COTH ADMINISTRATIVE BOARD
Dupont Plaza Hotel
Dupont Room
Washington, D.C.
9:00 a.m. - 1:00 p.m.
December 12-13, 1973
AGENDA

I.	Call to Order	
II.	Consideration of Minutes	TAB A
III.	Membership Application Veterans Administration Hospital, Alexandria, Louisiana	TAB B
IV.	Report: Department of Health Services - Dr. Hudson	
V.	AAMC Committee on Health Manpower	TAB C
VI.	Policy for Release of AAMC Information	TAB D
VII.	Classification of Salary Study Information	TAB E
VIII.	Report of the AAMC Committee on Graduate Medical Education	TAB F
IX.	Physician Manpower and Distribution Report to the CCME	Separate Attachment
X.	Report of the Advisory Committee on Academic Radiology	Separate Attachment
XI.	Consideration of Association Priorities - Review of the Officers Retreat	
XII.	FMG Task Force Recommendations	TAB G
XIII.	Information Items:	TAB H

A. COLC Letter
B. Senate Finance Committee Report
C. AAMC Recommendations on Medical School Acceptance Procedures
D. Proposed Bylaws of LCGME

XIV. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
November 4, 1973
Washington, D.C.

Present:

Leonard W. Cronkhite, Jr., M.D., Chairman
Robert A. Derzon, Chairman-Elect
George E. Cartmill, Immediate Past Chairman
Daniel W. Capps
David H. Hitt
Arthur J. Klippen, M.D.
Sidney Lewine
Herluf V. Olsen, Jr.
Stuart M. Sessoms, M.D.
Eugene L. Staples
David D. Thompson, M.D.
John H. Westerman
Charles B. Womer

Staff:

Richard M. Knapp, Ph.D.
James Hudson, M.D.
Dennis D. Pointer, Ph.D.
Grace W. Beirne
Catharine A. Rivera

I. Call to Order:

Dr. Cronkhite called the meeting to order at 2:30 p.m. in the Chevy Chase Room of the Washington Hilton Hotel, Washington, D.C.

II. Consideration of Minutes:

The minutes of the Administrative Board meeting of September 13, 1973 were approved as distributed.

III. Membership Applications:

After a brief discussion the following action was taken by the Administrative Board:

ACTION #1

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS BE ACCEPTED:

VETERANS ADMINISTRATION HOSPITAL
WHITE RIVER JUNCTION, VERMONT

THE NORWALK HOSPITAL
NORWALK, CONNECTICUT

MUHLENBERG HOSPITAL
PLAINFIELD, NEW JERSEY

IV. Compucare Proposal:

At its last meeting, the Administrative Board considered a letter from Compucare, Inc., proposing to undertake an effort to provide background data and analysis to assess the current status of computer capability and information systems in university-owned teaching hospitals. Compucare proposed to develop and pretest a questionnaire to survey university-owned teaching hospitals regarding the organization, structure, staffing, cost effectiveness, productivity and development of their computer systems. The Administrative Board felt that while Compucare's bid of $6,000 to execute the study was reasonable, staff should attempt to obtain similar bids from other organizations capable of engaging in this type of effort.

Dr. Knapp requested the Board to reconsider this decision. He indicated that it would be difficult to obtain competitive bids from other firms without significantly compromising the Compucare proposal. Dr. Knapp said that he was convinced that Compucare could efficiently execute the project and had received written assurances from officials of the firm that knowledge gained from the study would not be used in any type of marketing activity.

ACTION #2

IT WAS MOVED, SECONDED AND CARRIED THAT COMPUCARE, INCORPORATED BE RETAINED FOR THE SUM OF $6,000 OR DIRECT COST WHICHEVER IS LESS, TO DEVELOP AND PRETEST A QUESTIONNAIRE TO SURVEY COMPUTER OPERATIONS IN UNIVERSITY-OWNED TEACHING HOSPITALS.

V. AHA Section on Teaching Hospitals:

Dr. Knapp indicated that the American Hospital Association Council on Manpower and Education has recommended against creating a special section on teaching hospitals. Dr. Knapp suggested that the action was taken because the AHA felt that actions on behalf of teaching hospitals did not require a special section in the Association, and that AHA-AAMC cooperation in many areas of legislative activity have grown in the past

year. Dr. Knapp indicated that the AHA and the AAMC may develop a cooperative venture during the next year to address the issue of community hospital affiliation arrangements with medical schools. There was general consensus that cooperative efforts with the AHA should be developed.

VI. Nominating Committee Recommendations:

George E. Cartmill, Chairman of the COTH Nominating Committee indicated that the following individuals have been slated for nomination to the COTH Administrative Board and the AAMC Assembly:

COTH Administrative Board

Chairman
Robert A. Derzon

Chairman-Elect
Sidney Lewine

Secretary
David L. Everhart
New England Medical Center Hospitals

Three-Year Term

David A. Gee
Jewish Hospital of St. Louis

S. David Pomrinse, M.D.
The Mount Sinai Hospital of New York

John M. Stagl
Northwestern Memorial Hospital

Two Year Term

J. W. Pinkston, Jr.
Grady Memorial Hospital

COTH Representatives To
AAMC Assembly

Three Year Term

Daniel W. Capps
University Hospital
University of Arizona

H. Joseph Curl
Georgetown University Hospital

AAMC Assembly

David L. Everhart
New England Medical Center Hopsitals

David A. Gee
The Jewish Hospital of St. Louis

L. Brent Goates
Latter-Day Saints Hospital

Wayne H. Herhold
Shands Teaching Hospital and Clinics

Sister Irene
St. Thomas Hospital, Nashville

S. David Pomrinse, M.D.
The Mount Sinai Hospital of New York

Charles A. Sanders, M.D.
Massachusetts General Hospital

David D. Thompson, M.D.
New York Hospital

John H. Westerman
University of Minnesota Hospitals

Jay O. Yedvab
Mount Zion Hospital and Medical Center
San Francisco, California

ACTION #3 — IT WAS MOVED, SECONDED AND CARRIED THAT THE AFOREMENTIONED INDIVIDUALS BE RECOMMENDED TO THE COTH MEMBERSHIP FOR POSITIONS ON THE COTH ADMINISTRATIVE BOARD AND THE AAMC ASSEMBLY RESPECTIVELY.

VII. Information Items:

Dr. Knapp indicated that Dr. Cooper has sent a letter to Irwin Wolkstein, Deupty Director, Program Policy of the Social Security Administration. In his letter Dr. Cooper requested taht the Association be given an opportunity to engage in meaningful discussion with the SSA regarding the cost regulations pursuant to Section 227 of P.L. 92-603. A copy of this letter can be found in appendix A of these minutes.

Additionally Dr. Knapp indicated that a technical amendment has been introduced to change the implementing date of Section 233 of P.L. 92-603. If passed, the provision would be applicable to hospitals for accounting periods beginning after December 31, 1973. The change is in response to comments prepared by the AAMC and the AHA. A copy of the AAMC response to the Section 233 regulations appear as Appendix B to these minutes.

Mr. Womer suggested that Drs. Knapp and Pointer be commended for their excellent job on preparing the AAMC's report on the impact of Section 227 on selected medical centers.

Dr. Cronkhite indicated that the Cost of Living Council proposed Phase IV rules for health services industry will be ready for publication in the Federal Register on November 6. He indicated that during the last several weeks, drafts of the regulations have been altered almost daily and that the health industry advisory committee has not had sufficient opportunity to examine the regulations in their final form. Dr. Cronkhite indicated that there will be a basic limitation of a seven and one-half percent increase on average revenue and expense per admission.

Dr. Cronkhite said that the regulations will also incorporate a volume adjustment factor whereas facilities experiencing admissions in excess of two percent or decreases in admissions of more than five percent will be allowed only a proportion of the base percentage increase. Initial data supplied by the American Hospital Association indicates that approximately 50 percent of the nation's hospitals exceed the allowable increase rate and thus would have to apply for an exception. Dr. Cronkhite indicated that the exceptions procedure has been taken off the agenda of the HIAC for the last three meetings but it appears that negative cash flow and/or cost justification is central to the process.

Dr. Cronkhite said that Alexander McMahon, in a letter to John Dunlop, stated that the AHA intends to file for an injunction of the proposed regulations when they become final. The basis of the AHA legal action is that: (1) the proposed regulations exceed statutory authority; and (2) they are contrary to the Medicare statute which provides that hospitals will be reimbursed on the basis of reasonable cost. At this time it appears that the Catholic and Protestant Hospitals Associations will either join in the AHA suit or file separate petitions. After much general discussion, it was agreed that the Council of Teaching Hospitals must develop a policy with regard to Phase IV regulations. There was consensus that the COTH comment must be framed from the perspective of detailing the specific effect of the proposed regulations on the nation's teaching hospitals.

Although no formal vote was taken it was agreed that the Chairman should appoint an Ad Hoc Committee on Phase IV to develop the Association position regarding the proposed regulations. Considerable emphasis was placed on the fact that legislative authority for the economic stabilization program expires in April, 1974 and the Association, in conjunction with other health care organizations, should begin to design a program that would influence the extension of this legislation.

ACTION # 4 — IT WAS MOVED, SECONDED AND CARRIED THAT THE ADMINISTRATIVE BOARD OF THE COUNCIL OF TEACHING HOSPITALS RECOMMEND THAT THE EXECUTIVE COMMITTEE OF THE ASSOCIATION BE AUTHORIZED TO ENGAGE IN ADMINISTRATIVE AND/OR LEGAL ACTION ON BEHALF OF ITS MEMBERS REGARDING PROPOSED REGULATIONS OF THE COST OF LIVING COUNCIL WITH RESPECT TO PHASE IV CONTROLS IN THE HEALTH CARE INDUSTRY.

Dr. Knapp and Dr. Pointer indicated that staff would begin to prepare data that would hopefully detail the impact of the Phase IV regulations on COTH members.

VIII. Adjournment:

There being no further business the meeting was adjourned at 4:30 p.m.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)
Hospital: Veterans Administration Hospital
Name

Alexandria
City

Louisiana
State

Street
71301
Zip Code

Principle Administrative Officer: Walter R. Armstrong, Jr., FACHA
Name

Hospital Director
Title

Date Hospital was Established Control assumed by VA in 1930

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating			
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine			
Surgery	(General) December 1968	3	3
OB-Gyn			
Pediatrics			
Psychiatry			
Other-Orthopedics	January 20, 1971	3	3
Urology	August 2, 1968	2	2
Ophthalmology	Approval pending	1	1

Information Submitted By:

Walter R. Armstrong, Jr.
Name

Hospital Director
Title of Hospital Chief Executive

November 27, 1973
Date

Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine Tulane University School of Medicine

Name of Dean William G. Thurman, M.D.

Address of School of Medicine 1430 Tulane Avenue

New Orleans, LA 70112

(See attached letter of endorsement October 4, 1973, from Dean Thurman)

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

_____

_____

_____

Invoiced_____ Remittance Received_____

TULANE UNIVERSITY
School of Medicine
NEW ORLEANS 70112

Office of the Dean
1430 Tulane Avenue

October 4, 1973

W.R. Armstrong, Jr.
Hospital Director
Veterans Administration Hospital
Alexandria, Louisiana

Dear Mr. Armstrong:

In a recent discussion with John A.D. Cooper, Association of American Medical Colleges, I had the opportunity to discuss at length with him the advantages of membership in COTH. After thinking it over, and also in view of my discussion with Dr. Wilkerson, I believe that there are enough advantages to membership in the Council of Teaching Hospitals for the Veterans Administration Hospital that I would recommend it to you. As an affiliated Hospital of Tulane University School of Medicine, it certainly would carry a strong endorsement. Dr. Cooper indicated to me that information could be provided at his office concerning the advantages and disadvantages of membership and I would not hesitate to contact him if you have any questions.

I will be pleased to discuss this with you personally sometime in the near future but in the interim, please accept this letter as my strong endorsement of membership for the Veterans Administration Hospital in the Council of Teaching Hospitals.

With best wishes, I am

Sincerely yours,

William G. Thurman

William G. Thurman, M.D.
Dean

WGT/ak

November 21 1973

AAMC Committee on Health Manpower

Report

Introduction

The Executive Council appointed the AAMC Committee on Health Manpower to develop an Association response in view of the approaching expiration on June 30, 1974, of the various authorities in the Comprehensive Health Manpower Training Act of 1971, the basic legislation dealing with federal support of health professions education.

The members of the committee who participated in its activities were Julius R. Krevans, M.D., Dean, University of California-San Francisco School of Medicine; Merlin K. DuVal, M.D., Vice President for Health Sciences, The University of Arizona College of Medicine; David R. Hawkins, M.D., Chairman, Department of Psychiatry, University of Virginia School of Medicine; Morton D. Bogdonoff, M.D., Chairman, Department of Medicine, The Abraham Lincoln School of Medicine; Sidney Lewine, Director, Mount Sinai Hospital of Cleveland; John C. Bartlett, Ph.D., Associate Dean for Health Affairs and Planning, University of Texas Medical School-Houston; Hugh E. Hilliard, Vice President for Finance and Treasurer, Emory University School of Medicine; and Bernard W. Nelson, M.D., Associate Dean for Medical Education, Stanford University School of Medicine. Dr. Krevans served as Chairman of the committee.

In authorizing appointment of the committee, the Executive Council charged it with reviewing the expiring authorities of the Comprehensive Health Manpower Training Act of 1971 and with recommending to the Executive Council appropriate modifications which the Association should support in working with Executive and Legislative officials on the extension of the expiring authorities. In its work, the committee reviewed the present federal health professions education assistance programs, the progress to date of the AAMC Committee on the Financing of Medical Education, and the provisions of known legislative proposals on health professions education assistance. The committee agreed to certain principles which should underlie the federal role in health professions education and developed a set of recommendations based on those principles.

This report sets out the committee's principles and recommendations and provides some additional explanatory material the committee considered useful in understanding fully its positions.

Principles

The AAMC Committee on Health Manpower believes the following principles should guide the federal role in health professions education.

There should be --

1. Stable, continuing, fiscally responsible federal support for medical

schools' educational activities, special projects and initiatives, student assistance, and capital expenses;

2. First-dollar capitation support of the undergraduate educational activities of the medical schools;

3. Project-grant support for special projects and initiatives reflecting national priorities and special emphasis fields;

4. Direct loans and scholarships to help meet student financial needs, with options for voluntary participation in loan forgiveness programs or service-obligation scholarship programs; and

5. Grants and loan guarantees with interest subsidies to meet physical plant replacement needs and to develop or expand new types of facilities such as ambulatory care facilities.

Recommendations

The AAMC Committee on Health Manpower recommends that legislation embodying those principles should be developed that provides fiscally responsible levels of funding in line with overall national priorities and that encourages prudent institutional planning over a five-year period beginning July 1, 1974.

The committee's specific recommendations follow, grouped under headings of institutional support, special projects, student assistance and capital support:

Institutional support

1. Delete the present capitation formula for schools of medicine, osteopathy and dentistry and substitute a new formula of $6,000 per student per year, regardless of the length of the curriculum or the type of training the student is undertaking.

2. Provide the capitation support as an entitlement with no separate authorization of appropriations.

3. Delete present provisions on enrollment bonus students.

4. Delete the present enrollment increase requirement, retaining the present maintenance of effort provisions.

5. Delete the present provisions requiring a plan of action in certain areas as a condition of obtaining capitation support.

6. Extend unchanged the present programs of start-up and conversion assistance.

7. Extend unchanged the present program of financial distress grants and authorize appropriations of $10 million per year (fiscal 1974 level).

Special projects and initiatives

1. Delete the following present programs: special projects, health manpower education initiative awards, grants to hospitals for family medicine training, capitation grants for graduate training in certain specialties, grants for health professions teacher training, and grants for computer technology health care demonstrations.

2. Substitute for those programs a new, consolidated program of special initiative awards under which the HEW Secretary could award grants and contracts for carrying out projects in three broad areas: (1) health professions education development; (2) special national emphasis programs; and (3) health care practice and the use of health care personnel.

3. Authorize the appropriation of such sums as may be necessary, and provide that appropriated funds are to remain available until expended.

Student assistance

1. Increase the present $3,500 loan ceiling to $4,500 per student per year.

2. Delete the present loan forgiveness formula and substitute a new formula providing 100 percent forgiveness for two years' service in a designated area.

3. Authorize appropriations of $70-$75-$80-$85-$90 million (15,000 students currently aided at $4,500 per year, plus growth of need for loans).

4. Delete the loan program for U.S. students abroad.

5. Increase the present $3,500 health professions scholarship ceiling to $4,500 per student per year.

6. Delete the present entitlement formula and substitute a new formula of $4,000 times the greater of one-tenth the number of full-time students or the number of students from low-income backgrounds.

7. Delete the health professions scholarship program for U.S. students abroad.

8. Increase the present $5,000 physician shortage area scholarship ceiling to $6,000 per student per year.

9. Delete the present shortage-area service requirement and substitute a new service requirement of two years in a designated area regardless of the time support was received.

10. Authorize appropriations of $13.5 million per year (5-percent student participation).

Capital support

1. Authorize appropriations, for medical schools alone, of $200 million per year, and provide that appropriated funds are to remain available until expended. Participation of other schools will raise the funding level.

2. Delete the enrollment increase requirement.

3. Extend unchanged the present loan guarantee and interest subsidy program, including the present appropriations limitation for interest subsidies of $24 million.

Commentary

The AAMC Committee on Health Manpower believes there is an appropriate role for the federal government in helping to meet some of the costs of undergraduate medical education. Undergraduate medical education is composed of interacting elements integral to a unified process leading to the M.D. degree. The elements of this process are the instructional activities covering the imparting of disciplinary and interdisciplinary subject matter through lectures, seminars and laboratory exercise; participation in the care and management of patients; and training in research methods for the solution of problems in health. The cost of the elements is high, and in the past has been shared by the federal government, state and local governments, medical schools themselves through tuition and endowment income, private foundations and others. The federal role has been justified because of the national mobility of physicians and because of an underallocation of resources to medical education by the private sector. In seeking an appropriate federal share, the committee agrees with the report of the Senate Committee on Labor and Public Welfare, accompanying the Comprehensive Health Manpower Training Act of 1971: "The bill ... entitles each educational institution to an award intended to cover approximately one-third of the average per-student educational costs incurred nationally by such institutions .... The costs of research and the

costs of patient care are integral to per-student costs of the institution. And ... they shall be included in the calculation of costs for the purpose of applying for their entitlement grant."

The AAMC Committee on Health Manpower believes there is a federal interest in the financial viability of medical schools as institutions, in equalizing financial opportunities for medical education, and in carrying out certain nationally determined special projects for which medical schools are particularly well suited.

Institutional support

Beginning with the White House Conference on Aging during the midyears of the Eisenhower Administration and continuing to the present, there is a growing agreement that access to health care is a right. This is a concept that has been endorsed by important political figures of both parties in both the House and the Senate; it was included as part of President Nixon's health message to Congress in February 1971; and it was a main theme of a White Paper issued by the Department of Health, Education and Welfare in 1971: Towards a Comprehensive Health Policy for the 1970s. This concept carries with it implications which are crucial to understanding the federal role in support of the undergraduate medical education activities of medical schools.

There is no way in which the right of access to adequate health care can be claimed or delivered without trained health personnel. Since the public has a claim for access to adequate health care, it must follow then that the public has a legitimate interest in sustaining the production of health personnel. Because of the setting in which education in the health professions is conducted, the educational expense is necessarily a joint product. This fact

means that the expenses of the environment of a health professions education are the integrated expenses of instruction, research and medical service. This is so because health professionals are educated in an academic environment, by the research and devlopment arm of the medical profession, some would say, rather than undergoing an apprenticeship process in which they are educated directly by practicing physicians.

Recognizing the issues of joint costs, the federal government in 1971 put in place a program which called for direct support of the education activities of health professions schools through a capitation grant. Through this device, the government acknowledged the legitimate public interest in the continuity and integrity of health professions educational institutions. The capitation grants have enabled the schools to respond to the need for increased numbers of health professionals. In doing so, the schools have expanded their facilities and have made commitments to new faculty and new programs which now must be sustained if the objectives are to be achieved. In addition, through the

device of capitation, the government recognized the value of the establishment of a creative partnership between itself and the academic health centers for the purpose of permitting leverage through which national purposes could be achieved.

The recommendations of the AAMC Committee on Health Manpower that capitation support be extended for five years, that the level of capitation be set at $6,000 per student per year, that capitation be an entitlement, and that capitation no longer be tied to enrollment increases are based on the following factors.

1. The $6,000-per-student-per-year capitation level corresponds with approximately one-third of the average of the annual cost per student for the elements of instruction, research and medical service at 12 schools studied by the AAMC Committee on the Financing of Medical Education. Further, adjusting the present $2,500-per-student-per-year capitation level, which was based on 1969-70 data, for rising costs projected to the midpoint of a five-year program of support also approaches $6,000 per student per year, when allowances are made also for rising research and medical service costs. Significantly increased capitation levels are needed also to help offset declines in other support, such as research training and the practice income from clinical faculty.

2. Converting the program to an entitlement and extending it for five years act together to encourage rational institutional planning, based on the program's continuity and predictability of support. With short-lived programs and fluctuating support levels, rational institutional planning is impossible.

3. Abandonment of the mandatory enrollment increase does not prejudge the issue of manpower supply. The facts are that since 1963 when federal aid to health professions schools was initiated, the number of schools has increased from 87 to 114; enrollment has increased from 32,001 to 47,259; and graduates

have increased from 7,336 to 10,000 per year. At the same time, new kinds of health personnel and new kinds of health care delivery are being developed. It is impossible to determine the adequacy of the present health personnel supply. Major increases in M.D. production have occurred, and other changes in health care are also underway. The AAMC Committee on Health Manpower feels strongly that the effect of these changes should be observed closely during the next five years before setting new incentives to alter the supply of health manpower.

Special projects and initiatives

There is a useful role for the project-grant approach to financing selected activities in health professions schools. This approach recognizes the incremental cost to the school of such a project and clearly separates the financial support for the project from the general pool of financial support for the basic undergraduate medical education program. Special projects serve as a vehicle for the health professions schools to participate in constructive change in the interest of improving the health and health professions education of the nation. Competitive rather than formula awards strengthen the entire health professions education system by ensuring heterogeneity; homogeneity would produce rigidity and resistence to any change. Competitive awards also allow research and demonstrations without total system involvement.

A problem with the current programs is that they have proliferated over time into an almost unintelligible patchwork of authorities whose complexities pose problems for both applicants and administrators. The AAMC Committee on Health Manpower Education therefore proposes a simplified program of special initiative awards which would permit the federal government to select

its own priority projects, the institutions or combinations of institutions to carry them out, and the levels of funding at which the government wished to support its priority projects. For this reason, the AAMC Committee did not recommend any specific levels of funding, although the AAMC is prepared to work with others in determining appropriate levels.

Student assistance

The Association of American Medical Colleges is committed to the goal that there should be equal financial opportunity for students wishing to attend medical school. A major barrier denying equal opportunity is the high cost of medical education that must be borne directly by the student. The existing health professions education assistance legislation traces its origin to student aid programs designed specifically to assist the socioeconomically disadvantaged student in entering medical school. The health professions loan program and the health professions scholarship program have constituted a major source of student aid for medical students. Since their implementation, the medical profession has been enriched by the addition of students with a greater diversity of socioeconomic backgrounds.

During the past five years, American medical schools have made substantial progress in improving the representation of minority groups in medical school programs. The enrollment of minority groups in the fall of 1973 is 7.4 percent of the first-year enrollment. The AAMC has adopted a goal of 12-percent minority representation in entering classes by September 1975. The AAMC reiterates its belief, as did the AAMC Task Force to the Inter-Association Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students in 1970, that financial assistance in the form of grants and loans is a critical factor if these goals are to be achieved. Without scholarship support

the acutely disadvantaged are forced to borrow sums of money that may exceed the earnings of the entire family. Many are persuaded that the risk of such a debt is too great for them to take -- an assessment frequently reinforced by the family's experience with past debts.

Equally fundamentally, an emphasis on loans focuses student attention on the future earning of the physician. Thus it would be predictable that the student's interest in earning large sums of money would be reinforced by his need to borrow large sums as a student. This is not a desirable characteristic to be sought in students; and it is detrimental to the efforts of the country to develop a physician population interested in developing modes of practice that are less costly to the patient and to the nation.

The AAMC believes that the success of continuing efforts to recruit individuals from minority backgrounds into the medical profession will depend on the continuation of federally sponsored scholarship and loan programs for medical students. In particular, scholarship funds are needed to insure the representation of minority groups and the representation of students from socioeconomically disadvantaged backgrounds. These students enter medical school with large debts incurred during their undergraduate years. These debts, coupled with the debts incurred during medical school, make it commonplace for a student to leave medical school with debts of $15,000 or higher.

It has been suggested that educational debts of a medical student could be forgiven in return for practice in designated areas or that scholarships should be made available on condition that the recipient later practice in a designated area. The AAMC has no objection to this approach, provided that it is offered as an alternative to a non-obligatory assistance program and provided further that participation is voluntary.

There is a great diversity of talent and ability among the socioeconomically disadvantaged, and these skills and abilities should be matched with the diversity of opportunity in medicine. The Association does not believe that a loan program that indentures a student to a particular form or area of practice is consistent with the goal of achieving financial equality of educational opportunity. Many of the proposals for the forgiveness of debt for practice in underserved areas restrict the participant to a fixed professional pathway. Over the long term, the Association does not believe that such an approach will attract to the profession the diversity of talent needed to meet society's needs. The Association believes there is a role for different and multiple approaches to the problem of financing the student costs of medical education.

The debt of students entering medical school is growing rapidly and is commonly underestimated. The Association believes that a limit on the amount of debt assumed by a student to meet the expense of attending college and medical school is reasonable. Excessive debt will reinforce the trend toward higher physician income. The Association believes it is only logical for physicians to focus their attention on higher fees if the government endorses the view that the future earnings of physicians should serve as the source of funds for repayment of educational expenses.

Loan guarantees as a sole source of debt financing of health professions education are unacceptable, although they may be offered in addition to a program of direct loans. A loan guarantee program, subject to the vagaries of the money market, removes from the educational institution all judgment concerning the individuals to whom loans are made, as well as the amount loaned, and places such judgment in the banks.

The AAMC Committee on Health Manpower recommends increasing the health professions loan and scholarship ceilings in recognition of rising medical student expenses, now estimated at between $4,000 and $5,000 per student per year. The shortage area scholarship ceiling was raised in an effort to make the program more attractive. Service periods were stabilized at two years to equalize the burden of service to participating students and to provide a uniform period of career interruption, intended to facilitate improved career planning.

Capital support

The appropriateness of a federal role in the construction and maintenance of medical school facilities parallels the federal role in the support of undergraduate medical education. And, as in the case of undergraduate medical education, the cost of capital expansion also is shared by the federal government, state and local government, the institution itself, and various private and other outside sources.

The recommendations of the AAMC Committee on Health Manpower include continued grant support because teaching facilities are inherently cost-generating rather than income-producing. As a result, income from the operation of such facilities can not be used to amortize the cost of the facility. Thus debt financing for such facilities is totally inappropriate. The committee's recommended funding levels are based on a professional judgment of an appropriate federal share of the cost of maintaining the existing physical plant of the schools, plus an allowance for new construction of ambulatory care facilities needed for the expanding number of primary care programs being established by academic health centers. In determining the level of medical school construction activity, the committee used published data in the Journal of the American Medical Association.

POLICY FOR RELEASE OF AAMC INFORMATION

The proposed policy for the release of AAMC information has been developed by staff, with the advice of the Data Development Liaison Committee. The Committee recommends it to the Executive Council. It has also been reviewed by the OSR and by the Student Records Committee of the Group on Student Affairs, as well as by the Association's attorneys.

RECOMMENDATION

The Data Development Liaison Committee recommends to the Executive Council that the policy for release of AAMC information be adopted

PROPOSED POLICY FOR RELEASE OF AAMC INFORMATION

It is the responsibility of the AAMC to make information on American medical education available to the public to the greatest extent possible, subject to limitations imposed by the sources of the data collected and by law.

Data collected by the Association will be owned and maintained by the Association for the benefit of medical education.

Data in the possession of the Association will be classified according to permitted access using the following categories:

I. Unrestricted - may be made available to the general public.

II. Restricted - Association confidential -- may be made available to member institutions and other qualified institutions, organizations and individuals subject to the discretion of the President.

III. Confidential - A) Institutional - Sensitive data collected concerning individual institutions generally available only to staff of the Association. It may be released with permission from the institution; and B) Personal - Sensitive data collected from individual persons generally available only to staff of the Association. It may be released with permission from the individual person.

Classification will be guided by a group of individuals broadly representative of the Association's constituency. No information will be released which could be identified with an institution unless reported or confirmed by that institution.

The Association will always be willing to disclose to the individual institution or individual person any data supplied by that institution or person.

In those cases where, as a result of collection by another organization, data is owned wholly or in part by the other organization, the data would be classified in one of the above categories so far as the AAMC is concerned, but additional restrictions imposed by the other organization may also be necessary.

INTERPRETATIONS AND COMMENTS

Data made public by the individual person or individual institution (as in the case of school catalogues, Who's Who, and news released to the press), will be classified as unrestricted.

When confidential or restricted data is aggregated, it generally becomes less sensitive. Thus, data related to groups of individuals or groups of institutions might be less restricted than the same data elements related to individuals.

In accordance with the above policy, restricted data concerning individual institutions or individual persons can be provided to scholars or institutions at the discretion of the President. The staff would try to verify the worthiness of the purpose and bona fides of the organization or individual scholar in such cases, and would insist upon assurances that any result in publication would adhere to Association policies restricting individual identification.

The intended classification of each element of data will be identified on the data collection instrument itself, so that the respondent will know what will be done with the information provided.

It is recognized that a general decision to identify an item as public or restricted, even though it represents a consensus of the constituency, may still lead some individuals to refuse to supply the data.

CLASSIFICATION OF SALARY STUDY INFORMATION

The Data Development Liaison Committee considered the question of classification of statistics developed from the annual salary survey of the Association, and the committee came to the following conclusion:

> "Descriptive statistics of the Salary Study should be classified as public information so long as individuals or institutions are not identified by these statistics."

The public classification is necessary, if statistics are to be published in the Journal of Medical Education. Median salaries by rank and by department have been published in the Journal in the past, without identifying individual institutions, and the possibility of publishing an additional 25th and 75th percentile range is under consideration.

The detailed distribution has been published in the past and sent only to deans of medical schools, with a label of "confidential". If the new release policy is adopted, there would be no basis for a confidential classification for this report, since no individual or institution is identified. Indeed, our past policy has been subject to criticism from some of our academic societies who conduct independent salary surveys and have not had access to the "confidential report". Staff plans to produce a more compact report for the present year, including some high and low percentile information, but without the extremes of salary. The report would then be made available to any member of the Council of Deans, Council of Academic Societies, or Council of Teaching Hospitals.

RECOMMENDATION

The Data Development Liaison Committee requests that the Executive Council confirm public classification for statistics from the annual Faculty Salary Survey.

REPORT OF THE AAMC COMMITTEE ON GRADUATE MEDICAL EDUCATION

The AAMC Graduate Medical Education Committee met in Washington on November 12. A major consideration at this meeting was the role of education and training in influencing the distribution of physicians across the specialties. Five major points were agreed upon by the Committee:

1. There is a need to produce substantially more primary care physicians. Primary care is defined to include family practice, general medicine, and general pediatrics.

2. There is a need to produce fewer specialists and subspecialists.

3. Fifty (50) percent of the first-year residencies should be allocated to primary care training in ambulatory settings with responsibility for longitudinal care. This may be accomplished through:

a. The establishment of innovative and attractive primary care educational programs;

b. The elimination of poor quality residency programs in all categories through a more stringent accreditation process. Improving the accreditation process is a logical function of the LCGME.

c. The federal government, initially through a grant program to support initial development, and third-party payers, ultimately through providing for adequate reimbursement in the ambulatory care setting, can create and sustain a major shift toward more primary care training opportunities.

The increase in first-year primary care residencies to 50% of the places should be reached between 1975-1980. Annual monitoring of trends in distribution of first-year positions across the specialty spectrum should be carried out by the Association, and the disparities of trends versus needs should be called to the attention of the institutions.

4. First-year residency positions should be limited to 110%-120% of the number of graduates produced by U.S. medical schools. It is assumed that the number of graduates of American medical schools will be adjusted to the demands of population growth and other factors which will influence physician manpower needs.

5. Further investigation of this complex issue can be approached in a variety of ways:

a. By an examination and analysis of data currently available from AMA, DMI, and SOSSUS studies;

b. By an examination and analysis of physician tasks in terms of the lowest common denominator of education necessary to perform the task; and

c. By an examination and analysis of existing models of health systems, such as the Kaiser-Permenente, H.I.P., and plans in Great Britain, Sweden, and Denmark.

FMG TASK FORCE RECOMMENDATIONS

This is an interim report on the deliberations by the FMG Task Force regarding the influx of FMGs into the United States and the responsibilities of the AAMC constituency for a physician manpower pool of varying academic quality. There are two principal foci of concern:

(a) The effect of the influx of large numbers of FMGs on the quality of medical education and the quality of medical care,

(b) The specific problems of U.S. foreign medical graduates.

The FMG Task Force has developed the following recommendations regarding educational quality:

1.0 The flow of FMGs into the United States should not exceed the number for which U.S. resources can provide high quality graduate education which is appropriately organized to assure that FMGs achieve a level of knowledge and clinical competence equivalent to the (acceptable) U.S. medical graduate.

To accomplish the objectives implicit in this statement, actions are urged in terms of both program accreditation and FMG admission.

1.1 Accreditation-- Development of guidelines for criteria regarding resources and organization of U.S. graduate medical education programs to ensure quality education of FMGs. Graduate medical education programs must be required to meet these criteria if they are to accept FMGs for training.

1.2 Admission-- Development of a universal qualifying examination (e.g. such as the Qualifying A examination proposed in the GAP Report) to select U.S. and foreign medical graduates for admission into U.S. graduate medical education programs according to a uniform standard.

1.3 Interim Measure-- Adoption by the ECFMG of more stringent criteria to certify the eligibility of FMGs for U.S. graduate medical education. This could be accomplished through:

-- Selection of questions for the ECFMG examination which compare more nearly in their degree of difficulty with those used for the National Board Examination, Parts I and II.

-- Re-evaluation of the passing score on the ECFMG examination.

-- Limitation on the number of times the ECFMG examination can be taken.

2.0 Should it be necessary to accept substantial numbers of FMGs into the U.S. medical education system beyond those who can be accommodated in terms of the above criteria, additional support must be provided for such programs to meet expanded instructional obligations.

December 4, 1973

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

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

WASHINGTON: 202: 466-5175

November 30, 1973

Executive Secretariat
Cost of Living Council
2000 M Street, N.W.
Washington, D.C. 20508

RE: Proposed Phase IV Health Docket: General (§§150.501-.504) and Acute Care Hospitals (§§150.516-.523)

Gentlemen:

The purpose of this letter is to express the views of the Association of American Medical Colleges (AAMC) regarding the proposed Phase IV Health Care Regulations as published in the Federal Register November 6, 1973 (6 CFR Part 150). The Association, through its Council of Teaching Hospitals, represents 400 of our largest tertiary care - teaching hospitals, as well as all of the nation's schools of medicine and 59 academic societies.

Fundamental Position

As proposed, the regulations would impose arbitrary ceilings upon both inpatient charges and expenditures per admission. These limitations will effect fundamental medical decisions such as the length of a patient's hospital stay and the intensity of that patient's treatment in terms of both the type and amount of services provided during that stay. The American Hospital Association (AHA) has raised serious questions regarding the legality of the proposed regulations. Specifically, the AHA holds that: (1) the Cost of Living Council will exceed its legal authority if it proceeds to formally adopt the regulations as presently proposed; (2) the proposed regulations violate the Medicare law in that they compromise the assurance that hospitals will be reimbursed for the "reasonable costs" of providing services to Title XVIII beneficiaries; and (3) the proposed limitations on per admissions charges and expenditures are contrary to sound medical practice and to the provision of adequate community health services. The AAMC believes these are reasonable and responsible assertions, and the Association supports the position of the AHA in this regard. Given the stated position of the American Hospital Association, the legitimacy of the aforementioned assertions will, no doubt, be considered by the courts.

If the regulations are implemented, in substance, as proposed the industry might be faced with the necessity of operating under them while litigation is in process. Given this possibility the Association has chosen to submit substantive comments on the regulations as currently proposed. It is the Association's position that adoption of the modifications noted below will increase the interim workability and decrease the onerousness of the proposed regulations.

Recommended Modifications In Proposed Regulations

The Association strongly urges that the following modifications be made in the regulations prior to formal adoption and implementation by the Cost of Living Council. The first seven recommendations are of particular importance to teaching hospitals. The rationale underlying certain suggested modifications and the impact of the proposed regulations on the nation's teaching hospitals will be more fully developed in a subsequent section of this letter.

(1) The entire structure, criteria and process of the exceptions procedure should be published with an appropriate time period for comment prior to the effective date of the Phase IV regulations. The industry's experience with the exceptions process to date has been highly unsatisfactory and confidence in such procedures can only be developed through competent leadership, adequate staffing, a reasonable response period and published specific criteria. Adoption of the following recommendations would substantially improve the exceptions process.

(a) Exceptions requests should be acted upon no later than thirty days following receipt of the request; failure to act should result in a decision granting the requested exception to the petitioner.

(b) Following prenotification, certain self-executing exceptions should be permitted:

(i) in those instances where charges are lower than cost;

(ii) where specified costs are beyond the control or jurisdiction of the individual hospital such as: increased costs resulting from actions of the Joint Commission on Accreditation of Hospitals or the State Health Department; wage exceptions granted by the Cost of Living Council; excessive price increases in decontrolled sectors of the economy as well as excessive price increases which have been granted by the Cost of Living Council in controlled portions of the economy;

(iii) where approval of specific capital projects have been granted by the designated state agency acting pursuant to §221 of P.L. 92-603 (in these cases, both the expense and charges generated from the capital project should be excluded from the current

year charge and expense base upon which the hospital determines compliance for a period of three fiscal years beyond the completion of the project).

(c) Specific and interpretable guidelines must be developed regarding the manner in which alterations in case mix can be demonstrated for the purpose of obtaining an exception to base allowable limits of charge and expense per admission increase.

(d) In order to provide credibility, equity and administrative fairness, an Appeal Board should be established to handle exceptions. The composition of such a board should include fifty percent provider representation, and should report directly to the Director of the Cost of Living Council. Additionally, the Board should have a separate staff of hearing officers and an Executive Secretariat.

The equity of the exceptions process is particularly critical to teaching hospitals since it is these institutions that will be experiencing alteration in case mix, adding new services, and developing new health technologies. Indeed, initial analysis indicates that fully fifty-eight percent of COTH member hospitals would be out of compliance under the proposed regulations and thus would require an exception.

(2) The basic limitation on a hospital's increases in inpatient charges and expenses per admission in any fiscal year should be raised from 7.5 to 9 percent. This recommendation is particularly important for teaching hospitals which will be experiencing higher than average cost increases, and which will be predictably experiencing a change in case mix resulting in services with more intensity and complexity.

(3) The corridor within which hospitals are allowed the base amount of charge and expense per admission increase should be raised from two to five percent.

(4) Assumptions regarding the proportion of a hospital's costs that are fixed and variable do not appear to be formulated on the basis of either empirical evidence or operational reality (see text and citations associated with footnotes 2-10). For increases in admissions in excess of +5.0 percent, variable cost should be defined as sixty percent of average cost. For decreases in admissions greater than -5.0 percent, fixed cost should be defined as eighty percent of average cost.

(5) The limitation on price or cost increases for outpatient services should be set at a level consistent with inpatient limitations. This is particularly important since the proposed regulations provide no incentive to transfer a low cost inpatient procedure or service to a high cost ambulatory service or procedure; indeed, the proposed regulations provide a disincentive for such action.

(6) Embodied in the outpatient service section is a "class of purchaser" concept which applies to all instances where outpatient services, by contract or legislation, are reimbursed on a cost basis. The "class of purchaser" concept should be omitted, and compliance should be evaluated on a aggregated occasions of service basis.

(7) Due to both functional and organizational rearrangements as well as the anticipated implementation of specific legislation (e.g., Section 227 of P.L. 92-603) hospitals, particularly teaching institutions, are continuing to experience alterations in the manner in which physicians are compensated. The last decade has witnessed significant increases in the number of physicians who are compensated for professional services provided by institutional funds rather than by reasonable charges per unit of service rendered. Therefore, the Association urges that where hospital charges and/or expenses are altered due to a change in the basis for the renumeration of physicians, the hospital be allowed to adjust for such changes by altering the amount of total charges/expenditures in either the base or control year for the purpose of computing the compliance calculation. For example, if a hospital experiences an increase in charge/expense of $300,000 due to an increase in the number of practicing physicians on the hospital payroll during a specific control year it should be, for the purpose of calculating charge/expense per admission, allowed to: 1) increase the total charges/expenses of the base year by $300,000 or 2) deduct $300,000 from the total charges/expenditures of the control year.

(8) There should be an optional starting date for hospitals to become subject to the new regulations. Hospitals with fiscal years beginning after June 30, 1973 and before July 1, 1974 should have the option of functioning under Phase III or Phase IV.

(9) Both the charge and expense limitations should be reviewed and updated at specified periods based on the latest data of the consumer and wholesale price indices. This is necessary since the original limitations have been constructed with specific estimated percentages by class of expense in the non-wage category.

(10) A section on "violations" should be included in the regulations. Nowhere in the proposed regulations is there any indication of what action will be taken if limitations in the regulations are exceeded. Proposed regulations regarding the manner of handling violations should be published; hospitals and other interested parties should be given an opportunity to comment prior to the time that the Phase IV regulations are effective.

(11) Any state or the District of Columbia should be required to demonstrate broad provider acceptance before applying to the Cost of Living Council for authorization to administer the state control program in lieu of administration of the program by the Cost of Living Council.

(12) §150.517(e) should apply for beds which are licensed but not in use, and the application of the limitations should not apply until the third fiscal year following the increase in bed complement.

Impact On Teaching - Tertiary Care Hospitals

The Association of American Medical Colleges strongly believes that it is the nation's teaching hospitals which will be most severely affected by the proposed rules. Such rules, if implemented, will seriously erode the capability of our teaching hospitals to continue in their efforts to serve as the institutions where new technology and medical procedures are developed, refined and implemented and will inhibit their ability to provide highly sophisticated (and increasingly more expensive) tertiary care services. These observations are developed in detail below:

CLINICAL INVESTIGATION AND DEVELOPMENTAL FUNCTIONS. Teaching - tertiary care hospitals are the primary locus of health services clinical investigation and development. New methods of treatment, innovative types of health manpower and patient care team configurations, as well as new types of medical technology are developed, initially utilized and refined in such hospitals for eventual deployment throughout the health services industry. Teaching hospitals must recruit and retain large numbers of highly trained personnel. They must purchase and develop highly sophisticated and increasingly expensive equipment, modify and improve on it so that such technology, if beneficial, can be applied on a broader scale. The development of such health technologies as transplantation, neo-natal intensive care, cardiac intensive care and radio-holographic brain scanning are testimony to the effectiveness and efficiency of the nation's teaching hospitals in translating biomedical and bioengineering research into significant patient care procedures. One would expect that this clinical investigation and developmental involvement would be associated with both larger absolute costs and higher rates of cost increase. Indeed, a recent econometric study demonstrates that the rate of cost increase is 1.7 times greater for major teaching hospitals than community (non-teaching) hospitals even when controlling for absolute average cost, location, bed size and utilization.[1]

The regulations as proposed are detrimental to and penalize those institutions that are significantly involved in health services clinical investigation and development functions. If implemented as proposed, the regulations would inhibit both the development and application of new technologies. Given the aforementioned rationale the Association strongly urges the adoption of recommendation (1)(b)(iii) previously detailed. Additionally, since many clinical investigation and developmental activities are not directly related to capital expenditures (e.g., alterations in the type of manpower and the nature of treatment modalities), it is further proposed that specific guidelines be developed so that exceptions can be sought and subsequently obtained for increases in costs associated with such innovations.

ALTERATIONS IN CASE MIX. Given the nature of the proposed regulations there will be a direct and immediate stimulus for some hospitals to reduce expenditures and lower lengths of stay by attempting to reduce the number of

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[1] Judith R. Lave and Lester B. Lave, "Hospital Cost Functions", American Economic Review, Vol. 7 (June 1970), pp. 379-395.

admissions requiring complex and/or sophisticated treatment modalities. These cases will undoubtedly find their way into the nation's teaching hospitals. When viewed in isolation, the anticipated incremental shifting of tertiary patients to tertiary hospitals has laudable planning and regionalization effects. However, under the proposed regulations, the nation's teaching hospitals are not given the means to cope adequately with this development. The impact of an increased flow of complex cases into teaching hospitals, given the structure of the proposed regulations, would have a two-fold effect upon such facilities. First, increases in admissions will be those of the relatively high expense category with larger than average lengths of stay causing the average expense per admission to increase -- thereby heightening the probability of non compliance with the proposed regulations. Second, if the admissions of such facilities increase in excess of two percent over a base year, only forty-three percent of that base year's expense per admission will be deemed allowable. That is, teaching hospitals experiencing increases in increasingly costly cases will be allowed only fractional (43 percent) increases in expenses to provide such care.

Given the nature of the teaching hospital's mission, it is unrealistic to expect that such institutions would either directly or indirectly attempt to limit the increase of admissions requiring tertiary services except as a last resort to preserve institutional survival. The regulations as presently proposed would severely penalize institutions for avoiding such action. One would expect, however, that teaching hospitals would be forced to limit the expansion of already existing tertiary services when capacity is reached and to avoid or delay the implementation of new tertiary services as their clinical efficiency is demonstrated. Limiting the expansion of already existing services when current capacity is reached would inhibit the efficient utilization of such services by mitigating the distribution of relatively high developmental costs over increasing volume. Decisions not to develop and/or implement new tertiary services based upon arbitrary economic guidelines would inhibit medical progress and completely circumvent professional judgments regarding the efficacy of such services.

For the aforementioned reasons the Association urges the development of clear and implementable guidelines regarding the consideration of exceptions on the basis of alterations in case mix as previously specified in recommendation (1)(c). Additionally, to allow a greater degree of operational flexibility the Association urges the adoption of a widening of the admission increase corridor as detailed in recommendation (3).

FIXED AND VARIABLE COSTS. The proposed regulations assume that the fixed and variable cost of hospital operations are sixty and forty percent respectively of average cost. Listed below are estimates of marginal cost (MC) as a proportion of average cost (AC) obtained by all known econometric analyses of hospitals conducted during the last four years.

Authors (Date of Research)	Estimate of MC/AC
Berry and Carr (1973)[2]	0.84 - 0.96
Kuenne (1972)[3]	0.65 - 0.91
Lave, Lave and Silverman (1972)[4]	0.68
Evans and Walker (1972)[5]	0.80 - 0.90
Evans (1971)[6]	0.76 - 0.86
Lave and Lave (1970a)[7]	0.40 - 0.65
Lave and Lave (1970b)[8]	0.58 - 0.68
Cohen (1970)[9]	0.67
Francisco (1970)[10]	0.73 - 0.87

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2 Ralph E. Berry, Jr. and John W. Carr, Jr., "Efficiency in the Production of Hospital Services," unpublished paper (June 1973).

3 Robert E. Kuenne, "Average Sectorial Cost Functions in a Group of New Jersey Hospitals," Research Monograph #1 (Princeton University: General Economic Systems Project, October 1972).

4 Judith Lave, Lester Lave and Larry Silverman, "Hospital Cost Estimation Controlling For Case Mix," unpublished paper (1972).

5 Robert Evans and H. Walker, "Information Theory and the Analysis of Hospital Cost Structure," Canadian Journal of Economics, Vol. 5 (August 1972), pp. 398-418.

6 Robert Evans, "Behavioral Cost Functions For Hospitals," Canadian Journal of Economics, Vol. 4 (May 1971), pp. 198-215.

7 Judith Lave and Lester Lave, "Hospital Cost Functions," American Economic Review, Vol. 6 (June 1970), pp. 379-395.

8 Judith Lave and Lester Lave, "Estimated Cost Functions for Pennsylvania Hospitals," Inquiry, Vol. 7 (June 1970), pp. 3-14.

9 Harold Cohen, "Hospital Cost Curves With Emphasis On Measuring Patient Care Output," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore, Maryland: The Johns Hopkins Press 1970), pp. 279-293.

10 Edgar Francisco, "Analysis of Cost Variations Among Short-Term General Hospitals," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore, Maryland: The Johns Hopkins Press 1970), pp. 321-332.

Additionally, an analysis conducted at a large midwestern university owned hospital found that variable and fixed costs were 65 and 35 percent respectively.

Even though heterogeneous, all of the estimates provided above are in excess of the variable cost allowance provided for in the proposed regulations. The nature of the variability across studies (based upon different subsets of hospitals) and type of control variables employed within each study (case mix, size, utilization, etc.) appears to indicate that the proportion of costs that are fixed and variable are specific to an individual hospital at a given time depending upon the nature of the product produced, the scale of production, the percent of capacity at which the institution is operating and the method employed to finance capital facilities.

Given these observations (and elaborating on recommendations (3) and (4) noted previously) it is reasonable to suggest that increased flexibility be provided to different hospitals operating under different circumstances and constraints. In line with the aforementioned comments this could be accomplished in either or both of two ways. First, we urge that the corridor within which hospitals are allowed the full allowable amount expense/charge increase (107.5 percent of the previous year's base) be widened to a zone encompassing increases in admissions less than +5.0 percent to decreases in admissions less than -5.0 percent. Second, the regulations should be altered to recognize more reasonable specifications of variable costs consistent with empirical evidence and operational realities. The Association urges that for increases in admissions in excess of +5.0 percent, variable cost be defined as sixty percent of average cost. This figure is consistent with empirical findings and takes account of the fact that variable costs increase proportionately greater than admissions when occupancy increases. On the other hand, for decreases in admissions greater than -5.0 percent, fixed cost should be defined as eighty percent of average cost. This allowance takes adequate account of the fact that significant declines in occupancy, over the short run, in no way reduces gross expenditures as an adequate capacity must be maintained to meet the demands for service when occupancy increases. The adoption of these recommendations are particularly critical to teaching - tertiary care institutions as variable (marginal) costs are a large proportion of average cost given marginal increases in increasingly complex and hence high expense admissions.

OUTPATIENT SERVICES. The proposed regulations provide that outpatient cost and prices may increase by no more than six percent as determined by either an individual unit or an aggregated weighted calculation (in those cost centers where outpatient services account for at least seventy percent of total billed charges or costs). Furthermore, the regulations provide that where outpatient services are reimbursed at cost, the six percent allowable increase (per occasion of service) is to be applied to each class of purchaser considered individually.

Teaching hospitals have served as the leader in developing new modes of providing ambulatory care and expanding the delivery of such services to increasingly broader population groups. For example, the outpatient departments

of many teaching hospitals are serving as the base for the development of family practice clinics and comprehensive ambulatory care centers. Additionally, teaching hospitals have led the way in the transferrance of many medical procedures from an inpatient to an outpatient base. Creation of new modes of ambulatory care provision generally entails an increasing intensity of the amount and nature of the care provided per occasion of service (e.g., comprehensive family care versus episodic treatment), such developments are penalized under the proposed regulations. The transferrance of procedures provided on an inpatient basis to those provided on an outpatient basis would entail the conversion of a relatively low cost inpatient admission to a relatively high cost outpatient visit, engaging in such action drastically heightens the probability of non compliance for both outpatient and inpatient activities. Therefore, the Association urges that the allowable rate of expenditure and revenue per occasion of service increase be raised so that it is at least equal to the rate of increase provided for expense and revenue per inpatient admission (9.0 percent) -- see recommendation (10). Additionally, we recommend that the class of purchaser provision (§150.518(c)) be struck from the regulations when formally adopted -- see recommendation (11).

As evidenced above the Association of American Medical Colleges has deep concern and substantial reservations regarding the Phase IV regulations as they are presently proposed. Indeed, we are convinced that the proposed regulations will erode the ability of the nation's teaching hospitals to translate the results of biomedical research and development into effective diagnostic and therapeutic procedures, and to serve as the locus for the provision of intensive and complex tertiary care services. The Association stands ready to elaborate upon specific observations and/or recommendations presented in this letter.

Sincerely,

JOHN A. D. COOPER, M.D.
President

SOCIAL SECURITY AMENDMENTS OF 1973

Report of the Committee on Finance
U.S. Senate

PAYMENT FOR SUPERVISORY PHYSICIANS IN TEACHING HOSPITALS

(Sec. 176 of the bill)

Section 227 of P.L. 92-603, the Social Security Amendments of 1972, dealt with payment for supervisory physicians in teaching hospitals. The primary objective of the provision was to make it clear that fee-for-service reimbursement should be paid for the teaching physician's services only where the patient is a bona fide private patient. The Report of the Committee on Finance which accompanied the provision explained its concept of "private patient" in some detail. However, because of the extremely wide variety of teaching programs throughout the country and the lack of reliable data on the character of the professional care and the nature of the financial arrangements established to support the physicians' services rendered in them, the law authorized the Secretary to define "private patient" by regulation.

In its comments to the Department of Health, Education, and Welfare on the regulation proposed by the Secretary to define "private patient" for Medicare reimbursement purposes, the Association of American Medical Colleges submitted a report to the Secretary which, among other things, assessed for the first time the financial and programmatic impact of the proposed regulations on six unnamed member medical schools and teaching hospitals. While the data presented in this study are far too limited to serve as a basis for drawing conclusions about the appropriateness of the proposed regulations, they do raise questions about the impact of both the present and proposed reimbursement policies which deserve further study.

The committee amendment would authorize and direct that a more extensive study be done including at least 40 or 50 hospitals.

The study, which would be carried out at medicare expense, would encompass all aspects of third party financing for professional services rendered in the medical school and teaching hospital setting. The study would be carried out by personnel of the Social Security Administration who would be assisted to the extent they deem appropriate by personnel from the Association of American Medical Colleges as well as others with necessary expertise. In view of the limited time in which the study must be completed and for reasons such as the broad scope of the undertaking, the Committee would assume that the Social Security Administration would also find it useful to utilize the services of non-governmental organizations and persons other than the AAMC who could contribute substantial fiscal, administrative and program expertise in the areas of Medicare, Medicaid, patient care and graduate medical education. Representatives of the Association have agreed to cooperate fully with the Social Security Administration in obtaining the needed information and have stated that they will strongly urge their member medical schools and teaching hospitals to lend their full cooperation to the effort.

The study would describe both past and current practices of both private and public health insurance programs, relating to the payment for the services of supervisory and teaching physicians. The study would describe variations which exist among different teaching settings and variations which exist in the relationship between patients and physicians in these various settings.

The study would include data on the costs of providing teaching and supervisory services and it would include data on the extent of current fee-for-service and other reimbursement from public and private programs.

The study would analyze the impact of various alternative methods of financing professional services in a teaching setting. Both the fiscal and the programmatic aspects of various reimbursement mechanisms would be analyzed. Special attention would be given to the impact of current Medicare reimbursement mechanisms and the mechanisms outlined under Public Law 92-603.

In view of the expanding role of public health insurance programs, the study would analyze the effect of Government reimbursement policy not only on the institutions involved, but also on the practices of private insurers, and the Federal budget.

The amendment calls for the Secretary to submit a report of his findings, including any recommendations for legislative changes he may deem appropriate, to the Congress on or before July 1, 1974, but in no case may it be submitted later than December 31, 1974.

In view of the prospect that the information derived from the study could point up problems in the Secretary's proposed regulations or the law that should be remedied, the amendment would defer the implementation of the private-patient requirement of Public Law 92-603 for 1 year, so that it would be effective for hospital accounting years that begin after June 30, 1974. Moreover, under the amendment the Secretary could, if he believes that further study is warranted, defer implementation of the 1972 provision for an additional 6 months.

The 1972 legislation also provided for more favorable cost reimbursement than had been available previously where fee-for-service reimbursement is not paid for the services of a teaching physician. Since there is no reason to defer the implementation of these more favorable cost reimbursement provisions in teaching hospitals where no fee-for-service reimbursement is paid, the amendment would retain the original effective date insofar as these hospitals are concerned.

AAMC RECOMMENDATIONS ON MEDICAL SCHOOL ACCEPTANCE PROCEDURES

The Association's Medical School Admission Requirements publication includes AAMC recommendations on medical school acceptance procedures. To recognize recent developments in medical school admissions, the Association's Group on Student Affairs has revised these procedures and submitted them for Executive Council approval.

RECOMMENDATION

It is recommended that the Executive Council approve the attached six points as AAMC recommendations on medical school acceptance procedures.

Proposed Revision

AAMC RECOMMENDATIONS ON MEDICAL SCHOOL ACCEPTANCE PROCEDURES

For the information of prospective medical students and their advisers, the recommended procedures for offering acceptance to medical school and for student responses to those offers are printed below:

1. Each medical school should prepare and distribute to applicants and pre-medical advisers a detailed schedule of its application and acceptance procedures, and should adhere to this schedule unless it is publicly amended.

*2. An applicant should be given at least two weeks to reply to an offer of admission. After that time, an applicant may be required to file a statement of intent, or a deposit, or both. The statement of intent should provide freedom to withdraw if the applicant is later accepted by a school which he or she prefers; and the deposit, which should not exceed $100, should be refundable without question. The refundable deposit may be credited against tuition charges if the applicant matriculates in the school.

*3. No medical school should use any device which implies that acceptance of its offer creates a moral obligation to matriculate at that school. Every accepted applicant should be free to deal with all schools and to accept an offer from any one of them even though a deposit has been paid to another achool. On the other hand, every accepted applicant retains under all circumstances an obligation to notify a school promptly of a decision not to accept its offer, and to withdraw at once if, after accepting an offer from one school, the applicant receives and accepts an offer from another school.

4. Each school is free to make appropriate rules for dealing with accepted applicants who, without adequate explanation, hold one or more places in other schools. These rules should recognize the problems of the student who has multiple offers and also of those applicants who have not yet been accepted.

5. Subsequent to June 1, a medical school seeking to admit an applicant already known to be accepted by another school for that entering class should advise that school of its intent. Because of the administrative problems involved in filling a place vacated just prior to the commencement of the academic year, schools should communicate fully with each other with respect to anticipated late roster changes in order to keep misunderstandings at a minimum.

6. After an applicant has actually enrolled at a U.S. medical school, no further acceptances should be offered to that individual. Once enrolled in a school, students have an obligation to withdraw their applications

promptly from all other schools. Enrollment is defined as being officially registered at a school on or subsequent to the formally publicized starting date for the first year class of that school.

*Most of these two procedures to not pertain to students accepted under the Early Decision Plan (EDP) because such students agree in advance to attend a given medical school if offered a place during the "Early Decision" segment of the application year.

Table 3.4

Recommended Acceptance Procedures of the Association of American Medical Colleges

For the information of prospective medical students and their advisers, the recommended procedures governing medical school acceptance offers and student's response to those offers are printed below.

1. No offer of admission to medical school should be made to an applicant more than one year before he will enter the course of instruction offered by the medical school.*

2. When an offer is made to an applicant, he should have not less than two weeks in which to reply.

3. A student receiving an offer may be required to file within two weeks a statement of intent, or a deposit, or both. The statement of intent should leave the student free to withdraw if he is accepted by a school he prefers; and the deposit, which should not exceed $100, should be refundable without question. The refundable deposit may be credited against tuition charges if the student matriculates in the school.

4. Each medical school should prepare and distribute to applicants and college advisers a detailed schedule of its application and acceptance procedures, and should adhere to this schedule unless it is publicly amended.

5. No medical school should use any device which implies that acceptance of its offer creates a moral obligation to matriculate at that school. Every accepted applicant should know that he is free to deal with other schools and accept an offer from one of them even if he has paid a deposit to another school. Every accepted applicant does retain under all circumstances an obligation to notify a school promptly if he decides not to accept its offer to him, and to withdraw at once if, after accepting an offer from a school, he receives and accepts an offer from another school he prefers.

6. Each school is free to make appropriate rules for dealing with accepted candidates who hold one or more places in other schools without adequate explanation. These rules should recognize the problems of the student who has multiple offers, and also of those applicants who have not yet been accepted.

7. Subsequent to July 15, a medical school seeking to admit an applicant already known to be accepted by another school for that entering class should advise that school of its intent. Because of the administrative problems involved in filling a place vacated just prior to the commencement of the academic year, schools should communicate fully with each other with respect to anticipated late roster changes in order to keep misunderstandings at a minimum. *After an applicant has actually enrolled at a U.S. medical school, no further acceptances should be offered to that individual. In this connection, students have an obligation to withdraw their applications promptly from other schools when they enroll elsewhere, especially if their own school's classes start prior to September 1.*

*Under special circumstances a school may make an offer more than one year before the expected matriculation date to encourage the educational development of the student, but all such offers should state explicitly that the student is completely free to apply to other schools at the usual time.

Source = Medical School Admission Requirements, 1974-75

PROPOSED BY-LAWS
OF THE
LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

Foreword

These by-laws are based on and intended to conform to the previously adopted statement entitled: "A proposal for the establishment of the Liaison Committee on Graduate Medical Education, as developed from the five points of agreement by the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council on Medical Specialty Societies on January 25, 1972, in Washington, D.C."

Article 1 - NAME

The name of this organization shall be the Liaison Committee on Graduate Medical Education.

Article II - PURPOSE, OBJECTIVE, AND FUNCTIONS

Section 1. Purpose. The purpose of the Liaison Committee on Graduate Medical Education is to accredit programs in graduate medical education.

Section 2. Objective. The objective of the Liaison Committee on Graduate Medical Education is to develop the most effective methods to evaluate graduate medical education, to promote its quality, and to deal with such other matters relating to graduate medical education as are appropriate.

Section 3. Functions. The Liaison Committee shall:

(a) Develop standards and criteria common to all programs in graduate medical education for approval by the Coordinating Council on Medical Education;

(b) Approve specific guidelines provided by the individual residency review committees;

(c) Establish general standards and criteria for evaluation of programs in graduate medical education;

(d) Recommend and initiate studies pertinent to improving the organization and conduct of programs in graduate medical education;

Section 3. Functions (continued)

(e) Receive and consider proposals for new types of programs in graduate medical education for which accreditation is being sought;

(f) Review periodically the criteria by which programs of graduate medical education are evaluated;

(g) Provide a means whereby programs in graduate medical education may appeal adverse decisions;

(h) Receive from and provide information to the public and the governement concerning the evaluation and accreditation of programs in graduate medical education;

(i) Initiate studies and recommend policy to keep programs in graduate medical education responsive to public and social needs.

Article III - MEMBERSHIP

Section 1. Membership on the Liaison Committee shall consist of the following number of representatives from the member organizations:

American Board of Medical Specialties	4 Representatives
American Hospital Association	2 Representatives
American Medical Association	4 Representatives
Association of American Medical Colleges	4 Representatives
Council of Medical Specialty Societies	2 Representatives

In addition, one public member, and one representative of the Federal Government, *and one representative of the house-staff organizations* shall serve on the Liaison Committee.

Section 2. Each organization so designated shall select its representatives in the manner it chooses, but each is urged, insofar as possible, to designate staggered terms to provide continuity of service.

The public member shall be selected by the members of the Liaison Committee.

The representative from the Federal Government shall be designated by the Secretary of the Department of Health, Education, and Welfare.

The representative from the house-staff organizations shall be designated by a liaison committee established by the AMA Intern and Resident's Business Session and the Physicians National Housestaff Association.

Section 3. Representatives of the professional organizations shall, except for the initial formation of the Liaison Committee, be appointed for three-year terms, with a maximum of six consecutive years.

The professional organizations shall notify the Secretary of the Liaison Committee at least one week prior to any meeting for which a new representative has been designated.

Additional organizations may be represented on the Liaison Committee by unanimous approval of the current sponsoring professional organizations.

The public member shall be elected annually, with a maximum of six consecutive terms.

The Federal Representative shall serve at the discretion of the appointing official.

The house-staff representative shall serve a two-year term, and must be a house officer at the beginning of his appointment but need not necessarily be a house officer for the full extent of the two-year term.

Article IV - OFFICERS

Section 1. The positions of Chairman and Vice-Chairman shall rotate, on an annual basis, among the parent organizations according to a schedule determined by the Liaison Committee.

Section 2. The officers shall be named by their respective organizations.

Section 3. The new officers shall take office at the conclusion of each annual meeting.

Section 4. The term of office shall be one year.

Section 5. Primary staff and secretarial services for the Liaison Committee shall be provided, for the time being, by the American Medical Association, with staff assistance provided by other members of sponsoring professional organizations as shall from time to time be deemed appropriate and necessary.

Article V - MEETINGS

Section 1. The Liaison Committee shall hold meetings on a basis that is felt to be appropriate by the membership of the Committee, with at least three meetings a year.

Section 2. The first meeting of each calendar year shall be considered the Annual Meeting.

Section 3. A majority of the members of the Liaison Committee shall constitute a quorum, provided representatives from at least three of the five professional organizations are present.

All designated members present at a meeting shall have the right to vote.

Section 4. Special meetings may be called by the Chairman or at the written request of any five (5) members of the Liaison Committee representing a minimum of at least three (3) of the five (5) parent organizations. The purpose of such Special meetings shall be stated in the call. At least twenty-one (21) days' written notice shall be given for a Special meeting.

Article VI - COMMITTEES

Section 1. The Chairman shall appoint standing or special committees for the Liaison Committee as shall from time to time be deemed necessary to carry on the work of the Committee.

Section 2. The Chairman shall appoint a finance committee to consider the financial support of any activities involving expenditures of the Liaison Committee beyond those in Article VII.

Article VII - FINANCES

Section 1. The expenses of Liaison Committee representatives from the various organizations shall be borne by those organizations.

The expense of the public member shall be shared equally by the professional organizations.

The expense of the representative of the Federal Government shall be borne by the Federal Government.

The expense of the representative of the house-staff organizations shall be borne by the house-staff organizations.

Section 2. The expenses of members and others who are asked to serve on subcommittees of the Liaison Committee shall be paid by the Liaison Committee and shared on a pro rata basis by the member organizations. Persons other than those named to the subcommittee or those named to staff the subcommittee may attend meetings of subcommittees, but expenses of such persons will be borne by their sponsoring organizations.

Section 23. Unless otherwise provided for by the finance committee, expenses above those incurred by the representatives of the professional organizations shall be shared on a pro rata basis by the professional organizations.

Article VIII - MODUS OPERANDI

Section 1. Accreditation. The Liaison Committee shall take action on the accreditation of each individual program following receipt of the recommendation from the appropriate residency review committee.

Section 2. Monitoring. Individual members of the Liaison Committee shall receive and review the full minutes of all residency review committees.

(a) The membership of the Liaison Committee shall be divided into four groups, each of which shall be assigned a proportionate number of programs by specialty areas for review of the program recommendations of the residency review committees.

(b) The files of all identified problem cases shall be scrutinized by the assigned groups. These shall include all programs that have been on probation for periods of time considered excessive by members of the Liaison Committee on Graduate Medical Education.

(c) The Liaison Committee shall review all programs requested by the residency review committees.

Section 3. Appeals. Programs may appeal adverse decisions.

(a) It is expected that a program will request reconsideration by its Residency Review Committee as the initial step in any consideration of an adverse decision.

(b) Following this, *if approval has been withdrawn or withheld,* the program may then appeal directly to the Liaison Committee. The Chairman shall appoint at least ~~four~~ *three* members *of the Liaison Committee on Graduate Medical Education* who have not been previously involved in the review process of that program *and such additional consultants as appropriate who will be representative of the specialty under review.* Representatives of the program and of the Residency Review Committee shall be entitled to appear before the appeal hearing board.

(c) The final decision shall be made by the Liaison Committee after receiving the recommendations of the appeal hearing board. *Any* members of the Liaison Committee who made the adverse decision or concurred in the adverse decision of the Review Committee would not participate in the final decision.

Section 4. Review of the Mechanism of Residency Review Committees.

(a) Basic Essentials and Other Policy Matters: Approval of "Essentials" relating to graduate training programs is the responsibility of the Liaison Committee on Graduate Medical Education, to which the Coordinating Council on Medical Education has delegated consideration of additions, revisions, and deletions. Major policy decisions, however, after discussion by the Liaison Committee, shall be forwarded to the Coordinating Council on Medical Education for its consideration. The Liaison Committee would determine the order and manner in which approval would be sought of the parent bodies involved in the production of the "Essentials."

Article IX - PARLIAMENTARY AUTHORITY

Section 1. The rules contained in the current edition of Sturgis' Standard Code of Parliamentary Procedure shall govern the Liaison Committee in all cases to which they are applicable and in which they are not inconsistent with these by-laws and any special Rules of Order the Liaison Committee may adopt.

Article X - AMENDMENTS

Section 1. These By-Laws can be amended at any regular meeting of the Liaison Committee by a two-thirds vote of the members of the Liaison Committee present, provided that the amendment has been submitted in writing and has been read at a previous meeting.