

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

March 25-26, 1981  
Washington Hilton Hotel  
Washington, DC

WEDNESDAY, March 25, 1981

6:30pm	Joint COTH/CAS Administrative Board Meeting	Military Room
7:30pm	Joint COTH/CAS Reception	Hemisphere Room
8:30pm	Joint COTH/CAS Dinner	Hemisphere Room

THURSDAY, March 26, 1981

9:00am	COTH Administrative Board Meeting	Kalorama Room
12:30pm	Joint Administrative Boards Luncheon	Map Room
1:30pm	Executive Council Business Meeting	Conservatory Room



# association of american medical colleges

## COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD MEETING

March 25-26, 1981  
Washington Hilton Hotel  
Kalorama Room  
9:00am-12:30pm

### A G E N D A

- I. Call to Order
- II. Consideration of the Minutes Page 2
- III. COTH Membership Applications
  - o Froedtert Memorial Lutheran Hospital Page 17  
Milwaukee, Wisconsin
  - o Massachusetts Rehabilitation Hospital Page 42  
Boston, Massachusetts  
(correspondence)
- IV. Future COTH Meetings
  - o 1983 Spring Meeting Location Page 44
  - o 1981 Annual Meeting Program Page 45
- V. Administration's Proposed Medicaid Budget Page 48
- VI. Report of the Ad Hoc Committee on Competition Executive Council  
Agenda - Page 56
  - Also for discussion is the AHA House Page 73  
of Delegates position on "consumer  
choice"
- VII. AAMC Position on Repeal of P.L. 93-641 Page 74
- VIII. General Requirements of the Essentials Executive Council  
Agenda - Page 17
- IX. GSA Resolution on Completion of Admission Process by May 15 Executive Council  
Agenda - Page 44
- X. Student Financial Assistance Executive Council  
Agenda - Page 47

XI. Discussion Items

- o Due Process for Students and Residents      Executive Council  
Agenda - Page 94
- o USFMS Committee - Status Report
- o Possible AAMC Activities in Geriatric      Executive Council  
Medicine      Agenda - Page 98
- o Legislative and Budget Matters

XII. New Business

XIII. Adjourn

Association of American Medical Colleges  
COTH Administrative Board Meeting

Washington Hilton Hotel  
Washington, D.C.  
January 29, 1981

PRESENT:

Stuart J. Marylander, Chairman  
John W. Colloton, Immediate Past Chairman  
Dennis R. Barry  
Fred J. Cowell  
Spencer Foreman, MD  
Robert E. Frank  
Earl J. Frederick  
Mark S. Levitan  
John A. Reinertsen  
Haynes Rice  
John V. Sheehan  
William T. Robinson, AHA Representative

ABSENT:

Mitchell T. Rabkin, MD, Chairman-Elect  
James W. Bartlett, MD, Secretary  
Robert K. Match, MD

GUESTS:

Thomas K. Oliver, Jr, MD  
Robert E. Tranquada, MD

STAFF:

Martha Anderson, PhD  
James D. Bentley, PhD  
Peter W. Butler  
John A. D. Cooper, MD  
Mary Eng  
Melinda Hatton  
Joseph C. Isaacs  
Paul Jolly, PhD  
Richard M. Knapp, PhD  
Jane E. Neubig  
Madeline M. Nevins, PhD  
August G. Swanson, MD  
Melissa H. Wubbold

## COTH ADMINISTRATIVE BOARD MEETING MINUTES

January 29, 1981

I. Call to Order

Mr. Marylander called the meeting to order at 9:15am in the Hamilton Room of the Washington Hilton Hotel.

He welcomed three new Board members -- Dr. Foreman, and Messrs. Rice and Sheehan -- and presented them with AAMC ties. He then introduced two guests -- Dr. Oliver and Dr. Tranquada, and noted the absence of Drs. Rabkin Bartlett and Match who were attending the Society of Medical Administrators Meeting in Puerto Rico.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the October 27, 1980 COTH Administrative Board Meeting without amendment.

III. Open Discussion

Dr. Knapp introduced staff members Dr. Paul Jolly, Mindy Hatton and Mary Eng, and described the cooperative agreement between the Administration on Aging (AoA) and the AAMC for a long-term care gerontology project. Dr. Knapp then introduced Dr. Madeline Nevins and Jane Neubig, the staff members who recently joined the Department of Teaching Hospitals to work on the AoA project.

Mr. Marylander announced the following appointments:

COTH Nominating Committee - John W. Colloton, Chairman  
Stuart J. Marylander  
Don L. Arnwine

AAMC Nominating Committee - includes COTH Nominating  
Committee chairman and one at-large member  
David L. Everhart

Ad Hoc External Examination Review Committee -  
Jerome H. Grossman, MD

Flexner Award Committee - Edward C. Andrews, Jr, MD

Mr. Marylander then gave a summation of the outcome of

the AAMC Officers' Retreat, December 12, 1980 and discussed the problem of getting across to the business community the features, problems and characteristics of the teaching hospital. He stated that the Business Roundtable has a Health Policy Task Force, chaired by Walter Wriston of CitiBank in NYC. Mr. Wriston is a board member of the New York Hospital, whose Director, Dr. David Thompson, has agreed to try and get COTH on the Task Force's March meeting agenda. He advised the Board it would be kept informed of any developments in this area.

Mr. Marylander then announced that the Management Advancement Program date, discussed at great length at the January Board meeting, had been changed from June to October 2-7, 1981 to accommodate those COTH members who would have been unable to attend because of schedule conflicts. All CEO's who have not participated in the past will be invited, as well as their senior associates, pending the response to the first round of invitations. He asked Mr. Sheehan to act as the VA liaison for MAP and encouraged the continued involvement of the VA directors in this program.

Dr. Knapp then described the program for the upcoming 1981 Spring Meeting in Atlanta. He pointed out that the 1982 meeting would be in Boston and asked for suggestions on the 1983 meeting site. He indicated that in spite of the relatively small size of the COTH Spring Meeting, problems with hotel space necessitate making this decision in the near future. Additionally, he asked for suggestions on the COTH General Session program at the 1981 AAMC Annual Meeting. He hoped that the suggestions requested would be discussed at the March Board Meeting.

#### IV. Membership Applications

Four applications for COTH membership were reviewed. Based on staff recommendations, the Board took the following actions:

ACTION: It was moved, seconded and carried to approve The Carney Hospital of Boston, Massachusetts for full membership.

ACTION: It was moved, seconded and carried to approve the Danbury Hospital of Danbury, Connecticut for full membership.

ACTION: It was moved, seconded and carried to approve

the Saint Mary's Hospital of Grand Rapids, Michigan for full membership.

ACTION: It was moved, seconded and carried to approve the University Hospital at Stony Brook, New York for full membership.

V. Report of the Ad Hoc Committee on Competition

Dr. Robert E. Tranquada, Chancellor/Dean of the University of Massachusetts Medical School (Worcester) and Chairman of the Ad Hoc Committee on Competition, reported on the Committee's activities and AAMC's draft report on competition.

Dr. Tranquada briefly discussed the background of the issue and noted that since 1950, disposable income in the U.S. devoted to medical care has grown from 4.4% to 9.3% or more than a 100% increase. The obvious public policy question, he stated, is how much further can that proportion increase and what measures are available to restrict its growth. He noted the increasing disenchantment with regulatory solutions and the substantial interest in moving toward incentives for price competition. However, he reported, a full economic impact analysis has yet to be done on the latter approach.

He then briefly outlined the issues and potential effects addressed in the report:

- o undergraduate medical education -- both direct and indirect costs are funded to a significant extent from patient care revenues which can be affected under price competition;
- o graduate medical education -- there may be a decreased willingness among affiliated hospitals to accept residents because of the attendant costs. This would probably have a more severe effect on primary care training than more highly specialized tertiary care training;
- o allied health sciences education may be negatively affected both by profit driven demands with respect to specific categories

of personnel needs and the considerable attendant costs of developing and maintaining educational programs that require hospital participation;

- o biomedical research is to some degree subsidized from patient care revenues;
- o case mix problems -- teaching hospitals will probably be able to compete well at the highly specialized tertiary care level, but their competitiveness at the primary and secondary care levels is less likely when the added burden of the education commitment is considered;
- o charity care -- the teaching hospital's role in the delivery of a non- or poorly compensated care will have to be re-evaluated under competition; and
- o ambulatory care which is rarely self-supporting will also have to be reassessed.

Dr. Tranquada reported that the Committee has discussed three possible responses to the above potentialities: (1) alter the state of medical education to prioritize cost areas to fit more closely the anticipated effects of price competition; (2) seek subsidies to maintain existing programs or support development of programs deemed worthy for the future; and/or (3) "join the fray" and compete as best as possible.

He again stressed the need for AAMC to develop a position on competition and the possibility of recommendations with respect to legislative activities. In response to questions from the Board, Dr. Tranquada noted that the Ad Hoc Committee did not address specifically the potential effects of competition on faculty practice plans or whether there is a need to quantify individual education and

research costs.

Mr. Colloton felt the AAMC's position should dovetail with Congressional deliberations on the issue. Dr. Tranquada stated that the Committee had discussed this and determined that there was time to refine the report and that Association policy should not be stated too early. Mr. Levitan asked whether the possibility of price competition increasing health costs was addressed by the Committee. He believed that unit costs may be reduced under competition, but total costs could increase substantially. Dr. Tranquada stated that such overall cost impacts were not addressed. Dr. Knapp suggested that the Committee report clearly state recognition that claims that competition will reduce costs remain assumptions.

Mr. Marylander remarked that one of the problems in dealing adequately with this issue is that no one has adequately defined "competition in the marketplace". As a result everyone discusses it from their own definition and confusion ensues. He noted that the thrust for competition is generated by two motivations; (1) to find an approach less onerous than regulation and, (2) to reduce the total number of dollars being spent on health care. Mr. Marylander stated that legislators are taking a surreptitious approach by giving the public the impression that competition by itself is going to bring down the cost of health care and therefore is a positively better approach. In fact, Mr. Marylander stated, what they are really doing is trying to find a way to reduce the demand for health care. Mr. Marylander felt that the legislators should not be allowed to duck the questions of the costs associated with the competition approaches. Additionally, he was concerned about the concept of providing separate funding for medical education. He felt that theoretically the concept may sound good, but practically, it might jeopardize medical education severely in the future. Dr. Tranquada agreed.

Mr. Barry concurred that competition will not necessarily save money unless the probability of recreating a two-class system is accepted. He felt that this premise should be pointed out more clearly in the Committee report. Additionally, he noted that other major impacts upon hospitals, such as possible capital starvation in the non-profit sector and a potential shift to a for-profit hospital industry, should also be addressed.

Mr. Colloton recommended a number of changes that he felt would make the report more effective and wondered whether it would be wise to distribute the document outside the constituency at this point.

Mr. Levitan believed, on the basis of the experiences of proprietary hospitals who segment the market, teaching hospitals could compete by foregoing some of their missions and generating sufficient patient care revenues. He emphasized that price alone is not the determinant of utilization or choice of coverage by consumers in the health care marketplace. He felt strongly that the question of how the cost versus quality of care needs to be resolved before any new approach involving price competition is undertaken. In addition, he wondered how much influence employers could really have on employee choice of coverage and use. Dr. Jolly felt that the point was people are willing to pay for more health care and seem to want it. Therefore, a competitive environment may not be conducive to reducing health care costs and use.

Mr. Marylander was concerned that the complexity of multi-institutional arrangements was understated on page 43 of the Committee report. Mr. Frederick agreed that the logistics involved in such arrangements should not be oversimplified and noted how difficult it is to build interest for such arrangements among the faculty at teaching hospitals. Mr. Colloton did not believe that the AAMC should endorse the American Hospital Association's Environmental Assessment in the manner stated on page 42 of the Committee report. He also felt that the reference to indigent patients in the first bullet on page 36 of the report should not be limited to those in the inner city, for teaching hospitals serve these patient's in suburban and rural areas as well. In addition, he noted that the discussion of major reform of the health care industry as a "long-term proposition" on page 61 of the report may be inappropriate in light of the legislative proposals that have been introduced. Dr. Knapp closed this portion of the discussion by stating that he felt the suggestions made were significant and that many would be used to rework the document in time for the March Board meeting.

Mr. Rice continued the discussion by stressing that more emphasis needed to be placed on how competition would affect the large segment of the population with little or no medical coverage, particularly in areas with only one general medical facility. He felt that the potentiality for recreating a two-class system of care was great, for there would be definite problems in educating the public on how to spend their health care dollars appropriately and further problems in caring for those with no means for any type of coverage.

Mr. Marylander emphasized that in all competition models the recipient is put at risk to a certain extent. He felt that recipients might easily make an error in choice of coverage and the outcome of such an error needs to be carefully examined. Mr. Frederick felt the question of who will be the provider of last resort under suggested voucher systems needs also to be answered. If the answer is teaching hospitals, Mr. Frederick saw this as a significant inhibitor of the teaching hospital's ability to compete effectively. Dr. Knapp felt it would be difficult to project the extent of the problem of care for the indigent patient under competition without more information on amounts of coverage that will be available, limitations on out-of-pocket expenses and other factors. He reminded the Board that in discussions with Representative Gephardt, it had been recommended that the burden of assuring payment to providers should be placed with the plan, not with the physician or hospital.

Dr. Foreman then questioned the wisdom of taking a stand for or against competition. He felt that competition among hospitals already exists and that teaching hospitals could lose their current advantages under a formalized competitive model. He argued that the health care industry has "built-in" factors that will cause costs to escalate anyway. However, he stressed that to take a stand against competition would necessitate endorsing stronger and more effective regulation if the Association is to influence those on Capitol Hill. In any case, he emphasized that legislators would not be impressed with a position that decried competition, decried increased regulation and could not offer viable alternatives or solutions.

Mr. Marylander agreed and suggested that introduction of a competitive approach to health care will not eliminate regulations for hospitals but create new ones. Dr. Foreman reiterated that he believed that competition is intense at present and that the "new" competition is simply intended to cut government's share of the costs and segment the health care system.

Mr. Marylander summed up the discussion by recommending that the report be labeled as a "preliminary draft working paper" and that staff be asked to rework the report to encompass the suggestions made at the various Board meetings. The paper would then be reviewed by the

Executive Council and, if approved, the document would be distributed to at least the membership of the Association and other interested parties. Dr. Knapp suggested that revised document could be used as the basis for discussion in small groups at the COTH Spring Meeting.

A number of Board members stated the section of the paper outlining future strategies for teaching hospitals could be deleted. Each of these options could be discussed at length; the report treats them too lightly. It was agreed the possibility of deleting this section should be considered.

**ACTION:** It was moved, seconded and carried that the draft report of the Ad Hoc Committee on Competition be labeled a "preliminary draft working paper" and be reworked by the staff to address issues raised at the January Board meetings in preparation for further discussion of the document at the March Board Meetings.

VI. Report of the Ad Hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals

Mr. Levitan provided an update on the Committee's progress, noting that two-thirds of the data (including patient diagnostic and hospital financial data) from the thirty-three participating institutions had been received. He indicated Systemetrics was pleased that this data would be extremely adaptable for data processing purposes. He reported that the diagnostic and financial data would be examined on two primary bases: (1) by DRG, which is hoped to be available by April 1; and (2) by disease staging method, which will hopefully be available by the end of June. He then expressed concern regarding a study questionnaire on research. He explained that the manner in which the accounting and budgeting systems are set up at the various institutions has not enabled them to distinguish accurately hospital based, research-related costs. He asked the Board for their thoughts and suggestions on how to approach this problem and acquire uniform data on the research activity at teaching hospitals since it is a major component of the distinctiveness of these institutions. Mr. Barry suggested using the percentage of research funding underwritten by the hospital. Discussion of this item continued without specific action being taken.

VII. Report on Commission on Professional and Hospital Activities

Dr. Bentley opened the discussion with a review of the Council's involvement with CPHA. In July of 1980, John Bassett met informally with Mr. Colloton and Drs. Knapp and Bentley to discuss COTH member participation in CPHA's medical abstract service, The Professional Activity Study. While about a quarter of the COTH members had subscribed in the mid-seventies, a substantial decline in COTH member participation in CPHA occurred in 1979 and 1980. Mr Bassett explained that he was looking for a way to make CPHA participation more attractive to teaching hospitals. Increased COTH participation would help CPHA attain fiscal viability, provide a more representative spectrum of hospitals for research purposes and create a national repository for all discharges.

In September, Mr. Bassett attended the Administrative Board's meeting and suggested that perhaps there should be a special COTH/CPHA data base. He then invited some COTH representatives to visit CPHA in Ann Arbor.

In November, five COTH representatives (John Colloton, Mark Levitan, Irv Kues of Johns Hopkins-Vice President for Finance, Dr. Knapp and Dr. Bentley; Earl Frederick could not attend) visted the CPHA offices in Ann Arbor. Three questions arose from that site visit: (1) should a COTH data base be established at CPHA? (2) what kind of data would be included in such a data base? and (3) what is the long range goal, mission and survivability of CPHA? Particularly as a result of the latter question, Gail Warden and Howard Berman of the AHA were invited to the Board's January Dinner Meeting to discuss the AHA's longrun commitment to CPHA.

Mr. Colloton recommended establishing a national data base for COTH members. He felt that there is a significant shortage of such information and that the absence of a data base makes it difficult to challenge HCFA assertions and proposals. He pointed out the tremendous financial problem for all teaching hospitals of ambulatory care deficits, and the fact that the numbers available on these deficits are very vague. He indicated that teaching hospitals cannot defend themselves satisfactorily without such descriptive data that is not now presently available. Mr. Colloton felt that it was time to create an ad hoc committee to address what is required of such a data base. Moreover, if AHA is as committed to CPHA as Mr. Berman indicated, CPHA would be a desirable option to pursue.

ACTION: It was moved, seconded and carried to form

an ad hoc committee to look into the establishment of a COTH data base designed primarily to assist teaching hospitals in coping with the future. This committee would be responsible for recommending the type of data base to be pursued and the advantages and benefits such data would provide the teaching hospital.

Mr. Levitan suggested that alternatives be sought and that CPHA not be considered as the only computer group for this project. This suggestion was supported by Mr. Barry and Dr. Foreman. Mr. Marylander concurred with this idea and recommended that other groups be explored. This stipulation was added to the motion.

#### VIII. Resident Moonlighting

Dr. Bentley reviewed the issue and noted that it was also an Agenda item at the September Executive Council and COTH Administrative Board meetings. He described the Wichita, Kansas court action that ordered HCFA to change its policy on payment of moonlighting residents under Part B of Medicare. Previously, it had been HCFA's policy that a resident could not be paid a Part B fee if he moonlighted in the institution in which he or she was receiving training. The court found that there was no reasonable basis for this criteria and ordered HCFA to begin payments under Part B for moonlighting residents wherever they provided services. Dr. Bentley stated that he and Dr. Knapp had met with Peter Boussein, the Deputy Director for the Bureau of Program Policy at HCFA, who explained that HCFA would interpret the court order strictly and suggested that, if the AAMC sought to minimize such internal moonlighting, the Association should distribute an Association policy on this issue.

Dr. Bentley then reviewed the Association's present policy on moonlighting which was developed in 1974.

The policy was essentially designed to support the concepts that: (1) residency training is essentially a fulltime endeavor; (2) moonlighting and residency training are often not compatible and if moonlighting is to be permitted, it needs to be carefully reviewed by the faculty responsible for the residency training program; and (3) the effects of the mix of moonlighting and training time must be carefully considered by the residency training program.

Dr. Bentley stated that the staff would recommend that the membership be alerted to the potentially negative effects of the HCFA policy change and that the

Association's current moonlighting policy be re-emphasized and redistributed. Mr. Marylander felt that the first paragraph of the AAMC policy, in which the Association states that it believes that moonlighting by house officers is inconsistent with the education objectives of house officer training is gratuitous and not particularly germane today. In addition, he supported HCFA's change in policy as a more realistic recognition of the issue. Mr. Levitan asked why the Association could not go on the record against the practice. Mr. Marylander explained that such a stance would require that the AAMC recommend corrective actions that would prevent the practice. Dr. Oliver described the situation at the University of Pittsburgh and explained that decisions on moonlighting should be made at the institutional and programmatic levels. He stated that this was essentially the position taken by the sponsors of the ACGME in the revision proposed for the Essentials for Accredited Residencies. Mr. Colloton believed that the premise behind the current AAMC position is compatible with the ACGME determination and would allow freedom at the programmatic level to decide on the issue. In addition, Dr. Foreman said it would not be very advantageous for the AAMC to take a negative stand on a situation that persists regardless of established rules.

ACTION: It was moved, seconded and carried to support existing AAMC policy on resident moonlighting, contingent on discussion before the Executive Council of the inconsistencies identified within the first paragraph of the AAMC statement.

#### IX. National Health Planning Program

Dr. Knapp reviewed the item for the Board. He explained that at the 1980 December AAMC Officer's Retreat, it was recommended that staff draft a short document setting forth the Association's concerns with the present health planning program. He noted that this document was to be used as an interim AAMC position statement on the problem until the AHA and others now reassessing the Health Planning Program completed their studies and enabled the development of a more detailed AAMC policy. Dr. Knapp credited the interim statement to Mr. Isaacs and asked the Board to consider whether it constituted an acceptable AAMC statement of concern on the Planning Program.

Mr. Colloton felt that the statement, as presented on

pages 105 and 106 of the Executive Council agenda, covered the concerns extremely well. However, he noted that State Agency governing boards under the planning law, those that make final Certificate of Need decisions, are not required to have provider members. He asked that this lack of representation be included among the concerns in the AAMC statement. Mr. Barry suggested that within the second bullet of the statement which addresses "an excessive federal role and overemphasis on regulation", more discussion be given to the rigidity with which the national health planning guidelines have been applied at the local level despite efforts to emphasize their flexibility. He also recommended that the Association indicate its concern that the current dollar threshold for Certificate of Need review is extremely low in light of the current inflationary economy. Dr. Knapp stated that these suggestions would be incorporated into the AAMC position statement.

ACTION: It was moved, seconded and carried to approve the recommendation on page 106 of the Executive Council Agenda regarding the AAMC position statement on the Health Planning Program, subject to inclusion of the revisions recommended by the COTH Administrative Board.

X. Eugene Talmadge Memorial Hospital Request for AAMC Assistance

Dr. Knapp introduced a letter from Donald C. Novak, Administrator at the Eugene Talmadge Memorial Hospital in Augusta, Georgia, requesting assistance from COTH/AAMC in the development of a logic, rationale or methodology upon which its health systems agency (HSA) could reasonably justify special consideration of teaching hospital bed needs. After discussion, the general consensus of the Board was that it was not in the best interest of the AAMC to pursue such activity at this time. Its decision was based primarily on three factors: (1) the current mood within the hospital industry to seriously reassess the entire health planning program and consider support for its repeal; (2) lack of a significant number of cases known wherein teaching hospitals confronted problems similar to those at Talmadge Memorial in justifying new bed need (ie, on the basis of training and research requirements rather than demand for services); and (3) uncertainty about the potential for successful application of the bed need formula in light of the particular facts in the Talmadge Memorial situation (ie, the significant gaps between the operating, HSA-projected, faculty-developed, and licensed bed figures, as well as the hospital's

average occupancy levels which was understood to be approximately 65%).

It was decided that no specific action should formally be taken by the COTH Administrative Board. Instead, Dr. Knapp was asked to convey the Board's determination to Mr. Novak.

XI. General Requirement Section of the Essentials of Accredited Residencies in GME

Dr. Oliver reviewed the recent joint CFMA/ACGME meeting he chaired, at which a consensus was reached on improved language regarding the areas of resident interaction with staffs and institutions. He felt that this language would be approved at the next ACGME meeting in February and expressed gratitude to Mr. Marylander for his assistance in this effort. In turn, Mr. Marylander stated that Dr. Oliver had done a superb job of chairing the meeting.

XII. Due Process for House Officers

Dr. Knapp reviewed the item for the Board, noting that five or six cases involving due process for surgical resident were brought to the attention of Joe Keyes, the AAMC's legal counsel. Mr. Cowell pointed out that a number of problems have arisen in many institutions due to a lack of concise guidelines. Dr. Foreman felt that the definition of due process itself needed clarification since due process for contracted employees was definitely different from that for attending medical staff. He believed that "breach of contract" was being discussed and that specific stipulations written into contracts would legally obviate the need for due process provisions to be formally established. Mr. Marylander stated that, however achieved, some sort of process was essential for the protection of house staff and thought that the statement which appears on pages 108-110 of the Executive Council Agenda provided a good starting point for development of guidelines to institutions. Mr. Colloton agreed and suggested that further examples be added to the discussion paper. Dr. Knapp explained that similar guidelines had been developed for undergraduate medical students in previous years and were not particularly appreciated by the constituency, which felt that they would deal with the matter at the institutional level.

Dr. Cooper reiterated the extreme importance of such a process for protection of house officer rights, especially in instances where there is little resident feedback, and the house staff may be subjected to unreasonable action. He endorsed an idea proposed by Dr. Krevans, AAMC Chairman,

that the issue be discussed within the context of the yet-to-be-adopted revised Essentials for Accredited Residencies, which contains a section on due process requirements. In such discussion, it was felt that the AAMC's concerns could be incorporated. Mr. Marylander suggested that if approval of the Essentials is significantly delayed, the AAMC should alert the COTH membership to the desirability of establishing formal due process or grievance procedures. Dr. Foreman suggested that this alert start with faculty and program directors. Dr. Cooper recommended that the material contained in the Executive Council Agenda be mailed to COTH membership without formal Association guidelines or directives, but with a recommendation that teaching hospitals review their own situations carefully. The Board generally agreed with this recommendation, and efforts to include the AAMC concerns in the Essentials for Accredited Residencies, but took no formal action on the issue.

#### XIII. GMENAC Report Response

Dr. Cooper stated that the GMENAC Report was reviewed at the 1980 AAMC Officers' Retreat, where it was suggested that the AAMC develop a response to it. He noted that the report was not well accepted by former HHS Secretary Harris, nor did it elicit much interest from Congress. However, he pointed out that it was attracting a lot of headlines in the media and its projections were being applied in some areas. He explained that the AMA had responded in detail to the report, but he felt that the AAMC should not respond in the same manner and give the report more credence than it deserved. Dr. Cooper did believe strongly that a brief AAMC response was necessary and that the statement appearing on pages 28-32 of the Executive Council Agenda would suffice.

Mr. Rice felt that the statement did not emphasize sufficiently the potential impact on minority enrollment in medical schools of GMENAC's recommendation for reduced class sizes. Mr. Barry recommended some attention be given to the regional variation in these projections. After further discussion of this and other issues relative to the GMENAC report, the following action was taken.

ACTION: It was moved, seconded and carried to approve the AAMC's response to the GMENAC Report as presented in the Executive Council Agenda, subject to the addition of discussion emphasizing concern for the potential impact

of GMENAC's recommendation for reduced medical school class sizes on minority enrollment and the regional impact of its projections.

XIV. Policies on GAO Report on Foreign Medical Schools

Dr. Cooper reviewed the GAO report for the Board, noting the alarming growth in the number of foreign medical schools with inadequate clinical education or training facilities. According to the GAO study of six foreign medical schools which enroll approximately half of the Americans studying abroad, the education and training offered by them is not comparable to that provided in U.S. schools. They were found to have deficiencies in admission requirements, facilities and equipment, faculty, curriculum and clinical training. It states further that U.S. hospitals, at which students from foreign medical schools arrange for clinical training, typically have no association with an American medical school and have received little assurance that U.S. citizens from foreign medical schools were adequately and properly prepared for clinical training.

Dr. Cooper stated that the AAMC was concerned about how to confront the issue of the increasing number of ill-prepared students now functioning in U.S. hospitals, including some COTH-member institutions. He noted that the Association has cautioned some hospitals against the possibility of committing a felony in utilizing students from nonaccredited institutions and that the American Hospital Association has taken similar actions.

Mr. Marylander offered the Council's support for the AAMC in its effort to address this issue, and asked that Board suggestions for addressing the problem be relayed directly to staff.

XV. Adjournment

Mr. Marylander adjourned the meeting at 12:45pm.



## FROEDTERT MEMORIAL LUTHERAN HOSPITAL

February 3, 1981

Richard M. Knapp, Ph.D.  
 Director  
 Department of Teaching Hospitals  
 AAMC  
 Suite 200/One Dupont Circle, N.W.  
 Washington, D.C. 20036

RE: APPLICATION OF FROEDTERT MEMORIAL LUTHERAN HOSPITAL  
 FOR COUNCIL OF TEACHING HOSPITALS

Dear Doctor Knapp:

I am enclosing the completed application for membership for Froedtert Hospital. The Froedtert Memorial Lutheran Hospital which opened on September 29, 1980 is on the campus of the Milwaukee Regional Medical Center which includes the Medical College of Wisconsin and Milwaukee County General Hospital which for many years has served as the "university hospital" for the medical school. Froedtert is adjacent to Milwaukee County Medical Center (County Hospital) and will function with it to be the Medical College's core hospital. Neither hospital is at present complete because some of the teaching programs were transferred in their entirety to Froedtert and others have remained at County Hospital.

Programs which have transferred to Froedtert in their entirety include the following:

- Dermatology
- Gastroenterology (partial)
- Pulmonary Medicine
- Neurology
- Neurosurgery
- Otolaryngology
- Plastic Surgery
- Urology

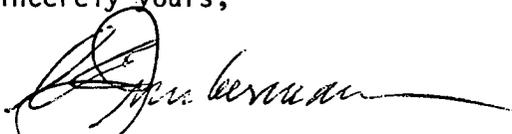
As soon as a connecting link building between the two hospitals is completed, it is planned to have Nephrology, Gastroenterology and Transplant Surgery also transfer. In addition to this, about half of General Internal Medicine and half of General Surgery will be at the Froedtert Hospital. Anesthesiology, Pathology and Radiology continue to function in both institutions.

Richard M. Knapp, Ph.D.  
Page 2  
February 3, 1981

Our short history makes it difficult to answer the data in Part II in a meaningful sense, but I have given you such figures as we have. In Part III-B, I cannot give you the date of the initial accreditation of the residency programs inasmuch as Froedtert does not have its own residency program. It shares residents with a number of other hospitals under the aegis of the Medical College of Wisconsin Affiliated Residency Program which has been accredited for a long period of time. The four major affiliate hospitals are Milwaukee Children's Hospital, the Veterans Administration Hospital at Wood, Milwaukee County Medical Center and Froedtert Memorial Lutheran Hospital. In addition to this, the affiliated residency program rotates its residents through a number of private hospitals in the area.

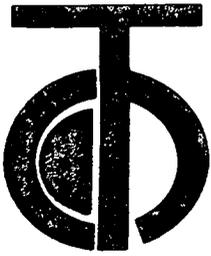
If there are any questions about this application or any parts that we have left incomplete, please do not hesitate to communicate with me. We look forward to joining the Council of Teaching Hospitals as a full member.

Sincerely yours,



Charles L. Junkerman, M.D.  
Senior Vice President  
Academic and Professional Affairs

CLJ/cag



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: KURTIS R. FROEDTERT MEMORIAL LUTHERAN HOSPITAL

Hospital Address: (Street) 9200 West Wisconsin Avenue

(City) Milwaukee (State) Wisconsin (Zip) 53226

(Area Code)/Telephone Number: ( 414 ) 259-3060

Name of Hospital's Chief Executive Officer: Dean K. Roe

Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year) 9/29-12/31/80

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>285</u>	Admissions:	<u>922</u>
Average Daily Census:	<u>100</u>	Visits: Emergency Room:	<u>---</u>
Total Live Births:	<u>---</u>	Visits: Outpatient or Clinic:	<u>990</u>

B. Financial DataTotal Operating Expenses: \$ 27,000,000Total Payroll Expenses: \$ 13,500,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 1,350,000  
Supervising Faculty: \$ 500,000C. Staffing DataNumber of Personnel: Full-Time: 450  
Part-Time: 80

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 301  
With Medical School Faculty Appointments: 301

Clinical Services with Full-Time Salaried Chiefs of Service (list services): \*See accompanying letter

<u>Medicine</u>	<u>General Surgery</u>	<u>Plastic Surgery</u>	<u>Urology</u>
<u>Neurosurgery</u>	<u>Otolaryngology</u>	<u>Neurology</u>	<u>Dermatology</u>

Does the hospital have a full-time salaried Director of Medical Education?: Yes--Senior Vice President for Academic & Professional AffairsIII. MEDICAL EDUCATION DATAA. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>3 Seniors/Month</u> <u>6 Juniors/Month</u>	<u>3 Seniors/Month</u> <u>6 Juniors/Month</u>	<u>Required</u>
* Surgery --Urology	<u>2 Seniors/Month</u> <u>4 Juniors/Month</u>	<u>2 Seniors/Month</u> <u>4 Juniors/Month</u>	<u>Elective *</u>
Surgery -- Plastic Surg.	<u>3 Seniors/Month</u> <u>3 Juniors/Month</u>	<u>1 Senior/Month</u> <u>2 Juniors/Month</u>	<u>Elective *</u>
Surgery -- ENT	<u>2 Seniors/Month</u> <u>3 Juniors/Month</u>	<u>2 Seniors/Month</u> <u>2 Juniors/Month</u>	<u>Elective *</u>
Surgery -- Neurosurgery	<u>2 Seniors/Month</u> <u>3 Juniors/Month</u>	<u>1 Senior/Month</u> <u>2 Juniors/Month</u>	<u>Elective *</u>
Psychiatry	<u>Nothing concrete set up yet--Will rotate students through sometime in 1981. Juniors--required; Seniors--elective.</u>		
Other: <u>Neurology</u>	<u>3 Seniors/Month</u>	<u>3 Seniors/Month</u>	<u>Elective</u>

\* Surgery as a specialty is required for both juniors &amp; seniors; however, students are allowed to elect a subspecialty within surgery.

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.

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible	0	0		
Medicine	14	14		
Surgery	8	8		
Ob-Gyn	0	0		
Pediatrics	0	0		
Family Practice	0	0		
Psychiatry	1	1		
Other: ENT	5	5		
Dermatology	2	2		
Anesthesia	6	6		
Neurology	7	7		
Neurosurgery	3	3		
* Pathology	3	3		

<sup>1</sup>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.

<sup>2</sup>As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

\* Continued--

Plastics	2	2		
Radiology	5	5		
Urology	5	5		
TOTAL	61	61		

#### 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: The Medical College of Wisconsin

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

Information Submitted by: (Name) Charles L. Junkerman, M.D.

(Title) Senior Vice President, Academic & Professional Affairs

Signature of Hospital's Chief Executive Officer:

Alan K. Roe (Date) 2/5/87



THE MEDICAL COLLEGE OF WISCONSIN

8701 WATERTOWN PLANK ROAD  
MILWAUKEE, WISCONSIN 53226

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

January 19, 1981

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

Gentlemen:

I write to endorse the application of the Froedtert Memorial Lutheran Hospital for membership in the Council of Teaching Hospitals.

The Hospital is a superb new facility which is a critical component of The Medical College of Wisconsin's teaching programs. The Hospital was constructed in close proximity to the Milwaukee County Medical Complex. The two hospitals, although administered by separate boards, function as an integrated entity. As the body of Froedtert Hospital's application indicates, a number of the medical school's critical clinical programs are contained exclusively within the Froedtert Hospital. The Hospital is fully affiliated with The Medical College of Wisconsin and all staff members of the Hospital are full time or clinical faculty members of the College. The Hospital is one of the four major affiliate hospitals of The Medical College of Wisconsin, the remainder being the Milwaukee County Medical Complex, the Wood-Veterans Administration Medical Center, and the Milwaukee Children's Hospital.

The Froedtert Hospital provides substantial support for the faculty and house officers related to the College. It is also an active participant in nurse and allied health educational programs. It provides approximately 25% of the critical core beds which support the College's educational programs. In addition, the Froedtert Hospital has provided research space for the full time faculty, including 20,000 gross square feet of shelled research space, which will be completed at the first floor level of the Hospital.

Council of Teaching Hospitals  
January 19, 1981  
-2-

There is no question in my mind that the Froedtert Memorial Lutheran Hospital is a completely appropriate addition to the membership of the Council of Teaching Hospitals.

Sincerely yours,



Edward J. Lennon, M.D.  
Dean and Academic Vice President

EJL:ch

cc: Leonard W. Cronkhite, Jr., M.D.  
John C. Geilfuss

AFFILIATION AGREEMENT BETWEEN THE MEDICAL COLLEGE OF WISCONSIN  
AND THE FROEDTERT MEMORIAL LUTHERAN HOSPITAL

PREFACE

When the work of the Medical College and of a hospital or other agency within the community coincide, a formal affiliation is mutually beneficial. An affiliation requires careful joint planning. To insure clarity regarding responsibilities, obligations and benefits to each institution to the affiliation, affiliations should be recognized through formal, written documents approved by the governing Boards of the affiliating institutions.

Medical College affiliations must be developed with and approved by the Executive Committee of the Faculty, and approved by the Board of Directors of the Medical College. In order to serve as the nucleus for the Southeastern Wisconsin Medical Center, all programs of the Medical College are to be conducted as Medical Center programs. All Medical College affiliations will require approval of the Medical Center Council.

The Medical College conducts programs of education leading to the M.D. degree, programs of graduate medical education and research programs for the development of new knowledge in the biological sciences, new skills in patient care and new approaches to the health care needs of the community. The size and scope of Medical College service programs

are determined by its educational and research needs.

This affiliation agreement consists of two parts. Part I is a statement of general conditions which apply to the affiliation of the two institutions. Part II identifies the programs that the two institutions agree to conduct. Following Part II, as an appendix to this agreement, is a definition of the types of affiliations between the Medical College and its various affiliated hospitals.

PART I - GENERAL CONDITIONS OF THE AFFILIATION.

A. Major Affiliation Between Froedtert Hospital and Medical College.

This affiliation agreement between The Medical College of Wisconsin (Medical College) and The Kurtis R. Froedtert Memorial Lutheran Hospital, Inc. (Froedtert Hospital) is for the purpose of conducting joint programs in health care education, health related research and health services in the Froedtert Hospital which is to be for the diagnosis, treatment, care, cure and hospitalization of sick and infirm persons. The affiliation agreement is for a major affiliation between the two institutions. It is agreed that it pertains to all professional departments and disciplines of the hospital.

This agreement does not apply to programs of either institution which are not mutually declared by them to be joint programs for the purposes of this agreement.

B. Other Affiliations of the Froedtert Hospital and The Medical College

The affiliation agreement shall not prevent either

institution from establishing other affiliations with hospitals or medical schools, as well as with other institutions in health related fields; but the two institutions as major affiliates recognize primary responsibility to each other, and agree to notify each other when such new affiliations are made; and to review in the Joint Committee described herein and in advance whether the establishment of new affiliations on the part of either significantly affects the affiliation arrangements herein established.

The Medical College has limited affiliation agreements with St. Luke's Hospital, Curative Workshop of Milwaukee, St. Joseph's Hospital, Columbia Hospital and Deaconess Hospital, and has major affiliation agreements with the Milwaukee County Medical Complex, Veterans Administration Hospital, Milwaukee Psychiatric Hospital and Milwaukee Children's Hospital. The Froedtert Hospital has affiliation agreements with the Milwaukee County Medical Complex.

#### Medical Center Relationships

The Froedtert Hospital and the Medical College are members of the Medical Center of Southeastern Wisconsin, and, while members, will abide by all policies and rules of the Medical Center Council.

#### C. The Joint Conference Committee

The Froedtert Hospital and the Medical College shall form a Joint Conference Committee to act under this agreement.

The purpose of the Joint Committee will be the review, development and recommendation of administrative policy for the conduct of joint programs. The 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 or financial requirements or which otherwise require board cognizance shall be transmitted to the governing boards with the recommendations of the Joint Conference Committee. All monies supporting joint programs, regardless of source, shall be used subject to policies recommended by the Joint Conference Committee and approved by the governing boards of the parties.

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 institution the member represents.

Persons with immediate and direct responsibility for the professional operation of affiliated 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 represent 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 Medical College will discuss with all concerned affiliated institutions through joint conference committees all matters affecting joint 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 full involvement and complete approval of the administration of the supporting institution.

The Committee shall meet regularly, as it shall determine, but not less than quarterly. The Committee shall submit a report to the governing body of each institution at least annually. The Committee shall develop written policies and procedures for its operation. The Committee shall maintain and publish as appropriate a log of policies jointly agreed upon by the two institutions

D. Responsibility of MCW Departments.

The departments of the Medical College have responsibility for the development of programs mutually satisfactory to the Medical College and to the Froedtert Hospital with respect to the joint programs of the Medical College and the Froedtert Hospital. The joint programs shall be operated pursuant to the

policies and rules of each institution.

E. Appointment of Personnel Engaged in Joint MCW-Froedtert Hospital Programs.

All physicians and other personnel with continuing responsibility for joint programs shall hold 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 appointment shall prevent the participation of persons concerned in joint programs of the hospital and the College, but shall not prevent participation in other programs of the hospital or College.

Persons may be appointed to joint programs as full time or as clinical faculty members. 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 may be nominated by the Froedtert Hospital.

The Medical College agrees to provide from its faculty a medical staff adequate to provide for reasonable and appropriate utilization of the Froedtert Hospital. If at any time the Medical College faculty is unable to provide a staff adequate for the reasonable and appropriate utilization of the hospital, the Froedtert Hospital will confer with the Medical College in

the Joint Conference Committee, provided herein, about appropriate courses of action, including the maintenance or dissolution of the affiliation and if the affiliation is to be continued whether staff members not members of the Medical College faculty are to be appointed. The staff of the Froedtert Hospital will be organized to include both full time and a substantial number of non-full time members of the Medical College faculty.

The chiefs of professional services of the hospital shall each hold appropriate appointments from the governing boards of both the hospital and the Medical College. The chief of a hospital service will be appointed with the approval of the head of the appropriate Medical College department. If either governing body declines to appoint a nominee, an alternate candidate shall be named. Appointments as chief of service shall be maintained at the pleasure of the governing bodies of the institutions and shall be withdrawn at the request of either governing body. The chiefs of services shall be responsible to the medical school for the quality of all programs of teaching and research. The chiefs of services shall be responsible to the hospital for hospital administrative functions and the quality of patient care.

The Medical College is responsible for the quality of joint programs of medical education and of research. The hospital is responsible to assure that there is a high quality

of patient care and to meet the standards of appropriate hospital accrediting agencies.

F. Research.

Well conceived and carefully executed research, whether in the laboratory or in the clinical environment, will result eventually in the improvement of medical care. Proposals for research programs and projects within the joint programs emanating from the hospital staff should be approved by the appropriate chief of service, the Hospital administration and the responsible MCW department chairman. Research support should generally be sought from outside sources. Proposals and requests for funds are to be submitted through the College.

The hospital should have a standing staff committee to review all research within the joint program and to determine that the guidelines of the U.S. Public Health Service concerning informed consent and the welfare of human subjects are followed. Arrangements should be in accord with Medical College responsibilities and procedures, and be coordinated through the Joint Conference Committee policy.

G. Grants in Aid.

Grants in aid may be intramural or extramural. An extramural grant is understood to mean a grant to carry out a specific project made by an agency external to the Medical

College and external to the Froedtert Hospital, such as the American Heart Association, the Wisconsin Regional Medical Program, the National Institutes of Health, or a foundation. All extramural grants in aid for joint teaching or research programs will be submitted through the Medical College department head of the principal investigator, and in accord with Medical College policies, and the Medical College shall be the responsible fiscal agent. With respect to grants involving delivery of services, the Joint Conference Committee shall be guided by the principle that grants involving members of the hospital staff who are members of the faculty of the Medical College shall be submitted through the Medical College as for teaching or research grants. Nothing herein contained shall preclude the Froedtert Hospital, without Medical College or Joint Conference Committee involvement, from seeking directly from prospective sources of funds (a) grants for equipment, administrative or capital purposes and (b) grants relating to the delivery of services in which faculty of the Medical College are not involved.

H. 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.

The two institutions will do joint budgeting for joint programs. Neither institution can commit the funds of the other. Either institution will be able to terminate, after due notice and discussion, a joint program that is financially burdensome. In jointly supported programs, all resources supporting the program will be made known to each other.

In general, the salaries of full-time professional persons involved with a joint program will be shared and remitted between the institutions on an equitable basis as determined by the Joint Conference Committee. In most cases, for medical student education, the Medical College will accept the major salary responsibility; for resident education, the Froedtert Hospital will accept the major salary responsibility insofar as funds can be recovered from patients and their third party payors. Research support should generally be sought from outside sources.

In general, the costs of office space, equipment and supplies, and laboratory space for joint programs conducted in the hospital will be allocated on an equitable basis as determined by the Joint Conference Committee. The usual rules and policies of the Froedtert Hospital shall apply to

such spaces and supplies and equipment. In the case of secretaries and laboratory technicians and similar persons based at the hospital, the Froedtert Hospital shall be the employer and the Medical College shall remit its share of salary and fringe benefit costs to the Froedtert Hospital.

I. Termination of Agreement.

The agreement will continue in force until ten years after the commencement of operations of the Froedtert Hospital. The agreement will be subject to automatic ten-year renewals unless either party gives notice at least twelve months prior to the termination date of the agreement.

J. Hospital Rules and Regulations.

It is understood and agreed that the Medical College and all students, faculty members or other Medical College personnel participating in the program or programs referred to in Part II hereof shall be required to abide by all applicable rules, by-laws, directives, regulations, policies and procedures of the Froedtert Hospital insofar as such rules, by-laws, directives, regulations, policies and procedures do not contravene or conflict with the provisions of this agreement.

K. Removal of Students From Program.

The Medical College shall remove any student from said program or programs upon request by the Froedtert Hospital for good and adequate cause except that reasons of race, religion, sex, age or national origin shall not be deemed good and adequate cause.

L. Future Provisions on Indemnification and Insurance.

The parties shall, prior to commencement of the admission of patients to the Froedtert Hospital, endeavor to reach mutual agreement on provisions to be added to this affiliation agreement with respect to (1) the nature and extent of the liability insurance to be maintained by each of the parties, and (2) the indemnification by each party of the other with respect to loss or liability arising out of the acts or omissions of the indemnifying party or its officers, agents or employees.

M. Physical Examination and Health Reports.

Prior to the commencement of any student assignment to the Froedtert Hospital, the Medical College shall submit to the Froedtert Hospital certificates of good physical health with respect to each such student. If the length of any student assignment should continue for one year or more, the Froedtert Hospital may require the student to submit such certificate from time to time as it may require.

N. Modification.

No agreement or understanding varying the terms and conditions of this affiliation agreement shall be effective unless made in writing and signed by both of the parties hereto.

O. Notice of Changes.

The Medical College and the Froedtert Hospital agree to inform each other in advance of any significant changes in curriculum, student schedules, the willingness of the Froedtert Hospital to accept students pursuant to this affiliation agreement and the names of faculty and staff personnel involved in the program.

P. Notices.

Any notice required to be given to either party hereunder shall be deemed sufficiently given if delivered in person or sent by first class mail, proper postage affixed thereto and addressed as follows:

In the case of the Medical College to:

Gerald A. Kerrigan, M.D.  
Academic Vice President and Dean  
The Medical College of Wisconsin  
561 North Fifteenth Street  
Milwaukee, Wisconsin 53233

In the case of the Froedtert Hospital to:

Mr. Dean K. Roe, President  
The Kurtis R. Froedtert Memorial Lutheran  
Hospital, Inc.  
10909 West Bluemound Road  
Milwaukee, Wisconsin 53226

or to such other address as either party may furnish to the other, in writing, for such purpose.

Q. Cancels Previous Agreements.

This agreement shall cancel and supersede any and all prior agreements between the parties providing for educational and clinical opportunities for students in the fields and disciplines set forth in Part II hereof.

R. Authority.

This agreement is executed by the duly authorized officers of each party and is authorized by the governing body of each party.

PART II - LIST OF JOINT PROGRAMS.

The parties hereby mutually declare that this agreement shall apply to the following joint programs of the two institutions to be conducted by them in the Froedtert Hospital.

Neurosurgery  
Neurology  
Renal  
Gastroenterology (medical and surgical)  
Other subspecialties of medicine  
and surgery

It is anticipated by the parties that the above list will be added to and further defined by mutual agreement of the parties.

IN WITNESS WHEREOF, the parties of this agreement have caused this instrument to be executed by their respective officers on the 30th day of August, 1976.

Signed by:

THE MEDICAL COLLEGE OF WISCONSIN

THE KURTIS R. FROEDTERT MEMORIAL LUTHERAN HOSPITAL, INC.

By Gerard Kenyon  
Academic Vice-President  
Title and Dean

By Neil A. Fisher  
Chairman of the Board  
Title

Attest: Richard Egan  
Assistant Secretary  
Title

Attest: Ralph W. Ellis  
Secretary  
Title

By David Carley  
President

By Alan P. Love  
President

By Carlton P. Wilson  
Chairman of the Board

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APPENDIXTypes of Affiliation

Limited Affiliations. A limited 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 its 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 limited affiliation for educational purposes.

Limited affiliations may be entered into for purposes such as the following:

- a) To provide special or additional education experiences to any or all of the following groups:
  - 1) Undergraduate medical students.
  - 2) Graduate medical students (interns, residents and fellows).
  - 3) Allied health profession students.
- b) To encourage meritorious shared programs of clinical, basic or health care delivery research.
- c) To foster community-wide economies in medical education, research and patient care by promoting a shared utilization of unusual or costly medical facilities and/or equipment.
- d) To improve patient care by promoting cooperative programs of patient evaluation and therapy.

When a limited affiliation encompasses educational experiences for undergraduate medical students or for interns, residents or fellows, the following conditions should exist:

- a) All members of the teaching staff of the affiliated programs will be members of the faculty of the Medical College, full time or non-full time. They will also hold hospital staff appointments.

- b) As an incident of their faculty appointment, all members of the teaching staff will participate according to the terms of the MCW Medical Service Plan.
- c) A jointly appointed member of the teaching staff of the affiliated institution will be responsible to the appropriate Medical College department chairman for the conduct of the teaching program.

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

- a) Conduct major clerkships for undergraduate medical students and residents in three or more of the following principal services: Surgery; Pediatrics; Medicine; Gynecology; Obstetrics; Psychiatry, or in the case of hospitals conducting a lesser number of principal services, in all principal services conducted by such hospital;
- b) And, initiate and support programs of research in support of teaching programs in the principal services conducted.

Major affiliations in addition meet the following conditions:

- a) All members of the hospital staff of each affiliated clinical discipline are also members of the faculty of the medical school, appointed respectively by the hospital and the Medical College after agreement between the two institutions on the appointments.
- b) 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.
- c) 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.
- d) A jointly appointed full time faculty member is chief of the affiliated discipline and bears responsibility to the medical school to insure excellence in all programs of teaching, research and patient care.



# Massachusetts Rehabilitation Hospital

125 Nashua Street, Boston, Massachusetts 02114  
Telephone: 617-523-1818

January 30, 1981

Richard M. Knapp, Ph.D.  
Director  
Council of Teaching Hospitals  
Association of American Medical Colleges  
One Dupont Circle, Suite 200  
Washington, DC 22036

Dear Dr. Knapp:

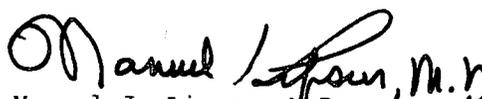
The Massachusetts Rehabilitation Hospital is interested in becoming an associate or an affiliate member of the Boston Council for Teaching Hospitals. We have been advised by Mitchell T. Rabkin, M.D., Chairman, that one of the criteria for membership is membership in the Council of Teaching Hospitals of the Association of American Medical Colleges. It is for this reason that we are requesting membership in the College.

You should be aware that we are in the process of seeking accreditation for a separate residency program and have begun formalized correspondence with the Liaison Committee on Graduate Medical Education. In addition, during the past two years, we have expanded our various fellowships with the Massachusetts General Hospital, New England Medical Center, and the Beth Israel Hospital. Even though we do not yet have a formalized residency program, we are academically involved through our diversified medical staff teaching programs, specifically in the areas of rehabilitative medicine. We also teach a large number of medical students from Tuft's University and Harvard Medical School. Also, all of our 25 geographic physicians have appointments at Harvard Medical School or Tuft's University School of Medicine.

We want to become more knowledgeable with the issues and concerns of the various graduate medical teaching programs within the Boston area. We are seeking membership in the Council of Teaching Hospitals of the Association of American Medical Colleges in order to learn more about the issues, concerns, and current events of various ongoing graduate medical programs, specifically within the Boston region. Our desire is to develop and offer a residency program which would be beneficial to the surrounding physicians who refer patients to us for rehabilitative care.

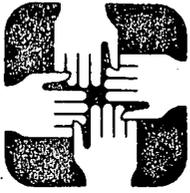
Your consideration for membership is certainly appreciated. Please advise.

Sincerely,

  
Manuel J. Lipson, M.D.  
Executive Director

MJL:MO

cc: Mr. Josiah Spaulding, President



**Massachusetts Rehabilitation Hospital**  
 125 Nashua Street, Boston, Massachusetts 02114  
 Telephone: 617-523-1818

March 10, 1981

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

Dear Dr. Knapp:

After our telephone conversation on Monday, March 9, 1981, I reviewed Dr. Lipson's correspondence file and reviewed his letter of January 30, 1981 requesting membership in the Council of Teaching Hospitals. (See attached photocopy.)

You will recall that we may meet much of the criteria as a corresponding member but need an overall decision as to the Not for Profit limitation. The Massachusetts Rehabilitation Hospital is a proprietary facility which is ten years old, borne out of a quasi affiliation with the Massachusetts General Hospital. Approximately 40% of our patients are from MGH and followed jointly by their staff and ours. Our medical staff teaches medical students from Tuft's University and Harvard Medical School in addition to overseeing various fellowship programs.

We are anxious to become members in the Council of Teaching Hospitals since it would be a natural linkage among us and other medical schools desiring to expand their medical student programs. I would not like to think that our type of facility would be a deterrent in our desire to become more knowledgeable and proficient in caring for our rehabilitative patients.

It is my understanding that you will discuss this issue at your March Board of Directors' Meeting and will communicate with me once the issue has been raised. I should be anxious to hear from you.

Sincerely,

George A. Demeritt  
 Associate Administrator

GAD:MO  
 Attachment

cc: Manuel J. Lipson, M.D., Executive Director



# association of american medical colleges

## COTH SPRING MEETINGS 1978 - 1982

1978	St. Louis, Missouri
1979	Kansas City, Missouri
1980	Denver, Colorado
1981	Atlanta, Georgia
1982	Boston, Massachusetts

The staff recommends that consideration be given to the following four cities:

Chicago

Indianapolis

New York City

Philadelphia

1981 COTH GENERAL SESSION PROGRAM  
AT THE AAMC ANNUAL MEETING

On the following page is an outline of the 1981 AAMC Annual Meeting, the theme of which is "Tomorrow's Medicine: Art and Science or Commerce and Industry". The COTH Business Meeting and General Session are to be held on Monday afternoon, November 2. The deadline for submission of a program title and speakers is June 5. Page 47 sets forth the COTH General Session program titles since 1972. The staff would like a discussion of proposed program titles so that we can move ahead fairly quickly.

1981 ANNUAL MEETING

Theme: Tomorrow's Medicine: Art and Science or Commerce and Industry?

Monday, November 2, 9:00 - 11:30 a.m.

The meeting's theme will be discussed from four perspectives:

The Biomedical Scientist:	David Kipnis, M.D. Chairman, Department of Internal Medicine Washington University School of Medicine
The University President:	Angelo B. Giammati President Yale University
The Industrialist:	John W. Hanley President and Chairman of the Board Monsanto
The Public:	Charles Crawford Science Editor CBS News

Tuesday, November 3, 9:00 - 11:30 a.m.

Presentations of Medical Education and Research Awards

Chairman's Address by Julius R. Krevans

Address by public figure. (Invitation will be offered to President Reagan)

Tuesday, November 3 2:00 - 4:00 p.m.

Special General Session: "Academic Functions in an Increasingly Commercial Hospital Environment"

Speakers: Robert Heyssel, Executive Vice President and Director, The Johns Hopkins Hospital on "Commercial Stress on the Academic Medical Center"

Donald S. MacNaughton, Chairman and Chief Executive Officer, Hospital Corporation of America on "Possible Roles for the Investor Owned Hospitals"

Responses from: G. Richard Lee  
Dean, University of Utah College of Medicine

Mark S. Levitan, Hospital of the University of Pennsylvania

Samuel Thier, Yale University School of Medicine



# association of american medical colleges

## AAMC ANNUAL MEETING COTH GENERAL SESSION THEMES

1972	EXTERNAL FISCAL CONTROLS ON THE TEACHING HOSPITAL
1973	THE ECONOMIC STABILIZATION PROGRAM AND OTHER HEALTH INDUSTRY CONTROLS
1974	NEW MANAGEMENT AND GOVERNANCE RESPONSIBILITIES FOR TEACHING HOSPITALS
1975	RECENT CHANGES IN THE HEALTH CARE DELIVERY SYSTEM: IMPLICATIONS FOR THE TEACHING HOSPITAL
1976	CLINICAL CASE MIX DETERMINANTS OF HOSPITAL COSTS
1977	PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR CONTROLLING THE DEMAND FOR HOSPITAL SERVICES
1978	MULTIPLE HOSPITAL SYSTEMS AND THE TEACHING HOSPITAL
1979	CONFLICT: CONTINUING ADVANCEMENT IN MEDICAL TECHNOLOGY AND THE QUEST FOR COST CONTAINMENT
1980	THE HIGH-COST PATIENT: IMPLICATIONS FOR PUBLIC POLICY AND THE TEACHING HOSPITAL

## ADMINISTRATION'S PROPOSED BUDGET FOR MEDICAID

The Reagan Administration has proposed that the formula for federal funding of state Medicaid expenditures be revised and capped. For the current fiscal year, federal Medicaid expenditures would be limited to \$16.38 billion, a reduction of \$100 million dollars over otherwise anticipated expenditures. In fiscal year 1982, the proposal would limit the federal expenditure to 105% of 1981 Medicaid expenditures, a reduction of \$1.043 billion over otherwise anticipated increases. In subsequent years, increases in federal Medicaid expenditures would be limited to the increase in an unspecified price index. These proposals are described in the Health Care Financing Administration Section of the Administration's March 10, 1981 budget summary, see Attachment A.

In proposing a reduction in federal financial support for the Medicaid program, the Administration is also proposing to provide the states with increased flexibility in determining eligible beneficiaries, covered services, and provider payments. The budget summary in Attachment A and other publically-available Administration documents do not specify the proposed legislative and regulatory changes which will be proposed to provide the states with increased flexibility.

Medicaid program expenditures are not evenly distributed across the nation. As shown in Attachment B, in fiscal year 1977, New York and California accounted for \$5.248 billion (32%) of the 1977 national Medicaid expenditures and nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Pennsylvania, Texas, and Wisconsin) accounted for \$10,348 billion (63%) of the 1977 national Medicaid expenditures. Similar patterns for vendor payments are shown in Attachment C.

Inpatient hospital expenditures, while 29.3% of the total in 1976, are also not evenly distributed across hospitals. Some hospitals serve large numbers of Medicaid beneficiaries; others have few Medicaid patients. Many teaching hospitals, however, because of their location, community role and extensive ambulatory care programs care for large numbers of Medicaid patients. As part of the 1977 COTH directory survey, members were asked to report the percentage of their admissions that were Medicaid patients. Attachment D lists COTH members reporting at least 25% Medicaid admissions in that survey.

No clear public consensus appears to have yet formed concerning the Administration's proposed Medicaid cap. For example, while the state governors favor the prospect of increased program flexibility, they have recommended replacing the Medicaid cap with a broader cost containment program which includes a 10% limitation on the increase in 1982 hospital Medicare payments, see Attachment E. On March 10th, the University of Chicago Hospital testified before the Waxman Subcommittee on Health and the Environment and opposed the Medicaid cap, see Attachment F. In the near future the AAMC will have the opportunity to testify on the Administration's proposed Medicaid cap. Therefore, staff recommends that the COTH Administrative Board propose an AAMC position on the Medicaid cap which can be discussed by the Association's Executive Council.

## HEALTH CARE FINANCING ADMINISTRATION (HCFA)

(Outlays in millions)

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>Change</u>
Medicare.....	\$35,035	\$41,155	\$47,094	+\$5,939
Medicaid.....	13,957	16,112	17,205	+ 1,093
Professional Standards Review Organizations (Program level)....	16 (155)	16 (135)	9 (70)	-7 (-65)
State Certification (Program level)....	--- (65)	5 (64)	1 (51)	-4 (-13)
Research and Demonstrations.... (Program level)....	18 (46)	23 (46)	23 (46)	--- ---
All Other HCFA.....	53	66	58	-8
<b>Total, Outlays...</b>	<b>\$49,079</b>	<b>\$57,377</b>	<b>\$64,390</b>	<b>+\$7,013</b>

## OVERVIEW

The HCFA 1982 revised request includes outlays of \$64.4 billion, an increase of 12 percent over the current estimate for 1981. Approximately 48 million beneficiaries will receive health care services through the Medicaid and Medicare programs in 1982, an increase of more than one million over 1981.

The 1982 revised budget contains a number of program innovations designed to increase the cost-effectiveness of financing for health care services, to reduce unnecessary Federal regulation of the health care industry, and to streamline program administration. Chief among these initiatives are proposals to establish an interim limit on Federal support for Medicaid in conjunction with expanded flexibility to States to reorganize their programs and to phase out the Professional Standards Review Organization program. These and other proposals represent the first step toward the development of health financing reforms that reduce the rate of health cost inflation by encouraging competition in the health sector and by making consumers more cost-conscious as they purchase health care.

## INCREASING THE COST-EFFECTIVENESS OF MEDICAID AND MEDICARE

### Interim Limit on Federal Medicaid Expenditures

As an interim measure prior to the adoption of comprehensive health financing and Medicaid reforms, the Administration will propose legislation to cap Federal Medicaid expenditures beginning in 1981. The limit would be structured to reduce Federal expenditures by \$100 million below the current estimates in 1981. Federal expenditures would be allowed to increase by 5 percent in 1982. Thereafter, Federal spending would rise only with the rate of inflation as measured by the GNP deflator. Within the overall spending limit, Federal payments would continue to match State expenditures at current rates. This arrangement would replace the current system of open-ended Federal payments to States, which has resulted in Medicaid expenditure increases of more than 15 percent per year for the last five years. By limiting Federal expenditures, States would have additional incentive to reduce fraud, abuse, and waste and to provide cost-effective services to those most in need.

Legislation will also be proposed giving States additional flexibility to target services to the truly needy and to develop innovative methods for the financing and delivery of services. In addition, cost-effective legislative initiatives in the AFDC program designed to better target welfare assistance would further reduce State Medicaid costs.

The Medicaid legislation is assumed to become effective July 1, 1981, and will result in 1982 savings of \$1 billion.

### Repeal of Certain Medicare-Medicaid Amendments

The budget proposes the repeal of several amendments to Medicare and Medicaid adopted by the Congress in late 1980 in the Budget Reconciliation Act (P.L. 46-499).

These provisions involve a number of low-priority benefit expansions that cannot be justified in light of the need for budget austerity. These items include expanded Medicare coverage of non-routine dental services, the recognition of free-standing alcohol detoxification facilities as separate providers under Medicare, and minor home health benefits.

In addition, repeal is sought of a provision that would have shifted normal Medicare hospital reimbursement under the Periodic Interim Payment (PIP) program from the last three weeks of 1981 to 1982. Although originally designed to reduce Medicare expenditures in 1981, this provision would cause major inconvenience to hospitals and ultimately result in higher Medicare expenditures due to hospital borrowing to meet current cash flow requirements. The budget also proposes to repeal a section of P.L. 96-611 authorizing Medicare coverage of pneumococcal vaccine, effective July 1, 1981. This vaccine has not yet been shown to be efficacious for Medicare beneficiaries.

Repeal of these provisions will avoid Federal costs of \$736 million in 1982.

#### Collection of Medicaid Disallowances

The budget assumes savings of \$270 million in 1981, resulting from legislation allowing accelerated collection of unapproved State Medicaid expenditures from prior years which are currently pending before the Federal Grant Appeals Board.

The legislation will also allow immediate collection of all future disallowances as they occur. Under current law, States can retain the payment in question until the Departmental appeals process has been exhausted, resulting in an average delay of 18 months.

Since the 1981 savings involve collection of prior-year payments, they will not reduce the Federal payment allowable under the Medicaid cap in 1982. Similarly, the collection of all future disallowances will not be deducted from the fixed Federal Medicaid payment.

#### Revised Reimbursement Rates for Chronic Renal Dialysis Under Medicare

Regulations will be issued to promote greater efficiency in the delivery of dialysis treatments for chronic renal disease by establishing a single reimbursement rate for all providers based on the experience of lower-cost, free-standing facilities. Currently, hospital-based providers receive higher average reimbursement per treatment for essentially the same service. This proposal would eliminate an unjustified payment differential for many hospital-based providers. This initiative would result in savings of \$105 million in 1982.

## REDUCING FEDERAL REGULATION OF THE HEALTH CARE INDUSTRY

### Phase-out of Professional Standards Review Organizations (PSROs)

As part of a general effort to restrain health care costs by stimulating competition in the health care industry, the Administration is proposing to phase out the PSRO program over the 1981-1983 period. During this period, contracts will be renewed with only those PSROs judged most effective in controlling health care costs and assuring a high quality of medical care. All Federal support will end in 1984.

To begin the phase-out, the budget requests a total PSRO program level of \$135 million in 1981, a reduction of \$20 million from the 1980 level. In 1982, the program level will be reduced by an additional \$65 million to a total level of \$70 million.

In conjunction with the phase-out of the PSRO program, legislation will also be proposed to eliminate the requirement for utilization review committees in providers not covered by PSRO review.

Elimination of Federal regulation in this area will allow State and private health care financing systems to determine the need for, and the most appropriate form of, utilization review, as reforms enhancing competition in the health care industry are implemented. Over the long run, requiring PSROs and other review entities to compete for contracts in the market place without Federal subsidy should ensure a more efficient use of health care resources.

### Less Frequent Surveys of Health Facilities

Beginning in 1981, the Administration is proposing to increase the productivity of the State Certification program and to eliminate unnecessary regulatory burden on providers by reducing the frequency of surveys of facilities participating in Medicare and Medicaid. The Department has the authority to change the survey cycle to a less than annual basis for all facilities except skilled nursing facilities, and, in fact, most hospitals are already certified for longer than one-year periods. Accordingly, the Department now plans to certify all facilities on a less frequent basis, and legislation will be proposed to permit less frequent surveys for skilled nursing facilities. To ensure that health and safety standards are maintained, surveys will be conducted on a sample basis with special attention given to providers with a history of non-compliance with program requirements.

## Elimination of End Stage Renal Disease (ESRD) Network Coordinating Councils

In 1982, legislation will be proposed to eliminate funding for End Stage Renal Disease Network Coordinating Councils in conformance with other decisions to phase out PSROs and health planning activities. Currently, the ESRD Councils provide advice to PSROs and health planning agencies on the quality of medical services given to ESRD patients and the need for ESRD facilities and services. With the phase-out of the PSRO program and health planning, continued support for the ESRD Councils is no longer necessary.

### STREAMLINING PROGRAM ADMINISTRATION

#### Research and Demonstration

As part of a general effort to minimize administrative costs, the budget proposes to maintain funding for research and demonstration projects in 1981 and 1982 at the 1980 level of \$46 million. A rescission of \$4 million is requested for these activities in 1981. Within the resources requested, funds will be targeted to the highest priority projects on Medicare/Medicaid policies regarding coverage, eligibility, and payment for health care services.

#### Administrative Costs

In 1982, the budget includes reductions in HCFA personnel and operating expenses related to program changes proposed for Medicaid, the PSRO program, State Certification, ESRD Network Coordinating Councils, and other program activities. These changes will result in a 1982 program level of \$174 million for HCFA administration, a reduction of \$9 million and 260 positions compared to the current estimate for 1981. Of the total reduction, \$4 million and 132 positions are associated with legislative initiatives.

## FY 1982 BUDGET SUMMARY

	MEDICARE			
	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>Change</u>
<u>Persons Enrolled (in thousands):</u>				
Hospital Insurance (HI) ..	27,448	28,027	28,575	+548
Supplementary Medical Insurance (SMI) .....	27,113	27,725	28,364	+639
<u>Current Program:</u> (Outlays in millions)				
HI Benefits .....	\$23,760	\$27,663	\$33,330	+\$5,667
SMI Benefits .....	10,150	12,321	14,430	+2,109
Administrative Costs and Research .....	1,097	1,156	1,183	+27
Hospital Reviews .....	97	93	47	-46
<u>Subtotal, current program</u>	<u>\$35,104</u>	<u>\$41,233</u>	<u>\$48,990</u>	<u>+\$7,757</u>
<u>Regulatory Initiatives:</u>				
Revised Rates for Renal Dialysis .....	---	-\$20	-\$105	-\$85
PSRO Hospital Savings .....	---	-31	-49	-18
Eliminate Utilization Review .....	---	+9	+4	+32
Section 223 Savings .....	-\$59	-98	-118	-20
Malpractice Insurance .....	-10	-360	-540	-180
Hospital-based Physicians .....	---	---	-32	-32
<u>Subtotal, regulatory initiatives .....</u>	<u>-\$69</u>	<u>-\$500</u>	<u>-\$803</u>	<u>-\$303</u>
Total, Medicare current program .....	\$35,035	\$40,733	\$48,187	+\$7,454
<u>Proposed Legislation:</u>				
Eliminate Utilization Review .....	---	-\$9	-\$66	-\$57
Eliminate Nursing Differential .....	---	-35	-250	-215
Repeal Reconciliation Act Civil Money Penalty .....	---	+466	-736	-1,202
Other .....	---	---	-9	-9
Other .....	---	---	-32	-32
<u>Subtotal, proposed legislation .....</u>	<u>---</u>	<u>+422</u>	<u>-1,093</u>	<u>-1,515</u>
<u>Total, Medicare .....</u>	<u>\$35,035</u>	<u>\$41,155</u>	<u>\$47,094</u>	<u>+\$5,939</u>
Trust Fund Income (Budget Authority) .....	(\$35,690)	(\$45,174)	(\$56,793)	(+\$11,619)

## FY 1982 BUDGET SUMMARY

## MEDICAID

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>Change</u>
<u>Recipients (in thousands):</u>				
Aged 65 and over.....	3,400	3,482	3,557	+75
Blind and Disabled.....	2,852	2,942	3,015	+73
Adults in AFDC families...	5,047	5,270	5,373	+103
Children under 21.....	10,436	10,819	11,045	+226
Total current program recipients.....	21,735	22,513	22,990	+477
<u>Current Program:</u>	<u>(Outlays in millions)</u>			
Benefits.....	\$13,232	\$15,616	\$17,345	+\$1,729
State and local admin.....	688	830	866	+36
State Certification.....	37	36	33	-3
<u>Subtotal, current program:</u>	\$13,957	\$16,482	\$18,244	+\$1,762
<u>Proposed Legislation:</u>				
Medicaid cap.....	---	-\$100	-\$1,043	-\$943
Collect disallowances.....	---	-\$270	---	+\$270
Other.....	---	---	+4	+4
<u>Subtotal, proposed legislation.....</u>	---	-\$370	-\$1,039	-669
Total, Medicaid.....	\$13,957	\$16,112	\$17,205	+\$1,093

## ATTACHMENT B

TABLE 20.—STATE-BY-STATE MEDICAID EXPENDITURES, FISCAL YEAR 1977  
(in millions of dollars)

State	Total Medicaid Payments <sup>1</sup>	Federal Share <sup>2</sup>	State/Local Share <sup>3</sup>
Alabama	196.2	144.0	52.2
Alaska	19.1	10.5	8.6
Arizona <sup>3</sup>			
Arkansas	146.1	110.1	36.0
California	2,214.4	1,104.1	1,110.3
Colorado	121.7	65.5	56.2
Connecticut	203.2	107.3	95.9
Delaware	22.2	11.6	10.6
District of Columbia	119.5	60.0	59.5
Florida	236.2	133.4	102.8
Georgia	334.2	218.9	115.3
Guam	1.7	.9	.9
Hawaii	66.3	32.7	35.6
Idaho	33.6	23.6	10.0
Illinois	843.9	452.2	391.7
Indiana	237.8	134.9	102.9
Iowa	158.8	90.7	68.1
Kansas	142.5	81.4	61.1
Kentucky	185.1	136.2	48.9
Louisiana	218.9	167.7	51.2
Maine	88.9	67.2	21.7
Maryland	262.5	132.2	130.3
Massachusetts	781.4	385.0	396.4
Michigan	836.2	422.0	414.2
Minnesota	379.5	212.4	167.1
Mississippi	136.4	109.8	36.6
Missouri	180.1	109.2	70.9
Montana	42.6	26.9	15.7
Nebraska	68.1	40.2	28.9
Nevada	22.1	11.2	10.9
New Hampshire	45.9	27.5	18.4
New Jersey	472.7	236.3	236.4
New Mexico	47.4	34.6	12.8
New York	3,033.2	1,521.5	1,511.7
North Carolina	255.0	171.0	84.0
North Dakota	34.1	19.3	14.8
Ohio	530.4	296.6	243.8
Oklahoma	207.7	139.6	72.1
Oregon	136.7	85.6	51.1
Pennsylvania	887.2	513.8	373.4
Puerto Rico	66.7	27.4	41.3
Rhode Island	102.6	61.9	40.7
South Carolina	143.9	104.5	39.4
South Dakota	32.1	21.9	10.2
Tennessee	224.2	160.7	63.5
Texas	716.0	450.3	265.7
Utah	44.5	37.6	4.9
Vermont	44.3	32.0	12.3
Virgin Islands	1.6	1.4	.2
Virginia	232.1	145.6	86.5
Washington	222.2	127.3	95.9
West Virginia	63.3	45.5	17.8
Wisconsin	505.4	312.3	193.1
Wyoming	8.4	5.1	3.3
Total	16,357.0	9,181.5	7,128.1

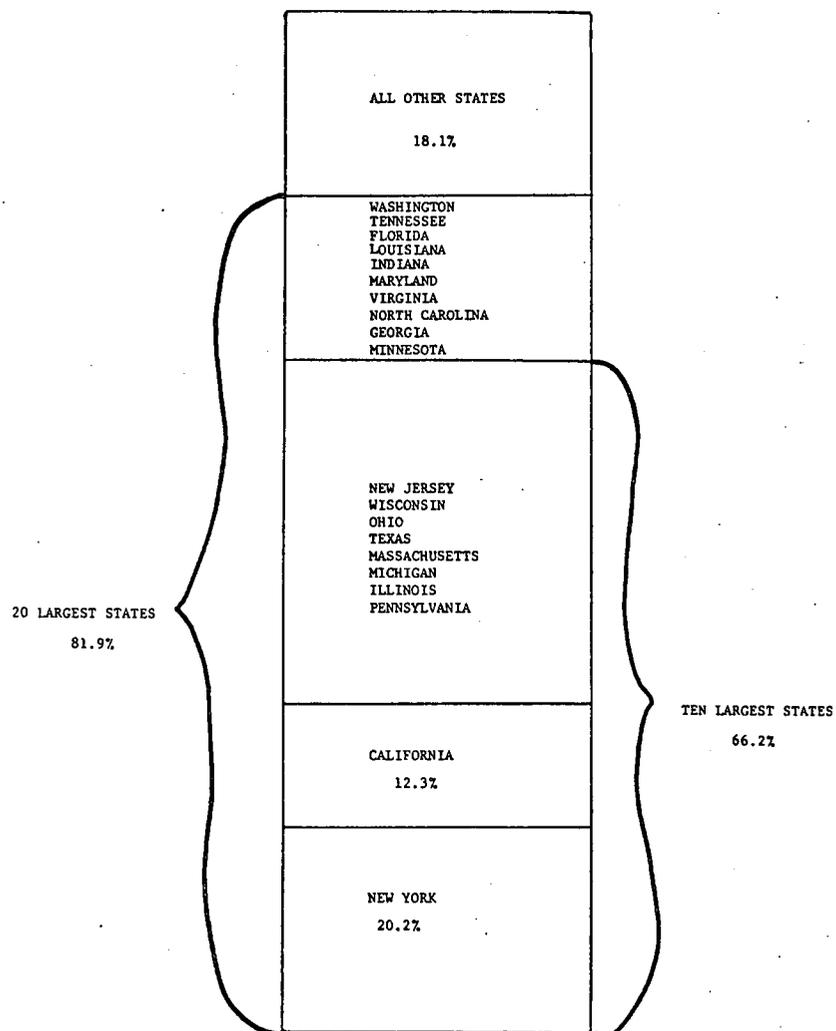
<sup>1</sup> This includes only medical assistance payments that are computable for Federal matching. This differs from the amount reported in Table 21 because expenditures for persons or services not covered under the terms of the Federal law are not included. See explanation preceding Table 21.

<sup>2</sup> Federal and State shares reflect actual expenditures. They differ from amounts calculated using Federal medical assistance percentages because of corrections made for past overpayments and underpayments and other adjustments.

<sup>3</sup> No Title XIX program in effect.

## ATTACHMENT C

**TABLE 28.—TOTAL MEDICAID VENDOR PAYMENTS BY SIZE OF STATE PROGRAMS, FISCAL YEAR 1977**



## "COTH Hospitals Reporting at Least 25% Medicaid Admissions for FY 1977"

<u>% Medicaid</u>	
38.5 %	Children's Hospital of Los Angeles
41	Los Angeles County - USC Medical Center
53.6	University of California - Irvine Medical Center
60	UCD - Sacramento Medical Center
35.0	University Hospital - University of California Medical Center, San Diego
27.4	Mt. Zion Hospital and Medical Center
47	Los Angeles County Harbor General Hospital
25	Children's Hospital, National Medical Center
37	Howard University Hospital
26	Queen's Medical Center
26.09	Children's Memorial Hospital
28.6	Illinois Masonic Medical Center
43.4	Mt. Sinai Hospital, Medical Center of Chicago
42.18	Schwab Rehabilitation Hospital
36.43	University of Chicago Hospitals and Clinics
32	Albert B. Chandler Medical Center
29.9	Louisville General Hospital
35	Baltimore City Hospitals
27	University of Maryland Hospital
20-25	Baystate Medical Center
37.7	St. Vincent Hospital
43	Children's Hospital of Michigan
26	Detroit General Hospital
31.6	Hutzel Hospital
57	Wayne County General Hospital
26	Hennepin County Medical Center

26.75 St. Paul-Ramsey Hospital and Medical Center  
28 University Hospital - Jackson, Mississippi  
25 Cooper Medical Center  
36 St. Michael's Medical Center  
65.7 Bronx-Lebanon Hospital Center  
26 Brookdale Hospital Medical Center  
29.6 Brooklyn-Cumberland Medical Center  
34 Jewish Hospital and Medical Center of Brooklyn  
31.63 Long Island College Hospital  
26.5 Methodist Hospital - Brooklyn  
33 State University Hospital - Downstate Medical Center  
33 Edward J. Meyer Memorial Hospital  
34 Nassau County Medical Center  
53.6 Beth Israel Medical Center  
58.9 Harlem Hospital Center  
33 St. Luke's Hospital Center  
40 Westchester County Medical Center  
27 Cincinnati General Hospital  
31.16 University of Oregon Health Sciences Center, University Hospital  
28 Children's Hospital of Philadelphia  
29 Episcopal Hospital - Philadelphia  
30 Hahnemann Medical College and Hospital  
28.29 Medical College of Pennsylvania  
33.3 Pennsylvania Hospital  
39.1 St. Christopher's Hospital for Children  
48 Temple University Hospital

- 46 Western Psychiatric Institute and Clinic
- 33 George W. Hubbard Hospital of Meharry Medical College
- 25 Children's Orthopedic Hospital and Medical Center
- 27.8 Martin Luther King, Jr. General Hospital
- 42.5 Harborview Medical Center
- 40 Riverside General Hospital
- 26.8 Deaconess Hospital of Buffalo, New York
- 26.4 Children's Hospital of Pittsburgh
- 40 Louisiana State Univ. Med. Ctr. - Shreveport, Confederate Mem. Med. Ctr.
- 48.1 Hospital for Joint Diseases and Medical Center
- 28 St. Margarets Hospital for Women
- 47 Kern Medical Center
- 70 Rancho Los Amigos Hospital

THE GOVERNORS SHARE THE PRESIDENT'S CONCERN ABOUT THE HIGH INFLATION, HIGH UNEMPLOYMENT, AND LOW PRODUCTIVITY THAT AFFLICT THE NATION'S ECONOMY. FIRM SHORT-RANGE MEASURES ARE REQUIRED TO PUT THE ECONOMY BACK ON TRACK.

WE SHARE WITH THE ADMINISTRATION THE BELIEF THAT FEDERAL EXPENDITURES MUST BE BROUGHT UNDER CONTROL, AND WE ARE PREPARED TO ACCEPT BUDGET CUTS -- BUT WE WILL VIGOROUSLY OPPOSE ANY ATTEMPTS TO SHIFT COSTS TO STATE AND LOCAL TAXPAYERS. OUR SUPPORT FOR SPECIFIC CUTS IS BASED ON THE FOLLOWING PRINCIPLES:

1. STATE GOVERNMENTS MUST HAVE SUFFICIENT LEAD TIME TO ADJUST THEIR OWN LAWS, BUDGETS AND ADMINISTRATIVE PROCEDURES TO MAJOR CHANGES IN FEDERAL FUNDING OR POLICY.
2. INCREASED FLEXIBILITY IN ADMINISTERING FEDERAL PROGRAMS MUST COME SIMULTANEOUSLY WITH BUDGET REDUCTIONS FOR THE CUTS TO BE ACCEPTABLE.
3. LEGISLATIVE AND REGULATORY PROPOSALS TO IMPLEMENT THE PRESIDENT'S PLAN MUST BE DEVELOPED IN CLOSE CONSULTATION WITH STATE OFFICIALS. THIS DETAILED CONSULTATION MUST BEGIN IMMEDIATELY.
4. THE FEDERAL GOVERNMENT, AS THE GOVERNORS HAVE LONG MAINTAINED, SHOULD MOVE TOWARD PRIMARY RESPONSIBILITY FOR WELFARE AND MEDICAID WHILE STATE AND LOCAL GOVERNMENTS MOVE TOWARD PRIMARY RESPONSIBILITY FOR SUCH FIELDS AS LAW ENFORCEMENT, EDUCATION, AND TRANSPORTATION.

5. *There must not be a disproportionate impact on the poor or handicapped*  
 WE PLEDGE OUR ASSISTANCE IN WORKING WITH CONGRESS TO ASSURE THAT

THE PROGRAMS WE JOINTLY DEVELOP ARE ENACTED. WE WILL ALSO WORK TO ASSURE THAT STATE GOVERNMENTS ARE PREPARED TO ACCEPT THE RESPONSIBILITIES OF RESTORED FEDERALISM.



National Governors' Association

George Busby  
Governor of Georgia  
Chairman

Stephen B. Farber  
Executive Director

## ALTERNATIVE MEDICAID COST CONTAINMENT RECOMMENDATIONS

ATTACHED, PLEASE FIND FOR YOUR INFORMATION ALTERNATIVE MEDICAID COST CONTAINMENT RECOMMENDATIONS THAT HAVE BEEN DEVELOPED BY THE COMMITTEE ON HUMAN RESOURCES. IT IS FELT THAT THE RECOMMENDED CHANGES, WHICH ARE CONSISTENT WITH ESTABLISHED NGA POLICY, WILL ENHANCE SUBSTANTIALLY THE ABILITY OF STATES TO CONTAIN MEDICAID COSTS.

ALTHOUGH THE ADMINISTRATION'S PROPOSAL FOR ADDITIONAL FLEXIBILITY FOR THE STATES IS SUPPORTED, THE PROPOSED NATIONWIDE 5% CAP ON FEDERAL PARTICIPATION COULD NOT BE ACHIEVED WITHOUT SHIFTING SIGNIFICANT FEDERAL COSTS TO AT LEAST SOME STATES. STATES THAT EXPERIENCE CASELOAD GROWTH DUE TO CIRCUMSTANCES BEYOND THEIR CONTROL WOULD BE PARTICULARLY HARD HIT. FURTHERMORE, A NUMBER OF STATES HAVE ALREADY EXHAUSTED MANY COST CONTAINMENT OPTIONS SUCH AS REDUCING REIMBURSEMENT RATES, ELIGIBILITY LEVELS AND SERVICE COVERAGE. EVEN WITH ADDITIONAL FLEXIBILITY, THE STATES' ABILITY TO LEVERAGE HEALTH CARE COSTS IS LIMITED, PARTICULARLY WITH NO CONTROLS ON THE FAR LARGER MEDICARE PROGRAM. AS AN ALTERNATIVE MEDICAID COST REDUCING PLAN, WE WOULD PROPOSE THAT CONGRESS ENACT:

- MAJOR CHANGES IN FEDERAL POLICIES THAT WILL ALLOW STATES TO ACT AS PRUDENT PURCHASERS OF MEDICAL CARE;
- DEVELOPMENT OF PROSPECTIVE REIMBURSEMENT POLICIES TO REPLACE INFLATIONARY MEDICARE COST-BASED HOSPITAL REIMBURSEMENT POLICIES (A 10% INTERIM LIMITATION IN FY'82 WOULD SAVE \$1.7 BILLION); AND
- A BLOCK GRANT FOR LONG-TERM CARE PORTION OF THE MEDICAID PROGRAM THAT WOULD ALLOW STATES TO CREATE ALTERNATIVE COMMUNITY-BASED SERVICES.

THESE PROPOSALS HAVE THE POTENTIAL TO REDUCE FEDERAL EXPENDITURES BY SUBSTANTIALLY MORE THAN THE \$1 BILLION SAVINGS PROPOSED TO BE ACHIEVED BY THE MEDICAID CAP.

1. States need much greater flexibility to act as prudent purchasers of medical services and supplies. Federal policies should allow states to develop cost-effective financing structures; to establish reimbursement policies that encourage efficiency and discourage waste; and to selectively purchase services from efficient providers.

For example, states should have the latitude to;

- o restrict or preclude the participation of providers whose costs are excessive (with certain exceptions, e.g., specialized care in tertiary institutions);
- o contract with physicians, hospitals, and other providers in a manner that establishes a point of responsibility and accountability for total medical costs. States should be allowed to use all the tools available to private industry, such as prospective budgeting, shared risks, and positive incentive reimbursement policies;
- o use competitive bidding and negotiated contracts for the purchase of laboratory services and medical devices;
- o adjust reimbursement rates consistent with the availability of resources, i.e., consistent with budget constraints;
- o limit reimbursement for certain complex medical procedures of a highly specialized nature--heart surgery, for example--to hospitals that have the appropriate expertise and volume of experience; and
- o establish prospective hospital reimbursement rates based upon the cost of care in efficiently-run hospitals, and especially to establish prudent rates for hospital admissions involving certain frequently performed and relatively simple procedures.

Rationale:

States are precluded by federal law from acting as prudent purchasers of care. Under current Medicaid law, clients are free to choose, and states are obligated to reimburse, any provider who is qualified to provide a covered service regardless of cost. States must pay a hospital its "reasonable" costs--costs largely determined by the hospital itself. In addition, states are limited to two basic financing approaches: fee-for-service and a heavily regulated capitation approach. These restrictive policies increase state and federal costs, and, in some instances, preclude states from ensuring that care is of adequate quality (e.g., by limiting highly specialized care to hospitals that are best equipped to provide it). States are not allowed to act as prudent consumers of care, and this fact contributes to the lack of market discipline in the health care sector. The changes proposed would remedy this problem.

2. Medicare retrospective reasonable cost hospital reimbursement policies must be replaced by prospective reimbursement policies that encourage efficiency and that do not subsidize waste.

Rationale:

Medicaid programs purchase medical services from the private medical care delivery system, and constitute only approximately a tenth of that market. Federal Medicare full cost retrospective reimbursement policies are inflationary, and contribute significantly to medical care inflation faced by the states and other payers. Medicare constitutes over 25% of the hospital market. Hospital costs currently are escalating at an annual rate of 18% and Medicare reimbursement policies must be revised completely if Medicaid and other relatively small payers are to realize reductions in hospital expenditures.

3. States should have the latitude to enhance the role of Medicaid clients as consumers of care, and to share the savings of cost-effective care with clients in the form of increased income, expanded benefits, or extended eligibility.

Rationale:

Medicaid clients have virtually no incentive to seek care from efficient providers, and this makes it much more difficult for states to expand the use of cost-effective providers and delivery mechanisms. Furthermore, some HMOs are reluctant to participate in the Medicaid program because of the month-to-month changes in the eligibility status of Medicaid clients. The proposed change would promote market discipline in the medical care sector.

4. States should have much greater latitude to reduce unnecessary utilization of health care services. Toward this end, the following changes in federal policy are recommended:
  - o states should be given wider authority to impose realistic and appropriate sanctions against recipients who willfully overutilize Medicaid, including the ability to suspend or terminate eligibility for clients who chronically overutilize services;
  - o/ federally-mandated Professional Standards Review Organizations' (PSROs) purview over Medicaid services should be removed, and states should be given the authority to establish utilization review programs and policies consistent with state needs and perspectives; and
  - o states should be allowed to implement a nominal co-payment on mandatory services for categorically eligible Medicaid recipients and be given the latitude to selectively apply co-payments only to certain services, diagnostic groups, and settings.

Rationale:

Current federal policies preclude states from effectively reducing the unnecessary use of services:

- o Medicaid clients face virtually no disincentives with respect to the overutilization of services;

- o PSROs tend not to be sensitive to the social implications of their decisions and have not been adequately responsive to state concerns; and
- o states are precluded from implementing cost sharing requirements for physician and other mandated services, which would provide incentives to clients to use services only when needed.

States also should have the latitude to selectively apply or waive cost-sharing policies (e.g., to waive co-payments for preventive care, or for recipients with chronic conditions).

5. States should be given greater flexibility to selectively provide services where the need is greatest and/or where resources will allow.
  - o states should be able to provide certain optional services only to selected diagnostic groups whose need for a given service is greatest; and
  - o states should have the authority to allow political subdivisions to provide matching funds to obtain federal financial participation for optional services and eligibility groups not covered statewide.

Rationale:

Federal policies require that Medicaid programs provide covered services to all Medicaid recipients on a statewide basis. States should be able to adopt reasonable policies to best meet client needs within limited resources. For example, states that are forced to reduce coverage of pharmaceuticals should be allowed to continue coverage for maintenance drugs for end-term illnesses (e.g., cardiac conditions, multiple sclerosis). Furthermore, states should be allowed to offer optional services and benefits where local resources are available but state resources are not.

6. Procedural requirements associated with fiscal penalties in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program should be repealed.

Rationale:

The current EPSDT requirements focus on process and not on performance. For example: states are required to inform eligible clients about the program on a face-to-face basis, and are precluded from more cost-effective alternatives. Furthermore, states are penalized for problems beyond their control, such as the lack of availability of dentists in some areas.

7. Federal laws and regulations should be amended to allow the Secretary to waive the 50% Medicaid/Medicare Enrollment mix requirement for Health Maintenance Organizations (HMOs) in medically underserved areas.

Rationale:

Current federal policies require that the served population of HMOs be comprised of no more than 50% Medicare and Medicaid clients within 3 years of start-up. This has a chilling effect on Medicaid HMO growth, particularly in areas where a disproportionate segment of the population is poor. Furthermore, HMOs that do participate in the program must curtail marketing efforts and Medicaid enrollment expansion as they reach the 50% threshold. HMOs constitute one of very few proven methods for containing medical care costs, and represent an important alternative to the fee-for-service approach. Furthermore, HMOs actually can enhance access to needed care by Medicaid recipients in underserved areas. The proposed change is a reasonable solution to the present problem.

8. A maximum 90-day time limit should be established for federal approval of program changes proposed by states. Federal requests for additional information would have to be made within 30 days of a state request for approval of a change, and if a final federal determination has not been made within the 90-day maximum, the proposed change automatically would be deemed approved.

Rationale:

Many states have been faced with extraordinary delays in federal approval of proposed program changes. This often has necessitated substantial cost overruns for states, and has forced undesirable reductions in other programs. States often are required to implement federal changes very quickly; the proposed change would force some discipline on federal agencies.

9. A uniform nationwide 5% cap on federal financial participation increases for FY'82 is not acceptable. The most immediate problem is that it will take time for states to develop and adopt many of the initiatives to contain costs. Furthermore, the cap would have widely different implications for individual states, depending on economic conditions, current service coverage and eligibility policies, and the rate of increase in local medical care costs. States that experience caseload growth due to circumstances beyond their control would be hit particularly hard. Finally, even with additional flexibility, the states' ability to leverage sky-rocketing medical care costs is limited, particularly when the Administration plans no controls on the far larger Medicare program. As an alternative Medicaid cost reducing plan, we would propose that Congress enact:

- o the changes recommended in Items 1-8;
- o/ a 10% limitation on Medicare hospital reimbursement rate increases for FY'82; and
- ✓
- o a capped block grant for long-term care.

See attached response to the 5% cap for further details.

States are urgently concerned with Medicaid program cost increases, and will welcome the Administration's proposal for "additional flexibility to adjust payment rates for providers, to organize more cost-effective systems of care, to change covered services, and to adjust eligibility in order to reduce program costs." We trust that the Administration actually will support our proposed changes in federal policies. States will use aggressively any new flexibility to reduce costs, and the federal government will share in the resulting savings. However, a fixed cap will have extremely different implications for individual states, depending on economic conditions, current service coverage, and eligibility policies and the rate of increase in local medical care costs. Before an arbitrary cap is imposed nationwide, states at least should have the latitude to demonstrate that, given the needed flexibility, together they can achieve the savings desired.

Medicaid programs purchase medical services from the private medical care delivery system, and constitute only approximately a tenth of that market. Federal Medicare full cost retrospective reimbursement policies are inflationary, and contribute significantly to medical care inflation faced by the states. Medicare constitutes over 25% of the hospital market. Hospital costs currently are escalating at an annual rate of 18% and Medicare reimbursement policies must be revised completely if Medicaid and other relatively small payers are to realize reductions in hospital expenditures. We would propose a cap of 10% on the rate of increase in Medicare hospital reimbursement rates until a more sophisticated prospective reimbursement methodology is developed. Based upon current estimates, this would decrease FY'82 Medicare expenditures on hospital care by about \$1.7 billion (from \$31.6 billion). This also would make it far more feasible for Medicaid programs to impose similar restrictions.

Unlike its role in the financing of medical services, the Medicaid program is the major purchaser of long-term care services and accounts for over one-half of nursing home expenditures. Given sufficient flexibility, states therefore have the potential to alter substantially the structure of long-term delivery. A capped block grant for only the long-term care portion of Medicaid may be acceptable to the states. However, such an approach must give states much greater flexibility with respect to such issues as service coverage, reimbursement policies, family supplementation, and institutional capacity limitations. A 7% cap would reduce federal Medicaid expenditures on nursing home services by about \$400 million (from \$6.9 to \$6.5 billion). To be acceptable, after FY'82, such a program should be indexed appropriately for input cost inflation (e.g., using the National Nursing Home Input Price Index) and for each state's weighted growth in its elderly population. We share with the Administration and Congress a deep concern over federal policies that encourage the unnecessary institutionalization of our citizens, and ask for greater flexibility to develop a comprehensive system of services which emphasizes the use of the least restrictive settings appropriate to individual needs. A block grant for long-term care would give states the desired latitude, and would reduce federal expenditures because nursing home services constitute the largest and most rapidly rising component of Medicaid costs. OMB documents refer to "the shift in services from state to Medicaid funding" as an argument for an overall Medicaid cap. The only data substantiating this claim is for long-term care, indicating that a long-term care block grant would address this federal concern. An appropriately indexed block grant would escalate much less rapidly than historical rates of increase in Medicaid nursing home costs. Most states can no longer afford that historical rate, and might accept constrained growth of federal financial participation in exchange for significantly enhanced flexibility.

OFFICE OF THE GOVERNOR

February 23, 1981

STATE OF MINNESOTA

FEDERALISM REPORT  
to the  
NGA HUMAN RESOURCES COMMITTEE

Albert H. Quie  
Governor of Minnesota

I. The policy from the NGA Denver meeting stated:

- A. Responsibility of the state and federal governments should be "sorted out" ... This division of labor should recognize the primary federal policy and financial responsibility for:

- income security
- a full employment economy
- sound anti-inflation initiatives

the primacy of state and local governments in such areas as:

- education
- local transportation
- police and fire protection

- B. As an interim step to "sorting out," federal programs should be consolidated and their enforcement focus should shift from prescriptive guidelines ... to achieving end results.

- C. If a situation is of such compelling national concern as to prompt enactment of a federal program to respond to it, the federal government should normally fund that program.

- II. Our assignment from Governor Busbee and Governor Hunt is to begin an orderly process of sorting out the proper roles with an early identification of possible recommendations for consolidations and increased flexibility for state governments.

III. Results thus far:

- A. An analysis of the OMB recommendations to President Reagan show:

1. There are many suggestions for program consolidation and deregulation which we can work with but which need fine tuning to fit the realities of state and local program administration.
2. There is no movement toward fundamental "sorting out" which would result in clear division of responsibility for some program areas (i.e., income assistance vs. education).

- over -

AN EQUAL OPPORTUNITY EMPLOYER

3. There is a danger that the budget cutting proposals will move more rapidly than the consolidation and the deregulation proposals. This could result in leaving state and local governments without the flexibility to adjust to a reduction in federal program funds.
- B. The Human Resources Committee can have detailed positions for consolidation and deregulation in four program areas prepared by May 1, 1981. These program areas are:
1. Medicaid (which is already prepared with the leadership of Governor Matheson)
  2. Public Health
  3. Elementary and Secondary Education
  4. Social Services
- C. Additional recommendations for consolidation and deregulation will be done as resources and time permit in the program areas of:
1. Income Security
  2. Child Nutrition
  3. Unemployment Insurance
  4. Employment and Training
- D. The task of addressing a fundamental sorting out of federal versus state responsibilities can proceed following this effort on consolidations.

TESTIMONY OF MR. DAVID BRAY  
HEALTH SUBCOMMITTEE OF COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE  
U.S. HOUSE OF REPRESENTATIVES  
10 MARCH, 1981

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. MY NAME IS DAVID BRAY. I AM EXECUTIVE DIRECTOR OF THE UNIVERSITY OF CHICAGO HOSPITALS AND CLINICS. WITH ME IS MR. JEFF GOLDSMITH, WHO IS DIRECTOR OF HEALTH PLANNING FOR THE HOSPITALS, AND OUR SPECIALIST ON THE MEDICAID PROGRAM. THE UNIVERSITY OF CHICAGO HOSPITALS AND CLINICS IS A 721 BED PRIVATE UNIVERSITY TEACHING HOSPITAL LOCATED ON CHICAGO'S SOUTH SIDE. WE ARE THE LARGEST PRIVATE SECTOR PROVIDER OF AMBULATORY CARE IN ILLINOIS, PROVIDING OVER 300,000 OUTPATIENT AND EMERGENCY VISITS ANNUALLY. BECAUSE OF OUR INNER CITY LOCATION, WE ARE DEEPLY INVOLVED IN THE MEDICAID PROGRAM. FULLY 45% OF OUR OUTPATIENTS AND 30% OF OUR INPATIENTS ARE ON MEDICAID, AND WE EXPECT TO RECEIVE OVER \$40 MILLION IN MEDICAID REIMBURSEMENT DURING THE CURRENT YEAR.

WE ARE HERE THIS MORNING TO EXPRESS DEEP RESERVATIONS ABOUT THE ADMINISTRATION'S PROPOSAL TO 'CAP' FEDERAL PARTICIPATION IN THE MEDICAID PROGRAM. WE ARE COGNIZANT OF THE FISCAL AND ECONOMIC REALITIES FACING THE COUNTRY. HEALTH CARE OUTLAYS ARE TOO LARGE A PART OF THE FEDERAL BUDGET TO REMAIN IMMUNE FROM TIGHTENING FEDERAL SPENDING. HOWEVER, MY TEN YEARS OF EXPERIENCE IN THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET SENSITIZED ME TO THE FACT THAT THERE ARE A LOT OF WAYS OF ACHIEVING SAVINGS. SOME OF THEM MAKE SENSE, OTHERS DO NOT.

FIRST, THE PROPOSAL TO CAP FEDERAL MEDICAID SPENDING COULD NOT COME AT A WORSE TIME FOR STATE AND LOCAL GOVERNMENTS WHICH ARE ALREADY STRUGGLING WITH THEIR OWN FISCAL PROBLEMS. REDUCING FEDERAL PARTICIPATION IN MEDICAID WILL ONLY WORSEN WHAT, IN ILLINOIS AND OTHER STATES, IS ALREADY A BAD SITUATION BROUGHT ON BY THE CONTINUING RECESSION. ILLINOIS IS PROPOSING TO CUT NEARLY \$80 MILLION FROM ITS MEDICAID PROGRAM NEXT YEAR. THE PROPOSED CAP WOULD REQUIRE NEARLY \$50 MILLION IN ADDITIONAL CUTS IN FY82. AND THE CUMULATIVE SHORTFALLS OF FUNDS UNDER THE 'CAP' WOULD REACH \$600

MILLION WITHIN FIVE YEARS FOR ILLINOIS ALONE. ACCOMODATING TO THIS LEVEL OF REDUCTION WOULD REQUIRE VIRTUALLY DISMANTLING THE ILLINOIS MEDICAID PROGRAM. THE CUTS WOULD AFFECT MUSCLE, BONE AND VITAL ORGANS AS WELL.

SECOND, THE IMPACT OF MEDICAID REDUCTIONS IS NOT SPREAD BROADLY ACROSS THE HEALTH CARE SYSTEM. IN ILLINOIS, FOR EXAMPLE, THE REDUCTIONS WOULD FALL MOST HEAVILY ON A FEW LARGE PROVIDERS WHICH ARE ALREADY STRUGGLING TO MEET THE HEALTH CARE NEEDS OF THE URBAN POOR. BECAUSE PHYSICIANS HAVE BEEN UNWILLING TO PRACTICE IN THE INNER CITY, THE RESPONSIBILITY FOR RENDERING PRIMARY CARE TO CHICAGO'S URBAN POOR HAS FALLEN ON A SMALL NUMBER OF PRIVATE HOSPITALS, INCLUDING SEVERAL LARGE TEACHING HOSPITALS LIKE THE UNIVERSITY OF CHIGAGO AND MICHAEL REESE AND SMALL COMMUNITY HOSPITALS, THE CHICAGO BOARD OF HEALTH CLINIC SYSTEM, THE COOK COUNTY HOSPITAL AND A FEW LARGE COMMUNITY HEALTH CENTERS. "

EVEN BEFORE THE PROPOSED STATE AND FEDERAL REDUCTIONS IN MEDICAID FUNDING, MOST OF THESE ORGANIZATIONS WERE IN SERIOUS FINANCIAL DIFFICULTY. WHEN COMBINED WITH THE PROPOSED CUTBACKS OF CATEGORICAL HEALTH FUNDING, THE MEDICAID CUTBACKS BEING CONSIDERED WILL THREATEN THE SURVIVAL OF AN ALREADY FRAGILE SYSTEM. FOR EXAMPLE, LAST YEAR COOK COUNTY HOSPITAL RAN AN OPERATING DEFICIT OF \$80 MILLION. COOK COUNTY HOSPITAL IS THE LARGEST PROVIDER OF AMBULATORY CARE IN THE REGION, WITH ALMOST 650,000 VISITS LAST YEAR. THE REDUCTIONS IN AMBULATORY CARE REIMBURSEMENT PROPOSED IN ILLINOIS FOR NEXT YEAR, WHEN COMBINED WITH COOK COUNTY'S ON-GOING FINANCIAL TROUBLES, MAY MAKE IT VIRTUALLY IMPOSSIBLE FOR COUNTY TO CONTINUE THIS LEVEL OF SERVICE.

THE CHICAGO BOARD OF HEALTH CLINICS, WHICH DELIVER ABOUT 500,000 VISITS ANNUALLY, HAVE BEEN PLAGUED BY CHRONIC SHORTAGES OF PHYSICIANS AND NURSES, AND ACTUALLY RAN OUT OF FUNDS FOR DRUGS DURING JANUARY FOR THE REST OF THE YEAR. THE SYSTEM IS EXPERIENCING TWO AND THREE MONTH WAITING LISTS FOR SOME TYPES OF CARE, SUCH AS PRENATAL CARE. FEDERAL AID CUTBACKS WILL VIRTUALLY ASSURE REDUCTIONS OF SERVICE OR OUTRIGHT CLOSURES OF SOME CLINICS. SEVERAL OF THE LARGEST FREESTANDING COMMUNITY

HEALTH CENTERS, SUCH AS THE MILE SQUARE HEALTH CENTER AND THE MARTIN LUTHER KING HEALTH CENTER, WHICH DELIVER ALMOST 250,000 VISITS EACH YEAR MAY BE UNABLE TO CONTINUE THEIR OPERATIONS WITH THE COMBINED REDUCTIONS IN CATEGORICAL AID AND MEDICAID REIMBURSEMENT.

THERE ARE ABOUT A DOZEN SMALL COMMUNITY HOSPITALS ON THE SOUTH AND WEST SIDES OF CHICAGO, SUCH AS PROVIDENT HOSPITAL IN OUR NEIGHBORHOOD, WHICH RELY ON MEDICAID FOR AS MUCH AS TWO-THIRDS TO THREE-QUARTERS OF THEIR REIMBURSEMENT. IF MEDICAID REIMBURSEMENT IS CUT BACK, THESE HOSPITALS HAVE NOWHERE ELSE TO TURN FOR OPERATING FUNDS, AND WOULD BE THREATENED WITH CLOSURE, LEAVING ONLY LARGE, RELATIVELY EXPENSIVE FACILITIES TO RENDER HOSPITAL CARE TO THE POOR.

THE UNIVERSITY OF CHICAGO OPERATIONS, WHILE LARGER THAN MOST, ARE TYPICAL OF MANY TEACHING HOSPITALS IN RELYING ON A LARGE, HOSPITAL BASED OUTPATIENT DEPARTMENT. WE ARE LOSING APPROXIMATELY \$5 MILLION A YEAR IN OUR OUTPATIENT DEPARTMENT. THE INCREASES IN WAGE AND MATERIAL COSTS, AND IN BAD DEBTS, ARE REAL -- THEY WILL NOT DISAPPEAR BECAUSE REIMBURSEMENT IS REDUCED. THE CUTS ALREADY PROPOSED IN THE ILLINOIS MEDICAID PROGRAM WILL MORE THAN DOUBLE OUR OUTPATIENT LOSSES, AND THREATEN THE HOSPITALS AS A WHOLE WITH LOSSES OF AS MUCH AS \$10 MILLION IN A SINGLE YEAR. WE CANNOT ABSORB THIS MAGNITUDE OF LOSS ON FOUR MONTHS NOTICE, AND YET WE FIND THE ALTERNATIVES -- SHARPLY INCREASING THE COST OF CARE TO EVERY NON-MEDICAID PATIENT OR RESTRICTING ACCESS OF AN ALREADY UNDERSERVED POPULATION TO OUR SERVICES -- VERY UNATTRACTIVE. FURTHER CUTS WILL MERELY WORSEN WHAT IS FOR US ALREADY A VERY SERIOUS FINANCIAL PROBLEM.

BECAUSE THEY WILL BE CONCENTRATED ON A FEW, ALREADY FINANCIALLY TROUBLED, INSTITUTIONS, THE SIMULTANEOUS CUTBACK OF FEDERAL HEALTH SERVICES FUNDING UNDER A HEALTH BLOCK GRANT AND THE PROPOSED FEDERAL RETRENCHMENT FROM MEDICAID COST SHARING MAY BE SUFFICIENT TO COLLAPSE WHAT REMAINS OF THE HEALTH CARE SYSTEM FOR CHICAGO'S INNER CITY. THERE IS NO SAFETY NET FOR CARING FOR THE URBAN POOR, AND THE FABRIC IS ALREADY STRETCHED TO

THE POINT OF TEARING. CAPPING MEDICAID PARTICIPATION BY THE FEDERAL GOVERNMENT WILL SEAL THE FATE OF MANY OF THESE CRITICAL HEALTH PROVIDERS, CREATING AN UNPRECEDENTED CRISIS OF ACCESS TO HEALTH CARE BY THE POOR.

AS A FISCAL MANAGER, I KNOW THAT THE BEST APPROACH TO RESTRAINING SPENDING IS TO GEAR DOWN. YOU CANNOT STOP A FIFTY TON TRUCK BY SIMPLY THROWING THE GEAR LEVER TO REVERSE. YOU NOT ONLY WRECK THE TRUCK, BUT YOU INJURE THE PASSENGERS. THE HEALTH SYSTEM BEING FINANCED BY MEDICAID IS MUCH MORE FRAGILE THAN MANY PEOPLE IN WASHINGTON REALIZE. I URGE YOU TO SEEK A RESPONSIBLE, MODERATE WAY OF RESTRAINING FEDERAL HEALTH CARE OUTLAYS WHILE PROTECTING THE HEALTH OF OUR INNER CITY INSTITUTIONS AND NEIGHBORS.

THANK YOU.



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

PROPOSED RESOLUTION ON CONSUMER CHOICE

Approved by Board of Trustees  
 for Submission to House of Delegates  
 February 3, 1981

- 1 WHEREAS, There is growing evidence that the current government regula-  
 2 tory approaches to containing health care costs are ineffective;
- 3 WHEREAS, The continually expanding role of government, as well as the  
 4 current federal tax laws, serve to increase demand for health care  
 5 services;
- 6 WHEREAS, Governmental controls on the supply of health care services  
 7 frustrate the emergence of innovative initiatives in the private and  
 8 voluntary sector;
- 9 WHEREAS, Alternatives to increasing regulatory controls in health care  
 10 have been developed; now therefore, be it
- 11 RESOLVED, the House of Delegates of the American Hospital Association  
 12 endorses the following principles of consumer choice approaches to  
 13 financing health care: mandatory choice of plan, fixed contri-  
 14 bution regardless of choice, and a limitation on the tax-free status of  
 15 contribution.
- 16 BE IT FURTHER RESOLVED, that the Board of Trustees be directed to continue  
 17 and expedite its study of the details of the various consumer choice approaches  
 18 and report to hospitals its analysis of the impact on various classes of hos-  
 19 pitals, other providers of care, and patients, and that the Board be directed,  
 20 in developing acceptable consumer choice approaches, to support the elimina-  
 21 tion of existing regulatory mechanisms which limit the ability of hospitals  
 22 to effectively respond to changing demand forces.
-

## AAMC POSITION ON REPEAL OF P.L. 93-641

On the following pages are the action taken by the AAMC Executive Council at its January 29, 1981 meeting. Note that reference is made in this action to the AHA statement on this issue. It appears that the AHA has changed, or is about to change its position. Al Monzano, Director of the AHA Washington Office, will discuss the current AHA position. The COTH Board may wish to recommend a revised AAMC position based on this discussion.

January 29, 1981

THE POSITION OF  
THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ON THE  
NATIONAL HEALTH PLANNING PROGRAM

More than six years have passed since the current health planning program was enacted under P.L. 93-641. During this period, the majority of local and state agencies created by the original Act have received either full or conditional designation from DHHS and have actively undertaken their mandates. The Association of American Medical Colleges (AAMC) has continued to support the program through two one-year extensions and a three-year reauthorization approved in October, 1979. While many of the legislative and administrative refinements recommended for the program by the Association have been adopted in statute and regulation, doubt persists regarding the actual accomplishments and potential successes of the present system. In fact, there appears to be a sizable contingent from within the health care and political arenas advocating the complete dismantling of the current planning structure in favor of a free market competition approach to health care.

The AAMC recognizes a growing consensus among health care leaders that the national health planning program is in need of significant alteration if it is to be effective. The major issues of concern, many of which have been reiterated throughout the implementation of the planning system, are:

- Academic Medical Center Applications - An ongoing concern has been the failure of health planning decision-makers to adequately recognize and accommodate the unique roles of the academic medical center in (1) the regionalization of highly specialized, referral health services, (2) the education and training of health care professionals at all levels of the health sciences, and (3) the conduct of its research and development mission.
- An Excessive Federal Role and Overemphasis on Regulation - The process that has evolved from P.L. 93-641 is not the "bottom-up," autonomous grassroots planning system originally envisioned by Congress, but is instead a "top-down" federal decision-making process emphasizing the regulation and reduction of the capacity of the health care system at the institutional level. Constructive planning has become an incidental secondary component to an excessive regulatory function. National guidelines are applied rigidly despite their explicit flexible nature to reflect adjustments for local conditions and circumstances.
- The Certificate of Need (CON) Review Program As The Principal Instrument of Regulation - Although the mandated CON review process was designed to foster health planning, planning has instead become generally characterized as a vehicle to support CON regulation. Increasingly, adversarial relationships between planners and providers have developed due to inequities and inefficiencies in the review process. As a result, providers have had to assume all

the burden of proving need (including provision of data that was originally assumed to be the responsibility of planners) and must often accept other unrelated responsibilities to obtain a certificate. Moreover, it is felt that (1) the applicant's time and expense to provide all required CON material often is overly burdensome, (2) the minimum dollar threshold for capital expenditure review is too low and minor non-health care expenditures are often unnecessarily reviewed, and (3) the CON review and decision-making process often adds to the cost of health care due to costly delays by the planning bodies.

- The Influence of Federal Program Funding - The regulatory emphasis of the planning program is not likely to change as long as the federal government substantially funds local agency operation. Participation in the financing of these agencies through a variety of sources needs to be explored to permit greater independence of the program from excessive federal bureaucratic control.
- Failure to Address Essential Factors for Effective Planning - Consideration of geographic and other variables are believed to be key components for effective health planning which have been lacking in the current health planning structure and its implementation. Additionally, it is felt that more thought should be directed to the role of physicians in the planning of institutional services.
- Inadequate Representation of Affected Parties on Health Systems Agency (HSA) Boards - It is felt that HSA governing boards lack adequate representation from key parties of interest such as hospitals, physicians, third-party payers, business and labor, local governments, and other types of health care providers. These Boards are required to be dominated by consumer members who often are just gaining the knowledge and experience to make effective decisions when their terms expire. Moreover, State Health Planning and Development Agencies (SHPDAs), the final decision-making authorities under CON, have no composition requirements and often exclude representatives of significantly affected parties, including hospitals.
- Appropriateness Review Viewed As An Unnecessary Evil - Provider groups (including the AAMC) have constantly sought the elimination of the appropriateness review requirement because: (a) it simply represents another layer of excessive regulation for the purpose of capacity control; (b) planning agencies have neither the expertise or resources to perform such reviews; (c) considerations upon which a finding of appropriateness rests are economic, not medical-quality or need-related; and (d) ultimate sanctions for findings of inappropriateness are as yet unclear and are feared will be aimed at preventing payment for services rendered in a service labelled inappropriate (without due process provisions for the provider).

Clearly, sufficient time has passed to enable a critical reevaluation of the planning program's strengths and weaknesses to date. Though P.L. 96-79, the "Health Planning and Resources Development Amendments of 1979," reauthorized the program through September 30, 1982, a major project has already begun at the American Hospital Association (AHA) to reassess its positions on health planning generally and the Health Planning Act's program more specifically. Upon completion of this initiative, an AHA statement of principles document on key issues related to health planning and the national program will be formulated for AHA Board approval by late August 1981.

#### AAMC ACTION

On January 29, 1981, the AAMC Executive Council adopted the above statement of major concerns as the current Association position on the health planning program until the AHA's statement of principles document on this subject matter becomes available and may be evaluated in development of a more detailed formal AAMC policy statement.