



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

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 17-18, 1975

WASHINGTON HILTOL HOTEL
WASHINGTON, D.C.

Wednesday, September 17

6:30 p.m.	Cocktails	Jackson Room
7:30 p.m.	Dinner	Kalorama Room

Thursday, September 18

9:00 a.m.	Administrative Board Business Meeting (Coffee and Danish)	Hemisphere Room
1:00 p.m.	Luncheon and Executive Council Meeting (All Administrative Board members are invited to stay as late as their travel schedule permits)	Lincoln West
4:00 p.m.	Adjourn	

AGENDA
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 18, 1975

- I. Call to Order
- II. Approval of Minutes

ACTION ITEMS

EXECUTIVE COUNCIL AGENDA

- III. By-Laws Amendment to Provide for Corresponding Members (33)
- IV. Planning Agency Review of Federal Funds Under the Public Health Service Act: Titles IV and VII (84)
- V. Report of the National Health Insurance Review Committee (67)
- VI. AAMC Policy on the GAP Report (81)
- VII. CCME Report on FMG's (40)
- VIII. Borden and Flexner Award Nominations (34)
- IX. U.S. Citizens Studying Medicine Abroad (AAMC Policy Toward Fifth Pathway Programs) (93)
- X. Legislation to Allow Suit for Withheld Medicaid Funds (92)
- XI. Recognition of New Specialty Boards (77)

DISCUSSION ITEMS

COTH ADMINISTRATIVE BOARD AGENDA

- XII. Project to Develop Models for the Provision of "One Class" Ambulatory Care Services in Teaching Hospitals Dr. Shipp
- XIII. Department of Health Services Staff Report Dr. Hudson
- XIV. Letter to Senator Talmadge Concerning Hospital Reimbursement (16)
- XV. Exception Procedure to Routine Service Cost Ceilings (26)
- XVI. AHA Public General Hospital Study (48)

- XVII. Request for Research Support (50)
- XVIII. Malpractice Insurance Experimental Reimbursement Project (53)

INFORMATION ITEMS

- XIX. Annual Meeting Program (57)
- XX. Status of House Officers in Case Before NLRB Dr. Knapp
- XXI. Status of AAMC Appeal on Section 223 Court Decision Dr. Knapp
- XXII. AAMC Response to End-Stage Renal Disease Proposed Regulations (58)
- XXIII. PNHA Convention (61)
- XXIV. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD
Dupont Plaza Hotel
Washington, D.C.
June 19, 1975

MINUTES

PRESENT:

Sidney Lewine, Chairman
Charles B. Womer, Chairman-Elect
Robert A. Derzon, Immediate Past Chairman
John W. Colloton
J. W. Pinkston, Jr.
S. David Pomrinse, M.D.
Malcom Randall
John M. Stagl
David D. Thompson, M.D.
Robert E. Toomey
William T. Robinson, AHA Representative

ABSENT:

Daniel W. Capps
Leonard W. Cronkhite, Jr., M.D.
David L. Everhart
David A. Gee
Baldwin G. Lamson, M.D.

STAFF:

James I. Hudson, M.D.
Richard M. Knapp, Ph.D.
Dennis D. Pointer, Ph.D.
Steven Summer
Catharine A. Rivera

I. Call to Order:

Mr. Lewine called the meeting to order at 9:00 a.m. in the Plaza Room.

II. Consideration of Minutes:

Mr. Womer called the attention of the Board to a typographical error in the minutes of April 3, 1975, on page three. Under the action of agenda item VI, National Health Insurance and Medical Education, it was noted that the Board recommended deletion of numbers 3 and 4, rather than 2 and 4.

The minutes of the April 3, 1975, COTH Administrative Board meeting were then approved as corrected.

III. Membership:

- A. The Board reviewed two applications for membership and took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATION FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS BE APPROVED:

LUTHERAN GENERAL HOSPITAL
PARKRIDGE, ILLINOIS

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATION BE DISAPPROVED ON THE GROUNDS THAT THE INSTITUTION DOES NOT FULFILL THE PRESENT MEMBERSHIP CRITERIA:

PENSACOLA GENERAL HOSPITAL
PENSACOLA, FLORIDA

- B. COTH Ad Hoc Membership Committee Report

Dr. Thompson reviewed the latest COTH Ad Hoc Membership Committee Report and summarized the changes in his Committee's Report vis a vis previous membership reports. He also noted that the AAMC staff recommendation varies somewhat from the Committee's final recommendation and the Report's conclusion. The Committee recommended (see Attachment A) establishment of a new category of AAMC membership entitled "Corresponding Member" and set the annual dues level at \$250. AAMC staff suggested that due to potential administrative difficulties, the new class of membership should be available to each Council and be called "Subscribers."

The COTH Administrative Board reviewed these findings and discussed the benefits which may accrue to institutions and entities which are granted the status of "Subscriber" or "Corresponding Member." While it was recognized that some confusion may result from utilizing the word "member" in the new category, the COTH Administrative Board did agree that it was more a more favorable descriptive term. A motion to substitute the word "affiliate" was not approved by the Board.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH AD HOC MEMBERSHIP COMMITTEE REPORT BE ACCEPTED AS SET FORTH ON PAGES 21 AND 22 OF THE EXECUTIVE COUNCIL AGENDA BOOK WITH THE EXCEPTION THAT THE DUES BE SET AT \$500, THE LEVEL RECOMMENDED BY THE AAMC STAFF.

IV. National Health Insurance Review Committee:

Mr. Womer presented the Report of the National Health Insurance Review Committee which included proposed modifications to the CCME/LCGME statement on National Health Insurance and its impact on medical education. After extensive discussion of Mr. Womer's Report, the COTH Administrative Board took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THE THE REPORT OF THE AAMC NATIONAL HEALTH INSURANCE REVIEW COMMITTEE BE APPROVED WITH THE FOLLOWING CHANGES:

A. LINE 6 - PREAMBLE TO READ

" . . . EXCELLENT MEDICAL SCHOOLS, TEACHING HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS. . . "

B. LINE 10 - NUMBER 1

" . . . OTHER AVAILABLE SOURCES RESTRICTED TO CLINICAL POST-DOCTORATE DOCTORAL MEDICAL EDUCATION BY THE DONOR SHOULD BE DEDUCTED. . . "

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE ABOVE MODIFIED REPORT AND THE TWO ITEMS NOTED IN THE COMMITTEE REPORT ON REIMBURSEMENT FOR TEACHING FACILITIES AND PHILANTHROPY SHOULD CONSTITUTE THE ESSENTIALS OF ANY FORTHCOMING AAMC POLICY STATEMENTS ON NATIONAL HEALTH INSURANCE.

V. Department of Health Services Report:

Dr. James Hudson, Director, Department of Health Services, reviewed three of the activities currently underway in his department: (1) Report of the Primary Care Institute; (2) HMO Curriculum Development Project; and (3) Proposal for Ambulatory Care Restructuring Projects.

The COTH Administrative Board thanked Dr. Hudson for this report and recommended that there be representation from the COTH Administrative Board appointed to an advisory panel for the Ambulatory Care Restructuring Project.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THERE BE REPRESENTATION FROM THE COTH ADMINISTRATIVE BOARD ON THE ADVISORY PANEL APPOINTED TO THE AMBULATORY CARE RESTRUCTURING PROJECT.

VI. Study of Medical School-Teaching Hospital Relationships:

Dr. Knapp briefly reviewed the genesis of this project and noted the role of the Department of Teaching Hospitals. It was the Board's recommendation that there be an advisory group appointed which would consist of representatives from teaching hospitals and medical schools. The purpose of this group would be to provide guidance to the project.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THERE BE AN ADVISORY GROUP APPOINTED WHICH WOULD CONSIST OF REPRESENTATIVES FROM TEACHING HOSPITALS AND MEDICAL SCHOOLS.

VII. Academic Medical Center Problem Identification Survey:

Dr. Knapp reviewed the purpose of the survey. After a brief discussion, the Board recommended that COTH participate in Round II of the survey.

VIII. CCME Relations With Parent Organizations:

The COTH Board reviewed the CCME recommendation on relations with parent organizations as noted in the Executive Council agenda. The Board took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE TWO RECOMMENDATIONS OF THE CCME BE APPROVED AND THAT THE EXECUTIVE COUNCIL AGREE TO IMPLEMENT THE PROPOSALS.

IX. AMA Policy on Eligibility of Foreign Medical Students and Graduates for Admission to American Medical Education:

The COTH Administrative Board discussed this new AMA policy and took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE EXECUTIVE COUNCIL COMMUNICATE THE FOLLOWING STATEMENT TO THE LCGME FOR CONSIDERATION BY THAT BODY AT ITS NEXT MEETING IN JULY.

"THE EXECUTIVE COUNCIL OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES BELIEVES THAT THE PATHWAYS INTO GRADUATE MEDICAL EDUCATION IN THE UNITED STATES SHOULD BE DEFINED BY THE LCGME AND FORWARDED TO THE CCME FOR APPROVAL AND FORWARDING TO THE PARENT ORGANIZATIONS FOR RATIFICATION."

X. Amendment of AAMC Bylaws:

The proposed change in the AAMC Bylaws was reviewed by the COTH Administrative Board. Dr. Knapp noted that according to the present rules, an OSR Administrative Board member cannot serve in a voting capacity unless the individual is the official representative of his/her institution to the OSR throughout his/her term on the Board. Since the current AAMC Bylaws prohibit more than one representative of the institution to the OSR, the amendment therefore will allow a school to designate a second voting representative should the Board member, because of elections or graduation, no longer serve as the primary school representative. After review of this amendment, the COTH Board took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE EXECUTIVE COUNCIL APPROVE THE PROPOSED BYLAWS CHANGE AND RECOMMEND ITS APPROVAL TO THE ASSEMBLY IN NOVEMBER.

XI. Recommendation of the Conference on Epidemiology:

The COTH Administrative Board reviewed the recommendations of the Conference on Epidemiology and took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE ASSOCIATION ENCOURAGE THE HEALTH RESOURCES ADMINISTRATION TO BRING TOGETHER REPRESENTATIVES FROM THE ORGANIZATIONS AND AGENCIES LISTED IN PARAGRAPH 6, OF THE CONFERENCE REPORT, FOR THE PURPOSE OF DEVELOPING THE GOALS AND OBJECTIVES OF AN EXPANDED EFFORT IN TRAINING IN EPIDEMIOLOGY. THE OUTCOME OF THIS EFFORT SHOULD BE A DOCUMENT PROVIDING SUFFICIENT DETAIL ON GOALS SO THAT THE FACULTIES OF HEALTH PROFESSIONS MAY JUDGE THEIR PROGRAMS AGAINST A NATIONAL CONSENSUS.

XII. Development of an AAMC Policy on the NBME GAP Report:

The Report of the AAMC Task Force on the Goals and Priorities Committee Report of the National Board of Medical Examiners was reviewed by the Board. Concern was expressed over item 5, "The Federation of State Medical Boards and their members should establish a category of licensure limited to caring for patients in a supervised graduate medical educating setting." The Board did not agree with the Task Force recommendation and stated that the statement was not sufficiently definitive. Therefore, the following action was taken:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD RECOMMEND THAT THE EXECUTIVE COUNCIL OPPOSE THE ESTABLISHMENT OF A CATEGORY OF LIMITED LICENSURE SET FORTH AS ITEM 5, ON PAGE 71, OF THE EXECUTIVE COUNCIL AGENDA. NO FURTHER FORMAL ACTION WAS TAKEN.

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XIII. Departure of Dennis D. Pointer, Ph.D.

Mr. Lewine announced that Dr. Pointer will shortly be leaving the Association to accept a position with the University of California, Los Angeles, In his new job, Dr. Pointer will hold the following titles: Associate Professor and Director, Program in Health Services Management, School of Public Health; Associate Director, UCLA Hospital and Clinics and Senior Research Economist, Institute for Industrial Relations.

The Board expressed their best wishes to Dr. Pointer on his appointment at UCLA and took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COIH ADMINISTRATIVE BOARD OFFICIALLY OFFER THEIR CONGRATULATIONS TO DR. DENNIS POINTER AND COMMEND HIM FOR HIS WORK WITH THE COUNCIL OF TEACHING HOSPITALS.

XV. Adjournment:

There being no further business, the meeting was adjourned at 1:00 p.m.

COTH AD HOC MEMBERSHIP COMMITTEE REPORT

The issue of COTH membership criteria has come before the Executive Council several times in the last three years. Initially, it was the feeling of a number of deans that COTH had grown too large and should limit its membership to university-owned and primary affiliate hospitals. In recent months this restrictive attitude has given way to a view that any hospital which a dean certifies as having a sincere commitment to medical education should be allowed to join COTH.

At present there are about 400 COTH members, a figure which has remained fairly constant for the last four years. This is in contrast with the 1,683 hospitals in the United States which have graduate medical education programs. The criteria currently governing membership in COTH are:

1. the hospital has a documented institutional affiliation arrangement with a school of medicine for the purpose of significantly participating in medical education; and
2. the hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: medicine, surgery, obstetrics-gynecology, pediatrics and psychiatry.

(The COTH Administrative Board is authorized to make exceptions to these criteria for specialty teaching hospitals which fulfill the criteria except for the number of residency programs.)

A summary of recommendations of the COTH Ad Hoc Membership Committee appears on the next page, followed by the full committee report. This report draws heavily on the report of last year's committee, which is also included in this agenda. Dr. David Thompson has chaired the 1975 committee; Mr. Charles Womer chaired last year's group.

RECOMMENDATION

The recommendation of the committee that a class of Corresponding Members be established would require Assembly action to change the Association Bylaws, Assembly action to establish dues, and Assembly action to elect each prospective member.

It is the staff recommendation that these administrative difficulties be avoided by considering these institutions to be "subscribers" rather than "members." Each Council Administrative Board would be allowed to nominate subscribers for approval by the Executive Council, consistent with criteria approved by the Executive Council. Thus, there would be COD subscribers,

CAS subscribers, or COTH subscribers. Subscribers would receive all of those services recommended in the committee report and others considered appropriate by the staff. In addition to the qualitative criteria to be developed by the Councils, one absolute requirement for becoming a subscriber would be ineligibility for any class of membership in the Association.

The staff further recommends that the subscription fee be set at \$500 per year (rather than the \$250 figure recommended by the committee). It is felt that this level is a more accurate reflection of the level of services which will be received by the subscribing institutions.

It is recommended that the report be approved with these modifications.

COTH Ad Hoc Committee
Membership Report

RECOMMENDATIONS

1. That the membership criteria established in November 1972 as amended later in this report continue to be applied uniformly to all new applicants for membership.
2. That the following considerations should be evaluated in determining the significance of a hospital's participation in medical education and the significance of its sponsorship or participation in approved, active residencies:
 - a. Availability and activity of undergraduate clerkships.
 - b. Presence of full-time chiefs of service or director of medical education.
 - c. Number of internship and residency positions in relation to size, the proportion (in full-time equivalents) which are filled, and the proportion which are filled by foreign medical graduates.
 - d. The significance of the hospital's educational programs to the affiliated medical school and the degree of the medical school's involvement in them.
 - e. The significance of the hospital's financial support for medical education.
3. That the COTH Administrative Board continue to be authorized to make exceptions to the membership criteria in the cases of specialty teaching hospitals (children's, rehabilitation, etc.) which fulfill the criteria except for their number of residency programs.
4. That the membership criteria adopted in November 1972, as amended by this report, together with the considerations listed in recommendation number 2 above, be communicated to all present member hospitals and that they be advised that their eligibility for continued membership after November 1977 will be determined on the basis of these criteria and considerations.
5. That family medicine will be added to the residency programs itemized in the existing criteria, of which an institution must participate in two to qualify for membership.

6. That a new category of AAMC membership entitled Corresponding Membership be established. This type of membership would be made available to non-profit and/or governmental hospitals which do not meet the COIH membership criteria and to other non-profit organizations with medical education objectives such as newly developing consortiums, federations and other corporate forms which are not chartered as hospitals.

In order to qualify for Corresponding Membership, a hospital, or other organization developed to achieve medical education objectives must have a documented affiliation arrangement with a school of medicine for the purpose of significantly participating in medical education. Applications for Corresponding Membership must be accompanied by a letter of support from the dean of the affiliated medical school outlining the role of the applicant in the school's educational programs. Teaching hospitals which are eligible for full participating membership in the Council of Teaching Hospitals are not eligible for Corresponding Membership.

The establishment of this new membership category should in no way alter current AAMC governance and organization. Benefits of such membership would be notification and eligibility to attend all open AAMC meetings as well as to receive the following publications and AAMC communications:

- . President's Weekly Activity Report
- . President's Memoranda
- . COD, CAS and COIH Memoranda
- . AAMC Bulletin
- . COIH REPORT
- . Journal of Medical Education
- . Other periodic publications such as the Advisor and STAR

The cost of such Corresponding Membership should be set at \$250, a level high enough to ensure that full cost of AAMC expenditures to provide services is received, but low enough so that no staff support or participation in AAMC is expected by those who qualify for this special membership.

REPORT OF THE
NATIONAL HEALTH INSURANCE REVIEW COMMITTEE

The Committee reviewed the recommendations of the CCME/LCGME Committee on National Health Insurance and recommends the modifications itemized in the attachment to this report.

Also, the Committee reviewed the Report of the AAMC Task Force on National Health Insurance and reaffirms the desirability of its many recommendations. The Committee wishes to specifically emphasize the importance of the Task Force's recommendations concerning reimbursement of teaching hospitals and philanthropy as being of particular and critical importance to academic medical centers. The Committee believes that the attached recommended modifications of the CCME-LCGME recommendations and the AAMC Task Force recommendations regarding reimbursement of teaching hospitals and philanthropy, with wording revised for purposes of continuity, directly and succinctly address the National Health Insurance issues with which the AAMC is most concerned.

The revised wording of the Task Force Report recommended by the Committee is:

"In addition to the foregoing educational issues, the inclusion of the following provisions in any National Health Insurance Program is especially critical to the maintenance of the excellence of the nation's academic medical centers:

- (1) The reimbursement policies must reflect that there are valid differences among the various types of providers in the cost of delivering care. The cost of services delivered in the teaching hospital, for example, will be greater for at least three reasons: (1) the severity of illness and complexity of diagnosis which patients bring to the teaching hospital; (2) the comprehensiveness and intensity of services provided by the teaching hospital; and (3) the teaching hospital's commitment to the incremental costs of providing the environment for medical and paramedical educational programs.

- (2) Philanthropy must be encouraged and its importance to the health care system recognized. Philanthropic contributions have provided non-profit and public hospitals with urgently needed support. Teaching hospitals, particularly, have relied upon philanthropy for support of new construction and for innovative programs. This vital support has stimulated research and development in medical care organization. More specifically, the tax system should continue to provide deductions from corporate and individual income taxes for charitable contributions. Second, hospital reimbursement formulas should specifically provide that unrestricted endowment principal and income, donations, legacies, bequests and other charitable contributions not be included in formulas establishing payment rates. Finally, expenditures of funds derived from philanthropy should be under the control of the governing body of the respective hospital subject only to the approval of authorized planning agencies."

The Committee believes that its recommended modifications of the CCME/LGCME recommendations and the above statement, taken together, should constitute the essentials of AAMC policy in regard to National Health Insurance. It also believes that they should form the basis for a response to Representative Rogers' letter to Dr. John Cooper of June 2, 1975, seeking the AAMC's views regarding National Health Insurance Goals.

Respectfully submitted,

Charles B. Womer, Chairman
Robert Buchanan, M.D.
Thomas R. Johns II, M.D.
David D. Thompson, M.D.
Phil Zakowski

June, 1975

COMMITTEE RECOMMENDED PREAMBLE

The United States as a matter of public policy should recognize the essentiality for the education and training of sufficient physician manpower to provide adequately for the medical services of its citizens. The education and training of the required physician manpower for this country will provide the public with physicians education and trained in the social milieu of this country and with a high degree of medical knowledge obtained in its excellent medical schools and the health care institutions which provide accredited programs in graduate medical education.

LCGME/CCME Recommendation #1

For the purpose of reimbursement under National Health Insurance, the cost of approved programs of graduate medical education in teaching institutions shall be included in the overall "cost of doing business." The cost of graduate medical education shall not be divided into cost for service, cost for education, and cost for teaching. The "cost of doing business" shall include the recompense of residents, payment to supervisors and teachers, and cost of facilities, including space and equipment.

Review Committee Recommendation

For purposes of reimbursement under national health insurance the costs of approved programs of clinical post-doctoral education in teaching institutions shall be included as an allowable cost (a cost of doing business). The allowable costs of graduate medical education include, but are not limited to, the recompense of clinical post-doctoral trainees (interns, residents and fellows), payments to supervisors and teachers, and are applicable to both inpatient and outpatient services as well as the cost of space, equipment and supplies. Revenue from grants, endowments and other available sources applicable to clinical post-doctoral medical education should be deducted from total cost prior to determining reimbursable cost. The manner and amount of compensation for clinical post-doctoral trainees should be left to local option.

LCGME/CCME Recommendation #2

Graduate medical education in all its aspects shall be provided for within health insurance premiums.

Review Committee Recommendation

The recognition of the costs of approved programs in clinical post-doctoral education as an allowable cost shall be acknowledged and paid by all purchasers of health care services whether governmental or private.

LCGME/CCME Recommendation #3

All individuals (defined as residents and clinical fellows providing patient care) involved in graduate medical education shall be considered part of the medical staff of the teaching institution under the bylaws, rules and regulations of that institution.

Review Committee Recommendation

This recommendation should be withdrawn.

LCGME/CCME Recommendation #4

The manner in which residents are paid shall be left to local option. Options may include:

- (a) Payment of stipend or salaries to residents within hospital budgets;
- (b) Payment to residents, out of fees earned for direct service to patients in accordance with the participation of residents in the practice plan of the teaching institutions.

Review Committee Recommendation

The final two sentences of substitute recommendation #1 serve the purpose of this statement. Therefore, it should be deleted.

LCGME/CCME Recommendation #5

A national health insurance system should provide support for research and development of programs in graduate medical education.

Review Committee Recommendation

This recommendation should be deleted since it is included in the following recommendation.

LCGME/CCME Recommendation #6

A national health insurance system should provide support for modification of programs in graduate medical education through the appropriate expansion of existing programs, the addition of needed new programs, or the elimination of programs which no longer fit the aims of education or needs of patient care.

Review Committee Recommendation

A national health insurance system should provide support for modification of programs in clinical post-doctoral medical education through the appropriate expansion of existing programs, the development and addition of needed innovative programs, and should facilitate the elimination of programs which no longer fulfill the aims of education or needs of patient care.

LCGME/CCME Recommendation #7

Any system of national health insurance should provide for ambulatory patient care. The recommendations 1-6 shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of graduate medical education in the ambulatory setting, including facilities, space and equipment.

Review Committee Recommendation

Any system of national health insurance should provide for and encourage clinical post-doctoral education in the ambulatory patient care setting. All recommendations herein shall apply to the field of ambulatory care. Reimbursement for ambulatory health care must include the additional cost of clinical post-doctoral education in the ambulatory setting, including facilities, space and equipment as well as personnel.



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

August 18, 1975

Honorable Herman E. Talmadge
Chairman
Subcommittee on Health
United States Senate Committee on Finance
109 Rayburn Senate Office Building
Washington, D.C. 20510

Dear Senator Talmadge:

The attached document sets forth the response of the Association of American Medical Colleges to your letter of July 9, 1975.

Your letter specifically requested suggestions and recommendations concerning suitable means of classifying and comparing hospitals for purposes of determining performance-based reimbursement. The comments and recommendations outlined in the attached paper are indicative rather than exhaustive and the beginning of what we hope will be a continuing dialogue. The material is organized in the following fashion. First, problems inherent in the present method for classifying hospitals, as employed in implementing Section 223 of P.L. 92-603, are discussed; a critique of the grouping mechanism is presented. Second, suggestions are forwarded for an interim adjustment of the present hospital grouping and cost limitation scheme. Third, several recommendations are provided regarding a long-run approach to implementing cost control and/or prospective reimbursement systems.

In your presentation before the Senate on June 20, you addressed a number of other matters in which we have an interest. Examples would be the termination of the Health Insurance Benefits Advisory Council and the establishment of a new combined Administration for health care financing, headed by an Assistant Secretary for Health Care Financing. We will provide our views on these and other proposals when hearings are held by your Subcommittee on Health.

Sincerely yours,

John F. Sherman, Ph.D.
Vice President

Attachment:

GROUPING HOSPITALS FOR COST CONTROL

"An Analysis of the Current Situation and Suggestions for Intermediate and Long-Term Modification"

Section 223 of P.L. 92-603, sought to define "reasonable costs" of hospitals that do not flow from inefficiency and/or the provision of unnecessary (luxury) services. Regulations implementing the statutory provision of the Act attempted to classify hospitals into roughly homogeneous groups so that highly aberrant costs of given hospitals could be presumed to be due to the inefficiency and/or the provision of unnecessary services. Given the technical and conceptual problems of developing a taxonomy of hospitals, initial efforts of cost control were focused on those costs that were presumed to vary little from facility to facility (routine service cost was selected). Initial implementation of the classification and cost limitation regulations were for cost reporting periods beginning on or after June 30, 1974. Minor revisions in the hospital classification mechanism were made and a revised schedule of cost limits became effective for cost reporting periods beginning after June 30, 1975. It has been the contention of the Association that the mechanism employed in implementing Section 223 is deficient in several respects; these deficiencies flow primarily from: (1) the inherent structure of cross-classification mechanisms; and (2) the nature of the variables employed to group hospitals.

Conventional cross-classification schemes, such as the one employed to group hospitals under Section 223, have long been recognized by taxonomist as possessing severe limitations, the most important of which are briefly discussed below.

1. Conventional cross-classification schemes place severe restrictions on how detailed (refined) the resultant groupings can be. Every such scheme is associated with a radical proliferation of groups (and an equally radical reduction of the number of hospitals in each group) as the number of dimensions (and the number of levels in each dimension) increase. For example, the revised schedule of cost limits implemented under Section 223, employs three variables (metropolitan location, per capita income and bed size) and produced a classification matrix of 32 groups. The addition of an additional dimension with only three levels (e.g., number of facilities and services offered -- high, medium or low) would generate a classification scheme with 96 groups. The proliferation of groups with the addition of factors (and/or levels within factors) makes it difficult if not impossible to construct a classification scheme employing more than several variables. Such schemes lack discriminatory power because of the small number of factors that can be employed in the classification; i.e., all the primary variables that differentiate the units to be classified can not be included.

2. Conventional cross-classification schemes require that continuous ordinal variables be "compressed" into a few number of levels. For example, the revised schedule encompasses hospitals that vary in size from six to 3,000 beds. These hospitals are subdivided into three classes based upon bed size (less than 100, 100-169, and 170 and above). As all hospitals that fall within the specified range are placed in the same bed size grouping, the implicit assumption is made that size differences existing within the group are unimportant. Possibly even more critical is the fact that cut-off points employed to establish the groups are arbitrary. The revised schedule breaks SMSA's and states into five groupings on the basis of per capita income by arbitrarily subdividing a rank order list. The principal point is that the break points are arbitrary (e.g., one could have just as well employed seven groups or subdivided the areas into five groups differently). One subdivision scheme is as good (or as bad) as any other.

3. Even if one could assume that the breaking points of each dimension were optimal when the dimensions are considered alone, there is no guarantee that they will remain optimal when all dimensions are employed together in a cross-classification scheme. This is due to the fact that when more than one dimension is employed in a cross-classification, interaction effects are introduced. Consequently, groupings different from one obtained from the cut-off points of the isolated dimensions may be (and usually are) more valid and meaningful.

The points noted above are problems inherent in the utilization of any conventional cross-classification scheme such as that employed in implementing Section 223. Equally, if not more important, is the relationship between design of the classification scheme and the purpose for which it is employed; design must match purpose. In enacting Section 223 of P.L. 92-603, it was the intent of Congress that a classification scheme be developed that would group similar hospitals so that extremely high per diem routine service costs within a group could be presumed to be due to inefficiencies and/or the provision of unnecessary services rather than to legitimate operating differences between hospitals. The classification scheme underlying the initial and revised schedules do not fully reflect this objective because many important factors causing cost differences across hospitals are not employed to establish the hospital groupings for which the limits are established. Dowling notes that:

Some hospitals have new and efficient plants; others (often inner-city hospitals) are old, inefficient, and in need of extensive renovation. Some with newly added or expanded facilities have high per unit costs associated with temporary low occupancy levels and high depreciation and interest expenses; other are operating debt-free facilities at high occupancy levels. Some are in areas of declining use, high, bad debts or uncollectables, and high salaries; other are in more favorable locations. Some handle the more complex or serious case types; others handle the more routine case types. Some have teaching programs; others do not. Amenity,

quality, and productivity levels differ from hospital to hospital. Finally, some hospitals have more freedom to make improvements, while others are constrained by a lack of resources, union contracts, etc.*

A classification scheme based upon per capita income, metropolitan area designation and bed size does not adjust for real produce differences between hospitals or hospital groups. Variations in routine service costs related to differences in the nature of facilities and services, the types of patients treated and the quality and intensity of services provided (as well as the numerous factors noted above) are not accounted for in the classification scheme. Thus, limitations based upon this classification have the potential to deny reimbursement for costs that are in every way reasonable. This is a fundamental and totally permeating criticism of the classification methodology employed in the regulations.

Inseparable from the criticism above are difficulties in the classification scheme flowing from the nature of the hospital costs that are subject to limitation. The decision to initially control routine service costs was probably made in light of the legislative history of Section 223 of P.L. 92-603 (H. Rep. at 84; S. Rep. at 189) which noted that:

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care -- for example, the cost of the "hotel" services (food and room costs) provided by hospitals -- the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed.

However, the concept of routine service costs is much broader than the cost of hospitals' "hotel services." Some hotel services can be presumed to be comparable types of costs for all hospitals. Indeed, widely variant "hotel service costs" might well indicate differences in the efficiency of providing such services and/or the provision of unnecessary services. By contrast, other components of routine service cost are extremely heterogeneous among hospitals. These distinctions may be illustrated by comparing the components of the per diem routine service costs of five hospitals located in New York City and in the same limitation group of the revised schedule (S.M.S.A. Group I). A comparison of the per diem dietary raw food and housekeeping costs (hotel services) of these five institutions reveals the following:

* William Dowling, "A Proposal for Evaluation of AHS and Medicaid Prospective Reimbursement Systems in Donstate New York;" submitted to and funded by the Social Security Administration (February, 1974).

	<u>Beth Israel Hospital</u>	<u>Montefiore Hospital</u>	<u>Mount Sinai Hospital</u>	<u>New York University Hospital</u>	<u>St. Vincent's Hospital</u>	<u>Maximum Percentage Difference</u>
Dietary raw food	\$3.35	\$3.08	\$3.36	\$3.07	\$3.42	11%
Housekeeping	4.20	5.52	4.01	4.48	4.30	37%

The dietary-raw food costs show only an 11 percent difference between the highest and lowest cost hospital and housekeeping costs vary by only a 37 percent difference between high and low costs (the respective standard deviations are only 4 and 13 percent of the arithmetic average or mean cost). By contrast, components of hospitals' routine service cost other than "hotel services" vary considerably, simply because different hospitals have different levels of involvement in various functions. These variations, using the three factors of interns and residents, supervising physicians, and school of nursing are indicated as follows:

	<u>Beth Israel Hospital</u>	<u>Montefiore Hospital</u>	<u>Mount Sinai Hospital</u>	<u>New York University Hospital</u>	<u>St. Vincent's Hospital</u>	<u>Maximum Percentage Difference</u>
Interns and residents	\$10.37	\$12.91	\$12.20	\$5.54	\$5.88	133%
Supervising physicians	4.24	16.78	9.10	2.52	6.84	565%
School of nursing	8.02	-0-	2.26	-0-	3.78	∞

The cost of interns and residents varies fully 133 percent between the highest and lowest cost hospital, while the costs associated with supervising physicians varies by 565 percent (the respective standard deviations are a significant 36 and 70 percent of the average cost). As an illustration, Montefiore Hospital has a wholly full-time salaried staff, all of whom are compensated for their housestaff supervision activities, whereas New York University Hospital, for the most part, relies on unpaid volunteer physicians. The differences in costs are not due to inefficiencies but rather to differences in the functioning of the activity and the mode of funding. The most dramatic difference in the table is the cost associated with a school of nursing. Montefiore and New York University Hospitals have no school of nursing and thus incur no such cost, while Beth Israel and Mount Sinai Hospitals incur such costs which very due to their degree of involvement in such activity. The percentage difference is infinite due to zero cost experienced by the two hospitals;

the standard deviation of the cost is fully 118 percent of the average cost. The foregoing data is provided to illustrate how these three particular components of per diem routine service in the five hospitals varies from a low of \$15.61 (New York University Hospital) to a high of \$38.29 (Montefiore Hospital), a range of difference between the high and low cost hospital is fully 145 percent. This dramatic difference reflects an array of factors influencing costs other than the degree of efficiency or provision of any unnecessary services.

Intermediate Term Modification of the Schedule of Limits

Notwithstanding the criticisms outlined earlier in this paper, it is recommended that any intermediate modification of the schedule of limits employ a cross-classification methodology; i.e., that the scheme attempt to group similar costs of roughly homogeneous hospitals. This method is simple to construct, it is easily understood by providers, considerable experience has been gained with such a scheme under both the initial and revised schedules, and a reading of the legislative history of Section 223 appears to indicate that Congress envisioned grouping hospitals for cost control rather than employing formula or regression approaches (although such approaches should be carefully considered in designing a final scheme, as will be discussed later). The cross-classification approach, as has been pointed out elsewhere, does pose several severe limitations. Most importantly, it limits the number of variables (and the number of scalar levels of each variable) that can be employed in the classification scheme, thereby decreasing the sensitivity of the mechanism. It also necessitates the construction of unavoidably arbitrary limits in each cell of the resultant matrix. Such problems, however, can be circumvented by controlling cost elements that are, themselves, relatively homogeneous.

It is strongly recommended that any intermediate modification in the Section 223 limitation mechanism seek to control those elements of hospital costs that are reasonably homogeneous across facilities (thus compensating for constraints imposed by a cross-classification methodology). Considerable thought should be given to controlling what may be termed "adjusted per diem routine service cost" (APDRSC) under any such mechanism. APDRSC could be operationally defined as follows:

$$\text{APDRSC} = \frac{\text{RSC} - (\text{E} + \text{C} + \text{D})}{\text{patient days}}$$

where: RSC = total aggregate routine service cost
E = educational costs*
C = depreciation expense
D = debt service

* Direct costs of interns and residents, cost of associated supervision and administration, and cost associated with the operation of a nursing school.

Thus, APDRSC would be roughly similar to what Congress referred to as "hotel service costs" in the legislative history of Section 223. Congress suggested that such costs might well be the focus of initial attention in the design of any limitation mechanism. Defining the cost to be subject to limitation in this manner reduces (although does not eliminate) the possibility that cost variation across hospitals is due to the nature of the product produced or to characteristics of the production process that cannot be altered in the short run. Differences in APDRSC between hospitals, however, could be due to: (1) economies and diseconomies of scale; (2) factor prices; and (3) the quality and intensity of patient services provided. Such factors, then, must be accounted for in classifying hospitals for the purpose of cost limitation. If such factors are incorporated into a classification scheme, it would appear reasonable to suggest that the PSDRSC for similarly grouped facilities would not be expected to vary widely absent inefficiencies and/or the production of unnecessary services. Two alternative classification schemes, varying in sophistication, are discussed below.

If controlled costs are defined as suggested above, greater latitude is available in the design of a hospital grouping mechanism. Since the controlled cost is more homogeneous across hospitals, the classification system itself need account for far fewer factors. Indeed, it is suggested that a reasonably valid classification system could be constructed employing, at a minimum, only two variables: (1) adult and pediatric short-term licensed bed capacity; and (2) some measure of the relative cost of a hospital "doing business" in a given market area. Available econometric studies suggest that relatively high proportions of the variability of "basic service costs" can be explained by scale (the level of production) and factor prices; both of which are accounted for by the aforementioned two variables. The operational definition of beds is self-evident (the same as that employed in the interim and revised schedule). The "cost of a hospital doing business" could be operationally defined as either: (1) per capita county income (the Office of Research and Statistics suggests that this is a highly efficient variable); or (2) Bureau of Labor Statistics county area data.* It is recommended that bed size be subdivided into seven levels (0-54, 55-99, 100-169, 170-264, 265-404, 405-684 and greater than 685; the same categorization employed in the initial schedule of limits) and that the measure of "the cost of hospital doing business" be subdivided into either five or six levels; thus producing a matrix with either 35 or 42 groups.

It must be emphasized that the aforementioned suggestion should be viewed as a minimally adequate strategy, at best. It has certain advantages over the scheme employed in the initial and revised schedule of limits, but the advantages flow from the nature of the cost that is subject to control rather than the properties of the classification mechanism. A more conceptually appealing and marketable intermediate approach could be constructed by employing APDRSC as the cost to be controlled and attempting to design, test and implement a more sophisticated hospital classification scheme.

* There are several alternatives here that would require more extensive investigation. The best possible option would be to employ service industry or hospital sector wage information; data routinely collected on a sample basis could be employed.

It is suggested that the following factors be examined for the purpose of inclusion in a cross-classification mechanism incorporating no more than four variables.

1. Adult and pediatric short-term licensed bed capacity (as specified previously):
2. A measure of the "cost of a hospital doing business" in a given market area (as discussed above):
3. Average occupancy rate;
4. Nature of facilities and services provided by the hospital; and,
5. Case mix.

Data is presently available to SSA so that the properties of such variables can be tested as to their relatively efficiency in explaining legitimate variations in APDRSC across hospitals. Factors 1 through 3 suggested above are either self-descriptive or have been addressed elsewhere in this paper; the quantification of factors 4 and 5 present numerous options although some work has been completed that is pertinent to their usefulness in a cross-classification scheme such as the one suggested here. Regarding the nature and scope of facilities and services offered, one should refer to: Ralph Berry, "On Grouping Hospitals for Economic Analysis," Inquiry, Volume 10 (December, 1973) pp. 5-12. A method to classify hospitals on case mix has received initial attention by the Office of Research and Statistics, SSA (refer to a memo and paper from John Carroll to James B. Cardwell dated February 11, 1975).

Using the APDRSC as a dependent variable, it is suggested that the relative efficiency of the aforementioned variables be initially evaluated through a step-wise regression methodology (including an examination of residual plots). The three or four most "efficient" variables could then be introduced into a cross-classification framework -- the cutting points of all variables could then be simultaneously altered through trial and error to maximize the homogeneity of the APDRSC distributions in each group (an upper limit of 50 groups is suggested). Specific attention should be given to homogenizing the coefficient of variation, kurtosis and skewness across the groups.

Whichever of the two intermediate strategies discussed above is selected, one is still faced with the task of specifying a cost limit for each group. Such a process is inherently arbitrary (unavoidably so). Given that "efficiency" (or the lack of such) is expressed as a statistical deviation from a given point, there is the natural tendency to tighten the accepted deviation as time progresses; such tightening may be more related to purely cost saving rather than efficiency considerations. Two suggestions appear appropriate. First, whatever general method is employed to establish the group ceilings it appears wise to model various cutting points as to their impact on the

number of outliers and the magnitude of total costs in excess of the limits. One could establish the number of outliers and/or the amount of experienced cost over the limit and work backwards based upon the volume of exceptions that could be handled and/or the "cost savings" desired. After the limits have been established the characteristics of the outliers should be examined (the procedures that could be employed are beyond the scope of this paper but easy to execute). Second, in developing the ceiling formula it is suggested that the percentile rank be reduced and percent of the median be increased. That is, rather than using the 90th percentile plus ten percent of the median, a more appropriate approach would be to set the limit at the 80th percentile plus twenty percent of the median (used as an example only). Such a procedure would increase the probability that cells containing hospitals with very homogeneous APDRSC's would have few, if any, outliers whereas cells with very heterogeneous costs would have a proportionally greater number of outliers.

While a cross-classification approach along the lines of the options suggested above is strongly recommended as an interim measure (only if APDRSC is employed as the cost that will be subject to limitation), it is suggested that other mechanisms be investigated for long-range "solution."

Long Term Approaches to Cost Control and Prospective Reimbursement

The design of a long-term approach to implement the intent of Section 223 of P.L. 92-603, should be viewed from two contexts. First, cost control (as mandated by the 1972 Amendments to the Social Security Act) should not be divorced from prospective reimbursement. Second, a standard cross-classification scheme is an inappropriate methodological approach to implement either cost control and prospective reimbursement (especially for total aggregate costs rather than specific cost components) for the reasons elaborated previously.

In designing any cost control/perspective reimbursement mechanism, decisions are required regarding the following:

1. the type of costs to be controlled or prospectively reimbursed (e.g., total aggregate costs, ancillary costs, routine service costs, etc.);
2. the denominator based upon which the controlled or prospectively reimbursed costs will be calculated (e.g., per patient day, per average daily census per admission, etc);
3. the methodology employed to execute the control/reimbursement mechanism (cross-classification, regression, discriminate analysis, etc.); and,
4. the variables that will be employed in the control/reimbursement mechanism.

It is important to note that the aforementioned considerations must be addressed simultaneously. That is, a decision regarding methodology cannot be made independently of decisions regarding variables that will be employed, the denominator base and the nature of the costs to be controlled or reimbursed.

Due to the above considerations, meaningful recommendations regarding the development of a long-run control/reimbursement-strategy cannot be made in the absence of engaging in empirical evaluation.

FOR DISCUSSION ONLY

Purpose

The purpose of this intermediary letter is to present the methodology by which established inpatient general routine service hospital cost limits for a cost period may be increased to reflect atypical intern and resident (Section I) costs as provided under section 405.460(f)(2)(ii) for purposes of determining interim rates and settlement amounts and to discuss intermediary procedures for handling exception requests (Section II).

Previously, intermediary letter no. 74-22 discussed the intermediary's responsibility to notify hospitals of their classification and to review provider requests for exceptions and intermediary letter no. 75-16 provided additional instructions concerning exceptions from cost limits and data necessary for BHI review of intermediary recommendations.

I. Description of Methodology to Compute Atypical Costs of Intern and Resident Programs

A. General

The following steps describe in general terms the methodology to be used to compute an adjustment to the cost limits for the cost of intern and resident programs. The methodology applies to adjustments for both interim rate and final settlement purposes. The methodology can be applied to all cost reporting periods to which cost limits are applied. Where adjustments to the limits are made, they are applicable for the entire cost reporting period for which the adjustment is made. If a provider requests an interim rate adjustment or final settlement adjustment for atypical costs resulting from intern or resident programs, the adjustment will be computed in the following way:

1. Computation of ratio of interns and residents to average daily census

Compute the ratio of full-time equivalent (FTE) interns and residents to the average daily census for the hospital requesting the adjustment.

The number of FTE interns and residents is obtained from the hospital and is determined from the number of full-time and part-time interns and residents in approved teaching programs. This figure may generally be obtained from the latest Annual Survey of Hospitals questionnaire of the American Hospital Association. If this report is not available, the number of full-time and part-time interns and residents on duty as of the preceding September 30th should be taken from payroll, personnel or other records. Full-time interns and residents are those that work 35 or more hours a week while part-time interns and residents are those that work less than 35 hours per week. The number of full-time equivalent interns and residents is determined by counting two part-time interns and/or residents, regardless of the number of hours worked, as one full-time intern-resident and adding this number to the number of full-time interns and residents on duty as of the survey date. (No adjustment is made for interns and residents working more than 35 hours per week.)

Example: Hospital X has the following intern and resident staff on September 30, 1974:

21 interns and residents working full-time

9 interns and residents working part-time (less than 35 hours per week)

The number of FTE interns and residents would be 25.5 - 21 full-time interns and residents plus 4.5 full-time equivalents (9 part-time interns and residents divided by 2)..

The average daily census is developed by obtaining the total number of inpatient days (Form SSA-2570, page 1, part II, line 4, column 1 plus column 2) and dividing by 365.

2. Comparison of ratio for hospital with ratio for hospital's class

Compare the ratio determined in (1) with the ratio of interns and residents for the class of the requesting hospital. Where the ratio for the hospital is equal to or less than the ratio for the class, no adjustment can be made.

The ratios of interns and residents to daily average census for hospital classes in Standard Metropolitan Statistical Areas where there are high concentrations of hospitals with teaching programs for cost reporting periods beginning on or after July 1, 1974, but before July 1, 1975, are:

<u>State Group</u>	<u>Bed Size</u>		
	<u>265-404</u>	<u>405-684</u>	<u>685 and Above</u>
State Group I	.371*	.466*	.318*
State Group II	.241*	.303*	.328*

Refer to the Schedule of Limits published in the Federal Register on or HIM-15, Chapter 25 June 6, 1974, for the States in State Group I and State Group II.

*These ratios represent the average number of interns and residents per patient day.

Where an intermediary receives an exception request for an adjustment to the limits on the basis of atypical costs of services associated with intern and resident programs from a provider in other classes or for reporting periods beginning on or after July 1, 1975, the intermediary should contact the Special Studies Section of the Provider Reimbursement Policy Branch at (301) 594-9710 for appropriate ratio data until such time as the ratio data is distributed generally.

3. Multiplication of Atypical Ratio by the Average Daily Census

Where the hospital's ratio of interns and residents to average daily census exceeds the ratio for the hospital's class, the ratio excess is multiplied by the average daily census for the hospital. This amount represents the number of interns and residents on the hospital's staff which are deemed to be atypical in terms of the class in which the hospital is grouped.

4. Total Atypical Intern and Resident Cost

The atypical number of interns and residents computed in (3) is then multiplied by an average intern and resident cost (salary plus fringes, supervising physicians and other overhead) applicable to inpatient general routine service (Section I(B)(1)). The resultant amount is the total atypical intern and resident cost for that hospital.

5. Per Diem Amount

The total atypical intern and resident cost (See 4) is divided by the total number of inpatient days (See Section I(A)(1)) to determine the per diem exception for intern and resident costs.

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B. Application - Including Computation of Average Intern and Resident Cost

1. Computation for cost reporting periods beginning on or after July 1, 1974, but before July 1, 1975

For hospitals requesting an exception for cost reporting periods beginning on or after July 1, 1974, but before July 1, 1975, the exception is computed for interim rate or final settlement purposes by using the number of FTE interns and residents on duty on September 30, 1974 (See Section I(A)(1)). The average daily census should be taken from the most current cost report on which a desk audit has been performed. The average intern and resident cost applied to inpatient general routine services is computed in the following manner:

- (a) Determine the average intern and resident salary by dividing the total annual salaries of all interns and

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residents (part-time or full-time) on duty on 9/30/74 by the number of FTE interns and residents. (If necessary data should be obtained from the Provider.)

(b) Multiply the amount calculated in (a) by the hospital's actual percentage of overhead applied to direct intern and resident costs,^{1/} (but not to exceed 50 percent) to account for additional costs other than salaries, such as fringe benefits, supervisory physicians, and other overhead.

~~This is then added to the average salary determined in (a)~~
to arrive at the total average intern and resident cost.

(c) Multiply the amount computed in (b) by the hospital's actual percentage allocation of intern and resident costs to routine services ^{2/} (but not to exceed 55 percent) to determine the average intern and resident cost allocated to inpatient general routine cost.

(The 50 percent and 55 percent factors are liberal maximum allocations based on data derived from cost reports of short-term general hospitals.)

^{1/} The hospital's actual percentage of overhead applied to direct intern and resident cost is obtained by dividing the overhead allocated to the intern and resident cost center (SSA Form 1562, Worksheet B, line 18, column 19 minus line 18, column 1) by the direct intern and resident cost (SSA Form 1562, Worksheet B, line 18, column 1).

^{2/} The hospital's actual percentage allocation of intern and resident costs to routine services is obtained by dividing the intern and residency costs allocated to routine cost (SSA Form 1562, Worksheet B, line 32, column 19) by the total intern and resident cost (SSA Form 1562, Worksheet B, line 18, column 19).

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6(a)

The hospital's actual percentage of overhead to direct intern and resident cost as well as the hospital's actual percentage allocation of intern and resident cost to routine services is to be computed based on the most current cost report on which a desk audit has been performed

Example - A

Hospital L has 25 full-time and part-time interns and residents on

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duty as of September 30, 1974, with a total annual salary of \$275,000. The hospital's actual percentage of overhead applied to direct intern and resident cost from the most recent desk audited cost report was 65 percent and the hospital's actual allocation of intern and resident cost to routine services from the same cost report was 60 percent. The average intern and resident cost allocated to inpatient general routine would be computed in the following manner:

- (a) Calculation of average intern and resident salary:

$$\$275\ 000 \div 25 = \$11,000$$

- (b) Multiplication of average intern and resident salary by

$$1.50$$

$$\$11,000 \times 1.50 = \$16,500 \text{ total average intern and resident cost}$$

- (c) Multiplication of total average intern and resident cost by 55 percent

$$\$16,500 \times 55 \text{ percent} = \$9,075 \text{ average intern and resident cost allocated to inpatient general routine services.}$$

EXAMPLE - B

If the hospital's actual percentage of overhead applied to direct intern and resident cost was 45 percent and if the hospital's actual allocation of intern and resident costs to inpatient general routine services was 52 percent, the computation would be:

$$\$11,000 \times 1.45 = \$15,950 \text{ total average intern and resident cost}$$

$$\$15,950 \times .52 = \$8,294 \text{ average intern and resident cost allocated to inpatient general routine services.}$$

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2. Adjustment After Cost Report Is Submitted For Final Settlement Exception

After the cost report for the pertinent period is filed, the exception is redetermined using the actual average daily census and the number of inpatient days. All other data remains the same. At this time, the intern exception is adjusted upwards or down to determine the actual exception amount to be granted for the period.

3. Application to Cost Reporting Periods Beginning on or After July 1, 1975

For cost reporting periods beginning on or after 7/1/75 and before 6/30/76, the procedure used is the same, except that data gathered as of 9/30/75 is used. For those providers who file an exception request before necessary data is obtained, the prior year data is used to adjust the interim rate until 9/30/75 data is available and the exception is computed as provided under Section I.

4. Example

Facts:

Hospital A located in Baltimore, Maryland Bed Size - 425

Number of FTE interns and residents - Hospital A - 142
September 30, 1974

Average Daily Census 322

Ratio of interns and residents for Hospital A's class
(See Section I-2) .303

Average intern and resident cost applicable to inpatient general
routine service cost (from example in I(B)(1)) \$9,075

Total number of inpatient days 118,000

Calculation:

Step A - Computation of ratio of interns and residents to average daily
census for Hospital A $142 \div 322 = .441$

Step B - Comparison of ratio for Hospital A with ratio for Hospital A's
class

	.441
	<u>.303</u>
Ratio Excess Hospital A	.138

Step C - Multiplication of the ratio excess by the average daily census
 $.138 \times 322 = 44.44$

The 44.44 represents the atypical number of interns and residents
for Hospital A.

Step D - Multiply the atypical number of interns and residents by the
average intern and resident cost applicable to inpatient general
routine service cost of \$9,075

$44.44 \times \$9,075 = \$403,293$ Atypical intern and resident cost
for Hospital A

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Step E - Conversion of the atypical intern and resident cost developed in Step D to a per diem amount

$$\$403,293 \div 118,000 = \$3.42$$

Conclusion:

Hospital A would be allowed an upward adjustment to its limit of \$3.42.

II. Intermediary Handling of Exception Requests

It should be noted that under regulations section 405.460(f)(2), there are no open-ended exceptions from the limits due to the cost of atypical services. The intermediary is required to compute a specific adjustment to the limits. The intermediary's preliminary decision (see IL 74-22) must show the basis for each exception request, and the specific amount approved above the limit with appropriate rationale showing how the intermediary reached its conclusion. The objective should be to provide sufficient data for BHI review, thereby avoiding the delays inherent in obtaining additional data.

The intermediary must submit for review its preliminary decision on each exception approval, whether for interim rate or cost report settlement purposes, to the Bureau of Health Insurance, Division of Provider Reimbursement and Accounting Policy, Attention: Provider Reimbursement Policy Branch. The intermediary will not implement its preliminary decision until BHI has reviewed the exception adjustment and notified the intermediary of its decision.

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Providers should be informed that an increase in the interim rate is not to be interpreted as final recognition or approval of the claim that the hospital provides atypical services. Providers should be advised that the final determination as to whether it is entitled to an exception from the cost limits applicable to its classification group because of the provision of atypical services (and the extent such costs are atypical) will not be made until its actual costs are reported and may be examined. Where it is determined that the hospital has furnished the acceptable atypical services which it forecast could cause it to incur acceptable costs in excess of the published limit, such determination will confirm an earlier allowance that may have been made of the hospital's request for exception. However, if the hospital does not act in full accordance with the plans that supported the earlier exception, the exceptional amount finally allowed would be related to the degree to which the actual performance justifies it.

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



August 5, 1975

John Jansak
Chief
Provider Reimbursement Policy Branch
Social Security Administration
6401 Security Boulevard
Room 401, East Highrise
Baltimore, Maryland 21235

Dear John:

The purpose of this letter is to provide comments on the draft intermediary letter distributed at the July 22, meeting in Manny Levine's office. This intermediary letter presents the methodology by which established inpatient general routine service hospital cost limits for a cost period may be increased to reflect atypical intern and resident costs for purposes of determining interim rates and settlement amounts. Additionally, the intermediary letter discusses intermediary procedures for handling exception requests.

I make these comments to be constructive in an effort to achieve the most effective exception procedure which is possible. However, I think you are aware that we still are in basic disagreement concerning the overall validity and fairness of the methodology utilized to achieve limits in the first place. Further, I do reserve the option of commenting on this particular exception process as it becomes operational.

I believe the following comments and observations are pertinent.

1. A more detailed explanation of the methodology used to determine the base point of the ratio of interns and residents to average daily census above which hospitals may routinely request an exception is required (page 3 of the discussion paper). If I recall correctly, you collected actual data from hospitals at the 85th through the 95th percentile and averaged the calculation. I believe it is important for all concerned to be fully aware of the process by which the base line limits are determined. The methodology as I understand it makes the assumption that hospitals at these percentile ranks are in that order due to the size of their intern and resident costs, and therefore their averaged ratios are such that any hospital with a lower

John Jansak
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ratio should not be allowed an exception based on atypical intern and resident costs. Are you certain your assumption is valid? One way to gain some insight is to put the hospitals in a particular cell in descending order on the basis of routine service costs and this new ratio to determine if there is a pattern of consistency.

2. This approach is a mechanical procedure. If the procedure does not meet the hospital's needs, the hospital should not be prevented from submitting an exception request based upon some other comparative formulation of intern and resident costs.
3. With regard to the fifty percent overhead limitation and fifty-five percent limitation on allocation to routine service costs, my small sampling of data indicates these percentages are on the low side. For instance, I am told in New York City the following routine service percentages are currently in use:

Montefiore	91%	Presbyterian	57%
Mount Sinai	75%	Long Island Jewish	57%
Beth Israel	71%		

If a hospital can demonstrate the reasonableness of its allocations, why is a ceiling on these two calculations necessary? If a ceiling must be set, I believe that somewhere in the document, it should be stated that a hospital has the option of an exception to these limits if evidence is produced justifying a higher percentage.

I formally request that you provide a list of the hospitals whose cost reports you reviewed to determine the appropriateness of these two limits. Further, I request that for each of these hospitals you provide the routine service cost allocation and overhead percentages.

4. If this mechanical procedure produces the necessary solution to the "problem," the hospital should be treated as if the exceptions request was never made. In other words, such a request based upon the routine exception procedure for intern and resident costs should not make the hospital's entire cost report subject to paragraph two of intermediary letter no. 75-16. I well remember Al Diamond's arguments to the contrary, but I do not agree with his point of view.
5. After you have experienced the opportunity to process some requests using this procedure I think a time period during which a decision must be made should be included.

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I appreciate very much the opportunity to comment on this draft intermediary letter. If you wish to discuss any of these points, please call me. I shall look forward to hearing from you.

Sincerely,

RICHARD M. KNAPP, Ph.D.
Director
Department of Teaching Hospitals

RMK:car



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
IHI-324

April 1975

PART A INTERMEDIARY LETTER NO. 75- 16

SUBJECT: Exception from Cost Limits; Data Necessary for BHI Review
of Intermediary Recommendation

General

Part "A" Intermediary Letter No. 74-22 provided instructions for the intermediary's review of provider requests for exception from the cost limits under Section 223 of P.L. 92-603, "Limitations on Coverage of Costs Under Medicare." The purpose of this letter is to advise the intermediaries that when any request for exception from the cost limits and intermediary recommendation is submitted to BHI, the recommendation must be accompanied by a copy of the latest desk-reviewed cost report plus any later unreviewed cost reports which are available. Cost reports are not required in the case of sole community provider exemptions. However, an exception or exemption request should not be made until the routine service portion of the provider's interim rate actually exceeds the cost limit.

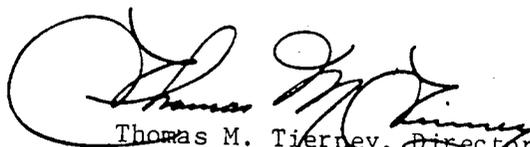
Review of Cost Reports

In our review of exception requests as a result of IL 74-22, we have noted some unusually high costs being incurred by hospitals for specific cost components. This has required us to contact the intermediary to request additional information. To avoid such followups, before an exception to the cost limits can be granted, a careful review of the reasonableness of all components of routine costs such as dietary, A & G, etc., is necessary. The intermediary review should be such that any seemingly abnormally high costs compared with peer hospitals have been investigated, a determination of their reasonableness made and the basis of the determination included with the exception request.

Provider Rights to Review

Regulations 405.460(e) indicated that a request by a provider for review of the determination of an intermediary concerning classification for, exceptions to, or exemptions from the cost limits imposed under the

provisions of Section 405.460, "Limitations on Coverage of Costs" shall be made to the intermediary under the provisions of sections 405.490 to 405.499f. The provisions, of course, are now contained in sections 405.1800ff.


Thomas M. Tierney, Director
Bureau of Health Insurance

Action Note: Annotate Part A IL 74-22, Section 223 of P.L. 92-603, "Limitations on Coverage of Costs Under Medicare"-- Intermediary Notification to Hospitals of Classification and Costs Limits, to indicate that it has been modified by Part A IL 75-16.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21205

July 1974

REFER TO:
HHS-324

ADVANCE COPY

PART A INTERMEDIARY LETTER NO. 74-22

SUBJECT: Section 223 of P.L. 92-603, "Limitations on Coverage of Costs Under Medicare"--Intermediary Notification to Hospitals of Classification and Cost Limits

General

Section 223 of P.L. 92-603, "Limitations on Coverage of Costs Under Medicare" authorizes the Secretary of Health, Education, and Welfare (HEW) to establish prospective limits on provider costs recognized as reasonable for purposes of Medicare reimbursement. Implementing regulations and a Schedule of Limits on Hospital Inpatient General Routine Service Costs were published in the Federal Register on June 6, 1974.

Implementing Information and Instructional Materials

Each intermediary and provider is being sent a copy of the Federal Register printing of implementing regulations and Schedule of Limits on Hospital Inpatient General Routine Service Costs. Complete instructions covering all aspects of the regulations will be issued at a later date.

Immediate Intermediary Action Required

The initial Schedule of Limits on Hospital Inpatient General Routine Service Costs are effective for hospital cost reporting periods beginning on and after July 1, 1974, and before the earlier of July 1, 1975, or the effective date of any revised schedule. Each intermediary is required to notify each hospital serviced of its limit prior to the start of a cost reporting period to which the limit is to be applied based on information currently reflected in its files. Intermediaries must notify hospitals with cost reporting periods beginning on July 1, 1974, immediately upon receipt of this Intermediary Letter. All other hospitals (hospitals with other than a July 1, 1974, beginning cost reporting date) should be notified at least 30 days prior to the start of their cost reporting periods.

Classification Notice

The classification notice (see sample) must inform the provider of its classification and applicable limit, and include a statement that where the provider believes it has been incorrectly classified it is the provider's responsibility to furnish evidence to the intermediary that establishes the classification is incorrect.

Hospitals have been classified on the basis of bed size, urban or nonurban location, and by State. Hospitals are classified on the basis of available beds for the type of service furnished as of the first day of the pertinent cost reporting period; except that multiple facility providers will be classified on the basis of the number of available acute beds and the limit based on this classification will be applied to acute and other type beds.

A provider which is located in a Standard Metropolitan Statistical Area (SMSA) is considered urban. Those areas located within SMSA's can be identified by use of Federal Information Processing Standards Publication (F.I.P.S. Pub. 8-3) which can be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. In addition, the Bureau of Health Insurance is in the process of distributing to each provider and intermediary as a part of the Provider Reimbursement Manual an SMSA listing in State order.

SAMPLE LETTER

TO: Hospital X

Our records indicate that, for purposes of the cost limits established under section 223 of P.L. 92-603, and implementing regulations (20 CFR 5405.460 and 405.461) your facility is classified as follows:

State:

SMSA/Non-SMSA:

Cost Reporting Period Beginning:

Bed Size Range (Acute Area or Long Term Area Where Appropriate):

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As a result of such classification, the limit of payment for general inpatient hospital routine services to your hospital is \$ _____ per day.

If you believe the above classification is incorrect, please furnish us evidence that establishes the classification you believe to be correct.

You are advised that you may be entitled to an exception, exemption, or adjustment under the provisions of Section 405.460(f) of the Social Security Administration regulations.

If you believe that your facility meets any of the conditions set forth in this section, you may request that your cost limitation be reviewed.

Fiscal Intermediary

Intermediary Review of Provider Classification

After receipt of the notice of classification, a provider may submit evidence establishing that its intermediary's records about the provider are incomplete and that the provider has been incorrectly classified or that the provider is a sole community hospital. If such evidence is satisfactory, the intermediary will change the provider's classification or make a determination on whether it is a sole community hospital and notify the provider accordingly. Where the intermediary's decision affects the provider's right to charge, or the amount he can charge a beneficiary for excess costs, an opportunity to contest the intermediary's decision on the provider's classification or on the issue of sole community hospital should be granted promptly. The intermediary will review the matter as expeditiously as possible.

Intermediary Review of Provider Request for Exception

Where a provider believes it is entitled to an exception from the cost limits applicable to its classification grouping because of the provision of atypical services and the intermediary has limited its interim rate

based on the provider's classification, the intermediary shall, where the provider demonstrates that the conditions indicated are present, make a preliminary decision, subject to BHI approval, that the interim reimbursement rate and final reimbursement for that provider should be adjusted by an appropriate amount in excess of the rate that would otherwise be paid. However, the burden of justifying an exception to the provider's limit for each cost reporting period would be on the provider. The ruling on the prospective request for exception to allow costs other than those considered reasonable for other providers in the same class would not predetermine the cost settlement and a determination of the amount of such reimbursable cost actually incurred by the provider. Such determination will be made at the end of the cost reporting period and will identify as allowable the costs approved and actually incurred under the terms of the exception.

Copies of all requests for and intermediary preliminary decisions concerning such exceptions, indicating the reason for such decision and the extent to which such exception would be recognized for interim rate purposes, should be forwarded direct to the Bureau of Health Insurance, Division of Provider Reimbursement and Accounting Policy, Attention: Provider Reimbursement Policy Branch (copy to BHI Regional Office servicing the provider). BHI will review the request and preliminary decision and affirm or otherwise advise the intermediary regarding the decision within 45 calendar days after the date of the intermediary preliminary decision. The intermediary will not implement its preliminary decision, pending receipt of BHI advice, except that it may assume affirmation of intermediary preliminary decision if advice is not received from BHI within the 45-day period. It is expected that this procedure of obtaining BHI advice on the intermediary's preliminary decision will remain in effect for only a limited period of time; that is, until bases for exception are more clearly defined and intermediaries can be furnished guidelines intended to make uniform the decision regarding such requests for exceptions.

Exemptions for Sole Community Hospitals

The determination that a hospital is the sole source of hospital services reasonably available to beneficiaries is based on such factors as (1) the normal commuting distance to work for residents of the locality served by the hospital, (2) travel time and availability of public transportation to the nearest like facility, and (3) the extent to which persons travel to other localities for hospital care. Generally, a hospital located within a 25 mile radius of a like facility (acute, long term), nor a hospital within an MSA can be found to qualify for a sole community hospital exemption. A hospital may request such an exemption whenever its costs exceed its applicable cost limitation or it may wait till it files its cost report.

Copies of all requests for and intermediary determinations either granting or denying sole community exemptions will be promptly forwarded by the intermediary to the HIL Regional Office servicing the provider. The Regional Office, in turn, will send copies of all such decisions to the Bureau of Health Insurance, Division of Provider Reimbursement and Accounting Policy, Attention: Provider Reimbursement Policy Branch.

Formal Appeal of Intermediary Determinations

As with other reimbursement determinations, after the submission of a cost report the provider will be entitled to a formal appeal under the regulations on the issues of provider classification, requests for exception, and sole community hospital status if it disagrees with the intermediary's determination on these issues, even though the provider has been afforded a review as specified above. The provider's request for such a hearing must be made within the time limit specified for filing an appeal from an intermediary's notice of program reimbursement.

Provider Charges to Beneficiaries for Excess Costs

Information on the calculation and validation of provider charges to beneficiaries for excess costs is being furnished to all providers and intermediaries in the form of an addition to the Provider Reimbursement Manual.

Thomas M. Tierney
 Thomas M. Tierney, Director
 Bureau of Health Insurance

HCSPITAL
RESEARCH
AND
EDUCATIONAL
TRUST



840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • TELEPHONE 312 645-9400

August 20, 1975



John A. D. Cooper, M.D.
President
Association of American Medical Colleges
Suite 200, I Dupont Circle
Washington, D.C. 20036

Dear John

We have been awarded a grant by the Robert Wood Johnson Foundation to draw up a definitive plan for a proposed study to be titled "An Examination of Public-General Hospitals and Their Role in the Development of Future Health Care Delivery Systems." For this purpose "public-general hospitals? are defined as those general hospitals managed by agencies or departments of local or state governments.

Several possible areas of investigation have been identified:

1. The distribution of, the local function of, and the extent of population dependence on public-general hospitals.
2. The distinctions in organization, operation, objectives, services, and consumers between voluntary and public-general hospitals in the same community.
3. The impact of the declining influence of local public health departments upon local public-general hospitals.
4. The long-term effects upon public-general hospitals of recently promulgated policies concerning postgraduate medical education.
5. The organizational and policy constraints in public-general hospitals that may be incompatible with the development of community-wide health care delivery systems using multiple providers.
6. The results of the various experiments with new corporate sponsorship for public-general hospitals and the benefits to be derived from public incorporation.

Dr. Cooper/2

8/20/75

The study plan need not be limited to these six areas, nor need they be considered of equal importance.

Because your organization has an interest in the future of the public-general hospital, the Study Planning Committee for this project seeks your advice.

Do these six areas provide an adequate basis for the proposed study? Should they be better defined? Do you have information or opinions about them? Should other topics be added or substituted? Can you suggest persons or organizations with special knowledge whose advice and cooperation we should seek?

Russell A. Nelson, M.D., president emeritus of the Johns Hopkins Hospital, is the chairman of the Study Planning Committee. I know he would welcome your counsel. Please send your suggestions and comments to him (601 North Broadway, Baltimore, MD 21205; telephone 301/955-5761) or to me.

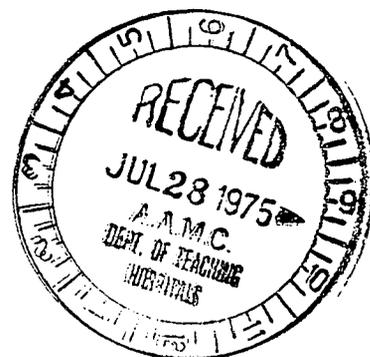
Sincerely



John Alexander McMahon
President

*P.S. We've asked Dick Knapp
to join Russ Nelson's Committee
to plan the study & we do
appreciate his help & yours
through time.*

Alex



July 23, 1975

Richard Knapp, Ph.D
Director
Council of Teaching Hospitals
American Association of Medical Colleges
1 Dupont Circle NW Suite 200
Washington D.C. 20036

Dear Dr. Knapp,

I am writing to inform you of my plans to perform a doctoral dissertation in the area of teaching hospitals and to ask your advice on how I might proceed to obtain some funding for the costs of the research.

I am currently enrolled as a doctoral student in Health Services and Hospital Administration at the UCLA School of Public Health. I have passed my written qualifying examination and now must complete the dissertation phase to obtain the Dr.P.H. degree. In addition, I work part-time as a Staff Associate for a group of Los Angeles teaching hospitals named Central Area Teaching Hospitals, Inc. where my primary responsibilities lie in staffing several committees on medical education and non-physician education.

My general research interest is on the effects of the implementation of medical education programs on hospitals which have recently entered into graduate or undergraduate educational programs. The many "effects" that can be examined are much too enormous for a dissertation, and, therefore, I have narrowed down the possible parameters to a study of case mix and average length of stay. I am particularly enthusiastic about performing a longitudinal study because I have not found any literature which attempts to link those frequently cited and unique characteristics of a teaching hospital with the actual implementation of a medical education program.

My plan is to select one or more hospitals that have implemented a major internal medicine or general surgery residency program (and preferably with an undergraduate program as well) within the last several years. I have in mind several other requirements relating to size, ownership and previous involvement in medical education, but the one overriding requirement is that the hospital(s) must have been on PAS for a minimum of three years prior to and following implementation of the medical education program. I see no other viable alternative than the use of PAS data to perform detailed studies on case mix and length of stay. From a review of the past issues of the Directory of Approved Internships and Residencies

I have located a few hospitals which -- at least on paper -- meet my criteria; they are located in Providence, Rhode Island and Chicago, Illinois. Based on this preliminary research, I feel that selection of a study group is feasible.

Concerning the methodology of studying case mix and length of stay, I have found, as you are well aware, that the state of the art is less than perfect. My proposal still requires some fine tuning on this respect but I will state the methodology very generally. For the study of case mix, I will use a Commonality of Diagnosis Index somewhat similar to that used by Lave and Lave in "Extent of Role Differentiation in Hospitals". In addition, I plan to select six diagnoses in order to study changes in case complexity over time according to preselected clinical criteria as suggested by a physician panel. If the cases become significantly more complex (and no other explanatory variable is evident) it may be strongly suggested that there is an association between the implementation of medical education programs and increasing case complexity.

Length of stay is far more difficult to analyze because of the many factors affecting this statistic. My current thought is to select diagnoses for study of which half are of very low variability in age adjusted length of stay (i.e. hemorrhoidectomy) and half are of high variability (i.e. myocardial infarction). In both groups I will attempt to control for changes in complexity by examining clinical criteria and patient characteristics by examining demographic data, but to the extent that these controls are tenuous, I will be at least able to draw some conclusions on LOS based on the type of diagnoses being studied. In other words, if LOS changes (or doesn't change) for diagnoses of a highly standardized treatment and recovery pattern, I can make some statement on the effect of medical education programs, despite arguments on the validity of case complexity and patient characteristic control measures.

This has been an extremely brief summary of the intent and nature of my dissertation proposal. In addition to the time series study described above, I have planned a cross sectional study on the length of stay of selected diagnoses according to several different degrees of involvement in medical education. This section is currently written into my proposal but I am still evaluating whether it will be feasible to perform both parts.

I will be very interested in your response to the topic I have proposed and whether COTH would be willing to fund part of the costs of my research. I am aware that you have made grants available in the past, but that no general announcement was issued this year. The major cost of this study will be in the use of PAS data and their programming time which I understand may run into a few thousand dollars.

I expect to have my dissertation proposal in final form by late September. As you may know or guessed, my committee chairman will be Dr. Dennis Pointer; I am awaiting his arrival to complete the details of the proposal.

I look forward to your response at your earliest convenience.

Very truly yours,

Sally Eberhard

Mrs. Sally Eberhard
3138 Barbara Court
Los Angeles, California
90068

A Possible Instant Basis for Spreading the Impact of The
Unexpected and Unpredictable Cost of Liability (Including
Malpractice) Insurance on Current Patient Charges

The experimental reimbursement programs under Public Law 89-97 might provide a mechanism, within current legislation, to spread the effect of malpractice insurance charges on patient-day costs. This mechanism, to be explained in more detail below would be a combined self-insurance - reinsurance program.

Insurance premiums which are on a one-year basis provide for reserves for the carriers to meet claims which could be made for a period of many years after the year of coverage. Carriers retain these funds and invest them until claims are settled. Under the present Medicare reimbursement regulations, a hospital can only claim for reimbursement actual expenses, including insurance premiums. Thus, any form of self-insurance must be funded from a hospital's voluntary donations or reserves, when available.

One area which might be explored with respect to eligibility for participation in an experimental reimbursement program of the type proposed might consist of selecting hospitals which meet specific criteria and are willing and able to meet special conditions, along the lines set forth below:

- A. Hospitals which are now faced with increases in insurance charges ranging from 400 to 600 percent

DRAFT 3/13/75
Page 2

per year, and in some cases representing additional per diem charges, possibly to as much as \$14.00 per day depending upon their bed occupancy.

- B. Hospitals which have a significant role in teaching and education, who operate extensive ambulatory care programs and have a bed-capacity in excess of 750, are particular targets for claims. This group is suggested as most appropriate for such an experimental reimbursement program. These hospitals generally have competent administrative and professional staffs, including legal counsel, either in-house or out of house.

Certain conditions might be imposed for participation in the program, such as:

1. Enabling a peer review procedure for the purpose of reviewing claims.
2. Development of an in-house program for the education and monitoring of hospital and related activities in relation to consumers and existing knowledge in improving the adequacy of care.
3. Defining the expense of and necessity for defensive medicine.

4. Developing an alternate mechanism of handling claims such as, arbitration, special referee committees, patient education, and other means which can be used in lieu of litigation.

Essentially, what is being suggested is along the following lines. Assuming a current \$3,000,000 premium for liability coverage, including malpractice, the hospital would be permitted to allocate and claim \$500,000 set aside as a claims fund. This fund would be solely for payment of claims in a depository designated by the Bureau of Health Insurance or the fiscal intermediary. In addition, the hospital would be reimbursed for purchasing insurance in excess of \$1,000,000 and for such amounts as might be necessary to provide claims administration, legal advice and special advice. The total cost for all of this could be limited to no more than 50 percent of the actual premium charge requested by a carrier in any year, or \$1,500,000 in the above illustration (or \$7.00 per bed-days).

Each claim for an amount to be designated by an independent review group would be subject to inquiry and decision by the group as to what further educational activities need to be undertaken or what educational activity should be modified.

Each year, the fund would be replenished to the original

sum of \$500,000, and an additional sum added to bring the fund to \$1,000,000. In any year in which the fund balance reaches \$1,000,000, no further additions would be made.

A claim award in an amount in excess of the fund balance would automatically be reimbursable as incurred expense up to the amount where reinsurance begins.

This is not in any sense proposed as a long-term solution. There is greater awareness of claims potentials and the interest of attorneys continues to center on this field. Malpractice costs and the amounts of reserves handled by the insurers will increase at an even greater rate. As medical institutions, particularly those with teaching and researching capacity, adopt new techniques in medicine to save lives, future reactions and potential claims are inevitable. For example, institutions which now engage in nuclear medicine as a form of treatment can not possibly predict what the short or long-term effect may be of the use of equipment, which, although tested, cannot be guaranteed to have no ill effect of any kind in the future.

AAMC
ANNUAL MEETING

Monday, November 3, 1975

7:30 - 9:30 a.m.	COTH Administrative Board Breakfast	Independence
9:30 - 11:30 a.m.	COD/COTH Joint Program	Ballroom East

CONSORTIA: NEW PATTERNS FOR INTER-INSTITUTIONAL COORDINATION

Speaker: Richard E. Wittrup
Executive Vice President
Affiliated Hospital Center

Panel: George E. Cartmill
President
Harper Hospital

Robert E. Massey, M.D.
Dean
University of Connecticut
School of Medicine

Noon	COTH Luncheon	Jefferson East & West
1:30 p.m.	Business Meeting	
3:00 - 5:00 p.m.	General Session	

*RECENT CHANGES IN THE HEALTH CARE DELIVERY SYSTEM:
IMPLICATIONS FOR THE TEACHING HOSPITAL*

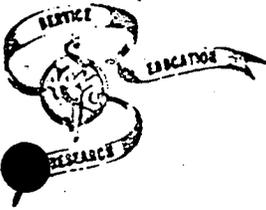
Speaker: Stuart Altman, Ph.D.
Deputy Assistant Secretary for Planning,
Evaluation - Health
Department of Health, Education & Welfare

Tuesday, November 4

9:00 - Noon	Plenary Session
1:30 - 4:00 p.m.	AAMC Assembly

Wednesday, November 5

9:00 - Noon	Plenary Session	
2:00 - 5:30 p.m.	COD/CAS/COTH Joint Program	Ballroom Center



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

WASHINGTON: 202: 466-5175

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

September 3, 1975

James B. Cardwell
Commissioner
Social Security Administration
P.O. Box 1585
Baltimore, Maryland 21203

Dear Mr. Cardwell:

The purpose of this letter is to provide the comments of the Association of American Medical Colleges on the proposed regulations for end-stage renal disease, Section 299 I of P.L. 92-603. These regulations appeared in the July 1, 1975 Federal Register (Vol. 40, No. 127, pages 27782-27793).

Section 299 I of the 1972 Social Security Amendments authorizes the Secretary of HEW to limit Medicare reimbursement for kidney transplant and dialysis services to facilities meeting "such requirements as he may by regulation prescribe." Two specific qualifications are stipulated in the law: (1) each institution must meet a minimum utilization rate; and, (2) there must be a medical review board to screen the appropriateness of patients for the proposed treatment procedures. Other than for these two points, the law is silent as to conditions with which institutions must comply. While recognizing that the Department must assure the quality, efficiency and cost effectiveness of each "qualified" ESRD program, the Association believes that the proposed regulations unnecessarily exceed the requirements of the statute. Furthermore, as is noted below, the Association believes that there are elements in these regulations which will have the effect of duplicating already existing or emerging Federal review mechanisms and the Medicare Conditions of Participation.

In order to be recognized as a Medicare participating institution, hospitals must comply with the Medicare Conditions of Participation (Sections 401.1020 et. seq.) of the Social Security Act. Compliance is monitored through inspection by state agencies, the Joint Commission on the Accreditation of Hospitals and other such bodies. The proposed end-stage renal disease regulations, however, create yet another accrediting process or mechanism with conditions similar to those already required of hospitals by Medicare. Not only will this be a duplicate procedure, but it has the potential for introducing different (and perhaps contrary) requirements of compliance depending on

the reviewing agency. This duplication problem notwithstanding, the facilities and Federal Government will be expending unnecessary funds in an effort to comply with two essentially identical regulations, and cause institutions to be reviewed by two separate agencies in the same legislation.

The Association believes strongly in most of the principles embodied in the ESRD Conditions of Participation. We are also aware that the Medicare Conditions of Participation do not apply to ESRD facilities not defined as hospitals. Therefore, this particular set of regulations should have the Conditions of Participation (Sections 405.2135 to 405.2140) apply to free-standing dialysis facilities only. For Medicare-approved hospitals, the ESRD Conditions of Participation should be waived since it is stated in Section 405.2131 that "a hospital. . . may be reimbursed under the ESRD program only if the hospital is otherwise an approved provider in the Medicare program."

Another area of concern to the Association relates to the apparent duplication and potential conflict among the local health systems agency functions for area planning and the Network Coordinating Council's responsibilities. Examples of the duplication include the review of an institutional plan (Section 405.2136(d)), determination of efficient utilization levels as a function of local area population and service characteristics, the need for the development of new resources, and the effective use of existing resources. The proposed regulations do not adequately delineate the relationship of a planning agency to the Network Council. Efforts should be made to integrate responsibilities where possible and to delegate to those entities with previously developed skills and expertise.

There should be clarification as to which agency's approval is required prior to an institution's initiating or altering an ESRD service. Is an HSA to delegate this responsibility to the Network Council? How will the Network Council's activities relate to the HSA's and the Statewide Health Coordinating Council? These and other questions about HSA and ESRD council relationships must be answered before promulgation of the final regulations. Institutions should not be subject to a maze of regulatory agencies and efforts should be made to consolidate these activities and clearly delineate authority patterns to avoid unnecessary duplication.

Functions to be performed by the Medical Review Board appear to duplicate the responsibilities of the Professional Standards Review Organization. As now proposed, the Medical Review Board and a PSRO will be performing essentially the same tasks with the exception of outpatient renal dialysis. Even though the proposed regulations allow the Secretary to "assign such responsibility to the PSRO," the inter-relationships of the two entities must be carefully outlined. Until "assignment" is made there will be uncertainty as to which agency will be the primary entity. In the situation of the delegated hospital (one which is performing its own PSRO review), what will be the role of the Medical Review Board and the PSROs in the case of inpatient ESRD procedures and transplantation? This situation will cause more duplication. Consequently, the Association recommends that the relationship between and responsibilities of the PSRO and ESRD medical review boards be defined so as to eliminate overlapping procedures:

James B. Cardwell
September 3, 1975
Page Three

The financing and process of formation of the Network Coordinating Council are nowhere addressed in these proposed regulations. It is obvious from their assigned responsibilities that significant staff support will be needed. At a time when a number of governmental agencies, including the Bureau of Health Insurance, are engaged in intensive cost containment programs, the financing of the networks should not be ignored.

Additionally, many of the network area designations seem to have been identified by HEW in the absence of information on successful existing ESRD program relationships. (For example, it has come to our attention that in New Jersey, all of the State except Bergen County would be joined with Delaware and several counties of eastern Pennsylvania. Bergen County would then be placed in the New York City network. Illinois is another example where existing arrangements have apparently been disregarded.) The Department is urged to utilize the mechanisms now in place in some areas for delineating the ESRD boundaries to prevent the creation of new areas at the expense of operational programs.

One final point to be discussed concerns the type and duration of facility approvals. In Section 405.2122, "Compliance with Minimal Utilization Rates; Types and Duration of Approvals," three categories of approvals are proposed. One of these, "Exception Status," if granted to a facility cannot exceed one-year when it cannot meet the unconditional or conditional utilization rates. The Association objects to the one-year limit in the absence of a regular renewal option. Some institutions simply lack the population to support a service at the prescribed utilization levels. Yet, because of the area's geographic and socioeconomic characteristics, the population may be precluded from traveling to another facility. A limitation of one-year in the absence of a viable renewal option assumes that the precipitating situation will be altered during that period. Consequently, it is strongly urged that the "Exception Status" be provided with an extension option if there is no change in the situation that warranted such a designation.

The Association hopes that these comments are helpful to the Department. The AAMC once again affirms its commitment to effective planning and quality control mechanisms, but urges HEW to utilize existing and/or emerging entities where feasible.

Sincerely,

Original signed by
J. A. D. COOPER, M.D.

John A. D. Cooper, M.D.

REVISED DRAFT AGENDA

PNHA CONSTITUTIONAL CONVENTION

Thursday, October 9

6:00 p.m. - 10:00 p.m.
6:00 p.m. - 10:00 p.m.
10:00 p.m. - Midnight

Registration
Informal Reception
National Council Meeting

Friday, October 10

7:30 a.m. - 8:30 a.m.
8:00 a.m. - 10:00 p.m.
8:30 a.m. - 10:00 a.m.

10:00 a.m. - 11:00 a.m.
11:00 a.m. - 12:00 a.m.

Noon - 1:00 p.m.
1:00 p.m. - 5:00 p.m.

Coffee & Rolls
Registration
Plenary Session
Call to order - Dan Asimus
Explanation of Convention Rules
Opening Remarks
President's Report - Bob Harmon
Treasurer's Report - Ralph Stanifer
Keynote Address - Senator Ted Kennedy
Executive Director's Report - Steve Diamond
Q & A Session to follow
Lunch - Cash buffet
Reference Committees
#1 C&B - Officers & National Council
#2 C&B - Membership & National Assembly
#3 C&B - Local Affiliates, etc.
#4 Miscellaneous Resolutions
Recruitment Workshops for National
Health Service Corps, Indian Health
Service, Bureau of Medical Services
Testimonial Dinner
Speakers: Jerry Wurf, Pres. AFSCME
Dr. Ed Martin, Director, NHSC
Regional & Minority Caucuses

Simultaneously

6:00 p.m. - 8:00 p.m.

8:00 p.m. - 10:00 p.m.

Saturday, October 11

7:30 a.m. - 8:30 a.m.
8:30 a.m. - 9:00 a.m.

9:00 a.m. - 9:30 a.m.

9:30 a.m. - Noon

Noon - 1:00 p.m.

Coffee & Rolls
Plenary Session
Call to order - Dan Asimus
Announcements
Address - William J. Usery, Director
Federal Mediation & Conciliation Service,
"Collective Bargaining in the Health
Sector."
Workshops:(45 min. each, rotate thru)
#1 "Organizing Your HSA" - Dr. Jim
MacIntyre, Dr. Bob Jahnke, Dr. Jay
Dobkin, Steve Diamond
#2 "Impasse Resolution in Hospital
Bargaining" - FMCS, Dan Asimus
#3 "Public Affairs - Peter Frishauf,
Others to be announced.
Lunch - Cash buffet

Saturday, October 11 Cont.

1:00 p.m. - 5:00 p.m.

Plenary Session

Debate and Action on Resolutions and
Amendments to C&B

5:00 p.m. - 6:00 p.m.

Regional & Minority Caucuses

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

Nominations for all Offices

7:00 p.m. - 9:00 p.m.

Dinner hour

9:00 p.m. - ?

Concert - "Chicago Slim Blues &
Boogie Band"

Sunday, October 12

7:30 a.m. - 8:30 a.m.

Coffee & Rolls

8:30 a.m. - 10:00 a.m.

Plenary Session

Campaign Speeches by Candidates

10:00 a.m. - 2:00 p.m.

Elections & Run-offs

2:00 p.m. - 4:00 p.m.

Meeting of the New National Council