aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

March 28-29, 1979
Washington Hilton Hotel
Washington, D.C.

Wednesday, March 28

5:30 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Meeting	Georgetown West
7:30 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Cocktails and Dinner	Georgetown East

Thursday, March 29

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	Ballroom East
2:30 P.M.	Executive Council Business Meeting	Caucus Room

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

Council of Teaching Hospitals
Administrative Board

March 29, 1979
Washington Hilton Hotel

9:00 a.m. - 1:00 p.m.

A G E N D A

I.	Call to Order	
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III.	Membership Applications	
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	New Rochelle Medical Center New Rochelle, New Jersey	Page 28
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IV.	Staff Report on the COTH Spring Meeting	
V.	System for Hospital Uniform Reporting	
	A. AHA Draft Response	(Attachment A)
	B. Special Concerns of the AAMC	Page 59
VI.	Medicare Proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs	Page 67
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VIII.	Report of the CCME Committee on Opportunities for Women in Medicine	Executive Council Agenda Page 18
IX.	LCGME 1979 Budget	Executive Council Agenda Page 56
X.	Proposed Revision to CAS Rules and Regulations	Executive Council Agenda Page 58
XI.	Proposal for OSR Report on Health Legislation	Executive Council Agenda Page 58
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DISCUSSION ITEMS

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XIV.	Proposed Revision of the General Requirements in the Essentials of Accredited Residencies	Executive Council Agenda Page 64
XV.	Proposal for FLEX I and II Examinations	Executive Council Agenda Page 65
XVI.	National Health Insurance	Executive Council Agenda (Separate Attachment)
XVII.	New Business	
XVIII.	Information Item: AAMC Testimony Before Senate Finance Committee, March 13	Page 78

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
January 18, 1979

M I N U T E S

PRESENT:

Robert M. Heyssel, M.D., Chairman
David L. Everhart, Immediate Past Chairman
Dennis R. Barry
Jerome R. Dolezal
Mark S. Levitan
Stuart Marylander
Robert K. Match, M.D.
Mitchell T. Rabkin, M.D.
Malcom Randall
Elliott C. Roberts
William T. Robinson, AHA Representative

ABSENT:

John W. Colloton
James M. Ensign
John Reinertsen

GUESTS:

D. Kay Clawson, M.D.
John A. Gronvall, M.D.
Charles B. Womer

STAFF:

Martha Anderson, Ph.D.
James D. Bentley, Ph.D.
Peter Butler
Kat Dolan
Gail Gross
James I. Hudson, M.D.
Joseph C. Isaacs
Paul Jolly, Ph.D.
Richard M. Knapp, Ph.D.
August G. Swanson, M.D.

I. Call to Order

Dr. Heyssel called the meeting to order at 9:00 a.m. in the Hemisphere Room of the Washington Hilton Hotel. He then reported on several items of interest to the Board:

- Letters were sent to 70 hospital directors inviting them to attend the Management Advancement Program (MAP) Executive Development Seminar in June; twenty to thirty acceptances are anticipated. To date, about 80 hospitals have been represented at past MAP seminars.

- Sheldon King, University of California at San Diego, and Merlin Olson, Colorado General Hospital, were appointed to replace John Westerman and Tom Smith as COTH representatives on the Editorial Board of the Journal of Medical Education.

- The COTH Nominating Committee is by tradition composed of the Immediate Past COTH Chairman who serves as Chairman of the Committee, the current COTH Chairman, and one member-at-large. Therefore, the members of this year's Nominating Committee will be David Everhart as Chairman, Robert Heyssel and Eugene Staples, West Virginia University Hospital.

- Charles Sanders, Massachusetts General Hospital, was appointed as the COTH Representative to the AAMC's Flexner Award Committee.

- Merlin Olson, Colorado General Hospital, was selected to replace Stan Nelson who resigned as a COTH representative on the AAMC's Graduate Medical Education Task Force.

- James Bartlett, Strong Memorial Hospital, Rochester, was recommended by last year's COTH Nominating Committee to replace Larry Hill who resigned his membership on the COTH Administrative Board. Dr. Heyssel called for a motion supporting this recommendation.

  ACTION: It was moved, seconded and carried that James Bartlett, M.D., Medical Director, Strong Memorial Hospital, Rochester, N.Y., be appointed to serve as a member of the COTH Administrative Board for the remainder of the two-year term expiring in 1980 to replace Lawrence Hill, New England Medical Center, who had resigned.

Dr. Knapp formally introduced and welcomed Peter Butler who would be joining the staff of the Department of Teaching Hospitals as a Staff Associate in February.

Dr. Heyssel reviewed the minutes of the AAMC Officers' Retreat highlighting some of the proceedings. He noted that the topic selected for the AAMC Annual Meeting was "Cost and Allocation of Medical Resources - The Role of the Academic Medical Center."

II. Consideration of Minutes

ACTION: It was moved, seconded and carried to approve unanimously the minutes of the October 23, 1978 COTH Administrative Board meeting without modification.

III. Membership Applications

Dr. Bentley reviewed the eight applications for COTH membership. He indicated that the affiliation agreements for Christ Hospital, Middlesex Hospital and St. Thomas Hospital found in Attachment A of the Agenda might be of interest to the Board. Staff recommendations and Board discussion regarding the applications resulted in the following actions:

ACTION: It was moved, seconded and carried to approve Ball Memorial Hospital, Muncie, Indiana, for COTH full membership.

ACTION: It was moved, seconded and carried to approve Carney Hospital, Boston, Massachusetts for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Christ Hospital, Oak Lawn, Illinois for COTH full membership.

ACTION: It was moved, seconded and carried to approve Huntington Memorial Hospital, Pasadena, California for COTH full membership.

ACTION: It was moved, seconded and carried to approve Middlesex General Hospital, New Brunswick, New Jersey for COTH full membership.

ACTION: It was moved, seconded and carried to approve Saint Francis Hospital Center, Beech Grove, Indiana for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Saint Mary of Nazareth Hospital Center, Chicago, Illinois for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Saint Thomas Hospital Medical Center, Akron, Ohio for COTH full membership

System for Hospital Uniform Reporting (SHUR)

Dr. Heyssel reviewed this item for the Board and called attention to the position paper, "Why Ernst & Ernst Opposes SHUR," which had been previously mailed to the Board members. He pointed out that the report was not for endorsement by the Board but simply a statement to be perused prior to the Board taking a position on this issue. Dr. Heyssel feared that SHUR would call for a new set of books to be kept and a multitude of new reports.

Dr. Heyssel called the Board's attention to a statement in the AAMC Testimony on S. 1391 submitted in June, 1977 which reads, "Therefore, the AAMC strongly recommends the immediate development and implementation of a uniform hospital cost reporting system as the first component of a national cost containment program." Dr. Heyssel then invited Bill Robinson to comment on the American Hospital Association (AHA) position regarding this issue. Mr. Robinson explained that the AHA has sought delay in the implementation of Section 19 of P.L. 95-142 which would establish a uniform reporting system. SHUR, he stated, is believed to be a uniform "accounting" system. He said that no overt attempt to repeal Section 19 would take place until after the study of 50 hospitals which is being conducted by HEW to purportedly demonstrate the low implementation cost of SHUR has been completed. He noted that the HEW study would be skewed to exclude the cost of training individuals to address SHUR and the addition of new employees. He explained that the AHA's current position was proving difficult to maintain since AHA constituents (including four Regional Advisory Boards) were calling for immediate action to repeal Section 19. Mr. Robinson speculated that when the study is complete the AHA would have to comment on the results, and taking membership attitude into account, would probably move toward repeal within 60 to 90 days. He encouraged the COTH Board members to take any course of action they believed necessary to oppose SHUR.

Following discussion, Dr. Knapp suggested that the staff be instructed to spend more time with this isue and that the Board could make a statement of severe reservation about the course of action being taken regarding Section 19 without pushing for repeal at this point. Mr. Marylander moved that the AAMC be opposed to SHUR for the reasons stipulated in the Ernst & Ernst source document. Further discussion resulted in the following action:

ACTION: It was moved, seconded and carried to recommend that the AAMC formally and actively oppose the development and implementation of SHUR.

Since Mr. Everhart perceived general agreement by the Board in support of uniform reporting, he proposed a companion motion that the AAMC express interest in a reasonable system for uniform reporting and that staff,

working with AHA and other organizations, give this issue high priority. Discussion resulted in the following action:

ACTION: It was moved, seconded and carried that staff prepare a position statement in opposition to SHUR in the context of responding the January 23rd Federal Register publication of the SHUR regulations. This statement would present the various concerns of the Board and express its interest in a reasonable system for uniform reporting.

XIII. Expenses, Revenue and Volume Changes in COTH Hospitals: 1974-77

Dr. Knapp reviewed this report which was based on financial and service data obtained from the AHA for the years 1974-1977 for the non-federal members of COTH. Mr. Roberts questioned some of the figures presented in the report and suggested the data be more thoroughly validated. Dr. Knapp did not believe that this would be necessary since only general trends were examined in reaction to AHA's concern that hospitals with more that 500 beds are doing poorly under the Voluntary Effort (VE). Mr. Womer observed that the methodology used by the AHA to convert outpatient visits to inpatient days distorts the actual situation in many of the teaching hospitals. He thought that staff should consult with AHA staff to come up with a better conversion method and definition that would be in the interest of better reporting. Dr. Heyssel suggested that Dr. Knapp and Dr. Bentley contact AHA about this matter.

Dr. Bentley then distributed a handout listing the 1977 vs. 1976 COTH members' total expenses which increased at a rate less than 9.7 percent. The handout was then discussed in relation to the President's hospital anti-inflation program.

XIV. COTH/AAMC Position on Administration Cost Control Initiatives

Dr. Heyssel told the Board that though this was a discussion item Congressional hearings would begin soon and the AAMC would be presenting testimony. He invited any suggestions from the Board as to what the AAMC position should be. Dr. Knapp said that previous testimony indicated that the AAMC was marginally supportive of the Talmadge Bill and asked the Board to review the testimony on page 45 of the COTH Agenda to decide if that position was satisfactory in terms of preparing new testimony. Mr. Marylander suggested that a soft position would have to be maintained to stay flexible, avoid contradictions at a later time, and to support the AHA against the counterproductive nature of mandatory controls triggered if the VE fails. He felt that the testimony should deal with the issues involved with mandatory control without linking those to the voluntary issues.

Mr. Robinson agreed that an "it depends" stand must be taken depending on circumstances at the time. Dr. Bentley asked how one argues with Congressional staffers who maintain that if the mandatory trigger is removed, then the voluntary incentive is diminished. He invited Board members to contact him individually with any responses to this argument. Mr. Levitan pointed out how Phase II mandatory controls led hospitals to increase their charges to protect themselves during the Nixon Administration. Dr. Heyssel summed up discussion saying that the Board's position on this issue would remain flexible and that staff should proceed with testimony accordingly.

VIII. Report of the Panel on Technical Standards for Medical Schools

Dr. Heyssel invited Kat Dolan to review this item in the absence of Ray Schwarz, Chairman of the Panel on Technical Standards for Medical School Admissions.

Ms. Dolan explained that Section 504 of the Rehabilitation Act of 1975 basically establishes a broad government program of nondiscrimination against the handicapped in programs which receive federal funds. The regulations implementing Section 504 say that no person may be denied admission to an educational program based solely on that person's handicap if he/she meets the academic and technical standards of the program. Ms. Dolan continued that while most medical schools have fairly explicit academic standards, their technical standards are not clearly defined. Therefore, the Panel on Technical Standards for Medical School Admission was established by the AAMC to study and recommend for institutional consideration guidelines for development of technical standards for admission to medical school. The panel, after several meetings, adopted the final report which begins on page 41 of the Executive Council Agenda.

Ms. Dolan reported that there was no court case currently pending regarding the admission of a handicapped person to medical school, but that the medical schools definitely recognized this as a potential problem. She said that she has had several conversations with HEW's Office of Civil Rights and the Panel has met with staff of that Office as well. A number of differences between the AAMC and HEW positions have been identified. HEW accused medical schools of being recalcitrant in admitting handicapped students and making accommodations for them. HEW officials believe it is within their authority to impose curriculum review and rule whether or not an applicant meets the technical standards of an institution or whether or not a specific technical standard is really essential to the education and training of a physician. HEW would also open the door for limited practice by allowing that all courses may not be necessary for certain specialties, thereby negating the M.D. degree as a broad, undifferentiated degree of the general physician.

Taking all this into account, the Panel developed its report which would serve as guidelines for the medical schools and assure them that in making their decisions regarding handciapped admissions that they would have the supprot of the AAMC. It's hoped that the guidelines will also serve to educate HEW with regard to the standards and the complexity of the problem. However, AAMC anticipates further intrusion on academic freedom from HEW.

Mr. Marylander wondered if the problem of the impaired physician had been considered. Ms. Dolan responded that it had been discussed and that it was felt that the newly admitted student should conform to higher standards, and that changing conditions after admission or as a physician was a somewhat different issue. Mr. Marylander complimented the Panel for its fine job and moved to approve the Panel's final report for dissemination.

ACTION: It was moved, seconded and carried to approve the final report of the Special Advisory Panel on Technical Standards for Medical School Admission for transmittal to medical schools.

V. A Proposal for Federal Regulation of Clinical Laboratories

Dr. Heyssel reviewed this item for the Board and pointed out that various agencies of government would like to extend the Laboratory Act to any biophysical measurement. Dr. Knapp added further explanation and indicated that Dr. Thomas Morgan was interested in the Board's reaction to the AAMC proposal.

ACTION: It was moved, seconded and carried to approve the Proposal for Federal Regulation of Clinical Laboratories as set forth on page 31 of the COTH agenda.

IX. Final Report of the Working Group on the Transition Between Undergraduate and Graduate Medical Education

Dr. Heyssel invited Dr. Kay Clawson, Dean, University of Kentucky, and Chairman of this working group to review the group's report. Dr. Clawson explained that a tremendous problem existed regarding how medical schools prepared medical students to go on to graduate medical education. This working group was formed a year and one-half ago as a subcommittee of the Task Force on Graduate Medical Education to address this particular problem as well as a number of other issues.

Dr. Clawson proceeded to review the Working Group's recommendations. The first recommendation was that the Liaison Committee on Medical Education (LCME) place particular emphasis on the advice and counseling provided to students in its review of schools for accreditation. Dr. Clawson said that this is already in effect and that the LCME adopted this policy independently of the AAMC recommendation. The second recommendation proposes that the AAMC take the lead in working with the NRMP and LCGME to publish an improved, up-to-date directory of graduate programs and residency listings for medical students in place of the current Green Book. With regard to the application cycle and the selection process the following recommendations were proposed:

- All programs in graduate medical education which select residents who are immediate graduates of medical schools accredited by the LCME should be required to utilize the NRMP as a condition of accreditation by the Liaison Committee on Graduate Medical Education.

- The AAMC should take the leadership role in developing a universal application form.

- Evaluation letters and transcripts should be sent by deans' offices to program directors prior to October 1 of a student's final year. (Dr. Clawson noted that the report as it appears in the Executive Council Agenda had been amended to reflect the change in date from November 1 to October 1.)

- The deadline for both students and programs to make their final decisions and submit their rank order lists to NRMP should be as close to the first of February as possible.

- There should be a uniform starting date for all graduate medical education programs, and this date should occur no earlier than June 24.

Dr. Clawson concluded with a review of the last section of the report which deals with the types of first graduate years. He explained that in order to eliminate the problems created by the current designations for the first graduate year, the Working Group recommended two types of programs: (1) categorical programs which are those in a specialty that meet the Special Requirements of the residency review committee for that specialty and (2) mixed programs which are for students in their first graduate year who desire a mixed experience in several specialties. The Group recommended that the two types should be based on the criteria set forth as items 1,2, and 3 on page 60 of the Executive Council Agenda. Dr. Clawson noted that the LCGME had also completed a report on this subject which was received after the Working Group's report was completed. The Working Group accepted it as an appendix to their report and as a suitable alternative to their proposal on this particular issue.

ACTION: It was moved, seconded and carried to approve the final report of the Working Group on the Transition Between Undergraduate and Graduate Medical Education as set forth on pages 53-68 of the Executive Council Agenda.

X. National Residency Matching Program Request for Endorsement

ACTION: It was moved, seconded and carried to approve: (1) the Task Force recommendation on NRMP as set forth in the second paragraph on page 69 of the Executive Council Agenda and (2) the Task Force recommendation that the staff explore with NRMP how specific mechanisms could be developed to accomplish the intent of the proposal set forth on page 69 of the Executive Council Agenda.

VI. Report of the CCME on Continuing Competence of Physicians

Dr. Knapp reported that he didn't disagree with anything he had read in the report and invited any observations.

ACTION: It was moved, seconded and carried to recommend that the Executive Council receive the CCME report on Continuing Competence of Physicians and approve the recommendations contained therein.

VIII. Report of the CCME Committee on Coordination of Data on Physicians

Dr. Jolly review this item for the Board.

ACTION: It was moved, seconded and carried to recommend that the Executive Council approve the report of the Committee on Coordination of Physicians of the Coordinating Council on Medical Education.

XI. Assessment of the COTRANS

Dr. Heyssel briefly reviewed this item and said that he felt this whole issue definitely needed attention and scrutiny.

ACTION: It was moved, seconded and carried to recommend that a small group be formed to assess the current status of the COTRANS Program and make recommendations for its phased discontinuation or modification.

XII. Use of the Faculty Roster for Recruiting Purposes

Dr. Jolly in reviewing this item stated that the Faculty Roster had been created in 1967 to permit studies of the development of biomedical and faculty manpower. The main purpose for its creation was to serve as a data base to support studies of manpower development and this remains its primary purpose. He explained the Association's policy on releasing data which assigns a classification of confidential, restricted or unrestricted to every data element maintained in Association files and prescribes policies for dealing with requests for data at each level of sensitivity. He drew the Board's attention to the justifications for expanding the use of the Faculty Roster for recruiting purposes which were set forth on page 71 and 72 of the Executive Council Agenda, and explained them to the Board. Dr. Jolly concluded by setting forth the four alternative courses of action presented on page 72 of the Executive Council Agenda. Board discussion of this issue resulted in the following actions:

ACTION: It was moved, seconded and carried to approve recommendations 1 and 2 on page 72 of the Executive Council Agenda.

It was generally agreed that approving recommendations 1 and 2 negated recommendation 3. Dr, Heyssel proposed that recommendation 4 be tabled for further study.

ACTION: It was moved, seconded and carried to table recommendation 4 on page 72 of the Exeuctive Council Agenda for a period of time pending results of projects proposed in recommendations 1 and 2 on page 72 of the Executive Council Agenda.

XVIII. Revisions of the General Requirements in the Essentials of Accredited Residencies

Dr. Swanson provided the background for this item. He said that the LCGME developed the General Requirements which must be met by graduate medical education programs. The General Requirements were then forwarded to the Coordinating Council on Medical Education and then to the parent organizations for approval. Dr. Swanson explained that the current General Requirements and the revisions to them were circulated as part of the Executive Council Agenda. The revisions have been forwarded to the parent organizations for their approval and they have been requested to comment by May, 1979. There will then be a conference committee composed of representatives from the CCME and LCGME designated by each parent organization to reconcile the document based upon the comments received from the parent organizations. He indicated that this item is part of the agenda at this time to allow review and discussion prior to March, at which time action would be taken by the Executive Council to meet the May deadline for comment. He also noted that the American College of Surgeons has launched a major attack on the LCGME because it wishes to maintain its current prerogatives and responsibilities.

Dr. Heyssel allowed that no action was necessary until the March Board meeting, but asked that staff circulate the "Essentials" to the Board before the March meeting as a reminder that the document should be read prior to action being taken then.

XV. Annual Meeting

Dr. Knapp told the Board that John Colloton as Chairman-Elect would be responsible for putting the program together for the COTH annual meeting which would be held during the Association's Annual Meeting, November 4-8. He suggested that if anyone had a particular theme in mind or other suggestions, they should contact Mr. Colloton or himself.

Dr. Knapp then invited Board reaction to the plan to hold future meetings of the AAMC in Washington, D.C. The Board generally agreed that decision should depend on the best interests of the Association.

XVIII. COTH Spring Meeting

Dr. Knapp informed the Board that registration materials for the Spring Meeting would be sent out shortly after the first of February. He also noted receipt of several letters expressing negative reactions to the Board's decision regarding the location for the meeting.

XVI. Chiropractic Litigation

Dr. Knapp reported that this was an item for discussion and information, not action. Dr. Heyssel provided some background on this item. Dr. Bentley presented the staff view, explaining some of the complexities and implications. He reported that the AAMC wants to stay removed from the political aspects surrounding the litigation and function only as a witness regarding the technical aspects of care.

XIX. Adjournment

The meeting was adjourned at 12:40 p.m.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: Health Sciences Center Hospital

Hospital Address: (Street) 4th and Indiana (P. O. Box 5980)

(City) Lubbock (State) Texas (Zip) 79417

(Area Code)/Telephone Number: (806) 743-3111

Name of Hospital's Chief Executive Officer: Gerald G. Bosworth

Title of Hospital's Chief Executive Officer: Executive Director

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	273	Admissions:	5,810
Average Daily Census:	96	Visits: Emergency Room:	10,952
Total Live Births:	4,104	Visits: Outpatient or Clinic:	52,544

B. Financial Data

Total Operating Expenses: $13,313,000

Total Payroll Expenses: $ 4,854,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 367,000
Supervising Faculty: $ 60,000

C. Staffing Data

Number of Personnel: Full-Time: 823
Part-Time:

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 164
*With Medical School Faculty Appointments: 95 Clinical Faculty
*All Medical Staff Members have Faculty Appointments

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Anesthesiology	Dermatology	Family Practice	Medicine
Obstetrics & Gyn.	Orthopaedics	Opthalmology	Pediatrics
Psychiatry	Radiology	Surgery	Phys. Med. & Rehab.

Does the hospital have a full-time salaried Director of Medical Education?: No - Person is provided by the Medical School

III. MEDICAL EDUCATION DATA SEE ATTACHMENT 1

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine			
Surgery			
Ob-Gyn			
Pediatrics			
Family Practice			
Psychiatry			
Other:			

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	-	-	-	-
Medicine	-	-	-	-
Surgery	-	-	-	-
Ob-Gyn	9	5	3	July 1, 1978
Pediatrics	20 (Including 2 Fellows)	1	9	July 1, 1978
Family Practice	24	16	8	Feb. 1973
Psychiatry	-	-	-	-
Other:				
Anesthesiology	7	1	4	July, 1978
Dermatology	1	1	-	July 1, 1978
Ophthalmology	5	3	2	July 1, 1976
Orthopaedic Sur.	4	4	-	Jan. 1, 1977

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

Additional Information is attached. (ATTACHMENT 2)

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: Texas Tech University School of Medicine

Dean of Affiliated Medical School: George Tyner, M.D.

Information Submitted by: (Name) Gerald G. Bosworth

(Title) Executive Director

Signature of Hospital's Chief Executive Officer:

Gerald G. Bosworth (Date) January 19, 1979

During the academic year most recently completed (1977-78) no clerkships were provided. During the current academic year only one required clerkship is being taught in the Health Sciences Center Hospital which is senior Internal Medicine. Fourteen students are taking this required clerkship. Beginning with the 1980-81 academic year regular required clerkships at the junior level will be provided in Internal Medicine, Surgery, OB/GYN, and Pediatrics. Approximately 20 students will be involved in each of those clerkships during that year. Additionally, approximately 15 students will receive their senior Internal Medicine experience during that period. The following year (1981-82) the numbers of students in each of these clerkships will increase to 40 and remain at that level for several years.

In addition to required clerkships elective study in the specialties and subspecialties represented by the TTUSM faculty will be provided to senior students. This will involve approximately 40 students per year.

ATTACHMENT 1

(Filled, p. 2)

LUBBOCK	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Anesthesiology	2	2	1				
Dermatology		1					
Family Practice	9	6	8				
Flexible	El Paso only						
Internal Medicine	Application submitted						
OB/GYN	2	2	3		1		
Ophthalmology	2	2	1				
Orthopaedic Sur.	1	2	1				
Pathology	Will apply in Nov. for beginning date Summer 1979*						
Pediatrics	6	0	2	1Fel.	1Fel.		
Preventive Medicine	Application submitted						
Psychiatry	Application in process						
Radiology	Will apply within the next year						
Surgery	Tentatively approved						

*HSCH will have to have 200 plus beds before Pathology program can be implemented.

ATTACHMENT 2

LUBBOCK	PGY-1	PGY-2	PGY-3	PGY-4	PGY-5	PGY-6	PGY-7
Anesthesiology	2*	2	2	1			
Dermatology		1					
Family Practice	12	12	12				
Flexible							
Internal Medicine							
OB/GYN	3	2	3		1		
Ophthalmology		2	2	1			
Orthopaedic Sur.		3			1		
Pathology	.5	.5	.5	.5	1/1/79		
Pediatrics	6	6	6	1Fel	1Fel		
Preventive Medicine							
Psychiatry							
Radiology	.5	.5	.5	1	1		
Surgery	2	1	2.34				

PROGRAM	EL PASO	AMARILLO	LUBBOCK
Anesthesiology	Approved	Approved	Approved In process
Dermatology	DNA	DNA	Approved In process
Family Practice	Approved In Process	Approved In Process	Approved In Process
Flexible	Approved In Process	DNA	DNA
Internal Medicine	Approved In Process	Application Being written	Application Submitted
OB/GYN	Approved In Process	Approved, In Process 1/79*	Approved In Process
Ophthalmology	DNA	DNA	Approved In Process
Orthopedic Surgery	Rotating from Lubbock	DNA	Approved In Process
Pathology	***	DNA	Will apply in Nov. for begining Summer 1979****
Pediatrics	Approved In Process	Application being written	Approved In Process
Psychiatry	Approved July 1979	Approved	Application in process
Radiology	Date Unknown at this time	DNA	Will apply within the next year
Surgery	Approved In Process	Tentatively Approved**	Tentatively Approved**
Preventive Medicine	DNA	DNA	Application Submitted

*Will rotate from Lubbock
**Lubbock-Amarillo Joint Program
***Dates questionable at this time due to inadequate lab space
****HSCH will have to have 200 plus beds before Pathology program can be implemented.

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTERS
SCHOOL OF MEDICINE / Office of the Dean
P.O. Box 4569 ☐ Lubbock, Texas 79409 ☐ (806) 743-3000

December 20, 1978

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

Gentlemen:

This letter is to support the application of the Health Sciences Center Hospital at Lubbock for membership in the Council of Teaching Hospitals.

The Health Sciences Center Hospital is our primary teaching hospital in Lubbock for Texas Tech University School of Medicine. We are housed in the same building complex and the Hospital was designed from its inception to be the Medical School's primary hospital resource. The Hospital is staffed totally by faculty of the School of Medicine, both full time and clinical. There is a formal, as well as informal, relationship between the Vice President of the Health Sciences Centers and myself to the Executive Director of the Hospital and the Board of Managers. There is also a working relationship between the Board of Regents of the School of Medicine and Board of Managers of the Hospital. Our teaching program is dependent upon our relationship and I, therefore, heartily endorse the application.

Sincerely yours,

George S. Tyner, M.D.
Dean

GST:bc

THE STATE OF TEXAS

AFFILIATON AGREEMENT

COUNTY OF LUBBOCK

THIS AGREEMENT MADE AND ENTERED INTO this 4th day of December, 1970, by and between the LUBBOCK COUNTY HOSPITAL DISTRICT of Lubbock County, Texas, by its lawful appointed Board of Managers, hereinafter called "Hospital District", and TEXAS TECH UNIVERSITY SCHOOL OF MEDICINE AT LUBBOCK, by the Board of Regents of Texas Tech University, acting in its capacity as the governing Board of Texas Tech University School of Medicine, hereinafter called "University".

WITNESSETH:

WHEREAS, it is mutually recognized that the Hospital District and the University have certain objectives in common, namely: (a) the advancement of medical services through excellent professional care of patients; (b) the education and training of medical and allied health personnel; (c) the advancement of medical knowledge through research; and (d) promotion of personal and community health, and that each can accomplish these objectives in larger measure and more effectively through affiliated operations; and

WHEREAS, it is mutually recognized that the primary function of the Hospital District is the provision of medical and hospital care for the residents of the district and for its needy and indigent inhabitants; and

WHEREAS, it is mutually recognized that the University shall operate a teaching, training, health care service and research institution for the education of medical students, pre-doctoral and post-doctoral physicians and of allied health personnel, and

WHEREAS, it is the desire of all parties that the hospital to be constructed by the Hospital District on land presently constituting a portion of the campus of Texas Tech University shall be a teaching hospital of the University in order that all parties can accomplish their objectives in larger measure and more effectively;

NOW, THEREFORE, for and in consideration of the foregoing and in further consideration of the mutual benefits, the Parties hereto agree as follows:

I.

1. That the University shall establish and operate a school of medicine as authorized by the laws of the State of Texas.

2. That all expenses incurred in designing, constructing, equipping, operating, maintaining, administering and personnel managing and staffing of the Medical School shall be borne by the University within the terms of this Affiliation Agreement and the laws of the State of Texas. That the facilities shall be located on the Texas Tech University campus adjacent to the facilities to be placed on the Texas Tech University campus by the Hospital District as hereinafter provided.

3. That the University shall retain all jurisdictional powers incident to ownership of the Medical School including the powers to determine general, fiscal, administrative and educational policies in conformity with the laws of the State of Texas and this Affiliation Agreement.

4. That the University shall retain all administrative and operational jurisdiction over members of the faculty of the Medical School as such members are involved in the terms of this Affiliation Agreement.

II.

1. That the Hospital District shall establish and operate a hospital or hospital system as authorized by the laws of the State of Texas and shall maintain necessary accreditation required for a medical school teaching hospital. That the hospital facilities to be hereinafter described shall be constructed on the lands to be conveyed by Texas Tech University to the Hospital District, being located on the campus of Texas Tech University as authorized by law.

2. That the hospital located on the campus of Texas Tech University in physical juxtaposition with the Medical School is functionally an integral and essential part of the educational, health care service and research environment of the Texas Tech University School of Medicine. As such, the hospital, with the Medical School and related facilities, constitutes the Texas Tech University Medical Center. The architectural design, construction, equipment, operation, maintenance, administration and personnel management and staffing of the hospital shall conform to the specifications for a complete teaching hospital for the Medical School as defined by the University, by the laws of the State of Texas, and by the Hospital District.

3. That all expenses incurred in designing, constructing, equipping, operating, maintaining, administering, and personnel managing and staffing of the hospital shall be borne by the Hospital District within the terms of this Affiliation Agreement and the laws of the State of Texas.

4. That the Hospital District shall retain all jurisdictional powers incident to ownership of the hospital including the powers to determine general, fiscal and administrative policies in conformity with the laws of the State of Texas and this Affiliation Agreement.

III.

1. That appointments to the medical professional staff of the hospital shall be made annually by the Board of Managers only upon nomination by the University of faculty physicians of the Medical School and that the active medical attending staff and the teaching physician staff of the hospital shall be one and the same and shall be the only medical staff of the hospital. Failure by the Board of Managers to appoint a nominee shall be based solely on professional incompetence of the nominee.

2. That the Constitution and By-Laws of the Hospital Medical Staff shall be in conformity with the provisions of this Affiliation Agreement and the laws of the State of Texas. That said Constitution and By-Laws shall be subject to approval by the University and by the Hospital District.

3. That the non-physician members of the Medical School faculty shall be nominated and appointed to the hospital personnel staff by the University.

4. That the Board of Managers shall appoint as chairmen or chiefs of the departments, divisions or services of the hospital staff the individuals who are chairmen or chiefs of the corresponding deparments, divisions or services of the Medical School. It shall be understood that the organizational structure may change from time to time and that the chairmen or chiefs of departments, divisions and services shall be appointed as provided in this paragraphs to conform to the organizational structure existing in the Medical School faculty. Provided further that upon nomination by the University,members of the Medical School faculty who are not chairmen or chiefs of departments, divisions, or services of the Medical School shall be appointed by the Board of Managers as chairmen or chiefs of departments, divisions or services.

5. That the Hospital District will maintain a non-faculty staff of personnel in the hospital adequate to meet the teaching hospital program needs of the University .

6. That the University shall determine the number and variety of students assigned to the hospital for education, training and research.

7. That the University shall appoint all interns, resident physicians and other categories of medical or health personnel trainees

in the hospital.

8. That the admission of patients to the hospital shall be in conformity with the requirements of legislation creating the Hospital District. The use of patients for teaching purposes shall be determined by the University. This Agreement shall not restrict the admission of private patients and patients with third-party payors.

9. That patient access policies and contractual agreements by the Hospital District with any county other than Lubbock County, Texas, or with the State and agencies of the federal government for the care and treatment in the hospital of the sick, diseased and injured persons for whom such county, state or agencies of the federal government are responsible, shall be made by the Hospital District with the advice and counsel of the University and shall be subject to and approved by the University before such agreements shall be binding on the medical staff or other personnel required to perform such services.

10. That a form of hospital organization and management shall be adopted that emphasizes the interrelationship of function and purpose of the hospital with the medical school as a medical center entity. In this connection, joint appointments of personnel may be made by both parties hereto on mutual consent.

11. That the annual budget of the hospital shall be jointly prepared by the Hospital District for consideration and appropriate action.

IV.

1. That, subject to the legal powers and limitations of Parties, joint employment of personnel between the hospital, University and related facilities constituting the University Medical Center shall be utilized. Pro-rata apportionment of such salaries and other related costs and expenditures shall be accomplished when feasible and when approved by the Hospital District and the University.

2. That the University shall provide a sufficient number of qualified physicians from the Medical School faculty to direct and to adequately supervise professional medical services to the patients of the hospital. Such professional medical services will be provided by the faculty of the Medical School at no direct cost to the Hospital District other than costs specifically identified in conformity with this Affiliation Agreement. Fees for professional medical services paid by the patient or by third-party payers such as conors, litigants, insurance companies, etc., local, state or federal government agencies shall be established by and accrue to the attending physician members of the Medical School faculty in conformity with this Affiliation Agreement and the regulations of the University.

3. That pricing policies for all hospital charges shall be established by mutual agreement between the Hospital District and the University.

4. That the intern and resident physician staff of the hospital shall participate in patient care under the direction of the University faculty. The salary and other expenses of the interns and resident physicians as members of the hospital staff shall be borne entirely by the Hospital District except in those instances where the University may be able, from time to time, to obtain special funds applicable to training programs of certain interns and resident physicians.

5. That the University in conformity with its responsibilities as the teaching institution shall retain all authority over education related programs and activities in the hospital.

6. That various categories of professional services shall be rendered in the operation of the hospital which are of little or no direct benefit to the educational or research activities of the University and that identification and accountability of such professional services rendered by physicians and other categories of personnel shall justify the pro-rata sharing of their compensation by the Hospital District and the University.

V.

1. That there shall be established a four member Liaison Committee which shall include as voting members two members of the Board of Managers of the Hospital District, two members of the Board of Regents of the University.

2. That the Liaison Committee shall also include as ex-officio members the Administrator of the Hospital District and the Vice President for Health Affairs of the University or his designee.

3. That the Liaison Committee shall consider and make recommendations to the respective governing bodies on matters including but not limited to the following:

a. Circumscribe a program which can be realistically funded by the Hospital District.
b. Determine priorities for developing new programs and expansion of current programs.
c. Periodically consider modifications in the Hospital District - University Affiliation Agreement.

d. Review major policy matters that will affect both the Hospital District and the University.

e. Consider ways by which the Hospital District and the University, working together, can best accomplish their mutual goals.

4. That the Liaison Committee shall establish its own rules of procedures.

VI.

1. That the term of this Affiliation Agreement shall be for twenty (20) years from and after the date of its ratification by the parties hereto unless sooner terminated by the mutual consent of the Parties in writing.

2. That this Affiliation Agreement may be amended in writing to include such provisions as the Parties may agree upon and that this contract may be renewed for an additional term of years.

VII.

1. Nothing herein shall be construed to contradict or contravene the provisions of Article 4494q, Vernon's Annotated Civil Statutes of the State of Texas, and H.B. No. 878, p. 1095, 60th Legisl., Reg. Session, 1967.

IN WITNESS WHEREOF, the Parties have hereunto set their hands the day and year first above written.

LUBBOCK COUNTY HOSPITAL DISTRICT

BY: /s/ B. E. Rushing, Jr.
B. E. RUSHING, JR., Chairman
Board of Managers, Lubbock
County Hospital District

ATTEST:

/s/ Joe A. Stanley
JOE A. STANLEY, Secretary

TEXAS TECH UNIVERSITY SCHOOL OF MEDICINE AT LUBBOCK

BY; /s/ Frank Junell
FRANK JUNELL, Chairman
Board of Regents of Texas Tech

University, acting in its capacity as the governing board of Texas Tech University School of Medicine at Lubbock

ATTEST:

/s/ Freda Pierce
(Mrs.) FREDA PIERCE

APPROVED:

COMMISSIONERS' COURT OF LUBBOCK COUNTY, TEXAS

BY: /s/ Rodrick L. Shaw
RODRICK L. SHAW
County Judge

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: New Rochelle Hospital Medical Center

Hospital Address: (Street) 16 Guion Place

(City) New Rochelle, (State) New York (Zip) 10802

(Area Code)/Telephone Number: (914) 632-5000

Name of Hospital's Chief Executive Officer: George A. Vecchione

Title of Hospital's Chief Executive Officer: Administrator

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 336

Average Daily Census: 286.36

Total Live Births: 885

Admissions: 10,865

Visits: Emergency Room: 30,192

Visits: Outpatient or Clinic: 9,906

B. Financial Data

Total Operating Expenses: $ 10,721,600

Total Payroll Expenses: $ 14,467,700

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 645,044
Supervising Faculty: $ 129,009

C. Staffing Data

Number of Personnel: Full-Time: 957
Part-Time: 182

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 201
With Medical School Faculty Appointments: 47

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Medicine

Does the hospital have a full-time salaried Director of Medical Education?: No.

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	1(every 3 months)	16	Required(year round)
Surgery	1(every 3 months)	16	Required(year round)
Ob-Gyn			
Pediatrics			
Family Practice			
Psychiatry			
Other: 5th Pathway	1	6	Required(year round)
Med. (Subst, Internship)	1 (every month)	14	Required (year round)
Med. (Electives)	4 (monthly)	12	Elective
Med. (Physical Diagnosis)	1 (3 mo	12	Required

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	0			
Medicine	22	4	18	
Surgery	20	0	20	1943
Ob-Gyn				
Pediatrics				
Family Practice				
Psychiatry				
Other:				

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: New York Medical College

Dean of Affiliated Medical School: Samuel H. Rubin, M.D.

Information Submitted by: (Name) George A. Vecchione

(Title) Administrator

Signature of Hospital's Chief Executive Officer:

George A. Vecchione (Date) 2/15/79

New Rochelle Hospital Medical Center
16 GUION PLACE, NEW ROCHELLE, NEW YORK 10802 · 914 632-5000

The New Rochelle Hospital Medical Center has offered approved residency programs in internal medicine and general surgery for many years. An affiliation with the New York Medical College was consummated in 1974. This is a major affiliation, as noted in the Dean's letter, and was based primarily on the professional ability of the teaching attending staff. As a result, the teaching responsibilities have increased tremendously and the hospital's performance has been viewed most positively by both the students and the medical school.

Current student offerings include, year round, the required third year, three month major medical clerkship (including daily lectures); a required clinical third year surgical clerkship; and a required fourth year sub-internship in medicine. Electives are offered, in medicine, to the fourth year students in pulmonology, nephrology, gastroenterology and emergency medicine. The required second year course in physical diagnosis is also taught here. Finally, a year-round fifth pathway program, under the sponsorship of the medical school, has been in operation since 1975, coordinated by the director of medicine.

NEW YORK MEDICAL COLLEGE

Valhalla, New York 10595
(914) 347-5090

OFFICE OF THE PROVOST AND DEAN

January 12, 1979

Ms. Carmen B. Alecci
Assistant Administrator
New Rochelle Hospital Medical Center
16 Guion Place
New Rochelle, New York 10802

Dear Ms. Alecci:

New Rochelle Hospital is a Group I Affiliate of New York Medical College. A Group I Affiliation is defined as one in which multiple major services of the hospital, including at least the medical and surgical services, participate in the regular required undergraduate teaching programs of the Medical School.

New Rochelle Hospital participates on a regular basis in the following required programs:

Second Year
1. The Pathology Externship Program
2. The Physical Diagnosis Course

Third Year
1. The 13 week Surgical Clerkship
2. The 13 week Medical Clerkship

Fourth Year
1. The 4 week Medical Subinternship Program

2. The following electives are offered by New Rochelle Hospital for our fourth year students:

Nephrology, Emergency Medicine, and Gastroenterology

Sincerely yours,

Samuel H. Rubin, M.D.
Provost and Dean

SHR:jc

NEW YORK MEDICAL COLLEGE
ELMWOOD HALL
VALHALLA, NEW YORK 10595
(914) 347-5000

OFFICE OF THE DEAN

April 12, 1974

New Rochelle Hospital
Medical Center
New Rochelle, New York 10802

Dear Sirs:

New Rochelle Hospital (the "Hospital") and the New York Medical College, Flower and Fifth Avenue Hospitals (the "College") recognizing that medical education and medical care are interdependent and that the best delivery of health services occurs in an environment of education and research, and that affiliation would be mutually advantageous, agree upon an affiliation in which the multiple major services of the Hospital, including initially at least the medical and surgical services, participate in the regular required undergraduate and graduate clinical teaching program of the College.

1. The Hospital is committed primarily to serving the medical care needs of its community, and assumes responsibility, wherever feasible, to use its resources for purposes of education and research. Its physical facilities, teaching facilities, medical staff and case material are suitable for such affiliation, and in addition, it offers adequate and competent pathology and radiology support and appropriate consultative services.

2. The College, which conducts a major teaching campus for educating medical students at its Medical School, a component of the Westchester Medical Center, at Grasslands Reservation, Valhalla, New York, is committed primarily to the education of physicians and other health care personnel, and assumes responsibility, wherever feasible, to use its resources to improve the delivery of health care through education, research, patient care and community service.

3. The College is desirous of rotating a substantial number of medical students through the Hospital for undergraduate education, and the Hospital is desirous of offering its manpower and facilities for the education of such medical students. It is the intention of the College to send medical students to the hospital on each affiliated service during each term.

4. The Hospital's Departments of Medicine and Surgery will be the first services to affiliate under this agreement. Other services will be phased into the program as soon as practicable. If in the opinion of the Hospital and the College, a satisfactory arrangement cannot be reached with some of the other services at the hospital, these departments are not precluded by this agreement from establishing affiliations with other medical colleges.

5. There will be either a geographic full-time chief of service, that is, a physician having his total practice and office facilities within the Hospital, or a full-time chief of service for each affiliated major service. The present Directors of Medicine and Surgery will be acceptable to continue to serve in their present capacities.

6. Full-time directors of service will be recommended by a search committee of the Hospital Medical Board which will include representatives from the College. The representatives of the College will be appointed by the Dean of the College following consultation with the faculty. The Executive Officer of the Hospital will be responsible for developing the terms of employment and the financial arrangements with the appointees, and the Dean and the department chairman of the College will be responsible for the faculty rank, which is subject to approval by the Tenure and Promotions Committee and the Board of Trustees of the College. Any physician holding the position of geographic full-time or full-time chief of service in the Hospital prior to January 1, 1972, will be eligible for appointment under this agreement.

7. The College will confer on the full-time chiefs of service an appropriate regular Medical School faculty appointment, the continuance of which will be dependent upon the discharge of teaching responsibilities. Upon the termination of teaching responsibilites such appointment shall be terminated forthwith.

8. Full-time chiefs of service and other full-time members of the medical staff of the Hospital holding such College appointments will be expected to serve on College and department faculty committees.

9. Voluntary or part-time members of the medical staff of the Hospital who are qualified and who wish to participate in the undergraduate teaching program at the Hospital will be recommended for College appointments by the chiefs of their respective services to the department chairman of the College. Such appointments are subject to approval as provided above. Nonparticipation in such teaching program will not jeopardize any physician's Hospital appointment. The Hospital will continue to make its own appointments to its medical staff and to formulate its own policy with regard to its staff appointments.

10. In view of the fact that some Hospital physicians who are eligible for the teaching program may hold faculty appointments at other medical schools, dual appointments will be permitted under this agreement for the period of one year following receipt of an appointment from the College. Thereafter all physicians holding appointments to the teaching staff at the College will relinquish faculty appointments at other medical schools unless, in the discretion of the department chairman, an extension of time is granted. At the discretion of the director of the service at the hospital and the department chairman, attendings without faculty appointments at a medical school can be used in the Hospital teaching service. Attendings with appointments at other medical schools can be utilized in the Hospital teaching service at the discretion of the director of the service at the Hospital and of the departmental chairman.

11. The duties of the full-time chiefs of service will be concerned principally with the undergraduate, graduate and continuing education programs. They will be responsible for the general conduct of the clinical work of their services and for the quality of patient care on their services. They must have sufficient authority within the Hospital to assure that their recommendations are carried out. They will be expected to participate in the teaching programs of their departments at the College. It is agreed that the Hospital will permit them to spend up to 20% of their time at the College.

12. The full-time faculty based at the College may participate in the teaching program at the Hospital, at the discretion of the College department chairman and the chief of service at the Hospital. Such faculty members may, in the sole discretion of the Hospital, be given appointments to the staff of the Hospital.

13. All patients admitted to the teaching service at the Hospital will be available for the teaching program unless the patient's physician, with the approval of the chief of service, deems that participation in the teaching program might adversely affect the patient's condition.

14. The College assumes responsibility for assisting in the development of the Hospital's residency programs. These programs may function as conjoint programs, as completely independent programs within the Hospital, or as independent programs with rotations to the College hospital. When rotations occur between the Hospital and the College, the Hospital shall pay the total cost of residents (including room, board and other necessary support) during their stay at the College. Should the Hospital require residents for the support of their program and rotations occur between the College and the Hospital, the Hospital shall pay the total cost of residents during their stay at the Hospital. When rotations occur on an equal basis, each party shall pay its cost of residents during the period of exchange.

15. Undergraduate teaching programs on a regular basis will not be established at the Hospital in any service that does not obtain an approved residency program. Following recommendation by the Medical College's Committee on Affiliation Policy and approval of the Executive Faculty, the department chairman, with the approval of the Dean, shall be responsible for all student assignments. The Hospital will at its expense provide suitable quarters for students assigned to clerkships at the Hospital for night and weekend duty. In addition the Hospital will provide, at its expense, a meal allowance, uniform laundry service, parking facilities, and all other necessary and customary requirements for student hospital activities and live-in support.

16. The College will support research grant applications of individuals in the Hospital provided such applications are first screened and approved by the College's Research Committee. Joint research endeavors will be encouraged.

17. The College and the Hospital will cooperate in the development of programs for continuing education for the medical staff of the Hospital and in the development of allied health programs as may be dictated by the needs of the Hospital and its community.

18. (a) All publications written by members of the Hospital staff holding College appointments and based on data or information obtained by reason of this affiliation agreement, shall, prior to publication, be approved by the appropriate Hospital committee and by the appropriate department chairman of the College.

(b) All such publications shall bear appropriate acknowledgement to both the Hospital and the College.

(c) All information, inventions and writings developed at the Medical School by members of the staff of the Hospital holding College appointments shall comply with the copyright and patent policies of the College.

(d) All information, inventions and writings developed at the Hospital by members of the staff of the Hospital, whether or not holding College appointments, shall comply with the copyright and patent policies of the Hospital.

19. The College has the ultimate responsibility for undergraduate education. If, in the opinion of the College, the teaching program in any participating service is inadequate, the Dean, following consultation with the chief of service at the Hospital and the College department chairman, shall have the right to limit or discontinue such undergraduate teaching program in the Hospital.

20. (a) The effectiveness of this affiliation will be in part dependent upon a continuance of the mutual understanding, confidence and trust of the parties. In order to provide a means for prompt indentification of problems in this affiliation program and a mechanism for negotiating equitable solutions, a Joint Review Committee will be formed whose membership will include the following: From the Hospital--Chief of Service of affiliated department and a representative each of Administration, the Medical Board and the Board of Trustees; From the Medical School--The Dean, department chairman of affiliated service, Chairman of the Committee on Affiliation Policy, and a representative of the Board of Trustees.

(b) The Joint Review Committee shall meet at agreed upon regular intervals and shall meet on call in any emergency. It shall evaluate ongoing needs for adequate space and facilities necessary or desirable for graduate and undergraduate education under the within affiliation program. Said Committee shall submit annually a written evaluation of the operational aspects of the affiliation program and shall suggest any changes or amendments to the within agreement to the Executive Director of the Hospital and the Chairman of the board of the Medical College.

21. This agreement shall become effective on and shall continue unless and until terminated by either party by giving to the other one year's notice in writing to that effect.

22. This agreement contains the entire understanding between the parties and no alteration or modification hereof shall be effective except in a subsequent written instrument executed by both parties hereto.

23. This agreement shall be construed in accordance with the laws of the State of New York.

If the foregoing fully and correctly sets forth your understanding and is acceptable to you, kindly indicate by signing and returning the enclosed duplicate original.

Sincerely yours,

New York Medical College, Flower and Fifth Avenue Hospitals

By: _____
Title

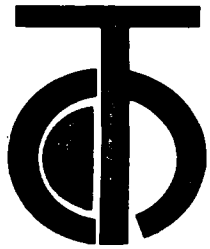
Executive Dean

Accepted and Agreed to:

The New Rochelle Hospital Medical Center

By: _____
Title

President



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: St. Luke's Hospital

Hospital Address: (Street) 2900 West Oklahoma Avenue

(City) Milwaukee (State) Wisconsin (Zip) 53215

(Area Code)/Telephone Number: (414) 647-6353

Name of Hospital's Chief Executive Officer: G. Edwin Howe

Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data (1978)

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	600	Admissions:	16,339
Average Daily Census:	449.3	Visits: Emergency Room:	45,506
Total Live Births:	-	Visits: Outpatient or Clinic:	42,308

B. Financial Data

Total Operating Expenses: $ 53,935,040

Total Payroll Expenses: $ 27,813,265

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 746,532
Supervising Faculty: $ 319,649

C. Staffing Data

Number of Personnel: Full-Time: 1863
Part-Time: 882

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 190
With Medical School Faculty Appointments: 68

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

General Surgery | Internal Medicine | | |

Family Practice | | | |

Does the hospital have a full-time salaried Director of Medical Education?: Yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	9	6	Required
Surgery	2	1	Elective
Ob-Gyn	--	--	--
Pediatrics	--	--	--
Family Practice	4	4	Elective
Psychiatry	--	--	--
Other: Radiology	2	2	Elective
Phys. Med. & Rehb.	1	--	--
Cardiology	3	3	Elective
Pulmonary	2	1	Elective

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	4	4	0	1975
Medicine	6	6	0	1978*
Surgery	10	6	4	1969
Ob-Gyn	--	--	--	--
Pediatrics	--	--	--	--
Family Practice	18	17	1	1973
Psychiatry	--	--	--	--
Other: Pathology	8	1	1	1960
Radiology	6	5	0	1960
Nuclear Med.	2	0	0	1974
Thoracic Surg.	1	1	0	1971*
Phy Med/Rehb	1	1	0	1971*
Cardiology	2	2	0	1972*
Otolaryngology	2	2	0	1971*

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

*Date St. Luke's Hospital began participation with the Medical College of Wisconsin.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

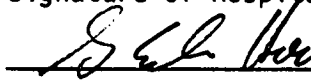
Name of Affiliated Medical School: Medical College of Wisconsin

Dean of Affiliated Medical School: Edward Lennon, M.D.

Information Submitted by: (Name) Mrs. Janet S. Schwarz

(Title) Executive Assistant to President

Signature of Hospital's Chief Executive Officer:



(Date) Feb 21, 1979

IV. SUPPLEMENTARY INFORMATION

St. Luke's Hospital is a JCAH accredited, not-for-profit, IRS 501(c)(3) hospital. With approved capacity of 600 beds, St. Luke's is the largest acute care hospital in the State of Wisconsin. Its major goal is as a community hospital serving the metropolitan Milwaukee area.

In addition to its community hospital services, the hospital acts as a community medical center for services such as Renal Dialysis, Radiation Therapy, and Emergency Medicine. The hospital has some regional medical center activities, and serves a major portion of the State of Wisconsin for open heart surgery, with approximately 1200 operations per year, and is a state-wide and national referral center for Hyperbaric Medicine.

The hospital is a member of the Milwaukee Regional Medical Center. The hospital sponsors graduate medical education, both by itself and in affiliation with the Medical College of Wisconsin. In addition to graduate medical education, the hospital is utilized for undergraduate medical education with the Medical College of Wisconsin, and nursing education experience in affiliation with Alverno College, University of Wisconsin-Milwaukee and Marquette University. The hospital participates with Mt. Mary College in providing dietetic education and is involved in several other allied health profession programs with the Milwaukee Area Technical College and some components of the State University system.

As the Medical College of Wisconsin expands its class size, St. Luke's Hospital will be playing an increasingly active role in providing clinical experience for both house staff and medical students.

February, 1979

THE MEDICAL COLLEGE OF WISCONSIN
8701 WATERTOWN PLANK ROAD
MILWAUKEE, WISCONSIN 53226

Office of the Dean
and Academic Vice-President
(414) 257-8213

Reply to: P. O. Box 26509
Milwaukee, Wisconsin 53226

February 22, 1979

Administrative Board
Council of Teaching Hospitals
Association of American Medical Colleges
Washington, D.C. 20036

Gentlemen:

St. Luke's Hospital and The Medical College of Wisconsin have been formally affiliated since June 23, 1971. The hospital plays an important role in the College's educational programs in Internal Medicine, Family Practice and Cardiothoracic Surgery. The hospital also offers residency rotations in Physical Medicine and Otolaryngology, and undergraduate student elective rotations in Preventive Medicine, Psychiatry and General Surgery. St. Luke's is, in addition, a component of the College's End-Stage Renal Disease Treatment Program.

I am pleased that St. Luke's Hospital seeks membership in the Council of Teaching Hospitals.

Sincerely yours,

Edward J. Lennon

Edward J. Lennon, M.D.
Dean

EJL:ch

AFFILIATION AGREEMENT BETWEEN THE MEDICAL COLLEGE OF WISCONSIN AND ST. LUKE'S HOSPITAL OF MILWAUKEE, WISCONSIN

This affiliation agreement between The Medical College of Wisconsin and St. Luke's Hospital of Milwaukee, Wisconsin is for the purpose of conducting joint programs in health care education, health related research and health service as hereinafter specified.

The affiliation agreement consists of two parts. Part I is a statement of general conditions which apply to the joint programs of the two institutions. Part II identifies specific joint programs which the two institutions agree to conduct.

The programs identified in Part II comprise all present joint activities of the two institutions. The institutions agree that new joint activities will be undertaken in accord with the terms of the affiliation agreement.

PART I

The affiliation agreement shall not prevent either institution from establishing other affiliations with hospitals or medical schools; but the two institutions now agree to notify each other when such new affiliations are made; and to review in the Joint Conference Committee described below whether the establishment of new affiliations on the part of either significantly affects the affiliation arrangements herein established. Either institution according to procedures herein set forth may, by mutual agreement, alter or may discontinue affiliation arrangements herein specified.

The Medical College presently has major and minor affiliation arrangements with several institutions.

A minor affiliation is one that provides components of teaching, research and/or patient care programs which are complementary to the broader programs conducted by the Medical College and major affiliates; or one that will provide field placement or collaborative research opportunities in association with the programs of the medical school. The nature and quality of the educational experiences available are the primary considerations in planning a minor affiliation for educational purposes.

A major affiliation is one in which the Medical College and the affiliated institution:

(i) Conduct major clerkships for undergraduate medical students in three or more of the following disciplines: Medicine, Surgery, Gynecology, Obstetrics, Pediatrics, or Psychiatry, and

(ii) Initiate and support programs of research in support of teaching programs.

The requirement that undergraduate teaching programs be conducted in multiple clinical disciplines shall not apply in the case of specialty hospitals (i.e. a psychiatric hospital) in which fewer than three of the principal services are normally operated.

Major affiliations in addition meet the following conditions:

(i) All members of the staff of each affiliated clinical discipline are members of the Faculty of the medical school appointed jointly by the hospital and the medical school.

(ii) All members of the teaching staff of each affiliated discipline hold teaching appointments in all other major affiliated hospitals providing undergraduate medical student education in the same discipline. Such appointments need not be at the same rank and may be at different ranks in different institutions.

(iii) At least one member of each affiliated discipline is a full time member of the medical school faculty, jointly appointed to the staff and to the faculty.

(iv) The senior full time faculty member is chief of the affiliated discipline and bears responsibility to the medical school to ensure excellence in all programs of teaching, research and patient care.

This affiliation agreement with St. Luke's Hospital is a minor affiliation agreement. The Medical College also has a minor affiliation agreement with the Curative Workshop of Milwaukee.

The Medical College has major affiliation agreements with the Milwaukee County General Hospital, the Milwaukee Children's Hospital, the Milwaukee Psychiatric Hospital and the Veterans' Administration Hospital.

St. Luke's Hospital has affiliation agreements with:

1. University of Wisconsin - Milwaukee

    a) Degree Nursing Program
    b) Graduate Nursing - Cardiac and Intensive Care
    c) Degree Medical Technology
    d) Speech Pathology

2. Alverno College

    a) Degree Nursing Program
    b) Degree Medical Technology Program

3. Wisconsin State University - Oshkosh

    a) Degree Medical Technology Program

4. Marquette University

    a) Speech Pathology
    b) Physical Therapy

5. Mount Mary College

    a) Dietetic students
    b) Occupational Therapy

6. Milwaukee Area Technical College

    a) Practical Nursing Program
    b) Operating Room Assistants
    c) Inhalation Therapy

7. University of Wisconsin

    a) Pharmacy Internships
    b) Clinical Affiliation - Physical Therapy
    c) Occupational Therapy

8. University of Minnesota

    a) Occupational Therapy
    b) Hospital Administration

9. Indiana University

    a) Occupational Therapy

10. College of Saint Catherine

    a) Occupational Therapy

11. Tufts University

    a) Occupational Therapy

12. Milwaukee School of Engineering

    a) Methods Engineering

13. Cardinal Stritch College

a) Dietetic Technician

14. Meharry Medical College

a) Cardiovascular Surgery - Elective (Med. Students)

St. Luke's Hospital is working in affiliation with Mount Mary College to develop a dietary internship.

The Departments of the Medical College have responsibility for the development of programs mutually satisfactory to the Medical College and to the hospitals affiliated with the Medical College with respect to the joint programs of the Medical College and the affiliated hospitals. The Medical College will discuss with all concerned affiliated institutions through common joint program committees of all involved institutions or other channels that are mutually satisfactory to the Medical College and the affiliated institutions all matters affecting affiliated programs. The assignment of personnel supported partly or fully by affiliated institutions to programs outside the supporting institution in all instances must be determined with full participation of the supporting institution in the planning discussions, and with the full involvement and complete approval of the administration of the supporting institution.

The Medical College of Wisconsin is a community member of the Medical Center of Southeastern Wisconsin and will conduct all of its health care education, research and service programs in accord with the policies and rules of the Medical Center Council. Such rules and policies of the Medical Center Council shall apply to the joint programs the medical school conducts with affiliated institutions.

Joint Conference Committee. The two institutions shall form a Joint Conference Committee. The purpose of the Joint Conference Committee shall be the review, development and recommendation of administrative policy for the conduct of joint programs. The Joint Conference Committee is not to be an operating administrative committee, nor an operative committee for the professional operation of joint programs. The Joint Conference Committee shall make its policy recommendations to the governing boards of the hospital and of the Medical College. All matters affecting joint program policy that require board cognizance shall be transmitted to the governing boards with the recommendations of the Joint Conference Committee.

The Joint Conference Committee shall consist of three representatives of each institution, of whom one shall be a member of the governing board, one a member of the administration and one a representative of the professional staff. Committee members shall be appointed annually by the governing board of the institution the

member represents. Persons with immediate and direct responsibility for the professional operation of joint programs of the two institutions shall not be members of the Joint Conference Committee but may be invited to attend meetings of the committee. It is agreed that professional staff members of the committee shall be persons whose experience and role in their respective institutions afford representations of the functions of the institutions in the broadest possible manner. The Joint Conference Committee shall seek the advice of appropriate department heads in each institution in developing recommendations.

The committee shall meet as it shall determine but not less than twice a year. The committee shall submit an annual report to the governing body of each institution.

Joint Appointment of Professional Personnel Engaged in Joint Programs. All physicians and other personnel with continuing responsibility for joint programs and who are identified by the Joint Conference Committee shall each hold appropriate appointments from the governing boards of both the hospital and the medical school made through usual institutional channels. If either governing body declines to appoint, an alternate candidate shall be named. Appointments to joint programs shall be maintained at the pleasure of the governing bodies of either institution, and shall be withdrawn at the request of either governing body. Withdrawal of joint appointments shall prevent the participation of persons concerned in joint programs of the hospital and the school but shall not prevent participation in other programs of the hospital or the school.

Persons may be appointed to joint programs as full time or as clinical faculty members. The chief of joint programs may be a full time or a clinical (non-full time) faculty member. The chief of a joint program shall be appointed with the approval of the head of the appropriate Medical College department. Persons to serve as chief of a joint program in an affiliated hospital may be nominated by the affiliated hospital.

Cost Sharing. The two institutions agree to examine jointly the costs of joint programs and to determine through the Joint Conference Committee mutually agreeable recommendations for the distribution of costs for education, research and service.

In general, in the case of full time professional persons with a joint appointment and giving the major portion of their professional effort to a joint program in an affiliated institution, salary and fringe benefit costs shall be shared equally between the two institutions, with the hospital's share being remitted to the medical school and the school making payment as the employer.

The hospital will bear the cost of office space, equipment and supplies and laboratory space for joint programs conducted in the hospital. The usual rules and policies of the hospital will apply to such spaces and supplies and equipment. In the case of secretaries and laboratory technicians and similar persons based at the hospital, the hospital shall be the employer and the school shall remit its share of salary and fringe benefit costs to the hospital.

Grants in Aid. All monies of every kind (intramural and extramural) supporting joint programs shall be used subject to policies developed by the Joint Conference Committee. All extramural grants in aid of joint programs will be submitted through the medical school department head of the principal investigator and in accord with medical school policies, and the Medical College shall be the responsible fiscal agent for extramural grants in aid. Extramural grant means a grant made by an agency external to the Medical College or the affiliated hospital such as the American Heart Association, W.R.M.P., the N.I.H. or a private foundation. Intramural funds are operating or endowment funds of the institution.

Termination of Agreement. The initial period of this agreement shall be for one year. The agreement is subject to annual renewal. Agreements for longer periods may be made by the respective governing bodies of the two institutions. Each institution agrees not to withdraw from the affiliation during the term agreed upon and to provide to the other at least six months' notice of intention not to renew at the expiration of term.

PART II

Joint Program in Thoracic Cardiovascular Surgery. The two institutions agree to conduct a joint program in the field of thoracic cardiovascular surgery for the education of medical students, house officers, fellows, nurses, technicians and other health care workers, for research in the field, and for service to patients.

The two institutions agree that teaching, research and service in thoracic cardiovascular surgery at St. Luke's Hospital will be carried on as a joint program of the two institutions as one of five medical school affiliated programs in thoracic cardiovascular surgery, the others being at the Veterans' Administration Hospital, the Milwaukee County General Hospital, the Milwaukee Children's Hospital and Deaconess Hospital. Both institutions recognize that members of the medical school department of Thoracic Cardiovascular Surgery are responsible to develop the programs in each of the five affiliated institutions, and that pediatric thoracic cardiovascular surgery shall be conducted by members of the medical school department primarily under the aegis of the Milwaukee Children's Hospital.

Other Joint Programs of The Medical College of Wisconsin and St. Luke's Hospital:

Physical Medicine - Residency Rotation
Otolaryngology - Residency Rotation
Preventive Medicine - Senior Elective
Introductory Psychiatry for 2nd Year Students.

In witness whereof, the parties to this agreement have caused this instrument to be executed by their respective officers on the 23rd day of June, 1971.

Signed By:

Louis Quarles

Mr. Louis Quarles
President of the Board
The Medical College of Wisconsin, Inc.

Merton E. Knisely

Mr. Merton E. Knisely
President of the Board
St. Luke's Hospital Association, Inc.

Gerald A. Kerrigan M.D.

Gerald A. Kerrigan, M.D.
Dean and Vice President
The Medical College of Wisconsin, Inc.

Robert E. Houston

Mr. Robert E. Houston
Secretary
St. Luke's Hospital Association, Inc.

AMENDMENT TO AFFILIATION AGREEMENT

BETWEEN

THE MEDICAL COLLEGE OF WISCONSIN

AND

ST. LUKE'S HOSPITAL OF MILWAUKEE, WISCONSIN

THIS AGREEMENT, made this 30th day of October, 1972, by and between The Medical College of Wisconsin, Inc. (hereinafter "College") and St. Luke's Hospital of Milwaukee, Wisconsin (hereinafter "Hospital"),

WITNESSETH:

WHEREAS, College and Hospital have entered an affiliation agreement dated June 23, 1971, which agreement calls for annual renewal thereof; and

WHEREAS, College and Hospital are desirous of continuing this agreement in full force and effect until such time as the parties thereto wish to cancel the same;

NOW, THEREFORE, in consideration of the mutual covenants herein exchanged, the parties agree as follows:

1. The second paragraph on page 6, part I, of the affiliation agreement shall be and the same hereby is amended to read as follows:

> "Termination of Agreement. It is agreed by the parties hereto that this agreement shall remain in full force and effect until such time as either College or Hospital desires to dissolve and terminate the agreement, either mutually or individually. Upon such decision to terminate, the party desiring to terminate shall give the other party 180 days' notice in writing

of the intention to so terminate, and upon the 180th day following the day upon which the notice is sent, this agreement shall terminate and be of no further force and effect."

2. In all other respects, the affiliation agreement is hereby affirmed by the parties hereto.

IN WITNESS WHEREOF, the parties to this agreement have caused this instrument to be executed by their respective officers acting pursuant to authority vested in them by their respective corporations on the day and year first above written.

THE MEDICAL COLLEGE OF
WISCONSIN, INC.

By: .....
Robert S. Stevenson, Chairman of the Board

By: .....
Gerald A. Kerrigan, M.D., Vice President

ATTEST:

.....
T. Michael Bolger, Assistant Secretary

ST. LUKE'S HOSPITAL ASSOCIATION, INC.

By: .....
President of the Board

By: .....
Secretary

October 30-74

Paragraph - Insert re St. Luke's Affiliation Agreement

The Walter Schroeder Professorship of Surgery. The hospital and the Medical College wish to take special note as a part of their affiliation agreement of the understanding of the two institutions about The Walter Schroeder Professorship of Surgery. This Chair of Surgery has been endowed by The Walter Schroeder Foundation by means of an endowment gift to St. Luke's Hospital. The Boards of Directors of the Medical College and St. Luke's Hospital have each acted to recognize and establish The Walter Schroeder Professorship of Surgery. It is agreed that the endowment funds for the support of this professorship shall be funds of St. Luke's Hospital, with the revenues therefrom being committed through the Joint Conference Committee between the Hospital and the Medical College for the support of The Walter Schroeder Professorship of Surgery. It is agreed that the person holding the professorship shall be identified jointly by the Hospital and the Medical College and appointed by the Board of Directors of the Hospital and by the Board of Directors of the Medical College upon nomination of the Joint Conference Committee of the two institutions. The provisions of the affiliation agreement between the Hospital and the Medical College shall be applicable to the professorship. The Walter Schroeder Professorship of Surgery shall be physically based at St. Luke's Hospital.

The terminology to identify the professorship shall be as follows:

The Walter Schroeder Professor of Surgery, St. Luke's Hospital - The Medical College of Wisconsin

Active Attending Surgeon, St. Luke's Hospital

Professor of Surgery (Associate Professor of Surgery, if appropriate), The Medical College of Wisconsin

GAK/ch

Program in Family Practice

The two institutions agree to conduct a joint program in Family Practice for the training of resident physicians. Medical students may be assigned to the program at a future time. Other health care personnel in training may be involved in the program in an incidental manner. The program shall also be a joint program for the provision of services to patients. The hospital shall be primarily responsible for patient services, and the Medical College for education.

The two institutions agree that faculty members responsible for instruction in this program shall be jointly appointed, according to the provisions of this agreement. The Program Director shall be Dr. John Palese. Appointment as Program Director is a joint administrative appointment. It is without term and is at the pleasure of the appointing institutions. It is also agreed that Dr. John Palese shall serve as the Acting Chairman of the MCW Department of Family Practice, an administrative appointment within the Medical College, also without term and at the pleasure of the Medical College. During the period of Dr. Palese's service as Acting Chairman, the Medical College will pay for 40% of Dr. Palese's salary and, in addition, will provide an administrative stipend of $3000 per annum.

The residents in training will be appointed to the training program by the St. Luke's Hospital with the recommendation of the Program Director and of the MCW Chairman of Family Practice. It is planned to expand the MCW residency training program to include residents appointed under accreditations to other hospitals. Arrangements with other hospitals acceptable to St. Luke's Hospital may be undertaken to develop and integrate a Family Practice training program to enrich residency training experiences by exchange rotations. The residents in training will be paid by St. Luke's Hospital.

It is agreed that all patients cared for in the joint Family Practice program will be considered to be patients of the teaching program unless in the judgment of the responsible attending physician for their own welfare they should not be involved in teaching circumstances.

St. Luke's Hospital
Milwaukee, Wisconsin

The two institutions agree to conduct a joint program in patient care, teaching, and research in the field of renal disease, hemodialysis, and renal transplantation. The medical program's supervision and direction will be in accordance with the basic affiliation agreement between the Medical College of Wisconsin and St. Luke's Hospital. Patient care programs will be directed at the best medical care available for all patients. The teaching programs will be directed at residents and practicing physicians but may also serve the educational needs of dialysis technicians and other allied health professions.

St. Luke's Hospital agrees to be an integrated and integral member of the Medical College of Wisconsin Renal Disease Program, and it is further agreed that all members of this program would be responsible for the development of standards of patient care, and conduct the dialysis programs generally, and when possible, reasonably, and for best patient care have renal transplantations conducted by the Medical College of Wisconsin, Department of Surgery, under the aegis of Milwaukee County General Hospital.

8/21/75

(Approved by Joint Conference Committee 10/15/75)

ADDENDUM TO AFFILIATION AGREEMENT BETWEEN THE MEDICAL COLLEGE OF WISCONSIN AND ST. LUKE'S HOSPITAL

The two institutions agree to conduct a joint program in Internal Medicine for undergraduate and graduate medical students. The program will be supervised by a fulltime faculty member based at St. Luke's Hospital, supported by other fulltime faculty members and by clinical faculty members who are on the Hospital Staff.

IMPLEMENTATION OF THIS PROGRAM APPROVED BY MCW-ST. LUKE'S HOSPITAL JOINT CONFERENCE COMMITTEE JULY 20, 1977

APPROVED BY MCW BOARD OF DIRECTORS/AUGUST 12, 1977

System for Hospital Uniform Reporting

Background

At its January meeting, the COTH Administrative Board voted to actively oppose efforts of the Health Care Financing Administration to implement its system for Hospital Uniform Reporting (SHUR). On January 23rd, HCFA published a Notice of Proposed Rulemaking which would initiate uniform hospital reporting for hospital costs, volume of services, and capital assets, see attachment A. While the Notice of Proposed Rulemaking did not include the SHUR Manual as a regulatory element, it did invite comments on the Manual which would be imposed as an administrative action.

Issues

The Ernst and Ernst statement opposing SHUR was distributed at the January Board meeting. The American Hospital Association's present strategy for opposing SHUR, attachment B, and the AHA's draft response to the Notice of Proposed Rulemaking, separate attachment, are included with this agenda.

The present staff plan is to prepare AAMC comments based on the AHA draft response. Board members are requested to review that draft response to determine (1) if any issues not raised by the AHA should be commented upon and (2) if the AAMC response should suggest technical improvements in addition to major conceptual criticisms.

[4110-35-M]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Care Financing Administration

[42 CFR Parts 402, 405 and 433]

UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Proposed rule.

SUMMARY: This proposal requires all hospitals participating in the Medicare or Medicaid program to report cost-related information in a prescribed uniform manner. It implements certain provisions of section 19 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Pub. L. 95-142). The purpose is to obtain comparable cost and related data on all participating hospitals for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning.

DATES: We will consider written comments or suggestions received by April 23, 1979.

ADDRESSES: Address comments to: Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare, Post Office Box 2382, Washington, D.C. 20013.

In commenting, please refer to File Code PCO-185-P. Comments will be available for public inspection in Room 5231 of the Department's offices at 330 C Street, SW., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 AM to 5:00 PM. (202-245-0950).

FOR FURTHER INFORMATION CONTACT:

Maurice Click, (301) 594-8544.

SUPPLEMENTARY INFORMATION:

STATUTORY BASIS

Section 19 of Pub. L. 95-142 (Section 1121 of the Social Security Act; 42 U.S.C. 1320(a)) requires the establishment of uniform reporting systems for providers participating in Medicare and Medicaid. The systems are to be established by October 24, 1978, for hospitals, skilled nursing facilities and intermediate care facilities; and by October 24, 1979, for home health agencies, health maintenance organizations, and other types of health serv-

ices facilities and organizations. The uniform reporting systems must provide information on (1) costs and volume of services; (2) rates; (3) capital assets; (4) discharge data; and (5) billing data.

Section 19 also requires (1) monitoring of the systems; (2) assistance with and support of demonstrations and evaluations of the systems; (3) encouragement to States to adopt the uniform systems for purposes in addition to Medicaid; (4) periodical revison to the systems to make them more effective and less costly; and (5) the provision of information obtained from the reports to appropriate agencies and organizations, including health planning agencies.

The law also requires:

1. Consideration of appropriate variations in applying the uniform systems to different classes of facilities; and

2. Making the system, to the extent practicable, consistent with systems already in effect under section 306(e)(1) of the Public Health Service Act.

Regulatory Implementation

HCFA will be phasing in the required reporting systems as they are developed. The reporting system covered by this proposed rule applies only to hospitals. Moreover, it applies only to those portions of the reporting system dealing with costs and volume of services and with capital assets. The remainder of the system, dealing with rates, discharge data and billing data, will be covered by a subsequent Notice of proposed Rulemaking.

This proposed regulation establishes a System for Hospital Uniform Reporting (SHUR). However, the proposed regulation does not set forth the details of SHUR. It merely sets forth the basic reporting requirements and the provisions for public disclosure of SHUR information. The details of the reporting requirements, including forms and instructions, are contained in the SHUR manual, which is also available for public comment.

Major Provisions

1. Reporting Requirements

This proposed rule would require all Medicare and Medicaid hospitals to report on the costs of their operation and the volume of their services, both in the aggregate and by functional accounts. It would also require them to report their capital assets.

In accordance with section 19, a hospital would be required to file SHUR reports for fiscal years that begin at least 6 months after the effective date of the regulation.

The hospital would be required to submit its report no later than 3 months following the close of its fiscal year. The hospital could, however, obtain a 30-day extension of its reporting deadline for good cause. Based on our previous experience, good cause would be found, for example, if a CPA could not complete his review or if the hospital had to replace lost or destroyed records.

These SHUR reports will incorporate and replace the present cost reports used by Medicare fiscal intermediaries to calculate reimbursement. Although the statute authorizes the reports to be submitted to the Secretary, we have concluded that since they are used by the fiscal intermediaries for cost settlement, they should be sent there directly. Hospitals participating in Medicare (including those participating in both Medicare and Medicaid) would submit the report to their regular fiscal intermediary, or the Medicare Division of Direct Reimbursement. Those hospitals participating only in Medicaid would submit the report to a fiscal intermediary designated by HCFA. We believe that having these Medicaid only reports collected by the fiscal intermediaries will facilitate the analysis and compilation of SHUR data.

2. Disclosure of SHUR Information

We are proposing that information contained in the uniform reports, that does not contain patient identifiers, be made available to health systems agencies, state health planning agencies, and upon request, to any other agency or organization. The decision to make this information available to any other agency or organization is predicated on the fact that section 1121(c) of the Act, which was added by Pub. Law 95-142, provides that we make the information available to "appropriate agencies and organizations," including State health planning agencies designated under section 1521 of the Public Health Act (42 U.S.C. 300m). We note, however, that State health planning agencies are required, by section 1522(b)(6)(C) of the Public Health Act, to make their records and data available upon request to the general public. Therefore, since we would be releasing the information to the State health planning agency, and since the public can obtain the information from the State health planning agency upon request, we propose to release the information directly to any requesting agency or organization. We are proposing to interpret "appropriate agencies and organizations" to mean any agency or organization that requests this information.

The issue of whether cost report data should be made available to the public has been the subject of litigation under the Freedom of Information Act. Our regulations, at 20 CFR 422.435, currently make hospital Medicare cost reports available to the general public upon request. Several courts have enjoined the release of these reports, based upon the Freedom of Information Act. However, these cases have been decided prior to the passage and implementation of section 1121(c). In our view, the implementation of section 1121(c) will form a basis for the Department to request that the courts reconsider their prior orders and to oppose successfully future suits.

The information covered by this proposed regulation would be provided by HCFA, or, as a matter of administrative convenience, directly by the fiscal intermediaries. When this regulation is amended to include further reporting requirements concerning rates of payment, discharge and bill data, we will review the question of disclosing that information and will solicit public comment. We would normally require an agency requesting information to pay for the cost of reproducing copies of the information.

The SHUR Manual

The draft SHUR manual sets forth the definitions, principles, and statistics to be used in preparing and submitting reports. It also contains a detailed, functional chart of accounts which must be used to reconcile a hospital's internal books and records in order to file the SHUR report. However, the chart of accounts would not be required as the hospital's day-to-day accounting system.

In order to avoid duplication, and to be consistent with section 1861(v)(1)(F), this draft manual would incorporate the current Federal cost report required for Medicare and Medicaid.

The manual contains special provisions for certain hospitals. We recognize that some hospitals, typically public hospitals, currently maintain a cash basis of accounting. The SHUR system, however, is based on an accrued basis of accounting. To give these hospitals time to convert to an accrual basis, they would be permitted to phase in the new reporting requirements over a 2-year period.

We are also concerned that the full reporting requirements of SHUR might be unnecessarily burdensome on small hospitals. Consequently, we would allow a less detailed report to be submitted by hospitals that, for the 3 accounting periods preceding the reporting period, have had average annual admissions of less than 4,000.

Regulatory Analysis

We have made every effort to minimize the cost and reporting burden associated with this proposed regulation. We estimate that the portion of implementation costs to be borne by the

hospital industry will be between $21 million and $45 million. the factors considered in calculating these estimates include: (1) The experience of States which have implemented systems similar to SHUR (based on their experience, we estimate that total implementation costs will range between $35 million and $75 million); and (2) that implementation and operational costs will be considered allowable costs and subject to reimbursement by all third party payors including Medicare and Medicaid. (For FY 1976, Federal programs covered approximately 40 percent of all hospital costs.) These estimates do not take into account any savings that might be realized as a result of combining new and existing requirements.

Nevertheless, because of the possibility that implementation costs may exceed present estimates, we are undertaking a study to establish more precisely the cost of implementing and operating the system. The study will also assess any additional reporting burden placed on the hospital by implementing the proposed system. The study will examine the hospitals' effort to meet existing requirements and the resultant change in burden effort to meet the SHUR requirements. Our staff has worked closely with American Hospital Association and the Blue Cross Association in structuring this study. We believe that it will provide an objective analysis of the cost and burden of complying with this proposed regulation. Based on the results of this study, the Department will decide if a regulatory analysis is needed.

Concurrent with this study and as an ongoing responsibility, HCFA will continue to examine the system and make changes, requiring only pertinent and necessary information to keep the costs and burden associated with the system to a minimum. We are particularly concerned about the extent to which SHUR would impose a new burden on providers. We specifically request suggestions on how to reduce burden in a manner consistent with the legislative requirements in the following areas:

- Level of detail
- Modification, consolidation, or elimination of specific reporting requirements or forms
- Eliminate requirements to directly assign such costs as fringe benefits
- Forms
- Forms design
- Alternatives to hard copy reporting
- Standard Units of Measure
- Modification or identification of alternate standard units of measure

We also welcome comments that identify potential omission or areas in which more detailed reporting is necessary to meet the intention of Pub. L. 95-142.

Prior to issuing final regulations, the proposed system will be evaluated on the basis of study results, HCFA's internal assessment and public comment. Changes will be made to SHUR which reduce burden to the degree possible, within the legislative mandate and the needs of the Department.

Opportunity to Comment

The draft SHUR manual was previously distributed to various hospital professional organizations and to selected State agencies for their views and suggestions. Copies of the draft manual are available for review and may be obtained by writing to:

Chief, Printing and Publications Branch, Division of Administrative Services, OMB, Health Care Financing Administration, DHEW, Room G-115 B, Mary E. Switzer Building, 330 C Street, S.W., Washington, D.C. 20201.

In order to assure that comments are fully considered, they should be submitted on or before April 23, 1979.

As further portions of this system are developed, we will provide a public notice that they are available for comment.

42 CFR Chapter IV is amended as set forth below:

1. The table of contents is amended to read as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER A—GENERAL PROVISIONS

SUBCHAPTER B—MEDICARE PROGRAMS

* * * * *

2. A new Part 402 is added, to read as follows:

PART 402—UNIFORM REPORTING SYSTEMS

Subpart A—Hospital Reporting

AUTHORITY: Secs. 1121, 1861(v)(1)(F), and 1902(a)(40) of the Social Security Act (42 U.S.C. 1320a, 1395x(v)(1)(F) and 1396a(a)(40)).

§ 402.1 Definitions.

"*Act*" means the Social Security Act.

"*HCFA*" means the Health Care Financing Administration.

§ 402.2 Statutory provisions.

(a) Section 1121(a) of the Act requires that the Secretary establish a uniform system for reporting of:

(1) Costs and volume of health care services;

(2) Rates charged for those services;

(3) Capital assets of health care facilities and organizations;

(4) Discharge data; and

(5) Billing data.

(b) Sections 1861(v)(1)(F) and 1902(a)(40) of the Act require Medicare and Medicaid providers to report in accordance with the system established under section 1121(a) of the Act.

§ 402.3 Applicability.

This subpart applies to all hospitals participating in the Medicare or Medicaid program.

§ 402.8 Reporting requirements.

The System for Hospital Uniform Reporting (SHUR), established by HCFA, requires hospitals to meet the following requirements:

(a) *Information to be reported.* Hospitals shall report: (1) Costs of operation and volume of services, both in aggregate and by functional accounts; and

(2) Capital assets.

(b) *Manner of reporting.* The hospital shall report in accordance with the forms and instructions prescribed by SHUR.

(c) *Timing and submission of reports.* (1) *Initial report.* The initial report under SHUR shall be for the hospital's first fiscal year that begins more than 6 months after the effective date of these regulations.

(2) *Submittal.* The hospital shall submit SHUR reports no later than the last day of the third month following the close of its fiscal year to:

(i) its Medicare intermediary (or the Medicare Division of Direct Reimbursement); or

(ii) if the hospital is participating only under Medicaid, to the Medicare intermediary designated by HCFA.

(3) *Extension.* The intermediary, after obtaining HCFA's approval, may, for good cause shown by the hospital, grant a 30-day extension for submitting the report.

§ 402.10 Availability of information.

HCFA or its agents will, in a timely manner, provide information collected under this subpart to:

(a) health systems agencies and State health planning and development agencies that need it to carry out their functions; and

(b) upon request, to any other agency or organization.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

3. Part 405, Subpart J, is amended by adding a new § 405.1050 to read as follows:

§ 405.1050 Conditions of participation: Uniform reporting.

The hospital complies with the requirements of Part 402, Subpart A, of this chapter, with respect to uniform reporting.

PART 433—STATE FISCAL ADMINISTRATION

4. Part 433 is amended by adding a new § 433.39 to read as follows:

§ 433.39 Uniform reporting: State plan requirements.

A State plan for medical assistance must provide that the State agency will require providers that are specified in Part 402 of this chapter to meet the applicable requirements of Part 402 with respect to uniform reporting.

(Secs. 1121, 1861(v)(1)(F) and 1902(a)(40) of the Social Security Act (42 U.S.C. 1320a, 1395x(v)(1)(F) and 1396a(a)(40)).
(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program; No. 13.773, Medicare-Hospital Insurance.)

Dated: September 25, 1978.

ROBERT A. DERZON,
Administrator, Health Care Financing Administration.

Approved: January 12, 1979.

HALE CHAMPION,
Acting Secretary.

[FR Doc. 79-2074 Filed 1-22-79; 8:45 am]

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-280-6000
TO CALL WRITER, PHONE 312-280-_____

February 5, 1979

TO: Annual Meeting Participants

SUBJECT: System for Hospital Uniform Reporting (SHUR)

In October 1977, Congress enacted section 19(a) of Public Law 95-142 which mandated hospitals report certain cost and statistical information in a uniform manner. Since then, staff of the Health Care Financing Administration's Office of Policy, Planning and Research (OPPR) has been working to develop the System for Hospital Uniform Reporting (SHUR).

The AHA has been continuously monitoring the OPPR's progress and has been involved in offering comments to draft proposals. The AHA still has serious problems with the SHUR and has expressed them to the HCFA.

On January 23, 1979, the HCFA published a notice of proposed rulemaking announcing the availability of the SHUR for public comment. The comment period extends for 90 days (until April 22, 1979) and we urge you to submit comments. The AHA is currently preparing its official response and we will have a completed draft on or about March 1, 1979. It will be made available to the membership.

Issues of Concern

There are four distinct issues relating to the SHUR. They are:

1. cost of implementing, adopting, and maintaining the system;
2. the use and users of reported data elements;
3. the redetermination of Medicare payment premised upon the SHUR; and,
4. the legality of the proposed SHUR manual in light of congressional intent.

Issue 1:

The AHA believes the cost of implementing and maintaining the system will be substantial. The HCFA contends that the average cost of initial implementation will approximate $3,000 to $10,000 per hospital. The AHA believes the cost could be as high as $100,000 per hospital.

As a result, the HCFA has signed a request for proposal (RFP) with the accounting firm of Morris, Davis & Company of Oakland, California, to conduct a demonstration project aimed at estimating the cost of implementing the SHUR system. The study is currently underway in 50 test site hospitals selected by HCFA.

We believe the preliminary results support our contention that cost of implementing the SHUR will be high. However, since ths study has not been completed and the results are only preliminary, no firm conclusion can be drawn at this time. Nevertheless, we believe it imperative that you estimate, as accurately as possible, the cost of implementing SHUR in your institution and express that in your response.

Issue 2:

With regard to the use and users of reported data elements, the SHUR manual is silent. The HCFA, in developing the SHUR, was more concerned about capturing all aspects of cost and statistical data rather than determining specific purposes of reported data. This results in the manual being extremely burdensome, costly and possibly ineffective, because the mechnanisms to deal with the data have not been developed.

Issue 3:

AHA perceives a potential and extremely severe problem if the SHUR manual forms are used as substitutes for the Medicare reporting forms. Interaction of a reimbursement system with a reporting system has serious implications. For example, reporting features may be different than Medicare payment features because Medicare does not pay for all hospital services and the more an institution has to reorganize its financial transactions to meet the functional classifications of the SHUR manual, the greater the effect on reimbursement. Such actions could be contrary to Medicare law and we are absolutely opposed to mixing reporting and reimbursement requirements.

Issue 4:

To a large extent, the SHUR manual represents efforts expended by the HCFA in developing a uniform accounting system under the authority of section 1533(d) of Public Law 93-641 (the planning law). Section 19(a) of Public Law 95-142 and its congressional intent, clearly indicate that section 19 mandates the establishment of only a uniform reporting system and not as the proposed SHUR, in reality is, a uniform accounting system.

Plan of Action

1. AHA will continue to work with HCFA, state associations and involved hospitals during the demonstration project to insure the validity of reported results. AHA will also communicate the results of the study as soon as possible to all concerned, including Congress.

2. AHA will distribute copies of its intended comments to the membership in sufficient time for use by them in preparing their own comments. All hospitals should submit written substantive comments to HCFA with copies of their comments to members of their congressional delegation.

3. Your contacts with members of Congress should:

   a. inform them that the proposed SHUR regulations would present serious problems and would impose substantial additional costs on hospital operations;

   b. advise them that they will receive copies of your responses sent to HEW concerning the proposed SHUR regulations; and

   c. request them to write the Secretary of HEW in support of the changes recommended in your responses to the proposed SHUR regulations.

4. Review of the SHUR manual and the proposed regulations already reveals fundamental problems should it be implemented in its present form. Among the priority changes that must be made are:

   a. Extension of the scheduled implementation date;

   b. Provision for implementation on an experimental, pilot basis to determine in actual operations the costs and benefits of these requirements, including an independent and impartial evaluation of the results:

   c. Recognition of the fact that SHUR was never intended to redetermine Medicare reimbursement; and

   d. Provision for congressional veto of the final rulemaking under the authority of Section 19(a) of P.L. 95-142.

If in the course of the HEW consideration of comments on these regulations it becomes evident that these changes will not be made, AHA should seek repeal or appropriate amendment of Section 19(a) of P.L. 95-142.

5. Since legal action may be necessitated if the above actions fail and SHUR is implemented without substantive revision, AHA staff has begun to identify potential areas for litigation and develop a protocal and strategy for itself and its membership to follow in order to expedite such litigation.

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Proposed Medicare Limitations for General Routine Operating Costs

Background

Section 223 of the 1972 Social Security Amendments, P.L. 92-603, authorized Medicare to impose limitations on the costs paid for services provided under the program's Part A coverage. Since 1974, Medicare has annually promulgated limitations on routine service costs based on a hospital's bed size, its geographic location, and the per capita income of its surrounding community. The AAMC has annually objected to this approach because it failed to recognize the intensity of the patient services provided by a hospital; because it failed to adjust for highly varying expenses, such as medical education costs; and because it has not included a workable and timely exceptions process. The Association also challenged the approach in court, but the suit was dismissed for lack of jurisdiction.

On March 1st, Medicare published a proposed schedule of limitations which differs significantly from past limitation schedules. The proposal, if finalized, would be effective for reporting periods beginning on or after July 1, 1979. The proposal is similar to the Talmadge approach and consistent with several past AAMC recommendations. The Notice of Proposed Rulemaking was distributed to all non-Federal COTH members with a cover memorandum summarizing changes in the methodology and several concerns resulting from these changes (see Attachment A).

Issue

While the proposed schedule contains several shortcomings which can be appropriately criticized in a comment letter, the general similarity of the approach to past Association comments and to the Association's position on the Talmadge bill suggests the AAMC would endorse the change in methodology. Such an endorsement should not be lightly provided. First, the proposed approach is sufficiently simple that it could be rapidly extended to other cost and revenue centers. Secondly, the proposed approach will give particular visibility to the excluded costs such as medical education. Therefore, the COTH Administrative Board needs to determine the basic policy framework within which the Association's response will be prepared.

Alternative Responses

1. Endorse the general approach with critical comments on the methodological shortcomings of the proposed schedule.

2. Condition Association support for the general approach upon adoption of a classification system for hospitals which groups hospitals according to the types of patients treated.

3. Oppose the general approach of the proposed schedule.

COTH General Membership Memorandum
No. #79-79
March 21, 1979
Subject: Proposed Medicare Limitations for General Routine Operating Costs

Section 223 of the 1972 Social Security Amendments authorized Medicare to impose limitations on the costs paid for services provided under the program's Part A coverage. Since 1974, Medicare has annually promulgated limitations on routine service costs based on a hospital's bed size, its geographic location, and the per capita income of its surrounding community. On March 1st, Medicare published a schedule of proposed limitations which differs significantly from the limitations proposed in prior years:

- The present limitation on inpatient routine service costs would be replaced by a limitation on general routine operating costs. To obtain general routine operating costs, capital and medical education costs are subtracted from the present inpatient routine service costs. The amounts subtracted would be those presently shown on line 46 of Medicare Worksheet B in column 2 (depreciation: buildings and fixtures), column 3 (depreciation: moveable equipment), column 18 (nursing school), and column 19 (intern and resident).

- The hospital classification system would be reduced from thirty-five categories to seven categories by deleting the variable of per capita income and using only bed size and rural/urban location.

- A wage index derived from service industry wages would be used to adjust the proportion of the limitations which represent wages paid.

- A "market basket" price index would be used to update historical data and to set projected ceilings. The market basket index is designed to measure and adjust for price changes in the goods and services purchased by hospitals.

A copy of the Federal Register announcement of the proposed limitations is attached. As proposed, the new limitations would be effective with cost reporting periods beginning on or after July 1, 1979.

While the AAMC staff believes the revised limitation is, in general, an improvement over the present method for setting the limits, we are seriously concerned about several parts of the proposal.

First, under the present limitation, the ceiling for a category is the 80th percentile plus 10% of the mean. At least in theory, this permits all hospitals to operate under the ceiling. By dropping the 10% add-on, a constant 20% of the hospitals in a category would be forced to have costs over the ceiling.

Second, while HCFA proposes to exclude capital and medical education costs because of their variability, they have not proposed exclusions for other highly varying costs such as malpractice coverage and energy costs.

Third, the adjustment for prevailing wage differences, based on service industry wages, fails to reflect the salary and wage patterns of nurses. For example, COTH hospitals in Washington, D.C. would have the wage portion of their limitation adjusted upward to 122.33% while those in Minneapolis would have theirs adjusted downward to 84.41%. It is unlikely that nursing wages paid in Minneapolis are only sixty percent (84.41/122.33) of those in the D.C. area.

Fourth, the use of only three bed size categories in non-SMSA areas (less than 100, 100-169, and over 169) could cause particular problems for hospitals such as the University of Virginia Hospitals and the University of Iowa Hospitals and Clinics.

Because of these deficiencies in the proposed limitation, you are urged to carefully review their potential impact on your hospital. If adopted, this approach to setting limitations is likely to establish a precedent for other cost and revenue centers. Therfore, you are also urged to comment on this approach and the proposed limitations. Comments -- which must be received on or before April 30, 1979 -- should be addressed to Administrator; Health Care Financing Administration; Department of Health, Education, and Welfare; P.O. Box 2372; Washington, D.C. 20013. Comments should refer to file code MAB-111-N.

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

[4110-35-M]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Health Care Financing Administration

MEDICARE PROGRAM

Proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or After July 1, 1979

AGENCY: Health Care Financing Administration (HCFA), HEW.

ACTION: Proposed Notice of Schedule of Limits on Hospital Inpatient General Routine Operating Costs.

SUMMARY: This notice sets forth a proposed schedule of limits on hospital inpatient general routine operating costs that may be reimbursed under Medicare for cost reporting periods beginning on or after July 1, 1979.

This is an annual update of the schedule and would replace the schedule published in the FEDERAL REGISTER on September 26, 1978 (43 FR 43558). It covers hospital inpatient general routine operating costs, and would apply to the entire cost reporting period of a hospital whose cost reporting period begins on or after July 1, 1979. It would not apply to the cost of special care units or ancillary services, to capital related costs, or to costs of medical education programs.

DATE: Consideration will be given to written comments or suggestions received on or before April 30, 1979.

ADDRESS: Address comments: Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare, P.O. Box 2372, Washington, D.C. 20013.

When commenting, please refer to file code MAB-111-N. Comments will be available for public inspection, beginning approximately 2 weeks after publication, in room 5231 of the Department's offices at 330 C Street, S.W., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (telephone 202-245-0950).

FOR FURTHER INFORMATION, CONTACT:

Carl Slutter, Health Care Financing Administration, Room 403 East Highrise Building, 6401 Security Boulevard, Baltimore, Maryland 21235, 301-594-9440.

SUPPLEMENTARY INFORMATION:

BACKGROUND

Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) as amended by section 223 (Limitation on Coverage of Costs) of Pub. L. 92-603, the Social Security Amendments of 1972, authorizes the Secretary to set prospective limits on the costs that are reimbursed under Medicare. Such limits may be applied to the direct or indirect overall costs or to costs incurred for specific items or services furnished by a Medicare provider, and may be based on estimates of the cost necessary in the efficient delivery of needed health services.

Regulations implementing this authority are set forth at 42 CFR 405.460. Under this authority, limits on hospital inpatient general routine service costs have been published annually since 1974. The schedule of limits set forth below includes several changes in the methodology used in establishing previous schedules of limits.

SUMMARY OF PROPOSED CHANGES

The proposed new schedule would be provide for:

1. Limits on hospital inpatient general routine operating costs. Unlike the current schedule, the proposed schedule would not include capital related costs or the cost of approved medical education programs.

2. A classification system based on whether a hospital is located within a Standard Metropolitan Statistical Area (SMSA) and on the basis of the hospital's bed size. In New England, New England County Metropolitan Areas (NECMA) are used to determine urban location. Area per capita income, which is presently used to account for general economic environment, would no longer be part of the classification system.

3. A wage index, developed from service industry wages, to adjust the wage portion of the limits to reflect differing wage levels among the areas in which hospitals are located.

4. A market basket index developed from the price of goods and services purchased by hospitals, to account for the impact of changing wage and price levels on hospital costs. This index would be used to adjust hospital cost data from the cost reporting periods represented in the data collection to the cost reporting periods to which the limits will apply.

5. Setting the limits at the 80th percentile of the comparison group. Previously, limits on inpatient general routine costs were set at the 80th percentile, plus 10 percent of the group median. The 10 percent tolerance is no longer necessary because of the improvements in the classification system.

DISCUSSION OF PROPOSED CHANGES

1. *Change from routine service costs to routine operating costs.* The current cost limits are based on, and applied to, inpatient general routine service costs (as defined in 42 CFR 405.452(d)(2), plus an inpatient routine nursing salary cost differential reflecting the fact that Medicare patients typicly require more extensive nursing services than other patients). Our proposed schedule would apply only to inpatient general routine operating costs. These operating costs are equal to the service costs (as defined above) minus captial-related costs and costs of medical education. Capital-related costs include interest, depreciation, insurance, rent and fixed asset related costs which are normally recorded in the depreciation accounts for Medicare reimbursement purposes. Costs of medical education are the costs normally recorded in the Intern and Resident and Nursing School accounts for Medicare reimbursement purposes.

This change is designed to achieve more homogenous cost groupings and a more refined schedule of limits. A large part of the difference in routine service costs among otherwise similar hospitals is attributable to capital related costs (which vary, among other reasons, because of the age of the physical plant) and to the existence and scope of medical education programs. However, our method of classification does not include consideration of these two factors. Therefore, hospitals that have been classified in the same grouping have disparate costs because of these two factors. We believe that removing these factors from the calculation of the cost limits is a better solution to this problem than making the classification scheme more complex.

2. *Deletion of area per capita income from classification system.* The current classification system is based on three factors—urban/non-urban location, bed size, and area per capita income. Analysis of the costs of operating hospitals shows that, for a given size of facility, it is more expensive to operate a hospital in an urban area than in a rural area. Therefore, this distinction has been retained as an element of the classsification system. Bed size has also been shown to correlate closely with services furnished by a facility. For this reason, the classification system will continue to use bed size as one criteria for grouping hospitals.

However, the use of per capita income, as an attempt to account for area differences in general economic environment, has been criticized as not being a valid indicator. As we discussed in the in the Schedule of Limits published on September 26, 1978, we have also been concerned about this and have explored various alternatives. However, until recently, we were not confident that uniform, reliable data was available for an alternative. We now believe that reliable data is available to support a wage adjustment in the calculation of cost limits (discussed in item 3, below) and that this treats otherwise similar hospitals more equitably than classifying them by area per captia income. Classifications by urban/rural location and bed size are set forth in Tables I and II below.

3. *Use of a wage index in calculating cost limits.* A third major factor in accounting for cost differences among otherwise similar hospitals is the variation in area wage levels. As noted above, we presently use area per capita income in classifying hospitals, in part as an adjustment for variations in wage levels. However, we now believe that our objective can be more directly and effectively achieved by using an area wage index in calculating the cost limits.

We propose to use an index developed from data supplied by the Bureau of Labor statistics to adjust, area by area, the portion of the cost limit attributable to wages. The data used would be that for the "service industry", a standard BLS reporting category that includes hospitals. In our view, because of the comparability between hospitals and the other types of employment covered under the service industry, it is reasonable to expect hospital costs to increase at approximately the same rate of increase for the service industry as a whole.

The wage index is based on data for the year 1977 and is the latest available data. Data for 1978 will not be available until late in 1979.

The index we propose to use was developed by computing the national SMSA (or NECMA) average wage for the service industry and dividing this average into the average service industry wage for each SMSA (or NECMA). The result is expressed as an index number, which is used to adjust the wage portion of the group limit. For non-SMSA areas, the index was developed by computing the national non-SMSA average wage for the service industry and dividing this average into the average service industry wage for all non-SMSA counties in a State. The index then applies to all non-SMSA counties in the State.

The wage portion of the group limit is determined by adding total costs for all hospitals in a group and dividing this total into the sum of all wages paid by hospitals in the group. The resulting percentage is multiplied by the group limit to determine the wage cost portion of the limit.

An example of how the wage index is used in adjusting the cost limits is set forth below and the wage indexes for urban and rural areas are set forth in Tables IIIA and IIIB.

4. *Use of a market basket index.* The present method for calculating cost limits uses an actuarial estimate of expected total increases in hospital routine costs to adjust for the effects of changing wage and price levels on these costs. This actuarial estimate is based, in part, on past experience with changes in hospital cost levels. We believe that the historical rate of increases in routine costs incorporated inefficient increases in the use of resources and therefore, has been excessive. Thus, we think this aggregate measure of increased costs should not be the basis for developing future cost limits. Instead, we propose to allow hospital routine operating costs to increase by an amount no greater than the average increase in the prices of the specific goods and services used by the hospital in furnishing routine care. This approach focuses any increase in the cost limits on the efficient utilization of resources. In order to do this, we have constructed what we call a "market basket" of goods and services typically used by a hospital and a "market basket index" for adjusting cost limits in accordance with increases in the costs of these goods and services. The market basket is

comprised of the most commonly used categories of hospital routine operating expenses. The categories we are using are based on those currently used by the American Hospital Association in its analysis of costs, by the U.S. Department of Commerce in publishing price indexes by industry, and by HCFA in its cost reports. A table listing the categories is set forth below.

The categories of expenses are then weighted according to the estimated proportion of hospital routine operating costs attributable to each category. These weights are based on surveys by the AHA, the Department of Commerce's input-output studies, and from our analysis of Medicare cost reports. Column 2 of the table set forth below specifies the weights for each category.

The next step in developing the market basket index is to obtain historical and projected rates of increase in the resource prices for each category. The table, in columns 3 and 4, identifies the price variables used in this process and the source of the forecast for the period August 1978 through December 1979. As more current data becomes available, we will update the forecasts. We are also reviewing whether and how to make retrospective adjustments in the cost limits if our forecasts turn out to be erroneous. Comments on that point are welcome.

[4110-35-C]

DERIVATION OF "MARKET BASKET" INDEX FOR ROUTINE INPATIENT HOSPITAL CARE

CATEGORY OF COSTS	ROUTINE COST WEIGHT (PERCENT) 1/	WAGE-PRICE PROXY VARIABLE USED	PRICE-WAGE FORECASTER FOR 1978 AND 1979
1. Wages and salaries	62.8	Average payroll expense per full time equivalent community hospital worker through 1978; Index of hourly earnings of service workers, Bureau of Labor Statistics, 1979 2/	HCFA currently, DRI 3/ beginning mid-March 1979
2. Fringe benefits-social security	4.7	Employer contributions for social insurance per worker in non-agricultural establishments	DRI
3. Fringe benefits-pensions	2.3	Same as cost category #1 above (wages and salaries)	HCFA currently, DRI beginning mid-March 1979
4. Fringe benefits-health insurance	1.2	Weighted average of American Hospital Association's cost per adjusted patient day (weight is .67) and per capita expenditures for physicians services (weight is .33)	HCFA
5. Fringe benefits-all other	1.0	All items consumer price index, all urban	DRI
6. Professional fees	0.6	Index of hourly earnings of production and non-supervisory workers, Bureau of Labor Statistics	DRI
7. Premiums for malpractice insurance	2.2	Historical time-series data on malpractice premiums, American Hospital Association	HCFA
8. Food	4.8	Food and beverages component of consumer price index, all urban	DRI
9. Fuel and other energy	2.6	Fuels and related products and power component of wholesale price index	DRI
10. Rubber and miscellaneous plastics	1.8	Rubber and plastic products component of wholesale price index	DRI
11. Business travel	1.6	Consumption of transportation services component of implicit price deflator	DRI
12. Apparel and textiles	1.6	Textile products and apparel component of wholesale price index	DRI
13. Business services	4.4	All services component of consumer price index, all urban	DRI
14. All other, miscellaneous, expenses	8.4	Commodities less food and beverages component of consumer price index, all urban	DRI
TOTAL:	100.0		

1/ The weights were derived from special studies by the Health Care Financing Administration using primarily 1977 data from the American Hospital Association and data from HCFA Medicare cost reports.

2/ For the period through 1977 average payroll expense per full time equivalent community hospital worker was taken from the American Hospital Association's annual survey as reported in Hospital Statistics (1978 edition). For 1978 the percent change in payroll expense per full time equivalent hospital worker was projected by HCFA using data reported in Hospitals magazine in the mid-month issues. For 1979 the percent change in the index of hourly earnings for service workers was projected by HCFA. Beginning in Spring 1979, Data Resources, Inc., 29 Hartwell Avenue, Lexington, Mass., will be forecasting the percent change in the index of hourly earnings for service workers.

3/ Data Resources, Inc., 29 Hartwell Avenue, Lexington, Massachusetts.

[4110-35-M]

5. *Setting the cost limits at the 80th percentile.* The current system sets limits on inpatient general routine service costs at the 80th percentile of the costs of the comparison group, plus 10 percent of the group median. These limits were set at this liberal level in recognition of the fact that the classification system did not fully take account of variations in hospital costs, due principally to the age of the facility, differences in teaching effort and area wage differentials. The change from the concept of limits on inpatient general routine service costs to limits on "routine operating costs" results in more homogeneous costs being subject to the limits. These more homogeneous costs, together with the direct adjustment of the wage portion of the group limit, justify a change in the level at which the limits will be set. We are therefore proposing that the limits be set at the 80th percentile of the costs of the group.

Our preliminary analysis of the impact of this proposed schedule of limits indicates that it may have a disparate effect on different regions of the country. We welcome suggestions on this point.

METHODOLOGY FOR DETERMINING PER DIEM ROUTINE OPERATING COST LIMIT

1. *Data.* The proposed limits have been determined by using actual hospital inpatient general routine operating costs data obtained from the latest Medicare cost reports available as of August 1, 1978. The cost data were then adjusted by means of the market basket index discussed above. These cost report data were projected from the midpoint of the cost report period used in the data collection to the midpoint of the first cost reporting period to which the limits will apply.

The percentage increases in the market basket over the previous year which were used for this projection are:

	Percent
1975	12.3669
1976	9.0877
1977	8.0085
1978	8.3171
1979	8.0381

2. *Group Basic Limit.* A basic limit was calculated for each group established in accordance with the hospitals urban/non-urban location and bed size. This limit, which is the 80th percentile of costs in the comparison group, was obtained by arraying the routine operating costs of all hospitals in the group in descending order and determining the 80th percentile of these costs.

3. *Adjusted Limit.* The basic limit has been divided into its wage and nonwage components on the basis of the ratio of total wages to total cost for all hospitals in the group. The wage component of the basic limit was adjusted, using a wage index developed from wage levels for service industry workers in the areas in which the hospitals are located. The adjusted limit which will apply to any hospital will be the sum of the nonwage component of the basic limit, plus the adjusted wage component.

EXAMPLE—CALCULATION OF ADJUSTED LIMIT

Limit from Schedule—$100.
Labor Portion—$60 (published in Tables I and II).
SMSA Wage Index—120.

COMPUTATION OF ADJUSTED LIMIT

$100−$60=$40 Non-labor Portion of Limit
$60×1.20 (wage index)=$72=Adjusted Labor Portion
$72+$40=$112 Adjusted limit for the SMSA Bed Size Group

The wage indices for each SMSA/NECMA and for the non-SMSA areas of each State are published in Table III.

4. *Adjustment for Cost Reporting Year.* If a hospital has a cost reporting period beginning on or after August 1, 1979, the published limit will be revised upward by a factor of .6916 percent for each elapsed month between July 1, 1979, and the month in which the hospital's cost reporting period starts. This factor is developed by dividing the projected increase in the market basket index by 12 and is used to account for inflation in costs which will occur after the date on which the limits become effective.

EXAMPLE

Hospital A's cost reporting period begins January 1, 1980.

The base group limit for hospital A's group is $90.

COMPUTATION OF REVISED GROUP LIMIT

Group Limit—$90.
Plus Adjustment for 6-month period.
6×.6916%=4.1497%.
104.1497%×$90=93.73.

Revised basic group limit applicable to hospital A for cost reporting period beginning January 1, 1980, $93.73.

This basic group limit will be divided into its labor and non-labor portions, using the percentage published in Tables I and II, and the labor portion will be adjusted by use of the wage index. The sum of the adjusted labor portion and the unadjusted non-labor portion will be the hospital's adjusted per diem routine operating cost limit.

If a hospital uses a cost report period which is not 12 months in duration, a special calculation of the adjustment factor must be made. This results from the fact that projections are computed to the midpoint of a cost reporting period and the factor of .6916 is based on an assumed 12 month reporting period. For cost reporting periods other than 12 months, the calculation must be done specifically for the midpoint of the cost reporting period. The hospital's intermediary will obtain this adjustment factor from HCFA.

SCHEDULE OF LIMITS

Under the authority of section 1861(v) of the Social Security Act, the following proposed group per diem limits would apply to hospital inpatient general routine operating cost (including the inpatient routine nursing salary differential) for cost reporting periods beginning on and after July 1, 1979. The adjusted limits (using the wage index published in Table III) would be computed by the fiscal intermediaries and each hospital would be notified of its applicable limit.

TABLE I.—*Group Limits for Hospitals Located in SMSA (NECMA)*

Bed size	Group limit	Labor portion	Percent labor portion
Less than 100	$123.19	$59.75	.485
100-404	122.94	62.21	.506
405-684	122.98	66.66	.542
685 and above	161.30	90.33	.560

TABLE II.—*Group Limits for Hospitals Located in nonSMSA (nonNECMA) Areas*

Bed size	Group limit	Labor portion	Percent labor portion
Less than 100	$96.61	$45.99	.476
100-169	96.63	47.64	.492
Over 169	95.47	48.79	.511

TABLE III A.—*Wage Index for Urban Areas*

SMSA	Index
Abilene, TX	.7559
Akron, OH	.9742
Albany, GA	.8224
Albany-Schenectady-Troy, NY	.9550
Albuquerque, NM	1.0481
Alexandria, LA	.7489
Allentown-Behtlehem-Easton, PA-NJ	.8416
Altoona, PA	.8502
Amarillo, TX	.7898
Anaheim-Santa Ana-Garden Grove, CA	1.0101
Anchorage, AK	1.7704
Anderson, IN	.7855
Ann Arbor, MI	1.0857
Anniston, AL	.7798
Appleton-Oshkosh, WI	.9212
Asheville, NC	.9093
Atlanta, GA	.9759
Atlantic City, NJ	.8049
Augusta, GA-SC	.8839
Austin, TX	.8504
Bakersfield, CA	.9121
Baltimore, MD	.9665

TABLE III A.—*Wage Index for Urban Areas*—Continued

SMSA	Index
Baton Rouge, LA	.9750
Battle Creek, MI	1.0044
Bay City, MI	1.0310
Beaumont-Port Arthur-Orange, TX	.8257
Billings, MT	.9075
Biloxi-Gulfport, MS	.8468
Binghamton, NY-PA	.8276
Birmingham, AL	.9251
Bloomington, IN	1.0658
Bloomington-Normal, IL	.8218
Boise City, ID	.9156
Boston-Lowell-Brockton-Lawrence-Haverhill, MA-NH	1.0141
Bradenton, FL	.8683
Bridgeport-Stamford-Norwalk-Danbury, CT	1.1298
Brownsville-Harlingen-San Benito, TX	.6988
Bryan-College Station, TX	.8758
Buffalo, NY	.8571
Burlington, NC	.7857
Canton, OH	.8630
Cedar Rapids, IA	.8151
Champaign-Urbana-Rantoul, IL	.9087
Charleston-North Charleston, SC	.8464
Charleston, WV	.9283
Charlotte-Gastonia, NC	.9046
Chattanooga, TN-GA	.8149
Chicago, IL	1.0979
Cincinnati, OH-KY-IN	.9563
Clarksville-Hopkinsville, TN-KY	.7542
Cleveland, OH	1.0232
Colorado Springs, CO	.8310
Columbia, MO	1.0303
Columbia, SC	.8596
Columbia, GA-AL	.7714
Columbus, OH	.9985
Corpus Christi, TX	.8026
Dallas-Fort Worth, TX	.9371
Davenport-Rock Island-Moline, IA-IL	.7533
Dayton, OH	.9837
Daytona Beach, FL	.8240
Decatur, IL	.8056
Denver-Boulder, CO	.9715
Des Moines, IA	.8855
Detroit, MI	1.1438
Dubuque, IA	.8023
Duluth-Superior, MN-WI	.8420
Eau Claire, WI	.9476
El Paso, TX	.7724
Elmira, NY	.7930
Erie, PA	.8518
Eugene-Springfield, OR	.9753
Evansville, IN-KY	.8336
Fargo-Moorhead, ND-MN	.8720
Fayetteville, NC	.8083
Fayetteville-Springdale, AR	.7981
Flint, MI	1.0678
Florence, AL	1.0039
Fort Collins, CO	.8553
Fort Lauderdale-Hollywood, FL	1.0810
Fort Myers, FL	.8779
Fort Smith, AR-OK	.8052
Fort Wayne, IN	.8115
Fresno, CA	.8673
Gadsden, AL	.8053
Gainesville, FL	.9670
Galveston-Texas City, TX	1.0808
Gary-Hammond-East Chicago, IN	.8062
Grand Forks, ND-MN	.8665
Grand Rapids, MI	.8097
Great Falls, MT	.9034
Greeley, CO	.8428
Green Bay, WI	.8967
Greensboro-Winston-Salem-High Point, NC	.8729
Greenville-Spartanburg, SC	.9082
Hamilton-Middletown, OH	.9748
Harrisburg, PA	.9240
Hartford-New Britain-Bristol, CT	.9285
Honolulu, HI	.9120
Houston, TX	1.0404
Huntington-Ashland, WV-KY-OH	.8520
Huntsville, AL	.9635
Indianapolis, IN	.9052
Jackson, MI	1.0383
Jackson, MS	.8793
Jacksonville, FL	.9034
Jersey City, NJ	.9516
Johnson City-Kingsport-Bristol, TN-VA	.8683
Johnstown, PA	.8846
Kalamazoo-Portage, MI	.9728
Kankakee, IL	.7169
Kansas City, MO-KS	.9220
Kenosha, WI	.8854
Killeen-Temple, TX	.8520
Knoxville, TN	.7916
Kokomo, IN	.8114
La Crosse, WI	.9461
Lafayette, LA	1.0175
Lafayette-West Lafayette, IN	1.0446
Lakes Charles, LA	.8265
Lakeland-Winter Haven, FL	.8174
Lancaster, PA	.7927
Lansing-East Lansing, MI	1.0212
Laredo, TX	.6532
Las Vegas, NV	1.0793
Lawrence, KS	1.0441
Lawton, OK	.6948
Lewiston-Auburn, ME	.7622
Lexington-Fayette, KY	.9446
Lima, OH	.8311
Lincoln, NE	.7449
Little Rock-North Little Rock, AR	.9181
Long Branch-Asbury Park, NJ	1.0838
Longview, TX	.7353
Lorain-Elyria, OH	.9117
Los Angeles-Long Beach, CA	1.1442
Louisville, KY-IN	.8242
Lubbock, TX	.7523
Lynchburg, VA	.7893
Macon, GA	.7806
Madison, WI	1.0658
Manchester-Nashua, NH	.7704
Mansfield, OH	.8471
McAllen-Pharr-Edinburg, TX	.7461
Melbourne-Titusville-Cocoa, FL	1.0946
Memphis, TN-AR-MS	.9055
Miami, FL	1.1009
Midland, TX	.8377
Milwaukee, WI	.9970
Minneapolis-St. Paul, MN-WI	.8441
Mobile, AL	.7987
Modesto, CA	.8796
Monroe, LA	.8512
Montgomery, AL	.8403
Muncie, IN	.9429
Muskegon-North Shores-Muskegon Heights, MI	.0065
Nashville-Davidson, TN	.8783
Nassau-Suffolk, NY	1.0338
New Bedford-Fall River, MA	.7909
New Brunswick-Perth Amboy-Sayreville, NJ	1.0730
New Haven-Waterbury-Meriden, CT	.0417
New London-Norwich, CT	.8878
New Orleans, LA	.8900
New York, NY-NJ	1.2086
Newark, NJ	1.1663
Newport News-Hampton, VA	.8537
Norfolk-Virginia Beach-Portsmouth, VA-NC	.8542
Northeast Pennsylvania, PA	.8598
Odessa, TX	.9752
Oklahoma City, OK	.8904
Omaha, NE-IA	.8888
Orlando, FL	.8690
Owensboro, KY	.7394
Oxnard-Simi Valley-Ventura, CA	.9923
Panama City, FL	.7320
Parkersburg-Marietta, WV-OH	.7794
Pascagoula-Moss Point, MS	.7954
Paterson-Clifton-Passaic, NJ	1.0070
Pensacola, FL	.8461
Peoria, IL	.9152
Petersburg-Colonial Heights-Hopewell, VA	.7886
Philadelphia, PA-NJ	1.0175
Phoenix, AZ	.9320
Pine Bluff, AR	.8387
Pittsburgh, PA	.9970
Pittsfield, MA	.7645
Portland, ME	.8198
Portland, OR—WA	.9903
Poughkeepsie, NY	.9211
Providence-Warwick-Pawtucket, RI	.8324
Provo-Orem, UT	.9816
Pueblo, CO	.8720
Racine, WI	.9439
Raleigh-Durham, NC	.9989
Reading, PA	.9500
Reno, NV	.9568
Richland-Kennewick, WA	1.3653
Richmond, VA	.8060
Riverside-San Bernardino-Ontario, CA	.8499
Roanoke, VA	.7368
Rochester, MN	1.0714
Rochester, NY	.9298
Rockford, IL	.8617
Sacramento, CA	.9664
Saginaw, MI	1.0666
St. Cloud, MN	.7772
St. Joseph, MO	.7785
St. Louis, MO-IL	.8734
Salem, OR	.9315
Salinas-Seaside-Monterey, CA	.8420
Salt Lake City-Ogden, UT	.8727
San Angelo, TX	.7260
San Antonio, TX	.9274
San Diego, CA	.9598
San Francisco-Oakland, CA	1.1055
San Jose, CA	1.1245
Santa Barbara-Santa Maria-Lompoc, CA	1.0012
Santa Cruz, CA	.7777
Santa Rosa, CA	.9172
Sarasota, FL	.9377
Savannah, GA	.8912
Seattle-Everett, WA	1.0421
Sherman-Denison, TX	.7631
Shreveport, LA	.8317
Sioux City, IA-NE	.7653
Sioux Falls, SD	.7849
South Bend, IN	.7881
Spokane, WA	.9020
Springfield, IL	.8404
Springfield, MO	.8363
Springfield, OH	.8460
Springfield-Chicopee-Holyoke, MA	.8850
Steubenville-Weirton, OH-WV	.8369
Stockton, CA	.9115
Syracuse, NY	.9333
Tacoma, WA	.8922
Tallahassee, FL	.9038
Tampa-St. Petersburg, FL	.9101
Terre Haute, IN	.8011
Texarkana, TX-Texarkana, AR	.7598
Toledo, OH-MI	.9936
Topeka, KS	.8904
Trenton, NJ	1.0810
Tucson, AZ	.8892
Tulsa, OK	.9445
Tuscaloosa, AL	.9002
Tyler, TX	.8757
Utica-Rome, NY	.7914
Vallejo-Fairfield-Napa, CA	.9829
Vineland-Millville-Bridgeton, NJ	.8606
Waco, TX	.8454
Washington, DC-MD-WA	1.2233
Waterloo-Cedar Falls, IA	.8668
West Palm Beach-Boca Raton, FL	.9669
Wheeling, WV-OH	.8078
Wichita, KS	.9092
Wichita Falls, TX	.7143
Williamsport, PA	.8109
Wilmington, DE-JN-MD	.8864
Wilmington, NC	.8340
Worcester-Fitchburg-Leominster, MA	.8074
Yakima, WA	.8275
York, PA	.7633
Youngstown-Warren, OH	.9222

TABLE III B.—*Wage Index for Rural Areas*

State	Index
Alabama	1.1085
Alaska	2.0477
Arizona	.9757
Arkansas	.8865
California	1.0310
Colorado	.9443

TABLE III B.—*Wage Index for Rural Areas*—Continued

State	Index
Connecticut	1.0736
Delaware	1.0483
Florida	1.0226
Georgia	1.0082
Hawaii	.9781
Idaho	1.1509
Illinois	.8257
Indiana	.9112
Iowa	.9583
Kansas	.9309
Kentucky	.9683
Lousiana	1.0592
Maine	.9476
Maryland	.9856
Massachusetts	.9704
Michigan	1.1298
Minnesota	.7740
Mississippi	.9904
Missouri	.8754
Montana	1.0581
Nebraska	.8087
Nevada	1.2869
New Hampshire	.9531
New Jersey	1.0024
New Mexico	1.0318
New York	1.0244
North Carolina	.9599
North Dakota	.9332
Ohio	1.0486
Oklahoma	.8933
Oregon	1.1500
Pennsylvania	1.1025
Rhode Island	.9183
South Carolina	.9116
South Dakota	.8907
Tennessee	.9736
Texas	.8416
Utah	.8675
Vermont	.9717
Virginia	1.0337
Washington	1.0900
West Virginia	1.0825
Wisconsin	1.0362
Wyoming	1.0136

(Secs. 1102, 1814(b), 1861(v)(1), 1866(a), and 1871 of the Social Security Act; 42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a) and 1395hh.)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance.)

Dated: February 26, 1979.

LEONARD D. SCHAEFFER,
Administrator, Health Care Financing Administration.

Approved: February 26, 1979.

HALE CHAMPION,
Acting Secretary.

[FR Doc. 79-6233 Filed 2-28-79; 8:45 am]

[4110-83-M]

Public Health Service

GRADUATE PROGRAMS IN HEALTH ADMINISTRATION

Application Announcement for Grants for Traineeships

The Bureau of Health Manpower, Health Resources Administration, announces that applications for fiscal year 1979 grants for traineeships for graduate programs in health administration are now being accepted under the authority of section 749 of the Public Health Service Act as amended.

Section 749 authorizes grants to public or nonprofit private educational entities (excluding schools of public health) with accredited programs in health administration, hospital administration, or health policy analysis and planning.

Of the amount received by a grantee, at least 80 percent shall go to students with previous post-baccalaureate degrees or 3 years' work experience in health services. Traineeships may include the payment of stipends, tuition, and fees.

Approximately $2 million is expected to be available in FY 1979 for grants.

Requests for application materials and questions regarding grants policy should be directed to:

Grants Management Officer, Bureau of Health Manpower, Health Resources Administration, Center Building, room 4-22, 3700 East-West Highway, Hyattsville, Maryland 20782, Phone: (301) 436-7360.

To be considered for fiscal year 1979 funding, applications must be received by the Grants Management Officer, Bureau of Health Manpower, Health Resources Administration, at the above address no later than March 15, 1979.

Should additional programmatic information be required, please contact:

Education Development Branch, Division of Associated Health Professions, Bureau of Health Manpower, Health Resources Administration, Center Building, room 5-27, 3700 East-West Highway, Hyattsville, Maryland 20782, Phone: (301) 436-6800.

Dated: February 16, 1979.

HENRY A. FOLEY, PH. D.,
Administrator.

[FR Doc. 79-5953 filed 2-28-79; 8:45 am]

[4110-83-M]

STUDENTS IN SCHOOLS OF PUBLIC HEALTH

Application Announcement for Grants for Traineeships

The Bureau of Health Manpower, Health Resources Administration, announces that applications for fiscal year 1979 grants for traineeships for students in schools of public health are now being accepted under the authority of section 748 of the Public Health Service Act as amended.

Grants will be awarded to accredited schools of public health for traineeships for their students. Traineeships may include the payment of stipends, tuition, and fees. Of the amount received by a grantee in fiscal year 1979, at least 55 percent shall go to students with previous post-baccalaureate degrees or 3 years' work experience in health services and who are pursuing a course of study in:

(1) Biostatistics or epidemiology;

(2) Health administrtion, health planning, or health policy analysis and planning;

(3) Environmental or occupational health;

(4) Dietetics or nutrition; or

(5) Preventive medicine or dentistry.

Approximately $6.2 million is expected to be available in FY 1979 for grants.

Requests for application materials and questions regarding grants policy should be directed to:

Grants Management Officer, Bureau of Health Manpower, Health Resources Administration, Center Building, room 4-27, 3700 East-West Highway, Hyattsville, Md. 20782, Phone: (301) 436-7360.

To be considered for fiscal year 1979 funding, applications must be received by the Grants Management Officer, Bureau of Health Manpower, Health Resources Administration, at the above address no later than March 15, 1979.

Should additional programmatic information be required, please contact:

Education Development Branch, Division of Associated Health Professions, Bureau of Health Manpower, Health Resources Administration, Center Building, room 5-27, 3700 East-West Highway, Hyattsville, Maryland 20782, Phone: (301) 436-6800.

Dated: February 16, 1979.

HENRY A. FOLEY, PH.D.,
Administrator.

[FR Doc. 79-5954 Filed 2-28-79; 8:45 am]

[4310-02-M]

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

TUSCOLA UNITED CHEROKEE TRIBE

Receipt of Petition for Federal Acknowledgment of Existence as an Indian Tribe

FEBRUARY 22, 1979.

This notice is published in the exercise of authority delegated by the Secretary of the Interior to the Assistant Secretary—Indian Affairs by 230 DM 2.

Pursuant to 25 CFR 54.8(a) notice is hereby given that the

Tuscola United Cherokee Tribe of Florida and Alabama, Inc.
c/o Mr. H. A. Rhoden
Post Office Box S
Geneva, Florida 32732

has filed a petition for acknowledgment by the Secretary of the Interior that the group exists as an Indian tribe. The petition was received by the Bureau of Indian Affairs on January 19, 1979. The petition was forwarded

AMERICAN HOSPITAL ASSOCIATION
701 Grove Road Greenville, South Carolina 29605 PHONE 803-242-8569

February 26, 1979

Richard M. Knapp, PhD
Director, COTH
One DuPont Circle, N. W.
Washington, D. C. 20036

Dear Dick:

As you are aware PL 93-641 encourages hospitals to develop programs which generally fall under the rubric of "Levels of Care". The COTH is comprised of institutions providing the most sophisticated and complicated care available to the people of this country. They represent the tertiary level of medical and institutional care.

As a Center for Multi-Hospital Systems and Shared Services Organizations, I am interested in developing Systems which would maximize the potential of each institution to become part of a "levels of care" process. At the same time, I am interested in maximizing the cost effectiveness of each institution and the institutional system as a whole.

It would appear to me that the COTH has the opportunity to develop a "system" thrust as a consortium as well as their current thrust in the area of medical education. I am constantly aware, in my new position, of the attempts within the hospital facet of the health care industry at restructuring to meet the problems of cost, power, leverage, independence and quality of care. I would like to have some of our Advisory Panel members meet with some of the COTH leaders to evaluate the current situation and to determine if there is the need or desire to give this situation further study.

I will look forward to hearing from you in the near future. With best personal regards.

Sincerely,

Robert E. Toomey
Consulting Director
Center for Multi-Hospital Systems
and Shared Services Organizations

CABLE ADDRESS AMHOSP

aamc association of american medical colleges

STATEMENT BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ON S. 505 AND S. 570

March 14, 1979

Mr. Chairman and Members of the Subcommittee:

I am David D. Thompson, M.D., Director of the New York Hospital and a member of the Council of Teaching Hospitals of the Association of American Medical Colleges. This morning I am accompanied by John A. D. Cooper, M.D., President of the Association and James D. Bentley, Ph.D., Assistant Director of the Association's Department of Teaching Hospitals.

The Association represents 400 of the nation's major teaching hospitals, all of the nation's medical schools, and sixty academic societies. Thus, the hospital cost containment and Medicare reforms being considered today are of vital interest to the Association's members.

The Administration's Proposal

In spite of the glowing characterization which the Secretary gave yesterday to the Administration's cost containment proposal, the Association is opposed to S. 570. In addition to the conflict of singling out one specialized industry for mandatory controls in a highly inflationary economy for which the President is advocating voluntary controls, the Administration's proposal has several inherent defects:

- First, it is an extremely general legislative proposal which provides the Secretary with overly broad policy and administrative powers. For example, the bill does not include provisions which the Secretary must follow in making volume adjustments, granting exceptions, or calculating adjustments for special circumstances. In another instance, the exception

for hospitals in states with rate or budget review programs, conditions approval of the program on "such other conditions as he (the Secretary) may establish." These are but two examples of the unrestrained authority sought by the authors of S. 570.

- Second, while I have read in the newspapers that the Secretary believes a staff of one hundred can administer the proposal, I seriously doubt that estimate. Extensive data gathering and analyses will be required, and these tasks must be done for the controlled hospitals and the exempted hospitals. Moreover, if only a quarter of the hospitals which HEW estimates will be subject to the controls submit exceptions, Federal authorities will have to analyze and review an estimated 620 exception requests.

- Third, the modified wage pass through is a logically inconsistent provision for a cost containment bill in a labor intensive industry. It is difficult to see how costs will be controlled if non-supervisory workers feel the hospital can increase their wages with no real penalty.

- Fourth, while the proposal does provide an explicit 1% increase for service and program improvements, this is an amount far below the historical average and will not provide adequate revenues for obtaining and introducing new technologies.

- Fifth, the Economic Stabilization Program demonstrated that some hospitals will respond to economic controls by reducing their most expensive case load. While S. 570 includes an "antidumping" provision, the provision is meaningless. The hospital receiving the expensive patients does not have the records necessary to demonstrate that its competitor is shunning

expensive patients, and the Secretary is unlikely to penalize a hospital by withdrawing its participation in Medicare.

- Lastly, no one should be deceived into believing that S. 570 combines a voluntary cost containment program with a mandatory program. Both cost containment sections are mandatory because the Secretary sets the limits on each. There is a truly voluntary program that is working now, The Voluntary Effort, and that program should continue to demonstrate the responsiveness of social institutions in a free market economy.

Mr. Chairman, in contrast to the Administration's nonspecific bill to provide the Secretary with a broad license to reduce hospital revenues, this Subcommittee continues to develop a thoughtful, careful, and non-precipitious proposal which will moderate hospital costs by redefining an institution's self-interest. The Association expresses its continued appreciation to the Chairman, Subcommittee members, and staff for their willingness to incorporate suggestions made at last year's hearings on this legislation and for their willingness to discuss underlying concepts and prospective provisions for the bill. We believe S. 505 is an improvement over its predecessor and offer our comments as constructive efforts to further refine it.

In the interest of brevity, I will restrict my comments on the Medicare Reform Act to issues of particular importance to the tertiary care and teaching hospitals of this nation.

First, the Association appreciates the flexibility that is being provided for classifying hospitals. In this area, that state-of-the-art is rudamentary and the combination of flexible legislation and a Health Facilities Cost Commission should provide for the necessary evolution of applied knowledge in this area. We are particularly pleased by the flexibility provided for the category for the

primary affiliates of accredited medical schools. Across four years, Association staff have worked with Subcommittee staff to develop more precise legislative language. Unfortunately, our efforts were unsuccessful. In this situation, the AAMC appreciates the Subcommittee's willingness to recognize the complexity of the problem of classifying tertiary care/teaching hospitals. If the present language of S. 505 is supported by last year's Committee Report language, we believe the Health Facilities Cost Commission will have an appropriate balance of guidance and flexibility.

Second, while the Association appreciates the provisions which would adjust a hospital's ceiling to reflect service intensity resulting from an atypcial case mix or a shorter than average length of patient stay, an additional type of case mix adjustment merits consideration. Regionalization of hospital services is beginning to stratify hospitals by case complexity. As the more expensive and complex cases are concentrated, costs for tertiary care hospitals will increase greater than hospital costs generally. Where a classification and comparison scheme uses past data to set reimbursement limits, some mechanism is needed to increase the historically generated limit to reflect this growing concentration of high cost patients.

Third, as a hospital director in a state with an agressive rate setting authority, I am concerned to see that S. 505 allows these programs to continue without establishing specific Federal guidelines. I must say, however, that the Association's membership is not of one mind on this issue and several distinct attitudes seem to be present. In some areas, where the rate agency is independent of the third party payors and is required to see that rates meet the legitimate cost of necessary hospitals, state rate review is endorsed as an appropriate governmental or quasi-governmental function. In other states, however, where the rate agency functions to help Medicaid agencies

live within available state resources, state rate review is opposed by the hospitals as simply shifting the burden of inadequate revenue. In the remaining states, where rate review is presently absent, hospital executives seem to evaluate state rate review according to their expectation of the reasonableness of state vis-a-vis Federal controls. In any case, it should be recognized by this Subcommittee that adoption of S. 505 will stimulate each state to evaluate the state rate review approach as an alternative to the comparative approach you have constructed over the past four years.

Finally, the Association would like to add a word of caution about the direction of hospital cost limitations. The Association recognizes the use of limitations based on comparisons of essentially similar hospitals as one legitimate approach to containing hospital costs. If the program becomes operational, the system of comparing cost centers to determine "reasonableness" could be expanded to include all or some ancillary service departments. From the perspective of regulatory complexity, and more importantly to us, from the standpoint of institutional management there is a question of how far one might wish to go in this regard. The deeper one gets into comparing specific revenue center and/or ancillary service departments, the more peculiarities of institutional characteristics become important to recognize, but difficult to quantitatively define. Also, I believe that one result of such an approach would be to fractionalize the management of the hospital. A hospital is a very complex institution whose many facets need to be carefully coordinated to serve the needs of patients and to accomplish effective cost containment. A hospital control system which establishes many intra-institutional ceilings threatens to undermine this coordination.

Mr. Chairman, we appreciate the opportunity to appear before this Subcommittee. In our formal comments, in addition to commenting on S. 505 and S. 570, we have commented on three of your staff's March 1st proposal. I would be pleased to comment on these issues or to answer any questions that you may have.

aamc association of american medical colleges

Testimony Submitted on S. 505 and S. 570
by the
Association of American Medical Colleges
to the
Subcommittee on Health
Committee on Finance
U.S. Senate

March 13, 1979

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the Hospital Cost Containment Act of 1979, S. 570 and the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979, S. 505. 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 hospital and physician reimbursement provisions in the proposed legislation are of direct interest and vital concern to the Association's members. In addition to commenting on S. 505 and and S. 570, the Association would like to respond briefly to several alternatives that Finance Committee staff have developed to reduce federal expenditures for health services.

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HOSPITAL COST CONTAINMENT ACT OF 1979

When the AAMC requested an opportunity to testify before this Subcommittee, it was assumed that the Administration's hospital cost containment legislation would be publicly available by mid-February. Unfortunately, the Association did not recieve a copy of that proposal until Tuesday, March 6th. Because the Administration's proposal is very complex and intricate, the AAMC has not completed its analysis of S. 570 and Association comments at this hearing are quite general in character. The Association hopes the Subcommittee will hold additional, detailed hearings on S. 570 at a later time so that the AAMC and other witnesses will have an opportunity to prepare a more extensive comment on the President's proposal.

In broad perspective, the AAMC is opposed to the Administration's proposal. First, while the proposal is written in elaborate detail in some areas, the proposal provides the Secretary with too much discretion. For example, Section 7(C)(1) describes volume adjustments, exceptions, and adjustments for special circumstances as follows:

> The Secretary may make further additions to, or subtractions from, the percentage determined with respect to a hospital's accounting period under the preceding subsections to allow for -- (A) changes in admissions, or (B) such other factors as the Secretary may find warrant special consideration.

If the Administration's proposal is to provide a fair and equitable control system, adjustments to accommodate particular individual situations are crucial. Public policy for these exceptions should not be left solely to the Secretary. Congress would be abdicating its legislative responsibility if it adopted a proposal granting the Secretary the power to both determine and implement public policy. Moreover, the delegation of such broad authority to the Secretary would undermine subsequent legal actions against the Department, for without established public policy boundaries, the courts would have difficulty determining if the Secretary exceeded his authority.

Secondly, the Association is concerned about the complex administrative structure that would be necessary to implement S. 570. The complexity of the proposal will necessitate a significantly expanded bureaucracy to collect and analyze data, determine and update voluntary and mandatory ceilings, monitor hospital and state rate agency compliance, and evaluate exceptions and special circumstances. The costs of such a bureaucracy are a direct increase in the number of persons supported by Federal tax revenues and a direct reduction in any savings resulting from the controls.

Third, the voluntary and mandatory controls in S. 570 necessitate vast amounts of data which must be gathered, analyzed and applied in a timely manner. Past practices indicate HEW will have difficulty performing these tasks. In establishing the present routine service limitations authorized by Section 223 of P.L. 92-603, HEW has repeatedly relied on either estimated cost data or dated cost report figures updated using estimating procedures. There is no reason to believe HEW would be able to process data in a more timely fashion for cost control purposes. As a result, future controls will be based upon estimates of recent cost data derived from outdated cost reports. The use of an estimate to describe the current state of affairs compounds errors and increases the arbitrary value of the projected ceilings.

Fourth, the AAMC is seriously concerned that S. 570 allows only a one percent factor for service improvements. Since 1950, Social Security Administration analysis have repeatedly shown that approximately one-half of the increase in hospitals costs has been a result of improvements in hospital services.* The Administration proposed only a 1% adjustment for service improvements. The AAMC does not believe the American public wishes to dramatically curtail improvements in hospital services. If the public is to continue to receive

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* Medical Care Expenditures, Prices and Costs: Background Book . September, 1975. page 39.

high quality patient care using up-to-date techniques and equipment, adequate funds must be provided for modernization and service enhancements.

Fifth, the Administration's proposed cost containment program includes a modified pass through of wage increases for non-supervisory employees. This provision will undoubtedly increase the demands of these personnel for significant wage increases, a demand that is in direct conflict with the bill's cost containment objective. Moreover, wage increases granted for non-supervisory personnel will probably determine the wage increase expectations of all other hospital personnel. Without a similar exemption for these latter employees, the hospital may be unable to fulfill expectations; morale will decrease, turnover will increase, and the relationships between supervisory and non-supervisory personnel will deteriorate. Thus, the wage pass through provision is undesirable in terms of the bill's objectives and the provision's likely impact on hospital operations.

Finally, the Association believes that the linking of a mandatory program to a voluntary program undermines the allegedly voluntary program. At the individual hospital level, this linkage encourages treating the voluntary ceiling as the floor. While this may be prudent behavior for an individual hospital, it undermines the likelihood that hospitals collectively can meet the initial goal. Few hospitals will have cost increases significantly below the Administration's voluntary goal while there will be some hospitals with costs substantially above the goal as a result of uncontrollable local factors such as local population increases.

In addition to these five general concerns, the AAMC notes that the proposal fails to clearly describe how hospitals under mandatory controls could qualify for voluntary controls in subsequent years, fails to distinguish between gross charges billed and actual revenues collected, makes the Federal treasury

the beneficiary of excess revenue collections, and includes an "antidumping" provision that is so harsh that the Secretary may be reluctant to use it. Because of these general and specific concerns, the Association is opposed to the President's proposal and believes that any further consideration of S. 570 should provide ample opportunity for additional testimony.

Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979, S. 505

A review of S. 505 clearly demonstrates that the Subcommittee and its staff are committed to establishing equitable reimbursement reforms that effectively address cost containment concerns without arbitrarily disrupting or penalizing health care delivery patterns that have effectively served the public. For this thoughtful approach and the staff's continued willingness to discuss general concepts and tentative positions, the Association expresses its appreciation to the Subcommittee and its Chairman. The Association is also pleased by the Subcommittee's dedication to developing a long-term, basic structural answer to the problem of rising hospital costs. In introducing S. 505, Senator Talmadge noted: "This is not a bill to indiscriminately cut and gut hospital operations. This is a bill, . . . which seeks to do no more -- and no less -- than to reform Government payment methods to hospitals with a system designed to encourage moderation by rewarding efficiency and not paying for inefficiency." And as Senator Dole, co-sponsor of S. 505, commented in his summary remarks: "The bill being introduced today builds on our experience of the last two congressional sessions. It has been improved by suggestions we have received and starts on a road to long-term, sensible cost moderation policy." It is within the context of these remarks that the Association would like to submit what it believes are constructive comments.

The members of the AAMC's Council of Teaching Hospitals are not a set of homogeneous institutions with similar organizational structures, staffing patterns, financial resources, patient care and educational programs, or facilities. They vary widely on these and other dimensions, for they have evolved to meet local, regional, and national missions within individual organizational and social constraints. Given this broad diversity, the Association has consistently advocated and supported hospital payment mechanisms which recognize the individuality of each institution and which make hospital comparisons only among truly similar institutions. The AAMC has recognized that payment limits derived from cross-classification schemes that are carefully constructed and conscientiously implemented to ensure comparability of institutions and costs are one legitimate approach to containing hospital payments. The following comments recognize those sections of the proposed legislation which contribute to more equitable and effective reimbursement provisions. The testimony also notes significant reservations about those aspects of S. 505 that need further study and consideration.

HOSPITAL REIMBURSEMENT PROVISIONS

A fundamental concern of the Association is the criteria employed to establish any hospital classification system used to calculate hospital payments. The Association is pleased that S. 505 recognizes the primitive "state of the art" of hospital costs comparisons and provides the Executive Branch with considerable flexibility in implementing the Congressional intent.

Health Facilities Cost Commission

In previous testimony on S. 1470, the Association strongly advocated the establishment of a "National Technical Advisory Board" 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 AAMC is pleased to note that the role of the proposed Cost Commission would encompass these activities.

The Association is also supportive of a Commission that includes representatives from both the public and private sector. However, it appears that the proposed limit of three hospital representatives would inappropriately exclude valuable and necessary viewpoints from certain types of hospitals with unique concerns. It would be particularly difficult, for example, to establish a rational classification group for teaching hospitals unless an individual were included who thoroughly understands the medical education process and its varying impact on hospitals which provide training and research capabilities for health professionals. Therefore, the Association recommends that five members of the fifteen person Commission be hospital representatives. In addition, the Association recommends that the provision for representation from "public health benefit programs" specifically permit inclusion of competent individuals from each of the following groups: large third party payors, state cost commissions which have implemented hospital rate review mechanisms, and knowledgeable managers of health benefits programs in private industry. Drawing on the extensive technical expertise available in all of these sectors is essential for assuring equitable and workable solutions to complex implementation problems that will arise.

Classification of Teaching Hospitals

In the past, the Association has expressed its opposition to a separate category for "primary affiliates of medical schools" that would be arbitrarily limited to one hospital per school. The AAMC is pleased that last year's Committee Report for H.R. 5285 recognized the need to include in the primary affiliates category more than one teaching hospital for some schools. The report stated:

> When classifying hospitals by type, hospitals which are primary affiliates of accredited medical schools would be a separate category, without regard to bed size. The Health Facilities Cost Commission should give priority to the development and evaluation of alternative definitions and classifications for the category primary affiliates of accredited medical schools. The Commission should ensure that the treatment of these medical center/tertiary care/ teaching hospitals accurately reflects the hospital's role as a referral center for tertiary care patient services, as a source for the development and introduction of new diagnostic and treatment technologies, and/or as the source of care for a high concentration of patients needing unusually extensive or intensive patient care services provided in routine service cost centers. In addition, these hospitals generally provide a broad range of graduate medical education programs and undergraduate medical clerkships. The committee recognizes that some medical schools, because of their organization and objectives, have more than one primary affiliate, and the primary affiliate classification should provide for the possibility of including more than one hospital in unusual situations. The primary affiliates category should not include affiliated hospitals which are not primary affiliates within the meaning of the concept described above.

If a special category for teaching hospitals is to be retained, the AAMC requests that a similar statement be included in this year's Committee Report.

While the modification in the teaching hospital category is a significant improvement, the AAMC remains concerned about the creation of a category for teaching hospitals because: (1) no one knows how routine operating costs in major teaching hospitals compare with routine operating costs in non-teaching hospitals; and (2) 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. In the absence of adequate data and operational experience to evaluate the proposed classification scheme, 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", and that this function be a primary responsibility of the Health Facilities Cost Commission.

Determining Routine Operating Costs

In the past, the Association has not specifically advocated a 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 or to characteristics of the production process. Therefore, the Association believes that the exclusion of capital costs; direct personnel and supply costs of hosptial education and training programs; costs of interns, residents, and non-administrative physicians; energy costs; and malpractice insurance expense is a step in the proper direction.

The Association is particularly pleased that the Health Care Financing Administration (HCFA) has adopted this approach in proposing new routine service limitations. While the Association is concerned with several aspects of the HCFA proposal (e.g., the use of the service industry wage index to estimate appropriate wage changes for nursing personnel and the use of a percentile cut which forces 20% of hospitals to always exceed the limitation), there is substantial merit in using a simplified classification system with cost exclusions rather than an ever more complex classification system.

The list of excluded costs in S. 505 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 permitting appropriate additions to the list of excluded costs without new legislation is recommended. The Health Facilities Cost Commission is an appropriate body to recommend additions to the list of excluded costs.

Following a rather complicated calculation, S. 505 establishes the ceiling for routine service payments at 115% of each classification group's average. As we have stated previously, the present Medicare reporting system does not permit identification of costs to be excluded in computing routine services costs. Therefore, no one knows what the actual distribution of of hospital costs by group will look like. The Association believes that a 115% 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. However, because many medical centers must recruit personnel outside of their immediate areas, the AAMC recommends that S. 505 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. 505. 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. Similarly, the AAMC is appreciative of the Subcommittee's exclusion of costs that are attributable to greater intensity of care because of shorter lengths-of-stay. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/ referral centers.

In the past few years as standards for hospital care have changed, hospitals have added special care units for coronary care, intensive care, burn care, kidney care, and other specialized services. Treatment of these units as routine services would decrease the comparability of costs across hospitals. Therefore, the AAMC requests that special care units, like ancillary services, be excluded from the definition of routine operating costs.

Exceptions Process

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 that developed 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 so that the initial application for an exception is judged complete; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the Secretary be required to regularly publish base line or typical costs for each group of hospitals in the classification system; and (4) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated, and easily accessible to all interested parties.

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. In some states, such systems may contribute equitably and effectively to cost containment efforts; these efforts should not be discouraged. The Association is concerned, however, that without specific federal operating guidelines in the bill, a state could use Medicare/Medicaid participation in a state rate setting/budget review process to dramatically, arbitrarily, and capriciously reduce hospital payments below the legitimate financial needs of hospitals. If the state option were used in this manner, it could undermine the financial integrity of many hospitals. Therefore, the AAMC's position is that state rate systems are acceptable where the following conditions are met: (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 commissioners appointed for relatively long staggered terms of office and staffed by competent professionals; (3) the agency is structurally and functionally independent of any governmental or private payor of hospital services; (4) 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 (5) 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.

Ancillary and Special Care Units' Costs

In Section 2(c), the Health Facilities Cost Commission is directed to devise additional methods for reimbursing hospitals for all other (i.e., non-routine) costs. Any effort to expand the payment provisions to include some or all of

the ancillary service departments and special care units is likely to present very difficult problems in terms of regulatory complexity. The deeper one gets into comparing specific revenue centers and/or ancillary service departments, the more important a hospital's distinctive characteristics become to an understanding of its costs. These individual differences are difficult to define quantitatively. In addition, an adverse result of such an approach would be to fractionalize the management of the hospital. A hospital is a very complex institution whose many facets need to be carefully coordinated to serve the needs of patients and to accomplish effective cost containment. A hospital control system which establishes many intra-institutional ceilings threatens to undermine this coordination. Therefore, the AAMC would advise the Subcommittee to proceed very cautiously with this approach.

PRACTITIONER REIMBURSEMENT REFORMS

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 6 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 professional 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 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. 505 to explicitly permit "physicians' services" compensation for a physician who is simultaneously functioning as an educator and personally performing or directing identifiable patient care services.

Anesthesiology Services

Anesthesiologists in the Association's Council of Academic Societies are concerned that the definition proposed in S. 505 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 6(a)(2) of S. 505 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. 505. 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 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). They 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 contributions pathologists make to patient diagnosis and treatment 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. 505 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 paid 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, the AAMC strongly urges this Subcommittee to clearly indicate in the legislative record of S. 505 that it is recognized and understood that the market for specialized physicians is often national in character and bears no necessary relationship to local community salaries.

Part A Compensation Arrangements

The apparent purpose of Section 6(c) is to eliminate Medicare and Medicaid recognition of renumeration 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 recognition of the national character of the medical marketplace.

Teaching Physicians

A fundamental concern of the Association has been the establishment of equitable and reasonable payment proviisions for physicians' services provided to Medicare and Medicaid beneficiaries in teaching hospitals. The AAMC is pleased that the legislative summary for Section 8 points out that Section 227 of P.L. 92-603 is intended to permit fee-for-service payments for medical

care in teaching hospitals where a patient receives a private service standard of care. More importantly, by extending the implementation date for Section 227 until October 1, 1979, S. 505 recognizes the critical need to avoid disrupting the current constructive discussions between the DHEW and the medical education community which have been undertaken to develop workable, equitable, and realistic regulations for implementing Section 227.

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 principles 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, excessive 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 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 under the review and supervision of the recommended Health Facilities Cost Commission.

COST SAVING ALTERNATIVES

In a March 1st press release, staff of this Subcommittee suggested several actions which could be taken to reduce federal expenditures for the Medicare and Medicaid programs. While the AAMC is concerned about all twelve of these proposals, and would welcome the opportunity to discuss each of them with Subcommittee staff following additional study and analysis, comments in this testimony are limited to three alternatives of particular interest to Association members.

Limiting Hospital Outpatient Costs

As previously stated, the member hospitals of the AAMC provide approximately nineteen percent of the emergency room visits and twenty-nine percent of the outpatient visits provided by non-Federal, short-term hospitals. Past studies of the costs of providing these services have shown that hospital-provided ambulatory services are more expensive than office-provided services because: (1) a larger percentage of the patients present more serious and complex medical conditions, (2) of the provision of extensive emergency and ancillary service capability, (3) hospital-based ambulatory costs often include ancillary and special care services for which office-based physicians make a separate charge, (4) present Medicare cost allocation procedures often burden outpatient activities with a disproportionate share of the hospitals administrative and indirect costs and; (5) the involvement of residents in the care of ambulatory patients decreases the productivity of clinic operations. Concerned that government-imposed limitations on inpatient costs may stimulate efforts to shift costs between inpatient and outpatient cost centers, Subcommittee staff have proposed limiting payments for outpatient

costs to twice the payments made for a service in a physician's office. Teaching hospital based outpatient departments have long been characterized as the principal financial "loss leader" of the academic health center. A number of reasons have been set forth as causes for this situation including: (1) private and public insurance payment programs often provide insufficient or non-existent benefit coverage for ambulatory services; and (2) patients who are attracted to hospital outpatient departments frequently have no insurance coverage or poor insurance coverage, and are unable to pay for services.

In the past few years, there has been substantial pressure and subsequent institutional commitment to provide a greater amount of educational experience in ambulatory settings to produce more primary care physicians. Generally, these commitments have been made without sufficient attention to longer-range financial considerations. The financing of all education programs in the ambulatory setting is a difficult problem and one which has not received the attention it deserves. Facing continuing large deficits in the operation of their ambulatory services, and diminishing ability to cover these losses from other revenue sources, teaching hospitals cannot significantly expand their ambulatory educational and service programs without adequate reimbursement for them. Providing adequate financing of ambulatory care services to encourage and permit improvement of "contact" specialty training programs, will help maintain and continue the growth in "contact" specialty positions and students which is already in progress. The March 1st staff proposal could further undermine the financial viability of hospital-based outpatient services. Thus, the proposal threatens the availability of both necessary patient services and essential educational resources. Given these serious consequences, the staff of the AAMC would be pleased to work with Subcommittee staff to assess the impacts of the proposal.

Stand-by Ancillary Limitation

One of the distinct virtues of S. 505 is its cautious application of cost controls where the techinical state-of-the-art is so underdeveloped. This prudent and careful approach would be undermined if the proposal is immediately expanded to include ancillary service costs. These services include a broad range of diagnostic and treatment activities produced with varying combinations of professional and paraprofessional personnel and with complex, rapidly developing technology. Thus, less is known about these costs than about routine service costs. In this situation, the AAMC strongly recommends that the Subcommittee retain its original plan of using the Health Facilities Cost Commission to develop and evaluate alternatives for extending limitations on non-routine service costs.

Reimbursing Teaching Physicinas Using a Unified Fee

Under present Medicare regulations, the costs of house staff stipends and benefits are an allowable hospital cost. Except in the special circumstances of free-standing ambulatory care centers, therefore, residents may not bill patients for any medical services. Faculty and attending physicians may bill patients, under Medicare Part B, for personally performed or directed medical, surgical, and consultative services. In the March 1st staff proposal, it is suggested that Medicare could pay fees to the physician-resident team, regardless of whether the physician or resident performed the patient service, in lieu of cost reimbursement for residents.

The AAMC is seriously concerned about the incentives such a proposal creates. First, if the physician-resident team seeks to maximize fee income, the educational aspects of residency training will be undermined. An unwholesome emphasis on resident-provided services will replace the present emphasis on using involvement in services as a critical learning activity. In short, resident provided services may become an end in themselves rather than a means toward continued clinical growth and development. Secondly, this proposal is financially most advantageous in procedurally-oriented specialties where each individual activity generates a fee. At a time when our nation is striving to stimulate the nonprocedural, primary care specialties, the adoption of the "unified" or "team" fee could undermine the financial support of primary care training while stimulating the procedural specialties and subspecialties.

For these reasons, the Association opposes the recommendation of a "unified" or "team" fee. The Association does recognize, however, that Section 222 of P.L. 92-603, provides authority for Medicare reimbursement experiments. The unified or team fee is, therefore, available to interested hospitals. To the extent that the legislated authority is presently being used to permit such practices, the AAMC would urge the Health Care Financing Administration to conduct careful, evaluative investigations of the impacts of this change in the pattern of funding graduate medical education.

Lastly, the Association would note that the medical education community and the Health Care Financing Administration are presently discussing alternatives for implementing the teaching physician payment provisions of Section 227, P.L. 92-603. Given the delicate and sensitive nature of these discussions, the Association would urge this Subcommittee to allow the regulatory process to proceed without the addition of constraining substantive legislation.

In conclusion, the Association expresses its appreciation to the Committee for this opportunity to testify on S. 505. The Association shares 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.

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Statement of the American Hospital Association

To the
Department of Health, Education
and Welfare

on

Proposed Uniform Reporting
Systems for Health Services
Facilities and Organizations

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AMERICAN HOSPITAL ASSOCIATION COMMENTS ON DHEW PROPOSED UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

I. INTRODUCTION

The American Hospital Association (AHA) submits these comments in response to the HEW Notice of Proposed Rulemaking (NPRM) for Uniform Reporting Systems for Health Services Facilities and Organizations, published January 23, 1979 at 44 FR 4742, as well as the latest draft manual issued by the Health Care Financing Administration (HCFA) entitled System for Hospital Uniform Reporting (SHUR) dated September 29, 1978.

The proposed rules, intended to implement certain provisions of Section 19 of P.L. 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977, would govern the reporting of cost-related information by hospitals participating in the Medicare or Medicaid programs. These rules purport to prescribe a uniform manner by which the information is to be reported. It is the SHUR manual which sets forth the details of the system being proposed.

The American Hospital Association has major objections to the SHUR proposal. Most of AHA's 6,400 member institutions participate in the Medicare and/or Medicaid programs of the federal government. As such, they are subject to the rules and regulations of the agencies administering these programs, and would be subject to the SHUR requirements. On behalf of the institutions which must bear the unsupportable and unnecessary burdens of the SHUR program, AHA has participated in the development of the SHUR program by presenting the concerns, objections, and recommendations of the hospital industry to HEW. Unfortunately, HEW has not accepted the position of the hospital industry in developing SHUR, and AHA will continue to oppose the direction HEW has taken on this issue.

AHA's objections are not with regard to development of a system for hospital uniform reporting. In fact, AHA has supported, and will continue to support, the concept of uniform reporting by health care facilities. But the HEW proposal goes far beyond the concept of a uniform reporting system. In a regulatory change that would impose the sweeping replacement of existing hospital accounting practices, SHUR would result in uniform accounting procedures for thousands of hospitals. HEW makes no attempt to disguise this intention--the SHUR manual explicitly admits that it provides:

> a uniform accounting system incorporating the chart of accounts, definitions, principles and statistics required by the Secretary to be used by hospitals to reach the uniform reconciliation of financial and statistical data necessary for uniform reporting under this act.[1] [Emphasis added.]

Through this proposal, HEW would impose tremendous and unwarranted costs upon the hospital industry. The proposal is particularly inappropriate because it is ill-conceived and impractical, because its impact has not been properly investigated as required by Executive Order 12044, and because it is inconsistent with Congressional directives. For these and other reasons which are discussed below, AHA objects to the SHUR as proposed and urges that the NPRM be withdrawn. No new proposal incorporating a uniform accounting system should be issued. Moreover, the entire reporting system needs much further study and development before uniform reporting is implemented in the over 6,000 hospitals to which such a system would apply.

AHA comments on the proposal are grouped into four major sections. Section II discusses the development of the SHUR proposal; Section III presents AHA's major objections to SHUR as presently proposed; Section IV addresses technical aspects of the proposal; and Section V describes an alternative approach to a uniform reporting system that would embody the statutory requirements of Section 19.

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[1] The HEW draft manual entitled System for Hospital Uniform Reporting, dated September 29, 1978, page 0.2.

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II. HEW'S PURPOSE: SHUR AS A UNIFORM SYSTEM OF ACCOUNTING

A. Conflicting Statements of HEW Objectives

The fundamental disagreement between HEW and the hospital industry concerning the 600-page SHUR manual is the purpose of this massive undertaking. Hospital industry representatives have asserted that practical considerations and statutory authority provide only for the development of uniform reporting--yet actions by HEW reveal that, as a prerequisite to implementing a system of uniform reporting, HEW is imposing uniform cost accounting on hospitals. While HEW statements conflict on the objectives of the proposal, these inconsistencies do not obscure HEW's intention to implement uniform accounting.

The preamble to the SHUR NPRM describes SHUR's intentions as limited to cost reporting:

> The proposal requires all hospitals participating in the Medicare or Medicaid program to report cost-related information in a prescribed uniform manner. It implements certain provisions of Section 19 of the Medicare/Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142). The purpose is to obtain comparable cost and related data on all participating hospitals for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning.[2]

The NPRM preamble also states that the SHUR manual "also contains a detailed, functional chart of accounts which must be used to reconcile a hospital's internal books and records in order to file the SHUR report."[3] However, according to the preamble, "the chart of accounts would not be required as the hospital's day-to-day accounting system. In order to avoid duplication, and to be consistent with Section 1861(v)(1)(F), this draft manual would incorporate the current federal cost report required for Medicare and Medicaid."[4] [Emphasis added.] Thus, according to the quoted

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[2] 44 FR 4742. The proposed rule would require all Medicare and Medicaid hospitals to report on the costs of their operation and the volume of their services, both in the aggregate and by functional accounts. It would also require hospitals to report their capital assets. The draft SHUR manual sets forth the definitions, principles, and statistics to be used in preparing and submitting the reports.

[3] 44 FR 4742.

[4] 44 FR 4742.

HEW statements of purpose in the NPRM, the proposal would appear to require simply a detailed uniform reporting system.

In conflict with the NPRM language, however, the SHUR manual makes it clear that what is intended is a uniform system of accounting.[5] The introduction to the manual explicitly admits that the manual provides a uniform accounting system.[6] The manual states that:

> the purpose of the uniform accounting system is to provide a common standard of measurement and communication through the use of uniform: (1) reporting principles, (2) classification system which identifies costs by cost center by the nature of costs incurred and revenues by revenue center by patients and payor sub-classifications, and (3) statistical and service data definitions.[7] [Emphasis added.]

While the manual's introduction states that the SHUR accounting system has been developed for use by hospitals either as their day-to-day accounting systems or to reconcile their internal accounting systems with the uniform reporting requirements, the foregoing demonstrates that hospitals will have to convert their systems to the "recommended" accounting system or support the cost of two entirely separate systems. In practice, hospitals would be forced to convert to an entirely different accounting system at enormous cost.

AHA objects to this HEW objective of imposing a uniform system of accounting on the hospital industry. AHA's objections are based both on practical considerations and because HEW is exceeding statutory authority as provided in Section 19 of P.L. 95-142. Another major objection to the proposal is the tremendous costs involved in implementing the SHUR as proposed, particularly when the intended countervailing benefits are unproven and even undisclosed. AHA also opposes the SHUR proposal in that it would combine uniform reporting with Medicare or Medicaid reimburse-

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[5] The NPRM preamble states that the proposed regulation does not set forth the details of the SHUR but that these are contained in the SHUR manual: "It merely sets forth the basic reporting requirements and the provisions for public disclosure of SHUR information. The details of the reporting requirements, including forms and instructions, are contained in the SHUR manual which is also available for public comment." 44 FR 4742.

[6] Refer to discussion in Section II A.

[7] Draft SHUR manual, p. 0.2.

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ment. That objection is based upon the practical problem that the two systems, reporting and reimbursement, present incompatible principles.[8]

B. HEW's Purpose Demonstrated in the Proposal's Development

In recent years, AHA has initiated meetings and discussions with staff of the Office of Research and Statistics (ORS) of the Social Security Administration (SSA) to discuss the Administration's efforts to devise and implement a uniform reporting system for health care facilities. In February 1976 AHA met with ORS to discuss not only the government's efforts to develop a uniform reporting system, but also to discuss how that system would relate to various accounting techniques. Thus, from the outset, HEW has received the hospital industry's position on the reporting-accounting issues.

In April 1976, AHA received a first request from HEW/SSA for an official response to its draft proposed system. AHA responded in May 1976 that an accounting system which lacks flexibility when applied to a variety of institutions cannot be implemented without impairing management and accounting innovation.[9] AHA emphasized the importance of flexible accounting systems and noted that such flexibility is a requisite for the wide diversity, scope and complexities of health care institutions.

AHA met with HEW staff again early in 1977 and the result of this meeting was an agreement that a uniform accounting system is not only costly, but also unnecessary as a prerequisite for the reporting of various uniformly determined cost data. Therefore, AHA understood that HCFA would devise a uniform reporting system without requiring uniform accounting as well.

AHA supported this principle in a letter dated July 14, 1977 to Mr. Grant Spaeth, Deputy Assistant Secretary of HEW,[10] and reaffirmed its agreement with HCFA in a subsequent letter on October 3, 1977.[11] Thereafter the basis of this understanding was carried forth in the enactment of Section 19 of P.L. 95-142,[12] which authorizes the Secretary to establish "a uniform system for the reporting by a facility of. . . [certain] information. . ."[13]

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8 See also Section III below.

9 See Appendix 1.

10 Appendix 2.

11 Appendix 3.

12 42 U.S.C. §1230a et seq.

13 42 U.S.C. §1320a(a).

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Therefore, the concept of uniform reporting as understood between HCFA and AHA was consistent with that embodied in the statutory framework of the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977.[14] [15]

One of AHA's activities over the several months following the issuance of a March, 1978 draft manual was to urge HEW to undertake a demonstration project to assist in the determination of what SHUR would cost to implement. AHA stressed that such a project should be undertaken because of the disparity between estimates of the HCFA and those of AHA.[16]

Convinced of the value of such a project and making plans to undertake it, HEW, nevertheless, persisted in its efforts to publish the manual in July 1978. It was not until January 23, 1979 that SHUR was published as an NPRM, but the SHUR manual itself was distributed to interested parties in October 1978.

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[14] 42 U.S.C. §1320a.

[15] Since that time, AHA has continued to provide information to HEW's Office of Policy, Planning and Research (OPPR) in its efforts to develop the system envisioned by Section 19. Section 19 of P.L. 95-142 requires the development of an appropriate uniform reconciliation system--a system to be used by the provider to report from the hospital's individual accounting method the uniformly required information. However, preliminary drafts of the manual developed by OPPR demonstrated that HEW efforts were directed toward devising a uniform accounting manual.

AHA objected to those drafts, primarily because the manual was predicated on the development of a mandatory uniform accounting system as a prerequisite to any reporting system. (See Appendix 3.) In addition, the accounting manual was designed to support a reporting system that had as yet been undeveloped.

In March 1978, a new draft of the manual was released. This draft, entitled System for Hospital Uniform Reporting (SHUR), included a uniform accounting system and, for the first time, a uniform reporting system. However, this system contained excessive reporting requirements and the data being required by this system had unidentified uses and users. During this period, AHA staff met with representatives of HEW, OPPR, HCFA and Congressional staff to once again convey the concerns of the hospital industry with the SHUR manual.

[16] See Section III below.

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AHA has convened two task forces, comprised of hospital industry representatives, to discuss and analyze the SHUR proposal. On January 24, 1979, the AHA convened its first task force to discuss general membership concerns with the SHUR proposal. Subsequently, on February 12, 1979, the second task force met to assess technical aspects of the proposal. AHA will continue to take active participation on the SHUR issue and, on behalf of the hospital industry, will continue its involvement in this rulemaking process.

III. MAJOR OBJECTIONS OF THE HOSPITAL INDUSTRY TO THE SHUR PROPOSAL

A. The SHUR Proposal has been Improperly Developed and Its Release is Premature.

Despite the many years that HEW has been working on the SHUR system, the release of this proposal is premature. HEW has failed to analyze the proposed regulation's economic impact and has not considered alternative systems. HEW has also failed to identify the uses for, and the users of, the information that the proposal would require hospitals to report. Finally, HEW has proposed for implementation a system whose burdensome costs and practical implementation problems have not been properly considered.

HEW has Failed to Conduct an Economic Impact Analysis.

Despite the clear cost burdens of the SHUR proposal, HEW has made no attempt to prepare a regulatory analysis as to its economic impact. Such a study is required of major regulatory proposals by President Carter's Executive Order 12044, and by HEW's revised "Operation Common Sense."[17]

When the SHUR proposal was published, HEW stated that it was undertaking a study to establish more precisely the cost of implementing and operating the SHUR. HEW said that:

> the study will also assess any additional reporting burden placed on the hospital by implementing the proposed system. The study will examine hospitals' effort to meet existing requirements and the resultant change in burden effort to meet the SHUR requirements.[18]

While the objectives of this study are appropriate, and indeed necessary, it should have been completed prior to the issuance of an NPRM. However, HEW states that the results of this study[19] will allow HEW to determine if a regulatory analysis is needed. This procedure conflicts with the entire purpose of a regulatory analysis--to determine before issuance of a regulatory proposal whether the contemplated proposal would be consistent with other regulatory systems and with economic necessities. In view of the great disparity in the estimates regarding the cost of implementa-

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17 See 43 FR 12663, Section 3, and 43 FR 23121, Section I.C.

18 44 FR 4743.

19 To be discussed below in Section III B.

tion of this proposed system,[20] it was particularly important that HEW conduct such an analysis before publishing the SHUR as a proposed rule. Unfortunately, HEW has published this proposal before performing the required regulatory analysis, contributing to the many areas in which this proposal has been improperly developed.

HEW Has Failed to Identify How the Enormous Amount of Hospital Data Required Under SHUR Will be Used.

The great amount of data to be reported under SHUR is a major concern of the hospital industry. Collecting and reporting departmental data in minute and immaterial detail serves no purpose until the uses of such data and, more importantly, the users of such data have been identified.

AHA urges HEW to determine, and to specify, the uses and users of the data to be reported upon which a national uniform reporting system could be based using the highest level of aggregate data--data that will result in the ability of the users to make meaningful decisions. Aggregate level reporting would substantially reduce, instead of increase, the concomitant costs of a new reporting system. AHA contends that proper decision-making by the users of the uniform reporting system can be made--and should be made--without the excessive detail proposed in the SHUR manual.

As stated above, the reporting system set forth in the proposal is designed to capture an enormous amount of data for purposes which have not yet been defined. The proposal states only that the purpose in collecting such data is "to obtain comparable cost and related data on all participating hospitals for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning."[21] However, the proposal fails to explain what use will be made of the intended "comparable" data. It is clear that HEW seeks to require hospitals to report all data related to cost issues so that such data could be used to meet whatever needs HEW eventually finds for this data. AHA objects to this HEW attempt to collect data without defining the uses to which it will be put. In fact, it is not

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20 See Section III B.

21 44 FR 4741.

clear that there is, or ever will be, any use for some of the data to be provided.[22]

AHA also objects to implementing the SHUR proposal because of the failure of the Medicare Bureau and HCFA to develop adequate information systems with respect to existing information it has on Medicare cost reports. The 1972 Social Security Amendments (P.L. 92-603) authorized the Secretary of HEW to develop and impose prospective limitations on various hospital cost components.[23] In July 1974, HEW developed and implemented limitations on inpatient routine service costs.[24] The resulting methodology utilizes bed size, geographic locations, and per capita income for grouping hospitals; limitations for each group are determined upon cost information obtained from Medicare intermediaries. This information is collected in the aggregate--that is, as total routine cost.

The Medicare Bureau was asked in 1977 to provide AHA with the component costs[25] of each of the hospital groupings. The Medicare Bureau advised AHA that it was unable to do so. This resulted from the fact that, while the Medicare Bureau had the information in the form of hard copy (i.e., complete cost reports), none of the information had been entered into a management information system.

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[22] AHA also objects to the proposal because of its failure to avoid even more duplicative and burdensome reporting by the hospital industry. The SHUR as proposed must be regarded as failing to address the needs of other agencies within DHEW. The NPRM states, for instance, that the purpose of §19 "is to obtain comparable cost and related data. . . for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms, and health planning." 44 FR 4741.

It is significant that the February 2, 1979 Federal Register contains another NPRM (44 FR 4842)--one that pertains to State Medical Facilities Plans--which sets forth requirements for an extraordinary amount of statistical and other data, some of which is cost-related. (In fact, much of the data is already available on existing Medicare cost reports or could be obtained through minor changes to those cost reports.) This demonstrates yet another deficiency that results from developing a system without first determining the uses and users of that system, for, if the uses are in fact similar to those intended for SHUR, this section of the NPRM would, of course, be duplicative and unnecessary.

[23] Section 223, codified as 42 U.S.C. 1395x and 1395cc.

[24] 42 C.F.R. §405.460.

[25] Specifically, depreciation, maintenance and operation of plant, laundry, and housekeeping, etc.

Before any attempt is made to implement the SHUR, HCFA should develop not only the necessary systems to capture and utilize the SHUR data, but also systems to handle the existing Medicare cost report information. We believe that a substantial amount of valuable information is presently contained in the Medicare cost report. If HCFA would utilize this source of information, much of the need for the SHUR requirements would be avoided.

B. The SHUR Proposal Will Impose Tremendous Costs With No Compensatory Benefits

The proposal for SHUR would result in new regulations for the hospital industry whose implementation will impose tremendous costs--both to health care providers and to the government. Such a proposal is particularly inappropriate at a time when the federal government and health care providers alike have been called upon to scrutinize more carefully their activities and to reduce unnecessary costs.

While estimates on the cost of implementation of this proposed system vary, there is no doubt that those costs would be well into the hundreds of millions of dollars.[26] Because of the great disparity in these cost estimates, AHA has contended that a demonstration project to determine the cost of compliance with SHUR must be undertaken before the system is proposed for implementation.

Therefore, over a period of several months, AHA convinced DHEW to undertake a demonstration project for this purpose. A request for proposal (RFP) was signed between HCFA and an accounting firm to conduct the demonstration project. This study is designed to document the cost that hospitals will incur in converting and/or reconciling their current accounting systems to the SHUR reporting requirements.

During discussions with AHA, HCFA determined that in order for the study to be valid, it must be conducted in a minimum of 50 randomly selected hospitals. After HCFA identified the test hospitals for the on-site test evaluations, AHA and state hospital associations agreed to assist the HCFA effort by obtaining permission to conduct the study from the hospitals that had been selected.

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[26] While the Health Care Financing Administration (HCFA) contends that the average cost of initial implementation and the annual maintenance of SHUR will approximate $3,000 to $10,000 per hospital, the American Hospital Association estimates that the implementation cost alone could reach $100,000 or more per hospital. If, on the conservative side, the average cost per hospital is $50,000, this will result in a national implementation cost of $300 million. For a fuller discussion of the SHUR cost estimates, see the remainder of the discussion of III B.

A preliminary study methodology was presented to AHA for its review and comment. AHA made several recommendations to improve the methodology and objected to the refusal to adopt a method by which the implementation cost estimates were to be validated, i.e., actual implementation of the system at a sample of the test sites.

The methodology first identifies those aspects of SHUR which have different reporting requirements than the requirements that are presently imposed on hospitals. The cost of compliance is then estimated through a process whereby the consultants for the study, together with respresentatives of each test hospital, attempt to quantify the effort and therefore the cost necessary to be expended in determining and satisfying the information requested under the available alternatives.[27] The serious flaw in this approach is that there is no actual implementation of the SHUR manual at these various sites which would verify the estimated implementation costs.

Despite flaws in the study's methodology, preliminary results indicate that the costs of implementing the SHUR manual greatly exceed the estimates originally advanced by the HCFA. As a part of its role in monitoring the project, AHA has contacted many of the hospitals involved in the cost review experiment. As these comments are being prepared, several preliminary observations can be made:

- The estimated cost of implementation varies significantly from hospital to hospital. In some hospitals the estimated cost has been low, while in others the cost has been estimated to range from $100,000 to $150,000. If the final results of the study indicate an average cost of $50,000 in the test hospitals, this would result in a national implementation cost of approximately $300 million ($50,000 x 6,000 hospitals = $300,000,000). Thus, the preliminary results of HCFA's own study demonstrate that HEW should have performed a regulatory analysis as required

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[27] SHUR permits hospitals the option of (1) reconciling their present accounting system to meet the SHUR requirements at year-end by means of reclassification entries or (2) converting their present accounting system to meet the SHUR requirements on a day-to-day basis so that year-end reporting can readily be obtained. The methodology requires cost estimates under both options.

by Executive Order 12044 before publishing the SHUR as a Proposed Rule.[28]

- The study does not include costs associated with data processing and programming changes of the test site hospitals which purchase or time-share their data processing services. Data processing changes are a costly undertaking.[29] Failure to recognize such costs drastically distorts and further underestimates the cost of adhering to the SHUR.

- Many of the hospitals involved in the experiment revealed that they did not have the opportunity to fully understand and assess the SHUR requirements prior to the evaluation. Participating hospitals were not always offered the choice of estimating costs under both alternatives. Rather, only one method--either year-end reconciliation or day-to-day conversion--was utilized. This situation also distorts true cost determinations.

Notwithstanding the above, AHA asserts that, when completed, the study will support the Association's contention that there are excessive costs associated with implementing the SHUR as proposed, and that the cost of compliance would be out of proportion to any potential benefits the SHUR system could provide. In fact, HEW has not indicated that it has ever performed an analysis of the claimed potential benefits of SHUR.

AHA further asserts that because there has been no evidence justifying the need for the present SHUR proposal, HEW has proceeded contrary to the intent of Congress. The legislative history of P.L. 95-142 reveals that Congress did not intend to impose enormous cost and administrative burdens on the providers of health care. The following position of the Interstate and Foreign Commerce

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[28] 43 FR 12663. One of the criteria [required by the Executive Order] to be employed by a governmental agency in determining whether a regulatory analysis should be performed is that the regulations "would result in a major increase in costs or prices for individual industries, [or] levels of government..." 44 FR 12663. Another is that the regulations would result in "an annual effect on the economy of $100 million or more." 44 FR 12663. Certainly the SHUR proposal falls in one if not both of these categories and yet HEW has failed, as stated above, to conduct a regulatory analysis prior to publishing the SHUR proposal.

[29] Unless the test site hospital owns its data processing equipment.

Committee is significant in this respect:

> The Committee views the disclosure requirements imposed by the bill to be of critical importance in the process of detecting and determining fraudulent and abusive practices within the Medicare, Medicaid...programs. The Committee does not intend, however, for these requirements to be unduly burdensome on providers,... It is, therefore, expected that implementation and administration will be accomplished in such a way as to preclude unnecessary additional administrative burdens on those complying with them.[30] [Emphasis added.]

The costs and benefits, of course, cannot be compared until each has been established. Despite AHA's concerns and recommendations to HEW/HCFA that the methodology being employed lacks a basis of verification, HCFA has refused to include experimental implementation of the SHUR as part of the current study. This refusal is based on HEW's assertion that it has insufficient time to conduct such studies. HCFA has stated that hospitals will need at least 18 to 24 months to implement its reporting system and that HEW does not want to delay adoption of SHUR by the hospital industry. AHA objects to this refusal to properly assess the costs and the consequences of this comprehensive proposal and contends that HEW's proposal results in a violation of the Congressional intent.

It should be noted that a similar situation existed with the national implementation of the Professional Standards Review Organization (PSRO) program: HEW quickly developed and implemented the PSRO program without proper testing or evaluation. Experience has demonstrated many problems with the PSRO system that need corrective action,[31] and remedying these deficiencies in an ongoing program has proved difficult.

Certainly, it is much easier to correct problems associated with test programs than to modify programs that have been fully implemented. Therefore, AHA requests HEW to conduct a study in which the SHUR is actually implemented in a sample of hospitals. Only after the results of this study have been obtained and appropriate modifications made to SHUR should HEW implement a new reporting system.

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30 H.R. Rep. No. 393, 95th Cong., 1st Sess. (1977), reprinted in [1977] U.S. Code Cong. & Ad. News. 3055.

31 Many of these problems have been cited by the General Accounting Office (GAO) in its September 12, 1978 Report to the Congress. See Appendix 4.

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C. Medicare Reimbursement Should Not be Premised on SHUR

AHA opposes HEW's attempt to combine a uniform reporting system with Medicare reimbursement such that a provider's reimbursement is premised upon a system for hospital uniform reporting. The objection to combining these two systems is that they are based on entirely different and, in fact, incompatible principles.

A fundamental principle of the Medicare program is that Medicare pays all the costs of program beneficiaries and pays none of the costs of non-beneficiaries. To determine each of these costs, HEW developed a system of cost reporting under Medicare which recognizes differences between institutions and their approaches to the delivery of health care. The system provides for flexibility to reflect the economic reality of individual hospital operations and organization structures and to insure adequate reimbursement for the cost of services actually provided. In contrast, SHUR does not provide for this flexibility because the purpose of this uniform reporting system is to compare data elements that relate to defined functional activities regardless of the particular characteristics of the institution.

Comparability of data does not necessarily reflect accurate determinations of the true cost of services provided to program beneficiaries.[32] Therefore a system for the uniform reporting of selected hospital information should only be combined with a Medicare cost reporting system that recognizes and accommodates differences from institution to institution so that the costs of treating patients under Medicare are fairly borne by the Medicare program.

Further, in attempting to use SHUR to alter the reimbursement system, HEW has exceeded statutory authority. There is no basis in P.L. 95-142 for premising reimbursement on the SHUR; the

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32 For example, the proposed SHUR requires that data processing costs be allocated to various functional cost centers on the basis of "central processing unit" (CPU) time. (CPU measures actual machine usage.) However, this allocation does not reflect the true cost of the entire data processing function because a particular data processing effort may have been extended to several other hospital departments. Specifically, if a large effort is provided by the hospital's data processing department in developing medical record information, allocations based upon the CPU time statistic would not reflect this effort. Therefore, there is no assurance that such an allocation results in payment by Medicare for services provided to its beneficiaries. Likewise, if considerable effort was directed at the provision of services to a non-allowable Medicare cost center, e.g., non-patient care research, then Medicare would be paying non-allowable costs. Both results would contravene rational financing and the Medicare law itself. (42 U.S.C. 1395x(v)).

purposes of the statute do not include reimbursing health care providers on the basis of a uniform reporting system. In fact, nowhere in the legislation governing uniform reporting is reimbursement mentioned. Therefore, HEW has proceeded without authority to premise reimbursement on SHUR.

HEW's attempt to combine the systems in this way is contrary to the legislative history of P.L. 95-142. During the introduction of the amendment to P.L. 95-142 that resulted in Section 19, there was no discussion with respect to combining uniform reporting with Medicare and Medicaid reimbursement. However, there was a most significant discussion of reimbursement in the context of Section 19 during the joint hearing before the Subcommittee on Health of the U.S. House of Representatives' Committee on Ways and Means and the Subcommittee on Health of the U.S. House of Representatives' Committee on Interstate and Foreign Commerce. In presenting testimony at the hearing on H.R. 3 and proposed amendments thereto, AHA stated that

> the proposed amendments. . . suggest that the Secretary of Health, Education and Welfare could change [such] reimbursement in any way he chooses, and then require all hospitals to enter into arrangements with Blue Cross and private insurors, as well as with Medicare and Medicaid, that adhere to the reimbursement approaches designed by the Secretary.[33]

At this point in the AHA testimony, Representative Paul Rogers interrupted to say: "May I point out here that you misread the bill. I don't think there is any authority to have the Secretary back that up, either to change reimbursement."[34] [Emphasis added.]

The above supports the AHA position that Congress did not intend to base Medicare reimbursement on a system for hospital uniform reporting. In attempting to do so, HEW has violated the intent of Congress.

In view of the above, AHA urges HEW to maintain any system for hospital uniform reporting separate from Medicare reimbursement.

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[33] Testimony of the American Hospital Association before the Subcommittee on Health of the U.S. House of Representatives' Committee on Ways and Means and the Subcommittee on Health of the U.S. House of Representatives' Interstate and Foreign Commerce Committee on H.R. 3 and H.R. 4211, March 7, 1977.

[34] Joint Hearings before the Subcommittee on Health of the U.S. House Committee on Ways and Means and the Subcommittee on Health of the U.S. House Interstate and Foreign Commerce Committee, 95th Cong., 1st Sess. 226 (1977).

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D. The SHUR Proposal Results in a Requirement of Uniform Accounting

As discussed in Section II, while the SHUR NPRM purports only to require uniform hospital reporting of cost-related information, the draft SHUR manual states clearly that it contains a uniform accounting system. While AHA opposes the imposition of any system of uniform hospital accounting, whether implemented directly or indirectly, it should be emphasized that AHA does not object to responsible implementation of a system for uniform hospital reporting. In fact, AHA has long supported the concept of a uniform reporting system and will continue to do so.

The accounting requirements in HCFA's current proposal are contained in the SHUR manual, which

> provides a uniform accounting system incorporating the chart of accounts, definitions, principles and statistics required. . . to be used by hospitals to reach the uniform reconciliation of financial and statistical data necessary for uniform reporting under [Section 19 of] this act [P.L. 95-142].[35]

The introduction to the manual also states that, "in developing a uniform accounting system, it was recognized that the system must provide the data necessary to support management and the different regulatory systems, cost allocation systems, disclosure requirements and state reporting requirements which exist." It further states that the purpose of the uniform accounting system is to "provide a common standard of measurement and communication through the use of uniform [accounting] principles."[36] The implication of all of this is, of course, that a uniform accounting system is necessary in order for uniform reporting to be achieved. AHA believes, to the contrary, that a uniform accounting system should not be required as a basis of uniform reporting.

As stated earlier, the proposed rule would require all Medicare and Medicaid hospitals to report on the costs of their operation and the volume of their services, both in the aggregate and by functional accounts. If, in order to comply with the detailed reporting requirements under the SHUR proposal, hospitals are forced to convert their internal accounting systems, effective and efficient management of those hospitals will be severely reduced. Such a result would obtain because functional accounting does not provide the information necessary to the successful management of a hospital; costs are assigned to cost centers

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35 Draft SHUR Manual, page 0.2 [Emphasis added.]

36 Draft SHUR Manual, page 0.2.

based on prescribed definitions of functional activities and not on the basis of a particular department's responsibility for incurring and controlling its costs. Therefore, any system that would, directly or indirectly, impose a uniform accounting system on hospitals is unacceptable to the hospital industry.

Moreover, the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977 provide no legal basis for HEW to require the imposition of a uniform hospital accounting system. A key provision of Section 19 provides:

> the uniform reporting system for a type of health services facility. . . shall provide for appropriate variation in the application of the system to different classes of facilities. . . within that type. . . In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary.[37]

Thus, the statute itself recognizes that there are variations in the financial and statistical data routinely utilized by hospitals. While the "reconciliation" of accounts was intended by this language, a system of uniform accounting as it is incorporated in the present proposal was not contemplated. Nowhere in Section 19 is there any requirement for implementation of a uniform hospital accounting system, nor is there any authority for HEW to impose such a requirement by regulation.

The legislative history of P.L. 95-142 further demonstrates that Section 19 was not intended to provide for a uniform accounting system for hospitals. The Congressional Budget Office reported to the House Committee on Ways and Means that the legislation does not mandate a uniform accounting system, as follows:

> Although proposals have been made to require uniform accounting as well as uniform reporting, the bill does not mandate a uniform accounting system. Your committee was not prepared to conclude that a uniform accounting system is necessary in order to generate the required comparable data. Your committee is inclined to believe at this time that the uniform reporting system, with specific documentation for the reported costs as part of the organization's accounting system is sufficient. . . [Emphasis added.][38]

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[37] Social Security Act §1121(a), 42 U.S.C. §1320(a). [Emphasis added.]

[38] H.R. Rep. No. 393, Pt. 1, 95th Cong., 1st Sess. 75 (1977).

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Congress indicated that a uniform accounting system might be considered at some future time if--and only if--an evaluation of uniform reporting proves insufficient to assure reliable and comparable data:

> Although this bill[39] does not require uniform accounting as well as uniform reporting, the Committee is convinced that the Secretary of HEW should develop a model uniform accounting system and that he should have the authority to require the use of such parts as he finds necessary in the future if his evaluation of uniform reporting indicates that it has not been sufficient to assure reliable and comparable data. . . .[40] [Emphasis added.]

Therefore, Congress intended that a system for uniform reporting be developed, implemented and tested before HEW requires hospitals to employ a uniform system of accounting. By proceeding to require uniform accounting before even attempting to develop a responsible reporting system, HEW has exceeded statutory authority and has ignored the intent of the authorizing Congress.

AHA urges HEW to reconsider its attempt to impose uniform accounting on the hospital industry and, instead, to devise a more responsible, less burdensome system to obtain the necessary hospital data.

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39 H.R. 3 as amended, which was enacted as P.L. 95-142.

40 H.R. Rep. No. 343, 95th Cong., 1st Sess. 83 (1977), Reprinted in [1977] U.S. Code Cong. & Ad. News 3086.

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IV. SPECIFIC CONCERNS AND TECHNICAL PROBLEMS

The preceding section discussed the AHA's major concerns regarding the conceptual development of the SHUR system. This section is intended to provide additional comments concerning the more technical problems associated with the SHUR itself. Problems exist in several key areas including: (A) the inability of the SHUR to reflect comparable and meaningful data, (B) the use of functional reporting as a concept, (C) various definitional aspects, (D) the SHUR's direct reporting of certain specific costs, (E) the development and use of standard units of measure, and (F) the required use and purposes of the SHUR forms.

A. Comparability Problems

The NPRM states that "the purpose [of the SHUR] is to obtain comparable cost and related data on all participating hospitals for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning."[41] We believe the information required by SHUR in its present format will not achieve an accurate or realistic comparison of hospital cost data. The SHUR presently requires hospitals to report only cost and statistical data; no provision is made for the collection of various nonfinancial data which is absolutely essential to explain the financial data being reported.

For example, the SHUR requires the allocation of depreciation expense on major movable equipment to each of the prescribed functional cost centers where such equipment is located. In the absence of any specified purpose for this requirement, we must assume this information will be utilized by the HCFA in determining, among other things, the appropriateness of depreciation expense of major movable equipment for interhospital comparisons. Unfortunately, this information alone will not provide any user of the system with vital information concerning the age of such equipment, the numbers of such equipment, or the technological sophistication of such equipment. Thus, attempts at comparability of this item are totally lost.

Furthermore, SHUR requires that employee benefits be assigned directly to the functional cost centers based on the number of full-time equivalent employees. Allocating these costs, which is not only a time consuming exercise, but also an expensive project because of the extraordinary amount of needed recordkeeping and data processing, will not reveal the extent of employee benefits offered by an institution. This is true whether an institution offers a higher level of benefits when compared to another, or

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41 44 FR 4741

whether the institution is unionized, or whether there are differences in wages and benefits within a defined geographic area. Therefore, SHUR will not, as the NPRM intends, collect data that can be compared in a meaningful manner.

The NPRM also states the uniform reporting system must provide information on the "(1) cost and volume of services; (2) rates; (3) capital assets; (4) discharge data; and (5) billing data."[42] In view of the recent emphasis placed on the importance of preambles to Notices of Proposed Rulemaking by government and others, information contained in the NPRM should state the exact purpose of implementing the SHUR. SHUR's enabling legislation provides that the uniform reporting system would require the following information: " (1) the aggregate cost of operation and the aggregate volume of services, and (2) the cost and volume of services for various functional accounts and subaccounts."[43] It is recommended that a second NPRM include a correction of this discrepancy.

B. Functional Reporting

The SHUR is premised on a functional reporting system. The majority of, if not all, hospitals currently employ a responsibility reporting system. Responsibility reporting accumulates data in accordance with a hospital's organizational structure and therefore provides management with an effective tool for evaluating each department's performance. In fact, the Joint Commission on Accreditation of Hospitals (JCAH) recommends that a hospital employ a responsibility type reporting mechanism.[44]

The difference between a responsibility reporting system and a functional reporting system becomes apparent, if for example, we look at the accounting treatment required for the salary of a nurse assigned to the operating room. In a responsibility reporting system, the entire direct (salary) cost of the nurse would probably be assigned only to the operating room cost center. Under the functional reporting mechanism, however, the only cost permitted to be accumulated in the operating room center would be those associated with the nurse for time spent in providing assistance during surgery.

It is common for such individuals to spend part of their time performing other tasks, such as, reordering or replenishing supplies of the operating room, or performing administrative duties. In these situations, the costs associated with the

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42 44 FR 4742

43 42 U.S.C. §1320a.

44 Accreditation Manual for Hospitals, 1979 ed., Joint Commission on Accreditation of Hospitals, p. 52.

reordering of supplies and the provision of administrative services would have to be charged to those functional centers. However, reporting this level of detail may not provide significant overall cost differences from one hospital's operating room to another hospital's operating room.

Prudent business practices dictate that primary responsibility for management reporting systems lie within the internal requirements of the organization. Only secondary considerations follow from external needs. While SHUR permits hospitals the option of reconciling a responsibility reporting system at year-end or converting on a day-to-day basis to the functional requirements of SHUR, hospitals may be forced to convert to the proposed SHUR requirements on a day-to-day basis, because of the extremely complicated and costly year-end reclassification entries that would have to be made in order to meet the SHUR requirements. At best, hospitals will be forced a great expense to maintain two separate reporting systems, one responsibility oriented and the other functionally oriented so that, respectively, management's needs are fulfilled and JCAH's standards are met, and the hospital is able to comply with SHUR. Hospitals object to the tremendous problems and extensive costs this situation creates.

C. Definitional Problems

The SHUR contains several items which run contrary to generally accepted accounting principles (GAAP). Both the legislation creating SHUR and the NPRM announcing the availability of the SHUR are silent regarding balance sheet items. AHA therefore questions the magnitude and emphasis being placed on these accounts. Also, SHUR aptly addresses the issue of materiality in two areas, but, in a third, goes on to require an overly conservative application of the process. Further, the SHUR's handling of its capitalization requirement is overly restrictive. The materiality and capitalization issues point to the costly pervasiveness of the information required by the SHUR, yet there is no clear evidence that such information will result in comparable data and meaningful information.

Problems with GAAP

Several of the early SHUR manual drafts required many reporting practices which varied significantly from GAAP. The September 29, 1978, version has greatly reduced the number of inconsistencies between GAAP and SHUR requirements. However, several still exist. For example, SHUR requires that "long-term security-investments are to be valued at hospital cost if purchased or, if acquired by donation, at the fair market value at the date of the gift."[45] In contrast, GAAP requires marketable securities to be

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[45] Draft SHUR Manual, page 1.15.

carried at the lower of cost or market value, determined at the time the balance sheet is prepared.

Similarly, SHUR appears to violate GAAP with respect to the treatment of malpractice insurance costs. SHUR states that

> self insurance by a hospital for potential losses due to unemployment, workman's compensation and malpractice claims, asserted or otherwise, places all or part of the risk of such losses on the hospital rather than insuring against all or part of such losses with an independent insurer, and payments into the fund or pool are to be considered as insurance expense for purposes of this [SHUR] report. Loss payments, even in excess of amounts in the fund or pool are not considered insurance expense.[46] [Emphasis added.]

However, the amount considered insurance expense under GAAP is the total amount actuarially determined to cover probable losses plus any amounts beyond such insurance reserves that a hospital might incur for actual losses in any given year.

Furthermore, SHUR appears to allow the use of any generally accepted inventory valuation method (e.g., fifo, lifo, average, etc.). However, the manual states that any method "may be used as long as it is consistent with that of the preceding accounting period."[47] Because the manual provides no instructions for changing inventory valuation methods, it must be assumed that such changes are not permitted. Therefore, while SHUR appears to permit any of several generally accepted accounting methods of valuating inventories, it restricts changes to other methods in contradiction to GAAP.

Balance Sheet Requirements

As stated earlier, the principle purpose of the SHUR is to obtain information regarding: "1) the aggregate cost of operation and the aggregate volume of services, and 2) the cost and volume of services for various functional accounts and subaccounts..."[48] Chapter 1 of the SHUR manual devotes considerable effort in stating its reporting principles and accounting concepts regarding

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46 Draft SHUR Manual, page 1.25.

47 Draft SHUR Manual, page 1.20.

48 42 U.S.C. §1320a.

balance sheet information. If the primary thrust of the SHUR is to obtain information concerning expenses and statistics, it seems impractical to require extensive and costly changes to obtain balance sheet information. In fact, AHA questions the requirement for balance sheet data; it appears that the requirement is not needed to fulfill SHUR's legislative directive. However, if the SHUR can justify the reporting of specific balance sheet items and requires the items to be reported in a manner that restricts the use of generally accepted accounting principles, a basic reconciliation of the hospital's reported line item to that required by SHUR could simplify this entire process.[49]

Materiality

The SHUR manual discusses the concept of materiality in three separate areas. First, section 1180 states that "materiality is an illusive concept with the dividing line between material and immaterial amounts subject to various interpretations. It is clear, however, that an amount is material if its exclusion from the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements."[50] [Emphasis added.]

Next, section 3200 states that

> it should be noted that reclassification must be made for material amounts of misplaced cost. Material is defined, for the purposes of this manual, as an amount equivalent to an aggregate amount of misplaced costs in excess of the lesser of:
>
> 1) 3% of the direct costs of the functional cost center transfered to or from, or
>
> 2) one-quarter of 1% of the total annual operating expenses.

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[49] For example, if the HCFA desires to restrict the reporting of the net value of fixed and major moveable assets to reflect depreciation expense on the straight-line method conversion from an accelerated method under GAAP to the straight-line method under SHUR could be accomplished through the use of a simple reconciliation schedule. This would result in a reduction of SHUR requirements, its instructions and, most importantly, the cost of preparation.

[50] Draft SHUR Manual, page 1.6.

> However, in no case is a reclassification necessary if the aggregate amount of misplaced cost per cost center is less than $1,000.[51] [Emphasis added.]

A definition of materiality is also contained in Appendix A-glossary. This definition states

> the relative importance, when measured against a standard of comparison, of all items (cumulative by cost center or account) included in or admitted from books of accounts or financial statements, or any procedure or change in procedure that conceivably might affect such statements. An amount is material if its exclusion from or inclusion in on an accounting statement would make it misleading.[52] [Emphasis added.]

The definition of materiality contained within the glossary tends to complement the definition contained in section 1180. These two definitions support GAAP. However, the formulistic definitions delineated in section 3200 contradict the basic thrust of GAAP. Because materiality is a concept based on judgments, a restrictive and/or formulistic definition of this concept is not only unnecessary, but unwise. The result will be to cause institutions to incur substantial costs for recordkeeping to determine the need for any possible reclassifications.

Since hospitals will have to determine, under the SHUR's definition, whether they have incurred costs considered material, it will be a costly undertaking for a hospital to accumulate many small costs, and then find that they total only $999.00. In that case, the cost would not be subject to reclassification because the amount does not exceed the materiality threshold.

Furthermore, by SHUR's own formulistic approach, comparability is lost. $1,000 in a 50-bed hospital, for example, is probably more material than $1,000 in a 500-bed facility. Therefore, AHA recommends that SHUR simply accept the concept of materiality for reporting purposes as expressed under GAAP and dispense with adherence to a formula approach.

Capitalization

Current Medicare policy requires capitalization of assets with a historical cost of at least $150 and a minimum estimated useful

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51 Draft SHUR Manual, page 3.25.

52 Draft SHUR Manual, page A-24.

life of two years. In contrast, SHUR requires that "if a depreciable asset has at the time of its acquisition an estimated useful life of three or more years, and a historical cost of at least $300, its cost must be capitalized, and written off ratably over the estimated useful life of the asset."[53] Thus we have a clear conflict between two government agencies over the issue of determining a threshold for capitalizing or expensing an asset.

Moreover, in this rapid inflationary environment, restricting limits for capitalization may, within a very short period, require extensive recordkeeping for small purchases as the value of the dollar continues to shrink. No benefit to comparability is realized by mandating a specific dollar amount as a capitalization policy. Rather, we believe adherence to GAAP and verification of hospital financial positions by independent year-end audit will provide sufficient safeguards to insure that hospitals are accurately expensing or capitalizing their assets. Adherence to GAAP will also relieve hospitals of additional, time-consuming, and costly recordkeeping.

D. Direct Reporting of Specific Costs

The concept of functional reporting as mandated by the SHUR requires the allocation of direct expenses to the functional center receiving or providing services. SHUR requires direct costing for such items as:

- Depreciation expense on major moveable equipment
- Salary and payroll related employee benefits
- Employee fringe benefits
- Medical supplies
- Drugs
- Maintenance of plant
- Data processing expenses
- Central patient transportation

Most, if not all, of these costs traditionally have been maintained by hospitals in individual accounts. As already noted, SHUR is intended to develop a comparable data base regarding hospital operations so that government can make meaningful decisions. It is AHA's position that allocation of these costs as prescribed by the SHUR will not enhance that objective.

Moveable Equipment: Depreciation Expense

Section 1612 requires the

> cost of depreciation and rent/lease on moveable equipment which is utilized solely by a

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53 Draft SHUR Manual, page 1.21.

> functional cost center must be directly assigned to that functional cost center based upon specific identification through plant ledger records. Where the cost of depreciation or rent/lease of the moveable equipment is utilized by two or more functional cost centers, the depreciation or rent/lease applicable to such moveable equipment must be directly assigned to such functional cost centers based upon cost center usage.[54]

Accumulation of this data in the functional cost center without specific nonfinancial information will not yield comparable data regarding the age of such equipment, the numbers of such equipment or, for that matter, the terms of rent/leasing arrangements. Therefore, AHA recommends that depreciation and rental expenses on moveable equipment be recorded as a separate unassigned functional cost center.

Salary and Payroll Related Employee Benefits

Section 1613 requires that salary cost

> must be assigned directly to the functional cost center to which the employee is assigned. This assignment must be based on each employee's actual...hours performed within...cost center multiplied by that employee's hourly salary rate while performing the...service.[55]

Not only will compliance with this requirement be a costly operation, we also question the effect of the requirement on determing comparability. Further, the provision requiring that float personnel be directly assigned to the functional cost center where they are providing services rather than to an administrative cost center further exacerbates a very difficult recordkeeping process. This is especially true in hospitals that do not use some form of electronic data processing. Again, if the purpose of the SHUR is to obtain comparable data requiring the functional cost allocation of salary expense without other specific nonfinancial information, such as the number of float personnel maintained by a hospital, meaningful conclusions cannot be reached.

Employee Fringe Benefits

Section 1614 requires that the cost of nonpayroll related employee benefits be assigned directly to the functional cost centers

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54 Draft SHUR Manual, page 1.28.

55 Draft SHUR Manual, page 1.29.

based upon the number of full-time equivalent employees.[56] Again, AHA recommends these costs be maintained in a separate unassigned functional cost center. Without the inclusion of specific information regarding the level of fringe benefits offered employees and other information pertaining to union contracts, geographic factors, etc., considering this cost data comparable is inappropriate.

Plant Maintenance

Section 1617 requires that the

> cost of noncapitalizable nonroutine maintenance and repairs directly assignable to a single cost center must be transferred to the cost center receiving the service. These costs include all direct expenses incurred by the plant operations and maintenance cost center in performing such services.[57]

AHA recommends that this requirement be eliminated and that all noncapitalizable, nonroutine maintenance and repairs be recorded in the plant operations and maintenance cost center. In the absence of nonfinancial information, requiring alloction of these direct costs to the functional cost center receiving the services does not provide evidence of the nature of the services being rendered. It also does not provide comparability among institutions since the information fails to recognize the age of a facility and/or its equipment. Therefore, recording these costs in the functional cost center in which the services are rendered creates serious distortions and prevents meaningful decision-making.

Data Processing

Section 1618 requires that "all the direct cost incurred in operating an electronic data processing center shall be transferred to the using cost center on the basis of CPU (central processing unit time)."[58] Previously it was noted that allocating data processing cost on CPU time does not equate services rendered by the data processing department with the actual user departments. It is recognized that data processing is an important and costly variable used in the provision of hospital operations. Therefore,

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56 Draft SHUR Manual, page 1.30.

57 Draft SHUR Manual, page 1.31.

58 Draft SHUR Manual, page 1.31.

it is imperative that the true cost associated with the use of data processing by using centers be carefully identified. AHA recommends that either data processing costs be maintained in an unassigned functional cost center or realistic allocation bases be developed to distribute the data processing costs to the users of the system in a manner that equitably and accurately relates to usage.

Central Patient Transportation

Section 1619 requires that

> central patient transportation cost of transporting patients to and from ancillary services are considered a part of the ancillary services function of the hospital. Therefore, all such costs, wherever they are incurred, must be transferred to the appropriate ancillary service cost centers for reporting purposes.[59]

We do not believe transportation costs are significant enough to require functional treatment. Rather, we believe such costs could be appropriately and adequately handled by either permitting the hospital to include the cost associated with central patient transportation to be accumulated in an unassigned functional cost center or to be allocated to ancillary departments based upon simple sampling techniques. This would reduce extensive record-keeping requirements while not affecting comparability of information.

E. Standard Units of Measure

The standard unit of measure (SUM), according to the SHUR, is required to provide a uniform statistic for measuring costs. SHUR provides that the standard units of measure for revenue prodcing cost centers are an attempt to measure the volume of services rendered to patients while those for nonrevenue producing cost centers are an attempt to measure the volume of support services rendered. The standard units of measure are further cited as the mechanism by which SHUR data is translated "to facilitate cost and revenue comparisons among peer group health facilities."[60] The AHA believes most of the required standard units of measure will not accomplish this objective.

In several situations a meaningful standard unit of measure does not exist. For example, in its list of standard units of measure,

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[59] Draft SHUR Manual, page 1.32.

[60] Draft SHUR Manual, page 3.40.

SHUR requires each $1,000 of gross patient revenue as a measure of hospital and professional malpractice insurance, each $1,000 of patient revenue to evaluate short-term interest expense, each $1,000 of total hospital operating expenses to evaluate general accounting functions, each $1,000 of funds pledged to evaluate fundraising, etc. The units derived from such computations do not reveal anything about the facility other than there is "so much" expense per $1,000.

In other instances, SUMs are defined too rigidly. For example, the SHUR relies on the number of gross square feet to include the total floor area of the plant including common areas (hallways, stairways, elevators, lobbies, closets, etc.) as a unit of measure for plant operations and security. Many hospitals have in the past kept square footage on a net basis. The net basis excludes the nonproductive common areas of elevator shafts, lobbies, and nonproductive space from the statisical basis. Mandating the use of gross square footage will require many hospitals to recalculate square footage statistics for their entire plant. This could be a very costly undertaking.

The intent of mandating a singular method for developing a uniform definition of square footage is to remove apparent differences for comparison purposes. However, we are not convinced that in this instance prescribing a uniform definition of square footage measurements will result in uniformity and comparability. To minimize conversion costs and burden in adopting either the net or gross square footage method, the HCFA should require the one most commonly utilized by all hospitals.

Nonetheless, comparability distortions will still arise using either square footage system because no information concerning the physical design of each hospital is being considered. Some may have larger common areas than others, some may be high rise facilities, while others may be sprawling complexes.

To a large extent, the design of a facility depends upon location (urban or rural) and its age. Therefore, careful consideration must be given to square footage statistics when used for allocation purposes in order for the data to be useful and meaningful.

The standard units of measure for many similar type cost centers are different. For example, the therapies--physical, occupational, respiratory, speech, and recreational--provide therapeutic treatments to patients in similar ways. However, the SUMs for these departments vary significantly. In some areas, relative value units are used, while in others, treatments or encounters of service are used. While we are concerned with the reliability of some of the relative value units, we are even more concerned with the use of visits as the SUM for defining treatments. We believe the latter does not adequately account for variances in mix or degree of difficulty in providing care.

Many of the clinic services SUMs count a visit as each registration of a patient in that particular unit of the hospital. Multiple services performed in any of these units during a single registration are only recorded as one visit. Use of this SUM in this manner seriously distorts comparability of services provided. Not only do we believe the SUM deficient for its failure to recognize mix and intensity factors, but also that similar cost centers should have similar defined standard units of measure.

F. SHUR Reporting Forms

In reviewing the proposed SHUR reporting forms, the issue concerning the required use of the requested data is recurring. Because the SHUR manual was developed without first determining the use and users of the system, we must not only question the purpose of obtaining much of the information, but also the purpose to which it will be used. Without knowing the latter, it is not possible to accurately address the efficiency of the forms and the validity of the requested information. As a result, our comments are limited, for the most part, to a discussion that either reveals noncompatability of the collected information or questions the purposes for seeking the data. In addition, we have a serious concern with the thrust of the certification statement.

Our comments are also limited to a discussion of worksheets A through E; these forms represent the major additions and/or changes to the existing Medicare cost reports. Since these forms provide part of the input to the remaining forms, any modifications or eliminations may cause the remaining forms to revert to the existing Medicare cost reporting system (which we are not reviewing in the context of the SHUR NPRM).

Certification Statement

The cover page to the uniform report contains a certification statement setting forth the language of sections 1877 (a)(i) and 1909 (a)(i) of the Social Security Act. The statement details possible penalities to be imposed for knowingly making false statements or representations of fact in completing the uniform report. We believe the presence and current location of the certification statement fosters a perception of federal government intimidation.

Below the cerification statement is a paragraph requiring certification by the chief administrative officer, chief financial officer, and the preparer of the uniform report. The language of this certification differs significantly from the certification page of existing Medicare cost reports which certifies that the cost report is prepared in accordance with applicable instructions "except as noted." Deletion of the phrase "except as noted" signifies that no exception will be recognized by the Health Care Financing Administration in filing a uniform report inconsistent

with its appropriate instructions. Together with the certification statement alluding to possible penalties for failure to comply with prescribed instructions for completing the uniform report, this could negate the entire appeal process dealing with Medicare cost reports.

At present, the only mechanism for hospitals to air grievances concerning disputed Medicare cost report issues is for them to take exception along with such items in the filing of the cost report. In order to preclude possible criminal prosecutions for failure to comply with SHUR instructions, hospitals may simply complete their Medicare cost reports in total compliance with instructions contained therein, having realized a loss of Medicare reimbursement, and having waived their rights for future appeal.

Worksheet A-1: General Hospital Information

This particular worksheet requires general hospital information. Most, if not all, of this information should be readily available from a hospital's records. Nonetheless problems may exist with obtaining accurate information because of a lack of clarity in the instructions and the purpose for which such information is to be used.

Item no. 4 regarding type of hospital requires teaching hospitals to indicate whether they are university teaching or university affiliated. A review of the instruction regarding completion of this activity could result in hospitals answering both questions. We do not believe a response to both questions is intended. Perhaps an important element, i.e., type of ownership, is missing and needs to be included.

Similarly, item no. 6 concerning medical education programs seek to identify which medical education programs are provided by the hospital. However, no information regarding the level of activity of such programs is requested. Simply indicating that a hospital has approved programs does not reveal their level or magnitude.

Again, item no. 7 concerning health planning requires the identification of a number of certain specified medical procedures. Such information in its present format will not reveal meaningful data. As an example, one of the items requires hospitals to submit the number of cancer patients who received megavoltage radiation therapy during the fiscal year. The hospital is required to count each patient only once, regardless of the number of treatments. Obviously, reporting in this manner significantly distorts the true level of service provided by a given institution.

Worksheet A2-1: Services Inventory
Worksheet A2-2: Services Inventory

According to section 4430 of the SHUR manual these worksheets are intended to "provide an inventory of services offered by the

hospital. The listing of services is not intended to be all inclusive. Each service must be coded in accordance with the codes provided."[61] As noted with worksheet A-1, the purpose of requiring this form is not identified nor is the use of the required information. Distortions will definitely result if the purpose of this form is for grouping hospitals according to their service mix, because not only is the data to be supplied ambiguous, but also the instructional definitions do not provide a level of clarity to insure that all hospitals understand what they are reporting. For example, a hospital can respond that a listed service is not maintained in the hospital, but is available from outside contractors. Listing the availability of the service does not reveal how often, if ever, such a service is utilized, or the scope of providing such services, if it is required. The question is raised, therefore, as to whether the supplying agency can always provide the service when called upon. In order to make such data meaningful, the instructions must state the purpose for requesting the information, as well as who is going to use it and in what manner.

Worksheet B-1: Daily Hospital Services Statistics

This worksheet requires hospitals to identify daily hospital service statistics, including licensed beds, beds available, and total inpatient days, by age, pediatric, maternity and other categories for specified cost centers. In states which have no licensing functions problems could exist with hospitals trying to report their bed complement, especially by the types the form requires. The instructions must clarify how to report beds in non-licensing states. Also, the instructions do not address the handling of statistics if a hospital should have an overflow condition; for instance the instructions do not specify the handling of a maternity patient who is placed in a medical/surgical area because the maternity area is temporarily fully occupied.

Finally the concept of swing beds, i.e., placing skilled nursing care or long-term care patients in acute areas, is not addressed. While the swing bed concept is presently experimental, legislation may soon be passed expanding its use. Failure to recognize these and other similar problems can cause further distortions of the information requested by overstating one statistic and understating others.

Worksheet B-4: Real and Tangible Property Financed and Real Property Rented

Part I of this form is aimed at obtaining information "regarding financing on real and tangible property as of the last day of the

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[61] Draft SHUR Manual, page 4.14.

hospital's reporting period."[62] While hospitals should be able to provide this information, we believe the form as proposed is seriously deficient and will hamper effective data collection efforts. The form only contains one line for hospitals to report their method of financing, for example, building and equipment. If a hospital secures financing under multiple means, i.e., conventional mortgages, tax exempt bonds, etc., or finances its plant and equipment at different times and thereby incurs different interest rates for any of the listed financial mechanisms, a hospital will not be able to insert all of the necessary information. Therefore, the form needs careful revision. Before the form is revised, however, the purpose of securing this information needs to be addressed in order to insure that the collection of such information has a purpose and that the data reported will achieve its desired purpose.

Worksheet B-5: Interns, Residents, and Fellow Profile

This form requires hospitals to report "the numbers of interns, residents, and fellows on the hospital's medical staff by clinical specialty on the last day of the hospital's fiscal year."[63] First, a definitional problem exists. The "intern" designation has been eliminated. Second, requiring hospitals to report this statistic as of the last day of their fiscal year fails to recognize possible rotational staff assignment. These individuals would be excluded from the computations. The form also fails to provide information relative to the experience of these individuals. The result could be serious distortions if the raw data is used for comparison purposes. Without a stated purpose for the collection of this information, it is impossible to comment further.

Worksheet C-1: Balance Sheet
Worksheet C-3: Statement of Changes in Fund Balances
Worksheet C-4: Statement of Changes in Financial Position - Unrestricted Fund

Since SHUR requires information regarding the: "(1) the aggregate cost of operation and the aggregate volume of services, and (2) the cost and volume of services for various functional accounts and subaccounts,"[64] there is no purpose served by requiring hospitals to submit detailed information on their financial position. These forms do not reveal anything about the cost of hospital operations or volumes of services. Furthermore, requiring hospitals to report restricted funds, as the form mandates, in

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62 Draft SHUR Manual, page 4.22.

63 Draft SHUR Manual, page 4.24.

64 U.S.C. §1320a.

the general (unrestricted) fund is not only arbitary, but contrary to many laws and long-term debt covenants (which may, for example, require specific sinking fund accumulations).

No comparable conclusions can be drawn from the information reported; it is seriously distorted by the inclusion of restricted fund balances. Because the NPRM does not address Balance Sheet information, we recommend that the HCFA completely delete requirements for this information.

Worksheet D-1: Statement of Patient Care Services Revenue
Worksheet D-2: Statement of Operating and Non-Operating Revenue

These worksheets (1) summarize gross patient revenue by revenue centers and (2) are used to report other non-operating revenue. The NPRM does not address the reporting of revenue--only costs, volume and services. Additionally, these worksheets contain fundamental violations of the concept of matching expenses and revenues. For example, the cost of data processing services sold to others must be accumulated within the hospital's administrative and general cost center while the instructions in these forms require the revenue to be reported in other operating revenue. Therefore, these forms should be deleted.

Worksheet E-1: Statement of Patient Care Expenses
Worksheet E-2: Statement of Other Operating and Non-Operating Expenses

These worksheets report expenses by the SHUR's definitional breakdown of natural classification of expense categories and the standard units of measure for each functional cost center. We believe these worksheets can be modified to achieve a level of uniform reporting embracing the intent of Section 19 without excessive detail and cost. We will expand upon this contention in Section V.

Worksheet E-3: Health Facility Manpower Statistics

Worksheet E-3 requires the reporting of all salaries, wages and full time equivalent employees by 11 designated classifications. The information required will be burdensome to gather, especially for those hospials not employing a data processing payroll accounting system.

The reason for collecting the data is not specified. If it is for comparison purposes, however, we believe the reported data will be deficient. First, small hospitals, because of the apparent burden of completing this form, are excused from its preparation. Secondly, the form requires full time equivalent to be determined by dividing total worked hours by 2080. This figure represents a normal 40 hour work week. Yet, not all hospitals have a standard

40 hour week; many are on 37 1/2 hours while others are on 35 hours. Furthermore, no information concerning vacation policies or other similiar leave programs is incorporated. As a result, the information may not prove reliable for comparison purposes. This worksheet should therefore be deleted.

Worksheet E-4-1)
Worksheet E-4-2)
Worksheet E-4-3): Cost Allocation Statistical Matrix
Worksheet E-4-4)

These worksheets, according to the SHUR, "report the required statistics for cost allocation."[65] SHUR further states that "the purpose of cost allocation is to determine the total or full costs of operating the revenue producing centers of the hospital."[66] The SHUR contains the definitions and sources of statistics for cost allocations in section 4582.

Several serious problems exist with the reporting of the required information. In a number of instances the cost allocation bases for these worksheets differ from the required standard units of measure calculation. Some also differ from the cost allocation statistics for Medicare cost finding. For example, the Medicare statistic for allocating laundry expense is dry and clean pounds processed while the allocation statistic for this worksheet is dry and clean pounds distributed.

The instructions to these worksheets also are incomplete. The instructions refer the reader to other sections of the SHUR for a further explanation of definitions and other material to be relied upon in completing the worksheets. However, the instructions have left those section numbers blank. The end result of all the reported data is not incorporated into any other forms. Therefore, the data appears to be an open-ended mechanism for government manipulations without unknown reasons or purposes.

Because the purpose or purposes of these worksheets are basically unknown, the data required in several instances is contrary to other SHUR requirements; the instructions are incomplete and the forms appear to be an open-ended mechanism for governmental manipulation, the worksheets should be deleted.

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65 Draft SHUR Manual, page 4.32.

66 Draft SHUR Manual, page 4.34.

V. AHA PROPOSED ALTERNATIVE TO SHUR

The following is a recommendation to help develop a less detailed and less costly System for Hospital Uniform Reporting. An AHA task force was formed for the primary purpose of reviewing the proposal, developing comments, and recommending an alternative to the proposed SHUR. The task force believes that the major component of any uniform reporting system is the proper identification and reporting of direct costs. These costs represent the majority of cost items that can, if properly identified, distinguish one hospital from another. The format of worksheet E-1 begins to offer the basis of such a system. Worksheet E-1 is a statement of patient care services expense. It lists the hospital's cost centers and requires specific information concerning direct costs attibuted to each of the cost centers. AHA is in the process of developing a cost accounting manual that will further develop the basis of such a system.

Direct Cost Approach

Many of our comments indicate a belief by the hospital industry that the SHUR will not achieve one of its basic objectives -- comparability of different institutional operations. The SHUR proposal is too concerned with accounting for every cost situation. Further, it does not seek non-financial data that is necessary to identify hospital differences.

The most important and readily controllable components of any hospital department are its direct costs. Present Medicare cost reporting forms only provide information of direct departmental costs in the aggregate, i.e., by total salaries and non-salaries. Expanding the level of information to several components by department -- that include vital nonfinancial data -- could result in an extremely effective uniform reporting system at minimal cost and inconvenience to the provider.[67]

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[67] For example, HCFA could require the following information for the radiology department:

1. Total salaries for assigned personnel;
2. Total fringe benefits for assigned personnel, based upon hospital sampling techniques;
3. Professional fees designated by specified natural classifications;
4. Medical supplies designated by major types;
5. Non-medical supplies designated by major types;
6. Purchased services designated by major types;
7. Other direct expenses;
8. Depreciation expense designated for major moveable equipment with information concerning types, numbers, and ages, etc.;
9. Rental/lease agreements designating the terms and types of leases and equipment, etc.

Also, pertinent standard units of measure recognizing valid differences and intensity should be included. The result would be knowledge of the direct components of hospital departments. Analysis could then be made without risk of erroneous conclusions stemming from improper allocation bases or short-term uncontrollable fixed costs.

Throughout this brief discussion on this approach, no indirect or overhead costs are addressed. These costs should remain within their appropriate cost centers. We would not burden hospitals with extensive reclassification of these costs because they are (1) non-controllable for the most part and (2) difficult for inter-hospital comparison purposes unless substantiated by excessive non-financial data. Rather, GAAP and year-end audit review should govern and validate these items. We are also not suggesting that every hospital department undergo reporting, only those in which a majority of costs are incurred and which the HCFA requires data for decision-making. Again, this is to reduce the costs of compliance and monitoring.

AHA Development

One of the fundamental differences that exist in accounting for a hospital's expenses in providing services and that of a typical business is the multitude and diversity of the hospital product when compared to that of a business. Hospitals produce virtually thousands, if not tens of thousands, of products, i.e., the types of care and treatments rendered. Because of this factor, hospitals, in cooperation with third-party payers, developed cost finding -- not cost accounting -- as a means of determining the average cost of providing units of care. Unfortunately, cost finding, while extremely useful for certain things, is very inaccurate for measuring and comparing costs among different institutions.

The AHA is currently developing a new cost accounting manual for hospitals. While it does not prescribe an exact accounting system, it begins to address a more rational and accurate method for the recording of the direct resources used in the provision of health care. This manual is currently approaching a final draft version. It is our intention to share it with you because we believe it would be useful in developing a reporting system acceptable to both HEW/HCFA and the hospital industry.

On behlaf of the hospital industry, AHA is most willing to meet with HEW/HCFA to further discuss development of an appropriate uniform reporting system.