the Council of Deans, Dr. Janeway asked for a somewhat more sophisticated poll of members of the Council with respect to their involvement with investor owned organizations. This information will be classified as Restricted in the AAMC Data Classification: "Association confidential -- may be made available to member institutions and other qualified institutions, organizations and individuals subject to the discretion of the President." Please take a moment to provide us the following information:

1. Has there been any contact between the school or university and investor owned organizations in the medical/health care field regarding affiliation relationships?

   _____ Yes

   _____ No

2. Is the activity which is the subject of the contact a:

   _____ hospital

   _____ nursing home

   _____ ambulatory surgery center

   _____ freestanding emergency room

   _____ HMO

   _____ Other, please specify _____

3. Does the contact involve an activity:

   _____ Already in being

   _____ Proposed for establishment

4. Who initiated the contact?

   _____ The For-Profit Organization

   _____ The School

5. Are there now negotiations underway?

   _____ No

   _____ Yes, but casual

   _____ Yes, serious

   _____ Agreement concluded

6. What is the primary motivation of the school for undertaking the negotiations? (Please check only one)

_____ Access to capital

_____ Access to patients for faculty

_____ Access to patients for students

_____ Other

7. If the sale of a hospital currently owned by the university or affiliated non-profit organization is under consideration, is the hospital currently profitable?

_____ Yes

_____ No

8. If there is a sale of a currently owned facility, does the plan call for: (Check all that apply)

_____ A. Undergraduate medical education to be conducted

_____ B. Residency training to be conducted

_____ C. Sponsored research

_____ D. The provision of patient care to indigents

_____ E. The academic medical center to share in any profits

9. Do you have a concluded agreement that you would be willing to share?

_____ Yes

_____ No

10. Are any of the hospitals owned by the university or affiliated with the college of medicine currently managed by a for-profit corporation?

_____ No

_____ Yes (please list hospitals)

_____

_____

Name_____

Institution_____

Date_____

Status of Research Facilities and Instrumentation

Background. The continuing deterioration in the quality of research facilities and instrumentation in the academic laboratories, including those in medical centers, has become a matter of increasing concern to scientists, institution officials, and those science-oriented agencies within the Federal government responsible for science programs. A major constraint to prompt and sound planning to contend with this problem has been the absence of timely information as to the quantitative and qualitative dimensions of these research resources.

At the time of the June 1981 Executive Council meeting, the decision was made to establish an ad hoc committee to examine issues relating to the funding of research resources. This was prompted by a number of considerations, including concerns about the quality and quantity of instrumentation in academic institutions, increasing competition for available funds, and some uncertainty with respect to the future within NIH of the Division of Research Resources. No meeting of that committee was ever convened, in part because the threat to the continuing existence of DRR disappeared, and because it seemed that more comprehensive examination of these issues would be undertaken by organizations with a broader base than the Association.

Since that time, the concerns about the underlying problem have continued to grow, and several studies have been initiated or proposed in the two areas. They are summarized as follows.

(1) National Survey of Academic Research Instruments and Instrumentation Needs. Sponsored and supported by the National Science Foundation and NIH, and conducted by WESTAT, Inc., the purpose is to "provide a factual basis for the review of Federal equipment funding levels and priorities. This survey will document for the first time: (a) trends in the amount, condition and cost of existing research instrumentation in the nation's principal research universities and medical schools, and (b) the nature and extent of the need for upgraded or expanded research instrumentation in the major fields of academic science and engineering." The study involves a nationally representative sample of 43 major R&D universities and a partially linked sample of 24 medical schools. Information will be collected on a representative sample about each type of research instrument's age, cost, means of acquisition, condition and so forth. The findings will be used to develop quantitative indicators of trends over time and differences among fields in instrumentation costs, investment, condition, and need. The study will be conducted over a two-year period that commenced late in 1982. Medical schools will be involved only in 1983-84.

(2) A Project to Assess and Disseminate Alternative Approaches to Meeting University Research Equipment Needs. Originally supported

by NSF, DOA, DOD, DOE and NASA and carried out by AAU, NASULGC and COGR, this is a 16-month project, with the objective of "increasing awareness among research universities of opportunities for better planning and management of research equipment at all levels." The project is planned in three phases. In phase I, six analyses will be conducted to:

- Assess the role of debt-financing of research equipment and sound university financial practice;
- Identify and evaluate opportunities to improve the procurement, management, use, operation and maintenance of research equipment;
- Assess present tax incentives for the donation of research equipment and suggest ways to increase support from the private sector;
- Identify opportunities to eliminate or reduce state and university budget and policy barriers;
- Identify opportunities for changes in Federal regulations;
- Evaluate present methods of direct Federal investment and suggest improvements.

Phase II involves regional seminars to disseminate and discuss the results of the six analyses within the university community. The third phase is a briefing in Washington to present to Federal agencies and Congress the results of these analyses.

Apparently during the planning phase there was some confusion about the possibility of NIH also being a supporter of the project. As a consequence, there was no specific biomedical aspect to the study. Because of that, AAMC staff expressed their concern about this seemingly unnecessary and serious defect. Negotiations were therefore reopened with NIH, with the result that partial funding for part of the project to add a biomedical component has been assured. The project is to be completed in February 1985.

(3) Interagency Study of Academic Science and Engineering Laboratory Facilities. The House version of the Authorization bill for the Department of Defense for FY 1984 included the following provision: "The Committee also directs that a study be undertaken by the Secretary of Defense on the need to modernize university science laboratories essential to long-term national security needs. The study should be submitted to the Committee by March 15, 1984." The Congress also directed NSF to be a lead agency in encouraging other Federal agencies, state and local governments, and the private sector to support renewal of university research facilities. A steering committee was formed with representatives

from NSF, DOD, NIH and DOE to plan a study of such facilities. The objective is to obtain an understanding of the condition of university facilities currently being used for science and engineering research and the estimated future needs for construction, remodeling and refurbishment.

A request has just been directed to the chief executives of approximately 25 institutions asking for 5-year facility plans and estimated expenditures for new construction and remodeling of existing structures over that period. The purpose of this request is to assist the steering committee in its planning of the study and the preparation of an interim response to the Congress.

No further details are available at the moment, except for the expectation that most research-intensive universities will be included in the final survey population. AAMC has urged that the planning for the study be certain to include recognition of the unusual circumstances of teaching hospitals with sizeable research programs.

(4) Legislative Incentives.

- S. 1537. Senators Danforth and Eagleton introduced S. 1537 last year, a bill which provides additional authorizations for appropriations for FY 1984 and each of the four following years with the goals of (1) strengthening support for fundamental research in science and engineering, (2) upgrading, modernizing and replacing university research equipment, (3) providing increased numbers of graduate fellowships, (4) supporting faculty career initiation awards, (5) supporting efforts to rehabilitate, replace or improve university research facilities, and (6) supporting modernization and improvement of undergraduate science education.

The authorized sums are specified for DOA, DOD, DOE, NASA and NSF, whereas for NIH the bill states "... those additional amounts necessary to restore the capacity of NIH to conduct and support adequate levels of biomedical research." The yearly authorized sums for the other five agencies total $139 million/year for acquisition, installation or modification of research instrumentation and $245 million available on a matching basis for programs to modernize, rehabilitate, replace, or improve existing university research facilities.

The sponsors of the Senate Bill now plan to introduce this subject in the House. Since S. 1537 was not intended to pass as a separate Bill, but to express a sense of the Senate about the urgent need to support the Nation's university research capability and to influence the outcome of the Appropriations Bills, it is possible that

a Resolution will be introduced in the House and passage of a Joint Resolution sought.

The objectives of this legislative proposal are highly commendable, but insofar as biomedical research and the NIH are concerned, two difficulties remain to be resolved. The first is the complication of introducing the concept of an authorization ceiling for NIH at the very time when we are vigorously opposing that concept in legislation directed more specifically at the NIH. The second, more pertinent to the facilities and instrumentation issues, is that NIH no longer has broad constructive authority on which any program for major construction or renovation of facilities might have to be based.

- H.R. 2350. One of the provisions of the House bill to reauthorize parts of the NIH, H.R. 2350, requires a study "concerning the use of live animals in biomedical and behavioral research." One component of that proposed study reads as follows:

> "Estimate:
>
> (A) the amounts that would have to be expended by entities which conduct biomedical and behavioral research with Federal financial assistance to equip and modernize their research facilities in order to meet the standards referred to in paragraph (2); and
>
> (B) The amounts that would be expended by entities which have not previously conducted such research with Federal financial assistance to establish, modernize, or equip facilities in order to meet such standards."

Other legislative initiatives have included the well-publicized efforts of several universities to obtain money for construction of research facilities through special-interest amendments in Congress. AAU, NAS, APS and AAAS have published statements strongly critical of that tactic, which bypasses the peer review processes of the scientific community and prospective funding agency.

(5) Current Mechanism for Funding Capital Improvements. Under OMB Circular A-21 it is possible to include depreciation or user charges for space and interest charges on money borrowed for major capital improvements in the indirect cost pool. The extent to which this mechanism is presently being employed is unknown.

The Association actions will be to:

1. urge its members to cooperate insofar as possible with any of the studies which are described above,

2. delay any further action as to additional surveys or other studies until the reports and analyses of the studies presently underway or pending are completed, and

3. monitor closely the progress and outcome of these studies.

association of american medical colleges

JOHN A.D COOPER, M.D., PH.D.
PRESIDENT

(202) 828-04E

July 12, 1984

Ms. Carol Young
Office for Protection from Research Risks
National Institutes of Health
9000 Rockville Pike
Building 31, Room 4B09
Bethesda, MD 20205

Dear Ms. Young:

The Association of American Medical Colleges is pleased to have an opportunity to comment on the draft document entitled "Proposed Public Health Service Policy on Humane Care and Use of Animals by Awardee Institutions."

As you and your colleagues are aware, much of the nation's biomedical research, including a high proportion of that involving the use of animals, is conducted within the laboratories of our member medical schools and teaching hospitals and by scientists whose discipline and specialty organizations form the Association's Council of Academic Societies. Therefore, the AAMC has a substantial interest in both the humane care and use of animals and any regulatory activities or requirements that would significantly inhibit the conduct of responsible research.

The membership of the Association is deeply and publicly committed to every reasonable measure that will assure the availability of laboratory animals as a valuable resource for teaching and research and is convinced that that objective is best assured by appropriate voluntary action on the part of scientists and others involved in or responsible for such research. It is our further belief that there is no evidential basis that substantial abuse exists in animal care and use, despite frequent allegations to the contrary. Under these circumstances, some aspects of the proposed policy seem unwarranted.

We offer the following general comments in response to the solicitation:

1. The continued inclusion of detailed considerations as a part of the Principles under "(B) The Research" is highly questionable. It is suggested that a simple statement about the importance of research involving animals and the necessity of appropriate care and use of them for humanitarian and economic as well as scientific reasons should suffice. Furthermore, the presence of the statement, "the research should be such as to yield fruitful results for the good of society and not random or unnecessary in nature" is unnecessary and gratuitously offensive to a scientific community, most of whose support has to pass muster through the ferociously competitive technical merit and program

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relevance peer review system of the NIH. Nor is the AAMC aware of any other source that is willing to support research of the type interdicted by this statement.

2. We suggest that the existing confusion as to the nature and status of the current guidelines will be worsened by what appear to be the introduction of additional ambiguities or contradictions. For example, the Introduction "mandates" certain components of the policy, refers to the "requirements" of the Guide having been "implemented" and involves a commitment to "implementing the recommendations of the Guide," all in one sentence. The legal standing of these various terms and their widespread variations in the interpretation by institutions of the several elements noted in that sentence are predictable. We endorse the concept of avoiding the incorporation of "directions," "requirements," "recommendations," "guidelines," or whatever in statute or regulation and of eschewing "mandates" and "requirements" in "guidelines." But the ambiguities in that sentence almost certainly will dilute efforts to assure continued and consistent humane care and use of animals throughout the country.

3. The change in the title of the institution committee from "Animal Care Committee" to "Animal Research Committee," together with the description of the functions of that committee are particularly troublesome. Although it is the announced intention of the Public Health Service that those committees should not become involved in assessment of scientific merit of protocols, the line to be drawn between the review functions of the committee and the assessment of merit is so subtle as to introduce the possibility and serious and undesirable intrusion into the traditional, highly respected peer review process. It seems probable as well that expectations on the part of animal rights advocates will be raised to an unreasonable level with respect to that review and the monitoring of ongoing research involving animals.

   Furthermore, the prospective review of research proposals together with the requirement that all protocols involving animals must be formally reviewed will create a major and unnecessary administrative burden for grantee institutions.

4. The granting by federal agencies of authority to the Animal Research Committee or to the "ARC's Doctor(s) of Veterinary Medicine" to "alter or suspend a research activity" or to "terminate the research activity" seems to be an improper invasion by the federal government into the internal relationships and authorities of non-federal institutions. It is suggested that this provision be modified to place the authority and responsibility clearly on the institution to initiate such actions, if warranted.

5. The required involvement of a veterinarian trained in laboratory animal medicine will place a particular burden on small institutions because the number of such individuals is limited. That problem of supply should be recognized by either a waiver or some other arrangement that will recognize the difficulty.

Should any of these comments require explication, please do not hesitate to contact me or members of the Association staff.

Sincerely yours,

John A. D. Cooper

John A. D. Cooper M.D.

ASSOCIATION OF ACADEMIC HEALTH CENTERS

July 13, 1984

Ms. Carol Young
Office for Protection from Research Risks
National Institutes of Health
9000 Rockville Pike
Building 31, Room 4B09
Bethesda, Maryland 20205

Dear Ms. Young:

On behalf of the Association of Academic Health Centers and the Association of American Medical Colleges, we write to convey to you and your colleagues some general concerns about the provisions of the draft document entitled "Proposed Public Health Service Policy on Humane Care and Use of Animals by Awardee Institutions."

The use of animals in research and education is absolutely vital to continued advances in medicine and to the health and well-being of both animals and humans. We are also mindful of the necessity of humane care and use of these animals and support reasonable measures to that end.

We are not persuaded, however, by the evidence offered in support of this policy or from discussions with large numbers of scientists and institution officials throughout the nation that the adoption of the policy is warranted. We recognize that significant numbers of constituent institutions have voluntarily instituted, wholly or in part, one or more of the measures required in the proposed policy. But the excessive administrative burdens resulting from prospective and formal review of all protocols involving animals, the surprising and serious intrusion on institutional prerogatives by placing authorities to terminate research in the hands of an institutionally constituted committee and the inclusion of mandates, requirements, and recommendations in a document labeled, "Guidelines," must be criticized.

We urge, therefore, that the comments by a variety of associations, societies and institutions be carefully considered before new policy is formally promulgated.

Sincerely yours,

John R. Hogness, M.D.
President
Association of Academic
Health Centers

John A.D. Cooper, M.D., Ph.D.
President
Association of American Medical
Colleges

association of american medical colleges

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

(202) 828-0460

October 2, 1984

John F. Sherman, Ph.D.
Chairman
Ad Hoc Steering Committee on
Animal Issues
1 Dupont Circle, N.W.
Washington, D.C. 20036

Dear John:

This responds to your letter to me dated August 21 which you wrote as chairman of the ad hoc steering committee for the exploratory effort considering more vigorous and effective activities to assure the availability of animal models in research, education and testing.

As you know, this subject is one of great interest to the Association and its members and the proposal mentioned in your letter and outlined in the accompanying document should, if properly implemented, markedly enhance activities currently underway by a number of organizations but carried on more or less in isolation. As you pointed out, it is important to recognize that individual organizations undoubtedly will and should continue efforts directed towards specific audiences and undertaken according to their own purposes and resources. However, it seems almost certain that unless there is a greater degree of cooperation and sharing of information and activities, the full potential on our side of the animal issue will never be realized.

Accordingly, the Association at the direction of its Executive Committee is prepared to provide financial assistance to such an endeavor, up to a maximum of $25,000 for each of three years. It is understood that other organizations, particularly the American Medical Association and the American College of Surgeons, will in all probability join in providing substantial funds for this purpose. Furthermore, although this support is not contingent on such an outcome, I urge strongly that such funding be viewed as a significant stimulus to a merger of the two organizations which presently represent the community in this subject area, namely, the Association for Biomedical Research and the National Society for Medical Research. Given the strength of the opposition confronting us on this issue, we can

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ill afford a situation in which two organizations seem to compete for available resources and where the strength of our efforts is unintentionally but seriously diluted.

Please keep me informed of the developments as the exploration continues.

Sincerely,

John A. D. Cooper, M.D.

aamc association of american medical colleges

August 21, 1984

John A. D. Cooper, M.D.
President
Association of American Medical Colleges
1 Dupont Circle, N.W.
Washington, D.C. 20036

Dear John:

The informal group which your organization, together with the American Medical Association and the American Physiological Society, convened to address the increasingly serious problems created by governmental and non-governmental organizations and agencies seeking to eliminate the humane and responsible use of animals essential to research, education and testing of drugs and devices has considered the situation and has prepared the enclosed proposal as a means of countering the forces seeking to impede scientific research and education as well as the testing of drugs and devices.

This proposal recognizes that many organizations are currently engaged in substantial efforts to assure the humane use of animals essential to research that deals with normal growth, development and disease in animals and human beings. It recognizes that an entity is needed to gather and disseminate current, reliable information on governmental and non-governmental proposals and actions to restrict or eliminate essential animal use, given our current state of scientific knowledge, as well as to facilitate the exchange of documents and other material of value in educating the public about the involvement of animals.

The proposal, therefore, envisages an alliance of organizations and institutions (to be named Friends of Research) that have active programs and financial resources to form a steering committee and an advisory body made up of organizations, agencies and institutions that have interest in scientific research, education and testing but who are involved to a lesser degree concerning the use of animals.

In order to begin the joint effort, it is estimated that approximately $150,000 needs to be raised for each of three years from the three convenors and a few other committed organizations. The attached proposal for requirements and budget explain the basis and amount of support required. Our committee strongly recommends to you the selection of Option 2 as preferable in terms of costs, ease and promptness of implementation and effectiveness.

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

The informal group that you and the others convened hopes that you will be in accord with the proposed Friends of Research and be prepared to support it.

Sincerely yours,

John F. Sherman, Ph.D.
Chairman
Ad Hoc Steering Committee

Attachment

PROPOSAL FOR FORMATION OF THE FRIENDS OF RESEARCH (FOR)

Background

The humane and responsible use of animals continues to be essential in the advancement of scientific knowledge of man, in the education of professionals who serve the medical and other health needs of human beings and animals, and in the testing of drugs and devices that affect human and animal health.

Despite the evidence that certain types of essential studies can be carried out only in intact organisms that are high on the evolutionary scale, including large mammals, primates and human beings in some circumstances, some groups are increasingly active in seeking to ban the use of animals in research and education. These groups are active, well organized and financed, politically astute and effective. They are not bound by evidence in their statements. Their activities include wide distribution of material to the media, the public, local organizations, local governmental officials as well as state and federal officials.

Such groups are increasingly effective in local situations. Recently, they have been seeking local ordinances and referenda against the humane and responsible use of animals in research related to human and animal health and diseases in addition to their efforts at state and national levels.

A recent major threat to animal research involves trespassing on the property of medical schools, universities, hospitals and research institutions. Such trespass has included unlawful breaking and entering and the destruction of research records that have not only set back or destroyed valuable research data but also have meant that the animals involved in the research have been used in vain.

In recognition of the seriousness of this threat to intellectual and scientific freedom, the responsible pursuit of new knowledge to benefit human beings and animals, and the education of physicians, veterinarians, and other scientists and health professionals, the chief executive officers of the Association of American Medical Colleges, the American Medical Association, and the American Physiological Society extended an invitation to a small number of organizations to discuss this subject.

At an April 1984 meeting of the representatives of these organizations in Washington, attendees examined the current status of animal research and the governmental, organizational and public barriers that were in place or developing to oppose the use of animals in science and education. Since April, representatives of some of these organizations have been meeting to determine what activities need to be strengthened or undertaken to continue support and to assure the humane and responsible use of animals in science, education and testing applications.

The following proposal outlines broadly the goals of the group and the means to achieve them.

Organization

The Friends of Research (FOR) should be formed to:

1. Collect and distribute to interested organizations, agencies, and institutions information on the use of animals in research, education and testing. This information would include standards that have been adopted for the humane and responsible use of animals. Those organizations and institutions forming Friends of Research would be the principal recipients of this information to use in accordance with their own policies and activities.

2. Solicit and distribute articles, statements, speeches, films, etc. on the essential humane use of animals in research and education. The distribution would be to the members of FOR.

3. Inform organizations and institutions of pending legislative and regulatory activity that would place undue restraint on the humane use of animals in research.

4. Facilitate communications regarding animal rights activities and responses to those activities.

Network

The convening organizations and those that have been involved in the development of this proposal have networks already in place to serve a variety of functions in furthering the aims of the organizations. These networks can be strengthened and used effectively with respect to animal issues through information and alerts provided by Friends of Research. A network of networks would be particularly valuable in alerting participant organizations in a variety of situations. These organizational networks would make use of the information distributed by FOR in accordance with their own policies and activities, and should prove mutually beneficial since they reach different elements of science, education, professional practice and the public.

Public Education

Education of the public is an essential element in assuring that animal research required to improve human and animal health can continue humanely. It is anticipated that all members of FOR will continue their effort in public education if their missions now include such efforts. The Foundation for Biomedical Research was created specifically to assist in the education of the public on the necessity for continuing to use animals in research that will improve the public health and the health of animals. It will, therefore, play a particularly important role in public education.

Structure of Friends of Research

Friends of Research shall have a Steering Committee consisting of one member appointed by each of the convening organizations (AAMC, AMA, APS) and

members appointed by other organizations that are currently active in the support of animal research and are prepared to participate in guaranteeing financial support for Friends of Research for at least three years. The Association for Biomedical Research/Foundation for Biomedical Research and the National Society for Medical Research would be ex officio members of the Steering Committee.

The Steering Committee shall determine the activities of FOR after consultation with their organizations. FOR shall also have an Advisory Board consisting of members appointed by participating organizations, institutions and agencies that have interests in scientific research, education, health, etc. involving animals. The Steering Committee shall also enter into agreements with other organizations, agencies or institutions to provide services to FOR or shall employ staff and rent space required to conduct the activities of FOR as outlined above. The Steering Committee shall be responsible for inviting other organizations to join Friends of Research. Each of these organizations may appoint a member to the Advisory Board.

Staffing

The aims of Friends of Research should be carried out with a small staff providing services to FOR through the Steering Committee. Expenses should be kept to a minimum and existing resources of the members of FOR should be used insofar as possible to assure the continuing humane use of animals in research, education and testing.

Staff services could be provided through one of two options:

Option 1.

The Steering Committee could rent office space in Washington, D.C. necessary for a small staff to accomplish the functions of FOR as outlined in this proposal. Such office space should, if possible, be in a scientific community (AAAS, FASEB, NAS, for example) rather than in the office space of one of the organizations appointed to the Steering Committee.

To perform these functions outlined, it is estimated that the secretariat for Friends of Research would consist of an administrator, two secretaries and two clerks. A summary of estimated costs is under budget Option 1.

Option 2.

Several of the functions described on page 3 are, in part, being pffered by the ABR/FBR or the NSMR. The Steering Committee could enter into an agreement with ABR/FBR and/or NSMR to provide those services, including personnel, space and equipment as required. Reimbursement would be based on a rate negotiated by the Steering Committee on behalf of FOR.

NSMR and ABR would be members of the Steering Committee as well as agreeing to provide specified services to FOR. A summary budget estimate is shown under budget Option 2.

Operating Agreements, Meetings, etc.

The specifics of operating agreements, agendas, frequency and location of meetings of the Steering Committee and the Advisory Board can be developed only after the purposes and organizational, staffing and budget proposals have been agreed upon by the Steering Committee and the organizations that appoint it.

Budget Option 1. Separate Staff and Office

Year One

Rent	$ 10,000
Overhead and fringes	30,000
Purchase and rental for fixed and moveable equipment	30,000
Direct Costs	
Salaries	110,000
Postage, office supplies, etc.	9,000
Telephone	5,000
Computer and related services	6,000
	$ 200,000

Budget Option 2. ABR and NSMR Staff Agreements

Year One

Overhead	30,000
Salaries	100,000
Postage, office supplies, etc.	9,000
Telephone	5,000
Computer and related services	6,000
	$ 150,000

FOLLOW-UP ON LENGTHENING OF TRAINING REQUIREMENTS BY SPECIALTY CERTIFYING BOARDS

American Board of Medical Specialties

On April 12, 1984 the Administrative Boards of the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals, and the Executive Council of the Association approved the recommendation that the Association introduce a resolution to amend the Bylaws of the American Board of Medical Specialties (ABMS) to require member boards to have the approval of ABMS for changes in educational requirements that have a significant impact upon the resources that must be provided by teaching hospitals for their graduate programs or that impinge upon the educational resources of programs in other specialties.

Accordingly, the letter and proposed amendment shown on the following pages were sent to Donald G. Langsley, Executive Vice President of ABMS, on May 14. In a letter dated May 18, 1984, Dr. Langsley informed the Association that the recommended amendment would be considered as a resolution at the ABMS interim meeting on September 20, 1984.

AAMC Chairman, Bob Heyssel represented the Association at the September 20 meeting. He emphasized that at a time when resources for medical care and medical education are under severe scrutiny, the traditional methods of decision making about the scope of graduate medical education programs must be reconsidered.

The ABMS Executive Committee recommended that action on the resolution be deferred until after an invitational conference on the issues raised by the proposed amendment is held early next year. There was a unanimous vote to defer action until the ABMS annual meeting in March 1985.

Accreditation Council for Graduate Medical Education

At the request of the AAMC, the Accreditation Council for Graduate Medical Education (ACGME) considered the issue of changes in specialty board certification requirements that affect the special requirements for the accreditation of programs in graduate medical education. The following statement was approved and has been transmitted to the ABMS and to the specialty certifying boards.

> "The ACGME recognizes that a mechanism is in place for review of a Statement of Justification/Impact Statement which must accompany requests for approval of revisions of 'Special Requirements.' The ACGME recommends that requests for changes in the duration of training programs not be approved, unless there has been full and open discussion of the broad impact of those changes upon the specialty itself, upon allied disciplines, upon the educational institutions providing the training and upon the public interest. This may include convening an appropriate forum for discussion of specific cases. The ACGME recommends that specialty certification bodies contemplating alteration of the duration of residency training requirements for certification should initiate discussion of the

proposal with the Residency Review Committees of which they are sponsors early in the process."

The Association of Pathology Chairmen has appealed to the Chairman of the ACGME regarding the decision by the RRC in Pathology not to change the special requirements for pathology, thus avoiding the necessity of approval of a lengthening of the pathology training program from four to five years. Their argument is that, although requiring candidates to have a broad clinical year in the course of their training does not directly affect pathology programs, two of the options other than broad clinical training do. These are a year of full-time research in pathology or a year of training in one of the specialty fields of pathology that includes clinical correlation and patient care. It is presumed that the request for consideration of this appeal by the ACGME will be referred to one of the ACGME subcommittees at its September meeting.

Actions by Certifying Boards

Subsequent to the April 12, 1984 meeting of the Executive Council, the American Board of Anesthesiology has announced a change in its certification requirements which eliminates a period of practice in lieu of a third year of training in an accredited program. Although it is not known how many anesthesiologists currently opt for practice instead of a third year of training, this change in requirements will definitely lengthen the training program for a proportion of residents in anesthesiology and will require additional resource allocations to programs in anesthesiology.

The American Board of Psychiatry and Neurology has announced a change in requirements for entry into programs in these specialties. The length of training remains the same, but a broad-based first year of training in accredited programs in internal medicine, family practice, or pediatrics, or a transitional year is required for psychiatry. Entry into neurology programs will require a year of training in internal medicine or in a transitional program which includes at least six months in internal medicine. These changes may place an added burden on training programs in the designated specialties.

association of american medical colleges

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

(202) 828-0460

May 14, 1984

Donald G. Langsley, M.D.
Executive Vice President
American Board of Medical Specialties
One American Plaza, Suite 805
Evanston, Illinois 60201

Dear Don:

On April 12, 1984 the Administrative Boards of the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals, and the Executive Council of the Association approved the recommendation that the Association introduce a resolution to amend the by-laws of the American Board of Medical Specialties (ABMS) to require member boards to have the approval of ABMS for changes in educational requirements that have a significant impact upon the resources that must be provided by teaching hospitals for their graduate programs or that impinge upon the educational resources of programs in other specialties.

We recognize that the 23 member boards of the ABMS are independent, autonomous entities and that the traditional role of the ABMS has been to serve a coordinating function among its members. However, the growth of specialization in medicine and the contraction of the educational resources available for the education and training of physicians in the various specialties requires reassessment of the role of the ABMS and the responsibilities of its member boards for ensuring that physician specialists are appropriately educated and trained in the most efficient and effective way possible. The ABMS is the only organization wherein the boards and organizations vitally interested in the education of specialists can act together to see that this is accomplished.

The AAMC believes that the time has come when the ABMS must extend its role beyond simply coordinating the activities of its members and assume the power to approve or reject changes that are proposed in educational requirements. We believe that this is essential to avoid conflicts among member boards and

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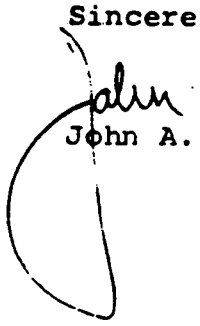
between boards and the institutions and organizations that provide the resources for graduate medical education in the United States. Accordingly, the AAMC requests that Section 12.4 of the by-laws of the ABMS be amended as shown on the attached page.

Sincerely yours,



John A. D. Cooper, M.D.

Attachment

cc: August G. Swanson, M.D.
Joseph E. Johnson, III, M.D.

Section 12.4 Change in Certification Requirements or Name

(a) Primary and Conjoint Boards have the responsibility of establishing their own educational requirements for certification and may change such requirements. ~~without being required to submit such change for prior approval of ABMS; however, such Members shall forward to the Executive Vice President written notice of any change in the Member's certification requirements at least one hundred eighty (180) days before the proposed change is to become effective.~~ *Changes that alter the resources that must be provided by teaching hospitals for their graduate programs or changes that impinge on the resources of educational programs in other specialties shall be submitted to the ABMS for approval prior to their implementation. Specifically, changes that lengthen the duration of training or that require a portion of the training period to be spent in an accredited program of another specialty shall be submitted for approval.*

AMERICAN BOARD OF MEDICAL SPECIALTIES

One American Plaza, Suite 805 Evanston, Illinois 60201 312/491-9091

May 18, 1984

John A.D. Cooper, M.D.
President
Association of American Medical Colleges
One DuPont Circle, N.W., Suite 200
Washington, DC 20036

Dear John:

This is to acknowledge receipt of your May 14th letter requesting an amendment to Section 12.4 of the ABMS Bylaws.

Section 10.2 of the Bylaws provides that a proposal for the alteration, amendment, or repeal of Bylaws, etc., may be initiated by any Member pursuant to a resolution which has been introduced by that Member and adopted at an Annual, Interim or Special Meeting of ABMS.

I will be happy to place this matter on the agenda for the Interim Meeting to take place on September 20, 1984, and will consider your letter and recommended amendment as a resolution to be acted on by the ABMS Assembly. If this resolution is passed by the Assembly, it would be reviewed by the Bylaws Committee and the Executive Committee, and considered by the Assembly at the Annual Meeting in March, 1985 in accordance with Section 10.3 of the Bylaws. The first action (passing a resolution) would require a majority vote, but the Bylaws require a two-thirds affirmative vote for the action of amending the Bylaws. For information, I will present it to the Executive Committee in July.

Cordially,

Don

Donald G. Langsley, M.D.
Executive Vice President

DGL/em

cc: William E. Laupus, M.D., President
William J. Dignam, M.D., Chairman, Bylaws Committee

GROUP ON BUSINESS AFFAIRS - PROGRESS REPORT

Memorandum to Executive Council

From: Michael A. Scullard, Chairperson

Subject: GBA Activities

Last March, the Group on Business Affairs sponsored its third Combined Regional Workshops in San Antonio, Texas. The theme of the workshops was "Management and Machines." The meeting featured two tracks of programming. One Focused on changing management structures; the other focused on the use of microprocessors in medical school administration. The workshop drew the largest attendance of any GBA meeting ever held, over 280 people.

This year began the second year of publication of the GBA newsletter, the "Group on Business Affairs Forum." The newsletter, which contains articles written primarily by GBA members, has been well received by the Group. It was designed to provide a mechanism for sharing information about the significant happenings within the medical schools of interest to GBA members as well as to provide indepth analyses of national issues affecting the operation of the schools.

August 13 - 15, the GBA will sponsor its annual summer educational program in Toronto. The theme of this year's meeting is "Financing Strategies for Medical Schools and Teaching Hospitals in the Last Half of the 1980's." The program will open with a noted economist discussing the forces at play in our economy which will be impacting on health care financing and medical education. Subsequent segments will feature representatives from the private and public sectors discussing national and state policy directions as well as specific strategies for medical schools and teaching hospitals to follow to fund research, education, and patient services. The program will be wrapped up with a futurist speculating about what our world will be like in 1990 and beyond.

For this year's annual meeting program, Roy Schotlan of Georgetown University, an outspoken critic of TIAA/CREF will debate with John Biggs, a trustee of TIAA/CREF on the topic of "University Retirement Plans - The Push for Change." In addition, J. Alexander McMahon, President of the American Hospital Association, has accepted the Group's invitation to be this year's Gus Carroll lecturer.

GROUP ON INSTITUTIONAL PLANNING - PROGRESS REPORT

Memorandum to Executive Council

From: Marie Sinioris, Chairperson

SUBJECT: GIP Activities

In April of this year we had the most successful of our Combined Regional Workshops. From a mailing list of 450 attendance was 140 registrants. The three simultaneously running tracks covered facilities development, strategic planning and cutting edge issues with the last highlighting these individual topics:

DRG Impact on Management of Medical Centers
The Changing Training Environment for Residents and Medical Students
Alternative Funding Sources for Education and Research
Pro & Con - Owning a Teaching Hospital
Creating a Regional NMR Installation
Marketing Faculty Discoveries

Victor Fuchs, the well known health economist gave an especially interesting talk entitled "Who Shall Live-Revisited".

One of our members, Leonard Heller having recently completed a year's stint with the Congress spoke about his observations of the legislative process from the inside. Edward Andrews, president of the Maine Medical Center gave the keynote address - "Planning Works - A Testimonial". Dr. Andrews also got the highest appreciation scores on the meeting's evaluation sheets.

Last Fall we published another edition of our planning projects book. This is a listing, in abstract form, of projects our members are working on. Its purpose is to generate cross fertilization of ideas and information between institutions. This edition had 390 entries from 88 institutions. The in-place value of the 142 facilities projects was over $3,000,000,000. The most common projects in the listing, after facilities, were Organizational Planning, Information Systems, and Institutional Strategic Planning.

Our membership has been growing over the last several years and now, at 350 members covers all U.S. and Canadian schools.

LOW LEVEL RADIOACTIVE WASTE DISPOSAL

The Issue. To date, implementation by state and federal legislatures of P.L. 96-573, the Low-level Radioactive Waste Act, has been less than effective. This raises the spectre of a possible catastrophe on January 1, 1986, when researchers and hospitals in many states could be denied access to low-level radioactive waste burial sites. The following synopsis is designed to sensitize the Executive Council to the importance of this issue and, if appropriate, to stimulate action on it.

Background. Low-level radioactive wastes are produced by myriad activities -- industrial, medical, and research. Low-level waste may include long-lived, low energy emitting radionuclides, from which protection can be provided by very modest shielding, and short-lived isotopes that are dangerous for very short periods. Hospitals, universities, and research laboratories generate from about one-fifth to one-fourth of the total volume of low-level radioactive waste in the USA. According to the American College of Nuclear Physicians, 30% of all biomedical research in this country is performed using a radioactive marker label.

In medicine, radionuclides are utilized for diagnostic *in vivo* procedures to establish the presence or absence of disease. Radiopharmaceuticals have been developed to examine many organs and body systems. Therapeutic *in vivo* procedures utilize radioactive drugs for the treatment of specific diseases such as thyroid cancer. Also, radioactive material is utilized for diagnostic *in vitro* procedures to examine body fluids to determine hormonal or enzyme levels. In research, radioactively labeled biochemicals are utilized to trace biochemical and physiological phenomena, both to gain new knowledge and to apply knowledge to disease.

Low-level radioactive waste produced through medical uses consists of a wide range of materials including dry solids, liquids, laboratory animal carcasses and contaminated handling materials. The radioactive half-lives of the many radionuclides used in patient care and medical research activities vary significantly, and, accordingly, may be disposed of differently. Radionuclides with short half-lives, generally those used in medical diagnosis, decay relatively quickly and may be disposed of as non-radioactive trash, after a suitable period of appropriate shielded storage. However, the longer-lived radionuclides used in medical research---tritium and carbon^{14}---as well as the radioactive materials and waste generated in the production of radiopharmaceuticals create a more significant disposal problem.

At the present time, the primary method of disposal of low-level radioactive waste is through burial at commercial landsites. The wastes are packaged in barrels or boxes, placed in long trenches and, as the trenches are filled, covered with several feet of earth. The burial sites are monitored to detect and prevent any release of radioactivity into the environment, although leakage is always a concern. Overall, four federal departments or agencies have jurisdiction over processes related to the generation of low-level radioactive waste: The Department of Energy, the Department of Transportation, the Environmental Protection Agency, and the Nuclear Regulatory Commission.

In the early 1970's 6 low-level disposal sites were in full operation. However, between 1975 and 1978, two were closed due to contamination problems and another site ceased activity because of an exhaustion of burial capacity, leaving only three to accommodate all of the nation's low-level waste. The extant sites are located in Hanford, Washington, Barnwell, South Carolina, and Beatty, Nevada. The availability of low-level disposal sites reached crisis proportions in 1979 when two---in Washington and Nevada---temporarily closed for safety reasons; the one remaining site, in South Carolina, was unwilling to be the dumping ground for the entire nation, and restricted the amount of wastes it would accept. This drastic reduction in waste disposal capacity threatened to shut down many essential diagnostic and therapeutic activities, as well as ongoing research activities; a number of institutions claimed they were within a few weeks of stopping certain types of medical research and patient care if the sites were not reopened -- which they were, but only upon the proviso from the governors of the 3 site states that some action had to be taken to reduce and eventually curtail the ever-growing flow of waste into their states.

The outcome of the 1979 crisis was the passage in late 1980 of P.L. 96-573, "The Low-Level Radioactive Waste Policy Act," which, in keeping with a position advanced by the National Governors' Association, placed the responsibility of radioactive waste disposal squarely on the states (in contrast to the treatment of high-level radioactive waste, which the federal government has chosen to take responsibility for). This law encouraged states to form radioactive waste disposal compact arrangements of two states or more. Each of these groups was either to negotiate access to an existing disposal site or to construct and get licensure for a new one; the multi-state arrangement was designed to mitigate the high cost of establishing a new site, as well as to circumvent interstate commerce laws barring the denial of "goods" shipped from one state into another. The compacts would have to be approved by the legislature of each member state, granted consent legislation by Congress, and then signed into law by the President. A key feature of P.L. 96-573, and the "stick" by which states were to be goaded into establishing compact agreements, lay in a January 1, 1986, exclusionary date, after which approved compact groups would be permitted to exclude non-compact states from using their disposal sites. The threat of application of this exclusionary date is what gives this issue its present urgency.

The formation of compact groups and the passage of ensuing legislation in state legislatures has been rife with controversy, particularly in areas where environmental concern is acute. Not surprisingly, those states with existing sites had little difficulty in negotiating compact groups, and these -- the Southeast, Rocky Mountain, and Northwest compacts -- now await Congressional approval. In the Northeast and Midwest regions of the country, which together produce over 50% of the nation's low-level waste, numerous political obstacles have emerged, although lately there have been some breakthroughs. The Northeast Compact, for example, has been fluctuating almost continuously in the composition of its proposed membership. On June 30 of this year, just before states were required to state their intent to join that compact, Pennsylvania announced its intent to form a compact with West Virginia, with all states contiguous to the former eligible to join the group. This development may serve to circumvent the serious gridlock which had beset the New York legislature's attempt to join a compact group. Tangible progress has also recently taken place in Massachusetts towards the creation of a single state compact; however, that state's voters have passed a referendum requiring another referendum prior to the construction of a burial site within the

state. Agreement in this state on an acceptable means of disposal of its radioactive waste would mark a major breakthrough. Also encouraging was news that Kentucky and Illinois -- the latter having been virtually paralyzed on this issue -- have recently stated their intent to form a bi-state compact. Nevertheless, a scant 15 months before the date by which they were to have established burial site access, many states have progressed only to the stage of choosing the terms on which they will jointly develop sites. At least three years, but more likely five or six, are required to develop a functioning site. At least six new burial sites, none of which will be in operation before the January 1, 1986, exclusionary date, have been proposed.

The patience of the Governors of the three states asked to bear the brunt of the inertia and/or non-performance of the majority of the states is clearly exhausted. These executives have written to the appropriate Congressional Committees and urged Congressional approval for their compacts. The problems of the Governors are practical as well as political, because the existing sites simply don't have the capacity to accept waste much beyond the early 1990s; furthermore, the Beatty site, the smallest of the three existing burial locations, is currently ensnared in legal problems and may soon curtail or terminate its operations.

Since the three compact groups with existing sites have been pressing for Congressional consent to their arrangements, and virtually all of the states have moved very close to some type of a compact agreement, attention on the low-level radioactive waste issue has lately shifted to the Congress, which now must implement a complicated law which has very few legislative precedents. Four Committees have oversight authority in this area; in the Senate, the Judiciary and Environment and Public Works Committees have jurisdiction over the compacts, while in the House, the Interior and Insular Affairs and Energy and Commerce Committees share jurisdiction. Legislators on these Committees have generally behaved parochially and the result, given the preponderance of legislators from the Eastern and Midwestern areas of the country sitting on these Committees, has been no action thus far. However, as January 1, 1986, approaches, legislators will find themselves on increasingly shaky ground as they attempt to justify their reluctance to act to ratify the actions they required states to undertake. Rep. Morris K. Udall, Chairman of the House Interior Committee, has indicated that he will float tentative compact consent langauge this fall in an effort to initiate the legislative negotiation and refinement that will need to take place before final language can be adopted. As of now, the necessary contents of the proposed consent language remain unclear. Also, it is undetermined if any alteration in a submitted compact will require re-ratification by the participating states. If so, major political haggling on the state level will undoubtedly ensue, and the compact approval process may be further delayed. Strom Thurmond, Chairman of the Senate Judiciary Committee, remains fully committed towards moving the submitted compacts -- he is standing for re-election this fall and passage of the Southeast arrangement is to his obvious political benefit -- but as of now Thurmond lacks the votes to move them out of Committee. It is extremely doubtful, however, that this gridlock can be sustained through the 1st session of the new 99th Congress.

Capturing the attention of the biomedical research community on the low-level radioactive waste issue has been difficult, given: the complexity of the

issue, and its relative obscurity; the continual changes in the status of the compact groups; and the inability of researchers to believe that a policy as self-defeating as the denial of access to the existing sites could ever be implemented. The AAMC supports an extension of access to the existing sites beyond January 1, 1986, contingent on demonstration by the outside region or state of "due diligence" in moving toward implementation of its own compact/ dump site. This position has been conveyed to the appropriate Congressional Committees. In an information memorandum dated December 1, 1983, the Association outlined the "doomsday" nature of the January 1, 1986, exclusionary date, and urged its membership to take action on this issue on both the state and national level. Joe Isaacs, former Senior Staff Associate in the Department of Teaching Hospitals, also contributed an article to Clinical Research on this subject this spring. Nevertheless, to date insufficient input has been heard from our constituency and the country's researchers, despite a vigorous publicity campaign by the Society of Nuclear Medicine to arouse action on the subject.

It is still not too late for effective action on both the federal and state levels. Major conflicts between regions are brewing and will probably turn incendiary when Congressional committees mark-up the compacts and the desires of one or another group will of necessity be short-changed. In the light of this inevitability, it is doubly important for an underlying, clearly articulated national consensus to be forged amongst the research and health care community on the necessity that some type of interregional agreement be reached, and on the urgency for compact groups without disposal sites to develop them as quickly as possible.

Question: How can the AAMC stimulate greater involvement of its constituency at the state and federal levels to secure a satisfactory resolution of the low-level radioactive waste issue?

EXECUTIVE COUNCIL ACTION:

The AAMC should highlight this problem in its regular communication with its members, continue to monitor developments and send to each medical school dean as status report on his state situation vis-a-vis this problem.

PAYING CAPITAL COSTS IN COTH HOSPITALS

Background

In adopting the Medicare prospective payment system, Congress expressed a strong interest in eliminating retrospective cost reimbursement for capital expenses.

- Congress indicated capital projects initiated on or after March 1, 1983 may be paid differently from projects initiated before that date;
- Congress required HHS to complete a major study of alternative methods of paying for capital; and
- Congress provided that if retrospective cost payments continued beyond September 30, 1986, no payment shall be made for major new capital expenses unless the project is approved by a Section 1122 planning agency.

Since the Congressional action, a number of organizations have developed proposals for paying capital costs, including the American Hospital Association, the Healthcare Financial Management Association, the Healthcare Financing Study Group, and the National Committee for Quality Health Care. Given the developments of these, and other, proposals, it is apparent that there is no clear consensus among hospitals for a single method of paying for capital under Medicare. While the AAMC could take the lack of hospital consensus as a sign that no strong statement on this issue should be made, the high capital cost of teaching hospitals and their dependence on capital for tertiary care services and new technologies require the AAMC to be an active participant in this debate.

The AAMC Ad Hoc Committee on Capital Payments for Hospitals, chaired by Robert E. Frank, President of Barnes Hospital, was appointed in December, 1983. A complete list of the committee's membership is shown in Attachment A. The Ad Hoc Committee met on January 6 and May 7 to begin formulating a draft AAMC policy on capital payments. The committee agreed on a number of substantive recommendations; however, no consensus was reached on an appropriate methodology to provide an acceptable transition period from the present cost reimbursement system to the committee's recommended long-term preference of including capital in the prospective payment. An interim report summarizing the areas in which the Ad Hoc Committee attained consensus and describing the policy options available for the transition period was presented to the AAMC Executive Council at its June 28, 1984 meeting. While final agreement was not reached, three policy options for the transition were discussed. Attachment B reiterates both background information of capital costs of teaching hospitals and the five areas of consensus reached by the Ad Hoc Committee. It concludes by presenting, with examples, the three transition options most favorably discussed by the Executive Council.

Executive Council Action:

On September 13, 1984, the Executive Council adopted an Association policy on paying capital costs under Medicare the five areas of consensus recommended by the Ad Hoc Committee and the transition period option which allows a hospital its choice of (1) cost reimbursement for depreciation and interst or (2) a prospective percentage add-on provided that the percentage add-on would be no less than Medicare's current percentage for capital expenditures.

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MEDICARE PAYMENT OF CAPITAL COSTS: AREAS OF CONSENSUS AND TRANSITION OPTIONS

Background Information

In light of Congressional interest in changing Medicare's capital payment policy, two empirical reports on hospital capital costs have major implications for teaching hospitals. One is the American Hospital Association's April 16, 1984 paper, "Capital-Related Cost Variation Across Hospitals," which has three major conclusions:

- o capital costs as a percentage of operating expenses vary substantially across hospitals even when hospitals are grouped by region, bed size, ownership, case mix, medical education activity, location and age of plant;
- o because of the variation in capital costs, capital payments based on peer groups create as many "winners" and "losers" as capital payments based on a single national rate;
- o because of the variation in capital costs, a transition mechanism from cost reimbursement for capital to prospective payment for capital is crucial.

Second, AAMC staff prepared a separate report reviewing the capital costs of COTH members. The analysis, which is included as Attachment C, resulted in three major findings:

- while capital costs of COTH members are a smaller percentage of total expenses than they are of non-member hospitals, COTH members do have greater absolute capital costs per unit of workload (i.e., per day or per admission);

- the physical facilities of COTH hospitals are 12% older than those of non-COTH hospitals; and

- recently increased capital spending by COTH hospitals may alter statistical relationships that existed in data collected in the 1970's and early 1980's.

The AAMC staff report concluded by stating, "given these conclusions and the 'lumpy' capital cycle of major facility projects, COTH hospitals must give particular attention to the impacts of proposed capital payment policies on hospitals which have recently constructed or are planning in the next few years to begin construction of major plant replacements. Special care must be taken to ensure that incorrectly interpreted or past trends are not used to restrict the financial viability and competitive attractiveness of major teaching hospitals which are presently involved in major plant projects."

Areas of Consensus

Using this information, the Ad Hoc Committee reached a consensus in five areas. At its June meeting, the Executive Council did not disagree with the consensus in any of these five areas.

First, THE AAMC SHOULD SUPPORT REPLACING INSTITUTIONALLY SPECIFIC, COST BASED RETROSPECTIVE PAYMENTS FOR CAPITAL WITH PROSPECTIVELY SPECIFIED CAPITAL PAYMENTS. The Part A Medicare trust fund, which is used to make payments for inpatient services, is headed for insolvency. Continuing the present open-ended cost passthrough for capital seems unlikely because it is philosophically inconsistent with prospective payment, is perceived to stimulate capital expansion and an over-investment in capital goods, and is likely to be under-funded or capped as Congress weighs service benefits for current beneficiaries against facility investments for future beneficiaries.

Second, THE AAMC SHOULD SUPPORT SEPARATING CAPITAL COSTS INTO TWO COMPONENTS--(1) MOVABLE EQUIPMENT AND (2) FIXED EQUIPMENT AND PLANT. This separation, which has historically been maintained in accounting records, recognizes that expenditures for movable equipment are constantly made by hospitals and that the useful life of the items purchased is generally rather short. Expenditures for fixed equipment and plant, on the other hand, tend to be aggregated into more infrequent major projects which have a relatively long useful life. Given these different characteristics, the committee believes a transition period is not necessary for movable equipment but is necessary for fixed equipment and plant.

Third, THE AAMC SHOULD SUPPORT INCORPORATING CAPITAL PAYMENTS FOR MOVABLE EQUIPMENT INTO PROSPECTIVE PAYMENT USING A PERCENTAGE "ADD ON" TO PER CASE PAYMENTS. Because movable equipment purchases are a regular and ongoing component of hospital operations, the committee believes no transition period or phase-in is required in order to include movable equipment in the per case price. Incorporating movable equipment into the prospective price would encourage managers to consider the relative advantages of capital and labor intensive alternatives. With both payroll costs and movable equipment incorporated into a single payment rate, a hospital would have the flexibility to select the labor-equipment mix most suitable to its particular circumstances.

In considering capital costs for plant and fixed equipment, it must be recognized that different hospitals are at various points in their capital cycles: some have new plants with high construction and financing costs; others have old plants and low costs but need to rebuild. Given this variability, THE AAMC SHOULD SUPPORT A PERCENTAGE ADD-ON TO PER CASE PRICES FOR THE CAPITAL COSTS OF FIXED EQUIPMENT AND CAPITAL PROVIDED THAT THE ADD-ON IS BASED UPON A PER CASE PRICE WHICH APPROPRIATELY COMPENSATES TERTIARY CARE/TEACHING HOSPITALS FOR THEIR DISTINCTIVE COSTS. Further, because hospitals are presently at different points in their capital cycles, THE AAMC SHOULD SUPPORT A LONG-TERM, HOSPITAL-SPECIFIC TRANSITION FROM THE CAPITAL PASSTHROUGH TO PROSPECTIVE PAYMENTS FOR PLANT AND FIXED EQUIPMENT. The transition period should recognize and make adjustments for plant additions approved by health planning agencies and alterations/modernizations required by life safety codes and licensing and accreditation agencies.

Having reached a consensus in five substantive areas, there has been difficulty reaching a consensus on an appropriate transition mechanism for phasing-in plant and fixed equipment costs. This inability reflects the fact that the views of individual COTH hospitals depend upon each hospital's position in the capital cycle.

Transition Payments: Conflicting Hospital Perspectives

Under prospective payments, change is the order of the day. Hospitals are examining long-standing operational practices and altering those found inconsistent with the incentives and requirements imposed by the new payment system. While changes in daily operating practices may be difficult, the everyday nature of these activities provides numerous opportunities for changing practices. The construction and financing of major facilities offer less flexibility: planning the project and obtaining all necessary approvals is a multi-year effort, the asset itself has a long useful life, and the permanent financing often is for 15 to 30 years. As a result of these long term dimensions of major facility changes, many hospital executives believe a change in capital payments must include adjustments "honoring" (1) new projects in the final planning stages; (2) the depreciation and interest originally anticipated for ongoing construction and recent plant additions; and (3) expectations of bondholders, lenders and donors. This view that commitments undertaken under the old system must be "honored" under a new system poses four difficulties:

- o because Medicare is operating under a philosophy of "budget neutrality," funds used to honor past commitments of hospitals with high capital costs decrease the funds available either for

capital payments to other hospitals or for per case payments to all hospitals.

- o if all past commitments are honored, hospitals with new additions or replacements will receive depreciation and interest payments greater than debt service requirements. This positive cash flow can be used by the hospitals to finance operating activites including price reductions;

- o if all past commitments are honored, the transition period may be from 15 to 30 years duration and this may be politically unrealistic; and

- o if the transition period honors past commitments for more than 5-10 years, a new cohort of hospitals will come forth seeking special consideration for the improvements and expansions they are planning.

Consequently, in its most emotional form, the debate among medical center executives generally about the transition mechanism includes the following confrontation. Those with above average capital costs argue the rules-of-the-game should not be changed for them and their bondholders; those with below average capital costs argue that they are willing to have a gradual change, but they do not want high capital cost hospitals to receive more than their debt service expenditures. Essentially, the debate revolves around (1) which hospitals should be protected and to what extent and (2) at whose expense should the protection be provided (the taxpayers by increasing program

expenditures or the low cost hospitals by reducing the amount of money available for the new capital payments).

Transition Options

At their June meetings, Board and Council discussions focused on three options.

Option 1. Choice of (1) Cost Reimbursement for Depreciation and Interest or (2) a Prospective Percentage Capital Add-On

Under this option, a hospital could elect to be paid on a cost reimbursement basis (depreciation and interest) for (1) existing capital, (2) capital projects under active construction, and (3) capital projects for which a certificate of need was sought prior to a given date. These "base period" capital costs would be increased only for mandatory life safety or accreditation requirements approved by a planning agency. Capital payments would not be increased for facility modernizations, expansions, or replacements undertaken after the base period. At any time during the allowed transition period, a hospital receiving depreciation and interest payments could elect to change and receive the prospective capital add-on to DRG payments. Once a hospital elected the prospective add-on, it could not subsequently receive payments based on depreciation and interest.

The advantage of this option is that it fully honors the existing cost reimbursement system for hospitals which made commitments under that system. This not only protects the hospital, it fulfills the expectations of investors

who purchased hospital bonds. There are two disadvantages to this option. First, because hospitals with above average capital costs would elect payments based on depreciation and interest, budget neutrality for Medicare capital expenditures can be maintained only if the prospective capital add-on to the DRGs is less than the average capital costs of all hospitals. As a result, hospitals electing the prospective capital add-on would receive smaller payments and the period of time required to accumulate any given amount of capital would take longer. Secondly, in the initial years of a new project, depreciation costs exceed principal payments. Thus, hospitals with new plants would receive more cash from the transition mechanism than they would pay to lenders. This positive cash flow would provide the new hospital with a cash infusion that could be used to develop new services or reduce prices. In a more competitive market, hospitals receiving the prospective add-on are concerned that hospitals receiving depreciation plus interest will have an unfair competitive advantage as a result of the positive cash flow.

Option 2. Choice of (1) Debt Service Reimbursement or (2) a Prospective Capital Add-on

Under this option, a hospital could elect to be paid either its debt service expenditures for base period capital or the prospective capital add-on. Debt service expenditures are based on principal and interest expenses rather than depreciation and interest expenses (as in Option 1). Because payments are based on principal rather than depreciation, there is no positive cash flow to the hospitals being protected by this option. Also, there is no capital payment for assets acquired with philanthropy, retained earnings, grants, or appropriations

As a result, the hospital may have to use retained earnings to finance sinking fund balances or maintain coverage ratios prescribed by the lender. Because fewer dollars are paid to hospitals with above average capital costs, more funds remain in the Medicare trust fund to be used in determining the prospective capital add-on for hospitals with below average capital costs. Thus, this option dampens both the advantages and disadvantages of Option 1.

Option 3. Determine Capital Payments for all Hospitals During the Transition Using a Fixed Phase-In Schedule

Under this approach, capital payments for all hospitals would be determined by using a predetermined, but declining, percentage of depreciation and interest plus a predetermined, but increasing, percentage of the prospective capital add-on. If a ten year transition period is assumed, capital payments would be determined as follows:

Year	Actual Depreciation and Interest +	Prospective Capital Add-on =	Capital Payment
1	90%	10%	
2	80	20	
3	70	30	
...			
9	10	90	
10	0	100%	

The hospital's actual depreciation and interest expenses are calculated annually. As a result, there is no need to identify base period capital and new capital. If a hospital opens a new facility in year 3 of the phase-in, the new depreciation and interest schedule is used but the formula uses 70% of that

schedule plus 30% of the prospective add-on. The later a major project is opened during the transition period, the smaller the protection provided by this option.

Advocates of this approach describe it as having three advantages: all hospitals are subject to the same formula, new capital costs may be added to depreciation and interest costs during the transition, and the declining importance of the depreciation and interest component will constrain unnecessary capital spending. Detractors include hospitals with recent projects who object that the old rules are not being fully honored, and hospitals with a project opening in the later years of the transition that receive little benefits from the transition.

Illustration of Options

To fully appreciate these options, it is necessary to consider them using empirical examples. To develop a series of examples, the following assumptions have been made about the capital cost of facilities and fixed equipment for two hospitals.

- The 2 hospitals, A and B, are similar except in their capital costs as a percentage of operating costs in year 1. For hospital A this figure is 5%; and for hospital B it is 11%.

- Both hospitals have an operating budget, including capital costs of $35,000,000 in year 1, and an average DRG operating price of $2,800. DRG operating prices equal costs in each year in order to isolate the impact of the capital payment. The DRG prices are increased 6% annually.

- The hospitals have 40% Medicare volume and revenues, and 5,000 Medicare discharges in year one.

- The percentage capital add-on is set at 8% of total expenses in each year.

- Example 2 shows hospital A, the low capital cost hospital, undertaking a $30,000,000 project in year 3. The project is necessary to comply with life safety codes. The project is financed with 75% debt at 10% interest and with equal annual debt service over 30 years. Depreciation is calculated on a straight line basis over 30 years.

Example 1 shows hospital A with below average capital costs that makes no major expenditures on plant and fixed equipment during a ten year transition period. The hospital would select the percentage add-on at the start of the transition period.

In example 2, hospital A completes a $30 million expansion in year 3 of the transition. Because the project is necessary for compliance with life safety codes, it can be included in old capital for determining depreciation and interest. Nevertheless, the hospital still maximizes its capital payments by selecting the percentage add-on. To improve cash flow in years 3-6, the hospital could elect depreciation and interest for years 1-6 and the percentage add-on for years 7-10. While this combination provides $63,000 less in total payments than

the add-on alone ($14,699,996 versus $14,762,700, respectively), the cash flow difference may be beneficial.

Example 3 shows a hospital with above average capital costs. To maximize capital payments, the hospital should elect the depreciation and interest option in years 1-5 and the percentage add-on in years 6-10. This combination yields $16,035,340.

Three illustrations cannot represent all of the capital costs variations that exist in the COTH membership. The illustrations can demonstrate several important points. The 10 year blended option and the debt service payment options are not favored by any of the illustrations. Essentially, each is a less favorable option that would be acceptable only in situations where others are proposing more restrictive capital payment options. The remaining two options--depreciation and interest, capital add-on--are both attractive to hospitals; a hospital's preference depends upon the hospital's position in the capital cycle.

Conclusion

To meet the differing interests of the COTH members, it appears most reasonable for the AAMC to favor the following transition:

Pay medicare capital costs for facilities and fixed equipment during the transition period by allowing hospitals a choice of (1) cost reimbursement for depreciation and interest or (2) a prospective percentage add-on. Cost reimbursement would be paid on base capital (i.e., existing capital, capital projects under construction, and projects already issued a CON) and

subsequent capital expenditures used for mandatory life safety or accreditation requirements approved by a planning agency.

Example 1

Hospital A: Capital Costs = 5% of Operating Costs in Year 1: No Major Project Expenditures

Year	Option 1: 8% Capital Add On	or	Option 1: Depreciation and Interest on Capital Base	Option 2: Debt Service on Capital Base	Option 3: 10 Year Blended Phase In
1	$ 1,120,000		$ 700,000	$ 595,000	$ 742,000
2	1,187,200		696,458	591,458	794,606
3	1,258,450		692,704	587,704	862,428
4	1,333,950		688,725	583,724	946,815
5	1,414,000		684,506	579,506	1,049,253
6	1,498,800		680,035	575,035	1,171,294
7	1,588,750		675,296	570,295	1,314,714
8	1,684,050		670,272	565,271	1,481,294
9	1,785,100		664,946	559,946	1,673,085
10	1,892,400		659,301	554,301	1,892,400
Total Payments	$14,762,700		$6,812,243	$5,762,240	$11,927,889

Note: Hospital's preference is the capital add-on for total payments of $14,762,700.

Example 2

Hospital A: Capital Costs = 5% of Operating Costs in Year 1: $30 Million Life Safety Project in Year 3

Year	Option 1: 8% Capital Add On	or	Option 1: Depreciation and Interest on Capital Base	Option 2: Debt Service on Capital Base	Option 3: 10 Year Blended Phase IN
1	$ 1,120,000		$ 700,000	$ 595,000	$ 742,500
2	1,187,200		696,458	591,458	794,606
3	1,258,450		1,600,000	1,500,000	1,497,535
4	1,333,950		1,592,705	1,492,705	1,489,203
5	1,414,000		1,584,680	1,484,680	1,499,340
6	1,498,800		1,575,853	1,475,853	1,529,621
7	1,588,750		1,566,143	1,466,143	1,581,967
8	1,684,050		1,555,463	1,455,463	1,658,332
9	1,785,100		1,543,714	1,443,714	1,760,961
10	1,892,400		1,530,790	1,430,780	1,892,400
Total Payments	$14,762,700		$13,945,806	$13,145,806	$14,446,465

Note: Hospital's preference is the capital add-on for total payments of $14,762,700.

Example 3

Hospital B: Capital Costs = 11% of Operating Costs in Year 1: No Major Projects

Year	Option 1: 8% Capital Add On	Option 1: or Depreciation and Interest on Capital Base	Option 2: Debt Service on Capital Base	Option 3: 10 Year Blended Phase In
1	$ 1,120,000	$ 1,540,000	$ 1,366,750	$ 1,498,000
2	1,187,000	1,529,286	1,356,036	1,460,829
3	1,258,450	1,517,930	1,344,680	1,440,086
4	1,333,950	1,505,892	1,332,892	1,437,115
5	1,414,000	1,493,132	1,319,882	1,453,566
6	1,498,800	1,479,606	1,306,356	1,491,122
7	1,588,750	1,465,269	1,292,019	1,551,705
8	1,684,050	1,450,071	1,276,822	1,643,254
9	1,785,100	1,433,962	1,260,712	1,749,986
10	1,892,400	1,416,866	1,243,636	1,892,400
Total Payments	$14,762,700	$14,832,014	$13,099,785	$15,618,063

Note: The hospital's preference is depreciation and interest in years 1-5 and the capital add-on in years 6-10 for total payments of $16,035,340.

association of american medical colleges

TOWARD AN UNDERSTANDING OF CAPITAL COSTS IN COTH HOSPITALS

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March 27, 1984

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BACKGROUND

When Congress adopted the Medicare prospective payment system, capital costs of hospitals were excluded from the prospective payment and continued on a cost reimbursement basis. This exclusion does not necessarily reflect a Congressional commitment to continuing cost reimbursement for capital: it does reflect the presently inadequate, conflicting, and occasionally surprising information on capital costs of hospitals. One of the initial surprises in the government's analysis of hospital capital costs in the Medicare program was the finding, by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), that capital costs in hospitals belonging to the Council of Teaching Hospitals (COTH) averaged 5.01% of total expenses while capital costs in non-COTH hospitals averaged 7.17%. Of equal significance was the ASPE finding that COTH members were consistently more heavily concentrated in the low capital cost categories, Table 1. These findings were in conflict with the "conventional wisdom" that major teaching hospitals have atypically high capital costs because of their roles in developing new technologies and initiating new diagnostic and treatment services.

Other ASPE analyses tended to corroborate the unexpected COTH/non-COTH differences in capital costs. As shown in Table 2, lower capital costs were also found in hospitals with CT scanners, pediatric/neonatal intensive care units, open heart surgery services, and Medicare case mix indices greater than 1.1. Each of these findings was contrary to the "conventional wisdom" on capital costs which held that higher capital costs would be present in clinically advanced and intensive hospitals.

ISSUE

An analysis of hospital capital costs under Medicare has produced the unexpected finding that COTH hospitals, as a group, have lower capital costs than other short-stay, non-Federal hospitals. A number of possible explanations could account for this difference:

- #1: COTH hospitals have lower capital costs as a percentage of expenses and per unit of output than non-COTH hospitals; or

  COTH hospitals have higher capital costs per unit of output than non-COTH hospitals but the higher operating costs of COTH hospitals result in capital costs being a smaller percentage of total expenses in COTH than non-COTH hospitals; and

- #2: COTH hospitals have older plant and equipment than non-COTH hospitals. As a result, COTH hospitals have relatively lower capital costs because construction and financing costs have increased rapidly across the past decade.

Using available data sources, this paper compares capital costs in COTH and non-COTH hospitals in order to help focus present discussions of capital costs.

ANALYSIS

Expenses

QUESTION: Do the relatively lower capital costs in COTH members mean that COTH hospitals use less capital per unit of workload performed?

Table 3 shows depreciation and interest expenses as a percentage of total hospital expenses for COTH and non-COTH hospitals. It should be noted that the interest expense percentage includes both interest paid on capital indebtedness and interest paid on working capital because the AHA's Annual Survey of Hospitals does not differentiate them. COTH members, as a group, report a lower percentage of expenses for both depreciation and depreciation plus interest. This is consistent with the ASPE finding.

In Table 4, depreciation and interest expenses for COTH and non-COTH hospitals are computed on a unit of workload basis using adjusted census days, adjusted patient days and adjusted admissions. In each case, the "adjusted data" provides a comprehensive measure of hospital workload by increasing actual inpatient workload by a hospital specific factor designed to convert outpatient services into inpatient workload equivalents. In both depreciation and interest expenses categories, COTH hospitals report significantly higher expenses per workload unit. This finding of higher capital costs per unit of workload but lower costs as a percentage of expenses is also supported when depreciation expenses for COTH and non-COTH hospitals are compared by census region, Tables 5 and 6. Thus, at the first level of analysis, it appears that COTH members have significantly higher capital costs per unit of workload than non-COTH hospitals.

Age of Plant

QUESTION: Do COTH hospitals have older or newer capital (equipment and facilities) than non-COTH hospitals?

In the past decade, construction and financing expenses have increased rapidly. As a result, hospitals having older plant and equipment have depreciation expenses based on lower construction costs and financing costs based on lower interest rates. Table 7 shows the standard financial ratio "average age of plant" in COTH and non-COTH hospitals. The average age of COTH hospitals is 7.4 years while non-COTH hospitals average 6.7 years. COTH hospitals are 12% older, on average, than non-COTH hospitals. Average age of plant is shown by census region in Table 8. In seven of the nine regions, COTH hospitals have older plant and equipment than non-COTH hospitals.

DISCUSSION

The data analysis clarifies somewhat the capital costs of teaching hospitals. Without fully explaining capital costs, the data suggest two independent factors are acting to influence the relative capital costs of teaching hospitals.

First, COTH members do have greater absolute capital expenditures per unit of workload. At the same time, COTH members have relatively smaller capital costs when capital costs are compared to total hospital expenses, at least for periods in the early 1980's.

This first finding has significant implications in evaluating capital payment proposals from the perspective of COTH members. Using historical data as an indicator of future relationships, the acceptability of a uniform capital "add-on" to the DRG payment system depends on COTH members receiving greater than average operating payments under the scheme. If the present resident-to-bed adjustment or a future severity of illness adjustment provides COTH members with payments per admission substantially greater than those in non-COTH hospitals, a uniform percentage increase for capital will more than adequately compensate COTH members as a group. If, however, prospective payment requires COTH members to accept operating cost and capital payments equal to non-COTH hospitals, COTH hospitals will not be able to maintain their greater capital intensity. This is illustrated in Table 9. If payments for operating costs in COTH hospitals drop either to the national or non-COTH averages, historical capital costs in COTH hospitals become relatively greater than capital costs in non-COTH hospitals.

Second, the capital stock of COTH hospitals is, on average older than that of community hospitals generally. This implies that either COTH

hospitals are relatively under capitalized or that non-COTH hospitals are relatively over-capitalized. In either case, if COTH hospitals are to offer competitive plant and equipment, COTH hospitals are more likely to undertake major capital projects in the near term, a development which would raise capital costs in COTH hospitals. This expectation is supported by Table 10 showing that COTH members, which have 18% of adjusted admissions, had 27% of the construction in progress in 1982. This increased capital spending is consistent with the finding of higher average plant age in COTH hospitals and suggests historical data, such as the 1981 Medicare data used by ASPE, may not accurately represent current capital expense patterns.

The current above average capital spending in COTH hospitals is further demonstrated in Table 11 where 1982 total capital expenditures for COTH and non-COTH hospitals are compared by census region and nationally. COTH members consistently report higher 1982 capital expenditures per adjusted admission than non-COTH members. This expenditure pattern suggests that COTH hospitals view themselves as undercapitalized and are modernizing to alter this perception. As a result, relative capital costs in COTH hospitals can be expected to at least approximate those in non-COTH hospitals in the next few years.

This paper was not developed to provide a conclusive discussion of capital costs in COTH and non-COTH hospitals. Four conclusions, however, are clear:

- o historical data which compares capital costs to total expenses have been misinterpreted by some to imply that COTH hospitals have lower absolute capital costs than non-COTH hospitals
- o capital costs per unit of workload performed are higher in COTH than non-COTH hospitals
- o COTH hospitals have older plants than non-COTH hospitals, and

- recently increased capital spending by COTH hospitals may alter statistical relationships that existed in data collected in the 1970's and early 1980's.

Given those conclusions and the "lumpy" capital cycle of major facility projects, COTH hospitals must give particular attention to the impacts of proposed capital payment policies on hospitals which have recently constructed or are planning in the next few years to begin construction of major plant replacements. Special care must be taken to ensure that incorrectly interpreted or past trends are not used to restrict the financial viability and competitive attractiveness of major teaching hospitals.

Table 1

Percentage Distribution of Capital Costs as a Percentage of Total Expenses by Membership in the Council of Teaching Hospitals, FY 1981

Percentage of Capital Costs	Percentage of Hospitals	
	COTH	Non-COTH
Less than 4%	37%	25%
4% to 6.57%	39	34
6.58% to 9.99%	17	23
10.0% to 14.99%	6	13
15% to 19.99%	1	4
20% or more	1	2
TOTAL	101%	101%

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 2

Capital Costs as a Percentage of Total Costs
by Selected Hospital Characteristics, FY 1981

Hospital Characteristic	Number of Hospitals	Mean Percentage of Expenses for Capital Costs
CT Scanner		
Yes	1108	6.47%
No	3867	6.75
Pediatric/Neonatal ICU		
Yes	1215	6.09
No	3760	7.09
Open Heart Surgery		
Yes	463	6.09
No	4512	6.85
Medicare Case Mix Index		
Less than .9	862	5.64
0.9 - 1.0	1517	6.72
1.0 - 1.1	1631	7.16
More than 1.1	814	6.07

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 3

Depreciation and Interest as a Percentage of Total Expenses for COTH and Non-COTH Hospitals, 1982

Expense Type	Percent of Total Expenses	
	COTH Members	Non-COTH
Depreciation	3.7%	4.2%
Interest	2.7	2.7
Depreciation and Interest	6.4	6.9

Source: AHA Annual Survey, 1982 data.

Table 4

Depreciation and Interest Expenses per Adjusted Census Day, Adjusted Patient Day, and Adjusted Admission in COTH and Non-COTH Hospitals, 1982

Workload Unit	Expenses per Workload Unit			
	Depreciation		Interest	
	COTH	Non-COTH	COTH	Non-COTH
Per Adjusted Census Day*	$8,596	$4,003	$4,345	$2,902
Per Adjusted Patient Day	23.50	10.90	11.91	7.95
Per Adjusted Admission	203.90	80.90	103.09	58.69

Source: AHA Annual Survey, 1982 data.

* A census day is equal to one bed occupied for 365 days. It is computed by dividing total patient days by 365.

Table 5

1982 Depreciation Expenses as a Percentage of
Total Expenditures in Short-Stay, Non-Federal Hospitals
by Membership in COTH and Census Region

Region	Depreciation as a Percentage of Total Expenses	
	COTH	Non-COTH
New England	3.5%	3.6%
Middle Atlantic	3.7	3.9
South Atlantic	3.8	4.3
East North Central	4.3	4.4
East South Central	4.3	4.4
West North Central	2.7	4.6
West South Central	3.9	4.3
Mountain	4.3	4.2
Pacific	2.9	3.9
National	3.7%	4.2%

Source: AHA Hospital Survey, 1982 data.

Table 6

Depreciation Expenses per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	1982 Depreciation Expense Per Adjusted Admission	
	COTH	Non-COTH
New England	$135.22	$ 86.94
Middle Atlantic	137.24	91.90
South Atlantic	133.45	88.02
East North Central	166.44	103.42
East South Central	128.87	77.13
West North Central	130.12	99.77
West South Central	122.68	81.93
Mountain	133.11	91.89
Pacific	128.57	111.08
National	$140.23	$ 92.93

Source: AHA Hospital Survey, 1982 data.

Table 7

Average Age of Plant in Short-Stay,Non-Federal Hospitals by Membership in COTH, 1982

Type of Hospital	Average Age of Plant*
COTH Hospitals	7.4 years
Non-COTH Hospitals	6.7 years

*Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$

Source: AHA Hospital Survey

Table 8

Average Plant Age in Short Stay
Non-Federal Hospitals by
by Membership in COTH And Census
Region, 1982

Region	Average Age of Plant*	
	COTH Hospitals	Non-COTH Hospitals
New England	8.74	8.16
Middle Atlantic	8.00	7.53
South Atlantic	7.04	6.19
East North Central	6.81	7.17
East South Central	7.32	6.22
West North Central	7.51	7.21
West South Central	6.74	6.01
Mountain	5.80	6.05
Pacific	7.74	5.99

*Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$

Source: AHA Annual Hospital Survey

Table 9

Estimating COTH Capital Costs With Price Competitive Total Expenses

Assumption: All capital costs in COTH and non-COTH hospitals are necessary.

Step 1: Estimate patient care capital costs per admission in COTH hospitals.

COTH Total Expenses per Adjusted Admission	$3778
Medicare Estimate of Capital Costs	5.01%
Capital Costs per Adjusted Admission in COTH Hospitals	$192.68

Step 2: Estimate capital percentage in COTH hospitals if total expense per admission was limited to the national average expense per admission.

National Average Total Expenses per Adjusted Admission	$2498
COTH Capital Costs from Step 1	192.68
COTH Capital as a Percentage of National Average Total Expenses per Adjusted Admission	7.71%

Step 3: Estimate capital percentage in COTH hospitals if Total Expenses per adjusted admission was limited to the average of non-COTH hospitals.

Non-COTH Total Expenses per Adjusted Admission	$2208
COTH Capital Costs from Step 1	192.68
COTH Capital as a Percentage of Non-COTH Total Expenses per Adjusted Admission	8.73%

SUMMARY:

Current Medicare Capital Costs as a Percent of Expenses

COTH Hospitals	5.01%
Non-COTH Hospitals	7.17%

COTH Capital as a Percent of "Competitive" Total Expenses

Using National Average	7.71%
Using Non-COTH Average	8.73%

Modifying the Medicare Payment System

The basic pricing element of the Medicare prospective payment system is the average urban (or rural) cost per case. Using this average cost, Medicare's payment for a particular patient is calculated by adjusting the average cost by three factors:

Adjustment Factor	Method of Adjustment
Case Type	use 468 service intensity weights derived using Diagnosis Related Groups
Patient Severity	for all hospitals, use supplemental payments for atypically expensive or long-stay patients
	for teaching hospitals only, also include additional payments in resident-to-bed adjustment *
Hospital Input Prices	for all hospitals, adjust payment by index based on relative wages in entire metropolitan (or rural) area
	for teaching hospitals only, also include additional payment in resident-to-bed adjustment. *

* This is a single adjustment which addresses both patient severity and input prices.

Because the system incorporates only those few adjustments when fully implemented, it is not capable of adequately adjusting for either hospital specific or patient specific differences which influence hospital costs. Since the enactment of prospective payment, hospitals and their associations have been examining adjustments to the system which could improve the equity of the payment by more fully incorporating additional hospital-specific and/or patient- specific adjustments.

The present structure of the New Jersey payment-system, which is based on DRGs for all payers, suggests a modification which is administratively feasible. In New Jersey, the DRG adjustment is not limited to the use of a single intensity weight for each DRG. Rather, the DRG adjustment is modified to reflect real

variation in observed costs for each case type. This is accomplished by applying the DRG intensity weight to a blended average cost per case in which the blend of hospital-specific and statewide costs are determined using the observed variation in hospital costs for that particular DRG. For example, if all hospitals have highly similar costs for a specific DRG, a relatively large proportion of the statewide average is used and a small proportion of the hospital-specific cost experience is used. On the other hand, if hospital costs for a DRG are highly variable (e.g., patients of different severity levels are in the same DRG), a relatively small proportion of the statewide average is used and a large proportion of the hospital-specific cost experience is used. The coefficient of variation is used as the statistical measure of the variability of DRG costs.

Using the New Jersey approach as a model, the American Hospital Association has developed a suggested modification for the Medicare system which blends hospital-specific and national average costs for DRGs using the observed coefficient of variation. Attachment A is AHA's summary of the proposal. The AHA proposal offers COTH members two benefits:

- to the extent that treatment costs vary in a DRG because of differences in patient severity, the blending of hospital-specific and national average costs provides payments more reflective of the hospital's own patients

- by incorporating more hospital-specific differences into the per case payment, the politically vulnerable resident-to-bed adjustment could be reduced in value, and replaced with an approach which has a much stronger fundamental basis for long term stability.

In a payment system which uses too few variables to adequately determine legitimate differences in hospital costs, these are major benefits.

Executive Council Action:

The Executive Council endorsed the DRG specific price blending proposal of the American Hospital Association and agreed that the AAMC would work with the AHA to incorporate this feature into the Medicare prospective payment system provided that further data development confirmed that this would be in the best interest of the membership.

Special Briefing

Medicare Prospective Price Blending on a DRG-Specific Basis:

A Potential Means of Reaching the Most Equitable Method of Determining the Medicare Prices to Be Paid to Each Hospital.

March, 1984

American Hospital Association

AHA

INTRODUCTION

On February 1, 1984, the House of Delegates of the American Hospital Association (AHA) adopted a Position on Equitable Determination of Medicare Prospective Prices. The position advocates prompt exploration of hospital-specific/national average price blending on a DRG-specific basis as the method for establishing DRG prices.* The House of Delegates viewed this blending approach as a potential means of reaching the most equitable method of determining the Medicare prices to be paid to each hospital. A basic part of the exploration process is full discussion by the field of this approach to price-setting. To initiate the discussion process this "special briefing" discusses the purpose of the price blending approach and how it would work.

As the title of the position indicates, the overriding purpose of exploring the DRG-specific price blending concept is to develop a more equitable system of establishing Medicare prices for hospitals.

Both the hospital field and the government recognize the importance of ensuring equity in payment to hospitals. Inequitable low payment reduces the quality and ranges of services which hospitals can provide to their patients. The problem of ensuring equity arises from the limitations of the current DRG system itself. The DRG classification system does not adequately take into account either differences in the severity of case mix among hospitals or the different socioeconomic and demographic characteristics of patients that affect patient recovery. Nevertheless, these factors directly affect the costs of treating patients.** The equity of the system is also compromised by a short-range issue -- the poor quality of the data base currently used to compute the cost weights and prices.

Equity of payment was a central issue when the AHA House of Delegates first approved the prospective pricing concept in 1983. At that time, the House recognized the uncertainties of the untested national DRG pricing system and called for institution-specific prices as the fairest way to implement prospective pricing in its early years. Congress, however, did not fully agree and settled instead on the three-year transition to national average payment rates.

Although Congress opted for a national average pricing approach, it recognized that provisions would be necessary to correct for the

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*For simplicity, "DRG-specific price blending" is used in various sections of this paper as shorthand terminology for hospital-specific/national average price blending on a DRG-specific basis.

**Although efficiency of operations may vary from one hospital to another, the differences in cost for treating patients in a given DRG are too great to be wholly attributed to greater or lesser efficiency.

limitations in the DRG system. A series of special rates and conditions has emerged to meet this need. The urban and rural rate distinctions and the regional and national rate distinctions are part of this patchwork adjustment mechanism.

Special treatment was also authorized for referral centers, cancer hospitals, and hospital serving a disproportionate number of Medicare and low-income patients. Additionally, the TEFRA indirect teaching adjustment factor was doubled specifically to account for severity differences in teaching hospitals.

Although the recognition of the need for adjustments is appropriate, the specific provisions developed have created their own inequities. The concerns over the geographic and urban/rural rates, which rely on arbitrary boundaries, are an example of the solution creating its own new set of problems.

The DRG-specific price blending approach was conceived as a more equitable method for recognizing and correcting for the limitations of the DRG system while simultaneously:

- keeping payments budget-neutral;
- maintaining the incentives for improved hospital performance;
- reducing the need for various types of patchwork adjustment provisions; and
- moving the pricing system toward national rates.

IMPLEMENTATION OF THE DRG-SPECIFIC BLEND APPROACH

DRG-specific price blending is based on the fact that nationally there is a range of costs per case for any given DRG. For some DRGs, this range is relatively narrow; i.e., a high percentage of patients have costs close to the national average. For others, it is broad, with the low and high ends varying significantly from the national average. If the range is broad, factors in addition to operating efficiencies are undoubtedly playing a role in causing the disparity in the costs of treating patients. These factors, outside the control of hospitals, relate to severity and other patient mix differences and to poor data. The DRG-specific price blending approach would compensate for these factors.

Key Features

1. The current transition approach, mandated in the law, would be eliminated and replaced with a requirement that an institution-specific/national average price blend be calculated for each DRG based on the national statistical distribution* of Medicare patient costs around the DRG's national average (mean) cost. Where the distribution of costs per case for a

* not the statistical distribution for the individual hospital

particularly DRG is narrow; i.e., a high percentage of Medicare patients in the DRG have costs close to the national average cost for the DRG, the price for that DRG would heavily reflect the national average rate. Conversely, where the distribution of costs per case is wide, the price for that DRG would be heavily weighted toward the hospital-specific rate.

a. The institution-specific/national average price blend percentages for a given DRG would be derived from a computation of the coefficient of variation in the cost distribution of the DRG. The coefficient of variation, which is computed by dividing the standard deviation in the cost distribution of the DRG by the national average (mean) cost for the DRG, indicates whether a high percentage of the patients in the DRG have costs close to the national average. (See Attachment 1 for a further explanation of coefficents of variation.) The lower the coefficient of variation, the higher would be the percentage weight given to the national average rate for the DRG. The higher the coefficient, the higher would be the percentage weight given to the hospital-specific rate for the DRG.*

b. The national component of the price for the individual DRGs would be a single national average rate.

c. An area wage adjustment would continue to be applied to the national component of the price for individual DRGs. However, to correct for current inaccuracies, the area wage factor would be modified to account for full- and part-time employment differences and would use more precise labor market areas, perhaps by clustering adjacent counties with similar hospital wage levels.

2. A payment adjustment would continue to be made to teaching hospitals for indirect medical education costs.

3. Special treatment provisions would continue to be needed for cancer hospitals, referral hospitals, hospitals serving a disproportionate number of Medicare or low income patients, and sole community providers.

4. The Department of Health and Human Services would be required to recompute the DRG cost distributions, coefficients of variations and resulting blend percentages as often as is feasible, probably every other year, based on the most currently available cost report and MEDPAR data.

*The method of computing the specific blend percentage for the individual DRG from the coefficient of variation would be subject to negotiation. The method could be very simple: if the coefficient of variation is 1 or more, the price for that DRG would be 100% hospital-specific; if the coefficient is less than 1 (e.g., .25), the hospital-specific rate percentage would be the coefficient value (e.g., 25% hospital-specific and 75% national average).

Attachment 2 presents a hypothetical example of how the prices and payments would be computed for an individual hospital in years 1 and 3 under the DRG-specific blending approach as compared to a transitional, uniform price blending method.

Benefits

- The DRG-specific price blending approach would result in a more equitable, evolutionary move to national average DRG pricing. A national rate would be paid for a given DRG where it makes sense to do so -- when the cost distribution is narrow. Importantly, it can be expected that DRGs with an initially wide cost distribution would move over time toward national rates as hospitals respond to the incentives for improved efficiency, as the quality of the DRG data improves, and as the patient classification system is refined.

- The need for the hospital field, the Congress, and the administration to revisit every year various equity issues would be substantially reduced.*

- The approach would be budget neutral, simply reallocating Medicare payments across hospitals. The reallocation, however, would be in a manner which would minimize the undeserved financial windfalls and shortfalls that could result from average pricing under the current DRG system.

- The incentives for improved hospital performance would be maintained. Even in the initial year of DRG-specific price blending, all hospitals would have at least some portion of their payments based on national average rates. Accordingly, hospitals would have a two-fold incentive: (1) to keep their Medicare costs per case below the national rate to avoid penalties on that component of the price; and (2) to keep reducing the rate of increase in their Medicare costs per case in order to achieve an operating gain on the hospital-specific component as well as the national component of the price.

- The DRG-specific price blending approach is administratively feasible. The Health Care Financing Administration (HCFA) currently has the types of data and computer software needed to implement the approach. However, under both the current system and a DRG-specific price blending approach, the quality of collected data must be improved.

*Regional and urban/rural rate distinctions would be eliminated. In addition, cancer hospitals, referral centers, and hospitals serving a disproportionate number of low income patients may well have reduced needs for special treatment under a DRG-specific blending approach.

CONCLUSION

This discussion paper has described the intent, key features and benefits of a DRG-specific price blending approach. The potential effect of the approach on specific DRGs, individual hospitals or on various regions or classes of institutions cannot be described at this time, because the data files necessary to evaluate these types of impacts have not yet been made available by the HCFA. AHA will be working closely with congressional leaders and HCFA staff to obtain and analyze the necessary data.

When the data are available and various analyses have been performed, the results will need to be interpreted with caution. The DRG cost weights are expected to change substantially over the next two to three years as a result of: (1) improved data quality -- the diagnostic and surgical procedure codes recorded on bills are now more complete and accurate than in 1981, resulting in more accurate DRG assignment; and (2) improvements in the DRG classification system -- as poorly defined DRGs are redefined, the weights for DRGs will change. Consequently, it is difficult to use the 1981 cost weights to forecast reliably 1985 or 1986 revenues under even the current transition plan.

Ultimately, the test of DRG-specific price blending may be conceptual soundness -- the extent to which it represents a common-sense approach to addressing the equity issue. It is an unbiased approach to setting DRG prices and, importantly, would eliminate the financial shortfalls, and windfalls, that could result from average pricing under the current DRG system.

The Association urges that member hospitals examine this approach to establishing Medicare prices. In evaluating it, a broad, "macro" view is urged. The issue that must be addressed is not whether the approach may be better in the short run for any individual hospital, but whether it is better for the field as a whole in meeting patient and community needs.

Questions, comments, and advice regarding the approach should be directed to the Association via its toll-free number 800/621-6712, in Illinois 800/572-6850, or by writing or calling the AHA's Department of Hospital Finance in Chicago.

DRG COST DISTRIBUTIONS AND COEFFICIENTS OF VARIATION: A FURTHER EXPLANATION

Using hospital cost report data and the MEDPAR billing file (a 20% sample -- soon to be 100% -- of Medicare patient bills from all Medicare participating hospitals in the nation), the Health Care Financing Administration (HCFA) can calculate for each DRG on a statistical "frequency distribution" how many Medicare patients generate various levels of estimated costs during their acute inpatient stays. The estimated cost per stay for each Medicare patient would be corrected for area wage differences and for any indirect teaching costs prior to computing the distribution, as is currently the case when HCFA computes national average rates and national cost weights by DRG.

The frequency distribution of Medicare costs for a DRG can be usually portrayed as a curve in a graph, and Figures 1 and 2 at the back of this attachment provide examples of the graphed cost distributions for two hypothetical DRGs.

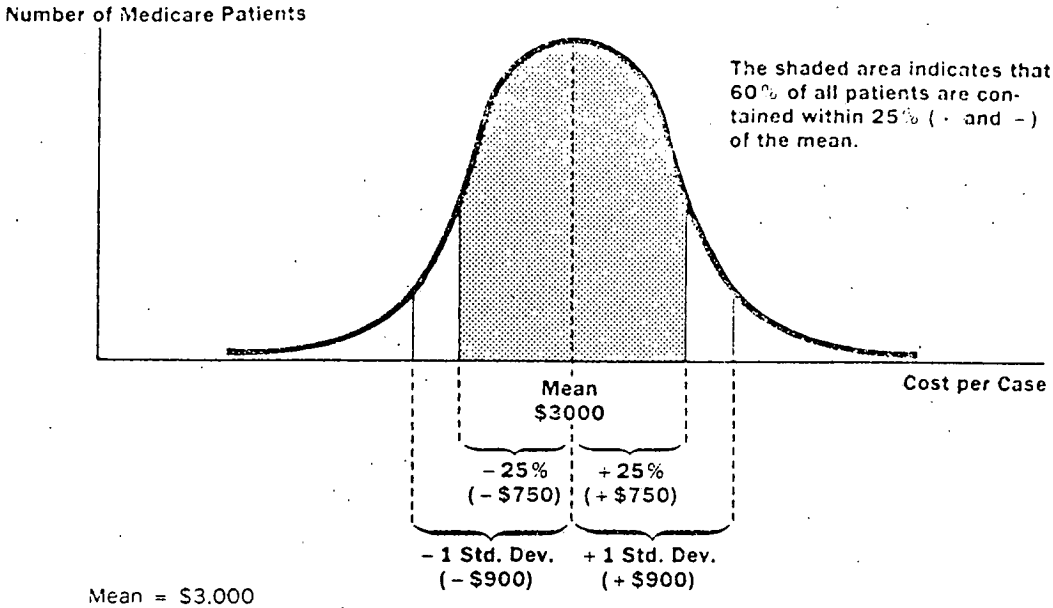
A comparison of Figures 1 and 2 reveals the fact that even where the cost distributions for two DRGs have the same national average or mean value ($3,000), the curves can vary markedly in terms of the relative narrowness (Figure 1) or width (Figure 2) of the distribution of patient costs around the national average for the DRG.

A statistical measure that is commonly used to quantify the degree of narrowness or width of the DRG's cost distribution is the coefficient of variation, which is computed by dividing the standard deviation of the DRG's cost distribution by the national average cost for the DRG.

If the cost distribution is narrow (Figure 1), the standard deviation ($900) would be small relative to the national average ($3,000), yielding a low coefficient of variation (.3 for Figure 1). Conversely, where the cost distribution is widely dispersed (Figure 2), the standard deviation ($2,400) would be large relative to the national average ($3,000), yielding a high coefficient of variation (.8 for Figure 2).

The significance of the differences in the coefficients of variation in Figures 1 and 2 is highlighted by computing the percentage of patients in each of the two distributions that is encompassed within 25% (both plus and minus) of the national average cost. In Figure 1, 60% of all Medicare patients in the DRG have costs within 25% of the mean, whereas in Figure 2, only 24% of all Medicare patients in the DRG have costs within 25% of the mean.

Figure 1: DRG With A Narrow Cost Distribution



Mean = $3,000

Standard Deviation (Std. Dev.) = $900

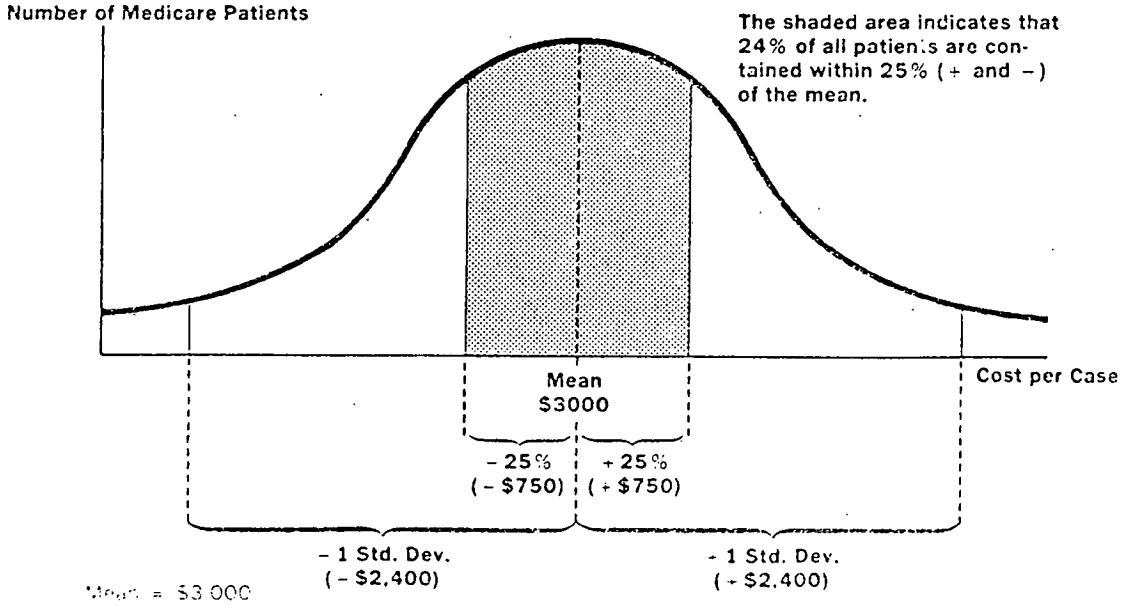
Coefficient of Variation = $\frac{\text{Std. Dev.}}{\text{Mean}} = \frac{900}{3000} = 0.3$

Price blend based on the coefficient of variation:

70% national average

30% hospital-specific

Figure 2: DRG With A Wide Cost Distribution



Mean = $3,000

Standard Deviation (Std. Dev.) = $2,400

Coefficient of Variation = $\frac{\text{Std. Dev.}}{\text{Mean}} = \frac{2400}{3000} = 0.8$

Price blend based on the coefficient of variation:

20% national average

80% hospital-specific

DRG-Specific Price Blending: A Hypothetical Example in Year 1

Assumptions:

- The hospital-specific rate is $3,000
- The national average rate (after adjusting for area wages) is $2,700
- The hospital has patients in three DRGs
- The three DRGs are hypothetical. Their coefficients of variation (standard deviation as a percentage of the mean), cost weights, and admission volumes are shown below. The coefficient of variation determines the institution-specific/national average price blend percentages (e.g., if the coefficient of variation for a DRG is 0.25, the price blend will be 25% hospital-specific and 75% national average).

Medicare Prospective Pricing and Payment Computations (Assuming No Outliers and No Indirect Teaching Payments) Under DRG-Specific Price Blending:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
DRG	Coefficient of Variation	Hospital-Specific Blend %	National Average Blend %	Hospital-Specific Rate	National Average Rate	Blended Rate*	Cost Weight	Admissions	Payments to the Hospital [(6)X(7)X(8)]
A	0.25	25%	75%	$ 3,000	$ 2,700	$ 2,775	.8000	2,000	$ 4,440,000
B	1.00	100	-0-	3,000	2,700	3,000	1.2500	2,000	7,500,000
C	.50	50	50	3,000	2,700	2,850	1.1000	2,000	6,270,000
								Total	$ 18,210,000

*[(2)X(4)]+[(3)X(5)]

In contrast, total payments would be the following if the blending percentages were uniform across DRGs as follows:

	Total Medicare Payments to the Hospital
75% hospital-specific/25% national average for all three DRGs	$18,427,500
50% hospital-specific/50% national average for all three DRGs	17,955,000
0% hospital-specific/100% national average for all three DRGs	17,010,000

DRG-Specific Price Blending:
A Hypothetical Example in Year 3

Assumptions:

Same as in year 1, except that the coefficients of variation have been reduced as shown below due to: hospital industry responses to the payment incentives; improved DRG data quality; and improvements in the DRG classification system itself. For purposes of comparison, the rates have not been increased from year 1 to year 3 for market basket inflation and technology.

Medicare Prospective Pricing and Payment Computations (Assuming No Outliers and No Indirect Teaching Payments) Under DRG-Specific Price Blending:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
DRG	Coefficient of Variation	Hospital-Specific Blend %	National Average Blend %	Hospital-Specific Rate	National Average Rate	Blended Rate*	Cost Weight	Admissions	Payments to the Hospital [(6)X(7)X(8)]
A	.15	15%	85%	$ 3,000	$ 2,700	$ 2,745	.8000	2,000	$ 4,392,000
B	.60	60	40	3,000	2,700	2,880	1.2500	2,000	7,200,000
C	.30	30	70	3,000	2,700	2,790	1.1000	2,000	6,138,000
								Total	$ 17,730,000

*[(2)X(4)]+[(3)X(5)]

In contrast, total payments would be the following if the blending percentages were uniform across DRGs as follows:

	Total Medicare Payments to the Hospital
75% hospital-specific/25% national average for all three DRGs	$18,427,500
50% hospital-specific/50% national average for all three DRGs	17,955,000
0% hospital-specific/100% national average for all three DRGs	17,010,000

RESIDENT TRACKING PROJECT

Commencing in 1983, the Association of American Medical Colleges (AAMC) and the National Resident Matching Program (NRMP) jointly conducted a follow-up study on the plans of current medical school graduates to pursue graduate medical education. Listings of students expected to graduate and their residency information (if matched through NRMP) were provided to the medical school. Schools were asked to indicate residency assignments for students who obtained a residency outside NRMP, graduated but not pursuing a residency or who did not graduate. Through the efforts of the Division of Student Service, 100% of the medical schools responded with the required information and a Graduate and Hospital Assignment list was generated for each medical school representing current year graduates and hospital assignments. These lists are used by many schools as a substitute for the LCME Report of Graduates, eliminating the need to re-type the information for their reporting obligations to the AMA and to the AAMC.

This year, at the request of the NRMP and in cooperation with them, the AAMC conducted the Resident Tracking Project for the 1983 cohort. This project tracks residents from their first year to their second-year of graduate medical training.

By virtue of the data gained a year ago from the follow-up study on 1983 graduates the Resident Tracking Project was an obvious and easily implemented endeavor.

Hospitals were furnished names of residents who started their programs in 1983 and were asked to confirm this information and to provide information as to what they are doing in 1984-85, i.e., continuing at the same hospital in the same program, or in another program and/or hospital.

The response to the tracking project to date is impressive. Inquiries were mailed by the Division of Student Services to a total of 825 hospitals. The following statistics apply:

SURVEYS TO	NUMBER HOSPITALS	SURVEYS RETURNED	RESPONSE RATE
Hospitals with known 1983 residents	723	687	95%
*Hospitals with no known 1983 residents	102	69	68%
Overall Response Totals	825	756	92%

*Many of these report that they do not have PGY-1 positions.

When completed, this file will be added to the Student and Applicant Information Management System (SAIMS) and will be available for studies useful in evaluating students' educational programs and forecasting manpower resources.