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

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 13-14, 1976

Tuesday, January 13

6:30 p.m.	Administrative Board Mr. Jay Constantine Dr. James Mongan	Grant Room Washington Hilton Hotel
7:30 p.m.	Cocktails	Farragut Room
8:00 p.m.	Dinner	Grant Room

Wednesday, January 14

9:00 a.m.	Administrative Board Business Meeting (Coffee and Danish)	Farragut Room
1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Board Luncheon	Hemisphere Room
	Executive Council Meeting Business Meeting	
4:00 p.m.	Adjourn	

AGENDA
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 14, 1976

INFORMATION ITEMS

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
November 3, 1975

MINUTES

PRESENT:

Sidney Lewine, Chairman
Charles B. Womer, Chairman-Elect
Robert A. Derzon, Immediate Past Chairman
Daniel W. Capps
John W. Colloton
David A. Gee
J. W. Pinkston, Jr.
S. David Pomrinse, M.D.
Malcom Randall
John M. Stagl
David D. Thompson, M.D.

ABSENT:

Leonard W. Cronkhite, Jr., M.D.
Daivd L. Everhart
Baldwin G. Lamson, M.D.
William T. Robinson, AHA Representative
Robert E. Toomey

STAFF:

Armand Checker
Robert Carow
James I. Hudson, M.D.
Richard M. Knapp, Ph.D.
Steven J. Summer
Catharine A. Rivera

I. Call to Order:

Mr. Lewine called the meeting to order at 7:30 a.m. in the Independence Room of the Washington Hilton Hotel.

II. Consideration of Minutes:

The minutes of the September 18, 1975 Administrative Board Meeting were approved as circulated.

III. Report of the COTH Nominating Committee:

Robert Derzon, Chairman of the COTH Nominating Committee, indicated that the following individuals would be proposed for nomination at the COTH Institutional Membership Meeting and the AAMC Assembly.

COTH Administrative Board

Chairman: Charles B. Womer
Chairman-Elect: David D. Thompson, M.D.

Three-year Term:

Robert M. Heyssel, M.D.
Stanley R. Nelson
Robert E. Toomey

One-Year Term:

John Reinertsen

COTH Representative to AAMC Executive Council:

John M. Stagl

COTH representatives to the AAMC Assembly are attached as Appendix A.

IV. Discharge of COTH Ad Hoc Committees:

Mr. Lewine expressed the appreciation and gratitude of the COTH Administrative Board for the work completed during the past year by the following committees and discharged them.

COTH Nominating Committee
Chairman, Robert A. Derzon

Committee on Membership Criteria
Chairman, David D. Thompson, M.D.

Committee on Section 223
Chairman, David L. Everhart

V. Financing Education in the Ambulatory Care Setting:

Dr. Pomrinse brought to the Board's attention a problem of increasing operating deficits in teaching hospital ambulatory care programs. He stated that the situation is extremely acute in New York City and questioned the Board on whether this was typical of what is happening elsewhere. The Board concurred with Dr. Pomrinse and suggested that it might be appropriate to determine the actual extent of the problem through a data collection effort.

Mr. Derzon added that it is also important to recognize that the appropriate method of reimbursement for ambulatory care services has not been determined. And, he noted, political relaities must be considered. The members of the Board stated that an analysis of this problem should be coordinated with other hospital organizations. Dr. Knapp stated that he would suggest this be placed on the Executive Committee retreat agenda.

VI. Retreat Items from the COTH Administrative Board:

Mr. Lewine stated that Dr. Cooper had requested that the Council of Teaching Hospitals Administrative Board submit suggested items to be placed on the retreat agenda which will be held December 10-12. The Board suggested the following items:

1) financing education in the ambulatory care setting;
2) recent activities of the Physicians' National Housestaff Association;
3) governance of academic medical centers.

VII. New Business:

Mr. Womer, on behalf of the COTH Administrative Board members, expressed appreciation to Mr. Lewine for his efforts as Chairman during the past year.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD COMMEND MR. LEWINE FOR HIS ACCOMPLISHMENTS DURING HIS YEAR IN OFFICE.

VIII. Adjournment:

There being no further business the meeting was adjourned at 9:30 a.m.

Attachment:

APPENDIX A

Nominations for the AAMC Assembly for a Three-Year Term Expiring 1978

Jess E. Burrow
Veterans Administration Hospital
Sepulveda, California

John W. Colloton
University of Iowa
Hospitals and Clinics

Donald W. Cordes
Iowa Methodist Hopsital
Des Moines, Iowa

Dr. Jeptha W. Dalston
University Hospital
Ann Arbor, Michigan

Harry C.F. Gifford
Medical Center of Western Massachusetts
Springfield, Massachusetts

Richard Gillock
Eugene Talmadge Memorial Hospital
Augusta, Georgia

Lloyd L. Hughes
Rhode Island Hospital
Providence, Rhode Island

Joseph J. Mason
Veterans Administration Hospital
Los Angeles, California

Dr. William Merchant
Veterans Administration Hospital
Madison, Wisconsin

James E. Moon
University of Alabama Hospital
Birmingham, Alabama

Stanley R. Nelson
Henry Ford Hospital
Detroit, Michigan

Joseph Paris
Veterans Administration Hospital
Buffalo, New York

John Reinertsen
University of Utah Medical Center
Salt Lake City, Utah

John R. Rowan
Veterans Administration Hospital
Lexington, Kentucky

Richard Schripsema
Hurley Hospital
Flint, Michigan

P. Whiteney Spaulding
Medical College of Ohio Hospital
Toledo, Ohio

John M. Stagl
Northwestern Memorial Hospital
Chicago, Illinois

Alexnader H. Williams
State University of New York
Downstate Medical Center, Brooklyn

Charles B. Womer
Yale-New Haven Hospital
New Haven, Connecticut

Nomination for a Two-Year Term Expiring 1977

Raymond S. Alexander
Mount Sinai Medical Center
Milwaukee, Wisconsin

Nominations for a One-Year Term Expiring 1976

John S. Arledge
Veterans Administration Hospital
Durham, North Carolina

S. H. Birdzell
Veterans Administration Hospital
Omaha, Nebraska

Roy C. House
Wesley Medical Center
Wichita, Kansas

Dan C. Macer
Veterans Administration Hospital
Oklahoma City, Oklahoma

Douglas S. Peters
University of Nebraska Medical Center
Omaha, Nebraska

A. Zamberlan
Veterans Administration Hospital
Allen Park, Michigan

The Commonwealth of Massachusetts
Department of Mental Health

MILES F. SHORE M.D.
AREA DIRECTOR

MASSACHUSETTS MENTAL HEALTH CENTER
BOSTON PSYCHOPATHIC HOSPITAL
72-76 FENWOOD ROAD
BOSTON, MASS. 02115

December 12, 1975

Association of American Medical Colleges
Suite 200 - One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Sir:

I am in receipt of your bill for $1000 Teaching Hospital membership for the academic year 1975-1976.

Although we valued our membership in AAMC and continue to have a strong academic program, there are very serious restrictions in State funding at this time and we are having to watch our expenditures extremely closely. Thus, I would like to drop out of the AAMC as a teaching hospital for this year hoping to renew our institutional membership as soon as our entire budget picture is clarified.

Sincerely yours,

Miles F. Shore

Miles F. Shore, M.D.
Area Director
Superintendent

MFS:lg

albert einstein medical center

Executive Offices
YORK and TABOR RDS.
PHILADELPHIA, PA. 19141
(215) 329-0700

ROBERT M. SIGMOND
Executive Vice President

December 1, 1975

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dick:

As of January 1, 1976, I will be leaving Albert Einstein Medical Center and throwing my lot in with Blue Cross.

I assume this means that I should resign as COTH representative to the Association of American Medical Colleges Assembly, since I will not be connected with a COTH hospital any longer.

Presumably, such seats in the Assembly are not transferrable. If they are (or even if they aren't), I recommend David C. Schmauss, General Director of our Northern Division. He is capable, knowledgeable, dedicated and is the Chief Executive Officer of a hospital (our Northern Division) which has a major affiliation with Temple University's Medical School.

It will be good for COTH and AAMC if you are able to latch on to him.

Best regards,

RMS/bs

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C., 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

(a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

(b) 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.

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions.

I. MEMBERSHIP INFORMATION

Overlook Hospital
HOSPITAL NAME

193 Morris Avenue — Summit
STREET — CITY

New Jersey — 07901 — (201) 522-2000
STATE — ZIP CODE — TELEPHONE NUMBER

Chief Executive Officer: Robert E. Heinlein
NAME

President and Director
TITLE

Date hospital was established: 1906

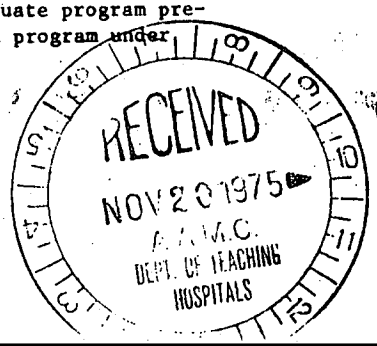
APPROVED FIRST POST-GRADUATE YEAR

TYPE[2]	Date of Initial Approval by CME of AMA**	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Flexible	1972	7	2	5
Categorical	1972	19		
Categorical*	1972	18	1	2

** Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

1. Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.

2. Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program directpr; Categorical*-graduate program under supervision of single program director but content is flexible.)



APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA**	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Medicine	1972	16	3	13
Surgery*	1973	3	2	0
Ob-Gyn*	1974	3	1	0
Pediatrics	1973	10	0	10
Psychiatry	none			
Family Practice	1972	18	15	2
Other (List): Urology**	1975	2	2	0

*Affiliated programs with St. Vincent's Hospital, NYC

**Affiliated program with Columbia Presbyterian Medical Center, NYC

II. PROGRAM DESCRIPTION

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specifici reference to the following questions.

A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).

B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).

C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).

D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristids and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: Columbia University College of Physicians and Surgeons, 630 W. 168th Street, New York, New York 10032

Name of Dean: Donald F. Tapley, M.D.

Information Submitted by:

William F. Minogue, M.D. WFM — Director of Medical Education
NAME — TITLE OF PERSON SUBMITTING DATA

November 12, 1975 — Robert E. Heineman
DATE — SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

Columbia University
College of Physicians and Surgeons
630 WEST 168TH STREET
NEW YORK, N.Y. 10032
OFFICE OF THE DEAN

October 28, 1975

Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Sirs:

I should like to take this opportunity to emphasize the importance of Overlook Hospital to the Health Sciences teaching program of Columbia University. Many of the staff hold faculty appointments, and seven important elective programs are offered as part of the official curriculum for our fourth year medical students. In addition, Overlook Hospital is an active participant in House Staff training. On the basis of our affiliation agreement and common educational effort we strongly support the application of Overlook Hospital to become a member of the Council of Teaching Hospitals of the Association of American Medical Colleges.

Sincerely yours,

Donald F. Tapley, M.D.
Dean

DFT:pl

$1,000. check received
Business Office is Loosing (M. Murphy)
11/20/75 CAR

II. PROGRAM DESCRIPTION

A. Overlook Hospital affiliated with Columbia University College of Physicians and Surgeons officially on May 22, 1975. The Hospital offers eight separate clerkships for senior medical students. We can accommodate 12 medical students during any given month including living quarters and meals. The number of students per month will average three in the 1975-1976 academic year. The Medical Staff currently commits about 10% of its time to the teaching of medical students.

B. The Hospital employs a full-time Director of Medical Education and full-time salaried Directors of the educational programs in Internal Medicine, Family Practice, and Pediatrics. There are also two full-time salaried Associate Directors in Family Practice (a Board certified Pediatrician and a Board certified Internist with a masters in Public Health). There is a half-time salaried (and half-time geographic) Director in Surgical Education. The Directors of the Radiology and Pathology educational programs are full-time geographic chiefs. There are full-time salaried Directors of Psychiatry and Community Medicine. All of the above mentioned directors currently hold or will shortly hold academic appointments at the Medical School ranging from Clinical Professor to Assistant Clinical Professor. Numerous other members of the voluntary staff will also hold medical school rank and many have been so designated as of this writing.

C. Financial support of Medical Education:

1. House Staff Salaries and Fringe Benefits: $1,051,000.00. Representing 5% of the hospital's budget.

2. Hospital's contribution to cost of supervising faculty: $420,000.00

   The Service Chiefs costs are paid in full by the Hospital budget (see paragraph B above). The chiefs are allowed to supplement their income through private practice up to 25% of their base salary.

D. The Columbia University College of Physicians and Surgeons faculty involvement is as follows:

1. Councilman Morgan, M.D., Dean of Curriculum, has been assigned as a liaison officer to Overlook Hospital. He will regularly attend Medical Staff Executive Committee meetings and meetings of the Medical Education Advisory Committee of the hospital. He will receive minutes from all other standing committees including those of the Board of Trustees and is invited to attend any and all such committee meetings should he so desire. The medical school faculty has begun to participate in hospital based continuing education activities. This is most notable to date in the fields of Internal Medicine (and Cardiology), Pediatrics (with emphasis on Neonatology and Perinatology) and Urology.

The Director of Medical Education of the Hospital will regularly attend Faculty Council meetings at the Medical School and the President and Director of the Hospital will attend the Chairman's Advisory Committee at the Medical School.

Directors of Education of our residencies meet at least monthly with the Departmental Chairman and their counterparts at other affiliated hospitals.

Overlook residents are allowed to take many subspecialty electives at Presbyterian Hospital.

Columbia faculty members conduct numerous continuing medical education conferences at Overlook. House staff and attending physicians at Overlook holding faculty rank at the school are allowed to audit post-graduate education programs at P & S at no cost.

E. The Hospital launched a major medical education effort in 1972 with the objective of training primary physicians. The largest and most emphasized residencies in our Hospital are therefore Family Practice, General Internal Medicine and General Pediatrics. Autonomous Radiology and Pathology programs were deemed essential to create the critical mass of educational activity in support of our primary care residencies. Affiliated residents in General Surgery (St. Vincent's Hospital, New York), Urology (Columbia Presbyterian Medical Center) and OBS/GYN (St. Vincent's Hospital, New York) were established to:

1) Provide community hospital experiences for the residents.
2) Create educational ferment on those services.
3) Provide peers in the surgical specialties for our primary care residents.

We believe that the graduate education program as organized at Overlook Hospital will help alleviate the local state and national problem of overspecialization.

In addition to the undergraduate and graduate education programs described above, the Hospital has an exceedingly active program in continuing education. This program has been approved by the Medical Society of New Jersey and the AMA Council on Medical Education for Category I credit toward the Physician's Recognition Award.

AGREEMENT

BETWEEN THE TRUSTEES OF COLUMBIA UNIVERSITY

IN THE CITY OF NEW YORK

AND

THE OVERLOOK HOSPITAL ASSOCIATION

AGREEMENT made this May 22, 1975 by and between THE TRUSTEES OF COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK, a corporation organized and existing under the laws of the State of New York (the "University") and THE OVERLOOK HOSPITAL ASSOCIATION, in Summit, New Jersey, a corporation organized and existing under the laws of the State of New Jersey (the "Hospital").

The University and the Hospital hereby enter into an affiliation upon the following terms and conditions:

1. PURPOSES:

The purposes of the affiliation are:

(a) To provide to the University facilities and opportunities at the Hospital for undergraduate medical education;

(b) To provide broadened facilities and opportunities for the training of interns and residents of the Hospital;

(c) To provide for the Hospital the stimulation and professional development of an association with a University educational and research program; and

(d) To carry out any activities necessary or incidental to the foregoing purposes.

2. RESPONSIBILITIES OF THE HOSPITAL

Subject to the limitations herein set forth, the Hospital shall be responsible for:

(a) All matters relating to the financial support of the Hospital, the clinical care of patients at the Hospital and the operation and maintenance of the Hospital facilities.

(b) Supervision of the clinical instruction by its professional staff of students of the University serving as clinical clerks in the wards and laboratories of the Hospital in accordance with the educational program of the Faculty of Medicine or the Faculty of Dental and Oral Surgery of the University; and the provision of space therefor.

(c) All matters relating to employment of all professional staff, interns and residents, and other personnel, and the granting of admitting or other privileges to the Hospital.

(d) The provision of advanced clinical experience to residents at the Hospital, who shall be included in the program of graduate medical education of the University.

(e) Employment of a full time Director of Medical Education and full-time or part-time Directors of Education of Clinical Services, as specified in Paragraph 6 of this Agreement.

3. RESPONSIBILITIES OF THE UNIVERSITY

Subject to the limitations herein set forth, the University shall be responsible for:

(a) The assignment of students from the Faculty of Medicine or the Faculty of Dental and Oral Surgery to the Hospital, to the extent and in the manner believed by it to contribute most to the clinical training of said students and the care of patients in the Hospital. The number of students shall be determined by the University and the Hospital.

(b) Academic titles to selected members of the professional staff of the Hospital in accordance with Paragraph 5 hereof.

(c) The nomination of 18 first year residents for Post Graduate Year I positions in the Hospital. The final decision as to appointment of residents shall be that of the Hospital. The distribution of these first year resident positions among various departments of various Columbia affiliated hospitals shall be the responsibility of the Dean of the Faculty of Medicine of the University in consultation with the Director of Medical Education of the Hospital.

(d) Offering opportunities for specialized instruction, research and advanced training to residents of the Hospital under the University's established program of graduate medical education, as provided herein.

4. THE JOINT COMMITTEE

For convenience of operation of the affiliation, there shall be established a Joint Committee of the Hospital and the University:

(a) The Joint Committee shall consist of six members, three from the Hospital and three from the University, as follows:

(i) The three members from the Hospital shall be the Director of Medical Education, the Chairman of the Medical Education Advisory Committee of the Hospital's medical staff and the President of the Medical Staff. For convenience of reference, these members are hereinafter called "Hospital Members".

(ii) The three members from the University shall be appointed by the Vice President for Health Sciences of the University. For convenience of reference, these members are hereinafter called "University Members".

(b) The Chairman of the Joint Committee shall be appointed from among its members by the Vice President for Health Sciences of the University.

(c) The Joint Committee shall elect a secretary from among its members to maintain minutes of the proceedings of the Joint Committee and provide copies thereof to the University and the Hospital, and to undertake such other duties as the Joint Committee shall determine.

(d) The Joint Committee shall review and evaluate, periodically, the joint educational efforts and make recommendations to both parties on any matters affecting the teaching program at the Hospital, including, without limitation, the following:

(i) Recommendations to the University as to the assignment of students to the Hospital as clinical clerks.

(ii) Recommendations to the University and to the Hospital as to the program of training of residents at the Hospital.

(iii) Recommendations to the University as to the possible interchange of residents with other hospitals and institutions affiliated with the University, subject

to the concurrence of such other institutions.

(e) In addition to the foregoing powers, the Joint Committee shall have power to hear and make recommendations to either party as to any disputes between the parties hereunder.

(f) The Joint Committee shall meet at least quarterly at such specific time and place as may be determined by the Joint Committee. Notice of time and place shall be given by the Secretary of the Joint Committee in such manner as may be directed by the Joint Committee. Special meetings of the Joint Committee shall be called by the Secretary on the request of the Dean of the Faculty of Medicine of the University, the President of the Hospital or the Director of Medical Education of the Hospital, stating the object of such meeting, and shall also be called at the request in writing by at least two of the members of the Joint Committee. Notice of the time and place of such a special meeting shall be given in such manner as may be directed by the Joint Committee. At all meetings of the Joint Committee, a majority

of the Hospital Members and a majority of the University Members shall constitute a quorum.

5. ACADEMIC APPOINTMENTS

(a) The University may, in its discretion, appoint members of the Hospital professional staff who participate directly in the instructional effort in the Hospital as Officers of Instruction in the Faculty of Medicine or the Faculty of Dental and Oral Surgery of the University. The appointment of any members of the Hospital staff shall be subject to the Statutes of the University, University rules and customs, and in conformity with the stated rules of the Faculty to which the appointment is to be made.

(b) The Director of Medical Education of the Hospital in consultation with the Director of Education of the appropriate Hospital Service may nominate qualified candidates to the Executive Committee and Chairman of the corresponding University Department for consideration for appointment in the University for the full time rank of professor or associate professor and for the full time or part time clinical ranks of professor or associate professor. Full time officers of

instruction may be designated as "Professor of (Department) in Overlook Hospital" or "Associate Professor of (Department) in Overlook Hospital" or Professor of Clinical (Department)" or "Associate Professor of Clinical (Department)" as the case may be. Part-time appointments will carry the title of "Clinical Professor of (Department)" or "Associate Clinical Professor of (Department)". All such appointments shall be annual. Similar procedures and designations shall be used for appointment to the ranks of Assistant Professor of (Department), Assistant Professor of Clinical (Department), Assistant Clinical Professor of (Department), Associate of Clinical (Department), Clinical Associate of (Department), Instructor of Clinical (Department), and Clinical Instructor of (Department).

Neither this agreement nor the University's participation in the award of the foregoing titles shall create any obligation on the part of the University to any persons awarded such titles for financial support or for any "tenure of title" in the University in the event of the termination or suspension

of their employment by the Hospital or in the event of the termination of the affiliation provided for hereunder.

Any member of the Hospital professional staff holding an appointment at the date of this Agreement shall not have the continuity of such appointment jeopardized by lack of appointment to a Faculty in the University. No future appointment to the Hospital's voluntary staff shall be affected by lack of appointment to a Faculty of the University.

6. DIRECTORS OF MEDICAL EDUCATION

The Hospital shall employ and pay all support and maintenance of Directors of Medical Education, to serve at the pleasure of the Hospital, as follows:

(a) A competent and experienced full-time Director of Medical Education who shall be its direct executive representative in the management of the affiliation provided for herein. He shall be responsible for administering the educational program provided for herein, subject to the guidance of the Joint Committee, to such policies as may be adopted by the Joint Committee, and to the educational requirements of the University. He shall serve as liaison officer between the Univer-

sity, the Hospital and the Joint Committee. He shall attend all meetings of the Joint Committee unless specifically excused therefrom. At least once annually, he shall report to the University and the Hospital on the status of the affiliation.

(b) Full time Directors of Education in the following Services: Family Practice, Internal Medicine, Pathology, Pediatrics and Psychiatry; a geographic full-time Director of Education in the Radiology Service; and a full or part-time Director of Education in the Surgery Service. The Directors of Education of the Hospital Services shall be responsible for the administration of the educational program of each Service, subject to the Director of Medical Education of the Hospital and the educational program of the University.

(c) Any vacancy in or new appointment to the positions of Director of Medical Education of the Hospital or of Director of Education of a Service shall be filled in accordance with the following procedure:

(1) The Dean of the Faculty of Medicine, with the approval of the Vice President for

Health Sciences of the University (or any successor officer performing the same or similar duties) shall request the President of the University to appoint a Search Committee to advise on the selection of a candidate for appointment to such directorship. The Search Committee shall consist of four members drawn in equal numbers from the Medical or Dental staff holding a University faculty appointment at the Hospital and from other medical or dental faculty of the University. The President of the University shall designate the Chairman of the Search Committee from among its members.

(2) The committee shall present the name of the selected candidate to the Dean of the Faculty of Medicine for his approval and if he approves, to the President of the University through the Vice President for Health Sciences.

(3) If the President of the University approves, the name of the candidate shall be presented to the President of the Hospital.

(4) If the President of the Hospital approves, he shall present the nomination to the medical staff of the Hospital for approval.

(5) If the medical staff approves, the nomination shall be presented to the Trustees of the Hospital for their consideration, and if they approve, for appointment.

7. LIMITATIONS, INDEMNIFICATION INTERPRETATION NOTICES

(a) Under this agreement, the University is and shall be under no obligation, express or implied, for the maintenance and support of the Hospital, including, but not limited to, the conditions of employment and rights and privileges of its professional staff, or for the disbursement of the income thereof, except as herein expressly stated. Under this agreement, the Hospital is and shall be under no obligation, express or implied, for the maintenance and support of the University, except as herein expressly stated.

(b) The University shall have no liability arising out of malpractice or other actions undertaken by any employee of the Hospital by virtue of this Agreement. The University shall be indemnified by the Hospital and held harmless against all claims, demands, actions and rights of action which shall or may arise by virtue of anything done or omitted to be done by any member of the professional staff of the Hospital, provided that the Hospital shall be promptly notified of the existence of any claim, demand, action or right of action and shall be given reasonable opportunity to participate in the defense thereof.

(c) The University and the Hospital is each to continue its independent existence and control. Nothing in this agreement is to be construed to affect any activities of the University or the Hospital not expressly covered by its terms. Nothing contained in this Agreement shall be construed to constitute either party the general partner of the other party or the agent of the other party, nor in any manner to limit the parties in the carrying on of their respective activities.

(d) All notices required or permitted by this Agreement shall be in writing and shall be sent by registered or certified mail addressed,

In the case of the University, to:

Dean, College of Physicians and Surgeons
Columbia University
630 West 168th Street
New York, New York 10032

and in the case of the Hospital, to:

Director of Medical Education
The Overlook Hospital
193 Morris Avenue
Summit, New Jersey 07901

or to such other address or to the attention of such other person as may be supplied in like manner.

(e) This Agreement is the only Agreement between the parties with respect to the subject matter hereof. No alteration, modification or interpretation hereof shall be binding unless in writing and signed by both parties. This Agreement shall be interpreted in accordance with the laws of the State of New York. This Agreement may be executed in one or more counter-

parts, each of which shall constitute an original, but which together shall constitute one agreement.

8. TERM

This Agreement shall take effect as of the date hereof and shall continue from year to year unless terminated as of June 30 in any year upon one year's notice in writing from either party to the other.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals, as of the day and date first above written.

THE TRUSTEES OF COLUMBIA UNIVERSITY
IN THE CITY OF NEW YORK

By _____
William J. McGill
President

THE OVERLOOK HOSPITAL ASSOCIATION

By _____
Robert E. Heinlein
President

MANAGEMENT ADVANCEMENT PROGRAM

At the September 18 COTH Board meeting Dave Everhart, who is a member of the Management Advancement Program Steering Committee, discussed the initiation of the management advancement program for deans and its progress to date. The Board discussed the possibility of joining this program and recommended that the staff definitely explore the possibility of doing so, and recommended that the Phase I session include some medical school deans if such a program is undertaken.

A Phase I program has been scheduled for June 18-23, 1976 to be held at La Coquille Hotel, Palm Beach, Florida. Following discussion with Dave Everhart and COTH Chairman Chuck Womer, the attached invitation list was compiled based upon individual participation in COTH and participation in a MAP Phase II problem solving seminar. A tentative seminar time schedule is also attached.

Since the program can accommodate approximately 25 hospital directors, board members will be asked to give a tentative indication of whether or not they will be able to attend. We will then have some idea of how many invitations should be sent. You are reminded that following the final day of the program (June 23) there is a COTH Board meeting (June 24).

AAMC EXECUTIVE DEVELOPMENT SEMINAR

June 18-23, 1976

SCHEDULE

FRIDAY, June 18, 1976

5:30 p.m. Reception, cocktails, and registration

6:15 p.m. Dinner

Introduction and Welcome: Marjorie P. Wilson, M.D.
Director, Department of
Institutional Development,
AAMC

Edward B. Roberts, Ph.D.
David Sarnoff Professor
of Management of Technology
M.I.T. Sloan School

8:00 p.m. General Session

Theme: MOVING TOWARD A HEALTHY ORGANIZATION Richard Beckhard

The program will begin with cocktails and a reception to be followed by dinner at 6:15. During dinner there will be a brief description of the relationship of the Seminar to the total AAMC Management Advancement Program, and the resource people who will be with us as faculty will be introduced.

Following dinner, the first general session will include a description of the plan of work for the week, including the types of activities and a review of the basis for the plan. The nature of the learning goals and the possible outcomes for individual participants will be outlined. After viewing what makes an effective organization, we will look at some of the issues in the management of human resources. Following that, there will be a description of various types of managerial strategies and assumptions and their relationship to effective organization.

10:00 p.m. Adjournment

SATURDAY, June 19, 1976

9:00 a.m. Theme: MANAGERIAL STYLES AND ENVIRONMENT Richard Beckhard

10:30 a.m. Coffee Break

Saturday, June 19, 1976 - continued

11:00 a.m. Theme: MANAGERIAL STYLES AND ENVIRONMENT — Richard Beckhard

12:15 p.m. Lunch

1:30 p.m. Theme: THE PROCESS OF CHANGE — Richard Beckhard

2:00 p.m. Theme: STRATEGIES FOR CHANGE — Richard Beckhard

We will begin by looking at managerial styles as one important aspect of managing change, and then study models of situational analysis using particular analytical tools. We will look at several ways of analyzing a situation needing change; and work teams will have an opportunity to apply these tools in a medical center situation. We will consider strategies for planning change effort and examine the role of the change manager and change agent.

5:00 p.m. Afternoon Break

5:30 p.m. Cocktails

6:15 p.m. Dinner

8:00 p.m. Theme: PLANNING AND CONTROL — Edward Roberts

Discussion of Planning and Control will start with the review of the concepts and structures of the planning process.

10:00 p.m. Adjournment

SUNDAY, June 20, 1976

9:00 a.m. Theme: PLANNING AND CONTROL — John Rockart

Characteristics of Effective Strategic Planning Systems.

10:30 a.m. Coffee Break

11:00 a.m. Theme: PLANNING AND CONTROL — John Rockart

Characteristics of Effective Management Control Systems.

12:15 p.m. Lunch

1:30 p.m. Theme: PLANNING AND CONTROL — John Rockart

(a) Characteristics of Effective Management Control Systems (Cont'd)

(b) Programs, Budgeting and PPBS

Sunday, June 20, 1976 - continued

3:00 p.m. Coffee Break

3:30 p.m. Theme: PLANNING AND CONTROL — John Rockart

The theme of Planning and Control will move into an analysis of the design of planning and control systems, both at the strategic level and the management control level. The implication of systems such as PPBS which relate both to programmatic aspects of implementation as well as behavioral change issues will be discussed. The focus will then switch to a situational analysis based upon a case study of a health center operation.

5:00 p.m. Afternoon Break

5:30 p.m. Cocktails

6:15 p.m. Dinner

8:00 p.m. Evening Open

MONDAY, June 21, 1976

9:00 a.m. Theme: PLANNING AND CONTROL — John Rockart

Some Management Aspects of Accounting Information Systems

10:30 a.m Coffee Break

11:00 a.m. Theme: PLANNING AND CONTROL — John Rockart

Planning and Control continues with an overview analysis of management information systems, including an example of a management information system application in an educational setting.

12:15 p.m. Lunch

1:30 p.m. Theme: TEAM DEVELOPMENT — Edgar Schein

3:00 p.m. Coffee Break

3:15 p.m. Theme: TEAM DEVELOPMENT — Edgar Schein

4:30 p.m. Afternoon Break

5:30 p.m. Cocktails

6:15 p.m. Dinner

Monday, June 21, 1976 - continued

8:00 p.m. Theme: THE FUNCTION OF POWER — Edgar Schein

The theme changes after lunch to Team Development. The subjects to be dealt with are the goals of the manager, the differential objectives of professionals and scientists and the problems that these produce, the nature of managerial authority vis-a-vis professionals and scientists, and the methods of influence available to the manager. We will look at a number of different team development designs available to the hospital administrator, the conditions for these, and some of the kinds of interventions that are appropriate. In the evening, the theme continues with focus on the function of power, followed by a participative exercise on power.

10:00 p.m. Adjournment

TUESDAY, June 22, 1976

9:00 a.m. Mid-Week Review — Edward Roberts

9:30 a.m. Theme: MANAGING PROFESSIONALS — Edward Roberts

(a) Selection of Academic Health Professionals
(b) Influences on Their Performance
(c) Academic Entrepreneurs

10:30 a.m. Coffee Break

11:00 a.m. Theme: ORGANIZATION DESIGN — Edward Roberts

The theme will deal with such things as alternative organizational structures and matrix designs.

12:15 p.m. Lunch

1:30 p.m. Theme: UPWARD AND LATERAL RELATIONS — Richard Beckhard

2:30 p.m. Coffee Break

3:00 p.m. Theme: STRATEGIC DECISION MAKING: FORECASTING/MODELLING — Edward Roberts

The theme of Strategic Decision Making will focus on methods by which models, both informal and formal, can be applied to assist and support strategic decision-making processes. Specific aspects of quantitative forecasting techniques useful in decision making will be covered. One specific model, a simulation approach, will be elaborated, to demonstrate the relevance to a medical center of formal modelling activities.

Tuesday, June 22, 1976 - continued

4:30 p.m.	Afternoon Break	
5:30 p.m.	Cocktails	
6:15 p.m.	Dinner	
8:00 p.m.	Theme: STRATEGIC MODELLING	Gary Hirsch
10:00 p.m.	Adjournment	

WEDNESDAY, June 23, 1976

9:00 a.m.	Theme: MANAGING INTERGROUP CONFLICT	Richard Beckhard

Through an organizational simulation, the work team will make a series of management decisions relating to a medical center and will have an opportunity to experience and analyze the aspects of intergroup and interorganizational relationships in the management of intergroup conflict. The simulation will serve as a basis for an analysis of application of these approaches to actual problems in the back-home setting.

10:30 a.m.	Coffee Break	
11:00 a.m.	Theme: MANAGING INTERGROUP CONFLICT	Richard Beckhard
12:15 a.m.	Lunch	
1:30 p.m.	Theme: MANAGING CHANGE	Richard Beckhard

After further faculty input on managing change as change agents or change managers, there will be an opportunity to identify types of possible action steps for individual participants in their own institutions.

2:30 p.m.	Coffee Break	
3:00 p.m.	Theme: PROGRAM ASSESSMENT AND FOLLOW-UP STRATEGIES	AAMC and Edward Roberts
4:15 p.m.	Adjournment	

CURRENT COTH ADMINISTRATIVE BOARD	DEAN	MAP ATTENDANCE
1. Charles B. Womer Director Yale-New Haven Hospital New Haven, Connecticut	Robert W. Berliner, M.D. Yale University	Yes
2. David D. Thompson, M.D. Director New York Hospital New York, New York	J. Robert Buchanan, M.D. Cornell	Yes
3. Sidney Lewine Director The Mount Sinai Hospital of Cleveland Cleveland, Ohio	Frederick C. Robbins, M.D. Case Western Reserve	Yes (Ed Lee, M.D
4. David L. Everhart		
5. Robert M. Heyssel, M.D. Executive Vice President & Director The Johns Hopkins Hospital Baltimore, Maryland	Richard S. Ross, M.D. Johns Hopkins	Yes
6. Stanley R. Nelson Director Henry Ford Hospital Detroit, Michigan	John A. Gronvall, M.D. University of Michigan	Yes
7. Robert E. Toomey General Director Greenville Hospital System Greenville, South Carolina	W. Marcus Newberry, M.D. Medical University of South Carolina	Yes
8. John W. Colloton Director & Assistant Vice President for Health Affairs University of Iowa Hospitals and Clinics Iowa City, Iowa	John W. Eckstein, M.D. The University of Iowa	Yes

CURRENT COTH ADMINISTRATIVE BOARD	DEAN	MAP ATTENDANCE
9. Baldwin G. Lamson Director UCLA Hospital and Clinics Los Angeles, California	Sherman Mellinkoff, M.D. UCLA	No
10. Malcom Randall Hospital Director Veterans Administration Hospital Gainesville, Florida	Chandler A. Stetson, M.D. University of Florida Gainesville	Yes
11. David A. Gee President The Jewish Hospital of St. Louis St. Louis, Missouri	M. Kenton King, M.D. Washington University	No
12. S. David Pomrinse, M.D. Executive Vice President The Mount Sinai Hospital New York, New York	Thomas C. Chalmers, M.D. Mount Sinai School of Medicine	Yes
13. John Reinertsen Executive Director University of Utah Medical Center Salt Lake City, Utah	John A. Dixon, M.D. University of Utah	Yes
FORMER BOARD MEMBERS (Since 1972)		
14. John M. Stagl President Northwestern Memorial Hospital Chicago, Illinois	James E. Eckenhoff, M.D. Northwestern University Medical School	No

	FORMER BOARD MEMBERS (Since 1972)	DEAN	MAP ATTENDANCE
15.	Don L. Arnwine President Charleston Area Medical Center Charleston, West Virginia	John E. Jones, M.D. West Virginia University	Yes
16.	Daniel W. Capps Director University Hospital Arizona Medical Center Tucson, Arizona	Neal A. Vanselow, M.D. University of Arizona	Yes
17.	Joe S. Greathouse University Hospital University of Missouri Columbia, Missouri	Joseph M. White, M.D. University of Missouri	Yes
18.	David Hitt Executive Director Baylor University Medical Center Dallas, Texas	Frederick J. Bonte University of Texas Dallas, Texas	Yes
19.	J. W. Pinkston, Jr. Executive Director Grady Memorial Hospital Atlanta, Georgia	Arthur P. Richardson, M.D. Emory	Yes
20.	Arthur J. Klippen, M.D. Hospital Director Veterans Administration Hospital Minneapolis, Minnesota	Neal L. Gault, Jr., M.D. University of Minnesota	Yes
21.	Herluf V. Olsen President Medical Center of Vermont Burlington, Vermont	William H. Luginbuhl, M.D. University of Vermont	Yes

	FORMER BOARD MEMBERS (Since 1972)	DEAN	MAP ATTENDANCE
22.	Eugene L. Staples Director West Virginia University Hospital Morgantown, West Virginia	John E. Jones, M.D. West Virginia University	Yes

COTH PAST CHAIRMEN

23.	Robert A. Derzon (73-74) Director Hospital and Clinics University of California San Francisco, California	Julian R. Krevans, M.D. University of California, San Francisco	Yes
24.	Leonard W. Cronkhite, Jr., M.D. President Children's Hospital Medical Center Boston, Massachusetts	Robert H. Ebert, M.D. Harvard	No
25.	George E. Cartmill (71-72) President United Hospitals of Detroit Detroit, Michigan	Robert D. Coye, M.D. Wayne State University	No
26.	Irvin G. Wilmot (70-71) Executive Vice President New York University Medical Center New York, New York	Ivan L. Bennett, M.D. New York University	Yes
27.	T. Stewart Hamilton, M.D. (69-70) President Hartford Hospital Hartford, Connecticut	Robert U. Massey, M.D. University of Connecticut, Farmington	Yes

COTH PAST CHAIRMEN	DEAN	MAP ATTENDANCE
28. Roy S. Rambeck (68-69) Executive Director of Hospitals University of Washington Seattle, Washington	Robert L. Van Citters, M.D. University of Washington	Yes
29. Lad F. Grapski (67-68) President Allegheny General Hospital Pittsburgh, Pennsylvania	Gerhard Werner, M.D. University of Pittsburgh	Yes
OTHER ACTIVE INDIVIDUALS		
30. Richard Wittrup Executive Vice President Affiliated Hospitals Center Boston, Massachusetts	Robert H. Ebert, M.D. Harvard	No
31. John Westerman Director University of Minnesota Hospitals Minneapolis, Minnesota	Neal L. Gault, Jr., M.D. University of Minnesota	Yes
MEMBERS WHO HAVE PARTICIPATED IN MAP PHASES II OR III		
32. Dennis Barry Administrative Director North Carolina Memorial Hospital Chapel Hill, North Carolina	Christopher C. Fordham, III, M.D. University of North Carolina	Yes
33. Judge T. Calton Director University Hospital University of Kentucky Lexington, Kentucky	D. Kay Clawson, M.D. University of Kentucky	Yes

	MEMBERS WHO HAVE PARTICIPATED IN MAP PHASES II OR III	DEAN	MAP ATTENDANCE
34.	Richard E. Gillock Administrator Eugene Talmadge Memorial Hospital Augusta, Georgia	Fair Goodale, M.D. Medical College of Georgia	No
35.	Floyd Hughes President Rhode Island Hospital Providence, Rhode Island	Stanley Aronson, M.D. Brown University	Yes
36.	Mo Katy Deputy Director Montefiore Hospital New York, New York	Ephraim Friedman, M.D. Albert Einstein College of Medicine of Yeshiva University	Yes
37.	John Lipes Administrator City of Memphis Hospitals Memphis, Tennessee	Charles B. McCall, M.D. University of Tennessee	Yes
38.	John Lynch Executive Vice President North Carolina Baptist Hospital Winston-Salem, North Carolina	Richard Janeway, M.D. Bowman Gray	Yes
39.	Charles Paxson Administrative Vice President Temple University Hospital Philadelphia, Pennsylvania	Roger W. Sevy, Ph.D.,M.D. Temple University	No
40.	Dick Stensrud Director St. Louis University Hospital St. Louis, Missouri	David Challoner, M.D. St. Louis University	Yes
41.	Daniel Strickler Administrator Presbyterian University Hospital Pittsburgh, Pennsylvania	Gerhard Werner, M.D. University of Pittsburgh	Yes

Annual Meeting Format

The San Francisco Hilton will be the headquarters for the 1976 Annual Meeting. The principal dates are November 11 - 15 (Thursday thru Monday). In addition to the Hilton the Association has commitment of 750 hotel rooms at the St. Francis Hotel (a more lavish and expensive hotel two blocks away). The majority of meetings, possibly all, will be held in the Hilton. However, because of the growth of the Annual Meeting (this year we had about 250 separate sessions in a 5-day period) it might be necessary to hold meetings in the St. Francis.

The format for the Annual Meeting is as follows:

WED.	THURS.	FRI.	SAT.	SUN.	MON.
OSR	OSR SOCIETIES	COUNCILS BUS. MTGS. & PROGRAM	PLENARY ASSEMBLY	PLENARY	RIME SOCIETIES

Please note--this schedule is similar to the Annual Meeting schedule of this past year with Thursday of 1976 being equated to Sunday of 1975. Although it would be desirable to spread out the different meetings so as to avoid all potential conflicts, it is the belief of the staff that most participants will only attend for a 3 - 4 day period and that, therefore, the major meetings must be scheduled in rapid succession.

Any thoughts you may have concerning the format and substance of the 1975 meeting in Washington would be appreciated. Suggestions for the San Francisco meeting would be helpful.

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:

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* 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).

	Beth Israel Hospital	Montefiore Hospital	Mount Sinai Hospital	New York University Hospital	St. Vincents Hospital	Maximum Percentage Difference
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:

	Beth Israel Hospital	Montefiore Hospital	Mount Sinai Hospital	New York University Hospital	St. Vincents Hospital	Maximum Percentage Difference
Interns and residents	$10.37	$12.91	$12.26	$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 Hopsital), 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 scale 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

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* 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. 3-12. 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.

HEALTH PLANNING LAW

ISSUE

To what extent should the AAMC strengthen, broaden, and intensify its efforts related to implementation of the National Health Planning and Resources Development Act? What areas of the law have particular implications for medical education?

BACKGROUND

On January 4, 1974 President Ford signed P.L. 93-641 into law. It creates a new system of health planning and health resources development to replace the Comprehensive Health Planning Program, the Regional Medical Program and the Hill-Burton medical facilities construction assistance program. The purposes of this legislation are threefold. First, the legislation is designed to facilitate the development of recommendations for a national health planning policy. This is to be accomplished through national health guidelines and health planning goals which will include standards with respect to the appropriate supply, distribution, and organization of health resources. The guidelines and standards are now being developed within HEW.

Second, the legislation is designed to promote the development of areawide and state planning for health services, health manpower, and health facilities within specific "health service areas." Initiation of these tasks was accomplished with the establishment of 202 health service areas on September 2, 1975 and the issuance of proposed regulations for HSA designation on October 17, 1975.

The third major purpose of the Act is to provide financial assistance for the development of health resources to further the development of each health planning area's policies and plans.

Since passage of P.L. 93-641, the Association has distributed three AAMC Assembly Memoranda; the first one in February provided a summary of the law, the second, in March, contained a list of "critical issues" and solicited constituent views. Most recently, the Association issued an Assembly Memorandum with the proposed HSA designation regulations. Other communications were contained in the COTH Report and the President's Weekly Report.

A task force on P.L. 93-641, chaired by Charles Sanders, M.D., General Director of Massachusetts General Hospital, was formed by the Executive Council at its April, 1975 meeting. It has been charged with responsibility for identifying the issues which require AAMC attention and with assisting staff

in formulating AAMC positions. An AAMC position paper pertaining to HSA review of proposed uses of Federal funds under Title IV (Research) and Title VII (Health Manpower Training) of the PHS Act was submitted to HEW in August. Department of Teaching Hospitals' staff is now preparing a paper, for review by the Task Force, on the subject of tertiary care referral patterns and the relationship to geographic and health service area boundaries. Other than the one meeting of the Task Force, held in May, the input from and the assistance of the Task Force has been minimal. In addition, there has been relatively little response from either teaching hospitals or medical schools with regard to our communications.

OPTIONS

1. The Association could convene a series of regional conferences for the purpose of educating its constituency on the planning law. Such a conference would serve to furnish the participants with information about the implementation process and the mechanisms by which they might influence its development. Although it may be somewhat late to initiate this activity, it is nonetheless important to make the schools and teaching hospitals aware of the law's consequences. Another drawback of this option is that it is difficult to say how implementation would be handled in each area. Guidelines and regulations are to be developed by HEW but the "action" takes place locally. It is questionable how much assistance the AAMC can provide at this juncture. However, by next spring there may be enough material available to warrant regional conferences.

2. A session could be developed and put on in conjunction with the deans' meeting in April. The purpose of this session would be to provide some information on the status of the law and determine if there are any specific problems occurring in any area.

3. The Association could maintain its present level of activity if it was determined that the schools and hospitals were already aware of the implications of this law.

FINANCING EDUCATION IN THE AMBULATORY CARE SETTING

ISSUE:

What actions are available to the AAMC for purposes of relieving the operating deficits of teaching hospital ambulatory care programs?

BACKGROUND:

Teaching hospital based outpatient departments have long been characterized as the principal financial "loss leader" of the academic health center enterprise. A number of reasons have been set forth as causes for this situation. Among the more frequently stated causes are:

1. Private and public insurance and payment programs provide poor or nonexistent benefit coverage for ambulatory services;

2. Patients who are attracted to hospital outpatient departments frequently have no insurance coverage and are unable to pay for services;

3. Involvement of house officers and medical students in the delivery of ambulatory medical care reduces productivity, thus raising the "per visit" cost to the point where it is not fully reimbursable;

4. The added educational costs, coupled with the productivity factor stated above further compounds the problem.

The current economic climate as well as the emphasis on educational programs in the ambulatory setting have served to raise this issue to the forefront in the priority of problems institutions are facing. State Medicaid programs are experiencing severe financial problems resulting in a lowering of eligibility standards (or at best, failing to raise them) and a "tightening" or "freeze" on reimbursement. Further, there has been substantial pressure, and subsequent institutional commitment, to provide a greater amount of educational experience in ambulatory settings to produce more primary care physicians. Generally, these commitments have been made without sufficient attention to longer-range financial consideration. For example, under the Manpower Act of 1971, a large number of family practice residency programs are being supported by Federal grant awards. In the absence of such awards, these programs probably could not financially survive.

The financing of all educational programs in the ambulatory setting is a difficult problem, and one which has not received the attention it deserves. Facing continuing large deficits in the operation of their ambulatory services, and diminishing ability to cover these losses from other revenue sources, teaching hospitals cannot significantly expand their ambulatory educational and service programs without adequate reimbursement for them.

OPTIONS:

1. The magnitude of the problem is not well understood. A first step could be a survey of COTH members in order to determine the extent to which member hosptials are experiencing this problem.

2. A thorough analysis could be undertaken of various reimbursement arrangements, fully identifying all costs, including educational costs.

3. The project to upgrade and restructure outpatient departments presently being conducted by the Department of Health Services could be utilized as a vehicle for generating analysis and publication of papers highlighting the problem.

4. At each and every opportunity, priority attention could be focused on this issue. Such opportunities should include testimony on national health insurance, manpower and other issues, as well as when commenting on major study efforts such as those undertaken by the Institute of Medicine and the RAND Corporation.

5. The AAMC could consider taking the following positions on the issue:

a) full support of ambulatory care benefits in all private and public insurance and payment programs;

b) support incremental educational costs as an educational "add on" for ambulatory service reimbursement;

c) explore the possibility of utilizing methods of allocating educational costs away from the outpatient department;

d) consider supporting the following amendment to the Social Security Act which has been recommended by the chief executives of some New York City teaching hosptials:

> To amend the Social Security Act or provide for the reimbursement of losses from ambulatory and emergency health services.
>
> Sec. 102. Section 1902(a)(13)(D) of the Social Security Act is amended by adding after "XVIII" the following:
>
> "provided, however, the the reasonable costs of inpatient hospital services shall include the net loss incurred by a provider of services in rendering ambulatory and emergency health serivces in any state which has required that such loss be included in all such payment rates for inpatient hospital services that are regulated by that state, and further provided that, to the extent of such net loss, the reasonable cost of inpatient hospital services may exceed the amount which would be determined under section 1861(v)"

Sec. 102. Section 1905 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(l) For the purposes of paragraph (13)(D) of Subsection 1902 subsection(a), the term 'new loss incurred by a provider of services in rendering ambulatory and emergency health services' means the difference, if any, between the reasonable costs of ambulatory and emergency services (exclusive of referred ambulatory, employee and courtesy services) rendered to all patients who require such services and the revenues received from all patients for such services."

HOSPITAL FISCAL INDICATORS

It was suggested at the Officers' Retreat that the Association should develop indices of the fiscal health of the institutions it represents. It was recommended that trend data be gathered for teaching hospitals on indices such as debt structure, accounts receivable, endowment principal and income and other items. The American Hospital Association is providing data from the annual survey which will be of some assistance. Following is a quick and brief discussion outline of those fiscal indicators which might be useful if we are to move ahead with the project. It is recognized that for many governmentally owned and operated teaching hospitals as well as V.A. hospitals, these statistics are inappropriate or unavailable.

For the most part hospital financial analysis can employ the same set of tools utilized in examining other corporate enterprises. These tools are the ratios constructed primarily from the firm's balance sheet and the statement of revenues and expenses. However, some modification is required. For example the stability of gifts, grants, and appropriations must be examined as well as income from the provision of patient services.

The following sets of ratios, drawn from two separate studies are indicators of such financial health:

Liquidity Ratios: Liquidity ratios reflect the hospitals' ability to meet its short-term liabilities. These ratios include:

1. Current ratio = CA/CL, or current assets divided by current liabilities;

2. Quick ratio = (CA-Misc-Inv)/CL, or current assets minus miscellaneous current assets minus inventories, divided by current liabilities;

3. Acid Test ratio = (CA-Misc-Inv-AR)/CL, or current assets minus miscellaneous current assets minus inventories minus accounts receivable, divided by current liabilities;

4. Average number of days revenues in accounts receivable;

5. Short-term borrowing for working capital.

Leverage Ratios: These ratios reflect the hospitals' long-term debt requirements and include:

6. Debt ratio = LTL/(LTL + FB), or long-term liabilities divided by the sum of such liabilities and the fund balance;

7. Coverage of fixed charges ratio = (NPI + Dep)/(Interest + Principal), or the sum of net patient income and depreciation divided by the sum of current interest and current principal payments.

Composition Ratios: These ratios reflect how total assets are divided among various asset categories and are particularly useful in combination with other ratios. These include:

8. Current asset composition ratio = CA/TA, or current assets divided by total assets;

9. Fixed asset composition ratio = FA/TA, or fixed assets divided by total assets;

10. Inventory composition ratio = Inv/CA, or inventory divided by current assets;

11. Accounts receivable composition ratio = AR/CA, or accounts receivable divided by current assets;

12. Cash composition ratio - Cash/CA, or cash divided by current assets.

Activity ratios: Activity ratios indicate the extent to which assets are used to operate the hospital;

13. Total asset turnover = PR/TA, or patient revenue divided by total assets;

14. Fixed asset turnover = PR/VA, or patient revenue divided by fixed assets;

15. Current asset turnover = PR/CA, or patient revenue divided by current assets;

16. Inventory turnover = PR/Inv, or patient revenue divided by inventories;

17. Accounts receivable turnover = PR/AR, or patient revenue divided by accounts receivable;

18. Cash turnover = PR/Cash, or patient revenue divided by cash;

19. Average collection period = AR/(PR/365 days), or accounts receivable divided by average daily patient revenue;

Profitability ratios:

20. Net operating profit margin = NPI/PR, or net patient income divided by patient revenue;

21. Rate of return on total assets = NPI/TA, or net patient income divided by total assets.

22. Self-Sufficienty = Total operating margin/Total revenue, where total operating margin = Total revenues - Total operating expenses

Endowment Indicators

23. Restricted and unrestricted principal;

24. Restricted and unrestricted endowment income;

Both of these items could be stated as percentages of total or plant assets and total or patient revenue respectively.

Plant Liquidation Ratio: This ratio shows the extent to which depreciation is being "funded";

25. Accumulation = replacement funds/debt adjusted building depreciation.

Data for all of these ratios can come, for the most part, from the hospitals' balance sheets and statements of revenues and expenses. Ideally, data should be for a five to ten year period. However, some inferences concerning financial health can possibly be made for as short as a two-year period.

Dr. James Bentley will be joining the COTH staff on March 1, 1976.

CURRICULUM VITAE

JAMES DANIEL BENTLEY, Ph.D.

PRESENT POSITION: Lieutenant, Medical Service Corps, U.S. Navy
Acting Research Director and Assistant Professor
Naval School of Health Care Administration
Bethesda, Maryland 20014
(February, 1971 to present)

Teaching Assignment:

Responsible for the development and presentation of undergraduate courses in the following subjects:

A Survey of Health Care Organization
Quantitative Methods in Health Care Administration
Analysis in Health Care Administration
Medical Sociology

Research Assignment:

Responsible for the direction and management of an administrative research unit whose primary objectives are: (1) to increase understanding of the variables which underlie and influence the delivery of health care services in the Navy, (2) to conduct problem-oriented studies designed to improve the efficiency and effectiveness of the organization and management of the Navy's health care system, and (3) to provide consulting services in management analysis to the Bureau of Medicine and Surgery of the Navy.

Personnel Supervised:

Three Research Associates
One Clerk/Typist

Funding (military salaries included):

Fiscal Year 1975--$66,000
Fiscal Year 1976--$95,000

OFFICE: Naval School of Health Care Administration
Bethesda, Maryland 20014
(301) 295-1467 or 295-0084

HOME: 12653 English Orchard Court
Wheaton, Maryland 20906
(301) 946-7805

PAST POSITIONS:

Associate Professorial Lecturer
Department of Sociology
The George Washington University
Washington, D.C. 20006
(January, 1973 to August, 1975)

Assistant Professorial Lecturer
Program in Health Care Administration
College of General Studies
The George Washington University
Washington, D.C. 20006
(September, 1971 to May, 1972)

Administrative Resident
Department of Mental Health
State of Michigan
Lansing, Michigan and Caro, Michigan
(January, 1967 to June, 1967)

EDUCATION:

Graduate

Received Doctor of Philosophy degree from the Horace H. Rackham School of Graduate Studies, The University of Michigan, Ann Arbor, Michigan, May, 1971.

Major: Medical Care Organization
Minor: Sociology
Thesis: "The Effect of Achieved and Ascribed Characteristics on Referrals and the Allocation of Medical Staff Positions in a Physician Community"

Undergraduate

Received Bachelor of Arts degree (with High Honors) from the Honors College, Michigan State University, East Lansing, Michigan, September, 1967.

Major: Health Facilities Management
Minor: Accounting

Continuing

"Trustee, Administrator, Physician Institute," Sponsored by the Joint Commission on the Accreditation of Hospitals, April, 1975.

"Critical Issues in Managing a Comprehensive Prepaid Health Care Organization," Sponsored by the American College of Hospital Administrators, October, 1974.

"HMO Cost Forecasting and Financing," Sponsored by the American College of Hospital Administrators, September, 1974.

"Alternative Organizations for Comprehensive Prepaid Health Care," Sponsored by the American College of Hospital Administrators, September, 1974.

"UCLA BMD Statistical Computer Programs," Sponsored by CACI, Inc, June, 1974.

"Current Trends in Health Care Administration," Sponsored by the U.S. Army Academy of Health Sciences, April, 1974.
"Current Trends in Health Care Administration," Sponsored by the U.S. Army Academy of Health Sciences, April, 1973.

AWARDS AND HONORS:

Comptroller of the Navy Letter of Appreciation (September 6, 1974)

Comptroller of the Navy Letter of Appreciation (May 13, 1974)

Surgeon General of the Navy Letter of Recognition (January, 1973)

Listed in Outstanding Young Men in America (1973 Edition)

U.S. Public Health Service Traineeship (August, 1967 to January, 1971)

Member, Pi Kappa Psi Honorary Society (Initiated May, 1967)

Schlitz Foundation Award for Academic Achievement (May, 1967)

Brunswick Foundation Award for Academic Achievement (May, 1966)

Statler Foundation Scholarship (May, 1966)

Michigan Nursing Home Association Scholarship (May, 1966)

PROFESSIONAL INTERESTS:

Studying the constraints on contemporary American government which limit the extent to which the government can effectively finance or provide personal services (health care, education, and welfare).

Studying the impact of changes in social institutions on the role of health service programs and facilities.

Developing performance measures at the departmental, institutional, and program levels for personal and community health services.

Studying the social organization of physician communities.

AFFILIATIONS:

Member, American Public Health Association
Member, Medical Care Section
Member, 1975 Annual Meeting Program Committee for the Medical Care Section
Chairman, 1975 Annual Meeting Session on "Alternatives to the Malpractice Dilemma"
Chairman, 1975 Annual Meeting Session on "Studies of the Quality and Costs of Health Care"

Associate Member, Operations Research Society of America

Member, Washington Operations Research Council

Member, Military Operations Research Society

MILITARY SERVICE:

Appointed--Ensign, Medical Service Corps, U.S. Naval Reserve (Inactive), July, 1968.

Appointed--Lieutenant, Medical Service Corps, U.S. Naval Reserve, January, 1971.

Augmented into the Regular Navy, August, 1973.

PUBLICATIONS:

Bentley, James D. "Using Cost Curves to Limit Decision Space," Proceedings of the Military Operations Research Society. Arlington: Military Operations Research Society, 1975.

Pointer, Dennis D.; White, Robert L.; and Bentley, James D. "The Composite Work Unit: A Critical Analysis," U.S. Navy Medicine, LXII (January, 1974), 17-20.

Bentley, James D. "Camels or Horses: Suggestions for Improving Committees," U.S. Navy Medicine, LIX (May, 1972), 34-38.

RESEARCH REPORTS

Bentley, James D. and Ambrose, Donald M. "A Population Data Base for the Navy Health Care System," NSHCA Research Paper No. 26. September, 1975. (Mimeographed).

Ambrose, Donald M. and Bentley, James D. "Entitlements to Care in the Navy Health Care System," NSHCA Research Paper No. 25. August, 1975. (Mimeographed).

Bentley, James D. and Ambrose, Donald M. "Performance Factors for Navy Medical Programs: The CNO/CMC Perspective," NSHCA Research Paper No. 24. August, 1975. (Mimeographed).

Hetrick, John; Kunkel, Clyde; McGann, Dennis; Randle, Ken; and Bentley, James. "Data Base on NNMC Manual Appointment System: Statistical Data Base Report," NSHCA Research Paper No. 23. June, 1975. (Mimeographed).

Hetrick, John; Kunkel, Clyde; McGann, Dennis; Randle, Ken; and Bentley, James. "Data Base on NNMC Manual Appointment System: Analytical Models of the System," NSHCA Research Paper No. 22. May, 1975. (Mimeographed).

Elkins, Bryan R. and Bentley, James D. "Summary of Literature Review: CHAMPUS-Service Area Study," NSHCA Research Paper No. 19. January, 1975. (Mimeographed).

Elkins, Bryan R. and Bentley, James D. "Financial Disincentives to Medical Care," NSHCA Research Paper No. 18. January, 1975. (Mimeographed).

Ambrose, Donald M.; Redd, Ray D.; Bentley, James D.; and Montgomery, John E. "An Analysis of the Average Cost Per Ration in Naval Hospitals, FY1970-1973: An Empirical Model," NSHCA Research Paper No. 16. January, 1975. (Mimeographed).

Bentley, James D. "HMO Enrollment: A Very Expensive Option," NSHCA Research Paper No 14. April, 1974. (Mimeographed).

Pointer, Dennis D.; White, Robert L.; and Bentley, James D. "Ambulatory Care Cost Functions in Naval Outpatient Departments: An Empirical Model," NSHCA Research Paper No. 10. December, 1973. (Mimeographed).

Pointer, Dennis D.; White, Robert L.; and Bentley, James D. "The Composite Work Unit as a Resource Allocator: A Critical Analysis," NSHCA Research Paper no. 8. Novmeber, 1972. (Mimeographed).

Pointer, Dennis D.; White, Robert L.; and Bentley, James D. "Workload Measurement in Naval Hospitals: An Initial Discussion," NSHCA Research Paper No. 7. October, 1972. (Mimeographed).

Pointer, Dennis D.; White, Robert L.; and Bentley, James D. "Towards the Development of a Valid Medical Activity Measure: Theoretical Foundations," NSHCA Research Paper No. 6. August, 1972. (Mimeographed).

Pointer, Dennis D.; Bentley, James D.; and White, Robert L. "Toward Defensible Navy Physician Manning Alternatives: Bases for BUMED Policy," NSHCA Research Paper No. 5. July, 1972. (Mimeographed).

Bentley, James D. and White, Robert L. "Physician Requirements for the Navy Medical Department," NSHCA Research Paper No. 4. May, 1972. (Mimeographed).

PERSONAL BACKGROUND AND INTERESTS:

Birthplace: Jamestown, New York

Date of Birth: February 17, 1945

Marital Status:

Married Lorraine Kay Anderson, June 17, 1967.

Wife presently on leave of absence from Montgomery County Department of Public Libraries.

Children:

Kimberly Ann Bentley, born January 1, 1975.

Health Status: 5'8", 180 lbs., excellent condition

Community Activities:

St. Luke Lutheran Church, Silver Spring, Maryland
Member, Church Council
General Chairman, Commission on Enlarged Facility
Teacher, SUPERTUESDAY Teen Program
Chairman, Committee on Emergency Planning

Prepared: September 15, 1975

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

December 23, 1975

Thomas M. Tierney
Director
Bureau of Health Insurance
Department of Health, Education
and Welfare
Social Security Administration
Baltimore, Maryland 21235

Dear Mr. Tierney:

The purpose of this letter is to object formally to the implementation of the exception processes as required by Section 405.460(f) and stipulated in Section 223 of P.L. 92-603.

To the best of our knowledge, the Bureau of Health Insurance (BHI) has to date officially distributed only one exceptions procedure: "Adjustment Amounts Due to the Cost of Approved Intern and Resident Programs," Intermediary Letter No. 75-50. The Intermediary Letter, mailed in September 1975, allows an institution to adjust its ceiling limit because of "atypical costs" due to medical education programs. AAMC comments on this procedure were outlined in my letter of August 5 to John Jansack. Our objections were largely ignored, and we continue to oppose the method of establishing the level at which medical education costs are determined to be subject to the exception procedure.

It is apparent that BHI has utilized additional types of methodologies and computational techniques to review and oftentimes adjust a hospital's limit. For example, one particular institution received an adjustment due to atypical labor costs based upon a formula which identifies the differences in wage levels between two adjacent areas. A "formula" such as this, while not necessarily the recommended method, should be published for review and comment and formally distributed by BHI so as to be made available to all providers. Consequently, the Association strongly recommends that the Bureau immediately take the proper steps to inform all hospitals of this and other existing methodologies. The AAMC has been informed by BHI staff members that exception methodologies for malpractice costs and utility expense have been developed and are being utilized in granting individual hospital requests. Again, if such methodologies are in use they should be made available for review and comment, and published for use by all institutions.

A similar situation exists in the use of "geographic location" for reclassification. Section 405.460(f)(1) allows a provider to change its classification "on the basis of evidence that such classification is at variance with the criteria. . . " One hospital, we understand, was granted an exception because the land on which it is located is "contiguous to the boundary line" of an adjacent SMSA with a higher limit. If the Bureau is going to utilize such "evidence" as a basis for allowing exceptions and changes in classifications, there is an obligation and requirement to formally publish and distribute the "criteria." Therefore, the AAMC recommends that you take such steps promptly.

The basis upon which BHI has reviewed exception requests, either formally or informally, fails to set forth methods to consider real and meaningful factors which affect routine service costs but are not reflected in the promulgated schedule or in the individual consideration appeal process. These elements of cost are in addition to the case mix and scope of service factors, and are as follows:

1. security provisions related to the environment within which the hospital is located;

2. malpractice costs;

3. wage variation due to intensive union activity not reflected in the per capita income variation;

4. variations in energy costs due to climate considerations and regional price variation;

5. nursing education costs;

6. amortization of capital expenditures through debt service and depreciation;

7. shortened length of stay (in response to government and other third party payers) results in more concentrated nursing care and other services for the time the patient is hospitalized and therefore higher (compressed) daily routine service costs.

We find extremely disconcerting the Bureau's haphazard and unresponsive procedures for processing exception requests. Hospitals are being told by BHI staff that "until the basic reason for an exception is set forth we (BHI) cannot determine what statistics are required nor the best source of these data." Yet, the very purpose of the hospitals' requests are to determine what BHI expects from and requires of the hospitals in order to substantiate exception requests. The attached letter from Robert Derzon, Director, University of California Hospitals and Clinics to Michael Maher is an example of the difficulties created by the poor handling of exceptions requested to date.

Mr. Thomas M. Tierney
December 23, 1975
Page Three

In a November 10 letter to George Thompson, Director of Finance, University of California Hospitals, Mr. Maher stated the following:

> Our review of exception requests to date has shown two major problem areas. First is classification of costs which according to Medicare Principles of Reimbursement should be ancillary costs as routine. The second concerns what is apparently excess staffing resulting in abnormal costs.

Since "excess" staffing resulting in "abnormal" costs have been identified, one infers "normal" costs and staffing patterns must be available. Given this inference, BHI has an obligation to make such norms available to all hospitals so that each institution may utilize them in determining whether an exception request is appropriate.

It is imperative that the Bureau of Health Insurance begin addressing the problems presented in this letter. I shall look forward to hearing from you, and would appreciate the opportunity to discuss these matters with you and members of your staff.

Sincerely,

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

RMK:car

Enclosure

cc: Raymond del Rosso

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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HOSPITALS AND CLINICS
OFFICE OF THE DIRECTOR

SAN FRANCISCO, CALIFORNIA 94122

December 12, 1975

Mr. Michael Maher
Assitant Bureau Director
Division of Provider Reimubrsement
and Accounting Policy
Bureau of Health Insurance

Dear Mr. Maher:

Thank you for your letter of November 10, 1975 (received November 17, 1975) which was written in response to our letters of August 15, September 9 and October 3, 1975. Unfortunately, your response does not adequately answer the questions raised in these letters, nor did our meeting of September 8, with Mr. Jansak of your staff, provide us with the basic information we must have to prepare an exception request under the guidelines established in Section 223 of PL 92-603.

On June 30, 1975, we notified Blue Cross of our intention to file an exception request and asked that Blue Cross officials forward all pertinent information necessary to the preparation of such a request within seven days. Subsequent to that time we have met with Blue Cross, sent staff on an expensive and time consuming trip to Baltimore, exchanged a variety of phone calls and letters with your office, and we are still left with major and unresolved areas of concern.

1. In our letter of September 9, we asked for listings of all hospitals that have ever requested an exception to the routine cost limit. No such listing was received.

   a. Do you have such a listing?

   b. Can a copy be forwarded to us as soon as possible?

2. In your response you did include a copy of BHI's response to certain exception requests.

   a. Did this represent all of the responses prepared by your office as of November 10, or simply a selected sample?

   b. If other responses do in fact exist, could they please be forwarded to my office?

3. Accompanying your memo you did forward a listing of hospitals within requested cell groupings by provider number. While it is unfortunate that actual names were not provided, we have subsequently found sources which we can use to translate the provider numbers to appropriate hospital names. However, the listing was not accompanied by any explanation of how the rank number and per diem rates were established.

   a. What do each of the column headings reflected on the listing in fact mean?

   b. How were the ranking numbers, per diem rates, days and costs established? What was the source of the data, what was the year or period upon which the data was accumulated. Were those costs then projected forward to the fiscal year 1975-76? If so, what was the basis for the projection?

   c. It is our understanding from Mr. Jansak that the review of our exception request will include a comparison of statistics for hospitals within our cell. Is this true, and if so, to what hospitals in the grouping will we be compared? To the average of all hospitals, or to those who fall into some selected percentage? If the rankings and per diem rate is in fact projected on the basis of previously gathered statistics and if this projection subsequently turns out to be erroneous, to whom will we then be compared? Will we be compared to the hospitals you anticipated would fall into a certain percentile per diem costs, or to those hospitals which actually turn out to fall into those percentiles? From what we are able to interpret from the listings it appeared that you anticipate UC San Francisco would fall under the reimbursement limit for 1975-76. However, we anticipate that we will certainly exceed the limit. Will you continue to consider us as being within the limit when reviewing other hospitals exception requests?

4. In response to our request for a description of the rationale which would be used to evaluate the University of California hospitals' exception request, you indicated you could not determine what data would be required until you had seen the basic reasons for exception. In our memo of August 15, 1975, we specifically set out the areas which we anticipated we would use in justifying an exception and requested specifically what statistics or guidelines would be used to evaluate an exception request in each of these areas. We also asked if the required statistics would be provided to hospitals, or if not, would the costs of collecting such data be directly chargeable to Titles 18 and 19. We also questioned how, since the only comparative cost data available to hospitals is historical, will prospective exceptions be

granted to reflect changing conditions, such as anticipated malpractice cost increases, patient mix, volume and new capital cost? How could such anticipated increases be determined and compared for hospitals in the SMSA? What inflationary factors were considered when establishing the current rates?

a. The above questions remain unanswered and we again request your response.

5. In addition to our request of August 15 for general information concerning exceptions related to salary differentials, my staff had several conversations with Mr. Jansak concerning the matter. Mr. Jansak originally indicated that his office would consider deviations because of average salary per FTE (as reflected in the cost reports) as justification for an exception. Mr. Jansak now indicates this is in fact not the case. We would specifically request your response as to whether or not salary differentials will be considered as basis for an exception and if so, what statistics will be required to demonstrate that the salary differentials that exist in a particular area are greater than was provided by the original limits.

6. In our letter of August 15, 1975, under "I-e, Pricing Methodology," we indicated that the University of California Hospitals include in routine service many central supply and pharmaceutical items which in other institutions are separately charged to the patient. We instituted this practice to reduce actual billing costs and we are reluctant to reverse this practice. Mr. Jansak verbally indicated in our meeting of September 8 that it would be appropriate to reclassify those costs normally charged for in other institutions from routine to ancillary items on the annual cost report.

a. Please confirm in writing that such a reclassification is allowed so that we may use it to resolve any questions the Medicare auditors may have concerning this.

7. In our letter we requested average salary per FTE for the hospitals within several cell groupings. This data was provided along with a statement that it had been computed from information contained in the most recent cost report available and did not necessarily represent the same time period for all hospitals. Without the availability of of comparable data from the same time period, the data you provided becomes meaningless. Is more precise data available?

8. In order that we may perform our own analysis of costs for hospitals in our cell and accumulate information necessary to the development of an exception request it is requested that the most recent cost reports available for all hospitals in our cell be forwarded to my office.

Mr. Maher, it is hoped that precise and definitive answers to the above questions as well as the statistical information requested can be forwarded to my office within the next ten days. I have become increasingly discouraged with BHI's lack of responsiveness in assisting our Hospital in gaining the basic information necessary to the preparation of exception request. It is clear from reviewing the many comments from legislative and judicial arms of our government that it is fully intended that an effective and meaningful exception process should and does exist for recognizing situations not adequately covered in the basic limits. Based on our experience to date, it would appear that the intent in fact, is not being adequately implemented.

Robert A. Derzon
Director, Hospitals and Clinics

RAD:jls

cc: George Thompson
Jacqueline Kuhn

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

REFER TO:
IHI-324

NOV 21 1975

Mr. Fred V. Amundsen
Medicare Audit Department
Massachusetts Blue Cross
P.O. Box 2194
Boston, Massachusetts 02116

Dear Mr. Amundsen:

This letter is in further reference to our previous communications concerning the request by the New England Medical Center Hospital (NEMCH) for an exception to the application of section 223 of Public Law 92-603 as provided under section 405.460, paragraph (f) of Chapter III, Title 20 of the Code of Federal Regulations. We have considered NEMCH's request for exception from the 1975 hospital cost limits and have reviewed the information which you and NEMCH staff have furnished. Our review of the entire record available to us has resulted in the following conclusions.

Intensity of Nursing Care

NEMCH supplied data to show the high ratio of complicated cases and sophisticated surgical procedures at NEMCH as compared to hospitals reporting to the Massachusetts Hospital Association Utilization Information Service (UIS). However, NEMCH has not established that the high ratio of complicated cases and sophisticated surgical procedures does have any effect on routine service costs. Also, NEMCH has not identified the additional nursing hours or the increased routine service costs which they allege are a result of the atypical case mix. This is important as a comprehensive study conducted by the American Hospital Association Nursing Activity Study (in 1966) found that there was no significant difference in routine nursing hours per patient day between university or university-affiliated hospitals and others. As NEMCH has failed to submit any evidence to support its allegation, we find it necessary to deny NEMCH's request for an exception based on intensity of nursing care.

Unemployment and FICA Expense

NEMCH has indicated that unemployment and FICA expense increased 24 percent from 1974 to 1975.

As you are aware, an annual adjustment factor of 10.5 percent was included in the limits to reflect estimated cost increases. Although the wage base and tax rate for FICA have increased, the aggregate increase is less than the rate of increase built into the limits. Therefore, we find it necessary to deny the portion of the request for exception based on an extraordinary expense for unemployment and FICA expense as the regulations allow exceptions only for high costs resulting from actions beyond the provider's control and not from controllable actions such as increasing the number of employees on the payroll.

Interest on Working Capital

NEMCH has indicated that interest on working capital increased 19 percent from 1974 to 1975.

Regulation 405.460 permits an exception to the cost limits only where a provider's costs exceed the limits because of the provision of atypical services and extraordinary circumstances beyond the control of the provider. Increases in interest on working capital do not meet either of the criteria. Therefore, we find it necessary to deny this portion of the request.

Malpractice Insurance

We have reviewed the malpractice premium crisis and have concluded that significant increases in malpractice premiums are the result of extraordinary circumstances and could be allowed as an exception to the cost limits under section 405.460 (f) (3). For this reason, we are authorizing an interim adjustment rate for that portion of malpractice insurance that exceeds the 10.5 percent increase, but only to the extent that such increase is applicable to inpatient general routine costs. Therefore, you are authorized to adjust NEMCH reimbursement based on the following methodology:

Example

Malpractice Premiums Related to Hospital Care

1974	1975	Increase
$ 123,000	$ 450,000	$ 327,000

$ 123,000
x 110.5 — 100% + estimated cost increase included in the cost limit
$ 135,915 — Amount included in limit

$ 450,000 — Estimated 1975 costs
-135,915
$ 314,085 — Excess amount
50% — Percentage allocated to routine as other A & G (to be computed)
157,042 — ÷ 122,000 Estimated Patient Days = $1.22 Adjustment

Utilities - Fuel and Electricity Only

NEMCH supplied data that showed utility expenses have increased 25 percent from 1974 to 1975. For the same reason that an exception to the cost limits can be allowed for malpractice insurance premiums, we will allow an adjustment to the cost limits for that portion of fuel and electricity expenses that exceed the 10.5 percent increase, but only to the extent that inpatient general routine costs are affected. To determine the per diem amount of the upward adjustment, apply the same methodology that will be used to compute the adjustment for malpractice insurance.

Professional Cost Center

We have examined the data supplied regarding the costs associated with the physician compensation and are approving an upward adjustment to the interim rate for that portion of physician compensation (basically related to atypical teaching activities) that affect inpatient general routine services. However, before a final adjustment is made, a review of the Professional cost center will be required to insure that allocation of the physicians' time is correct and the cost effect on routine services is accurately determined. Once that step is taken, the per diem adjustment can be computed by dividing that portion of physician compensation that is allocated to inpatient general routine services by the total number of inpatient general routine service days.

Intern and Resident Education Costs

An interim rate adjustment of $7.00 previously had been authorized by BHI for atypical education costs at NEMCH for interns and residents. Since this adjustment was based upon an earlier methodology, you are authorized to recompute the intern and resident adjustment on an interim basis using the methodology set forth in I.L. 75-50. As a special circumstance, resulting from our change in the method of computing this adjustment, the provider should be given the higher amount (either $7.00 or the result of your computation) as an adjustment for interns and residents. This applies only to this cost reporting period ending September 30, 1975.

Review of A & G Costs

You indicated in your letter that the analysis of the Administrative and General cost center has not been completed. Before a final adjustment can be made to the cost limits, a thorough review of the A & G expenses must be made to insure that such costs are reasonable. Please advise us of your conclusions. You should understand in this review that the burden for establishing the reasonableness of cost, as authorized by law, is on the provider. To the extent other A & G costs are found not to be reasonable, an offset must be made against amounts approved for exception.

We are authorizing you to make the adjustments indicated above on an interim basis, without further BHI review and to make whatever retroactive payment is appropriate. However, when the cost report for the reporting period ending September 30, 1975, is reviewed, care must be taken to assure that the interim adjustments are supported by the data on the cost report. Your recommendations for final exception amounts together with your calculations and the cost report must be submitted to BHI for approval as required by I.L. 74-22.

Sincerely yours,

Manuel Levine
Acting Deputy Director
Program Policy
Bureau of Health Insurance

Bulky Background - See Branch Files

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

REFER TO:
IHI-324

NOV 18 1975

Mr. Fred V. Amundsen
Manager, Medicare Audit Department
Blue Cross/Blue Shield of Massachusetts
P.O. Box 2194
Boston, Massachusetts 02106

Dear Mr. Amundsen:

This is in response to your letter concerning the request by University Hospital (UH) for exception to the application of cost limits as provided under 20 CFR 405.460(f)(2) for the cost reporting period ending September 30, 1975.

UH appears to be requesting an exception for all its costs that are in excess of the limits and is supporting this request by general statements that it is a major teaching hospital, whereas most hospitals in its comparison class are primarily community hospitals, and (1) incurs related education costs, (2) provides extensive peer review and quality of medical care studies through the Utilization Review Committee and as a result of this vigilance there are fewer days of care over which to spread routine costs, and (3) specializes in certain types of adult medical-surgical services providing an extremely high intensity of nursing services.

As explained in the regulations, the limits apply to the costs of hospital inpatient general routine services. These limits do not apply to the cost of special care units, ancillary services or outpatient services or, of course, to the cost of research. Thus, high costs associated with these services are not relevant to a determination of whether general routine service costs are atypical. For this purpose atypical costs are necessary and proper costs not generally incurred or generally incurred to a substantially lower degree by other hospitals in the comparison group.

In regard to the hospital's allegation that it is being compared with community hospitals, approximately two-thirds of the hospitals classified in the group with UH (State Group II, 265 to 404 beds) have teaching programs, and in Massachusetts alone approximately 80 percent of the hospitals so classified have teaching programs. The large percentage of teaching hospitals included in this group does not support UH's claim that it is being classified with hospitals that are not similar. Consequently, the real issue is not comparing teaching hospitals with nonteaching hospitals, but to what extent does UH provide appropriate teaching programs that require them to have routine costs that the other hospitals with which it is compared do not.

In regard to its claim that it incurs educational costs above that of other hospitals in its group, we previously advised you that an adjustment of $3.27 was appropriate for intern and resident education. The $3.27 adjustment was based on data that you supplied on May 12, 1975, indicating there were 99 full time equivalent (FTE) interns and residents. Subsequently, data supplied by you showed that there were only 92 FTE interns and residents. Since the provider has been advised, we will in the interest of equity, approve a final adjustment of $3.27 for intern and resident education. In the future, any adjustments should be made pursuant to the provisions of Intermediary Letter 75-50 (copy enclosed).

UH contends that they are committed to extensive peer review and quality of medical care studies, and that this program has resulted in fewer days of care over which to spread the routine costs. Since both the accreditation requirements of the JCAH and the certification requirements under Medicare require all hospitals to have such programs, it would appear UH has not acted differently from other hospitals.

In addition UH has requested an exception based on intensity of nursing care resulting from an atypical patient mix. In support of this claim, UH has submitted data showing that their patient mix differs from that of other Massachusetts hospitals. However, they have identified neither the additional nursing hours nor the increased costs which they allege are the result of this atypical case mix. Moreover, the American Hospital Association Nursing Activity Study (conducted in 1966) found that there was no significant difference in nursing hours per patient between university or university-affiliated hospitals and others. Because the provider has failed to submit any evidence to support its allegation, we find it necessary to deny the provider's request for an exception based on intensity of nursing care. This decision is subject to reconsideration if the provider submits evidence demonstrating routine cost effects of its atypical patient mix.

In reviewing the exception request, we carefully analyzed the provider's cost report and the following areas in UH's September 30, 1974, cost report appear to be questionable. The cost report shows depreciation costs are allocated on the square footage ratio of the extended care unit versus the hospital (84.4 percent hospital - 15.6 percent ECU). Yet the depreciation expense being allocated does not follow this ratio (90.2 percent hospital - 9.8 percent ECU). This error increases the depreciation expense to the hospital by approximately $3 per patient day and the routine cost by approximately $1.50 per patient day. In addition, we note that on Worksheet B, column 1a $48,195 of ECU depreciation costs appear to be incorrectly allocated to the hospital inpatient cost center. As you are aware, any errors found in the allocation of depreciation will affect the allocation of A & G costs. Also, UH shows a separate break out of A & G costs not applicable to research. Has this methodology been determined to be reasonable and approved by the intermediary?

The provider also has an Infections and Quality Control Cost Center and allocated the costs only to routine areas. This allocation base appears unacceptable because no costs have been allocated to ancillary areas or outpatient cost centers.

Our review of the intern and resident allocation shows no allocation to ancillary services except to the operating room. However, a review of the AMA Directory of Approved Residencies 1974 - 1975 edition shows that UH has residency positions available in the following ancillary departments: Diagnostic Radiology, Pathology, Physical Medicine and Rehabilitation and Therapeutic Radiology.

All questionable areas of cost and cost allocation should be carefully examined by your office before any additional relief from the cost limits is authorized under the regulations.

We are authorizing you to make the adjustments indicated above, on an interim basis, without further BHI review and to make whatever retroactive payment is appropriate. However, when the cost report for the reporting period ending September 30, 1975, is reviewed, care must be taken to assure that the interim adjustments are supported by the data on the cost report. Your recommendations for final exception amounts together with your calculations and the cost report must be submitted to BHI for approval as required by I.L. 74-22.

Sincerely yours,

Manuel Levine
Acting Deputy Director
Program Policy
Bureau of Health Insurance

Enclosure
cc: Regional Representative, HI
Boston

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

REFER TO:
IHI-324

DEC 10 1975

Mr. Thomas P. Knight
Manager
Provider Reimbursement and Audit Division
Blue Cross of Northern California
1950 Franklin Street
Oakland, California 94659

Dear Mr. Knight:

This is in response to your letter concerning the request of St. Joseph's Hospital (SJH) for exception to the application of cost limits as provided under 20 CFR 405.460.

As explained in the regulations, the initial schedule of limits applies to the costs of hospital inpatient general routine service. These limits do not apply to the cost of special care units, ancillary services or outpatient services or, of course, to the cost of research. Thus, high costs associated with these services are not relevant to a determination of whether general routine service costs are atypical. Atypical costs are necessary and proper costs not generally incurred or generally incurred to a substantially lower degree by other hospitals in the comparison group.

SJH is requesting a reclassification under regulation section 405.460(f)(1) on the basis that its costs and services provided are comparable to California hospitals of similar size located in Group I Standard Metropolitan Statistical Areas. Since regulation 405.460(f)(1) provides for a reclassification only if a provider's classification is at variance with the specified criteria, we are not able to approve St. Joseph's request for reclassification.

In order to obtain an exception to the cost limits under regulation section 405.460(f)(2), St. Joseph's must demonstrate that it incurs high costs because it provides items or services that are atypical in nature and scope as compared to the services generally provided by institutions similarly classified and appropriate reason exists for the provision of such items or services. Such adjustments may only be made where the provider

demonstrates (i) the provision of such atypical items or services is by reason of the special needs of the patients treated and necessary in the efficient delivery of needed health care, or (ii) the added costs flow from approved education activities. In addition, such adjustments may be made only to the extent that such justified costs are separately identified by the provider and can be verified by the intermediary.

The approach St. Joseph's must take to obtain an adjustment is to compare its costs to the costs of Group III hospitals and to demonstrate how it has atypical routine costs resulting from the special types of patients when compared to other providers in its group. The fact that a provider incurs higher costs than the comparison group is no reason for an exception.

SJH has attempted to compare itself with the providers in the group by the use of the Group Profile developed by the American Hospital Association based on the AHA Hospital Guide Issue 1974 Edition. That methodology compares a provider with all providers in its group in three categories, external variables, product-type variables and input type variables. We question the validity of the comparisons for cost limits purposes for the following reasons.

External Variables

The external variables are items such as per capita income, median family income and population density. The fact that St. Joseph's has variables higher than those for the group is not significant since under our system, the same limit applies to similar size hospitals located in SMSAs falling within a per capita income range. The limits were developed from the actual costs of all the hospitals in the group.

Product-type Variables

Product-type variables include such items as total facilities/services, advanced facilities/services, outpatient facilities/services, or surgical operations per day or admission.

These variables have not been shown to have a significant impact on routine costs, and, in fact, would seem to be a better reflection of costs in the special care, ancillary or outpatient cost centers. Patients with more complicated illnesses generally spend a considerable portion of their time in special care units, thus reducing the impact on costs incurred in the general routine service areas. Once a patient leaves the special care unit, the patient should require no greater degree of nursing care in the general routine area than a patient with a less complicated case.

3

Furthermore, the American Hospital Association Nursing Activity Study (conducted in 1966) found that there was no significant difference in nursing hours per patient between university or university-affiliated hospitals and others in spite of the fact that university or university-affiliated hospitals are presumed to have a more complicated case mix than otherwise comparable community hospitals.

Though we agree that a hospital with a more complicated patient mix should have a greater total cost per day than a hospital with a less complicated patient mix, it has not been demonstrated to us that a patient mix has a significant effect on <u>routine</u> cost per day.

<u>Input-type Variables</u>

Input-type variables are those over which the hospital has a considerable degree of control, such as nurses, assets, and interns and residents. In the first place, variables over which a provider has a large degree of control are subject to [illegible] and, as such, cannot be considered as a valid [illegible]

projected general routine service cost per day is only $2.73 above the limit (excluding consideration of the capital addition), careful analysis of these two seemingly high cost areas and any other cost components of routine service cost may result in a reduction of costs which may bring St. Joseph's below the limit and obviate the need for an exception.

The provider has indicated it is contemplating capital additions which it estimates will increase inpatient routine per diem by $7.33 in 1976.

Regulations section 405.460 does not allow an exception to the cost limits for costs associated with capital additions. The provider should be advised of this decision.

Sincerely yours,

Manuel Levine
Acting Deputy Director
Program Policy
Bureau of Health Insurance

cc:
Regional Representative, HI
San Francisco

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ADVANCE COPY

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

REFER TO:
IHI-324

December 1975

PART A INTERMEDIARY LETTER NO. 75-69

SUBJECT: Section 223 of P.L. 92-603, "Limitations on Coverage of Costs Under Medicare"—Classification of Hospitals Based on Standard Consolidated Statistical Areas (SCSA) for Cost Reporting Periods Beginning on or After July 1, 1975

General

A Schedule of Limits on Hospital Inpatient General Routine Service Costs was published on May 30, 1975, applicable to cost reporting periods beginning on or after July 1, 1975.

The revised classification system groups hospitals based on whether or not they are located in a Standard Metropolitan Statistical Area (SMSA) as established by the Office of Management and Budget (OMB). Hospitals in SMSAs are further classified on the basis of per capita income of the various SMSAs and on the basis of State per capita income for non-SMSA areas. The SMSA and non-SMSA groupings reflect the differing economic environments of various urban and nonurban locations.

New Standard Consolidated Statistical Areas

OMB has designated 13 areas containing one-third of the total population of the United States as "Standard Consolidated Statistical Areas" (SCSAs). The SCSA concept associates nearby SMSAs with a major metropolitan SMSA. Each of the new consolidated areas includes an SMSA with a population of at least one million, plus one or more adjoining SMSAs related to it by continuously developed high density population corridors and metropolitan commuting of workers. The attached schedule identifies each of the 13 individual SCSAs and its component SMSAs. The SCSAs are: Chicago-Gary, New York-Newark-Jersey City, Boston-Lawrence-Lowell, Cincinnati-Hamilton,

Cleveland-Akron-Lorain, Detroit-Ann Arbor, Houston-Galveston, Los Angeles-Long Beach-Anaheim, Miami-Fort Lauderdale, Milwaukee-Racine, Philadelphia-Wilmington-Trenton, San Francisco-Oakland-San Jose, and Seattle-Tacoma.

Application

When a hospital in an SCSA files a request for an exception to the cost limits, as authorized under regulation 405.460, you are authorized to apply the limit of the major SMSA in the SCSA group to determine whether an exception is necessary. However, where the cost limit for the major SMSA in the SCSA grouping is lower than the cost limit of the SMSA in which the provider is located (i.e., Philadelphia-Wilmington-Trenton SCSA), such providers will be permitted the higher cost limit for cost reporting periods beginning on or after July 1, 1975, and before the effective date of any revised schedule.

In the following SMSAs, cost limits may be applied as indicated below:

Beds	Less than 100	100 - 404	405 - 684	685 and above
Limit	$113	$111	$133	$174

SMSAs

California

Anaheim-Santa Ana-Garden Grove
Oxnard-Simi Valley-Ventura
Riverside-San Bernadino-Ontario
San Jose
Vallejo-Fairfield-Napa

Florida

Fort Lauderdale-Hollywood

Indiana

Gary-Hammond-East Chicago

New Jersey

Patterson-Clifton-Passaic
Long Branch-Asbury Park

Ohio

Akron
Lorain-Elyria

Wisconsin

Racine

3

Beds	Less than 100	100 - 404	405 - 684	685 and above
Limit	$91	$96	$96	$120

SMSAs

Ohio

Hamilton-Middletown

Texas

Galveston-Texas City

Washington

Tacoma

Thomas M. Tierney, Director
Bureau of Health Insurance

Attachment

SMSA GROUPING UNDER NEW OMB SCSA CLASSIFICATIONS

SCSA TITLE	SMSA Grouping (80th percentile limits) Group I	Group II	Group III	Group IV
Chicago-Gary-IL-IN	Chicago IL*		Gary-Hammond-East Chicago IN	
New York-Newark-Jersey City-NY-NJ-CT	1. New York NY-NJ* 2. Newark NJ 3. Jersey City NJ 4. Nassau-Suffolk NY 5. New Brunswick-Perth Amboy-Sayreville NJ 6. Norwalk CT 7. Stamford CT	Paterson-Clifton-Passaic NJ	Long Branch-Asbury Park NJ	
Boston-Lawrence-Lowell-MA-NH	1. Boston MA* 2. Brockton MA 3. Lawrence-Haverhill MA-NH 4. Lowell MA-NH			
Cincinnati-Hamilton OH-KY-IN		Cincinnati OH-KY-IN*		Hamilton-Middleto OH
Cleveland-Akron-Lorain-OH	Cleveland OH*	Akron OH	Lorain-Elyria OH	
Detroit-Ann Arbor-MI	1. Detroit MI* 2. Ann Arbor MI			
Houston-Galveston-TX		Houston TX*		Galveston-Texas Ci TX
Los Angeles-Long Beach-Anaheim-CA	Los Angeles-Long Beach CA*	Anaheim-Santa Ana-Garden Grove CA		1. Oxnard-Simi Valley-Ventura CA 2. Riverside-San Bernadino-Ontario CA

SCSA TITLE	SMSA Grouping (80th percentile limits) Group I	Group II	Group III	Group IV
Miami-Ft. Lauderdale-FL	Miami FL*	Ft. Lauderdale-Hollywood FL		
Milwaukee-Racine-WI	Milwaukee WI*		Racine WI	
Philadelphia-Wilmington-Trenton PA-DE-MD-NJ	1Trenton NJ 2Wilmington DE-NJ-MD	Philadelphia PA-NJ*		
San Francisco-Oakland-San Jose CA	San Francisco-Oakland-CA*	San Jose CA	Vallejo-Fairfield-Napa CA	
Seattle-Tacoma WA		Seattle-Everett WA*	Tacoma WA	

*Major SMSA - Limit to be applied to all SMSA's making up SCSA (see text for exception for Philadelphia SCSA).