



association of american medical colleges

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING
6:30 - 8:00pm

AND DINNER
8:00 - 10:00pm

November 1, 1981
Washington Hilton Hotel
State Room

A G E N D A

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Association of American Medical Colleges
COH Administrative Board Meeting
September 9, 1981

PRESENT

Stuart J. Marylander, Chairman
Mitchell T. Rabkin, M.D., Chairman-Elect
John W. Colloton, Immediate Past Chairman
Fred J. Cowell
Spencer Foreman, M.D.
Mark S. Levitan
Robert K. Match, M.D.
John V. Sheehan
William A. Robinson, AHA Representative

ABSENT:

Dennis R. Barry
James W. Bartlett, M.D., Secretary
Robert E. Frank
Earl J. Frederick
John A. Reinertsen

GUEST:

Julius R. Krevans, M.D.

STAFF:

James D. Bentley, Ph.D.
Peter W. Butler
John A.D. Cooper, M.D.
Joseph C. Isaacs
Joseph A. Keyes, J.D.
Richard M. Knapp, Ph.D.
John F. Sherman, Ph.D.
Emanuel Suter, M.D.
Kathleen Turner
Melissa Wubbold

I. Call to Order

Mr. Marylander called the meeting to order at 6:15 p.m. in the Hamilton Room of the Washington Hilton Hotel.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve the minutes of June 25, 1981 Administrative Board meeting without amendment.

III. Membership Applications

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

ACTION: It was moved, seconded and carried to approve:

- (1) Children's Hospital Medical Center of Akron, Ohio for full COTH membership;
- (2) Detroit Receiving Hospital and University Health Center, Detroit, Michigan for full membership;
- (3) Frankford Hospital, Philadelphia, Pennsylvania for full membership; and
- (4) Veterans Administration Medical Center Hospital, Mountain Home, Tennessee for corresponding membership

IV. ACCME Essentials

Dr. Suter reviewed this agenda item for the Board. He explained that the revised Essentials for the Accreditation of Sponsors of Continuing Medical Education do not differ substantially from the previous version, with the exception of a paragraph added on "Eligibility for Accreditation."

ACTION: It was moved, seconded and carried to approve the ACCME Essentials.

V. Election of Distinguished Service Members

Dr. Knapp presented staff's recommendation for Distinguished Service Member nominees, citing three former COTH Chairmen.

ACTION: It was moved, seconded and carried to approve Robert A. Derzon, Sidney Lewine, and Irvin G. Wilmot for nomination as AAMC Distinguished Service Members.

VI. Patient Satisfaction Survey and Indices

Due to the absence of Mr. Frank who was to review this agenda item for the Board, the topic was not addressed at this meeting.

VII. Describing the Teaching Hospital: A Progress Report

To update the Board on the Association's study of teaching hospitals and obtain its reaction on future plans for the study, a 279-page progress report was distributed as an attachment to the regular agenda. Discussion of the report began with Dr. Bentley and Mr. Butler summarizing data comparability and validity problems encountered and reviewing the proposed chapter outline, draft tables, and case mix report.

Board discussions of the progress report identified four areas for additional staff attention:

- o Staff need to be certain that payments for hospital-based physicians are consistently treated in constructing average per admission costs.
- o The inclusion of the detailed case mix information in the final report is somewhat inconsistent with the report's purpose of describing teaching hospitals. A separate mechanism should be used to furnish the detailed case mix information to Association members.
- o The case mix tables comparing actual and expected lengths of stay, charges, and costs illustrate potential uses for case mix data rather than a description of hospital characteristics. The case mix chapter should be redesigned to return the focus to a description of the patient case mix of teaching hospitals.
- o The use of the 25th percentile, median, and 75th percentile focuses too much attention on the statistically "typical" hospital and does not provide enough emphasis on teaching hospital variability.

The Board also discussed difficulties comparing study data with published data on non-teaching hospitals and the advisability of showing the difference between average billed charges and average costs. The Board concluded that the report should not include questionable non-teaching hospital comparisons, but should continue to include actual charge data even though uninformed persons could misuse it. Repeatedly, the Board stated its support for the direction the report was taking and encouraged staff to ensure that the text of the report used every opportunity to educate the general public about some of the distinctive characteristics (e.g., gross charges) of hospitals.

VIII. AAMC Position on Competition Legislation

Although the Board and the Executive Council have had numerous discussions on the subject of price competition, neither has formally endorsed or opposed legislation that promotes price competition. The Board was asked to discuss specific issues with respect to possible legislation: Medicare and Medicaid participation, charity and uncompensated care, pricing of plans, a special fund for the societal contributions of teaching hospitals,

and an evaluation commission.

The views on treatment of these issues were mixed, with the Board generally believing it was inappropriate to express support publicly for any particular approaches at this time. The discussion was lengthy and it was clear that the Board was equally split on the desirability of any form of legislation promoting competition. Those in favor of competition felt that: it would be preferable to regulatory "caps" on hospital costs; the cost-based reimbursement system can no longer be supported; the consumer choice principles merit testing; and price competition is going to occur with or without legislation. Those opposed argued that: the current system has been advantageous to teaching hospitals; state rate review would more likely protect the societal contributions of teaching hospitals; and price competition will not reduce costs so that both competition and regulation will result.

Mr. Colloton advanced a seven-point proposal that was premised on "refined regulation" being preferable to price competition. The seven points included: (1) multiple choice of plans, a minimum benefit package, equal employer contribution to all plans, a maximum on the tax-free status of premiums, and collection of deductibles and coinsurance by the plan should be supported; (2) separate funding of the \$6.9 billion educational fund, preemption of state licensure laws. Medicare and Medicaid vouchers, and separation of employer from voucher should be opposed; (3) reservations should be expressed about the tax-free status of proposed rebates and about disincentives for referrals created by placing physicians at risk; (4) the AAMC should examine the positions taken by other national associations to see if a consensus can be reached; (5) efforts should be made to identify an economist who could articulate the flaws of price competition theory; (6) state rate review should be supported as an alternative to price competition; and (7) the goals of dampening consumer demand and decreasing federal support of health care should be supported.

After additional discussion of Mr. Colloton's proposal, the Board generally concluded that it would be difficult, at best, to achieve a consensus among AAMC constituents for a strong statement supporting or opposing price competition. Two suggestions were made and generally agreed upon: (1) have each Board member submit to staff in writing, prior to the November Board meeting, his recommendations for approaches the Association should be pursuing on this issue, and (2) add a Sunday evening Board meeting on November 1 to discuss the subject in further detail. No formal action was taken beyond these agreements.

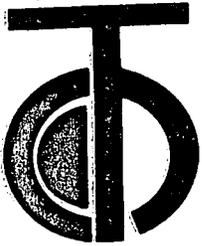
IX. Adjournment

The meeting was adjourned at 10:15 P.M.

REQUEST FOR MEMBERSHIP RECONSIDERATION

At the June, 1981 meeting of the COTH Administrative Board, the membership application of Grant Hospital, Columbus, Ohio was considered, and the Board voted to elect the hospital to corresponding membership. Dr. Jack E. Tetirick, Director of Medical affairs at Grant Hospital, believes Grant Hospital should be a teaching hospital member rather than a corresponding member of COTH. He has asked that the hospital's original application as supplemented by additional correspondence be reconsidered. The following items are attached for your review:

<u>Page</u>	<u>Item</u>
6	Original application for membership
10	Original supplemental information accompanying application
11	Dean's letter accompanying application
12	Affiliation agreement currently in effect
14	August 6th letter from Dr. Tetirick expressing dissatisfaction with corresponding membership
15	August 17th response to Dr. Tetirick from Jim Bentley
17	August 25th letter from Chairman of Surgery, Ohio State University
19	October 14th letter from Dr. Tetirick enclosing supplemental information on programs in surgery, family medicine, obstetrics/gynecology



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):	<u>601</u>	Admissions:	<u>22,440 (1979)</u>
Average Daily Census:	<u>490.3 (1979)</u>	Visits: Emergency Room:	<u>30,728 (1979)</u>
Total Live Births:	<u>1969 (1979)</u>	Visits: Outpatient or Clinic:	<u>8143 (1979)</u>

B. Financial DataTotal Operating Expenses: \$ 36,535,682Total Payroll Expenses: \$ 18,000,000

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

House Staff Stipends & Fringe Benefits: \$ approximately 600,000Supervising Faculty: \$ approximately 600,000C. Staffing DataNumber of Personnel: Full-Time: 1737 (FTE)Part-Time: 348

Number of Physicians:

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

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

<u>OB/GYN</u>	<u>Surgery</u>	<u> </u>	<u> </u>
<u>Family Practice</u>	<u>Medicine</u>	<u> </u>	<u> </u>

Does the hospital have a full-time salaried Director of Medical Education?: YesIII. MEDICAL EDUCATION DATAA. Undergraduate Medical Education

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

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

*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.

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

¹As 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.

²As 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)

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

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

January 29th, 1981

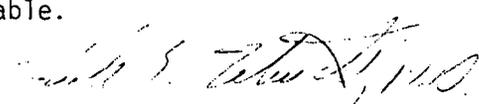
SUPPLEMENTARY INFORMATION

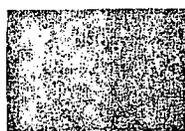
The decision to develop Grant Hospital as a teaching hospital was implemented in July of 1977 with the employment of a full-time director of medical affairs and subsequent recruitment and employment of full-time directors of medical education in Surgery, Internal Medicine, Family Practice and Obstetrics-Gynecology. 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).

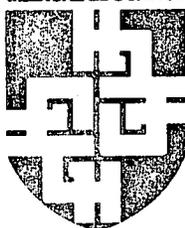
The Medical Education Program at Grant Hospital does not seek to establish independent residencies in other specialties, preferring a partnership with Ohio State to give these residents the discipline of an academic program and the experience of a community hospital. The patient population of Grant Hospital 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 neoplastic 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



**GRANT HOSPITAL
 MEDICAL EDUCATION**



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





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.
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.

Memorandum of Agreement - Grant Hospital and College of Medicine, OSU
-2-

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

For: Board of Trustees
Grant Hospital

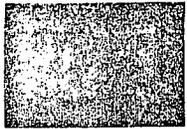
Novice H. Lawell
President

Paul P. English
President

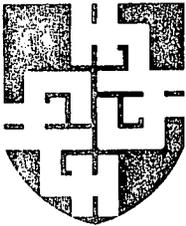
Date: July 17, 1964

Date: June 3, 1964

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



GRANT HOSPITAL
MEDICAL EDUCATION



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

August 6th, 1981

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

Dear Dr. Knapp

I was pleased to learn that Grant Hospital has been accepted for membership in the Council of Teaching Hospitals. However, I would appreciate receiving written clarification explaining why corresponding rather than full membership was designated.

I am particularly interested in knowing what the attitude of the Board of Directors is about a teaching hospital which has an established Family Practice Program and has decided by choice to use University speciality residents rather than to create new speciality residency programs. It was our feeling that the quality of the speciality residents would be higher, that their interaction with the Family Practice Residents would be more useful to both parties and that there is a stated surplus of speciality residencies outside of the University centers. I also need to know how we compare with the other community hospitals in the Columbus area, e.g. whether they are designated as full members or corresponding members. The decision we made to go to a nucleus of full time teaching staff was not easily arrived at and certainly not easily implemented. It was done because of a very strong conviction that such a nucleus is essential for a high quality educational program. I can't imagine that this was a negative factor in the decision of your Board but I would be most interested in clarification of this point since the other community programs in this area are essentially volunteer programs.

Thank you for your attention in this matter.

Very truly yours

J.E. Tetirick, M.D.

JET/lsw

August 17, 1981

J.E. Tetirick, M.D.
Director, Medical Affairs
Grant Hospital
309 East State Street
Columbus, Ohio 43215

Dear Dr. Tetirick:

Dr. Knapp is presently on vacation. Therefore, I am responding to your August 6th letter to him concerning Grant Hospital's corresponding membership status.

As you are aware the Council includes two membership categories: teaching hospital members and corresponding members. Teaching hospital membership has existed since the formation of the Council. It is designed to include teaching hospitals with comprehensive medical education programs. At the residency level, this has been translated into the offering of at least four residency programs for a general hospital, two of which are in medicine, surgery, ob-gyn, pediatrics, family practice, and psychiatry. While residency program sponsorship is not considered, the COTH Board does consider the number of residents in each program is a comprehensive component of the residency. In addition, the Board considers the hospital's involvement in undergraduate medical education in designating a hospital for teaching hospital membership. In the mid 70's, as many hospitals began to offer residencies in limited numbers and areas and as non-hospital organizations (e.g., Consortial, AHECs) began to offer residencies, the AAMC offered corresponding membership in the Council to permit these hospitals and organizations to establish a regular method of relating to the Council and its activities.

In June, 1981, Grant Hospital's membership application was presented to the COTH Administrative Board. The application showed an extensive commitment to family practice residency training. In medicine, surgery, and ob-gyn, the application showed the hospital provided essentially monthly rotations. Moreover, residency programs in other specialities (e.g., colon/rectal surgery, physical medicine) were limited to a single resident either for a year or a month. Thus, the Board concluded that Grant Hospital is primarily a family practice training hospital with limited participation in other residencies. The Board, therefore, categorized Grant Hospital as a corresponding member.

In the Columbus area, three hospitals are teaching hospital members of COTH: Childrens, OSU, and Riverside. Corresponding members, having programs similar to those at Grant Hospital, are the Community Hospital of Springfield and Clark County, in Springfield, and Greene Memorial Hospital, in Xenia.

I hope this letter clarifies how the Board's decision was made in naming Grant Hospital as a corresponding member. We are pleased to include you within

Page 2 - Dr. J.E. Tetirick
August 17, 1981

our membership and trust that membership will serve the interests of the hospital, its administration, and its medical education staff.

If I may be of further assistance, please contact me.

Sincerely,

James D. Bentley, Ph.D.
Associate Director
Department of Teaching Hospitals

JDB/alc



The Ohio State University

Office of the Chairman
Department of Surgery

410 West 10th Avenue
Columbus, Ohio 43210

Phone 614 421-8701

August 25, 1981

James D. Bentley, Ph.D.
Associate Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, NW, Suite 200
Washington, DC 20036

Dear Dr. Bentley:

I have received a copy of your letter of August 17th to Dr. J. E. Tetirick, Director of Medical Affairs at Grant Hospital in Columbus, Ohio. I thought it might be useful and avoid subsequent deliberations to explain the role of Grant Hospital in the surgical residency program.

We do currently, and have for some time, consider Grant Hospital an essential part of our residency program, and our residents spend several months of their training at Grant. The institution provides a useful balance for our tertiary care medical center and the residents benefit from and greatly enjoy their experience. The staff has made a significant commitment to teaching and the quality of the educational program for the surgical house staff is significant. At the moment, we have from two to five residents at the Grant Hospital at any given time for periods of one to three months at a time. In addition, we regularly and consistently have medical students assigned to the surgical services at Grant Hospital for their basic surgical clerkship and consider also the teaching at Grant for medical students to be of high caliber.

In reviewing the hospitals described in your letter, there is little similarity between Grant Hospital, as it relates to the Department of Surgery at any rate, and community hospitals in Springfield, Clark County, and Greene Memorial in Xenia. While I have not visited the community hospitals in Springfield, I have visited the Greene Memorial Hospital in Xenia and the difference in academic environment between it and Grant Hospital is not comparable.

I believe, from the standpoint of the Department of Surgery at Ohio State University, we consider Grant to be full partners in our teaching activity and, in that regard, wonder if reconsideration of the definition as it relates to membership in the AAMC might be entertained.

James D. Bentley, Ph.D.
August 25, 1981
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I hope this information has been useful, and it is not my intent to be presumptive, but rather informative.

Sincerely,


Larry C. Carey, M.D.
Robert M. Zollinger Professor of Surgery
Chairman, Department of Surgery

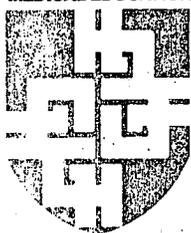
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cc: Dr. J. E. Tetirick
Dr. M. Tzagournis

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

**GRANT HOSPITAL
 MEDICAL EDUCATION**



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

October 14th, 1981

James D. Bentley, Ph.D.
 Associate Director
 Department of Teaching Hospitals
 Association of American Medical Colleges
 Suite 200
 One Dupont Circle N.W.
 Washington D.C. 20036

Dear Dr. Bentley

I have collected the information which seems pertinent if we are to ask your Board to reconsider the nature of Grant Hospital's membership in the Council of Teaching Hospitals. I will consult with Dean Tzagournis at the Ohio State University College of Medicine and perhaps he will also wish to comment in a letter to you. Enclosed with this letter will be the original application for membership and my original supporting letter and the additional data which bears on this question. Essentially it is documentation of the number of Ohio State residents and students who are regularly on rotation at Grant Hospital.

The medical student rotations in Medicine and Surgery are required rotations which are identical to those given at the University Hospital. The medical student rotations in other areas are all elective. They are well filled and very active. In addition to students in the clinical years we have for four years had the responsibility for teaching physical diagnosis to the Ohio State University students who are in the independent study program.

The surgical residency program has graded responsibility and long periods of service at Grant Hospital. It is divided into two services each with its full compliment of responsibilities, patients, quality control conferences and medical student assignments.

The Director of Medical Education - Internal Medicine, Dr. Guy, is a tenured professor at the Ohio State University College of Medicine. The residencies in Internal Medicine are at the third year level and have responsibility for the Ohio State University consult service and the general medicine service.

The residencies in OB/GYN also include residents at multiple levels so structured as to create graded responsibility of patient care. The O.S.U. OB/GYN residents have the additional responsibility of supervising the Family Practice Residents in their obstetrical work. This is not an easy relationship

Page -2-

and it has taken a great deal of hard work, co-operation and understanding between the two groups of residents and between my faculty and the department heads at Ohio State. In its present form, I believe it is an excellent system for teaching family physicians to deliver normal obstetrical care.

Grant residents spend a minimum of five months at the Columbus Children's Hospital under the supervision of the Chairman of the Department of Pediatrics at Ohio State.

You are correct in assuming that the Family Practice Residency is very important to us. A community teaching hospital is very advantageously situated to build a quality Family Practice Residency. We have and will continue to work closely with the Ohio State University College of Medicine to have strong Family Practice programs at both institutions. The Grant Family Practice Residency receives financial support from the State of Ohio as part of a program of the Board of Regents administered through the College of Medicine.

I hope that your Board will consider these items in their review of our application.

Respectfully submitted

J.E. Tetirick, M.D.
Director of Medical Affairs
Associate Clinical Professor of Surgery
The Ohio State University College of Medicine

JET/lsw

/enclosures

GRANT HOSPITAL
MEDICAL EDUCATION

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

OSU SURGERY RESIDENTS FOR YEAR 1980-1981

FOURTH YEAR RESIDENTS

Stan Alexander, M.D.	SIX MONTHS
Jeremy Burdge, M.D.	SIX MONTHS
David Denning, M.D.	SIX MONTHS
Dow Harvey, M.D.	SIX MONTHS

THIRD YEAR RESIDENTS

Scott Crocker, M.D.	THREE MONTHS
Chris Ellison, M.D.	THREE MONTHS
Steve Steinberg, M.D.	THREE MONTHS
Rick Zollinger, M.D.	THREE MONTHS

FIRST YEAR RESIDENTS

Dave Burgin, M.D.	THREE MONTHS
Andy Glassman, M.D.	THREE MONTHS
Mitch Fields, M.D.	THREE MONTHS
Dave Huber, M.D.	SIX WEEKS
Mary Mancini, M.D.	SIX WEEKS
Dave Mandelbaum	THREE MONTHS
Dan Martin	THREE MONTHS
Steve Walker	THREE MONTHS

OSU SURGERY STUDENTS FOR YEAR 1980-1981

JULY, 1980	4 STUDENTS
AUGUST, 1980	4 STUDENTS
SEPTEMBER, 1980	4 STUDENTS
OCTOBER, 1980	4 STUDENTS
NOVEMBER, 1980	4 STUDENTS + 1 ELECTIVE
DECEMBER, 1980	4 STUDENTS
JANUARY, 1981	3 STUDENTS
FEBRUARY, 1981	5 STUDENTS + 2 ELECTIVE
MARCH, 1981	4 STUDENTS + 1 ELECTIVE
APRIL, 1981	4 STUDENTS
MAY, 1981	3 STUDENTS
JUNE, 1981	5 STUDENTS

TOTAL 48 STUDENTS + 4 ELECTIVE

COLON RECTAL RESIDENT - ONE YEAR PROGRAM



The Ohio State University

Department of Family Medicine

University Hospitals Clinic
456 Clinic Drive
Columbus, Ohio 43210

Phone 614 421-8007

September 29, 1981

Jack Tetirick, M.D.
Director of Medical Affairs
Grant Hospital
309 East State Street
Columbus, OH 43215

Dear Dr. Tetirick:

I am writing this letter in the absence of the Chairman, Tennyson Williams, M.D., and relative to the educational relationship currently existing between Grant Hospital and The Ohio State University Department of Family Medicine and University Hospitals. I am happy to summarize the expanding projects and feel that it is critical for our educational programs to interact.

Grant Hospital contributes to many areas of education. Relative to the undergraduate level, our medical students rotate through the Grant Family Practice Center on a monthly basis. This can be up to four senior students per month for approximately 40 hours per week. Faculty at Grant also assists in teaching the early medical students the physical diagnosis/physical examination course. Grants residents also contribute in teaching our medical students.

As the affiliation of family medicine residency programs continues to grow, Grant and Ohio State residents are working and contributing toward joint projects. During the 1979-80 academic year, an affiliation coordinator was hired to coordinate activities between the four family practice programs here in Columbus. We have quarterly conferences wherein all residents and faculty participate, and the coordinator is presently organizing a practice management course for all programs. All residents come to Ohio State to obtain some of their subspecialty rotation training, and we reciprocate by sending some of our first and second year residents to Grant Hospital to obtain our general medical rotation. We will send approximately three residents down this year and will obtain approximately 12 months of general medicine at Grant Hospital during the 1982-83 residency year.

Between both hospitals and both teaching staffs, we have an abundant amount of teaching resources. With the formal affiliation growing and sharing resources, it enables both programs to benefit from each other's strengths.

In summary, the affiliation between Grant Hospital and our department is essential in providing our medical students and residents with a good sound educational training program. I appreciate the opportunity in which to comment.

Sincerely,



Robert E. Smith, M.D.
Associate Professor and
Residency Director

JW

cc: Tennyson Williams, M.D.

RESIDENCY IN FAMILY PRACTICE

3341 East Livingston Avenue
Columbus, Ohio 43227
(614) 239-0218

September 28, 1981

AFFILIATION WITH THE OHIO STATE UNIVERSITY
COLLEGE OF MEDICINE

WILLIAM H. HARRIS, M.D.
Asst. Director
STEPHEN J. HERRICK, M.D.
Asst. Director
WILLIAM T. CONWAY, M.D.
Asst. Director
JOHN L. ENGLE, M.D.
Asst. Director
RICHARD LUTES, M.D.
Asst. Director
VALERIE PENDLEY, M.D.
Asst. Director
LAWRENCE RATCLIFF, M.D.
Asst. Director
RANSOME WILLIAMS, M.D.
Associate Director
ALSTON QULLIN, M.D.
Dermatologist
LEE SPADE, Ph.D.
Dir. Behavioral
Science Education
JERI A. O'DONNELL, M.A.
Social Worker
LYNDA WAGER, R.D., M.S.
Nutritionist

Although there had been cooperation and regular meetings between the Grant Family Practice Residency Director, and the Ohio State University faculty since the program began, a formal affiliation agreement was signed in 1977.

FUNDING

Through this affiliation, the Grant Family Practice Program receives State funding from the Ohio Board of Regents via the Ohio State University.

UNDERGRADUATE EDUCATION

A total of 84 medical students from Ohio State have rotated through the Grant Family Practice Department since January 1980. This included 45 students on required rotations and 39 on elective rotations.

GRADUATE EDUCATION

Family Practice Residents from Ohio State University are rotating on the Grant Hospital Medical Service with the Grant Family Practice Residents.

EDUCATIONAL PLANNING

Numerous Grant Family Practice faculty and residents have served on College of Medicine Committees. This includes the undergraduate, curriculum, and research committees.

Affiliation meetings are held on a regular basis by the Residency Program Directors to discuss common goals and problems.

FACULTY APPOINTMENTS

Twenty-two members of the Grant Family Practice Department presently have faculty appointments at the Ohio State University ranging from Clinical Instructor to Clinical Associate Professor.

Faculty of the Grant Family Practice Residency Program are eligible for Ohio State University appointments. Lectures are given by Grant Faculty to Students and Residents at Ohio State University.

GRANT FAMILY PRACTICE RESIDENCY PROGRAM

OTHER EDUCATIONAL INVOLVEMENT

Residents from other institutions have rotated through the Grant Program the past two years including Psychiatry Residents from Ohio State and the Harding Hospital, and a Family Practice Resident from the University of Miami.

Medical Students from the Medical College of Ohio, Northeastern Ohio University College of Medicine, and Baylor University have taken elective rotations in the Grant Family Practice Department.

The Grant Family Practice Department has hosted the Ohio Practice Opportunities Conference in cooperation with the U.S. Department of Health and Human Services and the Ohio State Medical Association.

The Director of the Family Practice Program is also Regional Advisor for Continuing Medical Education for the Ohio Academy of Family Physicians.

GRANT HOSPITAL
Columbus, Ohio

MEMORANDUM

Date: October 5, 1981

From: Fred Abramovitz, M.D., Director of Medical Education, OB-GYN

Distribution: Jack Tetirick, M.D.

Subject: Ohio State University Residents on Rotation at Grant Hospital

- I. The Grant Hospital rotation for the Ohio State University OB-GYN Residents has been going on for over five years, but in its present day very structured form has been going on for the past four years. There are two Ohio State University Residents assigned to Grant Hospital for three month periods of time. The Chief Resident (fourth year OB-GYN Resident) is totally responsible for the running of the service and is responsible for delegation of management responsibility to the other residents. The second year OB-GYN Resident is formally assigned to management of the OB-GYN floor and is the responsible person for the management of problems in Labor and Delivery. He/she answers directly to the Chief Resident who is always available for his consultation and the Family Practice Residents work under the second year OB-GYN Resident according to the chain of command which is always followed.
- II. The Ohio State University OB-GYN Residents tell me what an important part of their training occurs while on their rotation at Grant Hospital. They really develop their decision making capabilities and for patient continuity of care, the Grant Hospital teaching staff has one person assigned to the attending for the clinical service each month. The residents preoperatively see the surgical patients, scrub on the cases, and take an active part in the postoperative management under the tutelage of the private attending physician. The second year Resident makes the decisions regarding problems in Labor and Delivery and is directly supervised by a private member of the attending staff.
- III. Formal attending rounds occur three times a week where all patients are presented. The Ohio State University Resident takes an active part in these sessions. In addition, two antepartum obstetric clinics have been established and one gynecologic clinic established. The Ohio State University Residents are responsible for the management of the patients in these clinics and directly supervising Family Practice Residents. Each clinic is held under the direct supervision of an on-sight member of the Grant Hospital teaching faculty (Dr. John Russ supervises the gynecologic clinic, Dr. Anthony Ruppertsberg supervises the obstetric clinic, and Dr. Roberto Villalon supervises the ECCO clinic).
- IV. Student rotations from Ohio State University have become an important part of the Grant program. We have established a nine member teaching faculty, we

have carefully delineated guidelines for the students and run a well-organized Core Curriculum Lecture Series for the students. Dr. Albert Hart is the full time Curriculum Coordinator and sees to it that the students cover certain topics and utilize the vast self-instruction modules which have been set up for their use. Dr. Jack Lomano is the Coordinator of Inpatient Obstetrics and is the liaison for any student problems that might occur on the obstetric unit.

In summary, the Grant Hospital phase of the Ohio State University OB-GYN program has been undertaken by Dr. Zuspan and the Grant Hospital teaching faculty as a permanent arrangement to accomplish increased surgical expertise by the OB-GYN Residents, increased problem recognition and decision making capabilities, an increased sophistication on the Family Practice Service along with better patient care. The OB-GYN Residents have responsibilities at Grant Hospital seven days a week, 24 hours a day and at all times are backed up by a member of the teaching faculty. They formally participate in the didactic sessions and keep close documentation of their surgical cases and obstetric cases while on rotation at Grant Hospital. These are reviewed on a monthly basis by the teaching faculty and when necessary inequities in caseload are managed through the Ohio State University Chief Resident. The concept of graduated responsibility, as proposed by the Council on Resident Education, Obstetrics and Gynecology is closely adhered to while at Grant Hospital.

COTH Administrative Board
Questionnaire on Competition

1. Consumer Choice Principles

a) Should employers be mandated to offer their employees a choice among health benefit plans?

Yes 6 No 1 Undecided 1

b) Should employers be mandated to contribute a fixed dollar amount to all employees for health plan coverage regardless of an employee's selection of plan?

Yes 5 No 2 Undecided 1

c) Should a limit be placed on the tax-free status employees are permitted for the premium contribution made by the employer?

Yes 4 No 3 Undecided 1

2. Impact of Consumer Choice Principles

a) Do you believe implementation of the consumer choice principles described in question 1 would lead to price competition among hospitals?

Yes 3 No 3 Undecided 2

b) Would implementation of the consumer choice principles result in a faster or slower rate of increase in health care expenditures than would otherwise occur?

Faster 1 Slower 2 No Difference 5

c) Do you believe implementation of the consumer choice principles accompanied by discontinuation of health planning, PSROs, cost-based reimbursement, and other regulatory programs would accelerate price competition among hospitals faster than implementation of consumer choice principles alone?

Yes 7 No 1 No Difference _____

3. Should employers be mandated to provide catastrophic insurance as a part of any health plan offered to their employees?

Yes 6 No 1 Undecided 1

4. Congress is likely to be considering a voucher system for Medicare beneficiaries. Would you:

2 support a mandatory Medicare voucher system

3 support a voluntary Medicare voucher system

3 not support a Medicare voucher system

5. Separate Fund for Medical Education

- a) Could you support legislation that would result in price competition among hospitals if it did not include provisions for separate funding for costs associated with medical education in teaching hospitals?

Yes 1 No 7

- b) Assuming the size of a separate fund was the same regardless of how it was distributed to hospitals, would you favor allocating the fund based on:

3 a single, national rate per resident

5 a cost-finding formula do not support concept 1

- c) If a separate fund is established, should medical schools be eligible to receive payments?

Yes 4 No 4

6. As a means to contain health care expenditures, which of the following two basic approaches would you support?

3 Legislation that would lead to price competition among hospitals

4 State rate review Undecided 1

7. Assuming federal health spending would be the same under each of the following budget approaches, which one would you prefer?

2 A variety of budget cuts similar to the approach taken by the budget reconciliation bill this year

3 A mandatory voucher system for Medicare beneficiaries

3 Caps on the Medicare and Medicaid programs with exemptions for states with rate review programs

3 Other, please specify, _____

8. Competition in Your Environment

- a) Who do you believe provides the greatest competition to your hospital in your current environment for routine medical services? (Please be as specific as possible).

SEE TALLY OF THIS REPOSE ON PAGE 32

- b) Who do you believe provides the greatest competition to your hospital in your environment for specialty/tertiary services?

c) If price competition became a more important factor, who would provide the greatest competition for routine hospital services?

d) If price competition became a more important factor, who could provide the greatest competition for specialty/tertiary services?

9. Does your hospital have any contracts to furnish services to large scale health benefits purchasers (e.g., HMOs, unions, corporations)?

Yes 3 No 5

If yes,

a) What is the basis for determining payments under the contract?

1 posted charges

_____ discount on charges

1 fixed, all-inclusive per diem

1 cost based formula

1 other, please specify _____

b) What clinical services are covered by the contract?

2 all inpatient services

1 specific inpatient services only, please specify _____

c) Must the hospital (or its medical staff) obtain the referring physician's approval for specific diagnostic/treatment services provided during the course of hospitalization?

Yes 3 No _____

10. Is there a consumer or business coalition in your community that currently urges patients to use low cost community rather than high cost teaching hospitals?

Yes _____ No .8

11. Has your hospital been reorganized or expanded in the last two years to create separate or subsidiary entities (e.g., clinical labs, outpatient services, foundations)?

Yes 1 No 6

If yes,

a) What are the entities? (please specify) _____

b) Are any of these for-profit?

Yes 1 No _____

c) Were they created primarily to:

_____ maximize reimbursement

1 increase non-patient revenue

1 improve management

_____ improve market share

_____ other, please specify _____

Name _____

Please return by October 16 to:

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

Responses to 8. Competition in Your Environment:

- Dennis Barry:
- a) Other community hospitals, especially the 100 bed proprietary hospitals.
 - b) Major medical centers.
 - c) The larger not-for-profit hospital - the for-profit cannot compete on a price basis.
 - d) Major medical centers.
- James Bartlett, MD:
- a) Private fee-for-service MDs.
 - b) Other communities and regions.
 - c) Same.
 - d) Same.
- Spencer Foreman, MD:
- a) Small, suburban community hospitals.
 - b) Large, university hospitals.
 - c) Same.
 - d) 400-500 bed community hospitals.
- Robert Frank:
- a) Too many in area hospital beds.
 - b) Other university hospitals.
 - c) General community (non-teaching) hospitals, suburban hospitals.
 - d) New specialty hospitals.
- Earl Frederick:
- a) Developing pediatric services in suburban hospitals (Lutheran General, Evanston Hospital, etc).
 - b) University of Chicago.
 - c) Same hospitals.
 - d) University of Chicago, Illinois Masonic.
- Stuart Marylander:
- a) All non-teaching hospitals.
 - b) Most of above plus university owned hospitals.
 - c) 8a.
 - d) 8b.
- Robert Match, MD:
- a) Numerous smaller community hospitals and proprietary hospitals within a 10 mile radius.
 - b) Two hospitals (North Shore and St. Francis) within about five miles and major teaching centers in New York City.
 - c) Proprietary hospitals.
 - d) Community hospitals with selective tertiary programs.
- John Sheehan:
- a) -
 - b) -
 - c) Community hospitals and private clinics.
 - d) Community hospitals which would expand their capabilities if profitable and health planning would not interfere.



CEDARS-SINAI MEDICAL CENTER

(213) 855-5711

September 23, 1981

Richard Knapp, Ph.D.
 Department of Teaching Hospitals
 Association of American Medical Colleges
 1 Dupont Circle, NW
 Washington, DC 20036

Dear Dick:

This letter is written in follow-up to our discussions concerning the need to formulate a policy on competition-consumer choice (or marketplace forces as it is also called) to recommend to the Executive Council of the AAMC at the January meeting.

I have attempted to set out the issues as I see them without coming to a definitive conclusion (because I do not know yet what that conclusion should be), and have included two sets of material prepared by the California Hospital Association as a part of its study of the subject. The first contains the "principles" which I believe you have seen before and the second contains a series of questions CHA will try to answer as a part of the development of its position and strategy. I thought you might find them germane to our effort.

I start from the perspective that the only way the amount spent on health care can effectively be reduced is by reducing the amount of health care being delivered, in effect, rationing health care.

Because the decision to ration health care is a societal issue, it should be made by those directly accountable to the members of society, namely, the legislators. However, because of the political consequences of such decision, the legislators will not face this issue forthrightly and, instead, have attempted to make the provider the "fall guy" by blaming the provider for the "high" cost of health care and endeavoring to find solutions that will force the provider to also be the rationer of care. More recently, there have been some proposed attempts to bring the consumer into a similar position - as a part of the "marketplace forces" concept.

I believe this effort of the legislators to shift this rationing decision-making to the provider must be resisted with all our efforts or it will inappropriately bring the wrath of the consumer down upon us. Instead, I believe we must hold the legislators "feet to the fire" in a fashion that the public can hold them responsible for the real results of their decision-making.

The legislators, in their effort to avoid directly deciding who should receive how much health care (which is in contrast to the model found in England), appear at this time to have three approaches available to them: (1) rate regulation; (2) consumer at risk; (3) provider at risk; and, an obvious fourth, a combination of two or all three of these alternatives.

Rate regulation by itself has fallen into disfavor for several reasons:

- (a) If the Public Utility concept is followed - that of providing the reasonable financial requirements of the provider in carrying out the utility function - then insufficient reductions in expenditures are accomplished.
- (b) If significant caps on reimbursement are employed, deterioration may well occur in the accomplishment of the mission, with the resultant unhappiness of both the consumer and the provider, with the consumer usually initially blaming the provider rather than the real culprit, the legislators, until it finally becomes evident that "Government" should be the focus of both the provider and consumer.
- (c) The bureaucratic effort required to intelligently administer this approach appears to exceed the human and system capabilities available to avoid either massive abuses or unacceptable inequities, and this condition makes those legislators who become involved in this area of government very unhappy with the rate setting approach.

Competition and its companion "consumer choice", together referred to as "marketplace forces", are currently the fashionable approaches to placing the consumer and provider "at risk" in reducing health care costs. These approaches appear to do this with less regulations and bureaucratic involvement and have "judgmental" appeal as being the "American" way to do things.

Notwithstanding the defects in endeavoring to apply marketplace forces to health care that have been described by economists and others elsewhere, one must examine the potential impact of this approach on the teaching hospital:

- The structure inherent in this approach requires the individual consumer to buy into a "plan" in which the "plan" makes the decision as to the environment in which specific incidents of care are to be rendered.
- A significant amount of care rendered in tertiary facilities is care that can be rendered in lower cost settings, per the Bently study, and the likelihood is great that such cases would be directed by a "plan" into lower cost facilities, thereby driving up the cost of care in the tertiary facilities to an even higher level.
- As non-teaching hospitals are gaining the capability of dealing with a large portion of the types of cases previously reserved for the teaching hospital, the patient base left for the teaching hospital becomes composed of an even more economically unsound group of patients to care for or to use in the education of students, nousestaff and practicing physicians.

For a strategic plan to exist within the current environment, many hospitals, both teaching and non-teaching, are "diversifying", i.e., forming different corporate structures and maximizing "profitable" activities, both health care-related and unrelated, for the purposes of generating additional income to support their hospital activities.

As this occurs, we see greater emphasis on non-teaching hospitals developing the capability to "pick off" high revenue and profitable activities of the teaching hospital, which further creates a competitive mode between the voluntary attending staff and the hospital, contributing to an environment that accentuates town-gown conflicts.

As marketing of profitable health care activities increases, we may see a somewhat unexpected outcome of competition, but nonetheless a natural outgrowth, namely, that increased competition may promote greater expenditures on health care, even if at a much lower cost as a result of sophisticated marketing techniques.

The issue then remains how can the teaching hospital remain viable in an environment that wishes to reduce the amount being spent on health care and, in doing so, endeavors to focus most on a high cost teaching hospital.

The objective, therefore, is to describe a system that will preserve the financial viability of the teaching hospital and, in doing so, to identify a set of principles which the Association could aggressively advocate either in a prospective rate-setting environment or a marketplace environment or, as most likely will ultimately evolve, some combination of the two.

Richard Knapp, Ph.D.

- 4 -

September 23, 1981

In this regard, I thought the materials from the CHA would be helpful in developing our own principles; with respect to its "Marketplace Task Force Issue Paper", considerable refinement has been undertaken and I will share this with you as soon as it becomes available.

Many thanks.

Sincerely,



Stuart J. Marylander
President

SJM/dk

Enclosures

Beth Israel Hospital³⁷

330 Brookline Avenue
Boston, MA 02215

A major teaching hospital of
Harvard Medical School

Mitchell T. Rabkin, MD
President

(617) 735-2000

A constituent agency of
Combined Jewish Philanthropies

5 October 1981

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

Dear Richard:

I am enclosing a copy of the program at Rush-Presbyterian-St. Luke's Medical Center in Chicago, which I think you got me signed up for a few weeks ago. I am glad I went, particularly for the opportunity of hearing Alain Enthoven and having a chance to chat both with him and with Bob Derzon. I came away with the feeling that Dr. Cooper's passions on the subject of Alain Enthoven may be a little overdrawn. Enthoven is to be commended for the important contribution of getting on the top of the table a general recognition of the primacy of economic incentives in the health care system. As a professor, he concludes that corrections of the system can therefore be attempted by tilting the economic incentives, but he does not have the certainty and fervor of its ready accomplishment that some others do. It is therefore important to make the distinction between Enthoven's position and that, for example, of Stockman or Gephardt, who are quite convinced the whole thing will work from A - Z.

Both Enthoven and Derzon emphasized to me that no one else will be looking out for the teaching hospitals, and therefore the COTH had better do so. Both seem to feel that a proposal along the lines of one voiced by Ginny Weldon was indeed constructive and a reasonable base from which we could operate. The practical politics of the matter, however, suggests that we have a great deal of homework to do in terms of establishing the magnitude of that teaching cost component on a basis much more sound than that which has allowed us to voice the figure Ginny spoke of. The reasons are twofold -- if we speak out for education, we had better include costs of other kinds of education in order to enlist nursing and other interests in the cause, and in order to open with a dollar figure that both realistically reflects the actual costs to the best extent we possibly can and that is inclusive enough to represent a solid opening figure in what will clearly be a series of negotiations that will bring that

figure down. Since the problem of teaching costs must be resolved, and since there may be no better way to do it than tying it in (in the case of graduate medical education, at least) to the number and location of house officers, no one will be as thoughtfully inclusive in totting up the costs of such education and in defending them as we. The ball-park figures we have used thus far are too chancy to rely upon, and we should therefore work up those costs as best we can.

We can then begin to contend with the problems that individual members of the constituency may run into with a straightforward, generalized formula. Perhaps we need an added factor, a multiplier of some sort related to intensity of teaching, that is, to the ratio of in-patient house officers to total beds. What I mean is that a thousand bed hospital with five house officers will likely run a per diem cost (after the direct and indirect cost of the house officers are removed) lower than might a comparable hospital with twenty-five times as many house officers, simply by virtue of the impact of teaching activities in ways in which, perhaps, even our best calculations will not be able to register. At any rate, we have got to get our hands on this problem because no one else will.

Furthermore, with a proposal for the methodology to deal with teaching costs, we can then come out with a position on the concepts of "consumer choice" and "competition" as well as subsequent specific commentary on individual pieces of legislation.

I would propose the following outline for our initial position on the concept, not on any specific piece of legislation.

1. Recognition of the primacy of economic incentives. Enthoven is to be complimented for the clarity of his presentation on the primacy of economic incentives in shaping aspects of the delivery, and quantity and costs of health care. He recognizes that the market is not a pure economic market, and we agree. Enthoven's concepts do not extend to the view that health care may be seen entirely as an economic good, a concept with which we disagree because of our adherence to the individual responsibilities of the physician towards the patient in acute illness and the concept of the proper role of teaching hospitals in relation to the societies in which they exist.
2. The nature of the "market." Central to the concept of consumer choice is the arrangement to induce the consumer to exercise prudent choice in the purchase of health care. While that may be possible at the time of selection

of health care payment plans, it is not necessarily successful at the time of acute illness, where voluntary choice may be influenced by a variety of considerations that lead to less prudent behaviour on the part of the consumer.

3. The aggregation of providers into more economical units. A second major weakness in the concept of implementation is that of the assumption that providers will be forced by economic pressures to form more economic units. It is not apparent how the vast bulk of present day doctor:patient relationships can be thus modified or how the modes of practice of present day physicians can be so changed. Inherent in these ideas is the limitation of the patient's choice of provider, which may prove both politically and practically unacceptable to a significant segment of the population.
4. The poor. It is not yet apparent how the poor will be cared for. The very poor, who will receive government support, may represent less of a problem than the near poor who will likely opt for lower cost insurance programs and thereby generate significant amounts of bad debt when they require hospital service. Traditionally teaching hospitals service large numbers of the poor. While they may compete with community hospitals under ordinary circumstances, the added burden of care for the poor may render them non-competitive. This problem has not yet been resolved to our satisfaction.
5. Adverse risk selection. The option to select one's plan annually, or even every two years, encourages the segregation of patients into good risk and bad. For the good risk patients, a largely healthy cohort, the costs are low and the limited benefits from the low cost plans of little concern. Patients with higher risks (or the good risk patient contemplating major elective surgery) will aggregate into a higher risk group, with increasing premium costs for the increasing benefits required. Disadvantaged will be the chronically ill and the elderly, both of whom are at higher risk but not so readily able to pay the out-of-pocket costs which will arise because their requirements, as a general rule, will continue to outpace the rising benefits required by this adverse risk group.
6. The costs of teaching. While COH proposes to offer a methodology whereby the costs of teaching will be reasonably reimbursed, it is imperative that this methodology have a continuity both in its nature and relative amount so

that the training enterprise for physicians, nurses and other health care professionals in-hospital is not weakened by marked annual variation in federal support from year to year.

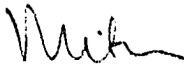
7. Deregulation. It seems axiomatic that, while some regulations may be abandoned, the extent of new regulations required to carry out these programs will be as great or greater than those seen in the past.
8. The bottom line. The question is not yet resolved concerning the true impact of the underlying intent of such legislation. That is, the major aim of the Federal Government with these "consumer choice" and "competition" proposals is to decrease its outlay of dollars for the Medicare program and for the Medicaid program. If successful, will the decline in federal support be accompanied by an increase in cost sharing by the private sector, by better purchasing through greater efficiency engendered in the providers of health care, by a diminution in "unnecessary" expenses, or by a diminution in the amount of genuinely needed care that the system is able to provide. In short, what are the realistic projections of effort and expense, juxtaposed with need, as these systems are developed and implemented?
9. Where do we go from here? We have felt vulnerable, when proponents of specific legislation have reacted to our expressions of hesitancy with the question, what do you have to propose in place of my legislation? But they are in as much a dilemma as we, in terms of practical first steps toward implementation. And that is really the question that has to be answered. We should not feel obliged to propose a "whole" system because one of our specific criticisms is that one can hardly tell with accuracy the impacts of the first few steps and therefore it is unrealistic to go beyond them, say in a broad conceptual fashion. What first steps should we recommend? Since we are dealing not only with ideas whose validity needs testing but also with action steps the implementation of which is politically determined, the first steps (it seems to me) are to examine whether a limit can be placed on the non-taxability of the employer's health care benefit. Should this be the same in all regions of the country? More important, perhaps, will this limit then lead to demands by labor for additional benefits in other arenas, in order to retrieve the benefits lost? Is management willing to move in this direction? (From the comments of the Washington Business Group on

Health, this does not seem that likely.) We should also examine in some detail the proposed requirement that several competing plans be offered by each employer, for there are some objections in certain circumstances to that proposal. Other first steps might begin to test whether there is any tendency for providers to aggregate into "more economical units" under incentives thought to push in that direction.

Dick, I think we have got to move forward with some specific proposal from COTH so that the membership can bat it about, and the medical schools can examine it in the light of their problems as well. It will not be long before one of us is down there testifying and we will look like nitwits if we cannot come across in a positive fashion, one which demonstrates our concern and puts across the important points which must be made by us, for no one else will do so.

I am interested in your thoughts in response to this letter -- clearly we should talk further before the meeting. I am sending a copy of this to Stu Marylander, and we should get him in on the discussion as well, particularly since I do not think he will be with us that Sunday evening. All good wishes.

Sincerely,



Mitchell T. Rabkin, M.D.
President

bjw

cc: Mr. Stuart Marylander

Statement of the
Association of American Medical Colleges

Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Oral Statement

October 2, 1981

I am Earl Frederick, President of The Children's Memorial Hospital in Chicago, Illinois. You are now approaching the end of a long hearing on a complicated subject. From what I've heard this morning and from reports I've received about previous days, much of the testimony presented has emphasized philosophical positions and policy concepts. I have submitted a written statement for the hearing record which addresses the two major concerns teaching hospitals have with price competition: namely adequate coverage for the poor and financing the societal contributions provided by teaching hospitals. Rather than re-iterate those points this morning, I'd like to take a few minutes to describe price competition from the perspective of one tertiary care and teaching hospital. I hope this will help you understand my concerns and reservations.

Children's Memorial Hospital, with 265 beds, is located on the rear north side of downtown Chicago. We will begin our 101st year of operation on our present site and we serve as the pediatric department of Northeastern University School of Medicine. We are a referral center for infants and children with major medical problems because the closest children's hospitals are in Detroit, St. Louis, Milwaukee, and Minneapolis. We are also a primary care site for many inner city Chicago residents. Sixty-five percent of our outpatient visits come from a five mile radius of the hospital. Last year, 96 residents and fellows received training in our hospital. Their stipends and benefits amounted to \$2,100,000, or 3.4 percent of the hospi-

tal's operating budget. To help advance our knowledge of children's diseases and developmental problems, hospital staff participated in 200 funded research projects with total expenditures of \$2,300,000. Last year, 11,112 children were admitted to our hospital and 133,954 outpatient visits were provided. In summary, I believe we provide valuable patient services to today's children both close at hand and from afar and important educational and research investments for the future.

It is generally agreed that teaching hospitals will be able to compete quite well for the high cost, tertiary care and that will probably be the case for our hospital; however, as my staff and I consider a price competitive marketplace for hospital services, we envision Children's Memorial trying to compete with four major disadvantages. First, we are located in an area of the city that is not particularly attractive to well-insured suburban patients to come to our setting for care. Barring a total relocation of the hospital we must attract paying patients to an area they often avoid, particularly for nontertiary care.

Secondly, because of our urban location, the hospital provided \$2,300,200 of charity care last year and wrote off \$6.8 million in bad debts. These services are subsidized by paying patients, donations, and lowered hospital income. If we have to compete on the basis of price and still have to provide care for patients who cannot pay, we will be competing at a substantial disadvantage to other hospitals with fewer charity patients.

Third, the State of Illinois is implementing a major Medicaid cutback. Last year, 27 percent of my inpatients and 38 percent of my outpatients were supported by Medicaid. The present Illinois cutback will reduce hospital revenues by \$4 million in our current fiscal year -- a reduction that will increase the need for charity care services. I'm concerned that price competition will not alleviate this situation.

Fourth, parents always envision creating a healthy, mature newborn. Unfortunately, this is often not the case. Last year, Children's Memorial provided 8,000 patient days of care for infants who were born prematurely and referred to our hospital for care as our hospital does not provide obstetrical services. Most survived. Overall, 40.8 percent of our inpatients are 18 months old or less. These children often consume massive amounts of medical care, and a young family is saved from financial ruin if it has comprehensive health insurance. The health problems of the newborn strike without warning and without waiting for an open enrollment period. A young family pressed by financial expenses in an inflationary economy may prefer a basic health insurance plan which results in a tax free rebate. But if they have a seriously ill newborn or infant, the basic plan will require heavy copayments and deductibles that place financial stress on a family undergoing emotional stress. The inadequate coverage will also decrease hospital cash flow and increase charity care.

In short, I understand the economist's point that hospitals respond to the economic incentives before them. I've seen it happen in the past and expect it to continue in the future. But, today's hospitals reflect the economic realities of the past. Some of our hospitals are well situated for a price competitive marketplace; others are not, for they are disadvantaged by location, patient population, and long term educational and technology transfer programs. Therefore, while I find it more exciting to think about the management challenges and rewards of a price competition marketplace, I have deeply felt, genuine concerns about rapidly implementing an untried, theoretical approach which places some patients and hospitals at substantial risk. Thank you.



association of american medical colleges

Statement of the
Association of American Medical Colleges

Subcommittee on Health

Committee on Ways and Means

U.S. House of Representatives

October 2, 1981

I am Earl Frederick, President of the Children's Memorial Hospital of Chicago and member of the Administrative Board of the Association's Council of Teaching Hospitals. Accompanying me is James Bentley, Associate Director of the Association's Department of Teaching Hospitals.

Hospitals in the Association's Council of Teaching Hospitals account for 18% of the admissions and 31% of the outpatient visits provided by all non-federal short term hospitals. These hospitals provide routine medical services for many of our citizens and the most complex, lifesaving, tertiary care services for all of our citizens. They are the primary sites for the patient component of physician training and the major centers for transferring new diagnostic and treatment technologies from the laboratory to the bedside. As a result of these multiple missions, teaching hospital costs are generally higher than non-teaching hospitals. Therefore, proposals which have been developed to stimulate price competition in the health care field merit careful evaluation.

The Association has no special expertise in assessing alternative tax reform proposals. We also are not in a position to evaluate the economic conse-

quences competition will have on the total dollars presently spent on health care in this Nation. The Association does believe, however, that we have an obligation to raise several questions about competition which have to date received inadequate attention in public forums. Hopefully, consideration of these issues will help to avoid unintended consequences of intended worthy objectives.

The Association believes that all of the present "pro-competition" proposals will stimulate price competition among hospitals. In some proposals, the stimulus to price competition would be direct and explicit with existing regulations and cost-based reimbursement programs repealed. With these changes, it is assumed that third party payers would enter into price sensitive arrangements for providing and purchasing medical care services. Other proposals, which seek to stimulate consumer choice in the selection of health insurance, would indirectly but inevitably stimulate price competition among hospitals by providing insurers with a major incentive to enter into price sensitive arrangements for providing and underwriting medical care services.

It is important to remember that there has been no wide-scale experience with these approaches. This is particularly significant because the proponents of price competition among hospitals have not addressed the potential implications of these approaches for certain types of providers, patient populations, and the nation's supply of trained health manpower. If our nation is to retain the strengths of the present system of medical care, the following questions about the possible consequences of competition must be posed and answered:

- Which institutions will most negatively be affected? Are those the ones that should be cutting back or closing their doors?
- What services will be encouraged? Will there be an excess of services that can be aggressively priced and marketed to healthy populations at the expense of services for the seriously ill and underserved populations?
- Who will treat indigent patients in the inner city, rural areas, or other locations if it is "bad business" to provide care in those environments?
- Will all patients, regardless of geographic location and financial status, have reasonable access to an adequate level and scope of services?
- Will sufficient incentives or standards exist to assure quality care when choices are presented in terms of their price?

In other words, although price competition will influence decisions by consumers and groups with purchasing power, there are no assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet reasonable needs of all of its citizens.

For the teaching hospital to be competitive in a price dominated marketplace, two broad issues have to be addressed: funding for charity care patients and funding for the unique societal contributions of teaching hospitals. Adequate funding for patients unable to pay for needed health services is not a need unique to teaching hospitals. While teaching hospitals do provide large amounts of uncompensated care, some neighborhood and community hospitals

also provide large amounts of uncompensated care.

Hospitals utilized by the poor must subsidize the costs of this care with higher charges to their paying patients. If a hospital has few charity patients, the increase in prices to paying patients will be small and the hospital's competitiveness will not be undermined. However, if the hospital cares for a large number of charity patients, the price increase required for paying patients will be large so that paying patients will be discouraged from using the hospital. As the hospital's proportion of charity care increases, the disincentive to paying patients increases. In a price competition marketplace, hospitals caring for the poor will be at a competitive disadvantage.

To permit hospitals to care for patients unable to pay for the services they need, proposals to restructure the medical care system must include full payment for the costs of caring for the poor. This is contrary to recent administration and congressional decisions to decrease the federal financial commitment to the poor, the medically indigent, and the aged. The trend begun in the recent budget reconciliation process must be reversed if all hospitals are to compete even-handedly on a price basis.

The second issue of major concern for teaching hospitals derives from the added costs teaching hospitals incur in meeting their obligations to society as a whole rather than to individual patients. These societal activities include the clinical components of undergraduate and graduate medical and allied health education, technology transfer and dissemination, community-wide tertiary care services with high standby costs, and primary care

ambulatory services in medically underserved areas. Presently, these activities are financed through patient care revenues. Price competition among hospitals raises questions about the future ability of teaching hospitals to finance these responsibilities.

One commonly proposed solution is to identify and separately fund these activities on their own merits. In effect, this approach argues for centralization and regulation of decisions for these activities, but decentralization, through price influenced market mechanisms, of all other decisions relating to patient care services. Efforts to carve out and separately fund unique, socially desirable attributes of teaching hospitals should recognize the potentially negative impacts of this approach:

- Separate funding of graduate medical education may limit the ability of medical schools and teaching hospitals to make local decisions about their residency programs.
- Federal support for graduate medical education may be subject to the budget and appropriations process which could make such a fund vulnerable to any major efforts to cut federal spending.
- The administration of the fund could be extremely complex. How would the necessary funds be collected? How would those responsible for distributing the funds decide which hospitals would get support and what that level of support should be?

As a result of these problems, teaching hospitals have been unable to identify a solution to the problems their societal missions create in a price competi-

tive environment. Nevertheless, a solution must be found.

Each of the issues is described more completely in the Association's publication, "Price Competition in the Health Care Marketplace: Issues for Teaching Hospitals". Copies of that publication have been appended to my statement. In the interest of time, I would request that the publication be included in the hearing record and would welcome the opportunity to address questions you may have.

Thank you.

DESCRIBING THE TEACHING HOSPITAL
 PROGRESS REPORT
 RESPONSE TO COTH BOARD CONCERNS

COTH Board Concern: In the case mix analysis shown on the yellow pages of the Progress Report, are payments for hospital-based physicians treated consistently?

Staff Response: We have review the cost reports for each of the 14 hospitals included in the charge and cost portions of the case mix analysis. In all cases, the cost-to-charge methodology used to estimate costs eliminates compensation for hospital-based physicians. In the charge data, our preliminary finding is that only one hospital submitted a tape which included charges for hospital-based physicians and in that case the physician component was for Medicaid patients only.

COTH Board Concern: Will the inclusion of the detailed case mix information shown on the yellow pages detract from the other descriptive information shown in the given-colored tables?

Staff Response: To eliminate this possibility, we are proposing two separate technical reports--one for diagnosis related groups and one for disease staging. The case mix component of the study report would then be reformulated as discussed below.

COTH Board Concern: If the final report includes the tables presented actual and expected length of stay (or charges or costs) will this change the focus of the case mix chapter from a description of teaching hospitals to an evaluation of anonymous institutions?

Staff Response: The Board's observation is correct. We propose a revised final report chapter as follows:

- a brief description of case mix methodologies
- data collection and analysis procedures used in this study
- DRG findings: most frequent and most expensive cases
- Staging findings: most frequent and most expensive cases
- developing and comparing case mix indices for teaching hospitals
- conclusions

COTH Board Concern: The use of the 25th percentile, median, and 75th percentile focuses too much attention on the statistically "typical" teaching hospital and does not provide enough emphasis on the variability of teaching hospitals.

Staff Response: We will revise the tables to show five values for each variable: the low reported value, 25th percentile, median, 75th percentile, the high reported value.

IMPACT ON TEACHING HOSPITALS
OF THE CHANGE IN
MEDICINE ROUTINE SERVICE COST LIMITS

The Omnibus Reconciliation Act of 1981 included a provision lowering allowable Medicare payments for general routine operating costs from 112% to 108% of the mean for each group of comparison hospitals. The California Hospital Association, using data furnished by the Health Care Financing Administration, has attempted to assess the impact of this change.

Table 1 shows the estimated state by state impact of the 112% limit and the 108% limit on all hospitals. Significantly, under the current 108% limit, almost twenty-five percent of all U.S. hospitals are expected to exceed the limit. Table 2 shows the national payment penalty estimated by CHA based on rural/urban location and bed size category.

Using the CHA estimates, Table 3 lists the COTH members expected to incur a penalty under the current 108% limit. 23.9% of COTH members are expected to be penalized versus 24.9% of all hospitals, and COTH members are expected to incur 24.4% of the total national penalty (Montefiore Hospital in New York excluded). Thus, while COTH members in some areas are heavily penalized (California, Illinois, Massachusetts, Michigan, and Ohio), the national impact is proportional to COTH member's share of the market. While the estimate for individual hospitals may be in error, the overall pattern is probably close to the impact of the limit on COTH members.

Projected Section 223 Penalties*

	Number of Hospitals	112 Percent Limits				108 Percent Limits			
		No. Over	% Over	Total Penalty	Penalty per \$100 of Cost	No. Over	% Over	Total Penalty	Penalty per \$100 of Cost
Alabama	121	16	13.2%	\$ 771,140	\$.45	18	14.9%	\$ 1,700,907	\$1.01
Alaska	15	8	53.3	280,094	5.52	8	53.3	355,289	7.10
Arizona	55	15	27.3	1,318,704	1.11	20	36.4	2,296,492	1.95
Arkansas	91	2	2.2	50,679	.05	8	8.8	171,486	.16
California	484	197	40.7	49,121,967	4.37	244	50.4	67,763,323	6.08
Colorado	81	25	30.9	1,265,472	1.12	34	42.0	1,873,116	1.67
Connecticut	35	2	5.7	102,373	.06	5	14.3	379,628	.23
D.C.	12	6	50.0	3,460,379	6.09	7	58.3	4,318,844	7.66
Delaware	7	--	--	--	--	1	14.3	7,983	.03
Florida	202	38	18.8	11,280,623	1.84	50	24.8	16,841,723	2.77
Georgia	155	25	16.1	2,482,121	1.43	27	17.4	3,429,633	1.99
Hawaii	20	4	20.0	258,641	.96	5	25.0	280,793	1.05
Idaho	45	15	33.3	532,911	1.83	18	40.0	923,983	3.19
Illinois	234	80	34.2	31,980,928	4.40	107	45.7	43,551,553	6.04
Indiana	118	12	10.2	1,554,268	.60	17	14.4	2,521,502	.99
Iowa	129	27	20.9	2,253,941	1.36	34	26.4	3,812,402	2.31
Kansas	137	35	25.5	1,730,791	1.38	44	32.1	2,566,804	2.06
Kentucky	102	1	1.0	16,344	.01	4	3.9	111,895	.08
Louisiana	128	22	17.2	1,871,431	1.13	31	24.2	2,821,685	1.72
Maine	49	11	22.4	1,048,036	1.73	14	28.6	1,637,429	2.72
Maryland	51	6	11.8	896,536	.48	7	13.7	1,761,085	.95
Massachusetts	121	40	33.1	9,812,909	2.23	53	43.8	14,939,664	3.41
Michigan	210	36	17.1	10,694,575	1.97	55	26.2	16,413,829	3.04
Minnesota	169	34	20.1	7,564,671	3.30	45	26.6	10,481,814	4.60
Mississippi	113	4	3.5	68,718	.06	4	3.5	107,947	.09
Missouri	134	17	12.7	2,452,862	.90	27	20.1	3,794,945	1.40
Montana	57	27	47.4	1,765,663	5.67	30	52.6	2,220,303	7.18
Nebraska	97	18	18.6	1,468,454	1.64	29	29.9	2,452,917	2.75
Nevada	17	9	52.9	914,839	4.54	10	58.8	1,167,512	5.85
New Hampshire	27	5	18.5	249,087	.63	8	29.6	407,111	1.04
New Jersey	97	2	2.1	333,105	.08	4	4.1	909,177	.22
New Mexico	35	7	20.0	341,777	1.03	10	28.6	596,448	1.80
New York	270	21	7.8	27,608,371	2.17	28	10.4	32,695,233	2.59
North Carolina	134	6	4.5	376,246	.18	10	7.5	523,995	.25
North Dakota	52	10	19.2	1,335,831	3.23	16	30.8	2,034,647	4.96
Ohio	197	30	15.2	12,767,679	2.07	45	22.8	18,159,482	2.96
Oklahoma	116	25	21.6	2,719,605	2.12	30	25.9	3,971,928	3.12
Oregon	73	17	23.3	1,228,231	1.07	29	39.7	2,869,162	2.51
Pennsylvania	232	8	3.4	1,947,677	.27	15	6.5	3,675,132	.51
Rhode Island	14	2	14.3	407,408	.67	2	14.3	759,999	1.25
South Carolina	68	4	5.9	147,941	.17	4	5.9	182,713	.21
South Dakota	56	18	32.1	946,248	2.76	23	41.1	1,293,936	3.80
Tennessee	145	3	2.1	175,134	.08	7	4.8	354,404	.16
Texas	460	60	13.0	6,219,504	1.12	78	17.0	8,117,459	1.48
Utah	35	14	40.0	426,773	1.40	15	42.9	508,158	1.68
Vermont	16	3	18.8	87,437	.34	7	43.8	226,319	.88
Virginia	101	4	4.0	366,543	.18	7	6.9	894,827	.44
West Virginia	65	3	4.6	231,791	.22	6	9.2	380,366	.36
Washington	103	32	31.1	1,577,906	1.09	35	34.0	2,371,657	1.65
Wisconsin	138	56	40.6	12,060,944	4.79	64	46.4	15,911,931	6.36
Wyoming	28	8	28.6	420,611	3.22	10	35.7	524,610	4.06
U.S.	5,651	1,070	18.9	\$218,995,917	1.88	1,409	24.9	\$308,075,181	2.67

*Projections based on HCFA data tape used to calculate 112 percent schedule of limits.

CHA Estimates of Section 223 Penalties

Bed Size	Percentage of Hospitals Penalized	Penalty per \$100 of Routine Cost
Urban: 0-99	24.3%	\$2.70
100-404	24.5	2.09
405-684	26.6	2.72
685 plus	26.0	4.91
Rural: 0-99	24.1	2.15
100-169	27.7	2.54
170 plus	28.9	3.01
TOTAL	24.9%	\$2.67

Source: CHA Insight (September 28, 1981)

CHA Estimate of 223 Impact
COTH Members Only

<u>State/Hospital</u>	<u>Estimated 223 Loss</u>
Alabama	
University of Alabama Hospitals & Clinics	\$ 371,562
Arizona	
Tucson Medical Center Hospital	322,409
California	
Mount Zion Hospital and Medical Center	1,494,225
Presbyterian Hospital-Pacific Medical Center	31,309
Childrens Hospital of Los Angeles	17,801
Riverside General Hospital-Univ. Medical Center	292,047
Orange County Medical Center	501,749
Los Angeles County/Univ. Medical Center	1,290,493
Stanford University Medical Center	342,863
University of California Hosps & Clinics	648,849
Hospital of the Good Samaritan-Medical Center	843,694
Martin Luther King Jr. General Hospital	140,921
Cedars-Sinai Medical Center	8,375,582
Colorado	
Presbyterian Medical Center	31,093
District of Columbia	
Howard University Hospital	1,423,044
Georgetown Hospital	180,818
Childrens Hospital National Medical Center	23,557
Illinois	
Evanston Hospital	336,003
Mount Sinai Hospital	204,807
St. Johns Hospital	49,203
Michael Reese Hospital and Medical Center	4,545,390
University of Chicago Hospital and Clinics	3,112,116
Rush-Presbyterian-St. Lukes Hospital	3,857,248
Cook County Hospital	2,016,510
Illinois Masonic Hospital	1,486,465
Memorial Hospital	441,318
University of Illinois Hospital	136,170
Little Company of Mary Hospital	1,271,170
Lutheran General Hospital	3,315,347
Northwestern Memorial Hospital	1,225,509
Childrens Memorial Hospital	21,095
Iowa	
University Hospital/Iowa City	939,135
Maryland	
University Hospital/Baltimore	389,149

<u>State/Hospital</u>	<u>Estimated 223 Loss</u>
Massachusetts	
Boston Hospital for Women	89,841
New England Medical Center Hospital	65,604
Faulkner Hospital	90,860
Childrens Hospital Medical Center	21,311
Sidney Farber Cancer Center	450,703
University of Massachusetts Medical Center	1,451,232
Massachusetts Eye & Ear Infirmary	169,289
Beth Israel Hospital	726,970
Michigan	
Blodgett Memorial Hospital	161,530
University Hospital/Ann Arbor	1,995,041
Henry Ford Hospital	335,106
Harper Hospital	1,572,235
Detroit General Hospital-Receiving Branch	1,042,107
Grace Hospital-Northwestern Unit	782,414
St. Joseph Mercy Hospital	725,613
Michigan Childrens Hospital	83
Minnesota	
Hennepin County General Hospital	1,120,261
University of Minnesota Mayo Memorial Med. Center	1,215,386
St. Paul-Ramsey Hospital	249,733
Nebraska	
Creighton Memorial St. Joseph Hospital	511,619
New York	
Montefiore Hospital	19,519,948
Rochester General Hospital	159,858
Memorial Hospital-Cancer and Allied Disease	2,317,838
Harlem Hospital Center	330,235
Hospital for Special Surgery	109,215
Ohio	
Cincinnati General Hospital	583,272
Childrens Hospital	174
Akron City Hospital	228,607
St. Lukes Hospital	821,842
Medical College of Ohio at Toledo	29,994
Good Samaritan Hospital	305,527
Metropolitan General Hospital	188,794
Mt. Sinai Hospital	3,007,695
Charles F. Kettering Memorial Hospital	406,353
University Hospital/Cleveland	3,247,723
Emanuel Hospital	181,573
Medical Center Hospital	4,832
Pennsylvania	
Conemaugh Valley Memorial Hospital	146,042
Albert Einstein Medical Center	1,158,391

<u>State/Hospital</u>	<u>Estimated 223 Loss</u>
Rhode Island Roger Williams General Hospital	433,368
Texas Hermann Hospital M.D. Anderson Hospital & Tumor Institution	26,902 2,538,977
Virginia Virginia Hospital Medical College	441,199
Washington University of Washington Hospital	230,401
Wisconsin St. Francis Hospital	360,668