

Ms. LITTLEMEYER



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

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

March 24-25, 1976  
Washington Hilton Hotel  
Washington, D.C.

Wednesday, March 24

6:00 P.M.	Administrative Board Management Advancement Program Discussion of June Meeting	Hamilton Room
	MAP Consultants: Mr. Ed Roberts Mr. Jack Rockhart Mr. Charles Seashore	

7:30 P.M.	Cocktails	Grant Room
8:00 P.M.	Dinner	Hamilton Room

Thursday, March 25

9:00 A.M.	Administrative Board Business Meeting (Coffee and Danish)	Independence Room
1:00 P.M.	Joint CAS/COD/COTH/OSR Administrative Board Luncheon	Military Room
	Executive Council Business Meeting	Military Room
4:00 P.M.	Adjourn	

AAMC MANAGEMENT ADVANCEMENT PROGRAM

June 18-23, 1976  
La Coquille Club  
Palm Beach, Florida

The following hospital directors have indicated they will attend the seminar: \*

Dennis Barry  
North Carolina Memorial Hospital

Judge T. Calton  
University Hospital, Lexington

George E. Cartmill  
United Hospitals of Detroit

Robert Derzon  
University of California, San Francisco

Richard E. Gillock  
Eugene Talmadge Memorial Hospital

Joe S. Greathouse, Jr.  
University of Missouri Medical Center

David B. Hitt  
Baylor University Medical Center

David L. Everhart  
Northwestern Memorial Hospital

J. W. Pinkston, Jr.  
Grady Memorial Hospital

Malcom Randall  
Veterans Administration, Gainesville

Richard L. Stensrud  
Saint Louis University Hospitals

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

Robert E. Toomey  
Greenville Hospital System

John H. Westerman  
University of Minnesota Hospitals

Irvin G. Wilmot  
New York University Medical Center

Charles B. Womer  
Yale-New Haven Hospital

The following deans have indicated they will be attending:

Clayton Rich, M.D.  
Stanford University  
School of Medicine

Chandler A. Stetson, M.D.  
University of Florida  
College of Medicine, Gainesville

\* Messrs. Lipes and Reinertsen have not yet responded.

(3/10/76)

AGENDA  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

March 25, 1976

- I. Call to Order
- II. Consideration of Minutes Page 1
- III. Membership
- A. Termination - Church Hospital Corporation Page 8
  - B. Criteria for Corresponding Membership Page 9
  - C. New Application - The Methodist Medical Center of Illinois Page 10
- IV. Follow-up Items to January Board Meeting
- A. Letter to Jay Constantine Page 20
  - B. Survey of Hospital Ambulatory Service Deficits Page 28
  - C. Hospital Fiscal Indicators (Letter to Bob Linde, AHA) Page 34
- V. AMA Request for Data Page 36
- VI. Review of ICM Social Security Studies Separate Attachment
- VII. Correspondence with The Wyatt Company on Malpractice Exposure of Faculty Physicians Executive Council (Page 94)
- VIII. LCME Guidelines for Functions and Structure of a Medical School Executive Council (Page 21)
- IX. Criteria for Subscribers Executive Council (Page 52)
- X. Approval of Subscribers Executive Council (Page 54)
- XI. Admission of Women to Medical School Executive Council (Page 57)
- XII. Report of the Task Force on Continuing Medical Education Executive Council (Page 59)
- XIII. Governmental Cognizance of the Institutional Well-being of Academic Medical Centers Executive Council (Page 65)

XIV. Information Item

A. Correspondence with Representative Cotter

Page 38

B. Correspondence with Mr. Thomas Tierney

Page 44

XV. New Business

XVI. Adjournment

Association of American Medical Colleges  
COTH Administrative Board Meeting

Washington Hilton Hotel  
Washington, D.C.  
January 14, 1976

PRESENT:

Charles B. Womer, Chairman  
David D. Thompson, M.D., Chairman-Elect  
Sidney Lewine, Immediate Past Chairman  
Leonard W. Cronkhite, Jr., M.D.  
David A. Gee  
Robert Heyssel, M.D.  
Baldwin G. Lamson, M.D.  
Stanley R. Nelson  
S. David Pomrinse, M.D.  
Malcom Randall  
John Reinertsen  
William T. Robinson, AHA Representative  
John M. Stagl

ABSENT:

John W. Colloton  
David L. Everhart  
Robert E. Toomey

STAFF:

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

I. Call to Order:

Mr. Womer called the meeting to order at 9:00 a.m. in the Farragut Room of the Washington Hilton Hotel.

II. Consideration of Minutes:

The minutes of the November 3, 1975 Administrative Board meeting were approved as circulated.

Minutes/2

III. Membership:

A. Termination Letter of Massachusetts Mental Health Center

Mr. Womer noted that because the State of Massachusetts has severely restricted all hospital expenditures, the Massachusetts Mental Health Center has notified the Association that it will not be able to continue its membership in the Council of Teaching Hospitals.

B. Assembly Representation

Mr. Womer stated that Robert A. Sigmond, Executive Vice President of the Albert Einstein Medical Center, Philadelphia, had written to inform the Association that he will be leaving the hospital and joining the Blue Cross Association. Mr. Sigmond will therefore no longer be eligible as a COTH representative to the AAMC Assembly and consequently has resigned his Assembly appointment. The Board accepted Mr. Sigmond's resignation with regret and asked that their best wishes be expressed. The Board recommended that the Assembly position remain unfilled for the remainder of the year.

C. New Membership Application

The Board reviewed one application for membership and took the following action:

ACTION:

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

OVERLOOK HOSPITAL  
SUMMIT, NEW JERSEY

IV. 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 Club, Palm Beach, Florida. The Board noted that the invitation list, included in the agenda, seemed reasonable and that the staff should continue to pursue development of this program. Five members indicated that they would attend the June session. Some members of the Board noted that there appeared to be some possibility for duplication for those hospital directors who had attended a Phase II program. The Board recommended that the curriculum be carefully reviewed with members of the faculty.

Minutes/3

V. CCME Report of Physician Manpower and Distribution:

Mr. Womer stated that the AAMC has been asked to reconsider its comments and recommended changes in the CCME Report concerning the role of the foreign medical graduate. Because unanimous approval of all CCME components is required for CCME approval, alternate wording has been proposed by the Coordinating Council on Medical Education. The COTH Administrative Board had originally recommended deletion of item A-4 and Mr. Womer called the Board's attention to the alternate wording included in the agenda. The Board discussed the wording of the change and took the following action:

ACTION:

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD VOTE TO APPROVE THE WORDING INCLUDED IN THE EXECUTIVE COUNCIL AGENDA.

VI. 1976 AAMC Annual Meeting:

Dr. Knapp asked the Board to review the Annual Meeting format as displayed in the COTH Administrative Board agenda. He questioned the Board as to whether there should be a joint COD/COTH session and if so, what topics the Board would recommend. In addition, Dr. Knapp asked what speakers and/or topic would be appropriate for the Friday afternoon plenary session. In response, the Board agreed that the format had been successful this year and should be continued. In an effort to be sure the program is topical the Board stated that it was too early to suggest what issues might be appropriate and suggested that the officers and staff take appropriate responsibility for program issues and speakers.

VII. Control of Hospital Routine Service Costs:

Dr. Knapp reviewed the proposed hospital reimbursement system as currently under study by the Senate Finance Committee. A paper had been prepared by AAMC staff which summarized the elements of the proposal and set forth the various problems and disadvantages embodied in the approach being discussed. The Board spent a considerable amount of time discussing the proposal and stating their concerns with it. The following major points were provided as guidance to staff in responding to the proposal.

- A. The most important prerequisite for proper evaluation and measurement of "routine operating costs" is the development of a system of uniform accounting and cost allocation. A mechanism for assuring the comparability of financial data should be developed prior to full implementation of the program. Experiences in California and Maryland, where uniform financial reporting systems have been developed, demonstrate that enormous time and effort are required to achieve this goal. The Board believes that a period of two-years subsequent to final passage of the bill is necessary.
- B. In the past the Association has not specifically proposed specific classification of teaching hospitals but rather has proposed the exclusion of specific components of "routine operating costs" so that variations in the remaining cost to be measured and compared

are not due to the nature of the product produced nor to characteristics of the production process that cannot reasonably be altered in short periods of time. The proposal provides for the creation of a separate group of "primary medical center hospitals." It is difficult to evaluate the implications of creating such a group because of the absence of data. Thus, there is uncertainty as to the relative merits of a separate group for "primary medical center hospitals." On balance, however, it is the Board's best judgment that a separate group or groups would be desirable.

- C. Even teaching hospitals differ greatly in the scope, breadth and depth of their commitment to educational purposes, the characteristics of patients they serve and the nature and scope of services they provide. Since there is not a commonly accepted definition of a "teaching hospital" for the purpose intended the Board strongly recommended that, instead of a specific definition, language should be incorporated into the bill which would require the Secretary to examine the implications for reimbursement of various definitions of the terms "teaching/tertiary care hospitals" to determine which definitions most accurately reflect the teaching hospital's role as a referral center for tertiary patient care services and as an educational institution.
- D. A fundamental concern of the Board related to the fact that the design of the hospital groups as well as other matters in the proposal are specifically set forth in the bill, thus making alterations based on experience most difficult to make on a timely basis. Realizing, however, that there are equally pertinent concerns with the extent to which Congressional intent is reflected in Executive branch implementation, the Board recommended that the bill provide that hospitals shall be classified by size and type and that it further provide for the establishment of an advisory body to evaluate alternative classifications of size and type, to review progress and monitor implementation and to examine problems encountered and make recommendations regarding solutions. The advisory group should include representation from the Legislative and Executive branches of the government as well as knowledgeable individuals from the private sector.
- E. The bill proposes that the ceiling for each group be determined by calculating the average adjusted cost and adding ten percent to that average. In the absence of precise data, it is difficult to know the percentile rank which will be set as a group ceiling. With the uncertainty concerning the proposal, the average plus ten percent could well result in too many hospitals being over the ceiling and therefore in danger of fiscal instability and make the exceptions process unmanageable. Therefore the Board strongly recommended that the initial ceiling be set at a higher level.



- F. The wage rate index should include consideration of hospital wage levels if available for the local or state area where they are higher than general wage levels. In such instances an initial adjustment should be made for the higher level with future increases controlled by increases in community wage levels. This approach addresses the concern expressed about the intensity of collective bargaining if a complete hospital wage level adjustment were allowed.
- G. Since there is wide regional and institutional variation in premium rates and because these rates are largely beyond the control of the hospital, the Board strongly recommends that malpractice insurance premiums be added to the list of exclusions from routine operating costs which are contained in the proposal.
- H. The definition of urban hospitals serving low income populations will pose very difficult problems of definition. The Board raised some question about the "implementability" and desirability of this section; however, the point was made that if such a provision were to be adopted it should clearly include both private and public hospitals.
- I. Experience gained since the development and operation of Section 223 of the 1972 Medicare Amendments has demonstrated the urgent need for an effective and timely exceptions and appeals process. An effective and equitable exceptions and appeals process has not been functioning under the present Section 223 limitations. For example, information describing the specific methodology and data utilized to derive exceptions should be made available to all institutions as well as the identity as comparable hospitals in each group. The basis on which exceptions are granted should be publically disclosed in each circumstance and easily accessible to all interested parties. Further, substantive response to appeal and exception requests should be required to be made in a reasonably short time period.

The Board was of the opinion that because many hospitals are reducing their patient length of stay, controls based on per diem routine operating costs may not in all circumstances be appropriate or equitable. This is due to the fact that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or even a reduction in the per admission costs. Therefore, the exceptions process should recognize this phenomenon and allow hospitals to demonstrate reasonable cost through the use of a per admission cost.

A hospital should also be permitted to establish through the exceptions process that it had an abnormal case mix and/or intensity of service which affects routine operating costs. In light of the fact that the tertiary care-referral hospital serves the more severely ill patients and that referrals of such patients from other hospitals tend to increase in times of adverse economic conditions this type of patient mix and intensity of service factor therefore should be recognized in the exceptions process.

The Board directed the staff to express its appreciation for the opportunity to set forth its views on the committee staff's proposal. While there were reservations as stated above, it was the general consensus that the course of direction which has been charged may be fruitful and is appropriate to bring before the Senate Finance Committee for consideration.

VIII. Health Planning Law

Dr. Knapp directed the Board members attention to the insert from the AAMC Officers Retreat agenda concerning the health planning law. The Board members agree that further staff efforts in this area would be inappropriate at the current time and that staff should continue the direction they are pursuing.

IX. Financing Education in the Ambulatory Care Setting:

Mr. Womer summarized the discussion which took place at the Officers Retreat concerning ambulatory care financing. He noted that it is possible that the AAMC Citizens Advisory Group may become involved in this activity. The staff reiterated its need to be aware of studies concerning the productivity of house officers in the ambulatory setting. It was generally agreed, however, that the ambulatory care reimbursement issue is one of financing for the service rather than financing for medical education. The Board requested that staff undertake a survey to determine the extent of the deficits being incurred by COTH members in the outpatient and emergency room settings. The Board asked for a status report on the survey at the next COTH Administrative Board meeting in March.

X. Hospital Fiscal Indicators:

Mr. Womer noted that at the Officers Retreat it was suggested that the Association develop indices of the fiscal health of the institutions it represents. It was further suggested that trend data be gathered for teaching hospitals on indices such as debt structure, accounts receivable, endowment principle and income and other items. Staff prepared a listing of ratios which could be used to gather this information. Following a review of the indices included in the Agenda book, the Board recommended that staff check with the American Hospital Association as to their efforts in this area. The Board agreed that while the information is important and needed, it is equally important to avoid duplication because of the extent of requests that hospitals receive for data. It was suggested that the staff report at the next Board meeting regarding efforts to coordinate their activities with the American Hospital Association.

XI. Report of the Department of Health Services:

Dr. James Hudson, Director of the Department of Health Services, reported on the status of a number of programs the department is currently undertaking. He noted that the project to develop curriculum in health maintenance organizations is now coming to a close. In another area, he noted, the Department has prepared issue papers on primary care for the Robert Wood Johnson Foundation.

Later this month, the Department will convene the first workshop under the ambulatory care project. Dr. Hudson noted that a total of 59 applications were received from institutions interested in participating in the ambulatory care project and ten were chosen.

There are currently two vacancies on the Health Services Advisory Committee and Dr. Hudson asked the COTH Administrative Board to suggest individuals who may be considered to fill these vacancies. The following names were suggested: Richard Wittrup, Irvin Wilmot, Whitney Spaulding, Richard Berman, Joseph Greathouse and Joseph Curl.

XII. COTH Nominating Committee

Mr. Womer stated that in addition to the Immediate Past Chairman, Mr. Lewine, and the present Chairman, Roy Rambeck has been recommended as a third member of the Nominating Committee.

XIII. Department Staffing:

Mr. Womer noted that Dr. James Bentley will be joining the Department of Teaching Hospitals on March 1, 1976.

XIV. Adjournment:

There being no further business, the meeting was adjourned at 12:30 p.m.

January 29, 1976

Mr. George W. Mason  
Vice President  
Church Hospital Corporation  
100 North Broadway  
Baltimore, Maryland 21231

Dear Mr. Mason:

The purpose of this letter is to confirm our conversation on Monday, January 26, regarding your indication that the Church Hospital Corporation has only one remaining residency program (surgery) which is definitely scheduled to close on June 30, 1976. In line with your request you will not receive a bill to continue your membership in the Council of Teaching Hospitals past July 1, 1976.

I hope that your association with the Council has been beneficial. If there is anything else I can do for you, please let me know.

Sincerely,

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

RMK:car

cc: J. Trevor Thomas  
Director of Business Affairs, AAMC

CRITERIA FOR CORRESPONDING MEMBERS

At the 1975 Assembly meeting the AAMC Bylaws were amended to provide for a category of Corresponding Membership. As defined in the Bylaws, and as approved by the Executive Council, Corresponding Members "shall be hospitals involved in medical education in the United States or Canada which do not meet the criteria established by the Executive Council for any other class of membership. Corresponding Members will be recommended to the Executive Council by the Council of Teaching Hospitals."

In addition to these requirements stated in the Bylaws, the Executive Council is authorized to establish additional criteria for any class of members.

RECOMMENDATION

It is recommended that the Executive Council require that any hospital requesting Corresponding Member status, in addition to meeting the criteria set forth in the AAMC Bylaws, also:

1. have a documented institutional affiliation with a school of medicine for the purpose of participating in medical education;
2. have the written endorsement of the dean of the affiliated school of medicine as part of its application for Corresponding Membership.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COUNCIL OF TEACHING HOSPITALS

Application for Membership (Corresponding)

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. See Attachment F.

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

The Methodist Medical Center of Illinois

HOSPITAL NAME

221 N.E. Glen Oak Avenue

STREET

Peoria

CITY

Illinois

STATE

61636

ZIP CODE

(309) 672-829

TELEPHONE NUMBER

Chief Executive Officer

James K. Knoble

President and Chief Executive Officer

NAME  
TITLE

Date hospital was established:

October 28, 1898

APPROVED FIRST POST-GRADUATE YEAR

TYPE <sup>2</sup>	Date of Initial Approval by CME of AMA**	Total F.T.E. <sup>1</sup> Positions Offered	F.T.E. <sup>1</sup>	F.T.E. <sup>1</sup>
			Total Positions Filled by U.S. And Canadian Grads	Total Positions Filled by FMG's
Flexible	_____	_____	_____	_____
Categorical	_____	_____	_____	_____
Categorical*	_____	_____	_____	_____

\*\* 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 director; Categorical\*-graduate program under supervision of single program director but content is flexible.)

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APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA**	Total F.T.E. <sup>1</sup> Positions Offered	F.T.E. <sup>1</sup>	F.T.E. <sup>1</sup>
			Total Positions Filled by U.S. And Canadian Grads	Total Positions Filled by FMG's
Medicine				
Surgery				
Ob-Gyn				
Pediatrics				
Psychiatry				
Family Practice	October 21, 1971	24	21	0
Other (List):				
<u>Pathology</u>	1939	4	0	3

II. PROGRAM DESCRIPTION See Attachments A-D

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 specific 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 characteristics and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION See Attachment E

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: Peoria School of Medicine of the University of Illinois, 1400 West Main Street, Peoria, Illinois 61606

Name of Dean: Nicholas J. Cotsonas, Jr., M.D.

Information Submitted by:

James K. Knoble

NAME

February 6, 1976

DATE

President and Chief Executive Officer

NAME OF PERSON SIGNING DATA

X [Signature]  
SIGNATURE OF PRESIDENT AND CHIEF EXECUTIVE



University of Illinois at the Medical Center, Chicago

PEORIA SCHOOL OF MEDICINE

1400 West Main Street Peoria, Illinois 61606-516  
Telephone (309) 674-8477

Office of the Dean

December 9, 1975

To: Council of Teaching Hospitals  
Association of American Medical Colleges

Through: Mr. James K. Knoble, President  
Methodist Medical Center of Illinois

From: Nicholas J. Cotsonas, Jr., M.D., Dean

I write in support of the application from the Methodist Medical Center of Illinois for a "Corresponding Membership" in the Council of Teaching Hospitals.

I write at this time to advise you that the Methodist Medical Center of Illinois is one of the major teaching affiliates of the Peoria School of Medicine of the University of Illinois College of Medicine.

The Methodist Medical Center of Illinois serves as a focus for a variety of programs in undergraduate medical education under the supervision of our faculty and is the focus of a community-wide residency in Family Practice which is also under the educational supervision of the faculty of the School.

I am pleased that the Methodist Medical Center of Illinois has chosen to take this step, and I support it without reservation.

NJC:set



THE METHODIST HOSPITAL OF CENTRAL ILLINOIS

PEORIA, ILLINOIS  
61603

W. V. HERRIN  
Administrator

*Document of affiliation  
attached*

April 21, 1971

Nicholas J. Cotsonas, Jr., M.D.  
Peoria School of Medicine  
405 First National Bank Building  
Peoria, Illinois 61602

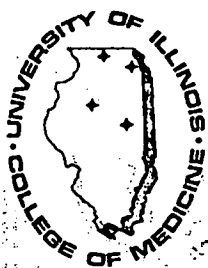
Dear Doctor Cotsonas:

This is confirming information to you reported at the last meeting of the Peoria Board of Medical Education that Methodist Hospital's Executive Committee did approve at its most recent meeting the Document of Affiliation between the University of Illinois and the Peoria hospitals.

Sincerely,

W. V. Herrin,  
Administrator

WVH:ga



University of Illinois at the Medical Center, Chicago

PEORIA SCHOOL OF MEDICINE

405 First National Bank Building  
Peoria, Illinois 61602

March 22, 1971

William J. Grove, M.D.  
Mr. W. V. Herrin  
Mr. Edward T. McGrath  
Rex O. McMorris, M.D.  
Mr. John A. Smith  
James S. Ward, M.D.

Dear Colleagues:

At the last meeting of the Peoria Board for Medical Education, Inc., held on Monday, March 15, 1971, the enclosed document was approved in its present form by the Board and is now being referred to the individual institutions for formal approval by their governing bodies.

If you will notify my office by letter when your governing body has approved the enclosed Document of Affiliation, I shall arrange for some sort of public ceremony.

You will recall that what is now the fourth revision was occasioned by the comments made by James P. Martin, Legal Counsel for the University of Illinois at the Medical Center. Implementation of this Document of Affiliation will be accomplished by means of a separate, signed agreement between the University and each of the institutions, indicating their agreement to implement the Document of Affiliation. (A copy of this latter document is enclosed. I have modified this from the agreement originally signed in Chicago, and it is intended only to serve as a sample.)

Sincerely,

Nicholas J. Cotsonas, Jr., M.D.  
Dean

NJC:mmp

Enc.

AGREEMENT

This Agreement is entered into this \_\_\_\_\_ day of \_\_\_\_\_, 1971,  
by and between The Board of Trustees of the University of Illinois and \_\_\_\_\_  
(Hospital or Institution) \_\_\_\_\_.

The Parties hereby implement the "Document of Affiliation" between the  
institutions and The Board of Trustees of the University of Illinois, which  
Document is attached hereto and made a part hereof by reference.

The Document of Affiliation is effective as of the date of this Agreement.

Peoria School of Medicine  
University of Illinois  
College of Medicine

For the (Institution) \_\_\_\_\_:

\_\_\_\_\_  
Executive Dean

\_\_\_\_\_  
Director of Business Affairs

\_\_\_\_\_  
Legal Counsel

\_\_\_\_\_  
Chancellor

\_\_\_\_\_  
Comptroller

\_\_\_\_\_  
Secretary of the Board

3/19/71

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DOCUMENT OF AFFILIATION

AFFILIATION AGREEMENT by and between the Board of Trustees of the University of Illinois, on behalf of the Peoria School of Medicine, University of Illinois College of Medicine, (hereinafter sometimes referred to as Peoria School of Medicine); Peoria Board for Medical Education, Inc., an Illinois not for profit corporation, (hereinafter sometimes referred to as Peoria Board); The Sisters of the Third Order of St. Francis, an Illinois not for profit corporation, owner and operator of the institution known as St. Francis Hospital, Peoria, Illinois; Methodist Hospital of Central Illinois, an Illinois not for profit corporation, owner and operator of the institution known as Methodist Hospital, Peoria, Illinois; Proctor Community Hospital, an Illinois not for profit corporation, owner and operator of the institution known as Proctor Hospital, Peoria, Illinois; Institute of Physical Medicine and Rehabilitation, an Illinois not for profit corporation, operator of institutions of the same name at three said Peoria Hospitals; State of Illinois Department of Mental Health, owner and operator of the institution known as George A. Zeller Zone Center, Peoria, Illinois; and owners and operators of such additional institutions that may hereafter become signatories hereto,

W I T N E S S E T H:

WHEREAS, the faculty of the College of Medicine has resolved to expand substantially its programs for the education of physicians, and in order to accomplish this goal effectively and efficiently, the College of Medicine has been reorganized into a series of semiautonomous schools of basic and clinical science; and

WHEREAS, the Peoria hospitals and other health care facilities have indicated a willingness to affiliate with the College of Medicine for the purpose of expanding medical education by entering into this affiliation agreement which represents the first phase of organization whereby the process for developing educational programs of the Peoria School of Medicine in the Peoria institutions can begin; and

WHEREAS, the purpose of this document is to make an agreement between and document the understandings of the parties hereto and future affiliates of the Peoria School of Medicine; and

WHEREAS, the Peoria School of Medicine, the Peoria Board and the institutions recognize they share common goals of conducting programs of medical education, improving the quality and delivery of health care, conducting research in health and health-related fields, and responding to the needs of the community, and all parties believe these goals may be achieved more effectively and efficiently if resources of institutions can be combined in a mutually agreeable manner;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein set forth, it is hereby agreed between the parties hereto as follows:

I. Faculty and Institutional Staff Appointments

- A. Coordination of staff and faculty function is to be encouraged. It is essential, however, to preserve as an institutional function the awarding of institutional privileges to qualified physicians. Similarly, appointment to the faculty of the Peoria School of Medicine is a function of the University.

- B. Institutional staff appointments shall continue to be awarded by the respective institutional governing bodies, upon recommendation of the staffs of these institutions.
- C. It is agreed that prior to members of the institutional staffs becoming engaged in the programs of the Peoria School of Medicine they shall be acceptable to and members of the faculty of the College of Medicine.

## II. Patients and the Educational Programs

All patients admitted by members of the medical staff to an affiliated institution, including inpatients and outpatients, shall be available for the educational programs. Exclusions will be made upon the request of the attending physician or the patient. A mutually acceptable mechanism shall be created which shall review periodically the reasons and consequences of these exclusions.

## III. Medical Students

- A. Medical students are recognized to be an integral part of the health care team. They will participate in the evaluation, the management and the care of patients under the supervision of the faculty-staff physicians and other mutually acceptable participants. The range of students' activities shall include, but not be limited to, obtaining and recording the patient's history and performing the physical examination, suggesting diagnostic and therapeutic procedures, and their inclusion in the programs of continuing care. The student's activities shall be in accordance with his level of educational development and shall be performed under constant professional supervision.
- B. The student shall not receive any payment or perquisites while at the Institutions (such as free meals, laundry, etc.). Exceptions, if any, shall be subject to the approval of the Peoria Board for Medical Education.
- C. The Peoria School of Medicine shall assign individual students to the Institutions. The number of students to be assigned to any institution shall be negotiated with the institution in advance of any assignment.

## IV. Curriculum

Curriculum is a responsibility of the faculty of the Peoria School of Medicine and is subject to approval by the College of Medicine.

## V. Responsibilities for Research

The Institutions shall encourage and approve the conduct of research in their health facilities. Such research should be directed towards health-oriented fields, research in basic science, clinical studies, studies of patient care, studies of medical education and investigations aimed at improving the systems in delivery of health care to the public. The Institutions shall communicate regularly with the dean's office on current and projected research activities.

VI. Intra-Institutional Affiliation Committee

A. There shall be an Intra-Institutional Affiliation Committee in each institution which shall include the following members:

1. A member of the governing body or its designee
2. A member of institutional administration
3. A physician responsible for any educational program conducted within the institution
4. An elected member from the Institutional Staff. If there is no physician responsible for any educational program (#3 above), two members will be elected from the Institutional Staff.

B. The Intra-Institutional Affiliation Committee shall act as liaison between the Office of the Dean of the Peoria School of Medicine and the governing body of the institution, the institutional administration and the institutional staff.

VII. The Peoria Board for Medical Education, Inc.

A. In addition to the members of the Board, the following shall be invited to meetings of the Board, if not already members:

1. The Dean of the Peoria School of Medicine.
2. Others the Board believes appropriate to invite.

B. The Peoria Board shall:

1. Invite the Institutions to suggest candidates to represent them on the various committees of the Peoria School of Medicine and the College of Medicine.
2. Subject to the approval of the governing bodies of the Peoria School of Medicine and the Institutions, propose activities and operations to be undertaken conjointly, recommend the means of implementing and obtaining support for these activities and operations, and recommend the allocation of income and expenses in connection therewith, including any expense for construction or equipment. These activities and operations shall include, but not be limited to, programs for the continuing education of physicians, training programs for interns and residents, programs of undergraduate medical education, and programs in the associated medical sciences.
3. Consider all matters affecting the affiliation between the Peoria School of Medicine and the Institutions and make recommendations to the appropriate governing bodies concerning such matters.

4. Periodically review this document and the inter-relationships which develop among the Institutions and recommend changes within the Peoria School of Medicine, including the inclusion of other health-oriented institutions.

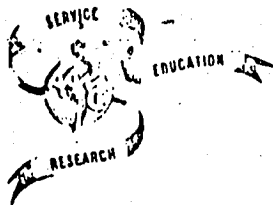
#### VIII. Financial Considerations

Costs related to patient care are an institutional responsibility; those costs related to undergraduate medical education are a responsibility of the Peoria School of Medicine. As other educational programs evolve, the division of financial responsibility may vary from institution to institution and shall be agreed to in advance.

IX. The Institutions shall provide information to the Peoria School of Medicine and the Peoria Board prior to proposing medical education programs with another medical school.

X. This Agreement shall become effective upon implementation by each of the parties and may be terminated as to any party upon at least one year's notice given by such party to all others then parties hereto, with such termination effective at the close of an academic year.

3/19/71



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

January 30, 1976

Mr. Jay Constantine  
Professional Staff Member  
Senate Finance Committee  
2227 Dirkson Senate Office Building  
Washington, D.C. 20510

Dear Jay:

In response to your request, I am writing to provide you with the Association's tentative observations and comments on the hospital reimbursement section of the proposed Medicare Amendments ("Talmadge Bill"). These are based on the attached summary paper which outlined our current understanding of the proposal at the time as it was discussed at the recent Council of Teaching Hospitals (COH) Administrative Board meeting on January 14, and at earlier meetings in your office. From our subsequent discussions on January 27, I realize that tentative decisions have been reached concerning some of our suggestions and reservations. However, the intent of this letter is to set forth the Board members' views based upon their knowledge of the proposal as of January 14.

It is clear to us that the Senate Finance Committee staff has made a sincere effort to take into consideration and to accommodate to many of the characteristics which make hospitals different from one another and consequently extremely difficult to classify. We appreciate very much the opportunity you have afforded us to offer constructive comments during the process of developing the proposal as well as the invitation to set forth our serious concerns with some portions of the proposal.

Recognizing that the new proposal represents a series of steps directed toward improving and moving forward from Section 223 of the 1972 Medicare Amendments and other aspects of retrospective cost determination, the COH Administrative Board spent a considerable amount of time deliberating over the potential impact of the proposal. The Board identified a number of problem areas which it requested that I bring to your attention.

Uniform Accounting And Cost Allocation

The most important prerequisite for proper evaluation and measurement of "routine operating costs" is the development of a system of uniform accounting and cost allocation. A mechanism for assuring the comparability of financial data should be developed prior to full implementation of the program. Experiences in California and Maryland, where uniform financial reporting systems



Mr. Jay Constantine  
January 30, 1976 -  
Page Two

have been developed, demonstrate that enormous time and effort are required to achieve this goal. The Board believes that a period of two years subsequent to final passage of the bill is necessary.

### Classification Of Hospitals

In the past the Association has not specifically proposed a separate classification of teaching hospitals, but rather has proposed the exclusion of specific components of "routine operating costs" so that variations in the remaining costs to be measured and compared are not due to the nature of the product produced or to characteristics of the production process that cannot reasonably be altered in short periods of time. Therefore, we believe that the proposed exclusion of capital, education and utility costs are steps in the right direction.

The proposal provides for the creation of a separate group of "primary medical center hospitals." It is difficult to evaluate the implications of creating such a group because of the absence of data. As you know, efforts to gain data and experience with this separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be excluded from the present scheme. Thus, there is uncertainty as to the relative merits of a separate group for "primary medical center hospitals." On balance, however, it was the Board's best judgment that a separate group or groups would be desirable, but that the appropriate definition and composition of this group(s) is a very serious matter which it could not specifically address without considerably more data, experience and thorough examination.

### Definition And Composition: Teaching Hospital Group

A serious effort has been made to define the type of hospital which includes those characteristics which we assume you imply with the term "primary medical center hospitals." Even teaching hospitals differ greatly in the scope, breadth and depth of their commitment to educational purposes, the characteristics of patients they serve, and the nature and scope of services they provide. The Association's governing body adopted the following policy statement in November of 1972.

"At least three major factors must be considered when attempting to characterize or classify hospitals:

- / The nature and scope of the hospital's educational objectives and the degree of institutional commitment to meet the incremental costs of providing the environment for undergraduate and graduate medical education;

- The severity of illness, complexity of diagnosis, and socioeconomic characteristics of the patients served by the hospital;
- The comprehensiveness and intensiveness of services provided by the hospital.

There is a great variation in the extent to which each teaching hospital meets these dimensions. Any attempt to characterize or classify teaching hospitals must recognize the limitations of grouping all teaching hospitals . . . . "

Since there is not a commonly accepted definition of a "teaching hospital" for the purpose intended, the Board strongly recommends that, instead of a specific definition, language should be incorporated into the Bill which would require the Secretary to examine the implications for reimbursement of various definitions of the terms "teaching/tertiary care hospitals" to determine which definitions most accurately reflect the teaching hospital's role as a referral center for tertiary patient care services, and as an educational institution.

#### Specific Statutory Requirements

A fundamental concern of the Board relates to the fact that the design of the hospital groups (and other matters) in the proposal is specifically defined in the Bill, thus making alterations based on experience most difficult to make on a timely basis. Realizing, however, that there are equally pertinent concerns with the extent to which Congressional intent is reflected in Executive branch implementation, the Board recommends that the Bill provide that hospitals shall be classified by size and type, and that it further provide for the establishment of an "advisory body" to evaluate alternative classifications of size and type, to review progress and monitor implementation, and to examine problems encountered and make recommendations regarding solutions.

The question of the most appropriate definition and classification of teaching/tertiary care hospitals is a good example of an issue which would be brought before this advisory group. There undoubtedly would be many other issues in light of the fact that the "state-of-the-art" in classifying hospitals for cost control is in its infancy, that the risks of initial inequities are high, and that the "phase-in" period for the program requires a careful, step-by-step review.

An advisory group should be established, and members of this group should include representation from the Legislative and Executive branches of the government as well as knowledgeable individuals from the private sector.

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### Establishment Of Payment Rate

The Bill proposes that the ceiling for each group be determined by calculating the average adjusted cost and adding ten percent to that average. In the absence of precise data, it is difficult to know the percentile rank which will be set as a group ceiling. With the uncertainty concerning the proposal, the average plus ten percent could well result in too many hospitals being over the ceiling and therefore in danger of fiscal instability and making an exceptions process unmanageable. The Board strongly recommends that the initial ceiling should be higher.

### Wage Rate Indices

The wage rate index should include consideration of hospital wage levels, if available, for the local or state area where they are higher than general wage levels. In such instances an initial adjustment should be made for the higher level with future increases controlled by increases in community wage levels. This approach addresses the concern you expressed about the intensity of collective bargaining if a complete hospital wage level adjustment were allowed.

### Malpractice Insurance Premiums

Since there is wide regional and institutional variation in premium rates, and because these rates are largely beyond the control of the hospital, the Board strongly recommends that malpractice insurance premiums be added to the list of exclusions from routine operating cost which are contained in the proposal.

### Exception And Appeal Procedures

Experience gained since the development and operation of Section 223 of the 1972 Medicare Amendments has demonstrated the urgent need for an effective and timely exceptions and appeals process. An effective and equitable exception and appeal process has not been functioning under the present Section 223 limitations. For example, information describing the specific methodology and data utilized to derive exceptions should be made available to all institutions, as well as the identity of "comparable" hospitals located in each group. The basis on which exceptions are granted should be publicly disclosed in each circumstance and easily accessible to all interested parties. Further, substantive response to appeal and exception requests should be required to be made in a reasonably short time period.

The Board was of the opinion that because many hospitals are reducing their patient lengths of stay, controls based on per diem routine operating costs may not in all circumstances be appropriate or equitable. This is due

Mr. Jay Constantine  
January 30, 1976  
Page Five

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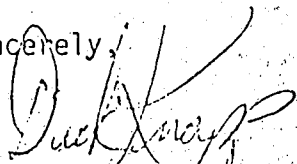
to the fact that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or even a reduction in the per admission costs. Therefore, the exceptions process should recognize this phenomenon and allow hospitals to demonstrate reasonable costs through the use of a "per-admission cost."

A hospital should also be permitted to establish through the exceptions process that it has an abnormal case mix and/or intensity of service which affects routine operating costs. In light of the fact that the tertiary care/referral hospital serves the more severely ill patients and that referrals of such patients from other hospitals tend to increase in times of adverse economic conditions, this type of patient mix and intensity (or scope) of service factor therefore should be recognized in the exceptions process.

In conclusion we wish to express again our appreciation for the opportunity to set forth our views on the Committee staff's proposal. I should emphasize that we have offered our observations on the proposal as a sincere and thoughtful effort to refine and improve Section 223 of the 1972 Medicare Amendments and other aspects of retrospective cost determination without addressing the advantages and disadvantages of a centrally administered national scheme. Nor have we evaluated the relative merits of this approach in contrast to others which do not use the "cost of a routine day of care" as the unit of analysis or control.

While we do have reservations as stated above, we believe the course of direction which has been charted may be fruitful and is appropriate to bring before the Senate Finance Committee for consideration.

Sincerely,



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

RMK:car

Enclosure

CONTROL OF HOSPITAL ROUTINE SERVICE COSTS

Hospital Reimbursement Proposal (Senate Finance Committee)

The determination of routine service costs of hospitals will conform to a uniform accounting and cost allocation system (to be established by the Secretary) and shall exclude:

- a) capital costs, such as interest expense on loans to purchase capital assets, and depreciation expense;
- b) costs of hospital education and training programs;
- c) costs of interns, residents, and salaried medical staff; and,
- d) energy costs associated with heating and cooling of the hospital plant. Such costs are excluded because:
  - 1) they are an uncontrollable factor of non-wage costs in national cells which may vary substantially; and,
  - 2) because of the unusual and unstable economic conditions currently involved in the purchase of energy.

Hospitals shall be classified according to:

- a) number of beds
  - 1) less than 25 beds (will be excluded from this proposal)
  - 2) 26-99 beds
  - 3) 100-249 beds
  - 4) 250-500 beds
  - 5) more than 500 beds
- b) type of hospital, including short-term general hospitals, primary hospital of a medical center (to be defined) and specialty hospitals including psychiatric, pediatrics, geriatric, maternity, or other specialty hospitals to the extent that such differences in type of hospital affect routine operating costs as determined under this proposal.
- c) urban hospitals whose patient mix is essentially derived from a low income population shall be considered separately and shall constitute one or more cells of the classification system, if the Secretary determines that location in such cases does affect routine service costs as determined under this proposal.

In the second quarter of each fiscal year (beginning with the January - March quarter of 1977), the average per diem routine service cost shall be determined within each cell of the classification system, and adjusted for variations in wages in the areas in which the hospitals in the cell are located, according to the following methodology.

- a) routine service costs shall be determined for each hospital, and divided into two components, a personnel cost component and other component. The personnel cost component shall be adjusted for variations in wages as follows:

- 1) a wage index shall be prepared for the cell based on general wage levels in the areas in which the hospitals are located, with the lowest wage area assigned a value of 1.000 and all other areas indexed to reflect their relations to the wage rates in effect in the lowest area;
  - 2) the personnel cost component of routine, operating cost shall be adjusted downward by the wage index described above by dividing the personnel costs by each hospital's wage index.
- b) The total of the "other" routine service costs and the adjusted personnel cost component shall be calculated for all hospitals in the cell. Such totals shall be divided by the total number of days of routine care provided by the hospitals to determine the adjusted average per diem routine service cost.

The adjusted average per diem routine service cost for each cell shall constitute the basic payment rate for routine services in the next fiscal year (beginning with the fiscal year starting October 1, 1977). In determining the adjusted average per diem within any cell, the Secretary shall exclude any hospitals which have significant understaffing problems, or other significant cost differentials resulting from failure to fully meet the statutory and regulatory conditions of participation as determined by JCAH, State agency certification procedures, or other information available to the Secretary. Such hospitals shall be reimbursed on the basis of their actual costs, not to exceed the rate which would be paid to them under this part.

Hospitals shall be reimbursed for their actual costs if their routine service costs exceed the average adjusted payment rate for their cell by no more than 10 percent. Hospitals with routine operating costs in excess of this amount shall receive no more than the average adjusted payment rate plus 10 percent.

An exception shall be provided in the first year of operation under this proposal so that hospitals can be reimbursed for their actual costs if they agree to narrow the gap between their actual costs and the adjusted payment rate ceiling by more than 50 percent.

Hospitals with costs less than the average adjusted payment rate shall be reimbursed their actual costs plus some added amount (method to be determined) as a reward for efficiency.

For cost increases occurring after determination of a hospital's adjusted rate payment, the adjusted rate of payment shall be adjusted on a quarterly basis by the lesser of:

- a) the hospital's estimate of the percentage increase in its costs, or
- b) the increase in prices estimated by the Social Security Administration for the mix of goods and services, including personnel and non-personnel costs, which comprise routine operating costs as determined under this part.

At the end of the fiscal year, a retrospective adjustment shall be made to the amounts reimbursed for such cost increases to the lesser of:

- a) the actual cost increases incurred by the hospital, or
- b) the actual increase in prices which the Social Security Administration determines has occurred for the mix of goods and services, including personnel and non-personnel, which comprise routine operating costs as determined under this part.

## HOSPITAL AMBULATORY SERVICE FINANCIAL SURVEY

On February 6, 1976, the Department of Teaching Hospitals distributed a draft questionnaire on hospital ambulatory service payments to members of the COTH Administrative Board. The purpose in sending out the draft document was to solicit comments and recommendations on the format and accuracy of the survey instrument. A number of changes were suggested and are summarized below for your consideration. Some of the points were incorporated into a second draft of the questionnaire (attached). Others could not be accommodated because of problems related to a lack of uniformity, inconsistent definitions and lack of available data. Because of these recurring problems, it is requested that the COTH Administrative Board review this most recent questionnaire prior to its distribution to constituent hospitals.

### Analysis of Comments Submitted

1. Many hospitals combine the "bad debt" accounts for purposes of write-off and may not be able to separate "bad debts" by emergency department and outpatient department categories. An alternative may be to simply utilize an inpatient/outpatient differentiation.
2. Would it be feasible to "key" the questionnaire into the Medicare cost report or other state reporting systems?
3. Situations may arise when a hospital has one "bad debt" rate for purpose of reporting (and allocating) costs and another "real estimated amount" of losses based on actual current performance. Since these two amounts may be significantly different, the question arises about which one should be reported.
4. How will a contracted physician-covered-emergency room be reported? Will it make a difference as to the "type" of contractual relationship, i.e., percent of revenue, guaranteed minimum, hospital billing versus direct physician billing?
5. Physician reimbursement in the outpatient department may be supported by funds that do not appear in the hospital billing structure. This "voluntary" service may result from the part-time, non-salaried faculty and staff, as well as directly from the university faculty which is supported by university funds, research grants and/or professional fee earnings from other areas. Given this variation between hospitals, how can this information best be accurately determined and uniformly reported?
6. Discounts and "bad debts" should be listed under "deductions from revenue" while "bad debts" should refer to the "provision for bad debts in lieu of actual write-offs."



7. Instead of using the term "discounts" the term "contractual allowances and adjustments" will help to avoid the wrong connotation.
8. Some volume measure (i.e., visits, occasions of service) may be helpful in evaluating the institutional responses.
9. Since some institutions may not be able to report actual direct and indirect expenses broken down by areas, it may be beneficial to include an optional estimated percentage breakdown with actual total dollars being reported.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Analysis of Hospital Ambulatory Service Deficits

FY ending: \_\_\_\_\_, 197\_\_

I. Emergency Department

a. Total Revenue\* \$ \_\_\_\_\_

Less: Discounts\*/Allowances \$ \_\_\_\_\_

Uncollectibles\* \$ \_\_\_\_\_

b. Net Revenue \$ \_\_\_\_\_

c. Expense\*

Direct \$ \_\_\_\_\_ or ( \_\_\_\_\_ %)

Indirect \$ \_\_\_\_\_ or ( \_\_\_\_\_ %)

TOTAL \$ \_\_\_\_\_

d. Loss/Gain in E.D. \$ \_\_\_\_\_

e. Total E.D. Visits \_\_\_\_\_

II. Outpatient Clinics\*

a. Total Revenue\* \$ \_\_\_\_\_

Less: Discounts\*/Allowances \$ \_\_\_\_\_

Uncollectibles\* \$ \_\_\_\_\_

b. Net Revenue \$ \_\_\_\_\_

c. Expense\*

Direct \$ \_\_\_\_\_ or ( \_\_\_\_\_ %)

Indirect \$ \_\_\_\_\_ or ( \_\_\_\_\_ %)

TOTAL \$ \_\_\_\_\_

d. Loss/Gain Attributed to Clinics \$ \_\_\_\_\_

e. Number of Service Units\* \$ \_\_\_\_\_

\*See Attached Definitions

III. Outpatient Physician Reimbursement

Note any additional identifiable dollar amount of physician services provided through the Emergency Department and/or Outpatient Clinic for which direct reimbursement is not received from a 3rd party payer or individual self-pay patient. Examples of this "voluntary support" include physician services supported through non-salaried faculty and staff or from university faculty funded by university monies, research grants, and professional fee earnings from other areas. If this amount is an element of either of the above sections, please specify.

\$ \_\_\_\_\_ Explain: \_\_\_\_\_

IV. Co-Insurance Losses

Report the actual or estimated annual net loss in Ambulatory Care attributed to the deductible and/or co-insurance portion of a cost reimbursement arrangement.

\$ \_\_\_\_\_

DEFINITIONS

I. Emergency Room

Total Revenue

Report the total dollar amount of charges for services of the emergency department. Include fees for visits and other charges for services performed by personnel in the emergency department. Include charges to patients for laboratory, radiology, pharmacy, and other ancillary services.

Discounts

Report the amount deducted from regular emergency department fees as discounts to third-party payers, employees, and others.

Uncollectibles

Enter the amount representing the estimated uncollectible accounts and notes receivable from patients treated in the emergency department during the year. This amount is the annual actual bad debt write off and not the balance sheet allowance or reserve account.

Expenses

Report all expenditures attributed to the emergency room separating (dollars and/or percentage) by direct and indirect amounts.

II. Outpatient Clinic\*

Outpatient Clinic

For many hospitals, it is assumed that ancillary service expenditures for inpatients and ambulatory patients are intermingled but that revenue and service counts can be differentiated. Data has been requested based on the identification and separation of expenses attributed to inpatients but the hospital is asked to explain the composition of the outpatient clinic data that is submitted. If inpatient service units cannot be separated from outpatient in the total, then the estimated percentage allocation of inpatient vs. outpatient is requested.

Total Revenue

Report the total dollar amount of charges to patients in the outpatient clinic(s). Include service unit fees and other charges for services performed by personnel in the clinics. Include charges for laboratory, radiology, and other ancillary services.

Discounts

Report the amount deducted from regular clinic fees as discounts to third-party payers, employees, and others.

Uncollectibles

Report the amount representing the estimated uncollectible accounts and notes receivable from patients treated in the outpatient clinic(s) during the year. This is the annual actual bad debt and not the balance sheet reserve.

Expenses

Report all expenditures attributed to outpatient clinic activity, separating (dollars and/or percent) by direct and indirect expenses. If the inpatient/outpatient amounts can be distinguished, please do so; otherwise a total will suffice.

Service Units

Defined as the responses by Clinic personnel (physicians and support staff) which result in a charge being incurred. When a patient sees more than one person in the clinic for the same general problem, only one service unit is generated. Separate problems seen in separate clinics with multiple charges are to be reported as more than one service unit.

February 2, 1976

Mr. Robert E. Linde  
Division of Information  
Services  
American Hospital Association  
840 North Lake Shore Drive  
Chicago, Illinois 60611

Dear Bob:

Last Friday, January 30, I had the opportunity to discuss with Dave Drake the possibility of developing a cooperative relationship for the use of data collected in the National Hospital Panel Survey. The purpose of this letter is to set forth a number of questions, and to outline a tentative proposal for your review and consideration of cost estimates.

I learned that 163 of the 999 current participants in the survey are COTH members. If possible, I would appreciate receiving a list of those participants so that we might determine the extent to which these 163 teaching hospitals are representative of the 325 non-Federal COTH members on the basis of bed size, region and ownership. I have become well aware of the difficulties in reporting financial data for some university-owned hospitals (particularly state institutions) as well as city and county hospitals. If you have any observations to make regarding problems in this area, I would be interested in hearing them.

We do have an immediate need for financial data in particular. Would it be possible to construct a table identical to Table 1 on page 31 of Hospitals, J.A.H.A. (January 16, 1976) for the 163 COTH members for the September quarters of 1973, 74 and 75? Since we have a most significant interest in the data which includes current assets and liabilities, I see no need to go back any further.

In the longer run, it is my understanding that the panel is being expanded to include 2,000 hospitals. I would be surprised if this expansion does not result in the inclusion of at least three quarters of the non-federal COTH membership. Therefore, I would like to encourage a long-term relationship that would result in a semi-annual or quarterly report for COTH participants at the time the revised panel group is fully implemented.

Mr. Robert E. Linda  
February 2, 1976  
Page Two

I would appreciate discussing the above matters with you, and assuming we are on an acceptable course, I have the following specific questions.

1. May we receive a list of the 163 current COTH participants?
2. What would be the cost of providing a three-year comparison profile of these 163 participants?
3. May we receive a list of the COTH members who are included in the expanded sample when it is completed?
4. What would be the estimated cost of a quarterly or semi-annual report, from the expanded sample, for COTH members? I realize that in this case there are probably development or programming costs, particularly if we agreed on bed size and regional variables being included. Assumedly, we can work out the front-end financial arrangement separately from the cost of quarterly or semi-annual reports.

Dave also made me aware of a number of technical decisions (e.g., how to deal with variable participation rates) which also must be considered. I look forward to hearing from you so that we can have a thorough discussion of these matters. If you feel I should visit Chicago, or you wish to come see us in Washington, please let me know.

Sincerely,

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

RMK:car

cc: David Drake



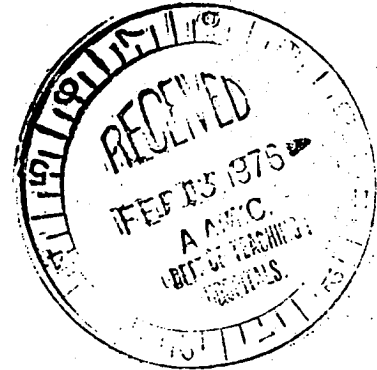
AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910-221-0300

DIVISION OF PROFESSIONAL RELATIONS

HARRY R. HINTON  
Director  
(751-6455)

February 10, 1976



Richard M. Knapp, M.D.  
Director  
Department of Teaching Hospitals  
COTH-AAMC  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Dear Doctor Knapp:

I recently had the opportunity to read the interesting survey you put together on Housestaff Policy. It is very complete and informative.

In particular, I was interested in your section on Collective Negotiations. As a new department in AMA, we are looking to all sources of information to build a factual file and library in order to be of assistance to our membership. Your survey showing 12% of the reporting hospitals with Housestaff contracts, 9% expecting negotiations and 50% having Housestaff associations without formal recognition opens up a large area to research.

I realize that surveys are intended to maintain anonymity in the presentation of their results. However, with our interest in building a library of source data, would it be too presumptive to ask if you could give me the names of the hospitals that make up the 12%, 9% and 50%? In corresponding with them I will make no reference to your survey, but merely request copies of contracts, cooperation procedures, etc.

Ike Mayeda, who is our Program Coordinator, just stopped by and asked me to say "Hello."

Thank you for whatever help you can give us. Certainly, if we can be of any service, please let us know.

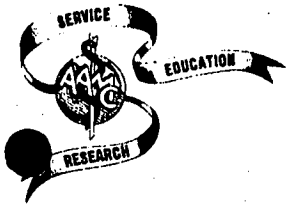
Sincerely,

Seymour J. Burrows  
Department of Negotiations

SJB:iem

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

February 26, 1976

Seymour J. Burrows  
Department of Negotiations  
American Medical Association  
535 North Dearborn Street  
Chicago, Illinois 60610

Dear Mr. Burrows:

I have received your letter of February 10 requesting the names of the hospitals that make up the 12% of the reporting hospitals with house-staff contracts, 9% expecting negotiations and 50% having housestaff associations without formal recognition. As you suggest, our survey reports are intended to maintain anonymity in the presentation of results. Our policy on this matter would not permit me to share the names of the individual hospitals in these various categories with you. However, I will bring your letter to the attention of the Council of Teaching Hospitals Administrative Board for review at its meeting on March 24. If an exception to our policy is recommended by the Board I will be in touch with you.

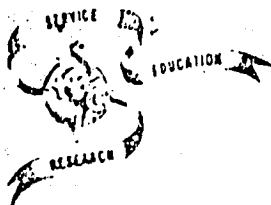
We do have some obvious areas of mutual interest, and I hope that if you are in Washington you would stop by and see me. Perhaps the next time I am in Chicago I might be able to spend some time with you.

Give my best to Ike Mayeda.

Sincerely,

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

RMK:car



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

February 27, 1976

Honorable William R. Cotter  
U.S. House of Representatives  
213 Cannon House Office Building  
Washington, D.C. 20515

Dear Mr. Cotter:

Following testimony on February 10, 1976, by David D. Thompson, M.D., before the Subcommittee on Health of the House Ways and Means Committee, you requested data comparing costs of "university" hospitals to community hospitals. There are sixty-three hospitals in the United States which are owned or operated by universities similar to the arrangement at the University of Connecticut Health Center.

All of these sixty-three university hospitals and an additional 333 major teaching hospitals comprise the membership of the Council of Teaching Hospitals (COH) of the Association of American Medical Colleges. There are a number of dimensions which characterize the unique nature of these teaching hospitals and these features as noted below, are worth reviewing:

- the size and scope of the intern and resident staff;
- the number of fellowship positions;
- the extent to which the full range of clerkships is offered to undergraduate medical students;
- the number and scope of allied health education programs sponsored by the hospital or in which the hospital participates;
- the volume of research undertaken;
- the extent to which the medical faculty is integrated with the hospital medical staff in terms of faculty appointments;
- the nature and substance of the medical school affiliation arrangement;
- the appointment of full-time salaried chiefs-of-service;

- the number of full-time salaried physicians;
- the number of special service programs offered, e.g., neonatal care units, pediatric evaluation centers or renal dialysis units;
- the level of complexity demonstrated by the diagnostic mix of patients;
- the staffing pattern and ratios resulting from the distinctive patient mix;
- the scope and intensity of laboratory and x-ray services;
- the financial arrangements and volume of service rendered in outpatient clinics.

Individual teaching hospitals demonstrate each of these characteristics in varying degrees as exhibited in Table I (attached). As noted, 96 percent of the COTH members have an intensive care unit as compared to 60 percent of all non-Federal, short-term, general hospitals. Additionally, 97 percent of the COTH members have social work departments compared to 46 percent of all community hospitals with such facilities; 73 percent of the COTH members have renal dialysis units compared to 12 percent for all community hospitals. It is the scope and intensity of care reflected in the provision of these services as well as the combination of unique features recounted above which result in the higher costs of teaching hospitals.

These institutions produce a different product in terms of patient care and professional service while serving as the environment for the conduct of clinical research and the education of future physicians and other health care personnel. Table II (attached) portrays the fact that these 303 major teaching hospitals (non-Federal, short-term) comprise approximately five percent of the nation's hospitals, while training sixty percent of the nation's interns and residents and 45 percent of all other health care professionals.

Tables III and IV present recent trends in hospital costs for hospitals which participate in the Hospital Administrative Service Program of the American Hospital Association (AHA). Table III arrays expenses per patient day for the years 1971-73. The teaching hospitals in this particular analysis include 129 hospitals which have a major affiliation with a college of medicine.

The table reveals a difference of \$31.68 in 1971 and \$35.48 in 1973 between the expenses per patient day for teaching hospitals and the community hospitals over 400 beds. The difference remains quite close to 29 percent for all three years, although the rate of increase for teaching hospitals decreased from 8.7 percent for 1971-72 to 4.9 percent for 1972-73.

Honorable William R. Cotter  
February 27, 1976  
Page Three

A basic problem with relating expenses to patient days is that it provides only a static picture of hospital unit costs. By not accounting for intensity changes and patient length of stay variations, historical comparisons of per diem costs are subject to substantial distortion. For example, if the number of admissions remained constant and the length of stay decreased over time, expenses per patient day would increase, although expenses per admission may remain the same or may, in fact, decrease. Consequently, comparisons made with per diem hospital cost measures would present an inflated picture of cost increases.

We are in the process of compiling a wide array of data which hopefully will provide a historical and contemporary statistical profile of teaching hospitals as they compare to community hospitals. We will submit additional data and analysis to you as it becomes available.

I do hope the documentation enclosed with this letter sufficiently addresses the question you raised on February 10. I would appreciate your ensuring that a copy of this letter becomes a part of the record of that hearing and our testimony.

Sincerely,



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

RMK:car

Attachments:

cc: Honorable Dan Rostenkowski  
Chairman, Subcommittee on Health  
House Ways and Means Committee

TABLE I  
COMPARISON OF COTH WITH ALL HOSPITALS\*  
LISTED IN AHA DIRECTORY, 1974

Category	COTH	AHA	COTH ÷ AHA	% of COTH	% of AHA
				With Facilities	With Facilities
	Special Facilities			%	%
1. Intensive Care Unit	292	3,601	8.1	96	60
2. Intensive Cardiac Care Unit	245	1,936	12.7	81	32
3. Open Heart Surgical Facilities	217	490	44.3	72	8
4. X-Ray Therapy	267	1,804	14.8	88	30
5. Cobalt Therapy	200	763	26.2	66	13
6. Radiation Therapy	258	1,408	18.3	85	24
7. Histology Lab	288	2,793	10.3	95	47
8. Organ Bank	66	161	41.0	22	3
9. Blood Bank	287	3,548	8.1	95	59
10. EEG	296	2,370	12.5	98	40
11. Inhalation Therapy	294	4,166	7.1	97	70
12. Premature Nursery	244	2,078	11.7	81	35
13. Self Care Unit	51	179	28.5	17	3
14. Extended Care Unit	26	655	4.0	9	11
15. Inpatient Renal Dialysis	220	690	31.9	73	12
16. Outpatient Renal Dialysis	179	573	31.2	59	10
17. Physical Therapy	296	4,059	7.3	98	68
18. Occupational Therapy	215	1,063	20.2	71	18
19. Rehabilitation Inpatient Unit	92	301	30.6	30	5
20. Rehabilitation Outpatient Unit	138	430	29.8	42	7
21. Psychiatric Inpatient Unit	190	949	20.0	63	16
22. Psychiatric Outpatient Unit	198	644	30.7	65	11
23. Psychiatric Partial Hospitalization	111	452	24.6	37	8
24. Psychiatric Emergency Services	197	1,030	19.1	65	17
25. Psychiatric Home Care	22	50	44.0	7	8
26. Social Work Department	295	2,742	10.8	97	46
27. Family Practice	129	382	33.8	43	6
28. Home Care	74	350	21.1	24	6
29. Emergency Department	289	4,820	6.0	95	81
30. Diagnostic Radioisotope Facility	290	2,720	10.7	96	46
31. Therapeutic Radioisotope Facility	254	1,317	19.3	84	22
32. Burn Care Unit	69	155	44.5	23	3
33. Organized Outpatient Department	283	1,427	19.8	94	24
34. Inpatient Abortion Service	131	1,066	12.3	43	18
35. Outpatient Abortion Service	72	495	14.5	24	8

\* Non-Federal Short-Term Hospitals

Source: From the Records of the AHA's Annual Survey of Hospitals, 1974

TABLE II  
COMPARISON OF COTH WITH ALL HOSPITALS\*  
LISTED IN AHA DIRECTORY, 1974

<u>Category</u>	<u>COTH</u>	<u>AHA</u>	<u>COTH :AHA</u>
<u>Hospital Utilization</u>			
1. Hospitals	303**	5,977	5.1
2. Total Beds	170,363	931,000	18.3
3. Total Admissions	5,269,616	32,943,000	16.0
4. Inpatient Days	49,071,937	255,761,553	19.2
5. Average Daily Census	134,144	701,000	19.2
6. Percent Occupancy	78.9	75.3	--
7. Average Length of Stay	9.3	7.8	--
8. Emergency Room Visits	10,720,289	67,056,890	16.0
9. Non-Emergency Room Visits	29,778,372	127,781,424	23.3
10. Total Outpatient Visits	40,753,042	194,838,314	21.0
11. Emergency Room Visits Per Bed	63	72	--
12. Total Surgical Operations	2,812,705	16,216,735	17.3
13. Surgical Operations % Admissions	52	49	--
14. Intensive Care Beds	5,123	29,113	17.6
15. Intensive Cardiac Beds	2,007	11,776	17.0
16. Self-Care Beds	1,539	4,447	34.6
17. Extended Care Beds	1,380	29,041	4.8
18. Inpatient Rehabilitation Beds	2,880	8,254	34.9
19. Inpatient Psychiatric Beds	9,513	30,822	30.9
20. Home Care Visits	374,575	1,514,930	22.9
<u>Personnel and Payroll</u>			
1. Total Payroll (\$000s)	\$4,179,503	\$17,861,000	23.4
2. Total All Expenses (\$000s)	6,813,761	32,751,000	20.8
3. % Payroll/Expenses	61.1	54.5	--
4. Physicians, Full-Time Equivalent	12,186	28,682	42.5
5. Interns and Residents (FTE)	32,756	54,168	60.5
6. Other Trainees (FTE)	10,290	22,574	45.6
7. Total Personnel (FTE)	528,812	2,288,721	14.0

\*Non-Federal Short-Term Hospitals

\*\*The difference between the 396 COTH members (333 plus 63 university-owned) referenced in the letter and the 303 reported here is due to "non-reporting" institutions and the fact that this table excludes Federal (Veterans Administration and other) hospitals as well as long-term facilities.

Source: From the Records of the AHA's Annual Survey of Hospitals, 1974

TABLE III  
EXPENSES PER PATIENT DAY (RCCAC)  
FOR THE THREE MONTHS ENDING  
MARCH 1971, 1972, 1973

Bed size category	RCCAC			Percentage Change	
	1973	1972	1971	1972-73	1971-72
Under 50 beds	\$ 66.29	\$ 60.24	\$ 55.38	10.0%	8.8%
50-74 beds	68.72	64.21	57.00	7.0	12.6
75-99 beds	75.29	70.34	64.37	7.0	9.3
100-149 beds	76.92	70.91	65.91	8.5	7.6
150-199 beds	85.39	78.71	70.95	8.5	10.9
200-299 beds	88.63	82.99	74.57	6.8	11.3
300-399 beds	90.84	86.18	77.70	5.4	10.9
Over 400 beds	91.48	86.05	79.65	6.3	8.0
Teaching	126.96	121.02	111.33	4.9	8.7

TABLE IV  
AVERAGE LENGTH OF STAY  
MEDICAL AND SURGICAL ADMISSIONS  
FOR THE THREE MONTHS ENDING MARCH 1972, 1973

	Length of Stay		Percentage Change 1972-73
	1973	1972	
Under 50 beds	6.6	6.8	-2.9%
50-74 beds	6.9	7.2	-4.2
75-99 beds	7.0	7.1	-1.4
100-149 beds	7.3	7.6	-3.9
150-199 beds	7.5	7.8	-3.8
299-299 beds	7.8	8.0	-2.5
300-399 beds	8.4	8.5	-1.2
Over 400 beds	8.8	9.1	-3.3
Teaching	9.6	10.1	-5.0

Source: Hospitals, Journal of the American Hospital Association, Volume 47,  
Number 16, August 16, 1973.



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

MAR 05 1976

REFER TO:  
IHI-324

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

Dear Dr. Knapp:

This is in reference to your letter concerning implementation of exceptions under section 405.460(f). You suggest we issue methodologies to assist hospitals in the preparation of exceptions for various items of cost including security, malpractice, wages, energy, nursing education, capital expenditures and shortened length of stay. We agree with you that additional instructional material would be helpful in this area so that a hospital is in a better position to determine whether it should file for an exception from the cost limits imposed under section 405.460(f).

However, we do detect from your letter some misunderstanding of the approach we are now following in evaluating exception requests. We will in this response try to clarify our approach. The rules under which an exception may be granted are described in section 405.460(f). In implementing such rules we have published, as we did in I.L. 75-50, formulas which allow the amount of the exception to be calculated when the facts indicate that such an exception is warranted. We have published, and will continue to publish, any calculation methods which have national application. It is important to note that our review of a provider's request for an exception is not the application of any particular methodology, but it is a review of the facts of a particular case under the rules specified in section 405.460(f). The cases which you mentioned in your letter of December 23, 1975, were simply adjudicated under the rules set forth in section 405.460(f), based on the facts presented by the provider. Of the situations which you mention in your letter, only malpractice insurance costs and energy costs have been presented with sufficient rationale and data for us to make a specific case decision and to prepare implementing instructions on calculating a precise limit adjustment. Other exception issues will be resolved when they are presented in actual case situations.

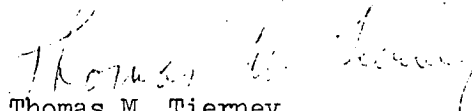


It cannot be overemphasized that exceptions are granted on the basis of evidence that a hospital has costs which are the result of an atypical situation causing it to exceed the cost limits and that otherwise its costs are reasonable. Moreover, the cost limits are based on the assumption made by Congress when it enacted section 223 that "data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of costs that would ordinarily not be expected to vary substantially from one institution to another." Broad brush allegations of atypical circumstances are made by some hospitals, but are not supported by evidence and are thus found unacceptable. It has become evident from our review of the exception requests to date that hospitals that have costs in excess of the limit often have inaccurate cost finding or are unable to justify the existence of these unusually high costs.

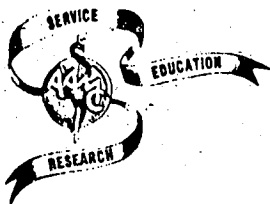
The Committee reports accompanying section 223 of P.L. 92-603 also discuss how relief from the cost limits may be obtained as follows, ". . . and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." This clearly indicates that the hospital needs to come forward with evidence to show that its high costs are attributable to a circumstance meeting the criteria for an exception (section 405.460(f)(2) and (3)) and thus rebut any inference that they result from the inefficient delivery of needed services. Thus, when a hospital exceeds the cost limit it is incumbent on the provider to demonstrate that its incurred costs are proper and necessary and that, for example, it is staffed at appropriate levels for the services provided. The basic tools needed for a hospital to make this type of self-analysis exist and are readily available. The HAS reports are but one example of such information.

But, as I stated at the outset of this letter, I am in total agreement with you for the need of further instructional material in this area. The cost limit exception process is a fairly new concept and as we get into it more deeply through the adjudication of individual requests for exceptions, guidelines will be emerging. We will, in time, be issuing these guidelines through I.L.'s and manual material so that hospitals and our intermediaries are better able to present and adjudicate cases.

Sincerely yours,



Thomas M. Tierney  
Director  
Bureau of Health Insurance



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.

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

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.

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Mr. Thomas M. Tierney  
December 23, 1975  
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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