



association of american medical colleges

MEETING SCHEDULE COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD

June 22-23, 1977
Washington Hilton Hotel
Washington, D.C.

Wednesday, June 22

6:00 P.M.	COTH Administrative Board Meeting	Bancroft Room
7:00 P.M.	Cocktails	Adams Room
8:00 P.M.	Dinner	Bancroft Room

Thursday, June 23

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

Council of Teaching Hospitals
Administrative Board

June 23, 1977
Washington Hilton Hotel
Kalorama Room
9:00 a.m. - 1:00 p.m.

A G E N D A

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|-------|---|--|
| I. | Call to Order | |
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Downey, California | Page 36 |
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Dr. Kennedy |
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| VIII. | Report on LCGME Activities | Dr. Heyssel |
| IX. | Medicare Payment of Interest Expense | Page 61 |
| X. | Report of the Ad Hoc Committee on
Administration's Hospital Cost
Control Program | Separate Attachment
Mr. Everhart |
| XI. | New Business | |
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Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
March 31, 1977

MINUTES

PRESENT:

David D. Thompson, M.D., Chairman
David L. Everhart, Chairman-Elect
Charles B. Womer, Immediate Past Chairman
John Reinertsen, Secretary
John W. Colloton
Jerome R. Dolezal
James M. Ensign
Robert M. Heyssel, M.D., Ex Officio Member
Mitchel T. Rabkin, M.D.
Malcolm Randall
William T. Robinson, AHA Representative

ABSENT:

Baldwin G. Lamson, M.D.
Stuart Marylander
Stanley R. Nelson
Robert E. Toomey

GUESTS:

Allen J. Manzano, AHA Vice-President

STAFF:

James D. Bentley, Ph.D.
Armand Checker
John A. D. Cooper, M.D.
Gail Gross
James I. Hudson, M.D.
Joseph C. Isaacs
H. Paul Jolly, Ph.D.
Richard M. Knapp, Ph.D.
Emanuel Suter, M.D.

I. Call to Order:

Dr. Thompson called the meeting to order at 9:00 A.M. in the Independence Room of the Washington Hilton Hotel.

II. Consideration of Minutes:

The minutes of the January 13, 1977 COTH Administrative Board meeting were unanimously approved.

III. Membership Applications:

The Board reviewed three applications for membership and took the following action:

The Children's Hospital
Birmingham, Alabama

IT WAS MOVED, SECONDED, AND CARRIED
TO RECOMMEND APPROVAL FOR REGULAR
MEMBERSHIP

Veterans Administration Hospital
Northport, New York

IT WAS MOVED, SECONDED, AND CARRIED
TO RECOMMEND APPROVAL FOR REGULAR
MEMBERSHIP

Veterans Administration Hospital
Hampton, Virginia

IT WAS MOVED, SECONDED, AND CARRIED
TO RECOMMEND APPROVAL FOR REGULAR
MEMBERSHIP

ACTION ITEMS

IV. Talmadge Committee Report

Federal vs. State Cost Control:

Mr. Manzano presented AHA's point of view on Federal vs. State cost control under Section 10 of the Talmadge Bill, stating that his Association supports state rate review under specific federal guidelines. Commenting on the AAMC's recommendation on this issue, he said that, as presently stated, it did not conform to the AHA position. Mr. Manzano also suggested that, with regard to Medicaid, inadequacy of funding, not cost control, was really the basic problem at issue here. Mr. Womer expressed that he was more satisfied with the administration of Medicare across the country than he was with Medicaid. He stated that the diversity of the state political environment across the country makes federal control less arbitrary and capricious than would be the case under local political control. Mr. Womer noted that there is much competition among regulators and that the option of state control would promote development of control mechanisms for all payors in states that would not have developed them otherwise. Dr. Heyssel pointed out that the Maryland state rate review system is not as onerous as many had anticipated and that he would have difficulty supporting any recommendation that didn't

leave the option of state controls open. Mr. Everhart emphasized the fact that federal programs such as PSROs and Health Planning were now being administered by the states under federal guidelines and that the reimbursement control system should be coordinated with these other federal programs. Mr. Randall, on the other hand, stressed that HSAs have been damaging to teaching hospitals in his area with decisions that have been punitive in nature and asked whether this is what is wanted under cost controls. In response to Mr. Randall's comment, Dr. Thompson stated that the Association must push for recognition of teaching hospitals as a national resource to be treated as such not only under reimbursement policies, but also under health planning policy to maintain synchronization. Mr. Colloton suggested coming down hard in favor of state rate review programs, providing that federal financial requirements or guidelines are fully met. This middleground position appeared favorable to the Board by a straw vote of 2 for the original AAMC recommendation to 6 for the revised recommendation suggested by Mr. Colloton.

ACTION: It was moved, seconded and carried that the present AAMC recommendation be revised to read:

"It is recommended that the AAMC strongly support federal payment standards for the Medicare and Medicaid programs based upon the full financial requirements of hospitals. This recommendation should not be interpreted to preclude support of state level administration of rate review systems, established either voluntarily or by statute, providing such systems meet federal standards."

Separate Category for Teaching Hospitals:

Dr. Knapp pointed out that the two problem areas with this issue are (1) the practicality of how to classify the teaching hospital and (2) how politically feasible is a separate classification category. Dr. Rabkin noted that the Harvard affiliated hospitals attempted to define teaching hospitals and recommended removing the size variable while advocating case mix (diagnostic related) and scope of services/facilities. He also suggested that the differences in costs might be recognized without having to define teaching hospitals. Dr. Heyssel stated that a hospital cannot be defined on the basis of its relationship with the medical school and stressed that the issue of how to define teaching hospitals will have to be confronted under the planning law and capital controls. Dr. Thompson suggested that the current AAMC recommendation on this issue be amended to reiterate its basic intent, while adding the need for a flexible classification system which considers case mix and intensity measures.

ACTION: It was moved, seconded, and carried that the present AAMC recommendation be amended to read:

"It is recommended that the AAMC's position on payment categories for the tertiary care/teaching hospital be retained and strengthened by advocating the development of a flexible classification system providing due consideration for case mix, intensity of care, and health science education."

Removal of Specific Costs:

ACTION: It was moved, seconded, and carried that the Ad Hoc Committee recommendation be approved as reported (as presented on page 63 of the Executive Council agenda), changing only the word "reimbursement" to "payment."

Wage Rate Adjustments:

ACTION: It was moved, seconded, and carried that the Ad Hoc Committee recommendation be approved as reported (as presented on page 64 of the Executive Council agenda), changing only the phrase "the segment" to "those segments."

Section 22:

ACTION: It was moved, seconded and carried that the six Ad Hoc Committee recommendations pertaining to Section 22 be approved as reported (as presented on pages 64-68 of the Executive Council agenda), substituting the word "payment" wherever the word "reimbursement" appears.

Section 8:

ACTION: It was moved, seconded, and carried that the Ad Hoc Committee recommendation be approved as reported (as presented on page 68 of the Executive Council agenda).

Section 12:

ACTION: It was moved, seconded, and carried that the Ad Hoc Committee recommendation be approved as reported (as presented on page 69 of the Executive Council agenda).

Section 40:

ACTION: It was moved, seconded, and carried that the AAMC retain its present opposition to the provisions of Section 40.

Copy of final report attached as Appendix A to these minutes.

V. Guidelines for the Application of Hospital Accreditation Standards in Surveying University Hospitals

Dr. Knapp recalled that an informal committee had been established at the last Administrative Board Meeting (January 13th) to revise the guidelines due to the Board's dissatisfaction with the document at that time. Mr. Colloton, who headed the committee, then highlighted and explained the revisions recommended by the group. A discussion of current Joint Commission on the Accreditation of Hospitals' (JCAH) policy toward university-owned and VA hospitals followed. Concern was expressed regarding how the prepared guidelines would be interpreted by the JCAH for use by its surveyors and the Board agreed that a letter of transmittal should accompany the document, outlining specific points to be considered in implementing the guidelines.

ACTION: It was moved, seconded, and carried that the "Guidelines for the Application of Hospital Accreditation Program Standards in Surveying University Hospitals" be approved and forwarded to the JCAH with a cover letter that summarizes the most salient of the unique characteristics of university hospitals upon which the guidelines focus.

Copies of the transmittal letter and report sent to the JCAH are attached as Appendix B to the minutes.

VI. Letter to HEW Secretary Califano

Dr. Knapp distributed copies of a draft letter to be sent to Secretary of HEW Joseph A. Califano, Jr. from Dr. Cooper in response to concerns expressed by a number of member institutions over particular rules in the Provider Reimbursement Manual regarding the treatment of federal and state grants (i.e., "seed money" grants) for medical education in computing allowable costs for providers under the Medicare program. Dr. Knapp expressed the belief that the position taken in the letter on this reimbursement issue was reasonable and asked the Board for its reactions and suggestions. The Board expressed support of the letter without change.

ACTION: It was moved, seconded, and carried that the letter to Secretary HEW Joseph A. Califano, Jr., concerning the treatment of federal and state grants (i.e., "seed money" grants) for medical education in computing allowable costs for providers under the Medicare program, be approved and sent to him as drafted.

A copy of the letter is attached as Appendix C to these minutes.

VII. Admission of FMGs as Exchange Visitors

VIII. Eligibility Requirements for Entry Into Graduate Medical Education

Dr. Suter distributed position papers entitled, "The Implementation of Title VI Provisions for Foreign Graduate Exchange Visitors" and "Problems Re Foreign Medical Graduates." He presented the major points of these papers and requested the Board's support for the recommendations set forth in them, as well as for those presented in the Executive Council Agenda that address the issues under discussion.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to approve the policy statements presented on page 50 of the Executive Council Agenda, which set forth the roles of the AAMC and the ECFMG to take effect at the termination of the blanket waiver issued by the HEW Secretary and upon the availability of the Visa Qualifying Examination abroad.

ACTION: It was moved, seconded and carried that the Executive Council be recommended to request that the LCGME withdraw recognition of ECFMG certification based upon passing the ECFMG examination, and require that after July 1, 1978 all physicians educated in medical schools not accredited by the LCME be required to have ECFMG certification based either on passing Parts I and II of the NBME exam or the exam determined as equivalent by the Secretary of HEW.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to authorize staff to press for speedy implementation of the provisions contained in Title VI of P.L. 94-484 regarding J-visas and waivers.

ACTION: It was moved, seconded, and carried that the AAMC should negotiate with the Department of State on arrangements under which FMGs with characteristics qualifying them for graduate medical education can be admitted under student (F1) visas, with the option to change to J-visa status as soon as the individual has met the J-visa requirements and is acceptable as a participant in an american graduate medical education program.

ACTION: It was moved, seconded, and carried that no special provisions need to be made at this time for advanced graduate medical education students being trained in the U.S. for faculty positions in foreign medical schools, or for other comparable responsibilities, but that remedial steps could be taken at a later date if necessary.

ACTION: It was moved, seconded, and carried that the AAMC request the Department of Justice amend the regulation for distinguished physician visitors, striking the word solely and that the AAMC request the chairperson of the appropriate Congressional Committees to inform the Department of Justice that the present regulations fail to reflect Congressional intent.

ACTION: It was moved, seconded, and carried that the AAMC recommend that a technical amendment to P.L. 94-484 or new legislation be formulated and enacted, under which the Secretary of HEW, upon application, could, on the advice of an appropriately constituted body determine whether the alien FMG candidate sought by U.S. medical institutions for a faculty position has competences equivalent to those embodied in U.S. faculty members. If the Secretary makes such a determination, he should be empowered to waive the examination requirement for issuance of a visa.

IX. CCME Committee on Physician Distribution Report: The Specialty and Geographic Distribution of Physicians

Dr. Thompson, as a member of this CCME committee, provided background information on the report and expressed certain misgivings he had regarding both the manner in which the report was developed and its contents. But he noted that there is considerable pressure to publish the report simply because the CCME cannot afford not to take a public position on such an important issue. Dr. Cooper pointed out that the report overlooked a number of very important concerns and was highly biased by the AMA representation on the committee (i.e., Drs. William Holden and Thomas Dublin). He stated that Dr. August Swanson was also a member of the committee, but his input was disregarded. The report, Dr. Cooper stressed, is not a scholarly document and does not assist one in arriving at factual conclusions or rational judgements. He indicated that existing legislation is extremely muddled on the issue of physician distribution. The report under discussion, in the staff's view, does not adequately address the issue; therefore, a strong AAMC response to the report is necessary to assure that what eventually does get published will address the issue much more appropriately. The Board agreed that the response to the report needed to be strong yet dignified.

ACTION: It was moved, seconded, and carried that the Executive Council be strongly recommended to transmit to the Coordinating Council on Medical Education the summary of responses to the report which are set forth on pages 43-47 of the Executive Council Agenda.

X. Letter from the American College of Surgeons

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to endorse responding to the American College of Surgeons by supporting the three principles presented on page 53 of the Executive Council Agenda.

XI. Uniformed Services University of the Health Sciences

Dr. Cooper expressed the feeling that the AAMC should stay out of the current politics surrounding the issue and noted that the Chairman of the House Armed Services Committee was strongly in favor of retaining the "military medical school."

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to reaffirm its position as presented in Dr. Cooper's letter of June 25, 1975 to Dr. Anthony Curreri, President of the Uniformed Services University of the Health Sciences. It was also recommended that the Executive Council agree that the Association members and staff work to help place the currently enrolled USUHS students in other U.S. medical schools and assist displaced faculty in finding new positions in the event that the Congress decides to close the school.

XII. AAMC Involvement in the USFMS Transfer Program

Dr. Cooper provided background information and distributed a position paper on the subject. He expressed the belief that handling the USFMS Transfer Program would be a "no-win job" for the AAMC and that the ECFMG would be a more appropriate unit for the job.

ACTION: It was moved, seconded, and carried that the AAMC should not undertake the task of verifying the documents submitted by USFMS transfer applicants.

XIII. LCCME 1977 Budget

ACTION: It was moved, seconded, and carried that the proposed interim LCCME budget for 1977 be approved with the request that a final budget be submitted as soon as possible.

XIV. Rules and Regulations of the Planning Coordinators' Group

ACTION: It was moved, seconded, and carried that the Rules and Regulations of the Planning Coordinators' Group be approved as modified.

XV. Kountz v. State University of New York (SUNY)

Copies of the original decision finding against SUNY were distributed. After some discussion, the Board agreed that the AAMC should join SUNY's appeal as amicus curiae, but expressed that the particular case in question is not one that they would have liked to have seen the Association have to support on the issue of faculty practice plans and the integral nature of teaching and patient care responsibilities.

ACTION: It was moved, seconded, and carried that the Association be recommended to join with the State University of New York in filing an amicus curiae brief in the case of Kountz v. State University of New York.

XVI. Reduced-Schedule Residencies

Dr. Rabkin described his experience with reduced-schedule residencies as "good", stating that "there is extra cost in administration but you get more than half of the schedule from each person sharing the residency." Mr. Ensign, on the other hand, questioned whether such residencies will serve to encourage "moonlighting" as well as part-time residents who are not motivated to take these positions for legitimate personal or social reasons.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to "recognize the need for" (instead of "both endorse encouraging," as stated in the recommendation on page 36 of the Executive Council Agenda) the development of reduced - schedule positions and to ask the LCGME to establish policies and mechanisms to permit their identification so that they may be listed in the NIRMP Directory.

XVII. Recommendation for Coordination of the Application Cycles for GME Programs Recruiting Medical Students for GME-II Positions

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to approve the statement presented on page 37 of the Executive Council Agenda, which will be forwarded to the LCGME, the American Board of Medical Specialties, the Council of Medical Specialty Societies, and organizations of program directors.

DISCUSSION ITEMS

XVIII. AAMC Grant for Gene Rubell

Dr. Knapp explained that the AAMC has engaged the services of Gene Rubell (former director of BHPRD) and granted him \$5,000 in travel money to visit a number (eight or so) of teaching hospital, medical school and Health Systems Agency (HSA) executives to determine the current and future implications of the implementation of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) as it pertains to the academic medical center. He will also be specifically examining the extent to which teaching hospital directors and medical school deans are involved in the decision-making process of HSAs. He will report to the AAMC on his findings and observations later in the year.

XIX. Letter to Jim Kaple Concerning Uniform Accounting Requirements in the Outpatient Department

Dr. Bentley reported that there was still no firm schedule for when the third draft of the Uniform Accounting Manual would be released by the Bureau of Health Insurance, but that it was expected out in the near future. At that time, the document will be circulated to all interested parties. BHI has been working to get it published in the Federal Register and will be implementing the requirements on an experimental basis in five states.

Dr. Bentley reported that recent discussions with SSA representatives indicated that the rigid outpatient clinic accounts proposed in the second draft of the Uniform Accounting Manual had been tentatively revised. If adopted the current proposal would establish mandatory accounts only for emergency, referred ambulatory, ambulatory surgery, and "other" ambulatory clinic services. While clinic-by-clinic subaccounts would not be mandatory, SSA would probably establish an optional list of subaccounts and suggest that institutions with the named clinics use the SSA account numbers whenever possible.

NEW BUSINESS

XX. An Expression of Appreciation to Cathi Rivera

Mr. Womer expressed that the COTH Administrative Board was quite surprised to learn of Ms. Rivera's departure from the AAMC and was disappointed that the Board didn't have the opportunity to say farewell, convey its gratitude, and wish her much happiness in her new position. Mr. Womer introduced a resolution to be sent to Cathi that was unanimously adopted by the Board.

ACTION: It was moved, seconded, and carried that the following resolution be both placed into the record and forwarded to Ms. Cathi Rivera:

The COTH Administrative Board expresses its sincere appreciation to Cathi Rivera for her yeoman (i.e., yeoperson) efforts and hard work on behalf of the COTH and for her unswerving spirit of friendship and helpfulness to the members of the Council and Administrative Board. We wish her well.

XXI. Adjournment

The meeting was adjourned at 12:45 P.M.

THE TALMADGE BILL:
A REVIEW OF AAMC POSITIONS

BACKGROUND

On March 25, 1976, Senator Herman Talmadge -- Chairman of the Subcommittee on Health of the Senate Finance Committee -- introduced the "Medicare and Medicaid Administrative and Reimbursement Reform Act." The bill, formally number S. 3205, was developed over a period of several months with the active cooperation of several health associations. Prior to the bill's introduction, AAMC staff met repeatedly with staff from the Senate Finance Committee to discuss general concepts and tentative provisions being considered by Senator Talmadge. Finance Committee staff also discussed the essence of the proposed bill with the COTH Administrative Board at the Board's January 1976 meeting.

As introduced, S. 3205 contained several significant provisions, including proposals to:

- centralize federal health care financing,
- implement a uniform hospital accounting and reporting system,
- establish a revised reimbursement limitation procedure for routine service costs to replace Section 223 of P.L. 92-603,
- establish a special reimbursement limitation category for the "primary affiliates of accredited medical schools" limited to one hospital per school, and
- eliminate Medicare/Medicaid recognition of percentage contracts for hospital-associated physicians.

At Senate hearings on July 26, 1976 and at House hearings on August 3rd, Charles B. Womer -- then Chairman of the Council of Teaching Hospitals -- presented the AAMC testimony which concentrated on the hospital classification and reimbursement provisions of the proposal. Appendix A is a summary of the Association's 1976 testimony.

Senator Talmadge is presently revising his 1976 bill, perhaps in cooperation with the Carter Administration. In anticipation of the introduction of the revised bill, the AAMC established an Ad Hoc Committee to Review the Talmadge bill and the Association's present position and testimony on the bill.

The Ad Hoc Committee chaired by Irvin Wilmot -- Executive Vice President of the University Hospital, New York University Medical Center -- was composed of Daniel Barker, Administrator of Crawford W. Long Memorial Hospital, Atlanta; Ellis Benson, M.D., Chairman of Laboratory Medicine and Pathology, University of Minnesota Medical School; Stuart Bondurant, M.D., President and Dean, Albany Medical College; John Colloton, Director, University of

Iowa Hospitals and Clinics; Marvin Cornblath, M.D., Chairman of Pediatrics, University of Maryland Medical School; John Dennis, M.D., Dean, University of Maryland; and Jerome Modell, M.D., Chairman of Anesthesiology, University of Florida College of Medicine. On February 1st, the Committee met to discuss the Association's position on Section 10 of the bill, "Improved Methods for Determining Reasonable Cost of Services Provided by Hospitals," and Section 22 concerning "Hospital Associated Physicians."

The Ad Hoc Committee's report was reviewed by each Administrative Board of the Association on March 31st. The COTH Administrative Board proposed amending the Committee recommendations on the role of federal vs. state payment controls and on the establishment of a separate reimbursement category for teaching hospitals. The report, with its proposed amendments, was considered and approved by the AAMC Executive Council at its April 1st meeting.

AAMC POSITIONS

Section 10

In addressing Medicare payments to hospitals, three basic issues underlying the specific provisions of the Talmadge bill were examined: the relative desirability of federal vs. state payment standards for teaching hospitals, the desirability of a separate reimbursement limitation category for major teaching hospitals, and the removal of certain costs from the reimbursement limitation calculations.

Federal vs. State Payment Standards

Last year's AAMC testimony implicitly favored federal payment standards over state standards for the Medicare program, for the testimony advocated refinements for the specific provisions of a federally-directed program. This position was contrary to that of the American Hospital Association which advocated that "... where a state rate review program has been established, either by statute as in Maryland and Connecticut, or voluntarily as in Indiana, which applies to all purchases of care other than Medicare and Medicaid, and which is designed to meet the full financial requirements of the hospitals covered by the program, then Medicare and Medicaid should be required to pay the rates so established."

POSITION: THE AAMC STRONGLY SUPPORTS FEDERAL PAYMENT STANDARDS FOR THE MEDICARE AND MEDICAID PROGRAMS BASED UPON THE FULL FINANCIAL REQUIREMENTS OF HOSPITALS. THIS POSITION SHOULD NOT BE INTERPRETED TO PRECLUDE SUPPORT OF STATE LEVEL ADMINISTRATION OF RATE REVIEW SYSTEMS, ESTABLISHED EITHER VOLUNTARILY OR BY STATUTE, PROVIDING SUCH SYSTEMS MEET FEDERAL STANDARDS.

The adoption of federal payment standards is sought for the following reasons. First, as a federally-funded program, Congress is responsible for ensuring that Medicare payments provide beneficiaries with appropriate benefits without undermining the financial integrity of hospitals. This responsibility should not be delegated to the states, for state rate review agencies could seek to establish inadequate Medicare payments to provide ceilings for state Medicaid and private payors. Second, if cost standards

for the Medicare program are established on a state-by-state basis, the medical education community will have to advocate and defend payment for medical education expenses in each state rather than at a national level. Third, because a given state can, to some degree, attract physicians rather than train adequate numbers, states may be tempted to substantially reduce Medicare payment for medical education. At the federal level, where a punitive reimbursement policy could harm the training of all physicians, arbitrary or capricious cutbacks in reimbursement expenses for education are less likely. Fourth, state cost standards could create artificial financial barriers inhibiting out-of-state referrals which are medically appropriate if care for patients from different states are reimbursed at different levels. These arguments for federal payment standards, do not necessarily preclude a role for state cost control agencies. Where such agencies establish specific payment rates meeting federal standards, the local option of having the state administer the program should be retained. This is especially true in states which have historically supported or assisted teaching hospitals and their medical education programs.

Separate Category for Teaching Hospitals

The Talmadge bill proposed a separate payment limitation category for the "primary affiliates of accredited medical schools" permitting one hospital to be included per medical school. In last year's testimony, the AAMC drew attention to the inadequacy of available data for examining the implications of this proposal, objected to the arbitrary limitations of one "primary affiliate" per medical school, and strongly recommended more flexible legislation requiring the Secretary of DHEW to examine the impacts of alternative definitions of the term "teaching/tertiary care hospitals."

The implications of a separate cost control category for major teaching hospitals are not clear, for no one knows how teaching hospitals will fare when certain costs are removed from the definition of routine costs. Proponents of a separate category argue (1) that teaching hospitals will exceed payment ceilings if classified with others because of the higher costs accompanying medical education programs, (2) that adequate methods to identify the impact of case mix differences do not presently exist so that a grouping of tertiary care facility is the only way to recognize the costs of atypical patient loads and hospital services, and (3) that a separate group will be essential for adequate payment when cost control is extended to ancillary services. Opponents of a separate category argue: (1) that a separate grouping will result, by definition, in a guarantee that some teaching hospital's exceed the teaching hospital ceiling; (2) that including major teaching hospitals in the general classification permits case mix to be used as a basis for an exception request; and (3) that it would be easier to alter the classification to establish a teaching hospital category, if experience demonstrates the need, than it will be to alter the classification to remove a teaching hospital category.

The government presently does not possess data which permit a description of the impact of a separate category as routine operating costs are defined under the Talmadge Bill. Thus, alternative definitions of the concept of major teaching hospitals can not be evaluated for their impact on reimbursement ceilings.

POSITION: THE AAMC RETAINS ITS OPPOSITION TO HOSPITAL CLASSIFICATION SCHEMES FOR MEDICARE/MEDICAID PAYMENTS (1) THAT DEFINE CLASSIFICATION CATEGORIES IN LEGISLATION RATHER THAN IN REGULATIONS AND (2) THAT LIMIT ANY TEACHING HOSPITAL CATEGORY TO ONE HOSPITAL PER MEDICAL SCHOOL. IN LIEU OF SUCH PROVISIONS, THE ASSOCIATION STRONGLY RECOMMENDS MORE FLEXIBLE LEGISLATION PROVIDING FOR HOSPITALS "TO BE CLASSIFIED BY SIZE AND TYPE" AND ADVOCATES REQUIRING THE SECRETARY OF HEW TO PROVIDE DUE CONSIDERATION IN THE CLASSIFICATION FOR THE IMPACTS OF CASE MIX, INTENSITY OF CARE, AND HEALTH SCIENCE EDUCATION ON HOSPITAL COSTS.

Removal of Specific Costs

The Talmadge bill excluded from routine operation costs: (1) capital costs; (2) direct personnel and supply costs of hospital education and training programs; (3) costs of interns, residents and medical personnel; and (4) energy costs associated with heating or cooling the hospital plant. It was also promised by the Senator that malpractice costs would be excluded. In its testimony before the House and Senate, the AAMC did not advocate a cross-classification approach. Rather, if such an approach is to be used, the Association has recommended the exclusion of specific costs components which will help ensure that variations in the remaining costs are not due to the nature of the product produced or the characteristics of the production process. Thus, given the approach proposed by Senator Talmadge, the Association supported the removal of these specific costs.

POSITION: WHERE CROSS-CLASSIFICATION SCHEMES FOR HOSPITAL REIMBURSEMENT CONTROLS ARE ADVOCATED, THE AAMC CONTINUES TO SUPPORT REMOVAL OF ATYPICAL AND UNCONTROLLABLE COSTS. FURTHER, THE AAMC SUPPORTS REMOVAL OF ASSOCIATED INDIRECT COSTS AND MORE FLEXIBLE LEGISLATIVE LANGUAGE WHICH WOULD PERMIT ADDITIONS TO THE LIST OF EXCLUDED COSTS WITHOUT NEW LEGISLATION.

The present list of excluded costs includes several significant items which make cost comparisons between hospitals difficult either because they are not uniformly present in all hospitals (e.g., stipends for residents), because they are uncontrollable by the institution (e.g., utility rates), or because there is substantial regional variation (e.g., malpractice premiums). However, because today's controllable cost may become tomorrow's uncontrollable cost, flexible legislation including, but not limited to, the costs excluded in the Talmadge bill is desirable. The specific exclusions could then be changed by regulation as circumstances changed.

Other: Wage Rate Adjustments

The procedure for calculating the reimbursement limitation for routine operating costs in the Talmadge bill includes an adjustment for changes in general wage levels in the hospital's geographic area. Because many medical centers must recruit personnel from outside of their immediate areas, last year's testimony recommended that the legislation be amended to include regional wage adjustments for skilled personnel. This position has been misunderstood by some who used a definition for the term region which is similar to the concept of health service areas. To reduce the possibility of this misinterpretation, a more broadly stated position has been adopted.

POSITION: THE AAMC RECOMMENDS THAT THE WAGE RATE ADJUSTMENT FOR SKILLED PERSONNEL BE BASED ON "THOSE SEGMENTS OF THE LABOR MARKET FROM WHICH HOSPITALS RECRUIT THEIR EMPLOYEES."

Section 22

This section contains three proposed amendments to the Medicare statutes: (1) a redefinition of the term "physicians' services," (2) some more explicit definitions of "physicians' services" for anesthesiologist and pathologist services, and (3) a limitation on Medicare recognition of certain payment arrangements for "physicians' services."

Defining "Physicians' Services"

Under present Medicare law, "the term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls. . . ." Section 22 proposes to extend the definition (proposed amendment in italics) to state: "the term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls. . . . *except that such term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any patient care service unless such service (a) is personally performed by or personally directed by a physician for the benefit of such patient and (b) is of such a nature that its performance by a physician is customary and appropriate.*"

Where a physician performs a "physicians' service," he is eligible for payment on a fee-for-service basis, under Medicare Part B; all other services performed by physicians are payable on a cost basis under Medicare Part A.

As presently stated, the amendment could be interpreted to mean that a faculty physician performing or directing personal medical services in the presence of a student is not eligible for a fee for his professional medical services because the physician will be defined as an educator whose services are to be paid on a cost basis. The AAMC is opposed to this interpretation and, therefore is opposed to the present wording of the amendment. Where a faculty physician is simultaneously performing or directing patient care and educational functions, the Association believes that the physician should be eligible either for professional service payment on a fee-for-service basis or for educator compensation on a cost basis. The Society of Academic Anesthesia Chairman has developed a revised amendment which would alter the language of the Talmadge Bill to permit these reimbursement alternatives (see Appendix B).

POSITION: THE AAMC ACTIVELY SUPPORTS AMENDING THE TALMADGE BILL TO EXPLICITLY PERMIT "PHYSICIANS' SERVICE" COMPENSATION FOR A PHYSICIAN WHO IS SIMULTANEOUSLY FUNCTIONING AS AN EDUCATOR AND PERSONALLY PERFORMING OR DIRECTLY IDENTIFIABLE PATIENT CARE SERVICES.

Anesthesiology and Pathology Services

Section 22 further defines "physicians' services" for anesthesiology and pathology services as follows:

Anesthesiology: In the case of anesthesiology services, a procedure would be considered to be 'personally performed' in its entirety by a physician only where the physician performs the

following activities:

- (A) preanesthetic evaluation of the patient;
- (B) prescription of the anesthesia plan;
- (C) personal participation in the most demanding procedures in this plan, including those of induction and emergence;
- (D) following the course of anesthesia administration at frequent intervals;
- (E) remaining physically available for the immediate diagnosis and treatment of emergencies; and
- (F) providing indicated postanesthesia care:

Provided, however, that during the performance of the activities described in subparagraphs (C), (D), and (E), such physician is not responsible for the care of more than one other patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E) and another individual performs the activities described in subparagraph (C), such physician will be deemed to have personally directed the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E) and the reasonable charge for such personal direction shall not exceed one-half the amount that would have been payable if he had personally performed the procedure in its entirety.

Pathology:

Pathology services shall be considered 'physicians' services' only where the pathologist personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. These include operating room and clinical consultations, the required interpretation of the significance of any material or data derived from a human being, the aspiration or removal of marrow or other materials, and the administration of test materials or isotopes. Such services shall not include such services as: the performance of autopsies; and services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operations that are customarily performed by nonphysician personnel.

Anesthesiologists have established and continue to maintain effective communications with Staff from the Senate Finance Committee, and it is understood that their proposed amendments (see Appendix C) are being actively considered.

POSITION: WITH THE INCORPORATION OF THE AMENDMENTS RECOMMENDED BY THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, THE AAMC SUPPORTS THE DEFINITION OF 'PERSONALLY PERFORMED' AND 'PERSONALLY DIRECTED' SERVICES FOR ANESTHESIOLOGISTS IN THE TALMADGE BILL.

Pathologists are opposed to the Talmadge bill on two grounds. First, the proposed provisions would tend to alter and restrict professional activities and services in clinical pathology. By emphasizing fee-for-service payment for surgical pathology services and hemato-pathology services, the bill would favor these two areas over other important areas of clinical pathology where distinct and medically important services are rendered.

Laboratory Medicine (Clinical Pathology) has become an important specialty of medicine within recent years both in teaching centers and in the community at large. Clinical pathologists provide a variety of services vital to medical care including the following: assurance of quality of laboratory procedures and results; guidance in the use of the laboratory, in the appropriateness of laboratory requests and in the interpretation of results; and interfacing between patient care physicians and the laboratory by providing two-way communication in the form of ad hoc consultation to clinicians on a wide variety of laboratory information and feed-back to the laboratory concerning specific clinical needs and problems. In addition to these vital functions, the clinical pathologist provides a broad variety of direct formal consultative functions in hematology, coagulation, microbiology, immunology, blood banking, and clinical chemistry (for example, bone marrow and peripheral blood examinations and reports in hematology).

Clinical pathologists have final medical and legal responsibility for all laboratory reports and verify their reliability. In this capacity, they also take responsibility for analytical validity and for the appropriateness of the methodological approach to the precise clinical needs, and they see to it that appropriate reference values are provided and are continuously reviewed and up-dated.

Secondly, by requiring Part A payment for some pathologist's services, pathologists feel they are being discriminated against in comparison with the treatment of other physicians. While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is opposed to payment mechanisms which would restrict the delivery of important physicians' services by pathologists and inhibit the development of the discipline.

POSITION: THE AAMC SUPPORTS COMPENSATION POLICIES WHICH WILL RECOGNIZE CRUCIAL PROFESSIONAL SERVICES IN PATHOLOGY AND WHICH WILL FURTHER THE DEVELOPMENT OF THE DISCIPLINE OF PATHOLOGY.

Limitations on Certain Compensation Arrangements

Where the hospital's allowable costs include "the charges of physicians or other persons which are related to the income or receipts of a hospital or any subdivision thereof," the Talmadge bill proposes that such charges would only be recognized as allowable costs to the extent that they do not exceed ". . . an amount equal to the salary which would reasonably have been for such services . . . if they had been performed in an employment relationship with such hospital . . .". This provision is the focus of two concerns. First, some specialists have traditionally been paid on a basis that is related to either hospital or departmental income or receipts. While not opposed to limiting the open-ended character of some of the compensation arrangements, the Association is concerned that the proposed limitation may place some disciplines at a financial disadvantage in comparison with other disciplines.

POSITION: THE AAMC OPPOSES PAYMENT LIMITATIONS ON ANY DISCIPLINE WHICH INHIBITS ITS DEVELOPMENT.

Secondly, while the objective of limiting Medicare recognition of charges based on percentage arrangements is clear, the bill includes no indication of the basis on which "... an amount equal to the salary which would have been paid. . ." is to be determined. Hospital chief executive officers and/or medical school deans are provided, in the proposed amendment, with no guidelines for determining the level of compensation that will be recognized as an allowable cost.

POSITION: THE AAMC RETAINS ITS PRESENT POSITION OF SEEKING A CLEAR AND CONSISTENT MEANS FOR DETERMINING A REASONABLE SALARY FOR PHYSICIANS IN EMPLOYMENT SITUATIONS.

Other: Hospital Associated Physicians

In the Talmadge bill, radiologists, pathologists, and anesthesiologists are referred to as "hospital associated physicians." The use of the terms hospital-associated or hospital-based physicians is objectionable to many physicians who feel that both imply that these specialists are somehow less independent than other specialists who perform in a hospital setting. Some have suggested, if it is necessary for the bill to refer generically to certain medical specialties practiced in the hospital, that the expression "physicians' services normally performed in a hospital" be used as the generic term.

POSITION: THE AAMC ENCOURAGES USE OF THE GENERIC PHRASE "PHYSICIANS' SERVICES NORMALLY PERFORMED IN A HOSPITAL" IN LIEU OF THE TERMS HOSPITAL-BASED OR HOSPITAL-ASSOCIATED PHYSICIANS.

OTHER TALMADGE PROVISIONS

Section 8

The Health Insurance Benefits Advisory Council (HIBAC) was established in the original Medicare legislation as a mechanism for providing the government with private sector advice on the implementation and operation of the Medicare program. Senator Talmadge has proposed that HIBAC be abolished. While current operation of HIBAC is not optimal, the AAMC believes it is desirable to maintain a formal mechanism whereby the private sector can provide the government with advice on Medicare operations.

POSITION: IF THE MEDICARE AMENDMENTS PROPOSE THE ABOLITION OF HIBAC, THE AAMC ACTIVELY ADVOCATES THE ESTABLISHMENT OF AN ADVISORY BOARD TO THE SECRETARY OF HEW WHICH IS COMPOSED OF PROVIDERS, PRACTITIONERS, AND CONSUMERS FROM THE PRIVATE SECTOR.

Section 12

The Talmadge bill advocates increasing the rate-of-return on net equity in investor-owned hospitals without a provision for a net operating margin (revenues less expenses) for non-profit hospitals. Without doubt, for-profit hospitals need a return on equity to attract investments, to support the risk taken in prospective payment systems, and to provide working capital. Non-profit hospitals also participate in prospective payment systems and require working capital. In addition, teaching and tertiary care hospitals need funds to support the transfer of new technologies from the research site the patient care setting. Thus a net operating margin is required to maintain the non-profit hospitals' financial integrity and to ensure their financial capability to underwrite the application of medical progress.

POSITION: THE AAMC ADVOCATES AN ADEQUATE MARGIN OF REVENUES OVER EXPENSES FOR NOT-FOR-PROFIT INSTITUTIONS.

Section 40

Section 40 requires the Secretary of HEW (1) to establish regulations for determining the reasonable cost or charges of direct and indirect overhead expenses and (2) to establish a program of review and advance approval of "consulting, management, and service contracts with an annual cost of \$10,000 or more." In last year's testimony, the AAMC opposed both provisions noting that the former places hospital management in an untenable position of both line-item and aggregate cost controls and that the latter would control whether hospital functions were performed by "in-house" or contract personnel.

POSITION: THE AAMC RETAINS ITS PRESENT OPPOSITION TO THE PROVISIONS OF SECTION 40.

CONCLUSION

The Association has carefully reviewed S. 3205 and its testimony on the bill. Position have been in general terms because the precise content and wording of a new Talmadge bill remains uncertain.

Appendix A

Summary of Written Testimony on S. 3205 of the Association of American Medical Colleges (AAMC)

I. Administrative Reforms

A. Establishment of Health Care Financing Administration

1. AAMC supports centralization of Federal health care financing.
2. AAMC recommends establishment of Under Secretary for Health with Assistant Secretaries for Health and Health Care Financing.
3. AAMC hopes consolidation is first step toward Cabinet-level Department of Health.

B. State Medicaid Administration: AAMC strongly endorses more rapid payment to providers.

C. Regulations of the Secretary

1. AAMC supports 60 day comment period.
2. AAMC requests some guidelines for defining "urgent" regulations.

II. Provider Reimbursement Reforms

A. Uniform Accounts, Cost Reporting and Allocation Procedures

1. AAMC supports uniform cost reporting.
2. AAMC urges adequate implementation period.

B. Classification of Hospitals

1. AAMC recommends more flexible legislation providing that hospitals "be classified by size and type" with guidance in the Committee report.
2. AAMC recommends appointment of a "National Technical Advisory Board" to recommend and evaluate classification systems.
3. AAMC opposes the establishment of a specific classification for "primary affiliates of accredited medical schools."
4. AAMC recommends that the Secretary, DHEW be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals."

C. Determining Routine Operating Costs

1. AAMC recommends providing Executive Branch with flexibility to specify ceiling with guidance in Committee Report.

2. AAMC supports exclusion of capital costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and medical personnel and energy costs associated with heating or cooling the hospital plant.
3. AAMC recommends exclusion from routine operating costs of malpractice premium costs and energy costs for lighting and facility operations.
4. AAMC recommends wage rate changes reflect regional costs for technical and professional personnel.
5. AAMC recommends Committee Report provide guidance on appropriate use of "surplus" for hospitals with costs below ceiling.
6. AAMC supports case mix provisions.
7. AAMC recommends strengthened exceptions procedure.
8. AAMC recommends advance notification of 120 days.

III. Practitioner Reimbursement Reforms: AAMC requests Subcommittee providing explicit guidelines for determining an amount equal to the salary which would have reasonably been paid . . ."

IV. Miscellaneous Reforms

- A. Percentage Contracts: AAMC requests clarification of intent of this subsection.
- B. Overhead Cost Controls
 1. AAMC believes simultaneous controls on individual overhead expenses and aggregate cost ceilings of Section 10 place management in untenable position.
 2. AAMC recommends Subcommittee adopt cost ceiling controls rather than line-item controls.
- C. Contract Approval
 1. AAMC recommends Subcommittee ensure that hospital governing boards and executive officers retain management control of their institutions.
 2. AAMC recommends subsection be re-written to focus on irregular, nearly fraudulent, and self-dealing contracts.

Appendix B

Talmadge Bill Amendment

proposed by

The Society of Academic Anaesthesia Chairmen

(a)(1) Section 1861 (q) of the Social Security Act is amended by adding "(1)" immediately after "(q)" and by adding, immediately before the period at the end of thereof, the following: "; except that such term does not include any service that a physician may perform as an executive or a researcher; or as an educator when such educational function is not performed simultaneously and in connection with the personal performance or personal direction of an identifiable patient care service; or any patient care service ----

Appendix C

Talmadge Bill Amendment

proposed by

The American Society of Anaesthesiologists

"(2) In the case of anesthesiology services, a procedure related to surgical or obstetrical care of a patient would be considered to be 'personally performed' in its entirety by a physician where the physician performs, for the benefit of one individual patient, the following activities:

- "(A) preanesthetic evaluation of the patient;
- "(B) prescription of the anesthesia plan;
- "(C) personal participation in the most demanding procedures in this plan, including those of induction and emergence;
- "(D) following the course of anesthesia administration at frequent intervals;
- "(E) remaining physically available for the immediate diagnosis and treatment of emergencies; and
- "(F) providing indicated postanesthesia care:

Notwithstanding the foregoing, a physician shall also be considered to have 'personally performed' such a procedure in its entirety for an individual patient if, provided during the performance of the activities described in subparagraphs (C), (D), and (E), such physician is responsible for the care of not more than one other patient and, as to maintenance of anesthesia for both such patients, is assisted by a resident physician, or nurse anesthetist or anesthesiology assistant in the physician's employ. In such event, the physician shall be entitled to reimbursement for his reasonable charge with respect to each such patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E); is responsible for direction, but does not participate in performance of the activities described in subparagraph (C); and the resident physician, or nurse anesthetist or anesthesiology assistant in the physician's employ performs the activities in subparagraph (C), such directing physician will be deemed to have 'personally directed' the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E), and the reasonable charge for such 'personally directed' services shall not exceed one-half the amount that would have been payable had he personally performed the procedure in its entirety.

April 12, 1977

F.C. Dimond, Jr., M.D.
Associate Program Director
Hospital Accreditation Program
c/o Joint Commission on Accreditation
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Fran:

In accord with our previous conversations and communications, the Council of Teaching Hospitals has, under the leadership of John Westerman, formulated the attached set of "Guidelines for the Application of Hospital Accreditation Program Standards in Surveying University Hospitals." We are hopeful that the guidelines which were recently approved by the Administrative Board of the Council will be helpful to your surveyors in their consideration of the unique characteristics of university hospitals.

By way of summary, the guidelines focus on the most salient of these unique characteristics which include the following:

- a) The manner in which the governance of university hospitals is interlinked with that of the universities with which they are aligned and the special and variable delegations by parent governing boards that are made for the purpose of achieving appropriate accountability in accord with JCAH and other requirements.
- b) The widely variable mechanisms which exist in university hospitals by which to secure "community" representation wherein the hospital's community oftentimes has a statewide or broad regional geographic base.
- c) The medical staff categorization and nomenclature common to the specialty nature of tertiary level university hospitals which often differs from that found in typical community hospitals.
- d) The interrelationship of the dual channel of appointment embracing both academic and clinical staff responsibilities essential to maintenance of the integrity in clinical credentialing in the university hospital setting.
- e) The integral nature of continuing education to the day-to-day teaching process common to university hospitals.

F.C. Dimond, Jr., M.D.

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April 12, 1977

We would be pleased to elaborate on any of these guidelines at a time of your convenience and we are most appreciative of the willingness of the Joint Commission to permit us to be involved in this collaborative endeavor.

Sincerely,

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

RMK/pgg

cc: John Westerman
bcc: Steve Portnoy

Attachment

**SUBJECT: Guidelines for the Application of Hospital Accreditation Program
Standards in Surveying University Hospitals**

The unique characteristics, special needs and particular problems of university hospitals with respect to the standards and procedures of the JCAH accreditation process must be acknowledged. This involves recognition of the university hospital's threefold mission -- patient care, health science education and clinical research. There is also the hospitals' concern that the rigid application of specific accreditation standards by JCAH will conflict with the need for a more flexible approach which recognizes the teaching hospital's additional responsibility for innovation in the organization of health services and the training of health manpower.

It should also be recognized that those Veterans Administration hospitals affiliated with medical schools have many of the same characteristics as the university-owned hospital. This is particularly true in terms of members of the medical staff who have faculty appointments, the organization of the medical staff, the role of house staff, the review of quality of care, and medical staff continuing education. The governance of the Veterans Administration hospital is also unique in that accountability requirements are an integral part of the Veterans Administration system.

Since the JCAH surveyor must be concerned with the "hospital" rather than the "university" aspect of the university hospital, and with the "quality of patient care" rather than the "teaching program" per se, it is appropriate to examine the relationship of hospital patient care to university academic programs. In assessing the teaching hospitals' responsibility to respond to patient care objectives, one must face the possibility that these objectives may differ from medical school objectives. Thus, it is necessary to distinguish between the roles of the physician acting as a member of the hospital's clinical

staff and his role as a member of the medical school faculty. Two primary areas that require this flexible, but careful, attention are governance and medical staff organization.

Governance - The adequate fulfillment of governance/accountability functions are as important to the university hospital as to any other hospital. Where the governing body is a university governing board, such as a Board of Regents, the multiple responsibilities of the university may not permit careful attention to the affairs of hospital governance. This can be particularly a problem in the board's responsibility for quality of care assurance, guaranteeing appropriate procedures for appointment to the medical staff, and assignment/approval of clinical privileges. The existence of an identifiable, accountable governance function is as important for the university hospital as the community hospital. Where there is no evidence of the governing board fulfilling a trusteeship function, either directly or through clear delegation, a problem may exist.

This problem may be resolved by the governing board delegating in writing the authority for another body, internal or external to the hospital, to act for them in whole or in part in critical clinically based areas, such as quality of care assurance, medical staff appointment, and privilege granting.

The JCAH requirement for community representation on the governing body must be approached realistically. The "community" is difficult to define where the hospital is a tertiary care referral center. The test of appropriate representation should be the ability to act objectively in conducting governance accountability. Basically, the JCAH accreditation process should address whether the essential process of governance is being adequately executed, regardless of the mechanism for accomplishing it. Recognition should be given to the variety of state legislative and executive review mechanisms other than the hospital

governing board which assure the public accountability of publicly-owned teaching hospitals and which bring the varied interests of community members to bear upon hospital decision making.

Medical Staff - The medical staff must have an organizational structure capable of addressing institution-wide health care delivery issues plus being able to meet the responsibilities of any organized medical staff. As required of any hospital, the organization of the medical staff is reflected in its bylaws, rules and regulations which must address procedures for appointment and re-appointment to the medical staff, delineation of clinical privileges, periodic reappraisal of the staff, and continuing medical education programs.

Most university hospitals require medical or dental academic appointments as a prerequisite for clinical staff appointment. This usually includes all departmental faculty, both full-time and those appointed to the teaching staff who serve on a part-time basis. Although appointments may be fairly automatic upon recommendation by the head of the clinical department/service, the hospital credentialing process cannot be omitted. However, duplication of effort performed during the academic appointment is not required, provided the information is made available to the hospital for its files. It is recognized that the evaluation of professional competence must take into consideration that a physician's excellent credentials in the research/teaching field does not necessarily ensure excellence in patient care. Medical faculty reappraisal information required for academic status, if made available for "hospital" use and retention, can obviate the need to duplicate the effort of obtaining this information for required periodic reappraisal of the clinical staff of the hospital. The university faculty reappraisal is usually performed at regular intervals and, thus, also satisfies the JCAH requirement for the regular reporting by departmental chairmen on the clinical performance of medical staff members. The tenure system must be

understood to relate to reappointment requirements for academic activities only.

Since the organization of the medical staff in the university hospital does not always follow the staff categories used in community hospitals, surveyors should expect categorization and nomenclature adopted to the needs of the particular institution.

In some university or university-affiliated large teaching hospitals there are teaching physicians, community physicians and house staff physicians. It is in this type of setting that particular care must be taken to ensure there is not more than one standard of care permitted.

To varying degrees, house staff members function as students, teachers, and providers of care. If their role is not clearly defined within the organized medical staff, they may hold significant service responsibilities that are not subject to the rules and regulations that govern the medical staff. Thus, the mechanism of supervision of house staff members and their role in quality of care assurance and other departmental activities must be defined.

There must be privilege delineation for all members of the medical staff. Medical staff and medical faculty qualifications should be distinguished in process of appointment to the medical staff and assignment of privileges. The delineation of privileges is usually very well established within the department/service structure; however, it should be reduced to writing.

It is required that there be an adequate review of the quality of care rendered in the facility. The university hospital has an intensive, prospective patient care review system conducted in conjunction with its educational programs. This is usually reflected in a heavy concentration of individual case review, often as the primary mode of assessment of quality of care. To provide a continuing evaluation of clinical judgment, a strong relationship of the quality of care activities to the teaching process is maintained. However, there is

still a requirement for the university hospital to participate in retrospective outcome audits as a measure of the quality of care rendered. The audit of cases through retrospective review can serve a function not met by individual case review. When retrospective audit is performed, care must be taken to ensure that the criteria used are equally applied to all patients in the hospital, otherwise there may develop more than one standard of care in the same hospital.

In evaluating either an area of care provided or a continuous monitoring function of the medical staff, it may not be possible to obtain all required information from one individual as usually occurs in a small community hospital. For example, in evaluating respiratory care services in a large teaching hospital, it may be necessary for the surveyor to interview the director of pulmonary medicine, the director of a specific intensive care unit, the director of the pulmonary function laboratory, the individual who provides blood gas analyses, the chief respiratory therapist, and so forth. Similarly, in evaluating the infection control program, he may be required to consult with the chairman of the infection control program, the hospital epidemiologist, the chairman of a department of infectious surveillance nurses, and so forth. Where possible, a group interview of these individuals provides maximum information and clarifies the interrelationship of roles.

The survey team should be very careful before making a recommendation relative to the lack of medical staff continuing education programs or its documentation. This normally abounds at all levels in all divisions (department/service/section) of the university hospital, and indeed the hospital is itself the provider of the continuing education not only for its own staff but for many other physicians. There is a recognized but unwritten self-educational effort inherent in the teaching of others and in the publishing of professional papers.



association of american medical colleges

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

202: 466-5175

April 4, 1977

The Honorable Joseph A. Califano, Jr.
Secretary of Health, Education and Welfare
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

The Association of American Medical Colleges (AAMC) -- which represents all of the nation's medical schools, sixty academic societies, and over 400 major teaching hospitals -- is deeply concerned about the current treatment of federal and state grants for medical education in computing allowable costs for providers under the Medicare program. Without prejudicing the opportunity of individual members to comment on this issue, the AAMC requests your immediate and personal attention to this reimbursement issue, strongly recommends constructive revisions in Medicare regulations, and offers its full support and cooperation in further deliberations on this matter.

Determining allowable Costs for Medicare and Medicaid: Graduate Medical Education Grants

In the past decade, there has been a substantial increase in the number and dollar value of state and federal grants for medical education made to health care providers. In many cases, these grants are a deliberate attempt by governments, at both levels, to expand the numbers, types and geographic locations of medical education programs. Grant programs have been established to encourage the growth and development of family practice, primary care specialties, and ambulatory care training programs. Grants have also been established to provide medical education programs in medically underserved areas, especially in rural communities. These grants are necessary because providers have found that the costs of operating these medical education programs exceed anticipated revenues from third-party payors and private pay patients. If medical education grants do not reduce the program deficit but simply change the source of funds from patient to grant monies, the provider has no increased incentive to undertake the program. On the other hand, if medical education grants reduce or eliminate the program deficit, the grants stimulate program development and continuation.

Existing Medicare regulations (section 405.421 of Title 20, C.F.R.) provide that "an appropriate part of the net cost of approved educational activities is an allowable cost" under the program where "the net cost means the cost of approved educational activities (including stipends of trainees, compensation

of teachers, and other costs) less any reimbursement from grants, tuition, and specific donations." Under these regulations, the Bureau of Health Insurance has taken the position that federal and state grants for medical education are restricted grants which must be deducted from the costs of education program prior to determining allowable costs for services provided to Medicare beneficiaries. The results of this reimbursement policy are clear: (1) the actual dollars received in federal grants are accompanied by a reduction in Medicare reimbursement. The consequences of these reimbursement reductions are similarly clear: (1) grant funds provide a lesser stimulus than that intended by the granting agencies; (2) state funds unintentionally support a federal social insurance program; and (3) provider incentives to respond to government programs are substantially reduced. Thus, the present Medicare reimbursement policy in this area functions to hinder government grant programs and to reduce provider initiatives.

The federal government is faced with a situation in which prudent public policy requires a change in Medicare regulations which will permit state and federal grants to attain their full effectiveness in stimulating medical education programs without providing windfall gains to providers from a combination of third-party payments and grants. In this situation, the Association of American Medical Colleges urgently requests and strongly recommends that Section 405.421 of the Medicare regulation (20 C.F.R.) be revised, at the earliest possible date, to provide that graduate medical education grants are not to be deducted from program costs in determining Medicare reimbursement to the extent that such grant funds do not result in a net operating gain (total program revenue less total program cost > 0) for the program supported by the grant.

Grants for Graduate Medical Education: Retroactive Changes in Medicare Policy

The reimbursement issue described in the previous section has received increased visibility because of developments and policy changes made by the Region IV (Atlanta) office of the Bureau of Health Insurance. In Intermediary Letter 3-75 of January 22, 1975, the Regional BHI office specified that "... grants from HEW for the establishment of residency programs in family practice" are to be classified as "seed money" grants which are not offset against provider costs in determining Medicare reimbursement (see enclosure A). On July 14, 1976, the Regional office issued Intermediary Letter 12-76 stating that its prior Intermediary Letter was in error (see enclosure B). As a result of this change in policy, intermediaries are attempting to retroactively recover funds approved under the original Regional Intermediary Letter. In at least one case (the Greenville Hospital System), this retroactive recovery has the potential to amounting to over one million dollars. The providers who

received these grants are non-profit corporations which exist to serve community needs. If they are to retroactively offset grant funds against reimbursements, the providers will have to substantially increase prices to generate necessary funds; otherwise, their financial viability will be seriously threatened. The providers are not in this position through fraud or deceit. They acted in good faith and in compliance with the government's instructions in not offsetting grant monies against program costs. Therefore, the Association of American Medical Colleges strongly recommends that the federal government not seek retroactive recovery of Medicare funds where graduate medical education grants were treated, under Regional BHI instruction, as "seed money" grants.

Conclusion

The treatment of graduate medical education grants by the Bureau of Health Insurance may enhance or reduce the effectiveness of government programs, including those established in P.L. 94-484 -- the Health Professional Education Assistance Act of 1976. To ensure that providers obtain the intended benefit of these and similar grants and to ensure that errors in government policy directives do not sour their interests in obtaining grants, the Association requests immediate consideration of the issue raised in this letter. We would be pleased to have the opportunity to discuss this matter with Mr. Robert Derzon, the new administrator of the Health Care Financing Administration.

Sincerely,


John A.D. Cooper, M.D.

January 22, 1975

Bureau of Health Insurance

REGIONAL INTERMEDIARY LETTER NO. 3-75

SUBJECT: Family Practice Grants

Attached is a list of hospitals that have received grants from HEW for the establishment of residency programs in family practice. The grants were made for the purpose of extending services and are classified as "seed money" as defined in Section 612.2 of the Provider Reimbursement Manual (PRM-15). As seed money grants, the funds would not be used as an offset against provider costs.

Residents training in a Family Practice Program would be subject to the same payment rules as residents in other types of specialty programs. (Section 6102.7, Part B Manual)

Enclosures: 3

This was retracted on 14 July

1976.

JMB 17 23 75

REGION IV

107th Street, N. E., Room 250

Atlanta, Georgia 30323

Bureau of Health Insurance

July 14, 1976

REGIONAL INTERMEDIARY LETTER NO. 12-76

SUBJECT: Family Practice Grants - Regional Intermediary Letter No. 3-75;
Customary Charge of DME Suppliers Which Waive Collection of
Deductibles and Coinsurance

Family Practice Grants - Regional Intermediary Letter No. 3-75

Our statement in the subject Regional Intermediary Letter was incorrect. Family Practice Grants should not be considered "seed money grants" within the definition of Provider Reimbursement Manual section 612.2.

The purpose of Family Practice Grants is to support medical education, not to develop new health care agencies or expand the range of services being furnished by established health care agencies. Such monies, for Medicare reimbursement purposes, are considered restricted grants which must be deducted from the costs to which they are directed. Program policy on this point supports regulations section 405.421(b)(2) which defines the net cost of educational programs as the cost less any reimbursement received from grants, tuition and donations.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

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

MEMBERSHIP CRITERIA:

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

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

AND

- (b) The hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

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

I. MEMBERSHIP INFORMATION

RANCHO LOS AMIGOS HOSPITAL

HOSPITAL NAME

7601 East Imperial Highway

STREET

Downey

CITY

California

STATE

90242

ZIP CODE

(213) 922-7022 (Administration)

TELEPHONE NUMBER

Chief Executive Officer

Edward J. Foley

NAME

Administrator

TITLE

Date hospital was established:

1888

APPROVED FIRST POST-GRADUATE YEAR

<u>TYPE²</u>	<u>Date of Initial Approval by CME of AMA**</u>	<u>Total F.T.E.¹ Positions Offered</u>	<u>F.T.E.¹ Total Positions Filled by U.S. And Canadian Grads</u>	<u>F.T.E.¹ Total Positions Filled by FMG's</u>
Flexible				
Categorical				
Categorical*				

Interns are regularly rotated from the Los Angeles County-University of Southern California; there are usually ten at a time, for four-week periods, on the various Department of Medicine services.

** 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.)

APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA**	Total F.T.E. ¹ Positions Offered	F.T.E. ¹	F.T.E. ¹
			Total Positions Filled by U.S. And Canadian Grads	Total Positions Filled by FMG's
Medicine	SEE ATTACHMENT #1			7 (fellows)
Surgery	Nov. 1962	SEE ATTACHMENT # 1		3 (Fellows)
Ob-Gyn	SEE ATTACHMENT #1			
Pediatrics	"	"	"	
Psychiatry				
Family Practice				
Other (List):	"	"	"	

II. PROGRAM DESCRIPTION

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the corresponding 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:

- 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).
- 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).
- Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school faculty participation in hospital activities (e.g., in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that membership indicates a significant commitment to 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

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: University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles, California 90033

Name of Dean: Allen W. Mathies, M.D.

Information Submitted by:

Robert L. Spears, M.D.

NAME

Medical Director

TITLE OF PERSON SUBMITTING DATA

Edward J. Foley

NAME

Edward J. Foley
SIGNATURE OF HOSPITAL CHIEF-EXECUTIVE
(Administrator)

8 January 1970

M E M O R A N D U M

To: All Department Chairmen,
Division Heads, and
Appropriate Administrative Staff

From: John E. Affeldt, M.D.
Medical Director
Department of Hospitals

Franz K. Bauer, M.D.
Dean
U.S.C. School of Medicine


Subject: Affiliation of Rancho Los Amigos Hospital
with U.S.C. School of Medicine

The attached statement of policy is intended to implement, as promptly and in the most practical manner possible, the established affiliation of the Rancho Los Amigos Hospital with the School of Medicine. The support of the various Hospital's Staffs and particularly that of the Faculty is encouraged and anticipated.


POLICY STATEMENT REGARDING AFFILIATION
OF RANCHO LOS AMIGOS HOSPITAL
WITH THE UNIVERSITY AND THE MEDICAL SCHOOL

1. The nature of this affiliation is to be identified as a formal, integrated, institutional affiliation with the School of Medicine. The nature of the affiliation with the rest of the University is to be worked out in time.
2. Affiliation of the Hospital with the School of Medicine is based on the premise whereby the established mission of the hospital is respected, despite the possible addition of new programs.
3. The time and extent of affiliation by any given department of the Medical School is to be determined by the Department Chairman, thus reflecting that Department's preparedness to assume an active role at Rancho.
4. Such affiliation is further based on an integrated relationship with the Medical School, whereby the medical programs and other programs of the Hospital would be designed to augment and supplement the Medical School's programs and under no circumstances compete with them.

5. Department Chairmen of the Medical School are to have official Chief of Service status at Rancho and have all established professional and administrative authority and responsibility that normally accrues to this identity. This includes establishment or expansion of graduate, undergraduate, and postgraduate education programs, as well as all research activities.
6. Under the above criteria, the Chairman of the Department may elect to assign Chief of Service responsibilities at Rancho to a high ranking member of his Department.
7. It is to be anticipated that a Department Chairman may allocate segments of his Departmental program at the Medical Center, Rancho, and (possibly Wesley), providing it is consistent with the mission of that hospital and has the support of the Dean and the Department of Hospitals.

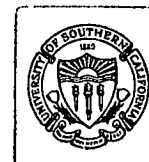


Franz K. Bauer, M.D.
D E A N
U.S.C. School of Medicine



John E. Affeldt, M.D.
Medical Director
Department of Hospitals

HM/mrd
12/30/69



SCHOOL OF MEDICINE
OFFICE OF THE DEAN
(213) 226-2001

9 November 1976

To Whom it May Concern:

It is a pleasure to recommend Rancho Los Amigos Hospital for corresponding membership on the Council of Teaching Hospitals. Rancho Los Amigos Hospital has been affiliated with the University of Southern California School of Medicine for a number of years and at the present time we are assigning students for required clinical clerkship experience at the hospital. As a result, we are assigning strong faculty members to Rancho Los Amigos Hospital and emphasizing postgraduate training.

The hospital is widely known for its outstanding rehabilitation program and its concept of team care utilizing paraprofessional personnel in the day-to-day care of the patient. In this context we have been supported by the Commonwealth Fund to develop and strengthen the team concept. A large and sophisticated Division of Rehabilitation Engineering is active at the hospital under the direction of Doctor James B. Reswick. Medical students, interns and residents, have opportunities to see many innovative patient care concepts in a population which is afflicted with chronic illness.

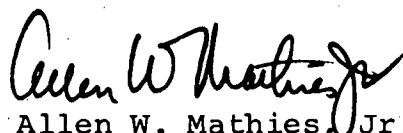
Because of the high rate of trauma in the Southern California area from vehicular and swimming and surfing accidents, there are opportunities for training in a wide variety of orthopedic problems. Our Department of Neurology rotates all faculty and postgraduate students through the hospital and the Department of Medicine is taking an active and vigorous part in training and patient care programs with diabetic patients, emphysema patients, cardiac rehabilitation patients, etc. By the end of this year we are moving our large liver service to Rancho Los Amigos Hospital under the direction of Doctor Telfer Reynolds and Doctor Allan Redeker, both renowned for their work in liver disease.

USC School of Medicine teaches primarily through public hospital settings in a contractual arrangement with the County

of Los Angeles. Financial restrictions due to the high cost of medical care are forcing us to utilize our existing resources more carefully than ever before and to assign our faculty carefully. Rancho Los Amigos Hospital will therefore be utilized more than in the past as a teaching setting for medical and postgraduate students and it will be to the advantage of the hospital personnel to have exposure to the benefits of membership in the Council.

I will appreciate your careful review of the application for corresponding membership, for I heartily endorse the application by Rancho Los Amigos Hospital.

Sincerely,



Allen W. Mathies, Jr., M.D.
Dean, School of Medicine

AWM/drn

ATTACHMENT #1

APPROVED RESIDENCIES

Medicine	Through affiliation with the Los Angeles County-University of Southern California Medical Center, and with approval by CME of AMA, eleven residents assigned from the Medical Center are at Rancho on a rotating basis at all times. Individual rotations vary from one to four months. The residents are assigned to the Pulmonary (including Tuberculosis), Diabetes, Cardiology, Neuromedicine, Liver Disease and General Medicine Services.
Pediatrics	Under the same arrangement, Rancho has at least one pediatric resident from the Medical Center at all times.
Urology	The same arrangement operates for one resident from the Medical Center. This service also has one full-time fellow.
Gynecology	At the present time the Medical Center does not provide residents for this service (Rancho does not have an Obstetrics service). However, we have one full-time resident and a half-time Board-certified physician from the residency program at White Memorial Medical Center, Los Angeles, assigned to this service. The CME of AMA has approved of Rancho Hospital's participation in the WMMC residency program. Salaries of the resident and the physician are paid by Rancho.
Ophthalmology	Rancho has the same training arrangement in this specialty with White Memorial Medical Center, with two residents in training at all times under the supervision of a half-time Board-certified physician.
Otolaryngology	The same training arrangement as above exists in this specialty, with one resident in training at all times with a half-time Board-certified physician.
Orthopedic Surgery	Rancho has 20 residents and an average of six fellows at all times on the various orthopedic categorical services. They are on six months' rotations, through affiliation with the Los Angeles County-University of Southern California Medical Center; Harbor General Hospital; Loma Linda University Medical Center; University of California at San Francisco; Northwestern University Medical Center; Chicago University Medical Center; Colorado University Medical Center; University of Oklahoma Medical Center; University of Saskatchewan University Hospital; Hawaii Combined Program; Martin Luther King, Jr. Hospital; etc. Rancho received approval by CME of AMA for this residency program in November 1962.

APPROVED RESIDENCIES (Cont'd.)

Plastic Surgery

We have two residents at Rancho at all times under agreements with the University of California at Los Angeles and UC-Irvine.

II. PROGRAM DESCRIPTION

- A. Rancho Los Amigos Hospital, a 700-bed, comprehensive care facility for severely disabled patients of all ages, is located in Downey, California, approximately 15 miles from the University of Southern California Health Sciences Campus in Los Angeles.

As an affiliated hospital of the USC School of Medicine, Rancho accepts students who have completed their third year of medical school for clinical clerkships, for a four- to six-week maximum. These clerkships are coordinated with the USC medical school's rotation schedule and are acceptable to us only after approval by the school's Curriculum Office (see copies of USC information, Attachment 2). In this fiscal year, we have 24 scheduled clerkships. An estimated 10 to 30 percent of the students' time each day is directly supervised by medical staff. In addition, students participate with house staff on rounds and at conferences and seminars. They are also given independent assignments by medical staff, followed up by appropriate review.

Rancho also participates in the USC School of Medicine's first- and second-year curriculum by offering clinical experiences to students enrolled in the "Introduction to Clinical Medicine" course. Five to seven small groups of students spend one-half day a week, under faculty preceptorship, on the various categorical services. Groups are rotated until all class members are taken through as many services as possible during the school year. Students are oriented to the problems of the disease or trauma category involved, take histories, and at an appropriate time perform physical examinations. They participate in team conferences, which include a staff physician, and may present patients they have "worked up." Students are also provided with an opportunity to have their patient interviews videotaped and their performance critiqued on playback.

Undergraduate medical students coming to Rancho receive their first, and sometimes their only, exposure to the team approach to the management of severely disabled patients, which Rancho pioneered and has successfully employed during the past twenty years.

- B. Each categorical service (see Organization Chart, Attachment 3) is directed by a Chief, who is a Board-certified specialist. All but seven are full time; four are half-time, three are three-fourths-time. Each holds a faculty appointment at the University of Southern California School of Medicine.

Each categorical service also has a full complement of nursing, occupational therapy, physical therapy, social service and psychology personnel who, with the physician, comprise the basic rehabilitation team. Where indicated, teams are augmented by speech pathology, orthotic/prosthetic, dental, vocational counseling, respiratory therapy, bioengineering, and recreation therapy staff.

The hospital also has a Medical Education Service staffed by full-time personnel.

- C. There are currently 62 full-time and 61 part-time salaried medical staff involved in the hospital's medical education program. Each has a USC School of Medicine faculty appointment.

-more-

PROGRAM DESCRIPTION (Cont'd.)

Residents' salaries, including fellows, paid by the hospital, are equivalent to approximately 33 percent of the hospital's budget for chiefs of service, department heads and staff physicians.

Approximately 30 percent of the Medical Education Service's annual budget of \$85,000 is expended for photographic materials, medical illustrations, printed materials for conferences, and in-service education for postgraduate students. This percentage includes salaries of Medical Education staff engaged in these pursuits.

A medical library is located on the hospital's grounds, and audiovisual aids such as 16 mm teaching films, slide-sound lectures, and videotape presentations are available on the various services.

TO: Medical Faculty Who Accept Non-USC Students for Clinical Clerkships

FROM: Louise Ball

DATE: January 20, 1975

SUBJECT:

Of recent date, the instructions to non-USC students applying for clinical clerkships have been altered. So that you will understand the reasons behind the change, this memo is being sent with samples of the form letter and the application blank routinely sent to inquiring students.

As a result of the increased class size at USC School of Medicine many clinical services are now accepting a full complement of full-time USC medical students who should have first call on faculty time and teaching facilities. At the same time non-USC students are writing to plan clerkships as far as 18 months ahead. Therefore, the new letter states that we will correspond with students and try to plan, but confirmations will only be made 60 days in advance of starting time and must come from this office. Please do not give personal assurances from your office that a student has been approved for a clerkship because it is essential that we accommodate our own full-time students before accepting non-USC students. However, it is equally important that you notify the Curriculum Office if you approve the academic qualifications of non-USC applicants. This should be done as soon as possible after you receive an inquiry.

To make it possible to accommodate more non-USC students the total length of time a student may sign up for clinical clerkships is four to six weeks. This is a change. In the past, we permitted non-USC students to stay for longer periods of time and charged tuition after nine weeks. The tuition was channelled into the medical student scholarship fund.

These changes have been agreed upon to make it possible for you to accept a few non-USC students for recruitment purposes to postgraduate educational slots and to maintain openings for our students in other U. S. medical schools they may wish to visit on free elective time. The crush has come as a result of the Autonomous University of Guadalajara permitting students to take an "eighth semester" in the U. S. in services which are invariably our most popular services. Some days we receive 15 requests for clerkships and it is obvious that there are not 75 clerkship openings every week.

The form has been changed to conform to the AAMC-AMA guidelines and to simplify approvals. To repeat, please route all non-USC applications and approvals through the Curriculum Office prior to responding to the student so that scheduling records of our own students and non-USC students can be accurately maintained and our own students protected. We also make arrangements for sign-in and photo identification at the Medical Center; it is very important that individual faculty members direct their communications to this office. ~~Mrs. Denise Anderson~~ is the staff member in the Curriculum Office who is responsible for the day-to-day management of the program. You may reach her at 226-2017 if you have questions.

Louise Gloria Lopez

UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
2025 ZONAL AVENUE
LOS ANGELES, CALIFORNIA 90033
226-2001

OFFICE OF THE DEAN

Dear Applicant:

Enclosed is an application for clinical clerkship instruction at an affiliated hospital of USC School of Medicine. Clinical clerkships are only available to students who have completed their third year of medical school, four to six weeks maximum. We will accept you for one six-week period a year only. The application form includes space for endorsement by the appropriate official at your medical school. Any application returned without this endorsement will not be processed. A current medical school transcript is also required to complete the application.

Because over 500 applications have been received this year for approximately 60 clerkship openings, the program is less flexible than in the past. The following restrictions are now in effect:

- (1) Please plan to commence your clerkship on the beginning rotation dates noted on the attached sheet if at all possible. A number of our faculty feel that your experience will be better if you receive a first day orientation with other medical students.
- (2) A limited number of openings will be available each rotation, approximately 10-12 at the Medical Center. Once those are committed, you will be placed on a waiting list, and notified by postcard that you are on a waiting list.
- (3) You are obligated to make a firm commitment that you accept the rotation and will not withdraw, except in extreme emergency (in which case you will notify us immediately).
- (4) You are obligated not telephone or write the clerkship faculty--they are busy with stringent patient care commitments and the Curriculum Office is the appropriate communication channel, designated by the Dean.
- (5) Applications will only be accepted six months in advance--we have discovered that most of the problems related to change of dates and change of mind occur because students are applying 18 months in advance and "ghosting" at several medical schools. If your school requires that you plan your program more than six months in advance, please do not apply.

All arrangements for scheduling your clerkship will be handled by Mrs. Gloria Lopez, Senior Secretary, Curriculum Office, Keith 514 on the Health Sciences Campus. When you arrive, please come to Keith 514 to register. The office is open between 9 a.m. and 5 p.m., Monday through Friday. The medical school is unable to provide or arrange for housing, board, or travel expenses. No stipend is provided.

Sincerely,



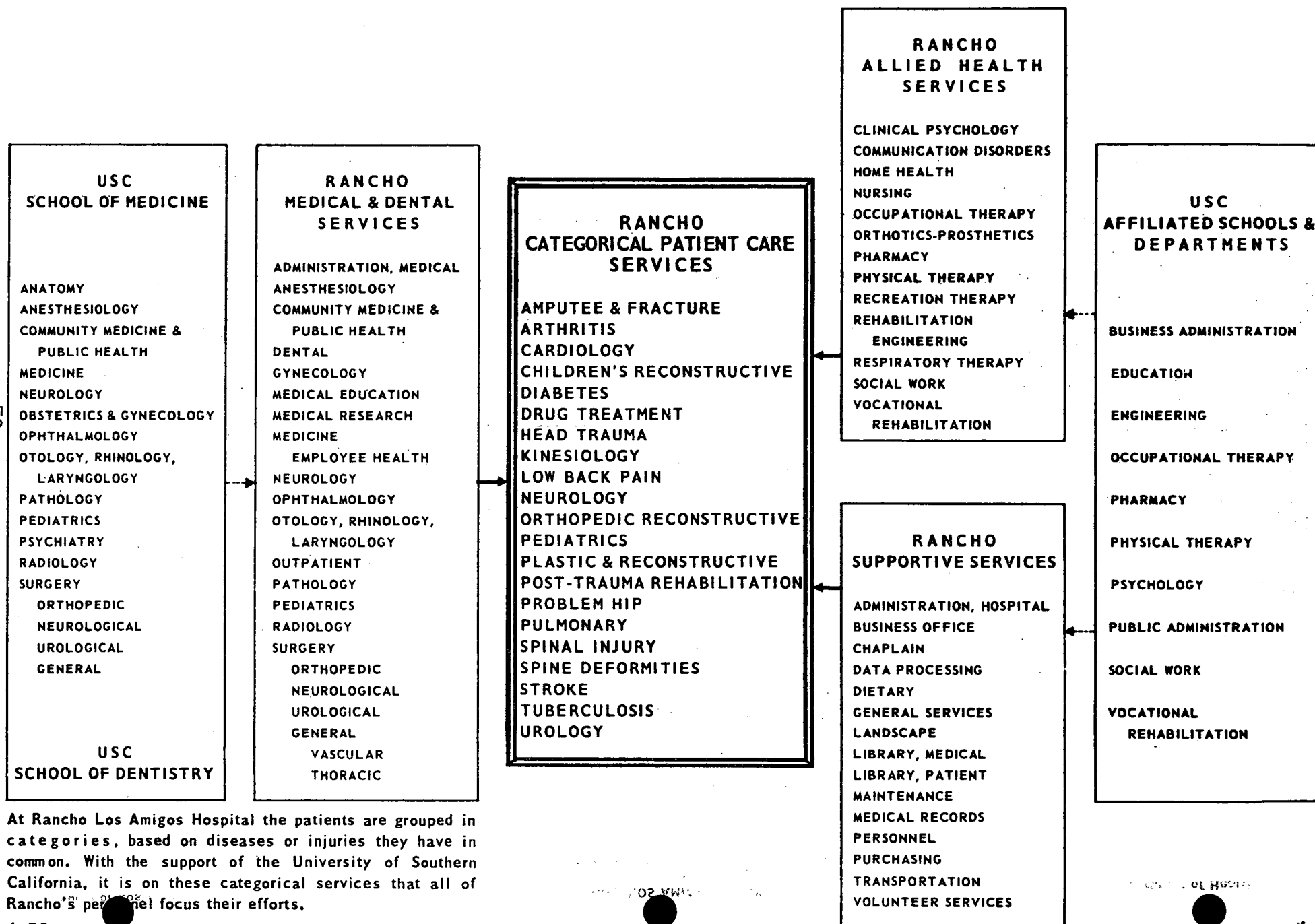
(Mrs.) Louise Ball
Special Assistant to the Dean

USC ROTATION DATES

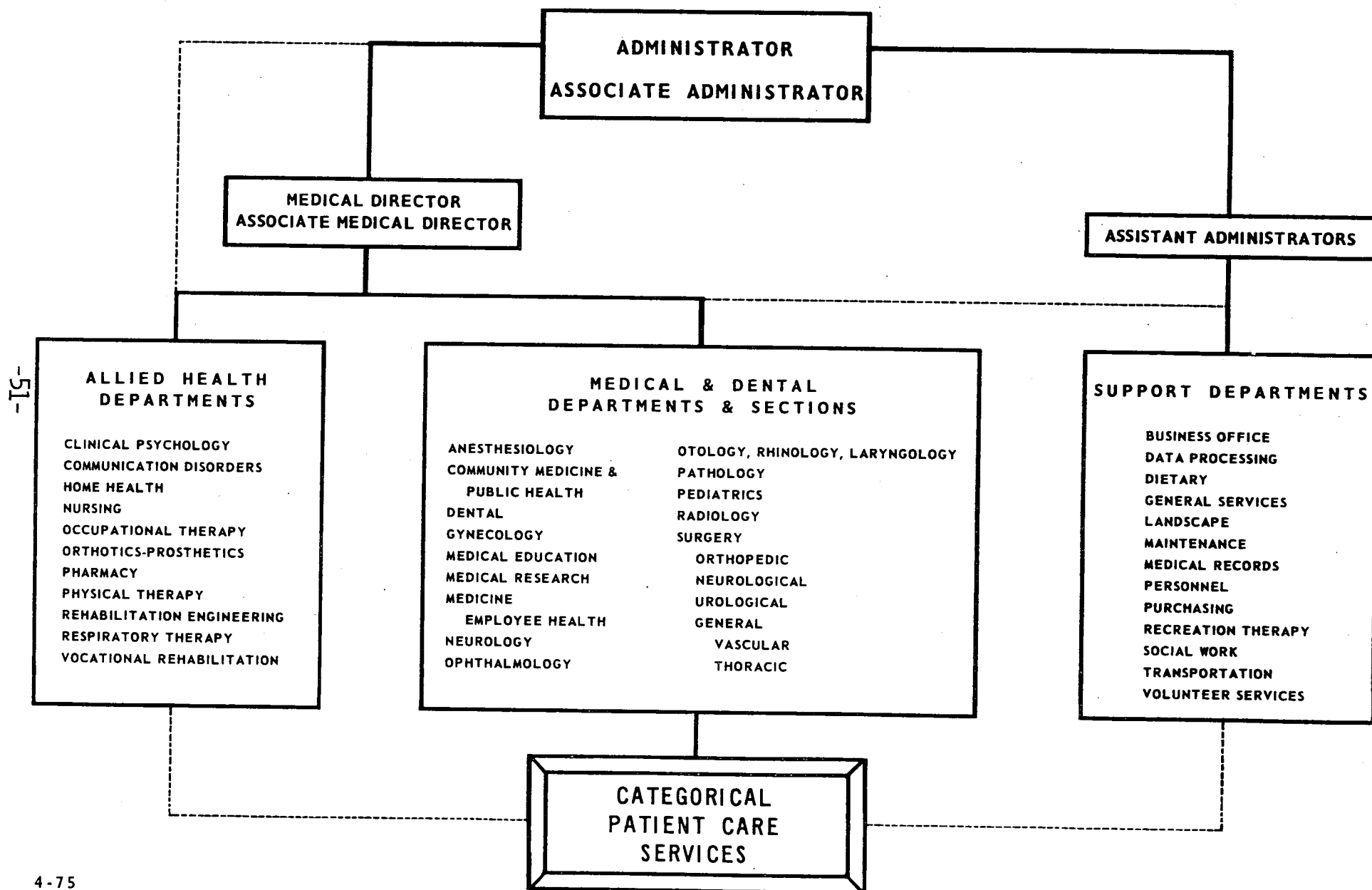
June 16 - July 27, 1975	- Rotation #A	May 31 - June 20, 1976	- Vacation
July 28 - September 7, 1975	- Rotation #B	June 21 - August 1, 1976	- Rotation #1
September 8 - October 19, 1975	- Rotation #C	August 2 - September 12, 1976	- Rotation #2
October 20 - November 30, 1975	- Rotation #D	September 13 - October 24, 1976	- Rotation #3
December 1, 1975-January 25, 1976	- Rotation #E (includes 2 weeks vacation)	October 25 - December 5, 1976	- Rotation #4
January 26 - March 7, 1976	- Rotation #F	December 6, 1976 - January 30, 1977	- Rotation #5 (includes 2 weeks vacation)
March 8 - April 18, 1976	- Rotation #G		
April 19 - May 30, 1976	- Rotation #H	January 31 - March 13, 1977	- Rotation #6
		March 14 - April 24, 1977	- Rotation #7
		April 25 - June 3, 1977	- Rotation #8

NOTE: Students will be on duty on holidays if they are assigned to admitting or other clinical duties as part of their regular rotation.

FUNCTIONAL ORGANIZATION



ADMINISTRATIVE ORGANIZATION



AAMC EXECUTIVE DEVELOPMENT SEMINAR

La Coquille Club
Palm Beach, Florida

June 6-11, 1977

SCHEDULE

MONDAY, June 6, 1977

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

7:00 p.m. Dinner
Introduction and Welcome

Marjorie P. Wilson
COTH Representative

The Plan for the Week
Orientation to the Conference

Edward Roberts

8:00 p.m. General Session

Theme: LEADERSHIP STYLES AND EFFECTIVE
ORGANIZATIONS

Richard Beckhard

*This session focuses on an examination of
characteristics of effective organizations
and an analysis of related managerial styles.*

10:00 p.m. Adjournment

TUESDAY, June 7, 1977

9:00 a.m. Theme: PLANNING AND CONTROL

Edward Roberts

*Throughout this day, the theme of Planning and
Control will be concerned with analysis of the
design of planning and control systems, both at
the strategic level and at the management con-
trol level. The theme will be initiated with
an overview of the process and its implications
for the manager's time allocation.*

10:30 a.m. Coffee Break

11:00 a.m. Theme: PLANNING AND CONTROL (Continued) Richard Beckhard

Methods for Assessing Environmental Factors Affecting Health Care Organizations. There will be an examination of the concept of organizational core mission--and its relationship to objectives--followed by a discussion of methods for mapping the environment around the organization.

12:15 p.m. Lunch

2:00 p.m. Theme: PLANNING AND CONTROL (Continued) John Rockart

Effective Strategic Planning Systems. The remainder of the afternoon and evening will be devoted to analyzing effective strategic planning and management control systems with special emphasis upon the top management role. Principles underlying effective planning and control systems in non-profit organizations will be explored.

3:15 p.m. Coffee Break

3:30 p.m. Theme: PLANNING AND CONTROL (Continued) John Rockart

Effective Management Control Systems.

5:00 p.m. Afternoon Break

6:00 p.m. Cocktails

7:00 p.m. Dinner

8:30 p.m. Theme: PLANNING AND CONTROL (Continued) John Rockart

Effective Management Control Systems. (Continued)

10:00 p.m. Adjournment

WEDNESDAY, June 8, 1977

9:00 a.m. Theme: STRATEGIC DECISION-MAKING: Edward Roberts
FORECASTING/MODELLING

The theme of Strategic Decision-Making will focus on methods by which models, both informal and formal, can be applied to assist and support strategic decision-making processes. Specific aspects of quantitative forecasting techniques useful in decision-making will be covered. Simulation modelling will be elaborated to demonstrate the relevance of formal modelling activities for a medical center. There will be a case illustration in the area of hospital financial planning.

10:15 a.m. Coffee Break

10:45 a.m. Theme: STRATEGIC DECISION-MAKING:
FORECASTING/MODELLING (Continued)

Edward Roberts

12:00 noon Lunch

2:00 p.m. Theme: ORGANIZATION DIAGNOSIS IN PLANNING
CHANGE

Richard Beckhard

This theme will deal with methods for "taking a picture" of the present state of affairs. Tools for organizational diagnosis will be described.

3:00 p.m. Coffee Break

3:30 p.m. Theme: ORGANIZATION DIAGNOSIS IN PLANNING
CHANGE (Continued)

Richard Beckhard

A case practice will provide an opportunity to use the methods.

5:00 p.m. Afternoon Break

6:00 p.m. Cocktails

7:00 p.m. Dinner

8:30 p.m. Evening Open

THURSDAY, June 9, 1977

9:00 a.m. Theme: INTERFACE MANAGEMENT

Richard Beckhard

Resolving the conflicts between organizations. A method called "responsibility charting" will be demonstrated.

10:00 a.m. Coffee Break

10:30 a.m. Theme: ORGANIZATION DESIGN

Edward Roberts

The next theme centers on the multiple tasks and roles of academic medical organizations and the organization structures designed to facilitate their effectiveness. We shall initially examine the many possible organizational alternatives, giving attention to the discipline, program and matrix variations. Strengths, weaknesses, pre-conditions and consequences will be described.

12:00 noon Lunch

2:00 p.m. Theme: WHAT THE HOSPITAL ADMINISTRATOR John Rockart
NEEDS TO KNOW ABOUT FINANCIAL
MANAGEMENT AND INFORMATION
SYSTEMS

During the afternoon, accounting principles, financial concepts, and computer concepts which contribute to the development of effective financial management in a hospital will be explored.

3:15 p.m. Coffee Break

3:45 p.m. Theme: FINANCIAL MANAGEMENT AND John Rockart
INFORMATION SYSTEMS (Continued)

5:00 p.m. Afternoon Break

6:00 p.m. Cocktails

7:00 p.m. Dinner

8:30 p.m. PARTICIPANT/STAFF DIALOGUE Richard Beckhard
Edward Roberts
John Rockart

10:00 p.m. Adjournment

FRIDAY, June 10, 1977 "MANAGING PEOPLE"

9:00 a.m. Theme: MANAGING PROFESSIONALS Edward Roberts

- a) *Selection of academic health professionals.*
- b) *Influences on their performance.*
- c) *Academic entrepreneurs.*

10:15 a.m. Coffee Break

10:30 a.m. Theme: MANAGING GROUPS & COMMITTEES William Dyer

- a) *Group dynamics.*
- b) *Issues in group dynamics.*
- c) *Techniques for managing groups.*

12:00 noon Lunch

2:00 p.m. Theme: MANAGING GROUPS & COMMITTEES William Dyer
(Continued)

3:15 p.m. Coffee Break

3:45 p.m. Theme: MANAGING INTERGROUP CONFLICT Richard Beckhard

Through the medium of a simulation, we will examine the issues involved in inter-unit conflicts. Methods of conflict resolution, managing vested interests, and getting consensus of goals will be analyzed.

5:00 p.m. Afternoon Break

6:00 p.m. Cocktails

7:00 p.m. Dinner

8:30 p.m. Theme: MANAGING INTERGROUP CONFLICT Richard Beckhard
(Continued)

10:00 p.m. Adjournment

SATURDAY, June 11, 1977

9:00 a.m. Theme: MANAGING ORGANIZATION TRANSITIONS Richard Beckhard

- a) *Issues of governance.*
- b) *Commitment planning.*
- c) *Developing a critical mass.*
- d) *Maintaining a changed condition.*

10:30 a.m. Coffee Break

10:45 a.m. Theme: PLANNING FOR PROGRAM Marjorie Wilson
IMPLEMENTATION

11:30 a.m. Adjournment



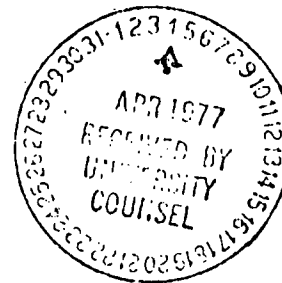
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

March 31, 1977

OFFICE OF THE COMMISSIONER

REFER TO:
IHI-321

Mr. C. L. Haslam
University Counsel
Duke University
Durham, North Carolina 27706



Dear Mr. Haslam:

This is in response to your letter requesting the advisory opinion of the Social Security Administration (SSA) with respect to Medicare reimbursement of interest expense incurred, or to be incurred, by Duke University Hospital. As indicated in your letter, SSA agreed to review your detailed presentation of the issue during the meeting held in Washington, D.C., on November 12, 1976.

While the enclosures to your subject letter provide additional information with respect to the incurrence of such interest expense, this information did not alter the policy issue previously addressed by the Bureau of Health Insurance in earlier correspondence with Duke University's accounting firm. As was indicated at that time, there is no basis under existing Medicare policy for allowing interest expense on internal or external loans when funds are available within the organization to meet such requirements. The disallowance of such cost is consistent with the provisions of health insurance Regulations No. 5, section 405.419, which spell out the conditions under which interest expense is allowable under the Medicare program.

One of the conditions of the regulations is that interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Since Duke Hospital is a teaching hospital which is owned, operated, and a part of the corporate entity of Duke University, the university and hospital must be treated as related organizations under program policy. As such, the funds which the university advances to its teaching hospital, which is a part of the university complex, cannot be considered loans under Medicare since they are merely a transfer of funds between two components of the same organization. Accordingly, the interest payments on funds generated from within the organization cannot be considered allowable interest expense in determining provider reimbursement under the program.

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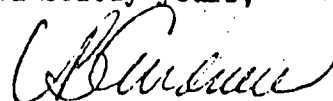
We do not think it is unreasonable to consider funds which are unrestricted funds of the university to also be funds of the hospital. To do otherwise would result in the reimbursement of unreasonable cost if provider organizations were permitted to transfer such funds between their operating activities in order to maximize Medicare reimbursement. Such action would be inconsistent with the provisions of section 1861(v) of the Social Security Act which limit Medicare reimbursement to the reasonable cost actually incurred in the necessary and efficient delivery of patient care services. If we allowed interest expense between a university and its related hospitals, consistency would also require similar treatment whenever one corporation advances funds to another which it owns and controls. The ultimate result is, of course, that the reasonable cost principle of related organizations as it applies to interest would have no effect, thus resulting in substantially increased Government expenditures. This sum would be very large if many presently independent institutions rearranged their corporate structure so that there were two corporations involved, one holding all grants, gifts, and endowments which would then lend them to a second operating company as needed. Such action would increase Medicare costs and would undermine the cost to related organizations principle which controls self-dealing and other than arm's-length situations.

It would also be erroneous to allow interest expense on external borrowings when existing funds are currently available within the corporate entity. Where a university and a hospital are operating components of the same corporation, the revenues and unrestricted funds generated from either corporate operation represent corporate moneys which are available to meet any corporate requirement. Accordingly, revenues derived from the university's operation (student fees, tuition, etc.) are corporate revenues which may be used to satisfy expenditures incurred by the hospital component. Similarly, funds used to meet the operating costs of the university might be derived from the hospital component of the corporate entity. Therefore, since the unrestricted funds of Duke University would also be available to Duke Hospital, external borrowings would not be necessary to meet the financial needs of the hospital, and the interest expense would not be an allowable reimbursable cost under the provisions of section 405.419 of the health insurance Regulations No. 5.

We believe our existing policy with respect to necessary and proper interest expense, and the associated provisions for cost to related organizations, are both appropriate and explicit in their application.

In addition, it is our position that the existing Medicare policy in the regulations and the reimbursement manuals is in accord with the intent of the Medicare law.

Sincerely yours,



James B. Cardwell
Commissioner of Social Security

Duke University
DURHAM
NORTH CAROLINA
27708

Office of the University Counsel

January 10, 1977

TELEPHONE 919-684-3500

The Honorable Bruce Cardwell
Commissioner of Social Security
Department of Health, Education and Welfare
Washington, D. C. 20201

Dear Mr. Cardwell:

During our meeting in Washington on November 15, 1976, with you and other representatives of the Department of Health, Education and Welfare, it was agreed that Duke University would provide your office with a detailed written discussion on three separate questions concerning reimbursement under the Medicare/Medicaid Programs for interest expenses incurred, or to be incurred, by Duke University Hospital. It was our understanding that your office would be willing to issue advisory opinions on these three separate questions, but that the opinions would not be considered binding upon Duke nor prohibiting our pursuit of further administrative or judicial remedies.

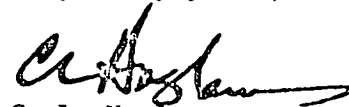
The enclosed attachments represent the aforementioned discussion of these issues.

As general background, and ancillary information which may be of value in considering the questions posed in the attachments to this letter, the following brief discussion of Duke University may be appropriate. Duke University is a private, nonsectarian institution of higher learning, with its principal campus located in Durham, North Carolina. The institution has an enrollment of approximately 8,500 (expressed in full-time equivalents) of which approximately 5,550 are enrolled in its undergraduate schools and approximately 2,950 in its graduate and professional schools. Undergraduate and graduate degrees are offered in a wide array of subjects and fields. In addition to its undergraduate and graduate Schools of Arts and Sciences, the University also has graduate or professional schools in Law, Forestry, Divinity, Business Administration, and Medicine. Although the University can trace its origins back to 1854, its present corporate structure and name follows from the terms of a trust indenture dated December 11, 1924, whereby James B. Duke established a trust to be administered for educational and charitable purposes. As one of the principal beneficiaries of this trust most of the existing buildings and facilities now known as Duke University were constructed during the late 1920's and early 1930's. The Duke Hospital, which is also located on the main campus of Duke University in Durham, North Carolina was built during this period of time and had no predecessor. Subsequent to that time, the University also acquired two smaller hospitals - Highland Hospital, which is a psychiatric hospital located in Asheville, North Carolina, and Sea Level Hospital, which is a general hospital located in Sea

Level, North Carolina. At the present time, therefore, the corporate entity of Duke University is comprised of (1) an educational and research institution located in Durham, North Carolina (with a Marine Laboratory facility in Beaufort, North Carolina), (2) Duke Hospital with 895 beds located in Durham, North Carolina, (3) Highland Hospital with 114 beds located in Asheville, North Carolina, and (4) Sea Level Hospital with 72 beds located in Sea Level, North Carolina. Although each of the above divisions are a part of a single corporate entity, each is operated from a management and financial standpoint as if they were separate stand-alone entities. The three hospitals are totally dependent upon revenue derived from their patient care activities and from external gifts or contributions which may be made to them; they do not share in the proceeds automatically accruing to Duke University from the trust indenture administered by the Duke Endowment or from the Duke University Endowment. Principal sources of revenue accruing to the University for its educational and research activities are from: Student tuition, fees, and other charges; external gifts, grants and contracts (either for unrestricted or, more commonly, restricted purposes); endowment income from Duke University's Endowment and annual disbursements from the Duke Endowment under the terms of the aforementioned trust indenture.

If we may be of any assistance in either providing any additional information and/or answering any questions you or your staff may have, please feel free to contact any one of the following: Mr. C. L. Haslam, University Counsel, phone (919) 684-3955; Mr. J. Peyton Fuller, Assistant Vice President and Corporate Controller, phone (919) 684-5148; or Mr. John Shytle, Assistant Vice President for Health Affairs, phone (919) 684-6125.

Very truly yours,



C. L. Haslam
University Counsel

CLH:ms

Attachments (3)

cc: David Matthews, Secretary of HEW
William Taft, General Counsel, HEW
John H. Weiner, Assistant Executive Secretary
Office of Undersecretary of HEW

Attachment #1

Subject: The Allowability under Medicare/Medicaid Cost Reimbursement Principles of Interest Expense Incurred by Duke University Hospital on Borrowings for Working Capital Requirements from Duke University (A Related Organization).

Prior to fiscal year 1973-74 Duke University Hospital had been able to maintain a cash flow sufficient to provide it with a working capital which was adequate to sustain its day-to-day operating requirements. As a result, prior to that time, the Hospital had never been faced with the problem of seeking external borrowings to supplement the working capital it had been able to generate through its own operations. During fiscal year 1973-74, however, three events occurred which, as the result of their simultaneous and cumulative effect, totally wiped out the working capital reserves of the Hospital and threw it into a cash overdraft position.

First, during the preceding fiscal year and until May of 1974, the Hospital was confronted with the impossible situation of having its revenue subjected to Cost of Living Council controls without any similar restraints being placed on its operating expenses. As a result, the Hospital was subjected to intense inflationary pressures on its operating expenses which it was precluded from recovering in its charges to patients. For the fiscal year ended June 30, 1973, the effect of this situation was an operating loss of almost \$600,000 which was followed in the fiscal year ended June 30, 1974, by a further operating loss of more than \$2.5 million.

Second, throughout this period of time the Hospital was attempting to conclude negotiations with its fiscal intermediary for both the Medicare and Medicaid Programs applicable to the annual cost reports filed by the Hospital applicable to both of these programs for all fiscal years dating back to their inception. As the result of the numerous and relatively significant differences of opinion concerning the reimbursability of certain types of expenses and the fact that the fiscal intermediary changed auditors during this period of time, the cost reports for all fiscal years remained open and only partial settlements were made by the intermediary to the Hospital. These difficulties also compounded the Hospital's cash position and, by June 30, 1974, the Hospital had recorded on its books a receivable of approximately \$2.4 million which it believed was owed to it under these Programs.

Third, in the fall of 1973 the Hospital attempted to implement a new automated patient accounting and billing system. Unfortunately, numerous unforeseen computer system problems arose which, for a significant period of time greatly impaired the Hospital's ability to issue bills to its patients and effect collections therefrom. Although these computer problems were solved subsequently, they further exacerbated the cash flow difficulties that the Hospital was already incurring.

The governing board of Duke University was, at this time, faced with three alternatives for covering the Hospital's cash overdraft: (1) make a "gift" to the Hospital from other unrestricted funds available to the University

continued/...

- 2 -

non-hospital operations, (2) negotiate an external loan, or (3) loan the Hospital sufficient funds to cover its cash overdraft from restricted funds of the University's non-hospital operations which were temporarily in excess of immediate requirements. Under the latter alternative, interest would be charged to the Hospital and paid to the restricted funds to compensate them for their loss of income from external investments. The first alternative was deemed unacceptable in that it would have deprived the University's educational programs of investment income which had historically and traditionally accrued exclusively to their benefit. In addition, there existed the very real question of whether such a "gift" could be authorized by the Trustees without violating their fiduciary responsibilities. The major potential source of such a "gift" would have had to have been the Quasi-endowment funds of the University. Although such funds are legally unrestricted and may be utilized at the discretion of the Board of Trustees, it was well established that such funds had been accumulated exclusively from the University's non-hospital activities and it was believed that the Trustees had a fiduciary responsibility to protect such funds for the University's educational programs rather than to divert them to supplement revenue derived from the Hospital's patient care activities. The second alternative, although feasible, was not considered preferable to the third alternative in that the University could without detriment to its educational programs, loan the required funds to the Hospital at a lower rate of interest than would be charged by any external lending institution...an interest break of at least one-half of one per cent.

As a result of the above considerations, it was decided that the University would cover the Hospital's cash overdraft by a floating loan exactly equal to the Hospital's cash overdraft at each month end as determined by the Hospital's stand-alone balance sheet. Interest at the prime rate in existence at each month end was charged to the Hospital and made available to the University's educational programs in lieu of the funds they would have received as income from external investments.

Applicable Medicare regulations state that, to qualify as a reimbursable cost, interest expense can only be paid to an external lender or to the provider's funded depreciation reserves or to funds comprised of donor restricted contributions and, in any event, will only be allowed to the extent that such interest expense is in excess of any investment income earned by the provider on unrestricted funds available to it. The Medicare regulations go on to state that the requirement for external borrowing is to ensure that the loan is necessary and that the interest rate is reasonable.

The Hospital acknowledges that it did not comply with that portion of the regulation requiring that the borrowed funds be obtained from an external lending institution. However, the Hospital contends that the amount borrowed was never in excess of its cash overdraft and that the interest rate paid on the loan was consistently less than what it would have had to pay to an external lender. As a result, the Hospital contends that it has met the spirit, if not the letter, of the regulation. Furthermore, the Hospital contends that it can demonstrate that at all times throughout the period of the loan it and its parent university had sufficient surplus funds available in funded depreciation accounts available to the Hospital and in accounts whose funding source was external donor restricted contributions so that the loan could have been made from those sources. In actual practice, however, the University manages the short-term investment of excess cash in all funds (i.e., unrestricted and donor restricted) on a pooled

concept similar to a mutual fund. In other words, specific investments are not identified with a specific fund, but rather each fund participates in the investment earnings of the pooled cash fund pro rata its contribution to the total fund. For ease of accounting and administrative simplicity, this pooled cash management fund was used as the vehicle for loaning the Hospital funds required to cover its cash overdraft and the interest expense charged to the Hospital was paid to the pooled cash management fund and distributed monthly to its participants.

During fiscal year 1973-74 these working capital loans averaged \$4.8 million per month for which the Hospital was charged \$474,000 in interest. During fiscal year 1974-75 the loans averaged \$7.2 million per month and the Hospital was charged \$723,000 in interest. In fiscal year 1975-76 the loans averaged \$7.1 million per month and the Hospital was charged \$535,000 in interest. It is the opinion of the Hospital that this interest expense should be allowed as a reimbursable cost in that the Hospital did comply with both the spirit and the intent of the Medicare regulations and that it should not be penalized because of a purely technical violation of these regulations.

Attachment #2

Subject: The Allowability under medicare/Medicaid Cost Reimbursement Principles of Interest Expense Incurred from Duke University Hospital's Funded Depreciation and Donor Restricted Funds.

This question is basically a continuation of the first question, but under somewhat different arrangements.

Although the need for a working capital loan by Duke University Hospital still exists and is expected to continue to exist for, approximately, the next five years, other funding sources available internally within Duke University Hospital had, by June 30, 1976, improved to the point that the Hospital no longer needed to look to its parent university for funds needed to meet the cash overdraft in the Hospital's operating fund. At that point in time sufficient funds had been accumulated in the Hospital's funded depreciation account and in other donor restricted funds available to the Hospital to the extent that the Hospitals' overdraft in its operating fund could be covered by internal borrowings from such funds.

As a result, beginning with the start of its fiscal year 1976-77 the Hospital is continuing the borrowing arrangement discussed in Attachment #1 but is not borrowing such funds from the parent university nor is it paying interest to the parent university. All such borrowings and the interest thereon represent internal transactions between the Hospital's operating fund and its funded depreciation account and donor restricted funds. This mechanism would appear to overcome even the technical difficulties as presented in Attachment #1. There remains a serious question as to whether quasi-endowment funds or other unrestricted funds which arose from and are being utilized by the University's educational activities may be diverted to meet working capital needs of the Hospital and, further, whether such a diversion would be consistent with the fiduciary responsibilities of the Trustees of Duke University. Accordingly, Duke University Hospital believes that such interest expense should be allowable as a reimbursable cost.

Subject: The Allowability under Medicare/Medicaid Cost Reimbursement Principles of Interest Expense to be Incurred by Duke University Hospital on External Borrowings for Physical Plant Construction.

At June 30, 1976, Duke University Hospital had no external debt applicable to any Physical Plant construction project (or, for that matter, for any other purpose). In the forty-five years or so that Duke Hospital has existed, various additions, modifications, and renovations have been made. In general, however, such Physical Plant construction has been funded by external gifts/grants and/or funds generated by the operation of the Hospital (including depreciation). All such capital projects were, however, of a nature which merely complemented or supplemented the basic structure that was built in the late 1920's and did not address themselves directly to the inescapable fact that changes in the technology and complexity of health care were slowly, but inexorably, rendering Duke University Hospital obsolete. Space limitations and the basic configuration of Duke University Hospital's Physical Plant now make it mandatory that a major construction project be undertaken if Duke University Hospital is to continue to provide the scope and caliber of health care required and expected by the people of the area it serves.

During the past several years intensive planning was underway to define the future Physical Plant structure and configuration needed by Duke University Hospital. This planning ultimately culminated in a decision to build an addition to the Hospital (to be known as Duke Hospital North) which would contain approximately 719,000 gross square feet and which would include space for approximately 616 acute and intensive care beds, an inpatient surgery suite, a cardiac center, a diagnostic radiology suite, a nuclear medicine suite, an emergency room, and related facilities. The cost of this construction project, which began in December of 1975 and is scheduled to be completed during the first quarter of 1979, is estimated at approximately \$92 million. Of the total project cost, the Hospital is attempting to raise \$34 million in equity funding from external gifts and funds generated internally by the Hospital. The balance of the project (i. e. \$58 million) is to be funded from the proceeds of a \$48 million bond issue (which was purchased by a consortium of institutional investors headed by the Prudential Insurance Company of America and Connecticut General Life Insurance Company) and \$10 million in short-term notes to be held by two North Carolina banks.

In all of the planning for this new facility a paramount consideration was to limit any external debt to the greatest extent possible so as to hold down the operating cost that would have to be borne by the patients served. Duke University Hospital believes that its efforts to acquire \$34 million in equity funding provides ample evidence of its good faith in this respect. However, throughout the planning for this new facility and in all related discussions with the various State and local regulatory agencies and with Blue Cross Blue Shield of North Carolina (which serves not only as the fiscal intermediary

for the Medicare/Medicaid Programs but is also the principal insurance carrier for patients served by Duke Hospital) it was fully anticipated and expected that the interest expense required to amortize the external debt would be treated as a legitimate cost for reimbursement purposes under the Medicare/Medicaid Programs and under the services provided by private health care insurance plans.

It was not until after commitments for the external bond issue had already been made and construction underway, that the auditors for the Medicare/Medicaid Programs' fiscal intermediary raised the spector that much, if not all, of the interest expense could not be treated as a reimbursable cost under the Medicare/Medicaid Programs in view of the fact that the Hospital's parent university had legally unrestricted funds available to it which were realizing income from external investments.

It was the auditors' contention that, theoretically at any rate, the University could liquidate that portion of its Endowment Fund which was not legally restricted by the original donors (and which had a market value at June 30, 1976, of approximately \$57.4 million) and use the proceeds to construct the new Hospital in lieu of borrowing any funds externally. Or, alternatively, borrow such funds externally but treat as a reimbursable cost only that amount of interest expense which exceeded the investment income realized in any year by the University from its investments of unrestricted funds. During the fiscal year ended June 30, 1976, the University realized approximately \$3.1 million of investment income from the unrestricted portion of its endowment and from the investment of unrestricted funds available to the non-hospital portions of the University which were temporarily in excess of their requirements.

Duke University Hospital does not believe the auditors' contentions to be either realistic, equitable, or within the intent of the Medicare/Medicaid regulations. To liquidate the unrestricted portion of the University's Endowment and expend such funds for the construction of an addition to Duke Hospital would virtually destroy Duke University as a fiscally viable educational institution, even if the Trustees are empowered to take such action. And, as discussed in Attachments #1 and #2, a very real question exists as to whether such action by the Trustees would violate their fiduciary responsibilities in view of the fact that the unrestricted portion of the endowment came from the non-hospital portion of the University and has historically and traditionally been reserved for such non-hospital activities. The alternative concept of treating unrestricted investment income of the University as an offset against the interest expense of the Hospital appears to be equally without merit. To effect such treatment, the University would either have to transfer such income to the Hospital, thereby depriving the non-hospital operations of the University of the benefit of such income, or allow the non-hospital portions of the University to continue to receive such income but, for Medicare/Medicaid purposes, merely pretend that such a transfer had been made and thereby reduce what is considered to be the operating cost of the Hospital for Medicare/

continued/...

Medicaid reimbursement purposes. The aforementioned alternative treatment has the same defects as liquidation of the University's Endowment - that is an unconsiderable financial hardship would be imposed on the University's non-hospital operations and there is still the question of whether such action would violate the Trustees' fiduciary responsibilities. The latter mentioned alternative also appears to carry an inherent defect. If no transfer of funds is made, but is merely assumed to have been made for Medicare/Medicaid purposes, then the operating cost of the Hospital is unchanged and that portion of this total cost which is not borne by the Medicare/Medicaid Programs must, legally and of necessity, be shifted to and assumed by the Hospital's non-Medicare/Medicaid patients. Such action would however violate the basic spirit and intent of Congress when it enacted the Medicare Program. At that time, it was clearly stated that it was the intent of the Medicare legislation to assume its fair share of a hospital's operating cost and not to pass on to non-Medicare patients a disproportionate share of such costs.

For all of these reasons cited above, Duke Hospital believes that its method of financing the aforementioned \$92 million addition is in the best interest of its patients and those third parties (including Medicare/Medicaid) that assume all or part of the patients' medical expenses. Duke University Hospital contends that the endowment of its parent organization which arose from non-hospital operations should not have to be expended in behalf of the Hospital nor should any investment income realized by its parent be required to be treated as an offset against the interest expense Duke University Hospital incurs in connection with this capital project.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

Retain - 6 mos. ☐

1 yr. ☐

5 yrs. ☐

Permanently ☐
Follow-up Date ☐

DATE June 13, 1977

TO: Drs. Cooper, Sherman, Swanson, Kennedy, Knapp, Mr. Keyes

FROM: James Bentley *Bentley*

SUBJECT: Questioning of AAMC Witness by Senator Talmadge

On June 8th, Dr. David Thompson testified on behalf of the AAMC before Senator Talmadge concerning the Senator's proposed amendments to the Medicare and Medicaid programs. This memorandum summarizes significant issues raised in questioning of Dr. Thompson and in a discussion held by Drs. Cooper and Thompson with Mr. Jay Constantine.

Questioning following Testimony

At the hearing, Senators Talmadge and Dole were both present and each questioned Dr. Thompson. In two areas of questioning, Senator Talmadge suggested that Association representative should work with the Subcommittee staff to explore and evaluate policy alternatives: (1) the development of "more equitable" solutions for eliminating excess hospital beds and (2) the development of alternative arrangements to the present practice of funding graduate medical education as a part of the hospital's patient care costs. In each case, Dr. Thompson promised AAMC cooperation with Subcommittee efforts.

Discussion with Jay Constantine

Following our testimony and associated questioning, Mr. Jay Constantine met with Drs. Thompson and Cooper in the corridor. Mr. Constantine indicated that Senator Talmadge was carefully studying the AAMC recommendations that a National Technical Advisory Board on hospital classification be established. He also indicated that the Senator was considering using a screen on discharges to establish eligibility for a case mix adjustment. As outlined, the screen would compare an institution's percentage of discharges in specified diagnoses with the average percentage for hospitals in the group. A hospital would be eligible for an exception adjustment if its aggregate percentage exceed the group's aggregate percentage.

Mr. Constantine also invited AAMC suggestions on extending the Talmadge bill to other costs and other payors. Lastly, Mr. Constantine sought to clarify the intent of Senator Talmadge's questions on financing graduate medical education. As elaborated, Senator Talmadge does not oppose significant federal funding of this investment cost. He would, however, like some alternatives -- such as a special trust fund within SSA -- to be developed for his consideration, and he expressly invites the AAMC to share in developing the alternatives(s).



association of american medical colleges

TESTIMONY SUBMITTED ON H.R. 6575
BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
AND THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
U.S. HOUSE OF REPRESENTATIVES

May 12, 1977

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the "Hospital Cost Containment Act of 1977," H.R. 6575. In addition to representing all of the nation's medical schools and sixty academic societies, the Association's Council of Teaching Hospitals includes over 400 of the nation's major teaching hospitals. These hospitals: account for over sixteen percent of the admissions and approximately twenty percent of the ambulatory care services provided by non-Federal short-term hospitals; provide a comprehensive range of patient services, including the most complex tertiary services; and are responsible for a majority of the nation's graduate medical education programs. Thus, the hospital revenue limitations and capital expenditure controls proposed in H.R. 6575 and the consequences of these controls are of a direct interest and a vital concern to the Association's members.

For ease and clarity of presentation, this testimony is organized in two parts with two supporting appendices. The first part addresses cost containment in the hospital industry, including a review of the causes of increased hospital costs; the inherent problems of using arbitrary percentage

caps as found in H.R. 6575; and an intermediate to long-term alternative to the President's proposal. In addition, Appendix A provides a section by section description of specific problems which are present in the revenue limitation provisions of H.R. 6575. The second part of this testimony addresses capital expenditures by hospitals, the arbitrary characteristics and likely adverse impacts of H.R. 6575, and recommendations for strengthening the National Health Planning and Resources Development Act. Appendix B provides a section by section statement of the specific problems of Title II of H.R. 6575.

HOSPITAL COST CONTAINMENT

The Problems of Hospital Expenditures

The AAMC and its members fully appreciate the fact that total national health expenditures have increased from \$12.7 billion, or 4.5% of the Gross National Product, in 1950 to \$139.3 billion, or 8.6% of the GNP, by 1976 and that aggregate expenditures for hospital care increased from \$3.9 billion in 1950 to \$55.4 billion in 1976. These twenty-seven year expenditure trends are paralleled by the trend for hospital expenses per unit of service. For example, hospital expenses per patient day¹ were \$7.98 in 1950, \$16.46 in 1960, \$118.69 in 1975.

The Association also appreciates the problems that these cost and expenditure trends have created: health insurers have had to seek substantial increases in premiums at frequent intervals, industrial firms and labor unions have had increases in the costs of the health insurance fringe benefits that

¹The statistic "expenses per patient day" is deficient as a basis for examining cost trends because it treats all hospital days as homogeneous, ignores ambulatory care provided in the hospital, and assumes the hospital product is a constant. Nevertheless, it is used here as an example of the statistical data which have contributed to the public's perception of the problem of hospital costs.

exceeded the expectations of all negotiating parties, consumers have found premiums for existing coverage rising at the same time that they have needed to increase their coverage limits to obtain adequate protection, and government officials and agencies have seen expenditure increases that have limited the opportunities to initiate new programs or strengthen existing programs. As a result, a national consensus is evolving that there is an urgent need to reduce the rate of increase in health care costs.

The AAMC recognizes this national concern, and the Association and its members are willing to work constructively with all parties in government and the private sector to develop, promote, and advance hospital cost containment programs which are practical, equitable, and administerable and which continue to maintain the quality of patient care demanded by the public. In order to develop a cost containment program consistent with these characteristics, factors responsible for the present rate of increase in the costs of hospital services must be understood and considered.

Sources of Increased Hospital Costs

Hospital cost increases are primarily the result of changes in the following cost components:

- the inflation in the general economy;
- the imposition of government-mandated programs;
- the introduction and changing mix of services and technologies;
- the population's utilization patterns; and
- the hospital's increasing complexity and its coordination needs.

Hospitals must purchase goods, services, and manpower. General and multi-purpose goods such as food, fuel, utilities, and general liability insurance are purchased from suppliers serving many industries. In purchasing these goods and services, cost increases for hospitals will be

similar to those experienced by the general economy. Hospitals also purchase goods and services of a distinctly medical character. Pharmaceuticals, laboratory supplies and reagents, and malpractice insurance have limited markets; changes in the prices of these goods may be greater or less than the economy's average inflation. Similarly, in recruiting personnel, hospitals compete in markets shared by other industries -- such as food service, housekeeping and construction -- and in specialized markets -- such as those for medical, paramedical, and technical personnel. In each of these labor markets, hospitals have traditionally experienced relatively low wages for their employees; however, as employee and community attitudes have changed in the past decade, hospitals have had to become and remain competitive with the general community in salaries and fringe benefits. For goods, services, and manpower, hospitals now pay a competitive price, and price increases in both general and specialized resource markets must be incorporated into hospitals' changing costs.

Hospitals are subject to government-mandated programs enacted by federal, state and local governments which increase costs. The hospital must comply with building, fire, and life safety codes. Antipollution and solid waste control standards must be attained. Pension reform provisions must be met. Higher Social Security taxes must be funded. Each of these programs, regardless of its social desirability, increases the operating expenses of hospitals without increasing their services.

Hospitals of the mid-seventies are significantly different from those of the early fifties. New and more effective diagnostic and therapeutic modalities are available. Life saving technologies such as intensive care and renal dialysis have been introduced. Standards of medical practice for many diseases have changed in response to new procedures and techniques.

Some of these developments have reduced hospital costs by providing comparatively less expensive therapies for previous services; many, however, have increased costs by adding new and complementary capabilities to hospitals. As a result, Social Security Administration findings, shown in Table 1, document that for the past twenty-five years approximately 50% of the total increase in hospital costs has resulted from improvements in hospital services.

The population's use of the hospital is changing. Increasing levels of education and income are accompanied by increasing demands for the most sophisticated and costly hospital services. Emergency rooms and organized outpatient departments are providing complex specialty and ancillary services in addition to primary ambulatory care. Increased numbers of aged citizens with serious acute disorders and severe chronic conditions require increases in the ancillary and nursing support provided by the hospitals. Long-term and self-care facilities organized apart from hospitals are being used for the less expensive recuperating patients, while the complex and expensive patients have remained in hospitals. Each of these changes contributes to increasing hospital unit costs.

As a public resource, hospitals are expected to meet the needs of their community. Therefore, hospitals have added new services, equipment, and personnel to meet the public's desire for access to the latest medical and scientific accomplishments. Unfortunately, some duplications of underutilized, but expensive, services have also occurred. As hospitals have increased services and staff, coordination of activities has become more difficult to maintain. Additional reporting and control systems requiring more staff have been developed and implemented to maintain institutional effectiveness. In these respects, hospitals, and their costs, are no different from other industries which have also found it necessary to expand administrative

Table 1

Average Annual Percentage Increase in Hospital
Costs Resulting from Improvements in Hospital Services

<u>Time Period</u>	<u>Average Annual Percentage Increase</u>
1951-1960	50.0%
1960-1965	48.5%
1965-1967	60.3%
1967-1969	41.8%
1969-1971	44.7%
1971-1973	48.7%

Source: Social Security Administration. Medical Care Expenditures, Prices and Costs: Background Book. September, 1975. Page 39.

services and, thus, to increase organizational overhead.

A cost containment program to reduce hospital costs without disrupting necessary health services must be designed with full recognition of the hospital's limited ability to influence or control many of its cost components. This is especially true of the inflation level present in the economy and the requirements of government-mandated programs. These cost increase factors are beyond the control of hospitals, individually and collectively.

Also beyond the control of hospitals are the unclear and inconsistent policies and priorities confronting these public service organizations.

For example,

- Practitioners are encouraged to "optimize" the use of hospital services to contain costs while large malpractice awards to patients with adverse outcomes encourage practitioners to request more professional consultations and ancillary services and dramatically increases malpractice premiums.
- Regionalization of health services, which concentrates expensive services in a few hospitals, is sought while reimbursement programs seek to apply uniform payment levels without recognition of case mix differences.
- Health planning regulations for capital expenditures in institutions are undertaken while similar expenditures in physicians' offices are excluded from review and approval.
- Free care and below cost care are mandated for public patients while third party payors and consumer groups pressure the hospital to prevent charges from exceeding costs for paying patients.
- Certification and licensure are sought and frequently legislated for paraprofessional and technical personnel while hospitals are encouraged to use fewer and more flexible personnel.
- Primary care emphasizing ambulatory and preventive services is sought while outpatient clinics lose money and special program funds for catastrophic care are more easily attainable and abundant.

- Utilization controls to optimize the use of hospital services are sought while fully-insured patients seek to remain through complete recovery and while chronic patients must remain until a long-term bed is available.
- Optimum standards for care are sought while high costs are opposed.
- Expanded health benefit programs are incorporated in collective bargaining agreements while consumer and industrial groups oppose increases in health insurance premiums.

Hospitals serve patient and societal needs. The presence of inconsistent patient expectations and contradictory public policies have placed these institutions in the position of trying to do everything for everyone. The absence of disciplined expectations and consistent policies has reinforced and heightened the impact of the five hospital cost components discussed earlier. Effective programs to contain hospital costs will depend on the emergence of more consistent public expectations and clearer public policies for hospital services.

To contain hospital costs in an effective and socially desirable manner, the AAMC believes public and private programs must include efforts (1) to moderate increases in the factors underlying hospital costs, (2) to unify and clarify societal expectations of hospitals, and (3) to design payment systems which provide hospitals with incentives to limit operating expenditures.

Title I of the Carter Administration's Proposal

Sharing the public's perception that the rate of increase in hospital costs is unacceptable, the Carter Administration, in Title I of H.R. 6575, has proposed a "temporary" mechanism for limiting hospital revenue increases, from all payors, effective one hundred and forty-one days from today. The Association of American Medical Colleges believes that this proposal of a nationwide cap on revenue is unreasonable in the short-term and that it will

have highly adverse effects on our nation's ability to rationally limit hospital expenditures in the long-run. In addition to the specific provisions and problems with H.R. 6575 discussed in Appendix A, the AAMC is concerned about several generic issues and problems underlying this proposed method for limiting hospital expenditures.

The Association is opposed to any proposal which prescribes an arbitrary percentage to cap payments to hospitals. While such an approach does limit third party and patient expenditures and hospital revenues, an arbitrary percentage cap is defective and inequitable by its very nature. First, a nationwide cap fails to recognize or account for the very real regional and institutional variations in uncontrollable costs. Hospitals in a region where the malpractice insurance crisis has already occurred have high insurance premiums already in their base, but those in areas just encountering the substantial increases in premiums will have to use a significant portion of their allowable increase in revenue just to pay the revised premiums. Second, an arbitrary percentage increase can unduly benefit hospitals with high proportions of fixed costs. For example, a recently constructed hospital with high debt service requirements can use the percentage increase calculated on these expenditures to add and improve services while older, inner-city hospitals with few capital debts have to use a significant portion of their revenue increases simply to repair and maintain an aging physical plant. Third, an arbitrary percentage increase has a punitive effect on the hospital which has already responded to the national objective of containing hospital costs. Having voluntarily worked to limit its cost increases, the hospital with an effective cost containment program has neither excess resources nor cost containment potentialities which could be used to offset the effects of

of the cap; the inefficient hospital does have such margins incorporated in its past operating expenditures as well as in its inefficient practices. Thus, voluntary compliance with cost containment goals is punished and possibly discouraged. Fourth, an arbitrary percentage increase penalizes hospitals whose costs have been held down by state rate review, for these hospitals start out with a smaller and more restricted base. Fifth, an arbitrary ceiling places an unusually heavy burden on tertiary care/teaching hospitals which pioneer new patient care services, must accept referrals of the most costly and complex patients, and are training expanding numbers of new physicians including those specializing in primary care.

In addition to its inherent defects, the Administration's proposal is highly inequitable for the following reasons:

- It seeks to limit hospital revenue in the absence of any similar limitations on hospital input prices. Goods, services, and manpower in the general economy are unrestrained and likely to increase independent of the hospitals' ability to pay such increased costs.
- No procedure or controls are proposed for limiting or distributing the volume of patient services required.
- Methods to adjust for case mix or patient care intensity are not provided. Regionalization of complex patient services is occurring as intensively ill patients are being referred to teaching hospitals. This regionalization, while cost effective when viewed nationally, results in greater cost increases for tertiary care/teaching hospitals than in other hospitals and, thus, more severe problems with arbitrary revenue limitations.
- There is an implicit assumption that net operating revenues in the base year were adequate to meet the operating revenues in the base year and no relief is provided for hospitals with inadequate revenues in the past.

Each of these four inequities means that some hospitals may easily comply with an arbitrary revenue limitation while other hospitals, of similar or greater efficiency, encounter substantial operating difficulties and

financial risk.

The Administration's proposal erroneously assumes that aggregate hospital characteristics are characteristics of individual hospitals. While the mix of patients cared for nationally by all hospitals may be stable, individual hospitals may encounter substantial changes in patient mix. Moreover, the presence of a revenue limitation provides some incentive for hospitals to avoid or transfer the more complex and costly cases to tertiary care and teaching hospitals. Concentrating complex cases is not undesirable, but, if it occurs in the presence of an arbitrary revenue limitation which does not include a case mix adjustment or exception, it seriously threatens the financial integrity of tertiary care and teaching hospitals. Secondly, the proposal assumes that any single ratio describing the relationship of fixed to variable expenses for the industry may be equitably applied to each individual hospital. This is untrue. Some hospitals may be able to adequately adjust to changes in the number of patient admissions if the revenue for the incremental patients is equal to fifty percent of the average revenue. For other hospitals, which would need to involuntarily terminate workers entitled to substantial unemployment payments as the volume of service decreased or which would need to re-open patient floors as volume increased, a volume adjustment of fifty percent would be most inadequate. Third, the hospital industry has historically maintained a relatively small operating margin of income over expenses. It should be understood, however, that not all hospitals have positive operating margins. For example, a study of the financial position of 295 teaching hospitals found that 128, or 43.4% had negative operating ratios for the twelve month period ending September 30, 1974. A more recent study in New York State continues to demonstrate this variation in operating margins. Thus, while

some have argued that a temporary program of revenue limitations will not cripple the industry, it may be financially catastrophic for a significant number of hospitals having negative operating margins. Lastly, while the proposal assumes that a decrease in the average length of patient stays will decrease per admission costs, it may actually increase costs in individual hospitals while simultaneously reducing revenues. In summary, because hospitals are not a homogeneous set of institutions, each of which can be individually characterized by nationwide averages, many of the adverse impacts of this proposal must be examined in terms of the individual hospital and its community.

The Administration's proposal ignores historical trends and recent developments in health care delivery which necessitate increased revenues. Medicare and Medicaid have improved the access and use of hospital services by our poorer and older citizens who often have severe and complex medical needs. The added services that have resulted are a tribute to our nation's hospitals. The costs of these additional services should not be considered as inflation. Secondly, utilization review and medical audit programs operate to minimize under-utilization as well as over-utilization of health services. By creating a medically appropriate range of discretionary services and treatment alternatives, these federally-instigated programs restrict the hospital's ability to adjust its operations in the face of inadequate revenues. Third, the Health Professions Education Assistance Act of 1974, P.L. 94-484, includes an expanded emphasis on primary care training opportunities. To meet the Act's objectives, the number of primary care residency positions in existing programs will have to be expanded and new programs will have to be added in additional hospitals. These expansions and additions will increase hospital costs and necessitate new revenues. The presence of an

arbitrary revenue limitation which does not recognize the justifiable increases accompanying primary care expansion threatens to thwart the Congressional intent of P.L. 94-484. Lastly, tertiary care and teaching hospitals have been increasing the number of salaried hospital physicians. While these physician costs increase the hospital's budget, it is not clear that they increase overall health care costs, for they are removed from the costs of non-institutional providers. An arbitrary percentage cap on hospital revenues threatens continuation of this desirable trend and may reverse it. Each of these four developments in the hospital industry is the result of its continuing evolution. The AAMC believes that these trends should not be indiscriminately reversed by the imposition of an arbitrary limitation on hospital revenues.

The revenue limitations of H.R. 6575 apply only to the inpatient services of hospitals. While this has been done to foster further development of ambulatory care services, it fails to recognize three key characteristics of ambulatory services: increased emergency services often increase rather than reduce admissions; increased outpatient clinic services, especially if established in underserved areas, often increase rather than decrease hospital admissions and inpatient days; and increased ambulatory services at many hospitals will require new capital expenditures which are restricted by Title II of the bill. The Association of American Medical Colleges has an active program for the improvement of ambulatory services in teaching hospitals. The proposed legislation threatens that improvement by failing to recognize the relationship between ambulatory and inpatient services and by ignoring the need for additional capital expenditures for ambulatory care services.

The rise in hospital costs which has led to the growing consensus

that the rate of increase in hospital costs must be contained developed across several decades. This rise in costs has several contributing components including rising expectations for the hospitals by the public. Arbitrary revenue limitations, while administratively easy to impose at the payors level, are inequitable, based upon false assumptions of hospital homogeneity, ignore historical trends and recent developments, and do not recognize the inter-relationship of hospital activities. Moreover, by indiscriminately providing highly favorable payments to some hospitals and relatively punitive payments to others, an arbitrary revenue ceiling threatens to disable the hospital industry, to impose irrational and unintended effects, and to create additional residual problems for any long-run containment of hospital costs. Therefore, the Association of American Medical Colleges strongly recommends that Title I of H.R. 6575 not be enacted.

Cost Containment Alternatives

If members of Congress and the Administration agree that it is a national policy that an increasing share of the GNP is not to be devoted to medical services, then a long-term approach to reducing the rate of increase in hospital costs is needed. However, it must be recognized that there is no evidence that the rate of increase in hospital costs associated with current levels of improving hospital services and introducing new technology for the diagnosis and treatment of disease can be ameliorated simply by reducing whatever inefficiencies exist in the system. It cannot be over-emphasized that the present levels of hospital costs have developed over a long period of time and as a result of hospital responses to national and state legislation, to prevailing economic and social conditions and public demands. The problems of instituting

controls over the reimbursement system to reduce increases in cost have been described by Alice Rivlin, Director of the Congressional Office of the Budget, in her May 17, 1976 testimony before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare: "It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in quality of health services, and imposing undesirable rigidities on the delivery system will be a sensitive and difficult task."

As the subcommittees and members of Congress examine alternatives for cost containment programs, the AAMC wishes to reiterate its position that a more rational cost containment approach could be based on reimbursement limitations derived from national cross-classification schemes that are carefully constructed and conscientiously implemented to ensure that similar hospitals and costs are being compared. An appropriately phased system which requires uniform hospital reporting, removes atypical and uncontrollable costs from comparisons, and provides an effective exceptions process could reduce the present rate of hospital cost increases. If incentives were included which enabled hospitals to share in the advantages of reducing costs below the reimbursement limitation, an important stimulus would be added to the present cost containment efforts of governing boards, hospital executive, and physicians.

This position on national cross-classification schemes for determining hospital payments should not be interpreted as an objection to state level administration of budget or rate review systems, established either voluntarily or by statute, providing such systems meet federal guidelines and standards. These standards for the operations of state systems should include the following important characteristics: (1) the system should be based on an adequately financed, politically independent agency headed by a small number of full-time,

well-compensated commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (2) the agency's operations should include clearly defined formal procedures, adopted after public hearings, for systematic review of rate or budget applications and with provisions for routine changes to be made with minimal procedure and expense; and (3) the agency should provide due process, including the right to judicial appeal for the applicant as well as for others affected by the decisions, and specific protections against undue delays in action.

In view of the probability that this cost containment alternative would not have a marked effect for eighteen to thirty-six months, the question remains as to what the Congress should do to control cost increases for the fiscal year beginning in one hundred and forty-one days. Can an effective program be put into place that will not have far reaching, undesirable and possibly disastrous effects on the medical care system? Should such a program focus its attention solely on dollar expenditures and adopt the Administration's revenue limitation proposal? After careful examination the AAMC believes such a course of action would be imprudent and unreasonable. It is not prudent public policy to take a long-standing problem of immense complexity and apply a "quick fix" through a short-term program that will create severe fiscal and service dislocations and compound the difficulties of developing long-term solutions. This position should not be interpreted as suggesting that there is nothing that governments, providers, and consumers can do before implementation of a long-term approach to cost containment.

It should be recognized that several programs already in place, if adequately financed and supported, can generate substantial cost savings over the short-term. The Professional Standards Review Organization program was established

to determine that medical services supported with Federal funds were necessary and timely. While enacted as a part of the 1972 Social Security amendments, PSRO agencies at state and local levels are now becoming an effective force in the health care system. They are stimulating changes in the system by altering utilization patterns. As these agencies reduce admissions, length of patient stays, and ancillary services, hospital revenues will be reduced. The Association of American Medical Colleges supports full implementation of Professional Standards Review Organizations as an important step in a short-run cost containment program. PSROs, through their impact on practice patterns, can also provide a foundation on which long-term programs can be built.

The health planning agencies established in response to P.L. 93-641, the Health Planning and Resources Development Act, are also taking effect. With more adequate funding and timely Federal direction, they could have a more immediate impact on hospital services and facilities which would reduce operating costs for hospitals. While this program is more completely discussed in the remaining part of this testimony concerning capital expenditures, the Association of American Medical Colleges supports full implementation of P.L. 93-641 as a socially rational means of limiting hospital operations. Community health planning is the second desirable step which leads into a long-run cost containment program.

Thirdly, cost limitations are presently being imposed on hospitals. Section 223 of the 1972 Social Security amendments has provided a ceiling on allowable routine service costs for hospitals participating in the Medicare and Medicaid programs. While the AAMC has challenged the implementing regulations, the Association believes this program has had a restraining effect on hospital revenues and expenses. In addition to Section 223, several states, including some of the larger ones, have established mechanisms for reviewing hospital budgets

and/or establishing hospital rates. Some of these programs are voluntary; others are mandatory. As a group, they are not only containing hospital costs, they are providing a real world test of some alternatives for long-term programs.

In conclusion, there is a very useful function that these hearings can serve and which should not be overlooked. Several government agencies, such as the Office of Technology Assessment and the National Center for Health Services Research and Development, have the authority to examine health issues of national concern. Following these hearings, these Subcommittees will be in a position to provide such agencies with an agenda particularly relevant to hospital cost containment. For example, the agencies could be encouraged to investigate:

- alternative schemes to classify hospitals to ensure that similar institutions are grouped together;
- the operating characteristics and policies of hospitals at the extremes of cost distributions in the grouping methodology currently in place under Section 223 of P.L. 92-603;
- methods for computing the impact of diagnostic case mix on hospital costs;
- a chain weighted price index which would measure the impact of inflation on hospital purchases;
- regional and institutional variations in the utilization of ancillary services;
- variations in the ratio of the marginal and average costs of hospital services.

There are undoubtedly other issues which have been or will be identified by other witnesses, and these should be added to this suggested agenda.

Effective cost containment programs will be complex; however, the Association of American Medical Colleges believes that long-term programs which combine peer review, health planning, reduced expectations, and a more sophisticated approach to payment controls will contribute significantly to a reduction in hospital cost increases without undermining the financial integrity of hospitals and while preserving the quality and accessibility of their services.

TITLE II

LIMITATION ON HOSPITAL CAPITAL EXPENDITURES

Title II of the proposed "Hospital Cost Containment Act of 1977" (H.R. 6575) would establish permanent limits on hospital capital expenditures of the type, size and scope presently controlled under both Section 1122 of the Social Security Amendments of 1972 (P.L. 92-603) and the "Certificate of Need" provisions of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641).

Before considering this new proposal, it is useful to examine the evolution of health planning in our nation. In 1965, the Regional Medical Programs Act (P.L. 89-239) was passed to promote regionalization, local participation in health planning, and a dual funding mechanism for both planning and operations. However, RMP's potential contribution to health planning was rendered negligible, in significant part due to inadequate funding, a lack of policy guidance, and needed technical assistance. In 1966, the Comprehensive Health Planning Act (P.L. 89-749) was enacted to promote comprehensive health planning for services, manpower and facilities at every level of government, primarily through a strengthening of leadership and capacities of state health planning agencies. CHP "B" agencies were chronically underfunded due in part to appropriations below authorization, and in part due to an inability to raise local funds to meet federal matching requirements.

In 1972 Section 1122 of the Social Security Act was enacted to tie federal reimbursement for capital expenditures to the planning process by requiring prior notification of a capital expenditure proposal by health care institutions and by further requiring a determination by the planning agency of the proposal's consistency with standards, criteria or plans developed on an areawide basis.

The current national health planning law, P.L. 93-641, combines the best features of each of its predecessors into a single program of state and local planning and development. Nevertheless, though authorization levels under P.L. 93-641 substantially exceed previous CHP funding levels, the issue of adequate funding for health planning remains a concern.

In the past twelve years, our nation has had four major health planning programs. The Administration is now proposing a fifth major change, one that would combine the local focus of health planning with a nationwide ceiling on total capital expenditures and with nationwide standards for bed supply and hospital occupancy. With this past history, the AAMC urges the members of Congress to ask whether it is logical to continue every few years to enact new federal health planning legislation to replace previous statutory programs that failed because they were poorly financed, ill-staffed and not given a fair chance to succeed. Or, has the time come to permit the current planning law an adequate opportunity to fulfill its promise by strengthening and improving existing mechanisms (i.e., capital expenditure review, Certificate of Need and review of new institutional health services) through increased government commitment in funds and priorities. The Association believes that, if the present health planning law is allowed to operate effectively, it will provide the necessary mechanisms to review and determine the need for proposed capital expenditures without introducing the arbitrary, inequitable and unadministerable provisions of Title II of the Administration's hospital cost containment proposal.

Title II is arbitrary by its very nature. Prior to the beginning of each fiscal year, the Secretary of HEW would establish an annual national limit on new capital expenditures by acute care hospitals under Title II of the proposed hospital cost containment act. The amount of this limit may not exceed \$2.5 billion. This ceiling is too low, and would necessitate an immediate drastic

cut of about 50% in the current level of capital expenditures (approximately between \$5-6 billion) by acute care hospitals in this country.

The capital expenditure ceiling is not only arbitrary, it is also inflexible. While the provisions of Title II are permanent, they contain no language that would leave room for exceeding the \$2.5 billion figure under any justifiable circumstances. Thus, hospitals would be confronted by a permanently fixed ceiling, inadequate at the start and becoming more so in later years as construction and equipment costs increase.

The AAMC is opposed to the \$2.5 billion ceiling not only for the reasons already described, but also because it fails to consider the sizeable capital expenditures that hospitals must make each year in order to comply with mandatory changes required by various codes, standards and regulations to which the hospitals must conform. Among the more frequently identified codes and standards are:

1. Joint Commission on Accreditation of Hospitals
2. Section 504 Regulations on Discrimination Against the Handicapped (45 CFR, Part 84).
3. Inspection standards and codes for federal and state hospitals and other government facilities.
4. Manufacturer's standards and instructions for operating equipment and devices.
5. American National Standards Institute standards.
6. National Electrical Manufacturers Association codes and standards.
7. Underwriter's Laboratories standards.
8. American Society of Heating, Refrigeration, and Air Conditioning Engineers standards.
9. Electronic Industries Association standards and publications.
10. Institute of Electrical and Electronic Engineers standards and related publications.

11. American Society for Testing and Materials standards.
12. Instrument Society of America standards and recommended practice.
13. U.S. Department of Health, Education, and Welfare, Public Health Service, Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities.
14. National Safety Council safety-evaluation checklist.
15. Model Code Groups/Southern Standard, Building Officials and Code Administrators, Uniform Building Code.
16. National Fire Protection Association.

These public, governmental and industrial bodies have exerted increasing pressure on hospitals to meet increased environmental and life safety standards that mandate changes which by themselves could require acute-care hospitals in this country to expend as much as, if not more than, the \$2.5 billion figure that has been proposed as a national capital expenditure limit under H.R. 6575.

Unfortunately, the magnitude of the capital invested yearly by hospitals on mandatory changes required by such sources as the Life Safety Codes is not well documented. But enough is known to realize that the proposed \$2.5 billion ceiling on national capital expenditures is a capricious recommendation that might even fail to keep hospitals abreast of their current basic capital needs. Hospitals are beset with standards and regulations to which they must conform in order to keep their doors open. For teaching hospitals, JCAH Accreditation requirements are critical for without such accreditation the hospital loses its educational accreditation. Thus, the AAMC opposes the arbitrary \$2.5 billion cap proposed under Title II, but strongly urges HEW to undertake detailed cost-benefit studies of the mandated capital requirements of hospitals and provide valid data on this subject for future reference.

H.R. 6575 also requires the Secretary to establish for each fiscal year a national ceiling for the supply of beds within health service areas and a national standard for the rate of occupancy of hospital beds within such areas.

No projects resulting in net bed additions will be approved in health service areas with more than 4 beds per 1000 population or less than 80% occupancy of hospital beds. These arbitrary standards have been challenged in the past and are strongly opposed by the AAMC. They are insensitive to local needs and conditions, to interarea migration of patients for tertiary level care, and to the difficulties and costs of local planning to accommodate such federally imposed mandated formulas. They ignore the fact that rural hospitals need a wider margin of safety than an arbitrary floor of 80% occupancy would allow. There are a number of medical centers which function as national referral resources which must maintain bed-to-population ratios in excess of the standard established in the President's proposal. Such areas as Durham, North Carolina and Rochester, Minnesota are well recognized examples of such referral resources.

Additionally, it remains unclear how the term "beds" is defined in each area. Are the standards applicable only to an institution's total licensed beds? Its total bed capacity? The total beds staffed and in operation for a given period of time? Only acute care beds? Are special care units to be included in the computation? Finally, while the provisions leave some room for flexibility by stating that the Secretary may establish a different supply ceiling or occupancy standard for health service areas which have special characteristics or which meet special requirements, the bill provides no guidance as to what these special characteristics or requirements might include.

The AAMC recognizes and concurs in the need to eliminate excess beds and to raise occupancy rates in some areas. The Association has supported utilization control mechanisms such as utilization review (UR), Professional Standards Review Organizations (PSROs) and the JCAH, and is working to make the product of these efforts more meaningful and useful. However, the Association questions whether an annual bed supply ceiling of 4 or less beds per 1000 population and

an 80% or above minimum occupancy rate for a health service area are standards which are workable and based in reality.

In summary, the Association of American Medical Colleges is strongly opposed to the permanent and arbitrary limit on hospital capital expenditures, the ceiling on the supply of hospital beds and the standard for occupancy of hospital beds to which short-term acute care hospitals would be subjected under Title II of the Administration's Hospital Cost Containment bill, H.R. 6575. Instead, the AAMC supports the following major recommendations as more appropriate means of achieving effective and efficient use of capital expenditures by hospitals and other providers in the health care industry:

- The National Health Planning and Resources Development Act of 1974, P.L. 93-641, must be strengthened and improved by means of increased government funding and technical assistance to give the health planning law the opportunity to further local areawide planning and determination of need.
- The Certificate of Need process under P.L. 93-641 should be strengthened so that all states will possess an operating approved program to review and determine the appropriate use of capital expenditures. The definition of "new institutional health services" under the Certificate of Need program should be broadened to include all providers of health care, regardless of the setting.
- The DHEW is strongly urged to perform or commission studies on approaches to introduction, deployment and cost-benefit analysis of expensive new medical technology (e.g., CT Scanner).
- DHEW is strongly urged to undertake or sponsor cost-benefit studies of mandated capital requirements of hospitals and provide valid data for later reference on this subject.
- The government should establish positive incentives for providers to bring the health care facilities and services available in an area in line with community needs. Such incentives may be provided through the reimbursement mechanism or capital expenditure review process. Mergers, shared services and other cost containment efforts should be promoted while preserving or improving high quality care.

P.L. 93-641 will, if allowed to operate up to its maximum potential, induce hospitals to be more critical and rational in their growth and program plans and to relate these plans to those of other institutions and to the needs of the community.

APPENDIX A

to the Testimony of the Association of American Medical Colleges on H.R. 6575

The foregoing testimony of the Association of American Medical Colleges discusses general issues raised by the hospital revenue limitations proposed in H.R. 6575. This Appendix supplements those general concerns with a section by section review of specific issues arising from Title I of the bill.

Section 111: Imposition of Limit on Hospital Revenue Increases

This section is deficient in four areas: (1) the use of gross costs and charges for determining limits; (2) the establishment of at least four separate classes of payors; (3) the retroactive controls of the updating procedure, and (4) the absence of a carry forward provision for deferring increases.

In establishing a revenue control program using gross revenues for calculating the limitation, H.R. 6575 ignores important operational characteristics of hospitals: (1) Cost-based payors frequently do not make a final determination of payment until two to four years following an accounting period. Thus, the hospital cannot accurately determine its limitation for cost-based payors. (2) If cost-based payors alter the provisions of their contractual allowances, net hospital revenues could vary substantially from the limit imposed. (3) The average charge imposed for charge-based payors has no consistent relationship to the amount of monies received by the hospital, for the volume of charity care and the bad debts experience are constantly changing. Thus, the hospital limited to increasing its gross charges has no assurance that its net revenues will

actually increase or even remain constant.

The establishment of separate payment categories for determining revenue limitations for Medicare, Medicaid, other cost-based, and charge-based payors does not recognize the payment characteristics of patients or the operational realities of hospitals: (1) the classification system is not mutually exclusive, for many patients are supported by two or more of these four types of payors. No information is provided in the bill on how such patients and their derived revenues would be classified. (2) The classification of patients by payor assumes each patient may be categorized prior to or upon admission. This is frequently not true for patients supported by Medicaid, workmen's compensation, automobile liability insurance, etc. (3) With per admission revenues limited by class of payor, hospitals appear to be unable to increase revenues from third-party payors which alter their benefit structure to cover additional services. (4) Unless hospitals abandon efforts to provide "one class" service and create separate and defined service units for different classes of payors, the proposal will necessitate four separate hospital control systems. At a minimum this will increase administrative costs; at worst it will render the institutions unmanageable.

The updating procedure for retroactively determining allowable increases from the conclusion of Fiscal Year 1976 to September 30, 1977 (and to the beginning of other fiscal years) is unreasonable and punitive: (1) the procedure for determining increases adds allowable increase percentages across fiscal years rather than compounds them. The effect of this procedure will be a reduction in the allowable revenue ceiling equal to the difference between (a) multiplying this year's allowable increase by last year's allowable ceiling and (b) adding this year's percentage increase to all past percentage increases and multiplying this sum by the base year

(1976) revenue limit. (2) For hospitals which have experienced cost increases in excess of 15 percent since the end of fiscal 1976, the retroactive provisions for the period from the end of fiscal year 1976 through September 30, 1977 proposes to limit recognition of expenditures which have already been made and which were allowable costs for reimbursement at the time they were made. (3) The retroactive adjustment and roll forward adjustments are stated in terms of costs rather than revenue. As a result, hospitals incurring cost increases below the allowable limits will have a decreased revenue limitation in future years. Thus, it is reasonable to hypothesize that the revenue ceiling simultaneously becomes an operating expenditure floor. (4) By stating the retroactive provisions in terms of costs rather than revenues, the procedure for determining limitations for charge-based payors effectively limits charge increases, in both the past and future years, to the program's recognized increases in costs. As a result, any hospital which presently has charges less than cost will be precluded from increasing charges to cover costs. Moreover, hospitals which adjusted charges to cover costs during fiscal years 1975 and 1976 will be forced by the mathematics of the retroactive and roll forward provisions to have charges below costs from Fiscal Year 1977 until the termination of the program.

Section 112: Determination of Adjusted Inpatient Hospital Revenue Increase Limit

The proposed procedure for determining a hospital's adjusted inpatient revenue increase limit has the following deficiencies: (1) it provides for inadequate notice of allowable increases, (2) it uses a wholly inappropriate measure of general economy inflation, (3) it does not provide any recognition for the atypical costs of teaching hospitals, and (4) it ignores governmentally-imposed cost increases.

Under the proposal, the Secretary would establish a new revenue limitation no more than ninety days prior to its effective date. As a practical matter, the delays inherent in federal statistical reporting could provide at most thirty days notice of the new limitation. Because personnel expenses are the largest portion of a hospital's expenses and because many hospitals require more than thirty days in order to involuntarily terminate an employee, hospitals would have difficulty reducing anticipated costs with only thirty days, or even ninety days, notice.

The implicit price deflator of the Gross National Product was not designed to measure general economy inflation because it measures both price and product mix changes. This has been acknowledged by the Commerce Department in a letter to the Hospital Association of New York State. The net effect of this deficiency is that the implicit price deflator understates the level of price inflation present in the general economy.

Teaching hospitals frequently include a substantial physician component in the hospital's budget. If these physicians were practicing in the general community, their incomes would not be controlled. However, because they are included in the hospitals' operating costs, they are subject to control. This will severely hamper the ability of hospitals to recruit physicians for their salaried staffs. Moreover, it is likely to encourage physicians presently on the staff to re-evaluate and change their source of income from salaries to patient fees. In addition to increasing costs, this threatens established community patterns of providing faculty services for graduate medical education. Secondly, the combination of expanded numbers of medical school graduates and new opportunities in primary care requires increasing the number of residency positions available. With no adjustment for these cost increases in educational programs, established teaching hospitals are unlikely to expand

or change their residency programs and hospitals without residencies are unlikely to seek them.

Hospitals are frequently incurring new costs to meet governmentally imposed requirements for such items as pension reform, occupational health activities, life safety activities, etc. The proposal provides no recognition, pass through, or exemption for these costs although they could exceed the allowable increases in revenues.

Section 113: Promulgation of Admission Load Formula

The admission load adjustments, or corridors, are always calculated in terms of the base year, fiscal 1976, regardless of how long the program lasts. In the present fiscal year, this poses a significant problem for some hospitals whose size, case mix, or community role has dramatically changed. In future years, increasing numbers of hospitals will face volume changes generating marginal revenues equal to 50% of or 0% of the average allowable revenues per admission.

Of nine studies of hospital economics published between 1970 and 1973,¹⁻⁹

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- ¹Ralph E. Berry, Jr. and John W. Carr, Jr., "Efficiency in the Production of Hospital Services," unpublished paper (June 1973).
 - ²Robert E. Kuenne, "Average Sectorial Cost Functions in a Group of New Jersey Hospitals," Research Monograph #1 (Princeton University: General Economic Systems Project, October 1972).
 - ³Judith Lave, Lester Lave and Larry Silverman, "Hospital Cost Estimation Controlling For Case Mix," unpublished paper (1972).
 - ⁴Robert Evans and H. Walker, "Information Theory and the Analysis of Hospital Cost Structure," Canadian Journal of Economics, Vol. 5 (August 1972), pp. 398-418.
 - ⁵Robert Evans, "Behavioral Cost Functions For Hospitals," Canadian Journal of Economics, Vol. 4 (May 1971), pp. 198-215.
 - ⁶Judith Lave and Lester Lave, "Hospital Cost Functions," American Economic Review, Vol. 6 (June 1970), pp. 379-395.
 - ⁷Judith Lave and Lester Lave, "Estimated Cost Functions for Pennsylvania Hospitals," Inquiry, Vol. 7 (June 1970), pp. 3-14.
 - ⁸Harold Cohen, "Hospital Cost Curves With Emphasis On Measuring Patient Care Output," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore, Maryland: The Johns Hopkins Press 1970), pp. 279-293.
 - ⁹Edgar Francisco, "Analysis of Cost Variations Among Short-Term General Hospitals," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore, Maryland: The Johns Hopkins Press 1970), pp. 321-332.

only one estimated the marginal costs of changes in patient volume to be approximately equal to 50% of average costs. Each of the other eight estimated that the marginal costs of volume changes to be substantially greater than 50% of the average cost. Thus, the Carter proposal seriously understates the marginal costs of changes in patient volume.

The renal dialysis program is presently attempting to establish regionalized centers for kidney care. Many have argued that this regionalization of referral services should occur for other tertiary care services; however, the marginal revenue volume adjustments of the proposal will discourage the development of new regionalized referral services.

Section 114: Base Inpatient Hospital Revenue

The base revenue period proposed does not provide for an adjustment for hospitals whose operating expenditures exceeded net revenues for that fiscal year. Thus, as with Economic Stabilization Program, the proposal traps those hospitals in a deficit position in 1976 in a deficit position throughout the period of this bill.

The base revenue period does not provide an adjustment for hospitals whose charges did not equal the costs of services provided in the base year. Thus, such hospitals are effectively precluded from increasing charge-based revenues to cover costs unless a reduction in bad debts happens to have this effect for one or two years.

By selecting a 1976 base year for a program that begins in fiscal year 1978, the program must establish a means of bridging 1977. The selected method (see Section 111) works to reduce the permissible 1978 revenue increase by the extent to which the increase in fiscal year 1977 operating costs exceeds base year costs by more than fifteen percent.

Section 115: Establishment of Exceptions

The exceptions process proposed in H.R. 6575 is deficient because:

(1) it provides no mechanism for necessary additional revenues resulting from changes in diagnostic case mix, (2) it requires a hospital to approach insolvency as a condition of granting any exception, (3) it requires a hospital to spend its unrestricted endowments in order to qualify for an exception, (4) it does not ensure that a hospital improves its current ratio before losing its exception status, and (5) it requires hospitals to accept all recommendations made by an operational review ordered by the Secretary in order to maintain exception status.

The exception process is available to hospitals in only two circumstances: hospitals with costs increased because of changes in inpatient volume exceeding $\pm 15\%$ and hospitals with costs increased because of changes in the scope of services available in the hospitals. No other grounds for exceptions are provided. In particular, no exception basis is provided for hospitals with costs increased because of changes in the diagnostic mix of patients treated. For tertiary care teaching hospitals which are the ultimate referral point for complex and costly cases, this is a most serious shortcoming.

Hospitals seeking exceptions as a result of volume and/or scope of service changes must also demonstrate that they are approaching insolvency by having a current ratio in the lowest quartile of all hospitals. For hospitals having serious financial problems at the present time, this additional requirement has little significance; however, for hospitals which presently are financially sound, this requirement constitutes financial brinksmanship. Such institutions must temporarily, and probably permanently, weaken their financial stability, increase their level of risk in the eyes of financial institutions, and increase their necessary borrowing for working

capital requirements. More significantly, hospitals approaching insolvency but without the required volume or scope of services changes have no basis for seeking an exception under the proposal.

Many hospitals have traditionally been the beneficiary of gifts and memorials which have been used to establish endowment funds. Hospital governing boards, in their fiduciary role, have frequently invested the endowment principal to preserve its perpetual character. Endowment income has then provided a source of revenue for a variety of hospital purposes, including the provision of care to those unable to pay. Because the definition of the "current ratio" proposed in this section includes marketable securities, hospitals may have to liquidate the invested endowment principal before qualifying for an exception. This violates both the fiduciary responsibility of the Board of Directors and the expectations and intentions of the donor.

Even if a hospital meets the conditions for an exception, there is no assurance that the exception will prevail until the current ratio improves. If some hospitals formerly in the upper 75% of the current asset distribution drop below the current ratio of hospitals granted exceptions, the cutoff point for the lowest 25% of hospitals will fall. Thus, a hospital that is exempt in fiscal year 1978 may not qualify for an exemption in fiscal year 1979 because its relative solvency has improved though its absolute solvency remains unchanged.

Finally, hospitals granted an exception are required to accept an operational review ordered by the Secretary. In addition, hospitals are required to implement all recommendations made by those conducting the operational review. No mechanism for appealing or reconsidering these recommendation is provided in the bill. For teaching hospitals with joint patient care and education

goals this is a significant issue. If the operational review recommends changes strengthening or improving the efficiency or economy of patient care services at the expense of the hospital's educational goals and programs, the binding recommendations could change the nature and character of the hospital.

Section 116: Enforcement

Many providers are currently challenging the legality of their Medicare and/or Medicaid payments. If these administrative appeals and suits are successful, the hospitals would normally be entitled to increased revenues. The proposal does not appear to recognize or adjust revenue limitations for such retroactive reimbursement gains. Further, it, in effect, precludes Medicare and Medicaid from correcting such deficiencies in the present or future fiscal years by imposing serious penalties on the states and hospitals involved in such payments. Thus errors in past years would be perpetuated.

Section 117: Exception for Hospitals in Certain States

States with approved cost containment programs may be granted an exception if the Governor certifies that the aggregate rate of increase granted under the state program will not exceed the aggregate rate of increase that would have been granted under the federal program. While this permits the state programs operational flexibility, it neither establishes operational standards for state administered rate programs nor provides assurances that the state will not impose a substantially more stringent rate of revenue limitation.

Section 124: Exemption of Nonsupervisory Personnel Wage Increases from Revenue Limit

By providing an exemption for wage increases granted nonsupervisory employers as defined by the National Labor Relations Act, the Administration's

proposal is likely to increase the demands of these personnel for increases. Increases granted to nonsupervisory personnel will probably determine the wage increase expectations of personnel defined as other than nonsupervisory. Without a similar exemption for these latter employees, the hospital may be unable to grant wage increases fulfilling expectations; morale will decrease, turnover will increase, and supervisory-nonsupervisory personnel tensions will increase.

By exempting pay increases for nonsupervisory personnel, the hospital's labor force may be artificially inflated. Labor saving and cost effective capital equipment may be avoided where capital and operating revenues are limited but nonsupervisory pay increases are exempt. In the long run, this will increase rather than decrease costs.

Section 126: Improper Changes in Admission Practices

While this provision is designed to prescribe continued acceptance of charity or partial pay patients, it ignores the issue of the diagnostic mix of the patients which are accepted. This may adversely effect teaching hospitals if hospitals complying with this provision substitute low cost admissions for high cost admissions without penalty.

APPENDIX B

to the Testimony of the Association of American Medical Colleges on H.R. 6575

The foregoing testimony of the Association of American Medical Colleges discusses general issues raised by the capital expenditure limitations proposed in H.R. 6575 and addresses the \$2.5 billion national capital expenditure ceiling, the 4 beds per 1000 population ceiling for the supply of hospital beds and the 80 percent standard for occupancy of hospital beds specifically. This Appendix supplements those general concerns with a section by section review of other issues arising from Title II of the bill that were not addressed in the formal testimony.

Section 1504.(a)(2)

Following his determination of an annual hospital capital expenditure limit, the Secretary would apportion the sum among the States on the basis of the ratio of their individual total populations to the nation's total population (at least for the first 18 months subsequent to the bill's enactment). The sources to be used for these population figures are not identified. This straight allocation-by-population method of distributing capital expenditure funds among the states is too simple and completely inequitable. It totally disregards such major factors as the need for capital expansion or modernization; the category of hospitals under consideration by level of care they provide and their case mix; construction costs which vary widely by geographic location; demographic and trend data on the population served; patient origin information and more. The provision suggests that these and other factors potentially important to equitable apportionment will be taken into account by the Secretary in later years. However, until then states such as New York, whose excess hospital bed condition has often been an item for discussion in

the press and by that state's governor, would receive a sizeable allocation though its use would be limited due to its already being overbedded. While, on the other hand, numerous hospital facilities in the south are facing obsolescence, but will not be able to make necessary improvements due to small state populations and, in turn, lower capital expenditure appropriations. Thus, many of the more populated, overbedded states will be rewarded for unsound planning, while many other states where hospitals desperately need capital improvements will be punished because of their smaller population sizes. This establishes a cap for capital expenditures in each state for the fiscal year (as promulgated within 60 days of the beginning of that fiscal year) and would severely limit the states' ability to plan to meet its local needs (as promoted under the existing national health planning law).

Section 1527 (a)(1)(2)&(3)

These provisions in Title II pertain to the Certificate of Need Program required under Section 1523 (a)(4)(B) of the Health Planning Act. The first two provisions generally conform to the language used in P.L. 93-641 to describe the basic intent of Certificate of Need programs to review and determine the need for services, facilities and organizations proposed to be offered or developed and administer the program to assure that only those found to be needed are offered or developed. The third provision is where the Administration's proposal begins to amend Title XV of the Public Health Service Act as it pertains to Certificate of Need programs by adding totally new stipulations to the Act. In this provision, the state is required to specify the capital expenditure ceiling (at the institutional level) that is tied to the Certificate of Need being issued. This is interpreted to mean that the institution would be told what it could spend on a capital project regardless of the source of funding. Thus, even if government funds account for only a small portion of the capital

to be expended, the state will establish a limit on the hospital's capital expenditure based on their analysis and interpretation of what the total project cost should be.

Section 1527(a)(4)

This section ties the total dollar amount of Certificates of Need awarded by a state in a fiscal year to the previously established (by population ratio) annual limit for new capital expenditures for that particular state in that fiscal year. However, it does allow a state to carry forward the unused portion of that fiscal year's state allocation to the next succeeding year. But it is not clear whether the amount carried forward in the next year can continue to be added to the state's allocation in subsequent years (a second year, a third year, etc.). This provision would also provide that if in a fiscal year there was a closure of a hospital (or part thereof) through which services found to be inappropriate were provided, then the undepreciated value of that hospital (the amount by which the hospital's historical cost exceeds the total amount of its depreciation claimed for purposes of establishing its reasonable costs of services for reimbursement under Medicare) can be added to the state's capital expenditure allotment for the next fiscal year. Again, it is unclear whether this additional amount can continue to be carried over into subsequent years.

Section 1527. (b) (1) & (2) and (c) (1) & (2)

Under these provisions, if a hospital proposed a capital project under Certificate of Need that would increase a state's bed to population ratio beyond the applicable bed supply ceiling previously established for that area or produce a number of hospital beds which would result in a hospital bed occupancy rate within that area which is less than the applicable occupancy standard for that area, then the proposed project would be rejected and denied a certificate of need, as well as, any federal grants, loan guarantees or tax

subsidies for construction. The arguments against these stipulations are the same as those pointing out the invalid and arbitrary nature of the standards themselves, as presented in the body of the Association's

testimony. Once again the definition of the term "beds" is open to question. With the underlying theme being encouragement of hospital closures, these provisions also provide that if in any fiscal year the number of hospital beds is in excess of the supply ceiling applicable to a health service area or the hospital bed occupancy rate within that area is less than the applicable occupancy standard, then a certificate of need may be granted for such a service or facility that would result in a number of new hospital beds which is not more than 50 percent of the number of beds removed permanently from service in that health service area in that fiscal year. Under the circumstances of Title II, this would seem to allow some flexibility in areas where the established standards have not been successfully met. However, if an institution in such an area desired to build a totally new hospital, would it then be forced to build one half its current size? And can the replacement beds be of a different category than those removed (e.g., can tertiary care beds replace primary care beds)?

Section 1527 (a) (6)

The term "hospital" is defined for purposes of Title II. As in Title I of the Act, Federal hospitals are excluded, as are hospitals deriving more than 75 percent of its inpatient care revenues on a capitation basis, disregarding revenues received under Medicare, from one or more HMOs. However, unlike Title I, included in the Title II definition are those hospitals who have for less than two years fulfilled the conditions for participation for reimbursement under the Medicare program. Such an institution may not have had time to establish an adequate revenue base or credit rating to

undertake necessary improvements on the basis of community health service needs and will be prevented from acquiring the capital necessary to undertake essential projects.

Section 1527 (a) (7)

This section defines the term "capital expenditure" under title II. One criterion for this definition is that the expenditure (not chargeable as an expense of operation and maintenance) exceeds \$100,000. This dollar threshold is inconsistent with that established in the final certificate of need regulations at \$150,000. The \$150,000 figure was defended by the Secretary at that time on the basis of (1) the experience of section 1122 and certificate of need programs; (2) the fact that few significant capital expenditures are less than \$150,000; and (3) the inflation in the cost of medical equipment in the years since enactment by Congress of the section 1122 program. This appears to be sufficient justification for maintaining the dollar threshold at \$150,000, as established in the existing regulations. This section also states that any donation of any equipment to a hospital shall be considered a hospital capital expenditure and included in determining whether such expenditure exceeds \$100,000.

Section 1527 (d)

This provision would alter the length of the cycle for review of proposed health system changes under P.L. 93-641 from 90 days to one year. The major concern here is that if review was done once a year, it would create a one year moratorium on all construction the first year of the bill's enactment, even though it would probably provide a mechanism for a more

objective, organized and quicker review process. The bill also fails to describe how the review process would operate under the new cycle length. Would the HSA take a backlog of applications and make determinations? Take all applications received for the rest of the year and put in descending order?

Section 202 (a) (1)

This provision amends section 1122 of the Social Security Act to authorize the Secretary to directly perform the review functions for new capital expenditures when a state has not entered into an 1122 agreement with the Secretary and does not have an approved certificate of need program. This would only add to the already unreasonable amount of authority given the Secretary under Title II and add another level of review into an already crowded arena. Currently, there are 37 states that have section 1122 contracts, and for the moment, no states have an approved certificate of need program for reasons discussed earlier (i.e., a combination of failure to develop viable health plans on the part of local agencies and the lack of guidance and patience on the part of the government). All the states are required to establish approved Certificate of Need programs and will if given the opportunity and assistance necessary to get such programs off the ground. The intent of P.L. 93-641 was the furtherance of areawide planning and determination of need at the local level, and any intervention by the Secretary would defeat this purpose before providing it a chance to succeed.

This section also amends section 1122 (d) (1) (B) (ii) (II) of the Social Security Act and establishes a multiplier (ten times) to the amount of money that is denied by the Secretary for reimbursement for depreciation, interest on borrowed funds, a return on equity capital (for proprietary facilities) or other expenses related to capital expenditures. In essence, this authorizes the Secretary to increase the financial penalty for those who have their projects denied, but subsequently proceed. This may be another example of the unreasonable authority placed in the hands of the Secretary as well as the potential that would exist for endangering the community health services. Such services may be vitally needed, but were rejected at the state agency by a slight margin due strictly to fiscal problems which no longer existed when it was decided to proceed with the project without delay. Of course, this example may be stretching things a bit, but one should consider whether the multiplier of "ten times" is too severe or not. These penalties would not apply in states where approved Certificate of Need programs have been established and therefore reaffirms the belief that if such programs are allowed and assisted to develop and operate appropriately, such harsh penalties would not be necessary.

Section 203(a)

It would appear that this section amends the internal revenue code of 1954 by adding a new subsection F. This new subsection appears to remove the tax exempt status for interest derived from income relating to hospital tax exempt bonds. This subsection ties this penalty to the applicable hospital bed supply ceiling. First, there is a question whether or not this particular sanction can be legally prescribed at all. Second, will the penalty only apply to new bond issues or will it have a retroactive effect on past

obligations? Third, it is not clear what process or procedures will be involved in applying this new subsection and how they might involve the Health Systems Agency, the State Planning Agency, etc. and the extent to which the bureaucracy will grow in order to monitor these bonds. Fourth, denying the hospital the benefits of tax exempt bonds for necessary capital expenditures would only serve to raise the cost of health care and defeat the purpose of the Administration's cost containment proposal. Fifth, approved Certificate of Need programs, allowed to fulfill their roles, would negate the need for such a penalty, since most bond merchants monitor certificate of need and require prospective capital investments in the hospital industry to undergo the Certificate of Need process first.

SUB-ISSUES SURROUNDING TITLE II

The following are some issues arising out of the content, or lack thereof, of Title II and which were not necessarily addressed directly, or at all, but should be considered:

- No Real Relationship Between Titles I and II of the Act - Even if approval is obtained under Title II for a new capital expenditure, there is no guarantee that expenses incurred in operating the approved new activity, service or facility will be allowed under the operating cost ceiling under Title I. In response to this situation, financing will become more difficult to obtain. Hospitals have been acquiring capital more and more through debt financing arrangements. Under such arrangements, there will be greater hesitancy by financing groups to invest in hospitals since the President's proposal would make it less certain that a hospital will have adequate future reserves to pay back the principal and interest of the debt or be able to pay off the debt

through the exceptions process under Title I. The exceptions process requires a hospital to be almost insolvent (with a very low current ratio), while most lenders give a hospital a good quality rating if its current ratio is at least 1 1/2 to 1 or better. Thus, this would retard or eliminate debt financing as a feasible alternative for acquiring needed capital, since the inability to guarantee reimbursement of debt principal and interest under the cost containment act would undoubtedly produce much higher interest rates to hospitals.

- Titles I and II Convey Different Messages On Encouraging Increased Outpatient and Ambulatory Services - Title I appears to foster the development of outpatient services, shifting away from unnecessary utilization of inpatient services. Title II, on the other hand, constrains the entire institution, impeding the shift from inpatient services to increased expenditures for hospital development of its outpatient facilities. Thus, it appears that the Administration wants to encourage increased development of ambulatory care, but in free-standing units and not in hospitals where they may fear too much of a shift of overhead to the outpatient areas.
- Permanence of Title II - Unlike Title I which is transitory in nature, Title II is a permanent proposal. Since there is nothing to say that Title II will change over time, it may be a worthwhile planning tool for hospitals if HSAs included a capital expenditure component in their Annual Implementation Plans (AIPs) to provide some fixed point from which hospitals can work each fiscal year.



association of american medical colleges

SUMMARY OF WRITTEN TESTIMONY OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON S. 1470

June 8, 1977

I. Hospital Payment Provisions

A. Uniform Cost Reporting

1. AAMC supports the provisions of Section 2 requiring uniform hospital cost reporting.
2. AAMC urges that the Committee Report state that the provisions of S. 1470 do not require or authorize the establishment of mandatory uniform hospital accounting.

B. Classification of Hospitals

1. AAMC recommends more flexible legislation providing that hospitals "be classified by type and size" with specific guidance in the Committee Report.
2. AAMC recommends appointment of a "National Technical Advisory Board" to recommend and evaluate classification systems.
3. AAMC strongly recommends deleting the present provision establishing a specific category for the "primary affiliates of accredited medical schools".
4. AAMC strongly recommends that the Secretary of HEW be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals".

C. Determining Routine Operating Costs

1. Where cross-classification schemes for determining hospital payments are used, the AAMC supports removal of atypical and uncontrollable costs.
2. AAMC supports more flexible legislation which would permit additions to the list of excluded costs without new legislation.
3. AAMC recommends providing Executive Branch with flexibility to specify payment ceiling with guidance in the Committee Report.

4. AAMC recommends permitting wage rates to be used as the basis for an exception where a hospital can demonstrate that it had to pay atypical wage rates to recruit personnel.
5. AAMC supports case-mix provisions.
6. AAMC recommends provisions for exceptions process.
- D. State Rate Control Authority: AAMC finds state rate systems are acceptable where they meet specific organizational and operational characteristics

II. Physician Payment Provisions

- A. Defining "Physicians' Services": AAMC recommends amending S. 1470 to explicitly permit "physicians' service" compensation for a physician who is simultaneously functioning as an educator and personally performing or directing identifiable patient care services
- B. Anesthesiology Services: AAMC supports broader definition of anesthesiology services
- C. Pathology Services
 1. AAMC is concerned that the proposed emphasis on fee-for-service payment for surgical pathology services and hemato-pathology services would favor these two areas over other important areas of clinical pathology.
 2. AAMC is concerned about payment mechanisms which could possibly discourage the involvement of pathologists and inhibit the development of the discipline.
- D. Percentage Fee Compensation
 1. AAMC is concerned that the proposal may inhibit the development of some clinically necessary disciplines by placing them at a disadvantage with others.
 2. AAMC requests explicit guidelines for determining "an amount equal to the salary which would have reasonably been paid".
- E. Part A Compensation Arrangements: AAMC requests explicit guidelines for determining "an amount equal to the salary which would have reasonably been paid"

III. Administrative Reforms

- A. Health Care Financing Administration
 1. AAMC supports centralization of Federal health care financing.
 2. AAMC advocates Cabinet-level Department of Health.
- B. State Medicaid Administration: AAMC strongly endorses more rapid payment to providers

C. Regulations of the Secretary

1. AAMC supports 60 day comment period.
 2. AAMC requests some guidelines for defining "urgent" regulations.
- D. Abolition of HIBAC: AAMC strongly recommends the maintenance of an advisory board to the Secretary of HEW which is composed of providers, practitioners, and consumers from the private sector



association of american medical colleges

TESTIMONY SUBMITTED ON S. 1470
BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE

June 8, 1977

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the "Medicare-Medicaid Administrative and Reimbursement Act," S. 1470. In addition to representing all of the nation's medical schools and sixty academic societies, the Association's Council of Teaching Hospitals includes over 400 major teaching hospitals. These hospitals: account for approximately sixteen percent of the admissions, almost nineteen percent of the emergency room visits, and twenty-nine percent of the outpatient visits provided by non-Federal, short-term hospitals; provide a comprehensive range of patient services, including the most complex tertiary services; and are responsible for a majority of the nation's graduate medical education programs. Thus, the Medicare and Medicaid amendments proposed in S. 1470 -- concerning hospital and physician payments and program administration -- are of direct interest and vital concern to the Association's members.

A review of S. 1470 clearly shows that the Subcommittee and its staff have given careful consideration to suggestions made by witnesses during past hearings on possible Medicare and Medicaid amendments. Several improvements have been made in these proposed amendments including increased flexibility in the classification of hospitals, the addition of malpractice insurance costs to the list of expenses excluded from routine operating costs, and the establishment of provisions for relative value scales for physicians'

services. For these modifications and for the staff's willingness to discuss general concepts and tentative provisions of S. 1470, the AAMC expresses its appreciation to the Subcommittee and its Chairman.

The Association is well aware of the fact that spending for health care -- as a result of general economic inflation, increased service availability, improvements in service quality, growth and changes in population, and increased per capita utilization -- has increased more rapidly in the past two decades than have most other segments of the economy. This fact has focused consumer, industrial, governmental, and provider attention on the nation's health care expenditures. In recent legislation -- such as P.L. 92-603 and P.L. 93-641 -- the Congress has attempted to establish programs and policies which will help stimulate a more efficient and effective health industry.

It should be emphasized that the present levels of hospital costs have developed over a long period of time and as a result of hospital responses to national and state legislation, to prevailing economic and social conditions, and to public demands. Thus, the Association is pleased that Senator Talmadge, in introducing S. 1470, described it as ". . . a long-term basic structural answer to the problem of rising hospital costs. . ." To reduce the increase in hospital costs, the AAMC supports the position that a long-term approach is needed, and critical comments made in this testimony are submitted with the intention of strengthening the proposed legislation.

Amendments Concerning Hospital Payments

Uniform Cost Reporting

A most important prerequisite for the proper measurement, evaluation, and comparison of hospital costs is the development and implementation of a system of uniform cost reporting. Therefore, the Association supports the provisions of Section 2 of S. 1470 requiring uniform hospital cost reporting.

Some organizations and government officials have argued that uniform reporting requires mandatory uniform accounting. The Association does not support this contention. That uniform reporting data can be provided without mandatory uniform accounting has been demonstrated by several state rate control agencies and by non-hospital industries. Therefore, the Association urges that the Committee Report accompanying this bill clearly state that the uniform reporting provisions of S. 1470 do not require or authorize the establishment of mandatory uniform hospital accounting.

Classification of Hospitals

A fundamental concern of the Association is the criteria used to establish any hospital classification system used to calculate hospital payments. While the Association is pleased that S. 1470 provides the Executive Branch with increased flexibility in implementing the Congressional intent, the AAMC remains concerned that some specific grouping criteria -- such as bed size categories -- are initially designated in the bill. Recognizing that there is a lack of data available for analyzing the impact of these grouping criteria, the AAMC believes a more prudent approach would be to permit some additional flexibility with which to construct the system. Therefore, the Association recommends that S. 1470 state that hospitals "be classified by type and size" with specific guidance in the Committee Report, rather than stipulate the specific bed categories and types of hospitals prior to the availability of adequate data for examining the effects of such classification variables.

It is further recommended that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review program progress, monitor program implementation, examine problems encountered and make recommendations regarding appropriate

solutions for problems identified. The advisory board to be established should include representatives from the Legislative and Executive Branches of Government, as well as knowledgeable individuals from the private sector. In addition to its technical expertise, this advisory board would provide public visibility for the decisions implementing these amendments. The Association's experience with the implementation of the payment limitations of Section 223 of P.L. 92-603 leads it to strongly recommend such an advisory board.

S. 1470 provides for the creation of a separate group of hospitals which are the "primary affiliates of accredited medical schools." It is difficult to evaluate the implications of creating such a group because of the absence of data. Efforts to gain data and experience with a separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be excluded from the proposed scheme. Thus, there is uncertainty as to the relative merits of a separate group for teaching hospitals.

More importantly, the present legislation would restrict the "primary affiliates of accredited medical schools" to a single hospital per medical school. This is a gross injustice to many teaching hospitals. Limiting each medical school to one and only one "primary affiliate" is arbitrary and does not recognize the complexity or the reality of medical education in this nation.

In this situation, the Association strongly recommends that the Subcommittee delete the present provision establishing a category for the "primary affiliates of accredited medical schools." First, no one knows how routine operating costs in teaching hospitals will compare with routine operating costs in non-teaching hospitals. Secondly, the principal source of atypical costs in major teaching hospitals results from the scope and intensity of service provided and the diagnostic mix of patients treated, not from the presence of an educational relationship with a medical school. Third, if a separate category is to be established, the limitation of a single hospital per school is arbitrary and does not accurately recognize the number of "tertiary care/teaching hospitals" which presently exist.

In the absence of adequate data and operational experience to evaluate the proposed classification scheme and to avoid arbitrarily limiting the "primary affiliates of accredited medical schools" to one hospital per school, the Association believes that the combination of a flexible classification system and an adequate phase-in period are essential elements of the program's chances for success. Thus, the Association strongly recommends that the Secretary of the Department of Health, Education and Welfare be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals." Instead of prescribing a pre-defined grouping for teaching hospitals, it is proposed that the Secretary be required to determine, in consultation with the appropriate knowledgeable health organizations, a definition which most accurately reflects the impacts of case mix, intensity of care, and health science education on the costs of teaching hospitals. In performing these consultations, the Secretary should be required to distribute and share the data upon which alternative definitions are to be evaluated. This is

a good example of an issue which would be brought before the proposed Technical Advisory Board.

Determining Routine Operating Costs

In the past, the Association has not specifically advocated a cross classification approach to cost limitations. Rather, if a cross-classification approach is to be used, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product produced or to characteristics of the production process. Therefore, the Association believes that the exclusion of capital and related costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and non-administrative physicians; energy costs associated with heating or cooling the hospital plant; and malpractice insurance expense is a step in the proper direction.

This present list of excluded costs includes several significant items which make cost comparisons between hospitals difficult either because they are not uniformly present in all hospitals (e.g., stipends for residents), because they are uncontrollable by the institution (e.g., utility rates), or because there is substantial regional variation (e.g., malpractice premiums). However, because today's controllable cost may become tomorrow's uncontrollable cost, flexible legislation including, but not limited to, the costs excluded in S. 1470 is recommended. If conditions change this would permit any appropriate additions to the list of excluded costs without new legislation.

Following a rather complicated calculation, S. 1470 establishes the ceiling for routine service payments at 120% of each classification group's average. As we have stated earlier, the present Medicare reporting system does not permit identification of costs to be excluded in computing routine

service costs. Therefore, no one knows what the actual distribution of hospital costs by group will look like. The Association believes that a 120% ceiling should not be established by statute without knowledge of these distributions. It is recommended that the bill provide some flexibility in determining the ceiling and that the Committee Report clearly state Congressional intent as guidance for Executive Branch action.

The procedure for calculating the reimbursement limitation includes an adjustment for changes in general wage levels in the hospital's geographic area. Because many medical centers must recruit personnel outside of their immediate areas, the AAMC recommends that S. 1470 be amended to add that wage rates may be used as the basis for an exception to a routine operating payment limitation where a hospital can demonstrate that it had to pay atypical wage rates to recruit personnel.

The Association strongly supports the case mix provision provided in S. 1470. Tertiary care/referral hospitals serve the more severely ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic conditions. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/referral centers.

Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends this legislation include provisions for an exception and appeal process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that

the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or reduction in the per-admission costs.

State Rate Control Authority

Where the Secretary of HEW and a state enter into an appropriate contract, the bill permits a mandatory state reimbursement system to be used to determine payment limitations. The Federal Government is the source of funds for the Medicare program and shares in the funding of Medicaid; however, apart from an aggregate payment cap, S. 1470 provides no Federal payment or operational standards for the state agencies. On the issue of state rate setting agencies, the AAMC's position is that state rate systems are acceptable where they meet the following conditions: (1) the system is based on the full financial requirements of hospitals; (2) the system is based on an adequately financed, politically independent agency headed by a small number of full-time, well-compensated commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (3) the agency's operations include clearly defined formal procedures, adopted after public hearings, for systematic review of rate or budget applications and with provisions for routine changes to be made with minimal procedure and expense; and (4) the agency provides due process, including the right to judicial appeal for the applicant as well as for others affected by the decisions, and specific protections against undue delays in action.

Summary

Assuring Medicare beneficiaries needed health care services, encouraging

efficiency in the provision of health care and paying the full and fair costs of health care providers should be the guiding principals of any reimbursement system. The compatibility of the goals can be maintained under a system which accounts for the many legitimate service and case-mix differences found between hospitals. When this is done, illegitimate costs arising from inefficiency or extravagance can be isolated. However, if care is not taken to identify the costs of inefficiency, legitimate reimbursement may be threatened and consequently the hospital's ability to provide needed health services will be reduced.

In this regard, one has to be impressed with the thought and effort that went into the provider reimbursement portion of this bill. One is also impressed with the real complexity of implementing the proposal on a national scale. While the Association finds the proposal, with suggested amendments, worthy of support, the Association recommends that we move forward cautiously and under the review and supervision of the recommended Technical Advisory Board.

Physician Payment

Defining "Physicians' Services"

Under present Medicare law, "the term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office and institutional calls. . ." Section 22 proposes to extend the definition to state: "the term 'physicians' services' means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls. . . except that such term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any patient care service unless such service (a) is personally performed by or personally directed by a physician for the benefit of such patient and (b) is of such a nature that its performance by a physician

is customary and appropriate."

As presently stated, the amendment could be interpreted to mean that a faculty physician performing or directing personal medical services in the presence of a student is not eligible for a fee for his professional medical services because the physician will be defined as an educator whose services are to be paid on a cost basis. The AAMC is opposed to this interpretation and, therefore is opposed to the present wording of the amendment. Where a faculty physician is simultaneously performing or directing patient care and educational functions, the Association believes that the physician should be eligible either for professional service payment on a fee-for-service basis or for educator compensation on a cost basis. Therefore, the AAMC recommends amending S. 1470 to explicitly permit "physicians' service" compensation for a physician who is simultaneously functioning as an educator and personally performing or directly identifiable patient care services.

Anesthesiology Services

Anesthesiologists in the Association's Council of Academic Societies are concerned that the definition proposed in S. 1470 for anesthesiology services could be so narrowly interpreted as to preclude payment for physicians' services traditionally performed by anesthesiologists. Therefore, the AAMC supports amending Section 12(a)(2) of S. 1470 to read as follows: "In the case of anesthesiology services, where anesthesia is administered to facilitate surgery, obstetric delivery or special examinations, a procedure. . ."

Pathology Services

The AAMC is concerned about the proposed pathology provisions of S. 1470. The proposed provisions would tend to alter and restrict professional activities and services in clinical pathology. By emphasizing fee-for-service

payment for surgical pathology services and hemato-pathology services, the bill would favor these two areas over other important areas of clinical pathology where distinct and medically important services are rendered.

Laboratory Medicine (Clinical Pathology) has become an important specialty of medicine within recent years both in teaching centers and in the community at large. Clinical pathologists provide a variety of services vital to medical care including the following: assurance of quality of laboratory procedures and results; guidance in the use of the laboratory, in the appropriateness of laboratory requests and in the interpretation of results; and interfacing between patient care physicians and the laboratory by providing two-way communication in the form of ad hoc consultation to clinicians on a wide variety of laboratory information and feed-back to the laboratory concerning specific clinical needs and problems. In addition to these vital functions, the clinical pathologist provides a broad variety of direct formal consultative functions in hematology, coagulation, microbiology, immunology, blood banking, and clinical chemistry (for example, bone marrow and peripheral blood examinations and reports in hematology).

Clinical pathologists have final medical and legal responsibility for all laboratory reports and verify their reliability. In this capacity, they also take responsibility for analytical validity and for the appropriateness of the methodological approach to the precise clinical needs, and they see to it that appropriate reference values are provided and are continuously reviewed and up-dated.

While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the involvement of pathologists and inhibit the development of the discipline.

Percentage Fee Compensation

Where the hospital's allowable costs include "the charges of physicians or other persons which are related to the income or receipts of a hospital or any subdivision thereof," S. 1470 proposes that such charges would only be recognized as allowable costs to the extent that they do not exceed ". . . an amount equal to the salary which would reasonably have been for such services. . .". This provision is the focus of two concerns. First, some specialists have traditionally been paid on a basis that is related to either hospital or departmental income or receipts. While not opposed to limiting the open-ended character of some of the compensation arrangements, the Association is concerned that the proposal may inhibit the development of some clinically necessary disciplines by placing them at a disadvantage with others.

Secondly, while the objective of limiting Medicare recognition of charges based on percentage arrangements is clear in principle it is clouded with ambiguities in practical application. The bill includes no indication of the basis on which ". . . an amount equal to the salary which would have reasonably been paid . . ." is to be determined. Certainly the Association realizes and appreciates the desire of the Congress to permit those developing regulations to have some flexibility in implementing this amendment; however, in recruiting and negotiating with the medical staff, the hospital chief executive officer and/or medical school dean must be able to determine the amount of compensation that Medicare and Medicaid will recognize. Therefore, the Association requests that the Subcommittee either modify the proposed amendment to incorporate some specific guidelines for regulations or so specify its intent in hearings and Congressional Reports that those preparing the regulations have a clear and consistent direction for determining a reasonable salary for physicians in employment situations.

Part A Compensation Arrangements

The apparent purpose of Section 12(c) is to eliminate Medicare and Medicaid recognition of remuneration arrangements between physicians and hospitals in which the physician's fee-based income rate in his professional medical service practice is used as a basis for computing his compensation for Part A reimbursable services. In place of such arrangements, the subsection proposes recognition of ". . . an amount equal to the salary which would have reasonably been paid for such services. . . ." Because this provision includes the same practical ambiguities discussed under percentage fee compensation, the Association reiterates its request for a clear and consistent means for physicians in employment situations.

Administrative Reforms

Establishment of Health Care Financing Administration

This section proposes a codification of the Federal health care financing function and a unification of administrative entities recently reorganized as the Health Care Financing Administration. The Association supports efforts toward centralization and unification of Federal health care financing. Costs incurred by hospitals which result from diffuse and conflicting administrative and reporting requirements and which add overhead to the provision of direct patient services should be somewhat moderated by the policy of unification and administrative standardization which should accompany this reorganization.

While the reorganization of the financing functions offers the potential of significant reform in program operations, the Association believes the benefits of this reform are limited by continuing the subordination of the health function within the Department of Health, Education and Welfare. A Cabinet-level Department of Health is needed to serve as the single point of responsibility for the nation's critically important health policies and

programs. If a separate Department of Health is not to be presently established, the Association recommends the establishment of an Under Secretary for Health to whom both the Assistant Secretary of Health for Health Care Financing and the Assistant Secretary for Health would report. The Under Secretary for Health would then be the Department's central individual for all health matters.

State Medicaid Administration

The reform of state Medicaid administration to provide more rapid payment of health care providers is strongly endorsed by the Association. Because of delays in Medicaid payments to hospitals, health care providers in many states have had to borrow funds at substantial interest rates to provide adequate cash flow. These additional interest costs add to the nation's health care expenses without contributing to the direct provision of personal health services. Decreasing the time required for Medicaid payments should contribute, in at least a small way, to moderating the nation's health expenditures as well as to reducing the tension between hospitals and state governments.

Regulations of the Secretary

The Association understands and shares the general Congressional concern with present procedures for proposing, evaluating, and publishing Federal regulations. The provisions of Section 32, which would establish a 60 day comment period for regulations, are a much needed reform in this area. Sixty days will allow time for a more thorough evaluation and review. Moreover, it will enable individuals and groups to collect appropriate data to illustrate and substantiate their comments and to offer constructive suggestions. To help ensure that the Subcommittee's intentions are achieved, the Association recommends that some clarification or definition be provided in the Committee Report for the term "urgent" as it applies to the regulations.

The Association would also like to emphasize that this reform should not be limited to Medicare and Medicaid programs alone. This Committee and others in both the House and the Senate are urged to consider the need for this reform and others in the area of administrative procedures for the publication of rules and regulations.

Abolition of HIBAC

The Health Insurance Benefits Advisory Council (HIBAC) was established in the original Medicare legislation as a mechanism for providing the government with private sector advice on the implementation and operation of the Medicare program. At least in its early days, it served this function well and helped make legislative language into a workable program. The provisions of S. 1470 -- especially those concerning hospital and physician payment computations -- make major changes in the present program. Without advocating a continuation of HIBAC as it has operated in recent years, the AAMC strongly recommends the maintenance of an advisory board to the Secretary of HEW of providers, practitioners, and consumers from the private sector which publically advises the Secretary of the implementation of program changes.

Conclusion

In conclusion, the Association expresses its appreciation to the Committee for this opportunity to testify on S. 1470. The Association share the Committee's objective of improving the Medicare and Medicaid programs, and the Association has offered this testimony on the legislation as a sincere effort to refine and improve the proposed amendments.