aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

June 24-25, 1981
Washington Hilton Hotel

WEDNESDAY, June 24, 1981

6:30pm	COTH Administrative Board Meeting	Hamilton Room
7:30pm	COTH Reception	Georgetown East
8:30pm	COTH Dinner	Georgetown East

THURSDAY, June 25, 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

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

June 24-25, 1981
Washington Hilton Hotel
Kalorama Room
9:00am-12:30pm

A G E N D A

	o John Colloton's theoretical approach to recognize societal contributions of teaching hospitals, excerpted from his Duke Private Sector Conference paper, "An Analysis of Proposed Competitive Health System Plans and the Implications for Teaching Hospitals"	Page 75
V.	Strategies for the Future	Executive Council Agenda - page 108
VI.	Due Process for Students and Residents	Executive Council Agenda - page 92
VII.	Committee on Foreign-Chartered Medical Schools and U.S. Nationals Studying Abroad	Executive Council Agenda - page 71
VIII.	External Examinations Review Committee Report	Executive Council Agenda - page 23
IX.	Urban Institute Report on the Effects of Reducing Federal Aid to Undergraduate Medical Education	Executive Council Agenda - page 98
X.	Proposed Bylaw Changes	Executive Council Agenda - page 20
XI.	Institutional Support Components on National Research Service Awards	Executive Council Agenda - page 103
XII.	Federal Support for Biomedical and Behavioral Research Resources	Executive Council Agenda - page 106
XIII.	New Business	
XIV.	Adjournment	

Association of American Medical Colleges
COTH Administrative Board Meeting

March 26, 1981

PRESENT:

Stuart J. Marylander, Chairman
Mitchell T. Rabkin, MD, Chairman-Elect
James W. Bartlett, MD, Secretary
Dennis R. Barry
Fred J. Cowell
Spencer Foreman, MD
Robert E. Frank
Earl J. Frederick
Mark S. Levitan
Robert K. Match, MD
John A. Reinertsen
Haynes Rice
John V. Sheehan

ABSENT:

John W. Colloton, Immediate Past Chairman

GUESTS:

Allen Manzano
Kevin Hickey

STAFF:

James D. Bentley, PhD
Peter W. Butler
John A. D. Cooper, MD
Mary Eng
Joseph C. Isaacs
Richard M. Knapp, PhD
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MEETING MINUTES

March 26, 1981

I. Call to Order

Mr. Marylander called the meeting to order at 9:10am in the Kalorama Room of the Washington Hilton Hotel. He introduced and welcomed guests Al Manzano, Senior Vice President of the American Hospital Association, and Kevin Hickey, Special Assistant to Alex McMahon, President of the AHA.

II. Consideration of the Minutes

Consideration was given to the Report on the Commission on Professional and Hospital Activities (CPHA), Item VII in the March COTH Administrative Board agenda. Dr. Knapp raised the issue of responding to CPHA on the issue of a COTH data base. He stated the action was more closely related to the pilot program to merge Monitrend and PAS data rather than to the current CPHA PAS program.

Dr. Bentley raised the question of actual demand for a data base and consideration of the type of data base and specific content. Additionally, he raised the issue of a timing conflict, noting that CPHA's preferences were in conflict with COTH's current needs. He noted January, 1982 would be preferable for COTH.

Mr. Marylander reviewed the background on the issue and suggested a medical data abstract should not proceed until the COTH study is completed. He added that such a commitment from COTH individual institutions to participate in such a data base must precede any preliminary work. Mr. Levitan stressed the need to recognize that COTH requirements must supercede other factors and expressed concern as to whether a CPHA data base would fit these needs.

Dr. Knapp suggested informing CPHA that COTH is not in a position to respond at this time.

A general discussion ensued on the advantages and disadvantages of such data summaries. Dr. Rabkin felt that Monitrend, for example, was not particularly useful and therefore had a low rate of return. Mr. Marylander, however, felt that such summaries can be very helpful if the needs are well-defined and provide the indicators and comparisons the industry is always complaining are lacking. Mr. Barry reiterated the need for the groups involved to be similar. Since the January 29 motion was

was not time-limited, it was agreed it reflected the sense of the Board, and need not be changed.

ACTION: It was moved, seconded and carried to approve the minutes of March 26, 1981 without amendment.

III. Membership Applications

Dr. Bentley reviewed the two membership applications. Based on staff recommendations, the Board took the following actions:

ACTION: It was moved, seconded and carried to approve Froedtert Memorial Lutheran Hospital for full membership.

ACTION: It was moved, seconded and carried to deny membership to the Massachusetts Rehabilitation Hospital since it is a proprietary hospital and thus not eligible for membership.

IV. 1983 Spring Meeting

Dr. Knapp reviewed past Spring Meeting sites and indicated some staff suggestions for the 1983 meeting. He cited geographic membership concentration, increased air fare and travel convenience as some of the factors considered in making these recommendations. He noted that New York is a very expensive city for this type of meeting, Philadelphia is the site of the upcoming AHA Annual Convention and Chicago is over-used for meetings as objections to some previous considerations.

General discussion followed on air fares and actual costs of cities, and it was unanimously felt by the Board that the site for the 1983 Spring Meeting need not be chosen on the basis of these two particular factors.

Dr. Match recommended the 1983 Spring Meeting be held in New Orleans. This suggestion was well received and the staff agreed to look into New Orleans as the 1983 Spring Meeting site.

ACTION: It was moved, seconded and carried that New Orleans be considered as first choice for the 1983 Spring Meeting, and that staff investigate this option and report at the June Board meeting.

V. 1981 Annual Meeting Program

Dr. Knapp reviewed page 46 of the March 26 COTH Administrative Board agenda and asked for discussion on the theme for the COTH General Session.

Mr. Marylander raised the competition issue, and also suggested the topic of corporate reorganization and diversification, and the impact on teaching hospitals and academic health centers. Mr. Barry agreed that he would like to see the issue of competition discussed further, and suggested representatives from investor-owned chains and HMO's be included on the program.

Dr. Knapp mentioned that four workshops at the 1981 Spring Meeting would be devoted to competition, and that the Tuesday afternoon program of the Annual Meeting would include discussion of "competition and commercialization."

Mr. Levitan suggested corporate restructuring as a topic even though it would not be applicable to all COTH members. Mr. Frederick favored that topic even if it was not particularly applicable to state-owned university hospitals and other publicly owned hospitals. He felt this would be a worthwhile subject for them to hear. Mr. Sheehan stated he believed this topic is one in which the VA directors should and would be interested.

Mr. Marylander concluded this discussion by asking the staff to plan a program around the theme of "corporate reorganization and diversification."

VI. The Administration's Proposed Medicaid Budget

Mr. Marylander asked for a review of COTH policy recommendations on the Medicaid program for discussion at the Executive Council meeting.

Dr. Knapp noted that the Association had been asked to present testimony before the Senate Finance Committee on March 31. He indicated Chuck Womer had been asked and agreed to testify for the AAMC. A copy of the first draft of the testimony was distributed.

Mr. Marylander expressed two major concerns regarding the issue: 1) Many COTH institutions are heavily dependent on Medicaid patient populations and the proposed cap would have considerable impact on them; and 2) Repeal of the "freedom of choice provision" could put teaching hospitals in a difficult position

if they wished to compete for Medicaid patients on a contract basis. He stated both these issues should be strongly expressed in the testimony.

Dr. Bentley reviewed the budget information appearing on page 56 of the agenda as well as data on pages 58-60 which examined the percentage of COTH hospitals' patient population for Medicaid. He noted that the Department had recently sent COTH members a survey to determine the percentage of Medicaid admissions and outpatient visits.

He then reviewed the draft testimony and its four major points:

- o No one has said Medicaid has been ineffective in eliminating patient care access problems;
- o There is concern that economic budget decisions have been made first with substantial policy and program changes to be made subsequently;
- o By 1986 the Federal commitment to the Medicaid program will be reduced to almost 19% below the current levels under the Administration's proposals;
- o With unemployment increasing, Medicaid eligibility in many states and their tax dollars already stretched to excess, it is difficult to see how the states would be able to compensate for the reduced Federal contribution to Medicaid.

In addition, the testimony emphasizes the role of teaching hospitals as major providers of Medicaid services and strongly opposes the proposed repeal of freedom of choice given Medicaid beneficiaries since it could leave the teaching hospitals with primarily expensive patients, eliminate educational opportunities and foster reinstituting a two-class system of medical care.

Dr. Foreman felt that there was a fictitious component to the freedom of choice issue. He believed that there would be no incentive for Medicaid patients to go to low-cost hospitals because most lower cost hospitals are too geographically dispersed and are not interested in picking up this patient population. At this point, the discussion pursued the question of whether it would be wise to suggest cuts in both the Medicare and Medicaid program.

Mr. Frederick noted that teaching hospitals must find ways to reorganize their outpatient departments, or get out of the business. He indicated time is needed to make

this shift away from Medicaid business and felt spreading the cuts over Medicaid and Medicare would be the only way of buying this time.

The following points were made in the ensuing discussion:

- Expenditures for health care cannot continue unrestrained;
- There are only two choices: 1) competition which destroys the least powerful; and 2) regulation that controls the system;
- A properly regulated system can allocate bad debts and charity allowances across the whole system;
- "Competition" could result in a dual system of health care, but likely would lead to the death of the public hospital system;
- There is no way under any system to bring the same class of health care to all people, and it is time to recognize this fact;
- Consumers may be willing to pay a great deal for health care, even greater than today. It may not be wise to think in terms of the market being saturated and that there are no more dollars;
- A large percentage of Medicaid dollars go to care of the elderly in nursing homes, and the public is blind to these expenditures when they analyze the spending of Medicaid dollars.

Mr. Marylander called for a more specific direction to the discussion. Dr. Foreman recommended fighting a holding action by opposing all changes in the Medicaid program, and stated the draft testimony was a proper step in that direction.

After discussion of the possible repeal of the "freedom of choice" provision and the requirement that Medicaid pay reasonable costs in the absence of a waiver, it was agreed the AAMC should oppose repeal of these two provisions. At this point, Dr. Cooper stated that at the special meeting of the CAS public affairs representatives the previous day, and in discussion with the CAS Board, it was generally recommended to oppose all of the proposed cuts in the areas of interest to AAMC constituents. Dr. Cooper further indicated he did not feel that the Association should make recommendations regarding where cuts should be made; rather the burden should be placed

on the Congress.

Mr. Marylander summarized the tentative Association position as one of opposition to the Medicaid cuts which will place the nation's teaching hospitals in a position where they will not be able to meet their obligations to a significant segment of the public. In response to the question of where the money to offset the cap should come from, the Association's position will be to recommend no alternative cuts but to describe the consequences of the actions proposed. It was the consensus of the Board that this position be presented in Mr. Womer's testimony. Mr. Marylander extended the Council's thanks to Mr. Womer for his willingness to testify on this issue.

VII. AAMC Position on Repeal of P.L. 93-641

Dr. Knapp reviewed the action of the COTH Board and AAMC Executive Council at the January meeting. While these actions seemed responsive at the time, he indicated that he felt that the Association should probably not be silent if the issue of repealing the planning law becomes a real possibility. Mr. Manzano was requested to update the probable course of action for the AHA.

Mr. Manzano reviewed the proposed low levels of funding for the planning program over the next two years as the intermediate objective toward terminating federal involvement in the planning program. He noted that the AHA had met with Dr. Brandt on this issue; who had indicated that at this time the Administration is seeking to modify the program and dramatically reduce the level of funding. Mr. Manzano noted that the AHA felt that was not a very useful approach, and mentioned that a number of the states were very concerned about such aspects as the sanction provisions. He indicated that the AHA is now attempting to develop proposed legislation to substantially modify the planning law if there is to be no funding. He stated they hoped to persuade the Administration to sponsor this proposal. He noted there is a new senator who is eager to push a bill through eliminating planning immediately and that the AHA is attempting to avoid becoming involved without offending him. However, if the chairman of the responsible committee, Labor and Human Resources, moves quickly to repeal, Mr. Manzano felt the AHA would probably be supportive. The AHA, however, will not sponsor such a move.

Dr. Foreman supported regulation and rational planning.

He stated that the notion of community based capital regulation is less destructive to the teaching hospitals than the competition notion. Dr. Match noted that the HSA network in New York has been relatively successful and wondered how to proceed without the HSA's. Mr. Reinertsen added that he believed to simply drop certificate-of-need and project review, at least in the Salt Lake City area, would mean instant acceleration of building. Dr. Bartlett concurred with these remarks though he did indicate he had no great wish to see the HSA's in their present structure remain; however, he said their total absence would lead to Mr. Reinertsen's prediction and that regional planning is essential to the teaching hospital constituency. He called for a VE effort in planning and restructuring, getting it out of the state and Federal government, and having it funded locally with more active participation by all involved.

Mr. Manzano pointed out that many states have their own CON laws. He noted that the majority of state hospital associations would support continuation of state CON laws and the Federation of American Hospitals voted to support this continuance. Mr. Barry stated he felt that doing away with P.L. 93-641 would be giving the states the right to do something about the issue. Mr. Rice felt that there would not be much growth in capital expansion of hospitals in the near future since there is a shortage of capital for financing such endeavors.

Mr. Manzano stated that the AHA will be supporting some kind of community-based planning, but does not necessarily support a Federal regulatory system.

It was the consensus of the Board members that a posture be recommended that advocates a state CON program with very few Federal guidelines which allows flexibility in financing and composition of currently operating HSA's and SHCC's, and does not mandate appropriateness review and similar requirements. However, no formal action was taken.

VIII. Report on the Ad Hoc Committee on Competition

Mr. Butler reviewed briefly the discussion on this issue in January and noted that for the most part, the Board felt that the tone was satisfactory and the useful suggestions made by all the Administrative Boards at that time have been worked into the present draft: a more specific definition of competition in the overview; recognition that competition may actually result in increased expenditures; a description of the possible

impact on volunteer faculty members; stronger emphasis on the problems of charity care and the two-class care issue; inclusion of a new section on faculty practice plans; and presentation of the separate funding issue in a more cautionary fashion. He noted the two different endings to the paper are in response to a suggestion from the COTH Board that perhaps the last section, "Strategy for Teaching Hospitals," was a bit superficial. In addition, it was not consistent with the purpose of the rest of the document. Hence, version #1 deletes that last section and version #2 includes the "strategy" section. He noted that staff recommends approval of version #1.

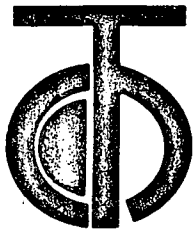
Dr. Bartlett asked about the purpose of this paper. Mr. Butler explained that the intent was to distribute the paper to all AAMC constituents and a wide variety of other interested parties to highlight the issues and problems for teaching hospitals of a competitive strategy.

After brief discussion, the following action was taken:

ACTION: It was moved, seconded and carried to approve the first version of the Report of the Ad Hoc Committee on Competition.

IX. Adjournment

The meeting was adjourned at 12:30pm.



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: THE AULTMAN HOSPITAL ASSOCIATION

Hospital Address: (Street) 2600 Sixth Street, S.W.

(City) Canton (State) Ohio (Zip) 44710

(Area Code)/Telephone Number: (216) 452-9911

Name of Hospital's Chief Executive Officer: Richard J. Pryce

Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data (1980 figures)

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 687

Average Daily Census: 618

Total Live Births: 2977

Admissions: 29,103

Visits: Emergency Room: 46,929

Visits: Outpatient or Clinic: 12,123 (clinic)

B. Financial Data

Total Operating Expenses: $ 49,797,756.

Total Payroll Expenses: $ 29,056,963.

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 1,069,200
Supervising Faculty: $ 1,042,000

C. Staffing Data

Number of Personnel: Full-Time: 1874
Part-Time: 684

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 197
With Medical School Faculty Appointments: 72 + 5 Ph.D.

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

FULL TIME SALARIED DIRECTORS OF MEDICAL EDUCATION

Radiology	OB/GYN	Pediatrics	Internal Medicine
Pathology	Family Medicine	Psychiatry	

Does the hospital have a full-time salaried Director of Medical Education?: Hospital has DME position

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

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

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	0			
Medicine	27	6	2	7/1978
Surgery	0			
Ob-Gyn	12	4	8	1950
Pediatrics	0			
Family Practice	18	18	0	3/26/75
Psychiatry	0			
Other:				
Pathology	8	1	3	6-14-67
Radiology	8	8	0	1970

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: Northeastern Ohio University College of Medicine

Dean of Affiliated Medical School: Robert Liebelt, M.D., Dean

Information Submitted by: (Name) Richard J. Pryce

(Title) President

Signature of Hospital's Chief Executive Officer:

Richard J. Pryce (Date) 3-11-81

AULTMAN HOSPITAL
2600 SIXTH STREET, S.W.
CANTON, OHIO 44710
PHONE 452-9911

(III. a.)

Aultman Hospital is a primary teaching affiliate of Northeastern Ohio Universities College of Medicine. This medical school has no clinical teaching hospital. Hence, all clinical student education is conducted in the community hospital setting in the eleven affiliated hospitals in Akron, Canton, and Youngstown.

Beginning in September, 1981, Aultman Hospital will provide training for twelve students in the Year IV of the Northeastern Ohio Universities College of Medicine six year curriculum. This is the first clinical year for our students. The courses encompass the traditional "Introduction to Clinical Medicine" and are systems oriented. The students receiving their clinical training for Year IV at Canton Aultman will have their basic core clerkship in family medicine. There will also be ongoing rotations in internal medicine, with attention to medical subspecialities, as well as continuing clerkships in pathology and radiology during the year.

Year V teaching will begin in Canton in 1982 with the traditional "core" clerkships being offered. These include medicine, surgery, OB/GYN, psychiatry, and pediatrics. Where total resources are not available at Aultman for these clerkships, supplemental learning experiences will be provided at affiliated Akron hospitals.

In addition to the required clerkships listed above, we provide a large number of Year VI electives in many fields.

AULTMAN HOSPITAL
2600 SIXTH STREET, S.W.
CANTON, OHIO 44710
PHONE 452-6911

(IV.)

Aultman Hospital is an acute, short-term general hospital founded in 1892.

In addition to the residencies listed in this application, there are 11 teaching programs in nursing and health technologies conducted by Aultman Hospital. The programs and residencies have a combined enrollment of 340 students. In addition, Aultman Hospital is the clinical affiliation for 8 training programs at a number of universities in Ohio.

These nursing and technology schools are: professional nursing, nurse anesthesia, medical technologies, radiological technologies, respiratory therapy and paramedic training.

The educational affiliations consist of surgical assisting, medical-social work, pharmacy, physical therapy, practical nursing and medical records technology.

A 6-story hospital addition was opened in 1980 which contains medical and surgical intensive care units, coronary care, medical and surgical step-down and coronary stepdown plus a pediatric unit. There are 110 total intensive care and stepdown beds. All of these sites are well oriented to and constructed for clinical teaching. Also included in this new addition is an expanded 6,000 volume, 120 periodical medical library that is open 24 hours a day for use by undergraduate and graduate students.

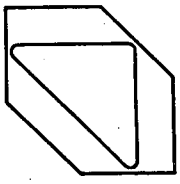
Supportive services for medical education are: a comprehensive laboratory with over 2,000,000 procedures carried out annually, radiology department with 155,000 procedures, and an operating suite with 15 complete rooms.

Also in 1980 a 30,000 sq. ft. ambulatory care facility was opened for undergraduate and graduate medical education. Students and residencies rotate through this facility.

The Nursing Department is well organized and is endowed with registered professional nurses in all areas of the institution, many of whom have advance preparation in specialty care. The Department of Nursing uses the team concept of care, with registered nurses acting as the team leader in all areas. The residencies are able to obtain more patient knowledge with this approach.

1981 will have the addition of open heart surgery, a 6-station renal dialysis unit, a new neonatal intensive care unit and the application for 2 additional residency programs.

Northeastern Ohio
Universities
COLLEGE OF MEDICINE



Rootstown, Ohio 44272 Phone: 216-325-2511

March 27, 1981

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

To Whom It May Concern:

I am writing to you in support of the petition of Aultman Hospital Association for membership in the Council of Teaching Hospitals. Aultman Hospital has been designated as one of the major teaching hospitals of the Northeastern Ohio Universities College of Medicine.

Aultman Hospital has had a long history of programs in graduate medical education; particularly, Internal Medicine, Obstetrics/Gynecology, Diagnostic Radiology, Pathology and more recently Family Practice. Undergraduate medical students will be assigned for the first time to Aultman Hospital in September, 1981, for Years IV, V and VI of the College's six-year combined BS/MD degree program.

Recently an ambulatory care teaching facility was constructed and occuppied as an integral part of the graduate and undergraduate teaching program. The College of Medicine contributed $1.6 million for the construction of the facility which I mention as additional evidence of the cooperative commitment to medical education.

It is indeed a pleasure to add my support to the request of Aultman Hospital to membership in the Council of Teaching Hospitals. Thank you for your consideration.

Sincerely,

Robert A. Liebelt, M.D.
Provost and Dean

AGREEMENT

THIS AGREEMENT is made and entered into as of the day of May 27, 1977, between the Board of Trustees of the Northeastern Ohio Universities College of Medicine (the "Trustees" and the "College" respectively), an institution of the State of Ohio created and organized pursuant to Sec. 3350.10 through 3350.14, both inclusive, Ohio Revised Code, situated in Kent, Ohio, and Aultman Hospital Association (the "Hospital"), a corporation not for profit organized and existing under the laws of the State of Ohio owning and operating hospital facilities within Canton, Ohio, known as Aultman Hospital Association, 2600 Sixth Street, S.W., Canton, Ohio 44710 (the "Hospital Facilities").

WHEREAS, the Ohio General Assembly did establish the Northeastern Ohio Universities College of Medicine and further did mandate in Sec. 3333.11, Ohio Revised Code, that all colleges of medicine supported in whole or in part by the State of Ohio, including the College, create and maintain a Department of Family Practice, to educate and train undergraduates and post-graduate physicians for the practice of family medicine; and

WHEREAS, the Ohio General Assembly has made appropriations in Amended Substitute House Bill No. 687 as amended by Amended Substitute House Bill No. 1508, both enacted by the 111th General Assembly and as further amended by Amended Senate Bill No. 134 enacted by the 112th General

Assembly, (collectively "Appropriations Bill") to the College for the purpose of paying costs of capital facilities comprising Ambulatory Teaching Facilities, which appropriations are to be disbursed to the College by and through the Ohio Board of Regents (the "Regents") with the approval of the Office of Budget and Management and the Controlling Board; and

WHEREAS, the Hospital and College heretofore entered into an Association Agreement dated as of November 4, 1974 (the "Association Agreement", a copy of which is attached hereto as Exhibit A); and

WHEREAS, the Hospital and the College have defined in said Association Agreement the terms under which the Hospital would accept students of the college for undergraduate instruction, and under which the College would utilize the Hospital's Facilities and Staff; and

WHEREAS, the Hospital, in cooperation with the College, plans to extend its Ambulatory Teaching Facilities described in Exhibit B hereto, certain portions of which are designated as Educational Space, and the parties have had discussions concerning the use of the State's appropriations to the College to pay costs of providing the Educational Space at the Hospital; and

WHEREAS, in connection with such discussions there were certain representations made by the Northeastern Medical Education Development Center of Ohio, Inc. and the College to the Ohio General Assembly that to minimize the

costs of the College's undergraduate medical educational program, student clinical instruction would be carried out in existing community hospitals such as the Hospital rather than in a newly constructed university teaching hospital and that such instruction would include the teaching of primary care, particularly, family practice; and

WHEREAS, the College deems the Hospital's Facilities adequate for clinical instruction involving the use of inpatients; and

WHEREAS, the Hospital has developed a plan acceptable to the College to expand the Hospital's Ambulatory Teaching Facilities through the construction of Educational Space as described in Exhibit B so the College's students may receive instruction in the Ambulatory Phase of clinical medicine; and

WHEREAS, the Trustees and the College's administration have participated with the Hospital in the planning of the Educational Space at the Hospital Facilities and obtained preliminary approval of architectural designs of such Educational Space from the Regents, the Director of Administrative Services and the State Architect as being satisfactory and in conformity with construction standards, costs of which are to be paid by State appropriated monies, and the State of Ohio Controlling Board (the "Controlling Board") may release funds appropriated by the Appropriations Bill to the Regents for disbursement

to the College for the payment of the costs of such Educational Space to be constructed, equipped and furnished by the Hospital; and

WHEREAS, it is the intention of the Trustees and the Hospital to set forth in this Agreement the terms, conditions and agreement of each party by which the College will contract with the Hospital for the construction, equipping and furnishing by the Hospital of the Educational Space pursuant to the terms of this Agreement, which construction, equipping and furnishing is to be funded in part by payment by the College to the Hospital from funds appropriated to the College by the Appropriations Bill; and

WHEREAS, the Regents have approved this Agreement by resolution adopted May 20, 1977

NOW, THEREFORE, the parties agree as follows:

A. NORTHEASTERN OHIO UNIVERSITIES COLLEGE OF MEDICINE AGREEMENTS:

1. The College agrees to pay to the Hospital $1,600,000 from and only from the funds appropriated to the College by the Appropriations Bill as amended, and disbursed by the Regents toward the cost of constructing, equipping and furnishing by the Hospital of the Educational Space i.e., a facility situated at the Hospital, acceptable to the College and Hospital as suitable for the teaching of ambulatory aspects of medicine.

2. The College agrees to cooperate to the fullest with the Hospital, the Regents, their agents and representatives to achieve the construction, equipping and furnishing of the Educational Space.

3. The College will, in accordance with the rules and procedures of the Regents and the Appropriations Bill, cause to be paid to the Hospital, through the State of Ohio, the appropriated monies toward the cost of the Educational Space, not to exceed the sum provided in paragraph A.1. provided that as the construction, equipping and furnishing of the Educational Space proceeds, the Hospital will, when required, properly certify that the costs of such are properly incurred and appropriately chargeable to the Educational Space and that such construction, equipping and furnishing meets the specifications and standards previously approved by the College, the Regents, the State Architect and the Director of Administrative Services.

B. HOSPITAL AGREEMENTS:

1. The Hospital agrees to use funds received from the College derived by it from the Appropriations Bill toward the construction, equipping and furnishing of the Educational Space as described in paragraph A.1. of this Agreement and Exhibit B hereto in accordance with the procedures required by this Agreement to be followed for such construction, equipping and furnishing, and to use, and permit the College to use the Educational Space, in accordance with the terms of the Association Agreement (Exhibit A), as a Facility for the training of undergraduate medical students in ambulatory care including the practice of family medicine so as to assist the College in complying with requirements set forth in Sec. 3333.11, Ohio Revised Code.

2. Pursuant to paragraph B.1. of this Agreement, the Hospital agrees to cooperate to the fullest with the College, the Regents, their agents and representatives, to achieve the construction, equipping and furnishing of, and to provide for the College's use of the Educational Space.

3. The Hospital grants to the College the privilege of carrying out at the Hospital in the Educational Space undergraduate training programs, subject to such reasonable regulations and policies as may be established by the Hospital from time to time concerning patient care and/or graduate education activities but the Hospital shall coordinate such activities with the College according to the terms of the Association Agreement all with the intent and purpose of making the Educational Space available to the College for its beneficial use in the conduct of those educational programs for which it has primary responsibility.

4. The Hospital agrees to maintain and operate the Educational Space in a manner that will assure compliance with standards of practice of The Joint Commission on Accreditation of Hospitals, The Liaison Committee on Medical Education, and the Liaison Committee on Graduate Medical Education, their successors, or such other accreditating authorities as may be required and mutually agreed to.

C. CONSTRUCTION OF THE EDUCATIONAL SPACE:

1. The Hospital agrees that in connection with the letting of contracts for construction, equipping or furnishing of the Educational Space, including without

limitation, renovation, or rehabilitation of existing facilities, the construction of new buildings, or the equipping or furnishing thereof, together with all appropriate materials and supplies therefor, it will do so in accordance with the procedures outlined in this Agreement.

2. The Hospital agrees to locate the Educational Space upon real estate which it owns or in which it has appropriate property interests which will allow for the Hospital's use and the College's use of the Educational Space for the term of this Agreement.

3. To the extent not previously accomplished and obtained, the Hospital will prepare, or cause its Architect to prepare, plans and specifications for any building or structure to be renovated, rehabilitated or constructed for Educational Space for the review and approval of the Regents, State Architect and the Director of Administrative Services, and shall proceed with such renovation, rehabilitation, or construction only upon receipt of such approval.

4. The rehabilitation, renovation or construction of Educational Space shall be, together with all other Hospital Facilities owned and operated by the Hospital, complete operating facilities ready for use and occupancy, and Hospital will provide, or insure that provision is or will have been made for, complete heating, lighting and lighting fixtures and all necessary utilities, ventilating, plumbing, and sewer systems for the Educational Space for the term of this Agreement.

5. No monies from the appropriations shall be used by the Hospital for the renovation, rehabilitation or construction unless the mechanics, laborers or workmen are paid the prevailing wage rates as prescribed in Section 4115.04, Ohio Revised Code.

6. The Hospital in connection with letting any contracts for the rehabilitation, renovation or construction of the Educational Space shall provide or cause to be provided by its contractors, an affirmative action program for the employment and effective utilization of disadvantaged persons whose disadvantage may arise from cultural, racial or ethnic background, or other similar cause, including without limitation, race, religion, sex, national origin, or ancestry. The Hospital, and any of its agents and representatives, shall in letting such contracts give equal consideration to contractors, subcontractors or joint venturers who qualify as minority business enterprise. As used herein "minority business enterprise" means a business enterprise that is owned or controlled by one or more socially or economically disadvantaged persons who are residents of the State. "Socially or economically disadvantaged persons" means persons, regardless of sex or marital status, who are members of groups whose disadvantage may arise from cultural, racial, chronic economic circumstances or background, sexual discrimination or other similar cause. Such persons include, but are not limited to Negros, Puerto Ricans, Spanish-speaking Americans, American Indians, Eskimos, Aleuts. Hospital further agrees to comply with the general non-

discrimination requirements specified in Chapter 153, Ohio Revised Code, in all contracts for rehabilitation, renovation or construction of the Educational Space.

7. The Hospital agrees that it shall solicit, or shall cause to be solicited, through a solicitation or an invitation for bids among several contractors in connection with letting of any contract for the several aspects and phases of the work of the Educational Space.

8. Subject to the terms of this Agreement and except as provided in the aforementioned Amended Senate Bill 134, title to and ownership of the Educational Space and all equipment and furnishings therefor, including materials and supplies, shall be in the Hospital.

D. OPERATION OF THE EDUCATIONAL SPACE:

Upon completion of the Educational Space, the Hospital shall implement therein, under the Hospital's own policies, patient care, and/or graduate education activities which it shall coordinate with the College in accordance with the terms of the Association Agreement with the objective and intention of making such Educational Space available to the College for its beneficial use in the conduct of the undergraduate medical education program for which the College has primary responsibility.

E. THE TERM OF THE AGREEMENT:

This Agreement shall be effective upon the date first written herein and shall continue in full force

and effect for a period of twenty-five (25) years from July 1, 1978 unless terminated pursuant to Section F. of this Agreement.

F. FAILURE TO PERFORM:

1. In the event the Hospital fails to perform, honor and comply with its agreements herein contained then the College, as its remedy, may terminate this Agreement and the Hospital shall (a) return any funds received from the College not used for renovation, rehabilitation, constructing, equipping or furnishing the Educational Space and (b) pay to the College an amount equal to one twenty-fifth (1/25th) of the funds received from the College times the number of years, and fraction thereof, remaining in the term of this Agreement from the date of termination and the College, in turn, shall either (a) return to the Regents those funds returned or paid by the Hospital or (b) use those funds, with the approval of the Ohio Board of Regents and the State Architect, for the providing of Educational Space at another location.

2. In the event the College fails to perform, honor and comply with its agreements herein contained then the Hospital shall continue to hold the Educational Space available to College for its medical educational programs for the then remaining portion of the term of this Agreement.

G. DESIGNATION OF ALTERNATIVE SPACE:

The Hospital, may, but only upon express approval of the College, designate alternative areas or space within Hospital Facilities of the Hospital for the purposes and activities herein required for the Educational Space, which express approval by the College shall be

evidenced by a Supplement to this Agreement and revised Exhibit B which shall describe such new or alternative areas or space.

H. COLLEGE'S PAYMENT TO HOSPITAL:

As stated in the Association Agreement the costs attributable to the education of the undergraduate medical students of the College, including that carried out in the Educational Space, shall be the responsibility of the College and payments shall be made only to the Hospital. Such payments shall be determined annually by mutual agreement of the College and Hospital prior to and effective as of July 1st of each year of the term of this agreement commencing July 1st 1978 and then such amount paid directly to the Hospital. No such payments to Hospital may be used for purposes other than the costs attributable to the education of the undergraduate medical students.

I. INSURANCE:

The Hospital agrees to provide and maintain at its own cost and expense, on the buildings, facilities, equipment and furnishings referred to in this Agreement and constituting the Educational Space, insurance against loss or damage by fire and such other casualties and hazards ordinarily covered in extended coverage insurance clauses to 100% of the insurable value thereof. The proceeds of such insurance shall be used to pay the costs of repairing, restoring, rebuilding or replacing the Educational Space described herein. In the event of fire or other casualty rendering the Educational Space non-usable for the purpose

herein then, during any interim restoration period, the Hospital agrees to make reasonable effort to provide substitute Educational Space so that the College can, to the extent possible, maintain its medical education program.

J. CONDEMNATION:

If all or any portion of the Educational Space described in paragraph A.1. of this Agreement and Exhibit B hereto which was constructed, rehabilitated or renovated, in whole or in part, with, funds received by the Hospital from the College is appropriated or taken under power of eminent domain or by paramount authority so as to make such Educational Space unfit for use by the College in accordance with this Agreement, then the Hospital shall provide other such areas or space within Hospital Facilities of the Hospital for the purpose herein required for the Educational Space, subject to the acceptance and approval of same by the College.

K. AMENDMENTS:

Except for the designation of alternate space under paragraph G. of this Agreement, this Agreement may only be amended by a Supplemental Agreement in writing and agreed to by both parties and approved by the Regents.

L. MISCELLANEOUS:

1. Notwithstanding any provision contained in this Agreement to the contrary, it is hereby declared and understood by and between the parties that the Hospital's

facilities to be utilized in the conduct of the College's undergraduate medical program pursuant to Exhibit "A" hereto is not to be limited to the "Educational Space" described in Exhibit "B" hereto.

2. For all purposes under this Agreement any notice required to the parties hereto and to the Regents shall be given by certified mail postage prepaid to the following addresses:

College: Attention:

Aultman Hospital: President Attention:

Regents: Attention:

M. If any provision of this Agreement shall be held invalid, illegal, unenforceable or inoperative, the balance of the Agreement shall remain in full force and effect as if such provision had not been included.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective representatives thereunto duly authorized and the respective seals to be hereunto affixed and attested by the proper officers, all as of the date hereinbefore written.

AULTMAN HOSPITAL ASSOCIATION

By Howard R. Taylor
President, Aultman Hospital Association

ATTEST
Secretary, Board of Trustees

NORTHEASTERN OHIO UNIVERSITIES COLLEGE OF MEDICINE

By
Chairman of its Board of Trustees

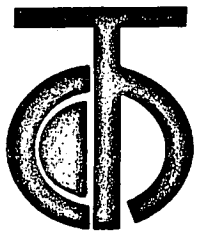
ATTEST
Secretary, Board of Trustees

APPROVED:

OHIO BOARD OF REGENTS

By

ATTEST



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: Grant Hospital

Hospital Address: (Street) 309 East State Street

(City) Columbus (State) Ohio (Zip) 43215

(Area Code)/Telephone Number: (614) 461-3232

Name of Hospital's Chief Executive Officer: Donald H. Ayers

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 601

Average Daily Census: 490.3 (1979)

Total Live Births: 1969 (1979)

Admissions: 22,440 (1979)

Visits: Emergency Room: 30,728 (1979)

Visits: Outpatient or Clinic: 8143 (1979)

B. Financial Data

Total Operating Expenses: $ 36,535,682

Total Payroll Expenses: $ 18,000,000

Hospital Expenses for: Medical Education - $1,500,000

House Staff Stipends & Fringe Benefits: $ approximately 600,000
Supervising Faculty: $ approximately 600,000

C. Staffing Data

Number of Personnel: Full-Time: 1737 (FTE)
Part-Time: 348

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 229
With Medical School Faculty Appointments: 117

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

OB/GYN	Surgery		
Family Practice	Medicine		

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year: July 1979 - June 1980

Clinical Services Providing Clerkships	Number of Clerkships Offered Per Month	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	4	25	required
Surgery	6	60	required
Ob-Gyn	4	39	required
Pediatrics			
Family Practice			
Psychiatry			
*Other: Emergency Room, Physical Medicine			all others are elective

*See elective brochure for complete descriptions of all offerings

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered Per Month	Positions Filled by U.S. & Canadian Grads July 1979 - June 1980	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
* Medicine	2	23		Ohio State Uni.
* Surgery	5	58		Ohio State Uni.
* Ob-Gyn	4	35		Ohio State Uni.
Pediatrics				
Family Practice	36	33	2	Initial: 1971 Full: 1978
Psychiatry				
Other: Colon/Rectal	1 (per year)	1		Grant Hospital
*Physical Med.	1	1		Ohio State Uni.
*Gastroenterology	1	4		Ohio State Uni.
*Ophthalmology	1	5		Ohio State Uni.
*Maxillofacial Surg.	1	12		Ohio State Uni.

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: The Ohio State University

Dean of Affiliated Medical School: Manuel Tzagournis, M.D. (Acting Dean)

Manuel Tzagournis M.D.

Information Submitted by: (Name) Jack E. Tetirick, M.D.

(Title) Director of Medical Affairs

Signature of Hospital's Chief Executive Officer:

Donald H. Ayers Donald H. Ayers (Date) 3-3-91

GRANT HOSPITAL
MEDICAL EDUCATION

309 East State Street
Columbus, Ohio 43215
(614) 461-3290

JACK E. TETIRICK, M.D.
Director, Medical Affairs

January 29th, 1981

SUPPLEMENTARY INFORMATION

The decision to develop Grant Hospital as a teaching hospital was implemented in July of 1977 with the employment of a full-time director of medical affairs and subsequent recruitment and employment of full-time directors of medical education in Surgery, Internal Medicine, Family Practice and Obstetrics-Gynecology. The remaining faculty consists of voluntary, part-time and full-time physicians and other health professions. The curriculum vitae of the director of medical affairs and of the directors of medical education is included as reference material and a teaching brochure with brief descriptions and vitae of other faculty is included for reference Also included in the reference material will be a table of organization of the Medical Education Department and of the Family Practice Program. The Department of Medical Education is both a Medical Staff Department and a hospital department.

The principle educational focus is the training of family physicians. This hospital program is one of the oldest and largest in the State of Ohio, it is fully approved, it consistently fills its residency with graduates of United States medical schools with occasional exceptions from foreign medical schools. The program has enjoyed a very low drop-out or transfer rate, it has a most adequate participation by minority residents and by women and has been highly effective in its principle objective of placing primary care physicians in under-served areas (see reference material - outcome analysis).

The Medical Education Program at Grant Hospital does not seek to establish independent residencies in other specialties, preferring a partnership with Ohio State to give these residents the discipline of an academic program and the experience of a community hospital. The patient population of Grant Hospital is ideal for resident education. There is graded responsibility at each level of resident participation which is closely supervised by the chairman of the respective departments at the University.

The hospital is actively engaged in clinical research particularly in the field of neoplatic diseases, it is a participating member in the Southwest Oncology group and is developing a research capability in community medicine and family practice medicine. A job description for major faculty positions, a set of goals and objectives for each major faculty position, individual annual reports and a bibliography of published articles is available.

Jack E. Tetirick, M.D.
Director of Medical Affairs

OSU

The Ohio State University

College of Medicine
Administration Center
370 West 9th Avenue
Columbus, Ohio 43210

March 16, 1981

TO WHOM IT MAY CONCERN:

The Dean's Office is pleased to support the application for membership of Grant Hospital in Columbus, Ohio, for membership in the Council of Teaching Hospitals. The Ohio State University College of Medicine has had a teaching affiliation with Grant Hospital since 1964. This has been a valued association and affiliation for the College of Medicine.

Our medical students take elective rotations at Grant Hospital and we have an active interchange of house officers with Grant Hospital. This has been a highly satisfactory relationship between our two institutions. Many of the medical staff members of Grant Hospital are clinical faculty members of our College and several courtesy staff members of University Hospitals. One faculty member has a full-time appointment in the College of Medicine and is located at Grant Hospital.

In view of the fine relationships which we have enjoyed and the importance of this affiliation, we are pleased to support Grant Hospital as a member of the Council of Teaching Hospitals of the Association of American Medical Colleges.

Sincerely,

Manuel Tzagournis M.D.

Manuel Tzagournis, M.D.
Acting Dean

MT:mjf

MEMORANDUM OF AGREEMENT

Affiliation of Grant Hospital
with the
College of Medicine of The Ohio State University

WHEREAS the Grant Hospital is an institution for the care and treatment of sick people and the Board of Trustees has authorized the medical staff of Grant Hospital to participate in research and medical education to supplement their patient care programs; and

WHEREAS the University through its College of Medicine is responsible for the educational programs of students of medicine, physicians and dentists in specialty and graduate studies; and for the maintenance of research and patient care programs planned to enhance the educational programs; and

WHEREAS the Board of Grant Hospital believes its total program will be enriched by the direct association with the College of Medicine in medical teaching; and

WHEREAS the University through its College of Medicine can by the use of the facilities of Grant Hospital complement its own facilities to the mutual enrichment of their educational programs;

NOW, THEREFORE, Grant Hospital, through its Board of Trustees, and the Dean of the College of Medicine, through the Board of Trustees of The Ohio State University, agree to the following:

1. The clinical facilities, including the inpatient and outpatient services of Grant Hospital are made available for the educational program of medical students of the College of Medicine of The Ohio State University.

2. The Administrator of Grant Hospital will coordinate the programs of diagnostic procedures, including the taking of medical histories and the physical examinations of both inpatients and outpatients, with the Dean of the College of Medicine so as to secure the uniformity and precision which are necessary for the proper instructions of students of the College of Medicine.

3. The treatment and care of all patients will be determined by the (physician) member of Grant Hospital medical staff in charge of the patient.

4. Only those hospital staff members holding faculty appointments in the College of Medicine of The Ohio State University may be assigned teaching responsibilities involving students of the College of Medicine.

5. The Dean of the College of Medicine shall be responsible for discipline of students willfully violating the rules and regulations of Grant Hospital.

6. The autonomy of Grant Hospital as an independent institution shall be observed at all times.

7. The President of the Board of Trustees of Grant Hospital and the Dean of the College of Medicine may collaborate directly in the accomplishment of the above program.

Either party may terminate this agreement by a written notification giving a six-months' period of advance notice.

For: Board of Trustees
The Ohio State University

Novice G. Fawcett
President

Date: July 17, 1964

For: Board of Trustees
Grant Hospital

Paul R. Leach
President

Date: June 3, 1964

Saint Mary of Nazareth
Hospital Center

2233 West Division Street, Chicagó, Illinois 60622/Telephone 312 • 770 •

May 29, 1981

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

Dear Dr. Knapp:

Your recent directory reached Saint Mary of Nazareth Hospital Center. The publication lists Saint Mary's as a Corresponding Member. I note that Teaching Hospital membership requires at least two approved resideny programs in the specialty areas. Saint Mary's now has the following programs: Internal Medicine, Surgery, Family Practice, Psychiatry and Orthopedics. In addition, our census of undergraduate clerkships through our affiliation with Chicago Medical School numbers well over 55. There is a full time Director of Medical Education and a full time Vice President of Medical Affairs and there are presently 43-45 residency positions filled as well as three fellowships in the programs in Cardiology and Metabolic Support. We significantly contribute to the educational programs of our affiliated medical school and our financial support is near $2 million dollars.

Your consideration in extending to us membership as a teaching hospital is formally requested.

Please let us know if we are eligible for the teaching hospital membership

Sincerely,

Sister Stella Louise

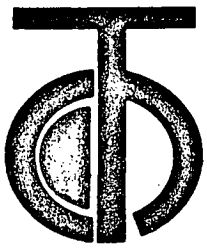
Sister Stella Louise, C.S.F.N.
President

SSL:bp

SAINT MARY OF NAZARETH HOSPITAL CENTER

	FTE Positions Filled
Internal Medicine	13
Surgery	6
Family Practice	18
Psychiatry	4
Orthopedics	1
Cardiology Fellows	2
Metabolic Support Fellows	1
Oral Surgery Fellows	2

Source: Dr. Anthony Sapienza
Director of Medical Education
June 11, 1981



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: Veterans Administration Medical Center

Hospital Address: (Street) 30th & Euclid

(City) Des Moines (State) Iowa (Zip) 50310

(Area Code)/Telephone Number: (515) 255-2173

Name of Hospital's Chief Executive Officer: Wayne Maddocks

Title of Hospital's Chief Executive Officer: Medical Center Director

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

A. Patient Service Data

	FY 80		
Licensed Bed Capacity (Adult & Pediatric excluding newborn):	318	Admissions:	5,835
Average Daily Census:	189	Visits: Emergency Room:	NA
Total Live Births:	-0-	Visits: Outpatient or Clinic:	74,202

B. Financial Data

Total Operating Expenses: $ 10,901,023

Total Payroll Expenses: $ 16,824,978

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 587,702
Supervising Faculty: $ 2,469,116

C. Staffing Data

Number of Personnel: Full-Time: 724
Part-Time: 83

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 45
With Medical School Faculty Appointments: 17

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

Audiology & Speech	Medical	Psychology	Social Work
Dental	Nursing	Radiology	Surgical
Laboratory	Psychiatry	Rehabilitation Med.	Ambulatory Care

Does the hospital have a full-time salaried Director of Medical Education?: Chief of Staff is also Chief, Medical Education

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	No specific number offered	21	14 required 7 elective
Surgery			
Ob-Gyn			
Pediatrics			
Family Practice			
Psychiatry			
Other:			

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine	12	12	- 0 -	*March 1976 November 1979
Surgery	17	16	1	*May 1949 February 1978
Ob-Gyn				
Pediatrics				
** Family Practice Broadlawns	32	32	- 0 -	*Dec. 1978 Sept. 1978
** Family Practice Iowa Luth.	24	24	- 0 -	* 1974 ~~Feb. 1980~~
Psychiatry				
Other:				

**The Family Practice Residents rotate from their home program at Broadlawns Medical Center and Iowa Lutheran Hospital. This cooperative education agreement accounts for approximately 35-45 man-months per academic year.

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

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

*Indicates initial accreditation of the program.

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: Univ. of Iowa, College of Medicine

Dean of Affiliated Medical School: Paul Seebohm, M.D.

Information Submitted by: (Name) GARY V. MORTON

(Title) AA/Chief of Staff

Signature of Hospital's Chief Executive Officer:

WAYNE MADDOCKS Wayne Maddocks (Date) June 4, 1991

COMPENDIUM OF TEACHING PROGRAMS AT VAMC, DMI - AUGUST 1979

	SERVICE	PROGRAM	AFFILIATE
1.	Audiology & Speech Pathology	Speech Pathology Trainee	NE Missouri State Univ.
2.	Chaplain	Chaplain's Trainee	Drake University
		Pastoral Hospital Visitation Training	Drake University
3.	Dental	Dental Assistant Student	Area XI Community College
4.	Laboratory	1 & 2 year for Laboratory Technicians	Area XI Community College
5.	Medical	Family Practice Residency	Iowa Lutheran Hospital
		Family Practice Residency	Broadlawns Medical Center
		Internal Medicine Residency	University of Iowa
		Medical Clerkship	University of Iowa
		Respiratory Therapy	Area XI Community College
		Physician's Assistant	University of Iowa
		Medical Clerkship	College of Osteopathic Medicine & Surgery
6.	Nursing	1st year Nursing Students	Area XI Community College
		Nursing Students	Grandview College
		Operating Room Technician	Area XI Community College
		Master Degree Program	University of Iowa College of Nursing
7.	Pharmacy	Pharmacy Students	Drake University
8.	Psychiatry	Physician's Assistant	University of Iowa
9.	Psychology	Psychology Trainee	LAPA Approved Universities
		Human Services Trainee	Area XI Community College
		Trainees in Counseling	Drake University
		Physician's Assistant	University of Iowa
10.	Radiology	Physician's Assistant	University of Iowa
11.	Social Work	Social Work Trainee	University of Iowa
12.	Surgical	General Surgery Residency	University of Iowa
		Orthopedic Surgery Residency	University of Iowa
		Ophthalmologic Residency	University of Iowa
		Physician's Assistant	University of Iowa
		Family Practice Residents for exposure to Orthopedics, Ophthalmology and CASU	Broadlawns Medical Center
		Senior Medical Students (CASU)	University of Iowa
		Medical Clerkships	College of Osteopathic Medicine and Surgery
		Urology Residents	University of Nebraska

ATTACHMENT to Application for Membership in Council of Teaching Hospitals Assn.

1. To assist the Council of Teaching Hospitals Administrative Board in its evaluation of our application, the list of hospital education programs is attached.

2. Two of the most active education programs conducted at the Medical Center are in General Internal Medicine and General Surgery. The General Internal Medicine program is a tripartite affiliation between the University of Iowa, College of Medicine, Iowa City, Iowa; Iowa Methodist Medical Center of Des Moines, Iowa; and the VA Medical Center, Des Moines. There are approximately 24 residents in General Internal Medicine equally sponsored by the VAMC and Iowa Methodist Medical Center. It is a three year fully accredited program. The General Surgery program is one which has a long-standing scholastic record, dating back to 1949. It has grown to approximately 17 General Surgical residents. In addition to General Surgery, Surgical Service provides active educational experience to University of Iowa and University of Nebraska residents, in Orthopedics, Ophthalmology, and Urology. There is a minimum of 12 months coverage for resident education in each of these three subspecialties of General Surgery.

3. The VA Medical Center, Des Moines also actively participates in the education of Family Practice Residents. Two Family Practice Residency Programs, one located at Broadlawns Medical Center, Des Moines, Iowa and Iowa Lutheran Hospital, Des Moines, Iowa, rotate residents to the VAMC for experience in General Internal Medicine and many of its subspecialties such as Cardiology, Gastroenterology, and Pulmonary Disease. Additionally residents are rotated for experience in Ophthalmology and Neurology.

4. To provide educational support to all of the above mentioned residencies, the VA Medical Center, Des Moines has developed a Core Animal Surgical Unit (CASU). This educational laboratory provides an opportunity for residents to learn suturing techniques, to work on animals and to gain basic research experience.

5. It is sincerely hoped that this additional information on our educational activities will allow the Administrative Board to make a decision in favor of this application.

The University of Iowa
Iowa City, Iowa 52242

College of Medicine
Office of the Dean

(319) 353-4843

May 20, 1981

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

Dear Sir:

The Veterans Administration Medical Center, Des Moines, Iowa, is making application to the Council of Teaching Hospitals for teaching hospital membership. I fully support this VA Medical Center's application and wholeheartedly recommend that you accept them into your membership.

Des Moines is essential to Iowa's postgraduate education of residents in the specialties of General Internal Medicine, General Surgery, Family Practice, Orthopedic Surgery, Otolaryngology, and Urology. The educational activities at the Des Moines VAMC are coordinated with the involvement of the Dean's Committee. Without the active teaching involvement of this Medical Center, I feel that the University of Iowa College of Medicine would be hard-pressed to find alternate sites for postgraduate education that would meet the high standards of quality in education as the Des Moines VAMC has demonstrated.

Sincerely yours,

Paul M. Seebohm M.D.

PAUL M. SEEBOHM
Executive Associate Dean

MEMORANDUM OF AGREEMENT (AFFILIATION) BETWEEN

THE VETERANS ADMINISTRATION HOSPITAL, DES MOINES, IOWA, AND THE UNIVERSITY OF IOWA, COLLEGE OF MEDICINE, IOWA CITY, IOWA.

This agreement, when approved by the United States Veterans Administration and the University of Iowa, College of Medicine, at Iowa City, Iowa, shall authorize the Veterans Administration Hospital, to affiliate with the University of Iowa, College of Medicine, at Iowa City, Iowa, for the purposes of education and training. The College of Medicine accepts advisory responsibility for the education and training programs conducted with the Veterans Administration Hospital. The Veterans Administration retains full responsibility for the care of patients, including all administrative and professional functions pertaining thereto.

Responsibilities shall be divided as follows:

1. The University of Iowa, College of Medicine, at Iowa City, Iowa

   a. Will organize a Dean's Committee, composed of senior members of the faculty of the College, and other appropriate educational representatives, and recommend its nomination to the Chief Medical Director of the Veterans Administration.

   b. Will nominate to the Veterans Administration Hospital Director on an annual basis a staff of consulting and attending specialists in the number and with the qualifications agreed upon by the Dean's Committee and the Veterans Administration.

   c. Will supervise, through the Veterans Administration Hospital Director and the staff of consulting and attending specialists, the education and training programs of the Veterans Administration Hospital and such programs as are operated jointly by the Veterans Administration and the College.

   d. Will nominate all physicians for residency or other graduate education and training programs in the numbers and with the qualifications agreed upon by the Dean's Committee and the Veterans Administration.

2. The Veterans Administration

   a. Will operate and administer the Veterans Administration Hospital.

   b. Will appoint qualified physicians to full-time and regular part-time staff of the Hospital. Nominations to the Hospital Director by the Dean's Committee for full-time and regular part-time positions shall be welcomed; and, unless there be impelling reasons to the contrary, shall be approved wherever vacancies exist. The regularly appointed staff, including chiefs of service, shall be fully responsible to their immediate superiors in the Veterans Administration.

c. Will consider for appointment the attending and consulting staff and the physician trainees nominated by the Dean's Committee and approved by the Veterans Administration.

d. Will cooperate fully with the University of Iowa, College of Medicine in the conduct of appropriate programs of education, training, and research.

3. The Director, Veterans Administration Hospital, Des Moines, Iowa

a. Will be fully responsible for the operation of the Veterans Administration Hospital.

b. Will cooperate with the Dean's Committee in the conduct of education and training programs and in evaluation of all participating individuals and groups.

4. Chiefs of Service

a. Will be responsible to their superiors in the Veterans Administration for the conduct of their services.

b. Will, in cooperation with consulting and attending staff, supervise the education and training programs within their respective services.

5. The Attending Staff

a. Will be responsible to the respective chiefs of service.

b. Will accept responsibility for the proper care and treatment of patients in their charge upon delegation by the Hospital Director or his designee.

c. Will provide adequate training to house staff assigned to their service.

d. Will hold faculty appointment in the University of Iowa, College of Medicine, or will be outstanding members of the profession with equivalent professional qualifications acceptable to the College of Medicine and the Veterans Administration.

6. Consultants

a. Will be members of the faculty, of professorial rank, in the University of Iowa, College of Medicine, or will be outstanding members of the profession with equivalent professional qualifications acceptable to the College of Medicine and the Veterans Administration, subject to VA regulations concerning consultants.

b. Will, as representatives of the University of Iowa, College of Medicine, participate in and take responsibility for the education and training programs of the Veterans Administration Hospital, subject to VA policy and regulations.

c. Will afford to the Hospital Director, Chief of Staff, and the appropriate Chief of Service the benefit of their professional advice and counsel.

TERMS OF AGREEMENT:

1. The University of Iowa, College of Medicine will not discriminate against any employee or applicant for employment or registration in its course of study because of race, color, sex, creed, or national origin.

2. Nothing in this agreement is intended to be contrary to State or Federal laws; and in the event of conflict, the State and Federal laws will supersede this agreement.

3. Civil actions arising from alleged negligence or wrongful conduct of house staff while engaged in patient care or related activities at VAH, Des Moines, Iowa, will be considered and acted upon in accordance with the provisions of 38 U.S.C. 4116.

4. This agreement may be terminated at any time upon the mutual consent of both parties or upon six (6) months notice given by either party. An annual review of policies and procedures will be made.

John W Eckstein 7/9/73
JOHN W. ECKSTEIN, M.D. (Date)
Dean, College of Medicine
University of Iowa

Donald C Munson 7/23/73
DONALD C. MUNSON (Date)
Hospital Director
Veterans Administration Hospital

[signature] 7/28/73
Chief Medical Director (Date)
Department of Medicine and Surgery
Veterans Administration

aamc association of american medical colleges

December 29, 1980

MEMORANDUM TO: The Record

FROM: Richard Knapp

SUBJECT: December 19, 1980 Meeting with Congressman Gephardt

Present at the meeting were the following individuals:

Robert Blackburn
John Colloton
John A. D. Cooper, MD
Robert Frank
David Gee
Robert Heyssel, MD
Richard Knapp, PhD
Mitchell Rabkin, MD
Charles Womer
Katie Bolt
John Crosby
Rosalyn Davidson
John Hoff
John Horty

John Crosby, legislative assistant to Congressman Gephardt presided at the meeting. He indicated that Congressman Gephardt would be present shortly, and he did appear after the meeting was underway for approximately twenty minutes. He stayed at the meeting for about one hour and fifteen minutes. Mr. Crosby indicated that similar meetings have been held with independent groups of physicians and administrators as well as the American Medical Association, the American Nurses Association, the American Hospital Association, the Washington Business Group on Health and representatives from the Business Roundtable.

He stated that H.R. 7527 would be reintroduced in the new Congress immediately as a vehicle to engage discussion and debate with an understanding that much more work needed to be done on the bill. Further, he indicated that discussions and negotiations were under way with Senator Durenburger, Republican from Minnesota, who is a likely co-sponsor for the bill in the Senate. Also, they are pleased that former Congressman Stockman, Director-designate of the Office of Management and Budget continues to be very supportive and HHS Secretary-designate Schweiker is also very supportive of the bill. They plan to push very hard and to sustain the momentum that now they perceive to be behind the bill and the competitive approach generally. As a parenthetical comment, he stated that it

was his understanding that the Chrysler Corporation could save 176 million dollars if its employees would switch to a low option health insurance plan. He then went on to introduce Rosalyn Davidson, Katie Bolt and John Horty who are the staff members of the National Council of Community Hospitals. It is very apparent that Mr. Horty and John Hoff, a lawyer with whom Mr. Horty is doing a fair amount of work, have had a great deal to do with putting together the bill. A list of the membership of the National Council of Community Hospitals is enclosed with this memorandum.

Mr. Crosby then continued the meeting by posing the rhetorical question, "why have we done this?" He went on to say that many people have told him and his colleages that they are getting used to planning, PSRO's and other regulations. However, it is his belief and the belief of those who support the bill that there is definitely going to be a financial crunch and that these dollar questions are going to have to be dealt with rather than pushed aside as they have been in the past. The scenario that he posed was one which placed the Kennedy approach to national health insurance at one end of the spectrum and the alternatives that Congressman Gephardt's bill embraces at the other end of the spectrum stating that the status quo is just not an option.

He then turned the meeting over to Dr. Weldon who outlined the nine concerns that the group present had developed as a problem list in the morning. She began by stating that it is really quite difficult to separate each of these concerns because they are each related one to the other and there is in effect a multiple impact. The basic points which she outlined are as follows:

1. quality of care with a perception that while deregulation may occur on the economic side, there may be a need for increased regulation in the area of quality. The question of whether or not patients will receive the appropriate level of care when financial risk is involved must be addressed;

2. the cost of undergraduate medical education;

3. the cost of graduate medical education;

4. the cost of allied health education;

5. the maintenance of an environment which would encourage the application of research and development;

6. problems of tertiary care and case mix as they relate

to equitable pricing and cost determinations. She pointed out that the problem with a burn unit or another identifiable patient care unit was less of a problem than the general patient care units on which very sick patients were present that required inordinate amounts of nursing and physician care;

7. charity care and illegal aliens. She pointed out here that not only was the absence of any financing for charity care a problem, but that patients in this category presented a more difficult and more expensive set of problems which require social services, psychological or psychiatric services, nutrition services and a host of other problems that are not presented in the average middle class patient;

8. the problem of ambulatory care deficits which result both from the large charity load in the outpatient departments as well as the productivity slow-down that occurs as a result of the presence of medical students and junior house officers in these areas;

9. the "out of area care" problem which is identified on page 10 of the short summary of the bill. A discussion of this item occurred later in the meeting which indicated that the intent of this provision and its explanation were quite different from the way in which it was read by those present at the meeting.

A general dicussion of the issues ensued and this memorandum will make no effort to identify which issues were discussed by which members of the group except where this appears to be important to understanding the views of John Crosby, John Horty or John Hoff. The problems of case mix and indigent support were discussed at great length and at some points in ways that brought the two issues together. The cost of taking care of these patients from the standpoint of social services and nutrition services, disposition services, interpreters and the more expensive security and other requirements for hospitals that are located in areas that serve large indigent problems were all discussed. One major suggestion that seemed to be well accepted by at least John Horty was that the "plan" be made responsible for the bad debts of any enrollees in the plan. In other words, the $2,900 which is the basic deductible ought to become a responsibility of the plan for collection rather than the hospital or physician who was providing the care. This would put the plan at risk for selling high deductible plans to individuals who might not be in a position to pay these deductibles.

The next item that was discussed concerns the interrelationship between educational programs, educational costs and tertiary care as well as low volume high cost procedures and services. The point was made repeatedly that it is very difficult to separate out the educational costs particularly in tertiary care programs where it is very apparent that the program cannot be sustained in any high quality fashion without the presence of residents and fellows. Further, the high standby costs associated with neonatology, high risk maternity programs, specialized oncology and radiation services and trauma centers was pointed out.

At this point, John Crosby asked whether or not you can start to break out the costs that do need special support. Mr Horty repeatedly stated that the issue was one of how to break out these costs and shift the burdens. Basically, he was asking how much of a subsidy do you need to be competitive both in tertiary care and primary care. It did seem apparent that Mssrs. Crosby, Hoff and Horty had a genuine concern for creating a fair, competitive environment in which the teaching hospital could survive.

Mr. Colloton stated that the data to quantify the unique products of teaching institutions is simply not available, at least at the present time. He went on to outline his thought that 150 (give or take 5 or 10%) major teaching hospitals ought to be identified and that they should be given some form of preferential reimbursement treatment that would allow them to compete. This is important he said to avoid getting into the whole area of cost allocation and other variables necessary to strip away the unique financial burdens of teaching hospitals in order to put them in a competitive position. Mr. Horty responded by saying, "doesn't that single you out in the worst possible way?"

Specific discussion of the provision in the present proposed legislation for financing "up to 70% of educational costs" then ensued. The discussion surrounded three questions:

- o through what mechanism to you raise the money?
- o how much do you raise?
- o how do you redistribute it back to the institutions?

The group generally favored a premium tax which would then follow the student and be paid in capitation form, perhaps to schools for undergraduate medical students and hospitals for house officers and fellows. Such an approach would respond to the questions of what mechanism to use in raising the dollars and how they would be

redistributed. The question of how much to raise would have to be decided on the basis of some estimate of undergraduate and graduate medical education costs and then politically negotiated. There was also some discussion of the role of a federal or a series of state commissions which John Horty several times indicated would be provider dominated. All parties in the discussion were very aware that while the foregoing proposal might provide some support in the area of undergraduate and graduate medical education, the other problems of case mix, allied health education, a research and development environment and charity care and ambulatory deficits would not be directly supported except to the extent that they might be covered under an educational cost burden. It was also pointed out that in some particular areas of prestigious hospitals, high turn-over occurs as the result of individuals who wish to work for short periods of time and then develop a competitive advantage in achieving a position at another institution by saying they worked at such-and-such prestigious hospital for a period of time and therefore were well qualified to fill a position. It was pointed out repeatedly by Mssrs. Crosby, Horty and Hoff that the only way to achieve special treatment for some of these items, irrespective of how the money was raised, is to provide some cost estimate and some mechanism for redistribution if these costs were to be recognized.

Mr. Horty at this point changed the focus of the discussion to the charity care problem which could result in large magnitude due to the fact that the phase-in of the Medicaid program does not occur for four years and the fact that Medicare would continue on a cost basis at least until large groups of Medicare patients choose to opt out and use their vouchers to purchase another plan. There is an understanding that many hospitals could get "clobbered" in the transition period. He indicated that he and his colleagues have attempted to think this problem through, and one suggestion they have developed would allow an experimental program to phase in Medicaid early for hospitals or groups of hospitals which would become sponsors of plans and sign up Medicaid patients for care. He indicated that the patients did not need to get the care at the institution or set of institutions which sponsored the plan, but that the plan would be responsible and financially at risk for the services those patients received. While no one disagreed that this was an option that could be pursued, no other ideas along these lines came out of the meeting.

It was stated several times by John Horty and John Hoff that there are more dollars in this bill than would otherwise be in the system in its absence. In their view, this is because the federal Medicaid contributions are based on community average expenditures and individuals would receive a tax credit for the health insurance policy if they pay for it out of their own pocket. The assumption

here is that these people would therefore upgrade their policy in order to achieve a larger tax credit and this would in turn result in more dollars in the system. Following some more general discussion of issues that had already been worked over, there was agreement that any suggestions the group had would be forwarded to John Crosby by February 1 or the middle of February at the latest.

RMK/mhw
encl (1)

WASHINGTON UNIVERSITY IN ST. LOUIS

Office of the Vice Chancellor for Medical Affairs

March 31, 1981

Mr. John B. Crosby
Administrative Assistant to
Representative Richard Gephardt
218 Cannon House Office Building
Washington, D.C. 20515

Dear John:

The attached memo is a follow-up to our December 19th meeting with you. It reflects the consensus of those present at the meeting who are listed at the bottom of the page. Although several members of the AAMC staff assisted in preparing the memo, the document has not been formally reviewed or endorsed by the AAMC or any other group. We look forward to further discussions with you after you have had an opportunity to review our comments.

Sincerely,

Ginny

Virginia V. Weldon, M.D.
Assistant to the Vice Chancellor

cc: Robert Blackburn
John W. Colloton
Robert E. Frank
David A. Gee
Robert M. Heyssel, M.D.
Mitchell T. Rabkin, M.D.
Charles B. Womer

Washington University
School of Medicine
Box 8106
660 South Euclid Avenue
St. Louis, Missouri 63110
(314) 454-3013

WASHINGTON UNIVERSITY IN ST. LOUIS

Office of the Vice Chancellor for Medical Affairs

March 31, 1981

TO: John B. Crosby

FROM: Virginia Weldon, M.D.

RE: Initial Thoughts Relating to Issues Raised at December 19 Meeting on the Implications of Price Competition Legislation for Teaching Hospitals

This memorandum is a response to issues discussed at our December 19 meeting with you. I understand that you received Dick Knapp's summary of the meeting so I need not repeat the details of our previous discussions. Based on that meeting, we have attempted to address: (1) the charity and uncompensated care issue and (2) three questions raised about a special fund for teaching hospitals under price competition:

- What functions should be funded and how large must the fund be?
- Through what mechanism should the funds be raised?
- Once collected, how should the funds be distributed?

Before addressing these questions, I would like to make it clear that the following comments are based on the ideas of those present at the December meeting. Neither the AAMC nor any other organization has reviewed or endorsed these ideas. Many of my colleagues in major teaching hospitals and medical schools are concerned that the societal contributions of teaching hospitals would be threatened by price competition; some of my colleagues believe, however, that separate identification and funding of these activities cannot and should not be done. In fact, they believe that the funding of these activities should be a intrinsic part of any reimbursement scheme and should not be separately supported. We agree with you that there is no easy solution for the issues discussed in this memorandum. Toward that goal, however, we have attempted to advance the understanding of the issues and offer constructive suggestions.

Charity and Uncompensated Care

Legislation encouraging price competition must provide assurances that the poor will have adequate coverage and access to health care services they need. Uncompensated care is already a major problem for many hospitals, and, in some cases, is almost overwhelming. Much of the charity care is concentrated in teaching hospitals located in urban areas. For major teaching hospitals alone, the

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costs of charity and uncompensated care have been estimated to be at least $2.0 billion.[1] Although charity care is concentrated in these institutions, it is by no means limited to teaching hospitals.

There are two ways to fund the costs of uncompensated care. The first is to increase coverage for those unable to pay for their services. Given the present proposals to decrease federal support for Medicaid and similar state and local government budget proposals, decreased coverage for the poor is more likely to occur. Hospitals serving large Medicaid populations or the uncovered poor will be extremely vulnerable. Among the 325 nonfederal members of the Council of Teaching Hospitals, 65 hospitals (20%) have over 25 percent Medicaid admissions.

The second way uncompensated care can be funded is by increasing charges to charge-paying patients. This presently occurs in many hospitals. In a price competitive market where consumers and health plans are more price sensitive, hospitals with a large volume of uncompensated care would not be able to continue this practice and remain competitive with hospitals providing very little charity care. Thus, increasing patient charges does not appear to be a way to fund uncompensated and charity care under price competition.

H.R. 850 attempts to resolve the uncompensated care issue by having the federal government fund bad debts for individuals not enrolled in qualified plans. Hospitals would receive 50 percent of the customarily billed charge for services provided to such patients. Bad debts and inadequate payments for governmentally-sponsored patients would apparently not be reimbursed because these individuals would be members of a qualified plan. For some hospitals, failure to cover these debts and inadequate payments for uncovered patients would undermine the hospital's fiscal viability. In addition, because price competition will encourage individuals to select lower option plans with more deductibles and co-insurance, an increase in bad debts for all types of patients is likely to occur. One way to address this problem may be to make the plan, rather than the hospital, responsible for collecting deductibles and co-insurance imposed by the plan. Finally, while 50 percent reimbursement for hospitals with small numbers of patients from uncovered populations may be manageable, 50 percent payment on such costs will threaten the existence of hospitals with large numbers of uncovered patients.

We cannot stress enough the importance of resolving this issue before any price competition scheme is put into place. Hospitals providing a large amount of uncompensated care and/or serving a large Medicaid population will not be able to be price competitive unless the legislation significantly expands coverage for uncompensated and charity care. While we offer no specific solution to the problem at this time, we strongly urge that greater attention be given to the consequences of price competition for charity and uncompensated care.

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1. John W. Colloton, "An Analysis of Proposed Competitive Health System Plans and the Implications for Teaching Hospitals," presented to the Sixth Private Sector Conference, Duke University Medical Center, March, 1981.

What Functions Should be Funded and How Large Must the Fund be?

In our December meeting, seven activities were noted as adding to the costs of teaching hospitals: provision of charity and uncompensated care, graduate medical education, treatment of a complex patient case mix, provision of ambulatory care in conjunction with medical education programs, the maintenance of an environment which encourages application of research and technological advances, undergraduate medical education, and allied health education including nursing education. The methodology in Attachment I provides an initial, crude estimate of most of these costs with two exceptions: uncompensated care and ambulatory care. Uncompensated care has been excluded from these estimates because, as was pointed out in the previous portion of this memorandum, the problem must be resolved on its own merits if fair competition is to ensue. Ambulatory care has been excluded only because we have not yet found a reasonable method to estimate the costs associated with the provision of ambulatory care in conjunction with medical education programs. Thus, the methodology presented in this memorandum is limited to five of the seven categories of costs we discussed.

Estimates of the costs of the five categories can be divided into two categories. Type I costs are measurable direct and indirect educational costs that can be estimated from hospital accounting data using the Medicare cost reports. These include:

- House staff stipends and benefits
- Salaries for faculty supervising and teaching the students in training
- Nursing education
- Direct costs of educational programs, including recruitment, programs, supplies, and personnel
- Indirect educational costs such as space and other overhead allocated to educational cost centers.

The total expenditures in 1980 for Type I costs, excluding nursing education which could not be estimated, were approximately $2.12 billion. This estimate may not be precise because it was based on extrapolation from a sample of 33 COTH member hospitals. However, it is important to recognize that these Type I costs can be accurately measured using an already available source of data, the Medicare costs report, and should be totalled in that fashion rather than predicted from the COTH sample.

The second category of costs (Type II) includes costs correlated with but not directly attributable to the presence of educational programs. These costs, which cannot be measured in an accounting sense, are attributable to activities closely related to educational programs. While research at HCFA has suggested

that Type II costs can be estimated by the ratio of number of residents per bed,[2] a precise definition of what Type II costs include has not yet been established. Type II costs may include such factors as:

- Productivity losses associated with the presence of residents and students;
- Diagnostic and socioeconomic patient case mix which require a higher level of resources;
- Utilization of ancillary and other resources attributable to educational programs;
- Resources required to maintain an environment which encourages research and advances in medical care to flourish;
- Administrative costs associated with the management of a complex organization which produces simultaneously multiple, diverse products.

Total expenditures for Type II costs for 1980 were estimated to be $4.23 billion. Thus, Type II costs added to Type I costs ($2.12 billion) totals $6.35 billion, which is about three percent of nationwide health expenditures.

In an inflationary economy, the $6.35 billion figure would have to be increased annually. At least two methods could be used to project annually the funds required for the next year. One method would be inflate the base year fund ($6.35 billion) annually by an inflation index. A second method would be to convert the $6.35 billion figure to a percentage of total national health expenditures. This percentage could then be fixed so that the level of the fund would increase at a rate directly proportional to total health expenditures.

Through What Mechanism Should the Fund be Raised?

Once the total size of the fund has been determined, several mechanisms to collect the fund might be considered. One would be to place a percentage tax on all health plan premiums, regardless of whether or not a plan's subscribers received care in a teaching setting. This method would ensure that all health insurance subscribers would contribute an amount proportional to the cost of the plan selected. Another benefit of this approach is that rather than having government fund the entire costs of the special fund as is proposed in H.R. 850, all purchasers would contribute to the fund. A shortcoming of this approach is that low option plans, which are generally cheaper but have high out-of-pocket obligations, would be taxed less per subscriber than comprehensive plans.

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2. Pettengill and Vertrees, "New Uses for Old Data: A Medicare Case Mix Index," Proceedings of the 18th National Meeting of the Public Health Conference on Records and Statistics, DHHS Pub. No. 81-1214, December, 1980.

A second option for collecting funds would be to charge insurers a fixed dollar amount per enrollee regardless of the level of benefits and cost of the plan. The size of the total fund using this approach would be the same as for the first option. This option, however, would divide the total dollars in the fund by the total number of health plan enrollees nationwide to arrive at a per capita cost. Each plan would be assessed an annual fee based on the per capita rate times the number of enrollees.

Once Collected, How Should the Fund be Distributed?

The most problematic task perhaps is determining how the funds should be distributed. Even if the total costs could be estimated and collection mechanisms established, inequities among hospitals are likely to occur when the funds are distributed. The Type I costs, which are primarily the direct and measurable indirect costs of residency training, should be distributed on a per resident basis. This approach would assure that dollars would follow the behavior of the housestaff recruitment market place.

Although a formulistic approach might be used to distribute Type I costs, it would be difficult to implement a similar method for distributing Type II costs. The number of residents per bed has been used to estimate Type II costs. While this approach may be appropriately used to estimate aggregate Type II costs, it does not follow that funds for these costs should be distributed using the number of residents as would be done with Type I costs. Type II costs vary dramatically by hospital and allocating these costs on a per resident basis would overcompensate some hospitals and undercompensate others. The complexity of the issue suggests that any proposed distribution method should be evaluated carefully in terms of its impact on individual hospitals.

Conclusions

It appears to us that there is no simple solution to this complex problem, and the complexities become increasingly apparent as we probe the various alternative approaches. We are reasonably comfortable with the suggested methods to raise the funds, but are less comfortable with the estimate for the level of funding. It is even more challenging to develop methods for distribution of the funds.

Special funding for specific purposes has been discussed by others and proposed in H.R. 850 as a federal, regulatory solution. This approach is in conflict with the deregulatory principles of price competition. We hope that

any proposal for a special fund will preserve the contributions of teaching hospitals while minimizing the external intervention required to achieve this goal. We hope you will view out comments as preliminary thoughts on this issue which will serve as a basis for future discussion.

cc: Robert Blackburn
John W. Colloton
Robert E. Frank
David A. Gee
Robert M. Heyssel, M.D.
Mitchell T. Rabkin, M.D.
Charles B. Womer

ATTACHMENT I

Methodology to Identify Total Costs in Teaching Hospitals Associated with the Presence of Educational Programs

Congressional proponents of price competition appear to be supportive of separately identifying and funding the educational-related costs of teaching hospitals. While there will be considerable debate about how large these costs are, there may be an opportunity to receive funding not only for resident stipends but for other costs associated with the presence of educational programs. The following presents one method to calculate these costs. The analysis breaks the distinctive costs of teaching hospitals into two types: 1) direct and indirect costs of educational programs recorded on Medicare cost reports; and 2) other distinctive teaching hospital costs which are correlated with but not directly attributable in an accounting sense to the presence of educational programs. This methodology may have credibility among legislators because it is based on the Medicare Section 223 payment limits on hospital inpatient costs. The cost estimates are summarized in Table 3.

Type I Costs: Educational Costs Recorded on Cost Reports

Since 1974, the Medicare program under Section 223 of the 1972 Social Security Amendments has set payment limits on per diem routine operating costs. Beginning with cost reporting years starting on or after July 1, 1979, these limits included a "pass through" provision for the direct and indirect costs allocated to the intern-resident and nursing education cost centers on the Medicare cost report. HCFA noted that the existence and scope of medical education programs made cost comparisons between teaching hospitals and non-teaching hospitals unfair unless the educational costs were excluded. A conservative estimate of the educational costs shown on the Medicare cost reports for 1980 is $2.12 billion. This estimate excludes nursing education which could not be determined. Because Medicare pays only its proportional share of these costs, it is estimated that the excluded Medicare costs are only about one quarter of this amount.

Type II Costs: Distinctive Costs Correlated with but not Directly Attributable to the Presence of Educational Programs

For Fiscal Year 1981, HCFA further refined the methodology in setting per diem limits. In addition to excluding the direct and indirect educational costs in establishing the limits, a new hospital-specific adjustment was made which adjusted teaching hospital limits upward based on the ratio of FTE residents/number of beds at the hospital. This new adjustment was based on an analysis by HCFA's Office of Research which revealed that even after excluding the direct and indirect costs of education, teaching hospitals still had higher per diem costs which could be explained by the number of residents per bed. The regulations stated:

"Our analysis of the data we used to derive the proposed limits shows that, even after education program costs have been removed, there is a high degree of correlation between a hospital's level of general inpatient routine operating costs and the extent of its teaching activity . . .

We believe these increases in per diem (routine operating) cost occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. For example, a hospital with an approved program may be required, for training purposes, to maintain more detailed and complete medical records than a non-teaching hospital. However, medical record costs are not considered educational expenses, and therefore are not excluded from the costs subject to limitation under the current schedule.

To prevent a disproportionate number of teaching hospitals from being adversely affected by the limits, we have, in the proposed schedule, provided an automatic adjustment for the costs generated by approved medical education programs."

Based on their research findings, HCFA developed a formula which adjusted each teaching hospital's limit upward 4.7 percent for each .1 resident/bed at the hospital. For example, a hospital with 250 FTE residents and 1000 beds received a limit that was 11.75 percent (2.5 x 4.7%) higher than it would have been if it had no residents.

This adjustment is applied only to routine costs which represent about one-third of all hospital costs. As a result, the formula is insufficient to estimate total inpatient costs correlated with presence of residency programs. However, HCFA is considering moving away from per diem limits to per admission limits, which unlike the per diem limits, would include all inpatient costs (routine operating costs plus special care unit and ancillary costs). These limits would be adjusted by a hospital's DRG case mix. Initial research by HCFA on this new methodology suggests that even after correcting for case mix and after excluding the direct and indirect education costs as has been done previously, the teaching hospital adjustment used in the per diem limits rises from 4.7 to about 7 percent for each .1 resident/bed under a per admission limit. In other words, the number of residents per bed explains an even greater percentage of the differences in hospital costs when total per admission costs, rather than per diem routine costs, are the unit of analysis. If the 7 percent figure were used, nationwide costs for this category of expenses would total approximately $4.23 billion (see Table 2).

Total Costs Associated with the Presence of Education Programs (Type I Costs Plus Type II Costs)

The above analysis results in several figures that could be used to estimate the total distinctive costs of teaching hospitals (see Table 3 for details).

Type I Costs

Total educational costs on Medicare costs reports, Nationwide 1980	$2.12 billion

Type II Costs

Distinctive costs (excludes Type I costs) of teaching hospitals correlated with presence of educational programs	+ $4.23 billion
Total (Type I plus Type II costs)	$6.35 billion

The totals range from $2.12 billion for measurable direct and indirect costs to $6.35 billion for all types of distinctive teaching hospital costs. These dollar figures translate into a range of approximately .9 to 2.7 percent of national health care expenditures or 2.1 to 6.5 percent of all hospital expenditures. On a per capita basis, the $6.35 billion projection amounts to $27 per person annually.

TABLE 1

TYPE I COSTS

Estimate of Educational Costs
Using Medicare Cost Report
(Non-federal Hospitals)

1.	Total 1980 expenses for 328 non-federal members of the Council of Teaching Hospitals (COTH)	$21.28 billion[1/]
2.	Average education expenses as a percentage of total expenses	7.15%[2/]
3.	Total education expenses in COTH member hospitals (line 2 x line 1)	$1.53 billion
4.	Number of FTE residents in COTH member hospitals	40,775[1/]
5.	Average expenses per resident (line 3/line 4)	$37,573
6.	Total FTE residents in all non-federal hospitals	56,350[1/]
	TOTAL DIRECT AND INDIRECT EDUCATIONAL COSTS USING MEDICARE COST REPORTS (line 6 x line 5)	$2.12 billion

1/ Source of data - 1979 AHA Annual Survey of Hospitals. COTH member inpatient expenses totalled $18.48 billion in 1979. The 1980, $21.38 billion figure assumes a 15.7 percent rise in total expenses from 1979 to 1980.

2/ This percentage figure was derived from a representative sample of 33 COTH member hospitals. Because nursing education costs could not be determined, they are not included in this estimate.

TABLE 2

TYPE II COSTS

Estimate of Distinctive Teaching Hospital
Costs Correlated with but not Directly
Attributable to Presence of Educational Programs
(Non-federal Hospitals)

1.	Total 1980 inpatient expenses for 328 non-federal members of COTH	$19.89 billion[1/]
2.	Total COTH beds	186,670[1/]
3.	Total COTH FTE residents	40,775[1/]
4.	Resident to bed ratio (line 3 divided by line 2)	0.22
5.	Percentage adjustment to inpatient expenses (7.0% x 2.2)	15.4%[2/]
6.	Total adjustment to inpatient expenses (line 5 x line 1)	$3.06 billion
7.	Total adjustment per resident (line 6 divided by line 3)	$75,046
8.	Total FTE residents in all hospitals	56,350[1/]
9.	Total adjustment for all hospitals (line 7 x line 8)	$4.23 billion

1/ Source of data - 1979 AHA Annual Survey of Hospitals. Total non-federal COTH hospital expenses in 1979 were $18.48 billion. From a sample of 33 COTH members, inpatient expenses averaged 93 percent of total expenses, so that total inpatient expenses were $17.19 billion. The $19.89 billion figure assumes a rise of 15.7 percent in inpatient expenses from 1979-1980.

2/ Based on HCFA research which shows total inpatient per admission costs increase by 7.0 percent (after adjustment for DRG case mix) for each .1 FTE resident/bed. See Pettengill and Vertrees, "New Uses for Old Data: A Medicare Case Mix Index," proceedings of the 18th National Meeting of the Public Health Conference on Records and Statistics, DHHS Pub. No. 81-1214, December, 1980.

TABLE 3

Estimates of Distinctive Costs of Teaching Hospitals

Type I Costs	Per Resident	Per 100 Residents	Aggregate Nationwide
Total educational costs on Medicare cost reports	$ 37,573	$3,757,300	$2.12 billion[1/]
Type II Costs			
Distinctive teaching hospital costs (excludes Type I costs) correlated with the presence of educational programs	75,046	7,504,600	$4.23 billion
TOTAL DISTINCTIVE TEACHING HOSPITAL COSTS (TYPE I PLUS TYPE II)	$112,619	$11,261,900	$6.35 billion[2/]

1/ Nursing education costs could not be estimated so they were excluded from the estimate.

2/ These costs are already being funded by patient care revenue. Thus, if price competition achieves its objectives, the separate funding of $6.35 billion would be a redistribution of funding sources for these costs, not additional dollars in the health system.

RICHARD A. GEPHARDT
3D DISTRICT, MISSOURI

WAYS AND MEANS COMMITTEE
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CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

May 1, 1981

Dr. Virginia V. Weldon
Assistant to the Vice Chancellor
Washington University School of Medicine
Box 8106
600 South Euclid Avenue
St. Louis, Missouri 63110

Dear Ginny:

I am in receipt of your much-delayed letter and memorandum of March 31, 1981, regarding the implications of price-competition legislation for teaching hospitals that you addressed to John Crosby of my staff. I know this took much time and effort on your part as well as that of the AAMC, for which I am deeply appreciative.

Without attempting to answer every point made in your memorandum, I would like to note the following thoughts, which are of immediate concern to me.

Page 1--While it appears that many of the major teaching hospitals and medical schools have reviewed H.R. 850 and/or other pro-competition bills, you note that neither the AAMC nor any other organization has reviewed or endorsed these ideas. May I expect a formal review or endorsement in the near future or not?

Page 2--H.R. 850's attempt to solve the uncompensated care issue by having the Federal government fund bad debts up to 50% of the customarily billed charges for services provided to patients not enrolled in Qualified Plans is 50% better than existing law. I believe the bill is significant in this respect and this should be readily endorsed by teaching hospitals. I am also of the opinion that the bill now requires the Qualified Plans to attempt to collect the other 50%. If not, the contractual relationship between a Qualified Plan and any hospital makes the distinction you have outlined somewhat irrelevant.

While I recognize that teaching hospitals bear a larger share of uncompensated and charity care at the present time, you should note again and again that under H.R. 850, all individuals of every income class will have available to them a voucher that provides health insurance coverage equal to the average of health insurance plans in the particular area. While the case mix may still be more severe than in a normal hospital, uncompensated care will no longer be a problem once H.R. 850 is enacted.

Pages 4 and 5--I note the different mechanisms to raise funds to cover the teaching costs and am intrigued by the second option described on page 5, i.e. per capita fees for such services.

If you believe that any legislative change can be accomplished without some regulation, you are naively approaching the problems our society faces in all sectors and how we can solve some of them in the health care area. In this regard, you might consult Representative Lagomarsino's bill, H.R. 1114. It provides that no regulation can be drafted or implemented to execute the provisions of his legislation, if passed. That, in essence, means that the bill will have no force and effect ever. I intend for H.R. 850 to have much force and effect on health care and health care costs in America. Any law requires some regulation to define and implement the same and I would only ask you to compare the structure designed by H.R. 850 to that now required by institutions like yours under the Health Planning Act, PSRO regulations, Medicare, Medicaid, and so on. I can also assure you that teaching hospitals cannot expect competition or legislation to effectuate the same to go away, or in other words, or the status quo to remain for long.

In conclusion, I guess my basic feeling about your memorandum is that I am disappointed in it. If my notes from our December 19 meeting are correct, I had expected your group to address not whether competition is a good idea or not, or how funds could be raised to pay for teaching costs under a competition environment, but rather which mechanism would be the best from your viewpoint to allocate the funds to the various teaching hospitals in the United States once competition is in place and those funds are raised. For example, much discussion is being raised by Doctor Colloton and others about the trust fund concept. Unfortunately, nowhere in your memorandum is the trust fund concept addressed or explained. What other concepts might be used instead of a trust fund? These are the issues that I wish you would address and advise me on in the near future if you are so inclined.

Again, thank you for your input on this most difficult and troubling issue. I look forward to future consultation along the same lines. Best regards as always.

Yours very truly,

Richard A. Gephardt

RAG:jbc

WASHINGTON UNIVERSITY IN ST. LOUIS

Office of the Vice Chancellor for Medical Affairs

June 4, 1981

MEMORANDUM

TO: Participants in December 19th Meeting with Congressman Richard Gephardt

FROM: Virginia V. Weldon, M. D. VVW

RE: May 1 Response from Congressman Gephardt to our March 31 Memorandum

Enclosed is the letter I received from Dick Gephardt and my response to it. My response was developed after consulting with Dick Knapp and John Cooper and others here at our Medical Center.

You will note that the last paragraph of my response refers to another meeting. John Crosby has told me that Dick would like our criticisms of John Colloton's two theoretical options. Although we are all aware that John was very careful to point out all the pitfalls of such an approach, I don't think Crosby and Gephardt believe that the problems are insurmountable. The risks of not responding to this request are obvious. I hope that you might be willing to meet again sometime in July. If, after that meeting, we do not believe it is possible to solve the problems that a competitive model will create for teaching hospitals, then I think we should convey that message to Congressman Gephardt.

Please let me know if you are willing to participate and we will start working on a date.

VVW:dlk
Enclosure

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WASHINGTON UNIVERSITY IN ST. LOUIS

Office of the Vice Chancellor for Medical Affairs

June 3, 1981

Congressman Richard A. Gephardt
218 Cannon Bldg.
Washington, D.C. 20515

Dear Dick:

I am responding to your letter of May 1, 1981, in which you raise a number of substantive issues which are deserving of answers.

The issue of uncompensated and charity care, covered on pages one through three of our March 31, 1981 memo, was and continues to be of major concern to the participants in the December meeting. Our memo stated that uncompensated care could be funded by two methods: increasing coverage for the poor or increasing charges to paying patients. With respect to the first option, my understanding of the voucher system provided for in HR850 is that the states would not be required to participate, and even those which did, would not move to the federal voucher system until four years after the bill is passed. We discussed this at the December meeting and most participants agreed that there would be significant problems for hospitals serving large numbers of the poor or nearly poor. Proposed cutbacks in both Medicaid and Medicare this year increase our concern about this problem.

With respect to the second option for funding uncompensated care (i.e., increasing charges to paying patients), we believe that hospitals with a large proportion of non-paying patients will not be competitive if they continue to use this pricing strategy. While we agree that fifty percent coverage of bad debts is a step in the right direction, hospitals which accept a large number of non-paying patients will be at a distinct disadvantage in a truly "price competitive" market if they have to shift 50% of their bad debts to paying patients. Furthermore, we were particularly concerned about who would be responsible for the deductible for those individuals who

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select low option plans and who subsequently find themselves unable to pay the $2900 deductible. It was my sense of the meeting that there was some interest among your staff and advisors for making the plans, rather than the hospitals, responsible for collecting the deductible.

The rest of our memorandum is addressed to the issue of a trust fund to cover the costs of medical education. Topics covered include: what functions would be funded and how large must the trust fund be; through what mechanisms should the funds be raised; once collected, how should these funds be distributed? The chief executive officers of many teaching hospitals believe that direct educational costs represent only a portion of the total costs associated with the support of an environment that encourages education and medical advancements to flourish. They fear that partial funding of only the direct educational costs would be insufficent for them to be price competitive if their societal contributions are to be continued. Redistributing such funds will be an equally complex problem and will not lend itself easily to a simple formula.

It is understandable that you are disappointed that after the December meeting we did not come up with a straight forward solution that would allow teaching hospitals to function well under HR850. Unfortunately, the problem is very difficult and the nation's teaching hospitals are not a homogeneous subset of institutions. Some are public; some are private; some are university owned; a few are free standing; many are loosely affiliated with schools of medicine; a far smaller number are the major teaching hospitals in this country. The group of hospital administrators who met with you in December are among the most able and imaginative I know and they are sincere in their desire to assist you with HR850.

They also realize and have attempted to emphasize, that because of the diversity of teaching hospitals they cannot speak for all such hospitals.

I have spoken to John Crosby recently and he has suggested that it would be helpful if this group would review the two theoretical options posed in John Colloton's paper and come up with specific suggestions for you. I hope we will be able to get together within the next month or so to do this. We would be happy to meet with you again shortly thereafter to continue this discussion.

Sincerely,

Ginny

Virginia V. Weldon, M.D.
Assistant to the Vice Chancellor

VVW:dlk

teaching hospitals assures that all students and trainees are exposed to an appropriate range of challenging medical problems at each level of clinical education so that they can be trained systematically and efficiently. Since the entire professional staff of the teaching hospital is oriented to and encourages education, the requisite environment for learning and appropriate supervision can be maintained, despite the associated loss in "productivity" related to patient care. Educational opportunities in affiliated community hospitals are an important adjunct to the clinical education in teaching hospitals, but cannot serve as a substitute as long as society desires to maintain and enhance the present level of performance of its physicians and other health professionals.

A THEORETICAL APPROACH TO STRUCTURING OF THE COMPETITIVE SYSTEM TO RECOGNIZE THE UNIQUE SOCIETAL CONTRIBUTIONS OF TEACHING HOSPITALS

While the wisdom and likelihood of widescale implementation of expanded competition in the health field is still a matter of broad debate, it is a fact that the concept currently has significant support. One of the perplexing questions that remains is how the nation might alternatively finance the approximately $6.7 billion cost of societal contributions now financed through teaching hospital patient charges (Exhibit II-1). If any competitive system which may evolve is to include teaching hospitals fairly and effectively, a practical answer to this dilemma must be found. Some competition advocates have proposed that the "teaching and research costs" of teaching hospitals be supported from another source(s). However, none of the current competition proposals have explored in sufficient depth how this might be accomplished.

A theoretical approach is set forth here to stimulate further discussion regarding options for addressing this vital concern. Based on the broad range of complexities and assumptions involved in structuring this conceptual approach

to reimbursement of societal contributions under competition, it would not be unreasonable to anticipate reservation, or even opposition, by teaching hospitals. Such concern would flow from the financial uncertainties involved in converting to a new, untried payment system for a broad range of their ongoing responsibilities. Nevertheless, a need to theoretically address the issue remains. If the movement toward expanded competition is to become a long-range reality, it is essential that the competitive proposals include some appropriate mechanism for preserving teaching hospital societal contributions.

Industries of all types finance "research and development" activities as an integral operating cost, recognizing that their future in the market will be impaired by lack of knowledge or failure to innovate. In the past, the financial decisions of teaching hospitals to invest in education, research, and development have served the public well. Fragmentation and/or scaling down of the existing system whereby teaching hospitals effectively invest in the future of the nation's health care system would be unwise and shortsighted. Two of the theoretical options for avoiding this problem are for the competition proposals to include mechanisms for payment of the cost of teaching hospital societal contributions through grants for individual programs or through payments for institutional support.

One of the first competition promotion bills to recognize the need for such mechanisms was the Gephardt-Stockman bill. It proposed a program grant approach by providing for grants covering not more than 70 percent of the direct costs of educational programs, "to the extent the Secretary [of HHS] finds such compensation is necessary to provide training for needed health care professionals."[43] As the authors of the bill recognize, this provision does not fully address the problems of teaching hospitals. It does not provide payment for any of the societal contributions other than education, and it implicitly assumes that teaching hospitals will be able to cover the remaining

30 percent of direct educational costs plus all of the indirect costs of these programs. However, the 1980 bill served its intended purpose because it has led to further discussion of this issue, assisting Representative Gephardt's attempts to formulate a more comprehensive approach to the whole problem of funding teaching hospital societal contributions for inclusion in a modified bill he plans to introduce later in the 97th Congress.

There are other difficulties with program grants which suggest that they are less practical than payments for institutional support. Program grants cannot provide the continuing commitment of resources to create the necessary stability within teaching hospitals because they are subject to frequent review and short-term decision making. Program grants would also present virtually insurmountable administrative barriers in separating the costs of each societal contribution. They would not provide for the continuing allocation of these monies within each teaching hospital by knowledgeable executive and academic staff, essential to sustaining the proper balance of all patient care and academic programs.

Institutional support payments could be viewed as more appropriate because they avoid many of these difficulties. The calculation of these institutional payments would still be based in whole or in part on the aggregate costs of programs within the institution, but the payments would not be tied to governmental program evaluations or to a mandated allocation among individual programs. However, the problem remains of maintaining a commitment over the long term. This problem could be mitigated, but not eliminated, by providing some insulation from short-term political decisions through an earmarked surcharge on premiums for all health plan coverage. The surcharge would be deposited in a trust fund and allocated to teaching hospitals under the guidance of an academically oriented Teaching Hospital Advisory Council. If this approach were adopted,

the government could wisely forego the additional burden of the program grant alternative to meet these needs, as well as the annual appropriation process. This would continue the flexibility and stability necessary for sustaining the vital clinical and academic environment now fostering a broad spectrum of societal contributions within teaching hospitals.

The theoretical payment approach outlined here is predicated upon teaching hospitals continuing to generate a large portion of their financial requirements through charges to competitive health plans and patients for patient care services at competitive rates. Beyond this, the approach would create a Teaching Hospital Societal Contribution Fund generated from a surcharge on health plan premiums. Monies from the Fund would be distributed to teaching hospitals to reimburse societal contribution costs through the two payment mechanisms specified below.

I. The first mechanism would encompass prospective payments for measurable societal contributions, which include graduate medical and dental education, other hospital sponsored educational programs, ambulatory care deficits, and charity care. The measurable cost of graduate medical and dental education for all nonfederal teaching hospitals is approximately $1.8 billion for 1980-81, of which $1.2 billion is incurred in the 270 COTH members with major college of medicine affiliations. The estimated additional costs for measurable societal contributions in these 270 teaching hospitals is $2.2 billion. Thus, the total estimated value of measurable societal contributions is approximately $4.0 billion for 1980-81 (Exhibit II-1).

II. The second mechanism would be retrospective payment of the costs of unmeasurable societal contributions, which include the indirect costs of hospital sponsored graduate and other educational programs, all

other undergraduate health educational programs, new technology testing, clinical research, and care of a highly intense patient case mix. The estimated cost of unmeasurable societal contributions for the 270 COTH members is approximately $2.7 billion for 1980-81 (Exhibit II-1).

Payment Mechanism I--Separately identified and quantified analysis of each teaching hospital's measurable societal contributions for prospective funding. All teaching hospitals would receive payment under this mechanism for their measurable societal contributions. This could enhance the capability of a large number of teaching hospitals, including many large urban and specialized children's hospitals, to compete fairly in a competitive health care system because their costs of societal contributions are predominantly in three areas -- graduate medical and dental education and other hospital sponsored educational programs, ambulatory care deficits, and charity care -- which are sufficiently identifiable for prospective quantification and payment. These hospitals would be able to obviate seeking payment under Payment Mechanism II with its attendant involvement in extensive financial analyses and reporting.

While the three societal contributions identified for prospective payment under Payment Mechanism I are reasonably measurable on a prospective basis, there are many contingencies, such as changes in the local or national economy, that could make prospectively calculated payments inequitable for some or all teaching hospitals in certain years. Thus, a means for teaching hospitals to apply for a retrospective adjustment of prospective payments would be necessary to preclude undue hardships.

Payment Mechanism II--Separate retrospective funding of the nation's comprehensive tertiary teaching hospitals' unmeasurable societal contributions. A second payment mechanism would be needed to accommodate the costs of the unmeasurable societal contributions of undergraduate education, indirect costs

of graduate and other educational programs, new technology testing, clinical research, and the incremental cost of the highly intensive patient case mix common to most comprehensive tertiary care teaching hospitals. These contributions defy separate and accurate quantification under any accounting system because they are so inextricably interwoven with the patient care and graduate medical and dental education programs of teaching hospitals. Sufficiently refined analyses of case mix and related costing methodologies, now under intensive investigation by the Association of American Medical Colleges, the Health Care Financing Administration, and others, are probably several years away from a sound methodological basis. One might consider encompassing the unmeasurable costs within the first payment mechanism described above by applying a multiplier to the measurable costs to arrive at the total required payment for measurable and unmeasurable societal contributions for each teaching hospital. However, as described in the Appendix, when the measurable costs of the group of 20 surveyed university teaching hospitals were compared, it became clear that the costs predicted by the multiplier were not reasonable estimations of actual costs. While it is natural to hope for a simple methodology such as a multiplier or resident trainee capitation allowance, it should be recognized that complex problems frequently require complex solutions. The fact that the competition dialogue over the past several years has not resulted in a single comprehensive proposed solution to the societal contribution issue reflects the high level of complexity involved.

The second payment mechanism suggested would be used by those teaching hospitals with substantial involvement in unmeasurable societal contributions. Generally, these would be the comprehensive tertiary teaching hospitals which serve as principal teaching hospitals of the nation's medical schools. Such teaching hospitals would charge insurers, prepaid health plans, and self-pay patients for hospital services at competitive rates. They would receive

prospective reimbursement of their measurable societal contributions through Payment Mechanism I. Unmeasurable societal contributions would be reimbursed through retrospective payments to these teaching hospitals of the difference between full financial requirements and the amounts received from direct patient care payments, Payment Mechanism I, and other sources of revenue, as certified by audited financial statements. As the Medicare and Medicaid programs have recognized, interim payments would be required with a retrospective settlement after the end of each year in order to maintain an operating cash flow within these hospitals.

Under this payment system, teaching hospitals would compete both on the basis of quality and price. They would be motivated to contain costs and prices by three forces. First, there would not be unlimited dollars available for societal contribution payments. In some years, the aggregate needs of teaching hospitals would exceed available funds, resulting in some hospitals receiving less than the full amount sought from the Fund. An equitable allocation system could be designed to assure that partial payments were made to the less efficient teaching hospitals, while full payment of the costs of societal contributions were reserved for the more efficient. This threat of potential nonpayment could motivate further cost containment and possible programmatic reduction efforts by teaching hospitals. Second, the long-term viability of the Surcharge and Teaching Hospital Societal Contribution Fund would depend on their political acceptability. Because cost would be an important factor in this outcome, teaching hospitals would be motivated to contain costs to preserve the Surcharge and Fund. Finally, public opinion would have substantial impact because attention would be focused on the costs of providing highly expensive tertiary services and other societal contributions common to teaching hospitals. It is possible that some teaching hospitals could not respond to

these forces immediately; but the system for allocation of the Fund would eventually require additional cost containment, except where other sources of revenue were developed on a local basis.

These payment mechanisms could substantially reduce one hazard in the competitive system related to quality. Because competitive plans would pay teaching hospitals at rates competitive with those paid to community hospitals, the disincentive to refer patients requiring expensive diagnostic and therapeutic care to the tertiary teaching hospital would be curtailed. Thus, teaching hospitals would be able to continue to serve as the referral centers for community hospitals without a substantial impediment related to price.

One practical difficulty in implementing Payment Mechanism II would be the identification of comprehensive tertiary teaching hospitals for participation. One approach would be to focus participation in Payment Mechanism II on these teaching hospitals which have substantial involvement with the full array of societal contributions, where the payment is most needed. Consultation with the AAMC and other organizations in developing criteria to be used in identifying appropriate hospitals for inclusion under the two separate payment mechanisms would be essential. Congress could place such criteria in the legislation or leave their development and promulgation to an administrative agency, specifying mandatory consultation with an appropriate academically related advisory group, such as the Teaching Hospital Advisory Council previously identified.

Both payment mechanisms would have the benefit of not interjecting any further governmental regulation of decisions regarding the numbers and types of residency training positions in teaching hospitals or the scope of other programs in teaching hospitals. The development of new technology and services would continue to be subject to substantial regulation by the Food and Drug

Administration and selective monitoring by the National Center for Health Care Technology.

These payment mechanisms would involve reimbursement of hospital dollars only. It is essential that physicians and dentists practicing in teaching hospitals continue to have the opportunity to be paid for their services in the same manner as their colleagues in the community, so that academic medical centers are not put at a competitive disadvantage in attracting and retaining clinical faculty of high quality.

The Teaching Hospitals Societal Contribution Fund and Surcharge: The dual payment mechanisms would be predicated upon the availability of a reliable continuing source of funding relatively insulated from short-term political decisions. It is suggested that a "Health Manpower Replenishment and Health Service Development Surcharge" on all health plan premiums could be such a source of funding. The Surcharge would not constitute new dollars to the health field or teaching hospitals and would not represent a new burden for patients. Rather, it would represent a "transfer payment" in order to continue the traditional practice of patients paying for the replenishment and advancement of their health care system while purchasing health insurance or hospital services.

The Surcharge could be collected from competitive plans and could be based on a percentage of their total premiums. If such a system were initiated on a national scale in fiscal year 1981, the Surcharge would be required to generate approximately $6.7 billion in teaching hospital societal contribution costs (Exhibit II-1). In order to cover this cost, an estimated 8 percent surcharge on competitive plan premiums would be required.[44] A flow chart portraying the theoretical flow of dollars into the Fund and its subsequent distribution among societal contributions is reflected in Exhibit III. As

shown on the Exhibit, the Fund would support approximately 30 percent of the total cash flow of the 270 COTH members with major college of medicine affiliations.

It should be recognized that inordinate inflation, the establishment of new programs in teaching hospitals and other factors would result in insufficient dollars in the Teaching Hospital Societal Contribution Fund in some years. To accommodate this circumstance and to moderate the reasonableness of teaching hospital requests from the fund, equitable standards and formulae for allocation of "shortfalls" would have to be developed by the Teaching Hospital Advisory Council previously described. As indicated, such standards and formulae could be used to create additional incentives for teaching hospitals to further contain costs and to be maximally competitive.

The Surcharge and resulting Teaching Hospital Societal Contribution Fund would serve as a safeguard for the entire health care system. The competition proposals have, as a prime feature, the minimization of regulation in the health field in exchange for hospitals' willingness to risk their survival in a free market. One of the anticipated outcomes is a shrinkage of the health system and resulting economy through closure of hospitals. Use of a free market for bringing this about represents a revolutionary change in the structure of this nation's health system, the outcome of which no one can accurately predict. Accordingly, discretion would require the establishment of certain safeguards in a system change as colossal as the one being proposed. One of these protections should be a device to sustain the vigor of our nation's teaching hospitals which underpin the quality of the entire health care system.

If the unique societal contributions of teaching hospitals were separately provided for in the manner outlined, the patient care functions of all hospitals theoretically could be encompassed in a competitive system. A provision for

the protection of teaching hospital societal contributions is the prudent minimum which should be in place if the nation is to conduct a massive experiment with competition within its health care system. After several years of experience with a competitive system, it may be appropriate to alter these safeguards when such changes could be based on actual knowledge of the effects of competition on teaching hospitals and other health system components. Techniques for quantifying the costs of the now unmeasurable societal contributions (such as patient case mix methodologies) could also evolve, permitting the consolidation of the two mechanisms for payment of societal contributions into a single, simpler method.

The foregoing discussion of a theoretical approach to financing the societal contributions of teaching hospitals under competition is intended to respond to the challenge to develop a framework for modified funding and examine its implications. It is not intended as support for the approach, but is presented as a contribution to the debate.

FUTURE CHALLENGES FOR TEACHING HOSPITALS

The competitive environment appears to be evolving, albeit slowly. To stay abreast of this trend, there are a number of initiatives which teaching hospitals should pursue with increasing vigor.

Teaching hospitals and health services researchers should undertake further studies of the resources committed to societal contributions and of possible alternative ways of securing support for these programs. If legislation promoting competition is not passed, teaching hospitals will require the results of such studies to support their submissions and their appeals to conventional funding agencies. If such legislation is passed, the research findings will be needed to justify reimbursement from the Teaching Hospital Societal Contribution Fund described earlier or some similar mechanism.

AMBULATORY CARE PROGRAM FINANCIAL SURVEY OF TWENTY UNIVERSITY OWNED TEACHING HOSPITALS
BY THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS

Ambulatory Care Program Data -- 1979-80

Hospital	Total Clinic Visits(1)	Gross Ambulatory Revenue(2)	Charity/Coll. Loss Allowances(3)	Contractual/ Other Allowances(4)	Net Ambulatory Revenue(5)	Total Ambulatory Operating Expense(6)	Net Operating Surplus (Deficit)(7)	Educational Program Costs(8)
1.	318,056	$ 14,410,000	$ 417,042	$ 706,958	$ 13,286,000	$ 19,108,200	$(5,822,200)	$ 3,053,114
2.	280,475	8,616,307	865,296	56,934	7,694,077	10,918,578	(3,224,501)	332,717
3.	219,921	14,337,445	1,546,112	645,367	12,145,966	20,174,172	(8,028,206)	4,066,089
4.	201,806	19,620,696	4,543,521	2,150,647	12,926,528	13,935,751	(1,009,223)	4,385,903
5.	200,792	14,333,461	129,748	--	14,203,713	15,976,617	(1,772,904)	1,055,901
6.	185,486	27,553,762	3,306,844	1,494,328	22,752,590	22,920,601	(168,011)	1,360,733
7.	182,008	10,654,415	1,065,442	(604,226)	10,193,199	13,791,697	(3,598,498)	1,588,990
8.	174,744	9,359,629	300,616	229,941	8,829,072	9,256,675	(427,603)	219,416
9.	168,823	6,201,515	1,089,367	497,845	4,614,303	8,575,578	(3,961,275)	1,168,489
10.	159,455	7,914,102	595,976	537,285	6,780,841	7,566,580	(785,739)	1,728,188
11.	157,756	5,250,782	765,466	555,350	3,929,966	4,899,238	(969,272)	401,897
12.	146,112	15,593,778	1,179,644	4,437,707	9,976,427	17,915,531	(7,939,104)	4,491,014
13.	140,762	5,770,959	917,670	(260,890)	5,114,179	7,346,886	(2,232,707)	973,211
14.	122,714	4,364,496	1,439,454	437,279	2,487,763	5,670,302	(3,182,539)	837,146
15.	100,255	5,127,294	1,673,184	147,134	3,306,976	4,705,017	(1,398,041)	867,128
16.	100,177	9,922,547	733,098	1,447,188	7,742,261	13,103,492	(5,361,231)	2,835,094
17.	96,062	3,510,436	837,642	258,255	2,414,539	6,404,743	(3,990,204)	1,967,944
18.	82,250	7,812,653	726,908	(435,315)	7,521,060	9,246,965	(1,725,905)	1,543,243
19.	37,876	7,021,578	503,482	841,440	5,676,656	5,969,332	(292,676)	201,410
20.	37,355	4,256,617	1,022,748	306,730	2,927,139	3,981,353	(1,054,214)	553,832
TOTALS	3,112,885	$201,632,472	$23,659,260	$13,449,957	$164,523,255	$221,467,308	$(56,944,053)	$33,631,459
TOTALS ADJUSTED TO 1980-81(9) .	3,112,885	$228,046,000	$26,758,000	$15,212,000	$186,076,000	$250,480,000	$(64,404,000)	$38,037,000

FOOTNOTES

(1) Includes all clinic and emergency visits.
(2) Includes gross ambulatory, clinic, emergency, and ancillary service revenues related to ambulatory patients.
(3) Charity allowances represent the uncompensated dollar value of services provided to patients who at the time of their clinic visit are determined to be unable to pay costs of their care, while collection losses represent the revenue from patient accounts which the hospitals were unable to collect.
(4) Contractual and other allowances represents the difference between gross revenue from services rendered and amounts received from patients and third party payors.
(5) Net Ambulatory Revenue represents Gross Ambulatory Revenue less Charity/Collection Loss Allowances and Contractual and Other Allowances.
(6) Total Ambulatory Operating Expense includes direct and indirect expenses for clinic, emergency, and ancillary services related to ambulatory patients.
(7) Net Operating Surplus (Deficit) represents Net Ambulatory Revenue less Total Ambulatory Operating expense.
(8) Educational Program Costs include all measurable ambulatory clinic, emergency, and ancillary service educational costs. These costs are defined as those borne by the hospital relating to health science educational programs, as well as medical and dental residency programs including payments for stipends; supervisory physicians and dentists; professional liability insurance; house staff health insurance; uniforms; subsidized cafeteria services and other educational overhead costs as defined by Medicare cost reimbursement principles.
(9) Department of Labor, Bureau of Labor Statistics. This reflects a 13.1 percent increase in the Consumer Price Index change for Hospital "Room" Component of "Other Medical Care Services" component from July, 1979 - July, 1980.

EXHIBIT I - 1

ESTIMATION OF TOTAL AMBULATORY CARE PROGRAM DEFICIT IN 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1979-80

1.	Total Ambulatory Care Program Deficit in 20 Sample Teaching Hospitals	$ 56,944,053
2.	Total Clinic Visits in 20 Sample Teaching Hospitals	3,112,885
3.	Average Ambulatory Care Program Deficit Per Clinic Visit in 20 Sample Teaching Hospitals	$ 18.29
4.	Total Clinic Visits in all 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (1)	39,630,854
5.	Total Estimated Ambulatory Care Program Deficit in 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (39,630,854 Visits x $18.29)	$724,848,320

1980-81

1.	Total Estimated Ambulatory Care Program Deficit in 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($724,848,320 x 1.131(2))	$819,803,000

ESTIMATION OF AMBULATORY CARE PROGRAM DEFICIT EXCLUSIVE OF CHARITY/COLLECTION LOSS ALLOWANCE COSTS IN 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1979-80

1.	Total Ambulatory Care Program Deficit ($56,944,053) Less Charity/Collection Loss Allowance Costs in 20 Sample Teaching Hospitals ($23,659,260)	$ 33,284,793
2.	Total Clinic Visits in 20 Sample Teaching Hospitals	3,112,885
3.	Average Ambulatory Care Program Deficit Exclusive of Charity/Collection Loss Allowance Costs in 20 Sample Teaching Hospitals Per Patient Visit	$ 10.69
4.	Total Clinic Visits in 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (1)	39,630,854
5.	Total Estimated Ambulatory Care Program Deficit Less Charity/Collection Loss Allowance Costs for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (39,630,854 Visits x $10.69)	$423,653,829

1980-81

1.	Total Estimated Ambulatory Care Program Deficit Less Charity/Collection Loss Allowance Costs for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($423,653,829 x 1.131(2))	$479,152,000

FOOTNOTES

(1) Council of Teaching Hospitals, Association of American Medical Colleges, Committee Structure and Membership Directory, 1980, Washington, D.C., 1980.

(2) Department of Labor, Bureau of Labor Statistics. This reflects a 13.1 percent increase in the Consumer Price Index change for Hospital "Room" Component of "Other Medical Care Services" Component from July, 1979, to July, 1980.

EXHIBIT I - 2

ESTIMATION OF CHARITY/COLLECTION LOSS ALLOWANCE COSTS INCLUDED IN AMBULATORY CARE PROGRAM DEFICITS OF 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1979-80

1.	Total Estimated Ambulatory Care Program Deficit in 270 COTH Teaching Hospitals with Major College of Medicine Affiliations	$724,848,320
2.	Total Estimated Ambulatory Care Program Deficit Less Charity/Collection Loss Allowance Costs	$423,653,829
3.	Total Estimated Charity/Collection Loss Allowance Costs Included in Ambulatory Care Program Deficits of 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($724,848,320 - $423,653,829)	$301,194,491

1980-81

1.	Total Estimated Charity/Collection Loss Allowance Costs Included in Ambulatory Care Program Deficits of 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($301,194,491 x 1.131[2])	$340,651,000

ESTIMATION OF EDUCATIONAL COSTS INCLUDED IN AMBULATORY CARE PROGRAM DEFICITS OF 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1979-80

1.	Educational Costs Included in Ambulatory Care Program Deficits in 20 Sample Teaching Hospitals	$ 33,631,459
2.	Total Clinic Visits in 20 Sample Teaching Hospitals	3,112,885
3.	Average Educational Cost Per Clinic Visit in 20 Sample Teaching Hospitals	$ 10.80
4.	Total Clinic Visits in 270 COTH Teaching Hospitals with Major College of Medicine Affiliations[1]	39,630,854
5.	Total Estimated Educational Costs in Ambulatory Care Program Deficits of 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (39,630,854 x $10.80)	$428,013,223

1980-81

1.	Total Estimated Educational Costs in Ambulatory Care Program Deficits of 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($428,013,223 x 1.131[2])	$484,083,000

FOOTNOTES

(1) Council of Teaching Hospitals, Association of American Medical Colleges, Committee Structure and Membership Directory, 1980, Washington, D.C., 1980.

(2) Department of Labor, Bureau of Labor Statistics. This reflects a 13.1 percent increase in the Consumer Price Index change for Hospital "Room" Component of "Other Medical Care Services" Component from July, 1979, to July, 1980.

EXHIBIT I - 3

TOTAL INPATIENT AND OUTPATIENT DATA FOR 20 UNIVERSITY OWNED TEACHING HOSPITALS -- 1979-80

Hospital	Total Patient Days(1)	Gross Patient Revenue(2)	Charity/ Collection Loss Allowances(3)	Contractual/ Other Allowances(4)	Other Operating Revenue(5)	Total Operating Revenue(6)	Total Operating Expense(7)	Net Operating Surplus (Deficit)(8)	Educational Program Costs(9)
1.	313,009	$ 117,054,402	$ 4,700,779	$ 4,552,023	$ 6,237,319	$ 114,038,919	$ 101,243,193	$ 12,795,726	$ 8,362,600
2.	59,939	28,596,224	1,583,114	188,963	1,925,088	28,749,235	32,288,974	(3,539,739)	1,298,307
3.	218,674	106,625,233	11,494,865	4,798,135	3,278,378	93,610,611	104,561,982	(10,951,371)	12,768,210
4.	159,017	82,788,641	17,828,528	10,082,332	26,886,987	81,764,768	77,420,841	4,343,927	4,385,903
5.	203,393	99,182,037	1,249,590	3,165,240	10,771,969	105,539,176	106,408,560	(869,384)	11,767,841
6.	183,896	137,163,155	6,347,110	7,639,046	8,982,901	132,159,900	130,122,933	2,036,967	7,828,665
7.	149,682	66,163,083	3,268,339	474,954	5,056,091	67,475,881	64,735,783	2,740,098	5,000,000
8.	105,112	44,672,332	1,434,803	1,097,481	6,093,554	48,233,602	45,739,755	2,493,847	952,017
9.	80,204	36,301,345	4,091,265	2,988,372	5,286,104	34,507,812	35,392,226	(884,414)	3,633,377
10.	126,816	56,979,436	4,290,221	3,868,723	2,011,859	50,832,351	45,079,517	5,752,834	3,111,610
11.	129,195	41,261,594	3,155,589	4,659,041	215,973	33,662,937	32,433,325	1,229,612	2,560,990
12.	162,846	76,768,655	10,446,000	17,212,056	24,787,727	73,898,326	73,446,385	451,941	9,073,084
13.	243,373	84,095,592	4,346,171	1,803,681	1,810,739	79,756,479	81,892,078	(2,135,599)	4,986,083
14.	177,687	54,075,846	13,644,504	4,144,928	11,831,663	48,118,077	45,613,957	2,504,120	3,386,539
15.	118,081	44,605,757	13,567,976	6,368,723	8,098,225	32,767,283	30,362,434	2,404,849	3,272,905
16.	103,844	46,396,984	3,878,089	7,655,623	283,725	35,146,997	51,630,130	(16,483,133)	4,444,395
17.	106,171	30,737,477	7,244,632	2,234,042	--	21,258,803	34,473,650	(13,214,847)	6,541,243
18.	170,905	73,446,282	7,126,966	5,743,300	1,275,122	61,851,138	60,551,156	1,299,982	3,942,523
19.	221,023	113,188,449	1,429,611	25,326,895	2,016,281	88,448,224	87,409,616	1,038,608	5,899,123
20.	96,334	48,169,040	3,455,711	2,757,261	--	41,956,068	38,975,870	2,980,198	2,010,203
TOTALS	3,129,201	$1,388,271,564	$124,583,863	$116,760,819	$126,849,705	$1,273,776,587	$1,279,782,365	$(6,005,778)	$105,245,618
TOTALS ADJUSTED TO 1980-81(10). . .	3,129,201	$1,570,135,000	$140,904,000	$132,057,000	$143,467,000	$1,440,641,000	$1,447,434,000	$(6,793,000)	$119,033,000

FOOTNOTES

(1) Includes newborn patient days.
(2) Includes all patient service revenues.
(3) Charity allowances represent the uncompensated dollar value of services provided to patients who at the time of admission (or clinic visit) or during their stay are determined to be unable to pay costs of their care, while collection losses represent the revenue from patient accounts which the hospitals were unable to collect.
(4) Contractual and other allowances represent the difference between gross revenue from services rendered and amounts received from patients or third-party payors.
(5) Includes other revenues not identifiable with patient services.
(6) Total operating revenue represents gross patient revenue less charity/collection loss allowance and contractual/other allowance plus other operating revenue.
(7) Total operating expense includes salaries and fringe benefits, supplies and services, interest expense, and depreciation.
(8) Net operating surplus (deficit) represents total operating revenue less total operating expense.
(9) Educational program costs include all measurable direct and indirect educational costs. These costs are defined as those borne by the hospital relating to health science educational programs, as well as medical and dental residency programs including payments for stipends; supervisory physicians and dentists; professional liability insurance; house staff health insurance; uniforms; subsidized cafeteria services and other educational overhead costs as defined by Medicare cost reimbursement principles.
(10) Department of Labor, Bureau of Labor Statistics. This reflects a 13.1 percent increase in the Consumer Price Index change for Hospital "Room" Component of "Other Medical Care Services" component from July, 1979 - July, 1980.

EXHIBIT I - 4

ESTIMATION OF TOTAL INPATIENT & OUTPATIENT CHARITY/COLLECTION LOSS ALLOWANCE COSTS FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1979-80

1.	Total Charity/Collection Loss Allowance for 20 Sample Teaching Hospitals	$ 124,583,863
2.	Total Adjusted Patient Days for 20 Sample Teaching Hospitals[1]	3,660,882
3.	Average Total Charity/Collection Loss Allowance Per Adjusted Patient Day for 20 Sample Teaching Hospitals	$ 34.03
4.	Total Adjusted Patient Days for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations[2]	52,403,477
5.	Total Estimated Charity/Collection Loss Allowance for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (52,403,477 Adjusted Patient Days x $34.03)	$1,783,290,322

1980-81

1.	Total Estimated Charity/Collection Loss Allowance for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($1,783,290,322 x 1.13[3])	$2,016,901,000

ESTIMATION OF INPATIENT CHARITY/COLLECTION LOSS ALLOWANCE COSTS FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1979-80

1.	Total Estimated Charity/Collection Loss Allowance for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations	$1,783,290,322
2.	Total Estimated Ambulatory Charity/Collection Loss Allowance for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (Ex. 1 - 3)	$ 301,194,491
3.	Total Estimated Inpatient Charity/Collection Loss Allowance for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($1,783,290,322 - $301,194,491)	$1,482,095,831

1980-81

1.	Total Estimated Inpatient Charity/Collection Loss Allowance for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($1,482,095,831 x 1.13[3])	$1,676,250,000

FOOTNOTES

(1) "Adjusted patient days" is an aggregate figure reflecting the number of inpatient days of care rendered by the 20 sample teaching hospitals (3,129,201), plus (531,681) equivalent patient days extrapolated for outpatient services. The extrapolation was made after determining for the 20 hospitals the ratio of their average revenue per clinic visit ($64.77) to their average revenue per inpatient day ($379.21) which yields (.1708 clinic visits to 1 patient day). The total clinic visits for the 20 hospitals (3,112,885) was then multiplied by .1708 to determine the 531,681 equivalent patient days.

(2) "Adjusted patient days" for the 270 COTH teaching hospitals was derived using the same ratio of revenue per clinic visit to revenue per inpatient day (.1708 clinic visits to 1 patient day) as for the 20 sample hospitals. On this basis, the clinic visits for the 270 hospitals (39,630,854) were multiplied by (.1708) to yield 6,768,950 equivalent patient days. When this figure is added to total patient days (45,634,527) for the 270 hospitals, the total adjusted patient days is 52,403,477.

(3) Department of Labor, Bureau of Labor Statistics. This reflects a 13.1 percent increase in the Consumer Price Index change for Hospital "Room" Component of "Other Medical Care Services" Component from July, 1979 - July, 1980.

EXHIBIT I - 5

SUMMARY OF EXHIBIT II

MEASURABILITY AND ESTIMATED ANNUAL COST OF SOCIETAL CONTRIBUTIONS FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

(Graduate Medical and Dental Educational Costs Relate to All Nonfederal Teaching Hospitals)

Societal Contribution	Measurable	Unmeasurable	
1) GRADUATE MEDICAL & DENTAL EDUCATION:			
A. Direct	$1,570,000,000	---	
B. Indirect (Measurable)	$ 238,000,000	---	
C. Indirect (Unmeasurable)	---	$?	
SUBTOTAL	($1,808,000,000)*	($?)	
2) OTHER EDUCATIONAL PROGRAMS:			
A. Direct	$ 126,000,000		
B. Indirect (Measurable)	$ 22,000,000		
C. Indirect (Unmeasurable)	---	$?	
SUBTOTAL	($ 148,000,000)*	($?)	
3) AMBULATORY CARE PROGRAM DEFICITS: (Excludes all educational program costs included in items #1 and #2 above and includes ambulatory charity/collection loss costs)	$ 336,000,000 **	---	
4) CHARITY CARE/COLLECTION LOSSES ARISING FROM INPATIENT CARE PROGRAMS FOR WHICH NO DIRECT COMPENSATION IS RECEIVED	$1,676,000,000 ***	---	
5) NEW TECHNOLOGY TESTING:			
A. Direct	---	$?	
B. Indirect	---	$?	
6) CLINICAL RESEARCH:			
A. Direct	---	$?	
B. Indirect	---	$?	
7) LOW VOLUME, HIGHLY SPECIALIZED SERVICES:			
A. Direct	---	$?	
B. Indirect	---	$?	
8) INTENSIVE CASE MIX:			
A. Direct	---	$?	
B. Indirect	---	$?	
TOTAL SOCIETAL CONTRIBUTIONS FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS	$3,968,000,000	$2,725,000,000	(Estimated on Exhibit II - 4)
GRAND TOTAL	$6,693,000,000		

* For source see footnote number 31 in paper.
** For calculation see Exhibit II - 3.
*** For calculation see Exhibit I - 5

MEASURABILITY AND ESTIMATED ANNUAL COST OF SOCIETAL CONTRIBUTIONS
FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS
(Graduate Medical and Dental Educational Costs Relate to All Nonfederal Teaching Hospitals)

1980-81

Societal Contribution	Measurable	Unmeasurable	Remarks
1) GRADUATE MEDICAL & DENTAL EDUCATION:			
A. Direct	$1,570,000,000	-----	Direct costs of Graduate Medical and Dental education could be derived directly from each teaching hospital's annual budget. The aggregate data reported here were derived from existing data and extrapolations of data from COTH, Institute of Medicine and GMENAC sources, adjusted for inflation.
B. Indirect (Measurable). .	$ 238,000,000	-----	Measurable indirect costs could be derived directly from each teaching hospital's cost finding report. These include depreciation on space and associated overhead costs (e.g. housekeeping, building maintenance, equipment depreciation, interest on capital borrowing) for clinical faculty and associated academic support personnel offices, call quarters, conference rooms, library and classrooms; and, subsidized cafeterias, housing services, uniforms, House Staff Affairs Office functions and other general supporting services. The aggregate measurable data reported here for indirect costs were derived from existing data and extrapolations from the sources indicated above.
C. Indirect (Unmeasurable)	-----	$?	Numerous unmeasurable indirect costs are also associated with graduate medical and dental education programs. These include the costs of staff other than teaching physicians who provide support to house staff in their learning process, additional space included in patient accommodations and other supporting facilities to meet educational program needs, and an undetermined proportion of diagnostic testing which may be utilized for educational purposes. However, no estimates exist or can be developed at this time which would provide these costs.
SUBTOTAL	($1,808,000,000)	($?)	
2) OTHER EDUCATIONAL PROGRAMS:			
A. Direct	$ 126,000,000		Actual cost figures of hospital sponsored educational programs in this category could be derived for direct and measurable indirect costs of Other Educational Programs from operating budgets and cost finding reports of each teaching hospital. The estimates provided here were derived by using 1978 COTH data to determine the relationship between graduate medical and dental education costs and other health science educational program costs for 58 university owned teaching hospitals and applying this relationship to the total graduate medical and dental education costs of the 270 teaching hospitals with major college of medicine affiliations. This estimate of total Other Educational Program cost was then segregated into direct and indirect measurable costs on the basis of the direct - indirect cost relationship for Graduate Medical and Dental Education set forth above.
B. Indirect (Measurable). .	$ 22,000,000		
C. Indirect (Unmeasurable)	-----	$?	Unmeasurable indirect costs also exist as they do for graduate medical and dental education, and no means is available for measuring them. Significant among these are programs for undergraduate medical education, nursing, pharmacy and dentistry.
SUBTOTAL	($ 148,000,000)	($?)	

EXHIBIT II - 2

Societal Contribution	Measurable	Unmeasurable	Remarks
3) AMBULATORY CARE PROGRAM DEFICITS: . . . . . (Excludes all educational program costs included in items #1 and #2 above and includes ambulatory charity/ collection loss costs.)	$ 336,000,000	-----	Figures for total Ambulatory Care Program Deficits could be measured for each teaching hospital from existing accounting records. The figure specified here was derived by extrapolating data from 20 university owned teaching hospitals on their clinic, emergency and ancillary ambulatory program deficits to the volume of ambulatory services provided by the 270 COTH teaching hospitals. See Exhibit I - 2 & 3: Total estimated ambulatory care program deficit in the 270 COTH teaching hospitals ($819,803,000) less total estimated educational costs in ambulatory care program deficits ($484,083,000) = $335,720,000.
4) CHARITY CARE/COLLECTION LOSSES ARISING FROM INPATIENT CARE PROGRAMS FOR WHICH NO DIRECT COMPENSATION IS RECEIVED .	$1,676,000,000	-----	This figure could be derived from existing accounting records in teaching hospitals. The estimate provided here was derived by extrapolating data obtained from 20 university owned teaching hospitals on uncompensated charity care and collection losses to the 270 COTH teaching hospitals.
5) NEW TECHNOLOGY TESTING:			
A. Direct	-----	$?	New Technology Testing encompasses all activities which teaching hospitals undertake to test and develop new equipment and procedures used for patient diagnosis and treatment. No means exist for measuring the direct and indirect costs of new technology testing and innovation, but it is generally recognized that the cost of this societal contribution is significant. At the University of Iowa Hospitals and Clinics alone, some 250 new procedures and tests were introduced for patient care and diagnosis in the period from 1973 to 1978.
B. Indirect	-----	$?	
6) CLINICAL RESEARCH:			
A. Direct	-----	$?	While the bulk of Clinical Research conducted in teaching hospitals is supported by grants and other separate funding awarded for research purposes, some clinical research is directly or indirectly supported through patient care earnings. There are no studies which have been conducted to determine the aggregate costs of clinical research support provided directly by teaching hospitals.
B. Indirect	-----	$?	
7) LOW VOLUME, HIGHLY SPECIALIZED SERVICES:			
A. Direct	-----	$?	No estimates of the cost of Low Volume, Highly Specialized Services are available and no methodology has been developed for deriving such estimates.
B. Indirect	-----	$?	
8) INTENSIVE CASE MIX:			
A. Direct	-----	$?	No studies have been conducted to determine the costs which the 270 teaching hospitals incur in providing Intensive Case Mix Services and no reliable methodology has yet been developed to provide such costs.
B. Indirect	-----	$?	
TOTAL SOCIETAL CONTRIBUTIONS FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS	$3,968,000,000*	$2,725,000,000	(See following page for calculation of this unmeasurable figure.)
GRAND TOTAL	$6,693,000,000		

*The above figure would be increased if all 332 nonfederal COTH teaching hospitals were included. However, inclusion of all 332, for other than Graduate Medical and Dental Education, was not felt warranted because the preponderance of societal contributions are generated in teaching hospitals with major college of medicine affiliations.

EXHIBIT II - 3

ESTIMATION OF UNMEASURABLE SOCIETAL CONTRIBUTIONS FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1980-81

1.	Estimated Average Charge Per Inpatient Day for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations[1]	$ 414
2.	Estimated Average Charge Per Inpatient Day for All U. S. Nonfederal Short-Term General and Other Special Hospitals Excluding 270 COTH Teaching Hospitals[2]	$ 297
3.	Average Cost Per Inpatient Day of Societal Contributions of Teaching Hospitals ($414 - $297)	$ 117
4.	Average Cost Per Adjusted Patient Day of Measurable Societal Contributions for 270 COTH Teaching Hospitals ($3.397 Billion[3] ÷ 52,403,477[4] adjusted patient days)	$ 65
5.	Average Cost per Adjusted Patient Day of Unmeasurable Societal Contributions ($117 - $65)	$ 52
6.	Total Annual Cost of Unmeasurable Societal Contributions ($52 x 52,403,477 adjusted patient days[4])	$2,725,000,000[5]

FOOTNOTES

(1) See Exhibit II - 5 for derivation.

(2) See Exhibit II - 6 for derivation.

(3) See Exhibit II - 7 for derivation.

(4) "Adjusted Patient Days" is an aggregate figure reflecting the number of inpatient days of care rendered by the 270 COTH teaching hospitals (45,634,527) plus (6,768,950) equivalent patient days extrapolated for outpatient services. The extrapolation was made by multiplying the ratio of revenue per clinic visit to revenue per inpatient day for the 20 sample hospitals (.1708 clinic visits to 1 patient day) by the 20 hospitals' total clinic visits (39,630,854) to determine the equivalent patient days (6,768,950). (Source for 270 COTH Teaching Hospital patient days and clinic visits - Council of Teaching Hospitals, Association of American Medical Colleges, Committee Structure and Membership Directory, 1980, Washington, D.C., 1980).

(5) The above figure would be increased if all 332 nonfederal COTH teaching hospitals were included. However, calculation of the additional increase by extrapolation to them is probably not warranted because the preponderance of these societal contributions is in the 270 COTH members with major College of Medicine affiliations.

ESTIMATION OF AVERAGE CHARGE PER INPATIENT DAY IN 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1980-81

I.	ESTIMATION OF RELATIONSHIP OF INPATIENT COST TO INPATIENT REVENUE IN 20 SAMPLE TEACHING HOSPITALS	
A.	Gross 1980-81 Inpatient Revenue in 20 Sample Teaching Hospitals [Weighted Average Charge Per Inpatient Day Reported by 20 Sample Teaching Hospitals ($388)[1] x 1.131[2] x Total Patient Days (3,129,201)]	$ 1,373,181,000
B.	Total Inpatient Expense in 20 Sample Teaching Hospitals [Total Operating Expense ($1,447,434,000) less Total Ambulatory Operating Expense ($250,480,000) less Expense Allocated to Other Operating Revenues[3] ($144,743,000)]	$ 1,052,211,000
C.	Relationship of Inpatient Costs to Inpatient Charges in 20 Sample Teaching Hospitals ($1,052,211,000 ÷ $1,373,181,000)	77%
II.	ESTIMATION OF AVERAGE COST PER INPATIENT DAY IN 270 NONFEDERAL COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS	
A.	Total Inpatient and Ambulatory Care Operating Expense for 270 Nonfederal COTH Teaching Hospitals with Major College of Medicine Affiliations [1978-79 Total Operating Expense ($14,744,786,000[4] x 1.259[2] = $18,563,686,000) Less Expense Allocable to Other Operating Revenue ($18,563,686,000 x the Ratio of Other Operating Revenue to Total Operating Revenue for 20 Sample Teaching Hospitals, .10[3] = $1,856,369,000)]	$16,707,317,000
B.	Total Adjusted Patient Days for 270 Nonfederal COTH Teaching Hospitals with Major College of Medicine Affiliations[5]	52,403,477
C.	Estimated Average Cost Per Inpatient Day for 270 Nonfederal COTH Teaching Hospitals with Major College of Medicine Affiliations ($16,707,317,000 ÷ 52,403,477 Adjusted Patient Days)	$ 319
III.	ESTIMATION OF AVERAGE CHARGE PER INPATIENT DAY IN 270 NONFEDERAL COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS	
A.	Estimated Average Cost Per Inpatient Day for 270 Nonfederal COTH Teaching Hospitals with Major College of Medicine Affiliations	$ 319
B.	Relationship of Average Estimated Cost Per Inpatient Day to Average Estimated Charge Per Inpatient Day in 20 Sample Teaching Hospitals	77%
C.	Estimated Average Charge Per Inpatient Day in 270 Nonfederal COTH Teaching Hospitals with Major College of Medicine Affiliations ($319 ÷ 77%)	$ 414

FOOTNOTES

(1) Calculated by multiplying the Gross Average Charge Per Inpatient Day Reported by Each of the 20 Sample Teaching Hospitals by their Individual Reported Patient Days and Dividing by Total Patient Days for all 20 Hospitals.

(2) Department of Labor, Bureau of Labor Statistics. This reflects a 13.1 and 25.9 percent increase in the Consumer Price Index for Hospital "Room" Component of "Other Medical Care Services" Component from July, 1979 - July 1980, and July, 1978 - July, 1980, respectively.

(3) Derived by relating Other Operating Revenue for the 20 Sample Teaching Hospitals ($143,467,000) to Total Operating Revenue ($1,440,641,000) and applying this relationship (.10 to 1) to Total Operating expense ($1,447,434,000).

(4) Council of Teaching Hospitals, Association of American Medical Colleges, Committee Structure and Membership Directory, 1980, Washington, D.C., 1980; and American Hospital Association, Guide to the Health Care Field, 1980, (Chicago: American Hospital Association, 1980).

(5) "Adjusted Patient Days" for the 270 COTH Teaching Hospitals was derived using the ratio of revenue per clinic visit to revenue per inpatient day (.1708 clinic visits to 1 patient day) for the 20 sample hospitals. On this basis, the clinic visits for the 270 COTH hospitals (39,630,854) were multiplied by (.1708) to yield 6,768,950 equivalent patient days. When this figure is added to total patient days (45,634,527) for the 270 COTH hospitals, the total is 52,403,477.

ESTIMATION OF THE AVERAGE CHARGE PER INPATIENT DAY FOR U.S. NONFEDERAL, SHORT-TERM GENERAL AND OTHER SPECIAL HOSPITALS EXCLUDING 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

	Gross Inpatient Revenue	Inpatient Days of Care	Average Charge (Revenue) Per Inpatient Day
1. 1978-79 Inpatient Revenue, Inpatient Days of Care and Average Charge (Revenue) Per Inpatient Day for 5,842 Nonfederal, Short-Term General and Other Special Hospitals . . .	$66,821,103,000(1)	265,205,203(2)	$251.96(1)
2. 1980-81 Inpatient Revenue, Inpatient Days of Care and Average Charge (Revenue) Per Inpatient Day for 5,842 Nonfederal, Short-Term General and Other Special Hospitals . . .	$84,127,768,677(3)	265,205,203(4)	$317.00(3)
3. 1980-81 Inpatient Revenue, Inpatient Days of Care, and Average Charge (Revenue) Per Inpatient Day for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations	$18,892,694,178(5)	45,634,527(6)	$414.00(7)
4. Estimation of Gross Inpatient Revenue and Inpatient Days of Care for U.S. Nonfederal, Short-Term General and Other Special Hospitals Excluding 270 COTH Teaching Hospitals			
a. Gross Inpatient Revenue ($84,127,768,677 - $18,892,694,178)	$65,235,074,499(8)		
b. Inpatient Days of Care (265,205,203 - 45,634,527)		219,570,676(8)	
5. Estimation of Average Charge Per Inpatient Day for U.S. Nonfederal, Short-Term, General and Other Special Hospitals Excluding 270 COTH Teaching Hospitals with Major College of Medicine Affiliations [Gross Patient Revenue ($65,235,074,499) ÷ Inpatient Days of Care (219,570,676)]			$297.10 = $297

FOOTNOTES

(1) American Hospital Association, Hospital Statistics (Chicago: American Hospital Association, 1980), p. 186.

(2) Gross Inpatient Revenue ($66,821,103,000) ÷ Average Charge (Revenue) Per Inpatient Day ($251.96) = 265,205,203 Inpatient Days of Care.

(3) These figures were obtained by multiplying 1978-79 Gross Inpatient Revenue ($66,821,103,000) and Average Charge (Revenue) Per Inpatient Day ($251.96) by 1.259. The 1.259 reflects a 25.9 percent increase in the Consumer Price Index for the Hospital "Room" Component of the "Other Medical Services" Component from July, 1978 - July, 1980, per Department of Labor, Bureau of Labor Statistics.

(4) It is assumed that Inpatient Days of Care remained constant between 1978-79 and 1980-81.

(5) This figure is determined by multiplying Total Inpatient Days of Care for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations (45,634,527) by the Average Charge (Revenue) Per Inpatient Day Estimated for the 270 COTH Teaching Hospitals ($414.00).

(6) Council of Teaching Hospitals, Association of American Medical Colleges, Committee Structure and Membership Directory, 1980, Washington, D.C., 1980.

(7) See Exhibit II-7 for derivation.

(8) It is assumed that all 270 COTH Teaching Hospitals are included in the 5,842 Nonfederal, Short-Term General and Other Special Hospitals in performing these calculations. This assumption is supported by the response rate to the American Hospital Association survey from which the 1978-79 Gross Revenue and Average Charge (Revenue) Per Inpatient Day data for the 5,842 Nonfederal, Short-Term General and Other Special Hospitals were drawn. All 270 COTH hospitals have over 100 beds and the response rate to the AHA survey for hospitals with over 100 beds exceeded 92 percent. See American Hospital Association, Ibid., p. xxi.

ESTIMATION OF TOTAL MEASURABLE SOCIETAL CONTRIBUTION COSTS FOR 270 COTH TEACHING HOSPITALS ONLY

1980-81

I. ESTIMATION OF GRADUATE MEDICAL AND DENTAL EDUCATION COSTS FOR 270 COTH TEACHING HOSPITALS WITH MAJOR COLLEGE OF MEDICINE AFFILIATIONS

1.	Total Graduate Medical and Dental Education Costs for All Nonfederal Teaching Hospitals[1]	$1,808,000,000
2.	Total Medical Residents[2] Engaged in Residency Training in All Teaching Hospitals[3]	64,615
3.	Total Medical Residents[2] Engaged in Residency Training in 270 COTH Teaching Hospitals with Major College of Medicine Affiliations[4]	44,206
4.	Relationship of 270 COTH Teaching Hospital Medical Residents to all Medical Residents (44,206 ÷ 64,615)	68.4%
5.	Total Graduate Medical and Dental Education Costs for 270 COTH Teaching Hospitals with Major College of Medicine Affiliations ($1,808,000,000 x .684)	$1,237,000,000

II. TOTAL MEASURABLE SOCIETAL CONTRIBUTION COSTS FOR 270 COTH TEACHING HOSPITALS ONLY

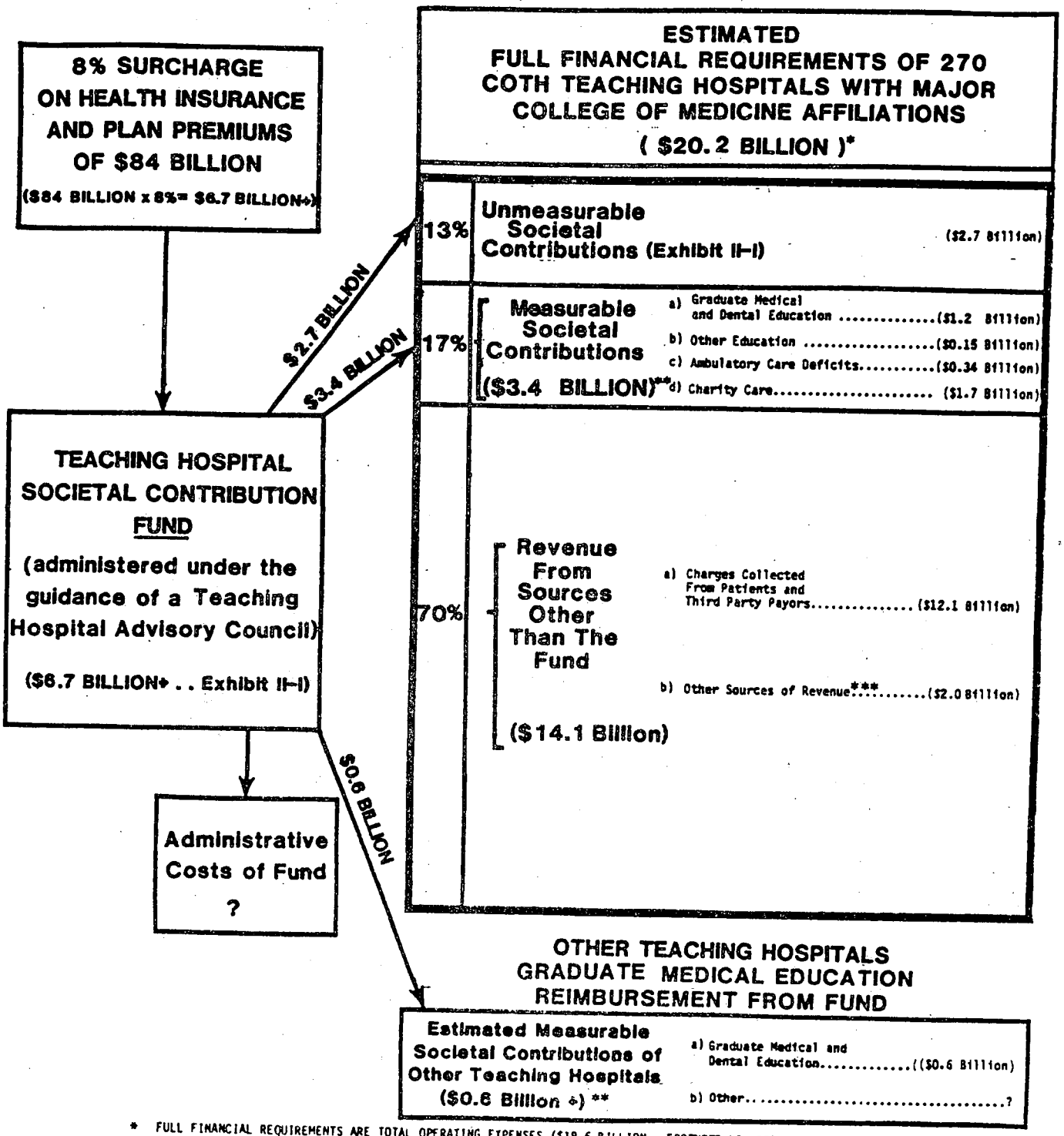
1.	Graduate Medical and Dental Education[1]	$1,237,000,000
2.	Other Educational Programs[1]	$ 148,000,000
3.	Ambulatory Care Program Deficits Excluding Educational Costs Included in A and B but Including Ambulatory Charity/Collection Loss Costs[1]	$ 336,000,000
4.	Inpatient Charity Care/Collection Loss Costs[1]	$1,676,000,000
5.	Total	$3,397,000,000

FOOTNOTES

(1) See Exhibit II - 2 and 3.
(2) Medical Residents only are used to estimate the proportion of total graduate Medical and Dental Education Costs funded from Hospital revenues which are attributable to the 270 COTH teaching hospitals with major College of Medicine affiliations because information is not available on the number of dental residents and clinical fellows in the individual teaching hopsitals.
(3) American Medical Association, 80/81 Directory of Residency Training Programs Accredited by the Liaison Committee on Graduate Medical Education, (Chicago: American Medical Association, 1980).
(4) Council of Teaching Hospitals, Association of American Medical Colleges, Committee Structure and Membership Directory, 1980, Washington, D.C., 1980; and Ibid.

A THEORETICAL APPROACH TO STRUCTURING OF THE COMPETITIVE SYSTEM TO RECOGNIZE THE UNIQUE SOCIETAL CONTRIBUTIONS OF TEACHING HOSPITALS

(DOLLARS ARE 1980-81 ESTIMATES)



* FULL FINANCIAL REQUIREMENTS ARE TOTAL OPERATING EXPENSES ($18.6 BILLION - FOOTNOTE NO. 27) INCREASED TO INCLUDE AN ESTIMATED EIGHT PERCENT MARGIN TO MEET WORKING CAPITAL AND A PORTION OF CAPITAL REQUIREMENTS. ($20.2 BILLION = $18.6 BILLION + .92).

** $3.4 BILLION + $.6 BILLION BELOW = $4.0 BILLION TOTAL OF MEASURABLE SOCIETAL CONTRIBUTIONS (EXHIBIT II-1).

*** SOURCES OF REVENUE OTHER THAN CHARGES AND THE SOCIETAL CONTRIBUTION FUND ARE ESTIMATED TO BE 10% OF TOTAL REQUIREMENTS (EXHIBIT II-5, FOOTNOTE 3).

EXHIBIT III

USE OF AN AVERAGE MULTIPLIER TO ESTIMATE TOTAL SOCIETAL CONTRIBUTIONS OF TEACHING HOSPITALS AN IMPRACTICAL METHOD

In view of the current inability to separately identify the costs associated with the multiple societal contributions of teaching hospitals, an alternative procedure has been proposed by some individuals for determining reimbursement to a teaching hospital for all such costs. This alternative procedure would involve estimating the cost of unmeasurable societal contributions on a formula basis from known characteristics and financial data about teaching hospitals.

An approach which has been proposed for deriving this estimation would involve selection of one societal contribution of teaching hospitals for which cost data are available--for example, measurable educational costs--and then applying a multiplier to these costs to estimate the total amount of a teaching hospital's societal contributions. In an attempt to determine if such a method would be feasible, data were collected from a sample of 20 major teaching hospitals on the costs of three measurable societal contributions: education costs, charity care costs, and ambulatory care deficits.

A review of the data indicates that a dramatic difference exists among teaching hospitals both in the individual amounts of each societal contribution and in the relative proportionality of the cost of individual measurable societal contributions to the aggregate costs of all measurable societal contributions. If the variation in unmeasurable societal contribution costs across teaching hospitals is as great as these measurable items, it is apparent that no simple estimating procedure would be satisfactory as a basis for reimbursement.

In order to demonstrate this point dramatically, the average ratio of educational costs to total measurable costs (defined here as the total of education costs, charity/collection loss allowances, and ambulatory care deficits) was calculated for all 20 hospitals in the sample (See Table I) and for hospitals grouped according to total clinic visits and by bed size (See Table II). The relevant ratio (multiplier) was then multiplied by each hospital's educational costs to derive a predicted aggregate cost of education, charity/collection loss allowances and ambulatory care program deficits. Comparisons of actual total measurable costs to predicted total measurable costs are presented in each of the tables. Table I compares the actual total measurable costs to the multiplier-predicted total measurable costs; and Table II compares total actual measurable costs to the distribution of the multiplier-predicted total measurable costs for each of the hospital clinic visit and bed size groupings. As is readily apparent, with a few exceptions, the predictions were in gross error; and these results show that a simple technique for estimation of the societal contributions of teaching hospitals does not appear to be viable.

More elaborate and accurate estimating procedures have, as yet, eluded researchers investigating this issue. Therefore, prospective reimbursement programs have been faced with many difficulties in their attempts to devise a systematic method for dealing with teaching hospitals. Most of these programs have resorted to bilateral bargaining mechanisms rather than depending on strict formulae for estimating. While several promising research projects for investigating this issue are now underway, none appear to provide an accurate and practical method that can be safely and equitably utilized in the near future.

COMPARISON OF THE ACTUAL AND AVERAGE MULTIPLIER PREDICTED TOTAL COST OF EDUCATION, CHARITY/COLLECTION LOSS ALLOWANCES, AND AMBULATORY CARE DEFICITS FOR A SAMPLE OF 20 UNIVERSITY OWNED TEACHING HOSPITALS

1979-80

Hospital	Actual Cost of Education	Actual Total Cost of Education Charity/Collection Loss Allowances, and Ambulatory Patient Care Deficits	Predicted Total Cost of Education Charity/Collection Loss Allowances, Ambulatory Patient Care Deficits*	Error Between Actual and Average Multiplier Predicted Total Cost of Education, Charity/ Collection Loss Allowances, and Ambulatory Patient Care Deficits	
				Monetary	Percentage
1.	$ 8,362,600	$ 15,832,465	$ 20,739,248	$ 4,906,783	31.0%
2.	1,298,307	5,773,205	3,219,801	(2,553,404)	(44.2)
3.	12,768,210	28,225,192	31,665,161	3,439,969	12.2
4.	4,385,903	18,837,751	10,877,039	(7,960,712)	(42.3)
5.	11,767,841	13,734,434	29,184,246	15,449,812	112.5
6.	7,828,665	12,983,053	19,415,089	6,432,036	49.5
7.	5,000,000	10,277,847	12,400,000	2,122,153	20.6
8.	952,017	2,151,943	2,361,002	209,059	9.7
9.	3,633,377	10,517,428	9,010,775	(1,506,653)	(14.3)
10.	3,111,610	7,469,260	7,716,793	247,533	3.3
11.	2,580,990	6,303,954	6,400,855	96,901	1.5
12.	9,073,004	22,967,174	22,501,248	(465,926)	(2.0)
13.	4,986,083	10,591,750	12,365,486	1,773,736	16.7
14.	3,306,539	19,376,436	8,398,617	(10,977,819)	(56.7)
15.	3,272,905	17,371,794	8,116,804	(9,254,990)	(53.3)
16.	4,444,395	10,848,621	11,022,100	173,479	1.6
17.	6,541,243	15,808,135	16,222,283	414,148	2.6
18.	3,942,523	18,590,549	9,777,457	(8,813,092)	(47.4)
19.	5,899,123	7,420,000	14,629,825	7,209,825	97.2
20.	2,010,203	5,966,296	4,985,303	(980,993)	(16.4)
TOTALS . . .	$105,245,618	$261,047,287	$261,009,132		

*Average Multiplier Used in Calculation = $261,047,287 ÷ $105,245,618 = 2.48

TABLE I

COMPARISON OF THE ACTUAL AND AVERAGE MULTIPLIER PREDICTED TOTAL COSTS OF EDUCATION, CHARITY/COLLECTION LOSS ALLOWANCES, AND AMBULATORY CARE DEFICITS FOR A SAMPLE OF 20 UNIVERSITY OWNED TEACHING HOSPITALS ACCORDING TO CLINIC VISIT AND BED SIZE GROUPINGS

1979-80

Sample Hospital Grouping	Actual Average Cost of Education	Actual Average Total Cost of Three Societal Contributions	Multiplier Value	Distribution of the Ratio of Cost Estimated by Use of A Multiplier to Actual Hospital Costs for Three Societal Contributions (Number of Hospitals in the Ratio Ranges)					
				Under .50	.50 - .75	.75 - 1.00	1 - 1.25	1.25 - 1.50	over 1.50
1. Distribution Based on Total CLINIC VISITS									
200,000 & Over	$7,716,572	$16,480,609	2.14	2		1	1		1
150,000 - 199,999	$3,851,110	$ 8,283,914	2.15		1	3	1	1	
100,000 - 149,999	$5,032,601	$16,231,153	3.23		2			2	1
Under 100,000	$4,598,273	$11,946,245	2.60		1	1	1		1
2. Distribution Based on BED SIZE									
Over 750	$8,004,004	$15,517,349	1.94			2	1		1
600 - 750	$5,842,237	$16,232,919	2.37	1	1			1	1
400 - 599	$4,788,908	$14,112,673	2.95		2		4	1	
Under 400	$2,467,660	$ 7,051,498	2.86		1	2	1	1	

TABLE II