



association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

April 12-13, 1982
Washington Hilton Hotel

MONDAY, April 12, 1982

6:30pm	COTH ADMINISTRATIVE BOARD Meeting	Military Room
7:30pm	COTH Reception and Dinner	Hemisphere Room

TUESDAY, April 13, 1982

9:00am	COTH ADMINISTRATIVE BOARD Meeting	Jackson Room
12:30pm	Joint Administrative Boards Luncheon	Map Room
1:30pm	Executive Council Business Meeting	Conservatory Romm

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

April 13, 1982
Washington Hilton Hotel
Jackson Room
9:00-12:30pm

A G E N D A

- | | | |
|-------|---|---|
| I. | Call to Order | |
| II. | Consideration of Minutes | Page 1 |
| III. | Membership Applications | Page 13 |
| IV. | Upcoming Meetings | |
| | A. Location of 1984 COTH SPRING MEETING | Page 25 |
| | B. COTH 1982 Annual Meeting Program | Page 26 |
| V. | Teaching Hospital Study
(with accompanying draft paper) | Mr. Levitan
Page 27 |
| VI. | Hospital Payments and Patient Mix | Page 30 |
| VII. | AHA Discussion Papers | |
| | A. The Situation Confronting the
Hospital Field in 1982 | Page 32 |
| | B. Developing Principles or Guidelines
for Effective Hospital Payment Systems | Page 39 |
| VIII. | Report of the Ad Hoc Committee on Health
Planning | To be distributed |
| IX. | Health Care for the Aged: Challenges and
Accomplishments of the Medicare Program | Executive Council
Agenda - page 33 |
| X. | Other Discussion Items on Executive Council
Agenda as Time Allows | Executive Council
Agenda - pp 18, 23,
29 and 78 |
| XI. | Other Business | |
| XII. | Adjournment | |

Association of American Medical Colleges
COTH Administrative Board Meeting
January 21, 1982

PRESENT

Mark S. Levitan, Chairman-Elect
Stuart J. Marylander, Immediate Past Chairman
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Earl J. Frederick
Irwin Goldberg
Sheldon S. King
John A. Reinertsen
William T. Robinson, AHA Representative

ABSENT

James W. Bartlett, Secretary
Fred J. Cowell
Robert E. Frank
Mitchell T. Rabkin, MD, Chairman
Haynes Rice
John V. Sheehan

GUESTS

Thomas K. Oliver, Jr., MD

STAFF

James D. Bentley, PhD
Peter W. Butler
John A. D. Cooper, MD
Melinda Hatton
Joseph C. Isaacs
Paul Jolly, PhD
Richard M. Knapp, PhD
Melissa H. Wubbold

I. Call to Order

Mr. Levitan chaired the meeting in Dr. Rabkin's absence and called it to order at 9:00am in the Grant Room of the Washington Hilton Hotel. Before moving directly to the Agenda, Mr. Levitan welcomed the three new members of the Board: Jephtha W. Dalston, PhD; Irwin Goldberg and Sheldon S. King. He asked each of them if they would send a copy of their curriculum vitae to Dr. Knapp.

He indicated that he had discussed with Drs. Rabkin and Knapp the fact that the Board Agenda is generally staff generated. He asked all Board members to be aware that if they have an item they wish placed on the Agenda, they should give Dr. Rabkin, Dr. Knapp or himself a call and efforts would be made to accommodate the request.

Mr. Levitan stated that Dr. Rabkin had asked him to announce committee appointments: J. Robert Buchanan, MD, President, Michael Reese Hospital and Medical Center in Chicago will serve as a member of the Flexner Award Committee. By tradition, the COTH Nominating Committee is chaired by the Immediate Past Chairman and includes the current Chairman and an at-large member. Thus, Stuart Marylander will chair the Committee, Dr. Rabkin will serve and he has appointed Jim Ensign as the at-large member. Jim is the President of Creighton Regional Health Care Corporation in Omaha.

Mr. Levitan then announced that Peter Bulter has decided to leave the AAMC and join the staff of the Rush Presbyterian-St. Luke's Medical Center in Chicago. Mr. Levitan indicated that he knows Dick Knapp and his colleagues view this as a significant loss to the Department, but also is aware that his colleagues wish him well in his new endeavor. Mr. Levitan stated that he is well aware of Peter's fine efforts, particularly as he had become very well acquainted with him as the study of teaching hospitals has progressed. It was agreed that the minutes should express the Board's appreciation for the fine work that Peter Butler has done over the past three years in the Department of Teaching Hospitals.

At this point, Dr. Bentley distributed to the Board members the recently printed publication entitled, "The DRG Case Mix of a Sample of Teaching Hospitals: A Technical Report." He indicated that two additional publications would be forthcoming from the study of teaching hospitals. The first would be a report similar to the DRG document, but based on the disease staging methodology, and the second would be a final report of the project completed sometime in May.

Mr. Levitan called on Dr. Foreman who chairs the COTH SPRING MEETING Planning Committee. Dr. Foreman reviewed the program for the meeting which begins on the evening of May 12 at the Colonnade Hotel in Boston and will adjourn at noon on May 14. He indicated that all speakers had been contacted and confirmed with one exception, and that he and Dr. Knapp would have that final task completed shortly.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the November 2, 1981 Administrative Board Meeting without amendment.

III. Membership Applications

Dr. Bentley reviewed the five membership applications. Based on staff recommendation and Board discussion, the following actions were taken:

ACTION(S): It was moved, seconded and carried to approve:

- (1) Bellevue Hospital Center, New York, New York for FULL MEMBERSHIP.
- (2) District of Columbia General Hospital, Washington, DC for FULL MEMBERSHIP.
- (3) Maimonides Medical Center, Brooklyn, New York for FULL MEMBERSHIP.
- (4) Ohio Valley Medical Center, Wheeling, West Virginia for FULL MEMBERSHIP.
- (5) St. Mary's Medical Center, Evansville, Indiana for CORRESPONDING MEMBERSHIP.

IV. Possible Administration Medicare and Medicaid Budget Cuts

Dr. Knapp reviewed for the Board the probable Medicare cuts that were discussed at the November 2 Board meeting that were designed to save between \$600-800 million. Since that time, a new proposal has surfaced which appears to be an option that the Administration will choose and will save the same amount of money. This proposal is a 2% across the board reduction in federal reimbursements to hospitals for the care of Medicare patients. While it was agreed that all

cuts should be opposed, the question of whether the "laundry list" of regulatory changes reviewed at the November 2 Board meeting would be preferable to the 2% across the board cut was raised. The following points were made as points which would indicate that the 2% across the board cut would be favorable:

- o Explicit recognition that the Federal Government is unwilling to pay its fair share of cost for services rendered on behalf of Medicare patients;
- o The proposal is easily explained to hospital governing boards;
- o The proposal is not complicated to administer. Neither hospitals nor the Federal Government would need new staff or reporting procedures;
- o The assumption is made that all hospitals would bear an equal burden.

The following points were made indicating the very undesirable nature of this 2% approach:

- o It violates the principle of full cost reimbursement;
- o It would be relatively easy to lower the percentage in subsequent years;
- o It is more harmful to hospitals operating with deficits;
- o It is more harmful to hospitals operating with low working capital;
- o It may increase referral of "bad debt" patients;
- o It assumes all hospitals to be inefficient and no institution can escape the penalty;
- o It is more harmful to hospitals with large numbers of other cost based payers who would not be able to shift the reduction to charge paying patients.

No action was taken on this item but there was general consensus by the Board that if a choice had to be made, the list of regulatory changes would be preferable to the 2% across the board approach.

Dr. Knapp described a number of the other changes in Medicare and indicated that it was probable that there would be a 3% reduction in federal reimbursements to states for the cost of optional services provided under the Medicaid program and a 3% federal reimbursement reduction to the states for the cost of programs for the medically indigent.

V. Proposed Health Planning Bill

Mr. Isaacs reviewed this agenda item, briefly outlining the current state of health planning generally and the national federally mandated programs specifically. In addition, he summarized the major components of the AHA's revised statement of principles on the issue of health planning and the American Health Planning Association's (AHPA) proposed legislation to create a new state developed and operated health planning program supported with matching federal funds. He explained the need for consideration of a new AAMC policy on health planning was not only an outgrowth of AHPA's request for support for its legislation, but was due also to recognition that the Association would soon only have a position criticizing an extinct program. He asked the Board to consider specifically:

- (1) Is the AAMC supportive of the concept of health planning?
- (2) If so, in what form?
- (3) Should federal funding be involved?

Lengthy discussion of the issue ensued during which several concerns were expressed regarding support for either the AHA position or AHPA's proposed bill.

Several individuals felt that the teaching hospitals had fared pretty well under the current system but that federal intervention had overemphasized the regulatory aspect. Others feared tremendous capital acceleration by proprietary hospitals without a health planning monitoring system, but felt that total state agency control should also be averted. Clearly sentiments varied widely. The AHA statement was generally viewed as vague and unrealistic in calling for provider coordination in planning strategies while advocating an increasingly competitive environment. The AHPA's proposal was not endorsed either, largely because of the probability that it would create a new layer of regulation and "the same

- 5 -

old problems" if tied to federal purse strings. Moreover, the Board felt the AAMC was not prepared to endorse any individual proposal or stance without further examination of the issue. In light of this acknowledgement, the Board took the following action:

ACTION: It was moved, seconded and carried to recommend that the Executive Council approve the creation of an ad hoc committee to develop an appropriate AAMC position on health planning.

VI. Discussion of AHA Reports

A. Medicare Differential Pricing

B. Hospital Payment System Shortfalls

The Regional Advisory Boards (RAB's) of the American Hospital Association considered two reports on the financial requirements of hospitals during their winter meetings: "Medicare Differential Pricing" and "Hospital Payment System Shortfalls." Dr. Knapp opened the discussion on both reports by noting the broad applicability and implications and asked Mr. Robinson to introduce and summarize each report. Mr. Robinson described the "Medicare Differential Pricing" paper as a staff document prepared in response to a RAB's recommendation and the increasing Medicare practice of setting payment limits for hospitals using payments to nonhospital providers. The Board found that statement to be a clear and useful exposition of the difference between full absorption costing and marginal costing. However, it was suggested some of the problems that could be encountered if Medicare permitted marginal costing:

- o The implication that the "real hospital" is a short term acute care component;
- o The possibility that the advantages of marginal costing will be eliminated by inpatient cost limits; and
- o The difficulty of establishing cost reporting consistency when each provider is allowed to structure its own marginal costing.

Because of the controversy with which the payment shortfall report has been received by the RAB's Mr. Robinson provided a comprehensive review of the report's recommendation and

the RAB's reactions to them. He noted that the diverse RAB responses meant that the AHA Board of Trustees must now consider what to do with the present draft of this paper. The COTH Board discussed the shortfall report but took no action upon it.

VII. Hospital Payments for Physician Services

Dr. Knapp reported that over the years the Department of Teaching Hospitals' staff have repeatedly received calls from member hospitals interested in obtaining information on hospital payments to physicians for various functions. These calls have generally sought to identify hospital payments in one or more of four areas.

- o Financial arrangements with the specialties of Radiology, Pathology and Anesthesiology;
- o Cost sharing arrangements with medical schools for physicians who are both school chairmen and hospital chiefs;
- o Costs incurred for physician supervision in graduate medical education programs;
- o Financial arrangements with physicians supervising specialized care units (eg; CCU, ICU).

The staff has had little or no data to share with many hospitals in any of these areas. Over the past six months the number of calls requesting this type of data has increased substantially. Dr. Knapp indicated that up until now he had resisted any initiatives to gather data in this area for the following reasons:

- o In order to present the total picture, many of these salaried arrangements also include arrangements related to fee for service income which in some cases reverts to the institution and in other cases reverts directly to the physician with some limit. This complicates the straight toward salary question substantially.
- o In some cases hospital/medical school negotiation has led to agreements where the hospital would financially support certain faculty based salaries in exchange for medical school support for a variety of other kinds of activities. In these cases one would need to know the quid pro quo

in order to make a fair comparison with other hospitals.

- o It is unlikely that a mail questionnaire could successfully be used to grasp the complexities set forth in the two items above.
- o Once the information is collected, it would have to be shared with all AAMC constituents and could create many problems.

After full discussion of the issue, it was agreed that a mail survey would not be a wise course to pursue. It was suggested by some Board members that perhaps an analytical approach to the issue would be appropriate without the use of actual data. Again, following discussion it was agreed that the staff should initiate no action in this area.

VIII. Malpractice Insurance

Drs. Knapp and Cooper reviewed this agenda item for the Board describing Mr. Chittenden's relationship to the AAMC, and the contents of his letter proposing that the Association become a vehicle for collection, analysis and dissemination of malpractice claims information as well as for the provision of technical assistance to its member institutions on this subject.

After review and discussion of Mr. Chittenden's proposal, Dr. Knapp was requested by the Board to notify him that pursuit of the recommended activities was deemed not to be in the best interests of the AAMC at this time. This decision was based primarily on two major factors:

- o The specific medical education orientation of the Association would not make it the most appropriate vehicle to pursue such an undertaking as is proposed; and
- o Other known national organizations which are broader in perspective and closer to malpractice issues are currently conducting data collection and analysis similar to that proposed.

A copy of Dr. Knapp's January 25 letter to Mr. Chittenden is attached as Appendix A to these minutes.

IX. ACGME Consensus Statement

Dr. Cooper reviewed for the Board the background of these

consensus statements and the reasons that they were put on the Agenda for discussion. After brief discussion, the following action was taken:

ACTION: It was moved, seconded and carried to recommend that the AAMC Executive Council endorse the language adopted by the Assembly of the Council of Medical Specialty Societies for statements (1) and (4) and direct its representatives to the ACGME to support the adoption of these changes in the statements at the February 22 meeting, and approve them as revisions for graduates of non-LCME accredited schools.

X. Biennial Report of the President's Commission for Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

Dr. Cooper reported that the Commission is in the process of issuing its first biennial report to the President and Congress on the adequacy and uniformity of the rules and policies and their implementation for the protection of human subjects in biomedical and behavioral research. The final version of the report has been sent to the Commission members and is expected to be published before the end of January unless there are serious objections to the staff's draft. Because of recommendations in the report with regard to institutional review boards, Dr. Cooper believes it important that the Executive Council take action at this time. He reviewed the nine recommendations item by item and following this review, the COTH Board took the following action:

ACTION: It was moved, seconded and carried to approve the staff recommendations set forth on pages 38, 39 of the Executive Council Agenda.

XI. Strategies for the Future: An AAMC Workplan

Mr. Levitan outlined the process by which work was begun on the workplan at the September 1981 Council meetings and the Officers' Retreat in early December. There was an extensive discussion of the role that the AAMC/COTH might play with respect to the many issues in nursing. While no specific recommendation was made, it was requested that Mr. Levitan raise the issue at the Executive Council

meeting.

It was pointed out by several Board members that the goal, "protect the professional role of the physician", appears to be very self-serving. Following it with an objective of seeking ways to foster a better collaborative relationship among physicians, nurses and other health professionals could create further problems, particularly with nursing. It was agreed to change the word "protect" in the goal to "maintain" or "enhance", and ask the Executive Council to consider the collaborative relationship with other health professionals as a separate matter.

XII. Other Business

Dr. Cooper presented in broad outline a proposal suggested by a member of the Council of Academic Societies to establish a "National Biomedical Research Week". While such an endeavor would require grass roots support and effort, the AAMC would provide substantial leadership and direction. The Board responded very favorably to the idea and suggested consideration be given to selecting a month which includes "National Hospital Week".

XIII. Adjournment

The meeting was adjourned at 12:20pm.



association of american medical colleges

January 25, 1982

Thomas S. Chittenden
Vice President
Marsh & McLennan, Inc.
1221 Avenue of the Americas
New York, New York 10020

Dear Tom:

To respond to your letter of January 11 without delay, it was added post haste to the January 21 Council of Teaching Hospitals (COTH) Administrative Board meeting agenda. After careful review and considerable discussion, our constituency leadership determined that it would not be in the best interest of the AAMC to pursue action on your proposals at this time. This decision was based primarily on two major factors:

- (1) the specific medical education orientation of the Association would not make it the most appropriate vehicle to pursue such an undertaking as is proposed, and
- (2) other known national organizations, which are broader in perspective and closer to the malpractice issue, are currently conducting data collection and analysis similar to that proposed.

Though the decision was not favorable to your request, the Association appreciates your interest and efforts to outline the major premises regarding the issue, and looks forward to a continuing positive relationship with you.

With kindest regards,

A handwritten signature in cursive script, appearing to read 'Dick', written over the typed name.

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

Marsh & McLennan, Incorporated
1221 Avenue of the Americas
New York, New York 10020
Telephone 212 997-7255

February 10, 1982

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

Thomas S. Chittenden
Senior Vice President

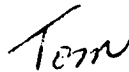
Dear Dick:

Thank you for your letter of January 25th telling me that the Administrative Board of COTH has decided not to pursue the suggestions I made in my letter of January 11th.

While I am naturally disappointed at this outcome, I can understand the Board's reluctance.

Let's keep in touch.

Sincerely yours,



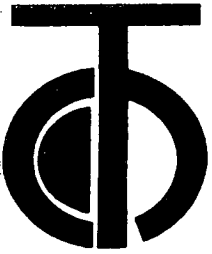
Thomas S. Chittenden

TSC/jmf

MEMBERSHIP APPLICATIONS

Two hospitals have applied for membership in the Council of Teaching Hospitals. The applicants and the staff recommendations for type of membership are:

<u>HOSPITAL</u>	<u>STAFF RECOMMENDATION</u>	<u>PAGE</u>
Providence Medical Center Portland, Oregon	Corresponding Membership	14
Saint Joseph's Hospital and Medical Center Paterson, New Jersey	Teaching Hospital Membership	19



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: PROVIDENCE MEDICAL CENTER

Hospital Address: (Street) 4805 N.E. Glisan

(City) Portland (State) Oregon (Zip) 97213

(Area Code)/Telephone Number: (503) 230-6085 & 230-6086

Name of Hospital's Chief Executive Officer: John Lee

Title of Hospital's Chief Executive Officer: Administrator

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>485</u>	Admissions:	<u>16,768/Yr</u>
Average Daily Census:	<u>436</u>	Visits: Emergency Room:	<u>27,000/yr</u>
Total Live Births:	<u>N/A</u>	Visits: Outpatient or Clinic:	<u>9,616/Yr</u>

B. Financial Data

Total Operating Expenses: \$ 53,713,000.00

Total Payroll Expenses: \$ 27,943,000.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 669,434.00
 Supervising Faculty: \$ 320,472.00

C. Staffing Data

Number of Personnel: Full-Time: 1,498
 Part-Time: 200

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 450
 With Medical School Faculty Appointments: 4 academic
 approx. 20 clinical

Clinical Services with Full-Time Salaried Chiefs of Service (list services):
 Dept. of Medicine & Infectious Diseases: David N. Gilbert, M.D.

Rheumatology Service: Richard Wernick, M.D.

Ambulatory Care Clinic Director: Mark Rosenberg, M.D.

Pathology Dept: Franklin Curl, M.D.

Psychiatry Service: William Zieverink, M.D.

Does the hospital have a full-time salaried Director of Medical
 Education?: Yes - David N. Gilbert, M.D.

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>Senior elective clerkships offered. Number of students taking the clerkships is approximately 10/yr.</u>		
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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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>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible				
Medicine	1st Yr: 12	12	0	Originally: 1947
	2nd Yr: 8	8	0	
	3rd Yr: 8	8	0	
Surgery				
Ob-Gyn				
Pediatrics				
Family Practice				
Psychiatry				
Other:				

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: OREGON HEALTH SCIENCES UNIVERSITY

Dean of Affiliated Medical School: Ransom J. Arthur, M.D.

Information Submitted by: (Name) David N. Gilbert
 (Title) Director of Medical Education

Signature of Hospital's Chief Executive Officer:

John Lee
 John Lee, Administrator

(Date) 2/22/82



OFFICE OF THE DEAN
SCHOOL OF MEDICINE

Area Code 503 225-8220

Portland, Oregon 97201

UNIVERSITY OF OREGON
HEALTH SCIENCES CENTER
March 1, 1982

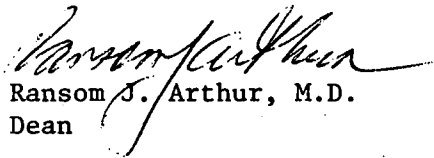
Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear Dr. Knapp:

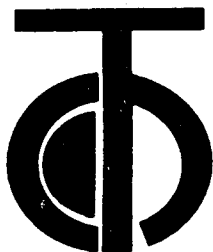
This letter is to certify that the Internal Medicine Residency at Providence Medical Center is affiliated with the Internal Medicine Residency program of the School of Medicine at the Oregon Health Sciences University. Both residency programs enjoy full accreditation by the Residency Review Committee of the American Medical Association.

I feel that the Providence affiliation appreciably strengthens our internal medicine curriculum. The patient population and the teaching faculty at Providence nicely complement our University Hospital program. For these reasons, I strongly support the application of Providence Medical Center for Corresponding Membership in the Council of Teaching Hospitals of the Association of American Medical Colleges.

Sincerely,


Ransom J. Arthur, M.D.
Dean

sg



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: St. Joseph's Hospital and Medical Center

Hospital Address: (Street) 703 Main Street

(City) Paterson (State) New Jersey (Zip) 07503

(Area Code)/Telephone Number: (201) 977-2100

Name of Hospital's Chief Executive Officer: Sister Jane Frances

Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>550 *</u>	Admissions:	<u>21,489</u>
Average Daily Census:	<u>494</u>	Visits: Emergency Room:	<u>35,573</u>
Total Live Births:	<u>1802</u>	Visits: Outpatient or Clinic:	<u>65,924</u>

* Merger November 1981 added 100 beds (Medical/Surgical) to capacity. Beds are located in different city and are not reflected in any of these statistics for 1981.

B. Financial DataTotal Operating Expenses: \$ 55,375,603Total Payroll Expenses: \$ 30,702,844

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 743,762Supervising Faculty: \$ 172,000C. Staffing DataNumber of Personnel: Full-Time: 1,592Part-Time: 601

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 310With Medical School Faculty Appointments: 143

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

<u>Anesthesia</u>	<u>Family Practice</u>	<u>Psychiatry</u>	<u>Radiology</u>
<u>Community Medicine</u>	<u>Medicine</u>	<u>Pediatrics</u>	<u>Rehabilitation</u>
<u>Dental</u>	<u>Ob/Gyn</u>	<u>Pathology</u>	<u>Medicine</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: (January-December 1981)

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>	
			<u>E</u>	<u>R</u>
Medicine	<u>43</u>	<u>15</u>	<u>10</u>	<u>5</u>
Surgery	<u>25</u>	<u>7</u>	<u>2</u>	<u>5</u>
Ob-Gyn	<u>25</u>	<u>23</u>	<u>4</u>	<u>19</u>
Pediatrics	<u>34</u>	<u>9</u>	<u>3</u>	<u>6</u>
Family Practice	<u>0</u>	<u>0</u>		
Psychiatry	<u>25</u>	<u>22</u>	<u>0</u>	<u>22</u>
Other: <u>Orthopedics</u>	<u>12</u>	<u>8</u>	<u>8</u>	
<u>Radiology</u>	<u>17</u>	<u>3</u>	<u>3</u>	
<u>Anesthesia</u>	<u>24</u>	<u>1</u>	<u>1</u>	
<u>Urology</u>	<u>12</u>	<u>1</u>	<u>1</u>	

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>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	0			
Medicine	44	1	43	1964
Surgery	0			
Ob-Gyn	8	7	1	1967
Pediatrics	25	0	25	1975
Family Practice	6			1982
Psychiatry	0			
Other:				
<u>Orthopedics</u>	6	3	3	1959
<u>Anesthesia</u>	15	0	15	1949
<u>Dentistry</u>	4	4		1974

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 University of Medicine and Dentistry
of New Jersey

Dean of Affiliated Medical School: Stanley Bergen, M.D.

Information Submitted by: (Name) Sister Jane Frances Brady

(Title) President

Signature of Hospital's Chief Executive Officer:

Sister Jane Frances Brady (Date) 2-17-82

IV. SUPPLEMENTARY INFORMATION

Although the data submitted herewith pertains to medical education and it should be demonstrative of an enormous commitment on the part of St. Joseph's Hospital and Medical Center to medical education, it does not tell the whole story.

In addition to what is itemized here with regard to medical education, St. Joseph's is heavily involved in education of medical students in almost every medical discipline, of physician assistants and as importantly, in providing superior continuing education for the attending physicians not only on our staff, but in the entire area. It is a fair statement to say that we view ourselves as responsible as a medical center for the latter and more and more, others view us the same way -- other physicians and other hospitals.

In addition to medical education, it is important to add that St. Joseph's is truly an educational center for much more than physician education. St. Joseph's maintains its own School of Medical Technology and a School of Nuclear Technology; additionally, we have on any given day students here in nursing (several affiliated programs), social work, rehabilitation medicine, psychology, pharmacy, seminarians, administration, and the list goes on and on. This hospital is a recognized educational resource for hundreds of other than physician students and the hospital is fully committed to this role.



COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY

NEW JERSEY MEDICAL SCHOOL
100 Bergen St.
Newark, New Jersey 07103

OFFICE OF THE DEAN

4 February 1982

CMDNJ

is now known as the
University of Medicine & Dentistry
of New Jersey

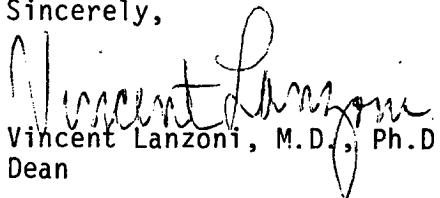
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C.

To Whom It May Concern:

Sister Jane Frances, President, St. Joseph's Hospital and Medical Center, Paterson, New Jersey has advised me that St. Joseph's is applying for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges.

St. Joseph's has an institutional affiliation agreement with the University of Medicine and Dentistry of New Jersey-New Jersey Medical School which has been in effect since December, 1973. St. Joseph's is an active participant in the educational programs of the University at the undergraduate and graduate level. Their application for membership in the Council of Teaching Hospitals has my endorsement.

Sincerely,


Vincent Lanzoni, M.D., Ph.D.
Dean

VL/mpp

cc: Stanley S. Bergen, Jr., M.D., President, UMDNJ



association of american medical colleges

COTH SPRING MEETINGS

1978 - 1983

1978	St. Louis, Missouri
1979	Kansas City, Missouri
1980	Denver, Colorado
1981	Atlanta, Georgia
1982	Boston, Massachusetts
1983	New Orleans, Louisiana

The staff recommends that consideration be given to the following three cities for the 1984 COTH SPRING MEETING:

Baltimore

Detroit

Philadelphia



association of american medical colleges

AAMC ANNUAL MEETING COTH GENERAL SESSION THEMES

- 1972 EXTERNAL FISCAL CONTROLS ON THE TEACHING HOSPITAL
- 1973 THE ECONOMIC STABILIZATION PROGRAM AND OTHER HEALTH
INDUSTRY CONTROLS
- 1974 NEW MANAGEMENT AND GOVERNANCE RESPONSIBILITIES FOR
TEACHING HOSPITALS
- 1975 RECENT CHANGES IN THE HEALTH CARE DELIVERY SYSTEM:
IMPLICATIONS FOR THE TEACHING HOSPITAL
- 1976 CLINICAL CASE MIX DETERMINANTS OF HOSPITAL COSTS
- 1977 PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR
CONTROLLING THE DEMAND FOR HOSPITAL SERVICES
- 1978 MULTIPLE HOSPITAL SYSTEMS AND THE TEACHING
HOSPITAL
- 1979 CONFLICT: CONTINUING ADVANCEMENT IN MEDICAL
TECHNOLOGY AND THE QUEST FOR COST CONTAINMENT
- 1980 THE HIGH COST PATIENT: IMPLICATIONS FOR PUBLIC
POLICY AND THE TEACHING HOSPITALS
- 1981 IMPLEMENTING COMPETITION IN A REGULATED HEALTH
CARE SYSTEM

The staff would appreciate some discussion and guidance in selecting a topic and speaker(s) for the COTH portion of the November, 1982 AAMC Annual Meeting

Describing the Teaching Hospital

At the 1979 COTH Spring Meeting, the membership asked the AAMC to develop a report or set of reports describing contemporary teaching hospitals, their mix of patients, and their educational costs. In response, the AAMC, with the approval of the COTH Administrative Board and the Executive Council, established an internally funded project to describe teaching hospitals. To date, five project reports have been published and distributed to the AAMC membership:

- Case Mix Measures and their Reimbursement Applications: A Preliminary Staff Report. (September, 1979)
- Medical Education Costs in Teaching Hospitals: An Annotated Bibliography. (May, 1980)
- Describing and Paying Hospitals: Developments in Patient Case Mix. (May, 1980)
- The DRG Case Mix of a Sample of Teaching Hospitals: A Technical Report. (December, 1981)
- The Disease Staging Case Mix of a Sample of Teaching Hospitals: A Technical Report. (February, 1982)

Enclosed as a separate agenda item is a draft of the final project report, "Describing the Contemporary Teaching Hospital."

On March 24th, the Ad Hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, chaired by Mark S. Levitan, reviewed the previous draft of this study report. The enclosed draft has been revised to incorporate the suggestions and recommendations of the Ad Hoc Committee. The COTH Administrative Board is requested to review this report, make suggestions for necessary revisions, and approve its publication.

Secondly, with the completion of this project and with the expectation that a replacement for Peter Butler will be hired by the June Board meeting, it is requested that the Board discuss alternatives for future staff activities. Staff observations on operational constraints and summaries of several project alternatives considered by the Ad Hoc Committee are presented below.

Staff Constraints

1. The Department of Teaching Hospitals has a four person staff to meet all its activities.
2. The Department of Teaching Hospitals has recently subscribed to the AHA's National Data Network to obtain timely access to the Annual and Panel Surveys conducted by the AHA. Substantial staff efforts will be devoted to using this data in the coming year.
3. With existing staff, it is difficult to initiate and maintain major data collection/analysis beyond present studies (housestaff stipends and benefits, university-owned income and expense analysis, and hospital executives salary survey).

Alternatives for Future Staff Activities

1. Develop a case study of teaching hospitals corporately reorganizing to establish educational and/or research subsidiaries. The project would present models of organizational alternatives in these areas and describe hospital objectives for establishing educational/research components.
2. Using the new uniform hospital billing form (UB-82) and the uniform hospital discharge data abstract, develop a minimum recommended data set that COTH hospital could retain to facilitate case mix studies and comparisons.

3. Working with Systemetrics, the case mix contractor for the present study, develop a small study comparing case mix data from the current study with case mix data in a sample of non-teaching hospitals. The analysis would be restricted to differences in the percentage of cases across categories and length of stay differences within categories.
4. Late this summer, Arthur Young and Company will complete an HHS funded study developing methodologies for estimating the costs of graduate medical education. Two cost methodologies will be developed: 1) an accounting based system for measuring the "direct" costs of the programs such as stipends, benefits, faculty, support staff, and allocated overhead and 2) an econometric model for estimating the "indirect" costs such as decreases productivity and increased ancillary use. The methodologies could be assessed by applying them in a sample of COTH members.
5. Establish a general purpose, on-line data base on non-Federal COTH members. The data base would be patient based and include medical abstract and patient billings data.

Hospital Payments and Patient Mix

As shown in attachment A, the Federation of American Hospitals is taking the position that payment systems for hospitals should be based on four guidelines. The final guideline specifically opposes the use of diagnosis related groups in calculating payments. Presumably, it represents the Federation's opposition to recognizing case mix differences in hospital payments. As Congressional staff discuss changes in Section 223 limits and as various organizations, including HCFA and the AHA, develop prospective payment proposals, the COTH/AAMC will have to have a position on recognizing differences in patient mix when computing hospital payments.

Staff Recommendation

Because state-based payment systems have demonstrated the importance of differences in patient mix in assessing differences in hospital costs and because the AAMC's study of teaching hospitals has shown that there are significant case mix differences within the community of teaching hospitals, staff recommend:

that the AAMC seek explicit recognition of differences in hospital patient mix in all hospital payment limitations and prospective payment systems.

American Hospital Association



840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6000
Cable Address AMHOSP

To call writer, telephone 312.280.

February 1982

TO: Councils
Regional Advisory Boards

SUBJECT: "The Situation Confronting the Hospital Field in 1982"

Attached is the discussion paper, "The Situation Confronting the Hospital Field in 1982", and an excerpt from the Report to the House of Delegates by AHA Chairman Stanley R. Nelson, which elaborates on issues raised in the "Situation" paper.

Origin of Document

The paper was developed by the AHA Executive Committee, and revised following review by the General Council and the Board of Trustees at the Annual Meeting.

Issues Involved

The "Situation" paper addresses a number of critical issues facing the hospital field within the broad context of cost containment. In listing eight issues the paper suggests approaches the Association should take in considering the issues.

The "Situation" paper generated much discussion by both the General Council and the Board of Trustees. Both bodies recommended that the paper be presented for intensive review and discussion by the councils, Regional Advisory Boards, and allied hospital associations, and that these groups consider the comprehensiveness of the list of issues as well as the suggested approaches. It was further recommended that the councils, RABs, and allied associations be informed of the concerns raised about the paper by the General Council and Board, in order that these and other concerns might be comprehensively addressed. Mr. Nelson's report to the House describes these concerns and indicates the Board's expectations with respect to the councils', RABs', and allied associations' discussions.

Approval Process

The "Situation" paper is not a policy document and does not require formal approval.

Recommended Disposition

The councils and the Regional Advisory Boards are requested to review and discuss the "Situation" paper consistent with Mr. Nelson's report to the House, and develop recommendations to be forwarded to the General Council for its April 14-15 meeting. The General Council will be responsible for synthesizing all of these comments and preparing a report for the Board of Trustees at its May meeting.

J. Alexander McMahon
President

American Hospital Association



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To call writer, telephone 312.280.

January 30, 1982

TO: AHA Councils
Regional Advisory Boards
Allied Hospital Associations

FROM: AHA Board of Trustees

SUBJECT: The Situation Confronting the Hospital Field in 1982

At the annual meeting in Washington in late January, the officers, the General Council, and the Board of Trustees gave attention to the many issues confronting the field. They recognized the interrelationships of the various issues, and they concluded that a statement of the environment and the directions AHA is taking could be useful in focusing the attention of the councils, the RABs, and allied associations on these issues and the directions. Comment is invited on any aspect of this statement to guide the Board as it continues to determine AHA policy on these issues.

For the past 10 years, health care and hospital cost containment has been a major public policy issue. For most of the period, the solution to rising costs most often offered was controls on the providers of care, generally on hospitals. Recently, the federal government has reduced appropriations for health care services to the aged and the indigent, and faced with a mounting federal deficit, it will consider in 1982 further cuts both in services covered and the payment for those services.

Two other significant developments have occurred in the discussion of health care and hospital cost containment. First, a number of economists, administration and congressional leaders on the federal scene, and a growing number of business leaders have recognized (as AHA, AMA, and other provider organizations have long urged) that the demand for health care services, stimulated by broad governmental and private health care financing mechanisms, and the incentives to providers to respond to that demand, through the reimbursement and payment mechanisms, have been a major contributor to health care cost escalation. Second, business and organized labor have evidenced a growing concern over the impact of the growth of the cost of employment-related health insurance on their production costs and on the take home pay portion of the total compensation package.

The AHA needs a broadly based and multi-faceted approach to all of these issues. It is proceeding as follows, and requests the views of the councils in March, the RABs at their spring round, and each of the allied hospital associations concerning the following:

- (1) The "consumer choice" approach to group health insurance offers a way to involve the individual in understanding the difference between "needs" and "desires" for health care services. It therefore must continue to be studied, not only for its promise to

- impact the "demand" for services, but also for its impact on health care providers, particularly those with a high cost role in the system, like teaching hospitals, tertiary care medical centers, and those with a large indigent census.
- (2) The "Medicare voucher" alternative to the present Medicare program must be explored for the same reason and with the same caution, with full attention to the possibility of experimental or incremental adoption.
 - (3) Immediate and expeditious attention must be given to the development of prospective payment alternatives to retrospective cost-reimbursement methods of paying hospitals for services to patients. The Board recognizes the consequence of the results involved to some hospitals, but it also recognizes the importance of modifying incentives to reward cost effective behavior and provide for capital formation. The Council on Finance will be asked to give priority attention to this issue.
 - (4) There are concerns over the implication of fiscal year 1982 federal budget cuts, but the impact is not yet fully understood. It is likely that the cuts will present problems for teaching hospitals, public hospitals and other institutions with a high indigent census, and small and rural hospitals. We must oppose further reductions, particularly in the Medicare and Medicaid programs, unless the consequences to those needing care are fully identified and unless adequate attention is given to those institutions most adversely affected.
 - (5) The implications of President Reagan's proposal to transfer Medicaid and services to the elderly to the federal government, and welfare, general education, and other services to the states and local governments are not yet understood. Recognizing the advantages of program simplification and clear assignment of responsibility, the proposal must be carefully studied for its possible adverse consequences for the people served and for those providing services.
 - (6) AHA believes that health planning is better handled at the community level than it has been under the federally-dominated system created by Public Law 93-641. If the federal government, however, decides to continue an involvement in health planning, funds should be available for projects with cost-saving potential rather than for mechanisms for greater controls. Similarly, the Professional Standards Review Organizations should be dismantled and utilization review processes strengthened at the institutional level.
 - (7) Recognizing the broad interest in strengthening existing and developing new broad-based community health care coalitions, AHA must help hospitals understand and work with these coalitions, and it must assist the coalitions themselves in understanding the hospital world. The General Council has been charged with overseeing these responsibilities.
 - (8) With the attention to cost containment, people have often lost sight of the value received from increased resources devoted to hospital care. Staff has been asked to develop a positive program to explain the hospital story in terms of high quality and improved access to care, exploring all avenues of reaching the public.

Finally, all of these areas of activity are grounded on the assumption of changes in the financing and incentives of health care in general and hospital care in particular. The perils inherent in any major change in direction are recognized if not fully understood, but they are preferred to the inherent programs of more and more regulations, with more and more demand for services, which ultimately would make the providers the rationers of care.

Stanley R. Nelson
Chairman

Excerpt: Chairman's Report to House of Delegates
 Stanley R. Nelson
 February 3, 1982
 Washington, DC

Subject: The Situation Confronting the Hospital Field in 1982 Discussion Paper

At this annual meeting, there has been a keen understanding of the need for AHA leadership and direction on a number of key fundamental issues--from the relatively straight forward federal cutbacks in health to the infinitely complex issue of federalizing Medicaid; from the "Medicare voucher" alternative to complete reform of the reimbursement system. It is, perhaps, an understatement to say that these issues have the potential for completely restructuring how health care is financed and delivered in this nation.

When the Executive Committee met last week, we reached the conclusion that the issues are fundamentally related and cannot really be effectively considered in isolation from each other or from a broad perspective of the state of health care today. As a result, the analysis of "the situation confronting the hospital field" was developed and subsequently shared with the General Council and the Board of Trustees. Both bodies believed that the issues addressed are significant enough to warrant the attention of the entire field. By now, most of you have probably seen and--I hope--read the document. It was attached to the A.M. Bulletin on Monday and additional copies are available at this House meeting. It will be on the agenda at your Spring RAB meetings and at the March council meetings.

Today, I want to discuss briefly what the document says and why it is essential that we give it thorough consideration. The key point for all of us to remember is that the statements and positions in it are by no means noncontroversial; the officers, the Board, and the General Council are not hoping for a rubber-stamp approval; we are seeking open debate.

WHAT THE DOCUMENT SAYS . . .

The analysis essentially places the various political issues facing us into the context of cost containment--and there is a basis for the contention that most current policy-thinking about health care stems from concern about costs. From this starting place, it goes on to tackle some of the most pressing issues facing the field.

What should the field's stand on "consumer choice" be? AHA is on record supporting some of its basic principles, and is studying the issue to determine its impact on demand and on some very concerned health care providers. Is it time to develop prospective payment alternatives to replace our current retroactive cost-based system? AHA is headed in this direction, because it seems like a way to reward cost-effective behavior by hospitals. What about federalizing Medicaid? Do we even know enough about it to take a stand? These are just some of the issues and questions the paper deals with. It also broaches the subject of health planning--an

issue that many of us thought we settled at our last meeting--as well as PSRO, the coalition movement, and public understanding--or lack of understanding--of the hospital story.

The document reflects current AHA positions and the directions they are taking us. The challenge before this House is to look at the directions, to think about them, and to decide if these are the directions we want the American Hospital Association heading towards.

WHY DISCUSSION IS ESSENTIAL

I don't think the answers are going to be easy. It is becoming increasingly clear that there is not one best route for all hospitals. Our concerns and priorities differ vastly. I would not expect hospitals in Massachusetts to have the same concerns as a hospital in North Dakota. And, I can guarantee that my hospital in the metropolitan Detroit area has very different interests than a hospital in the upper peninsula of Michigan--same state, but vastly different circumstances. And, geographic differences are only one of many factors accounting for the disparity in hospital priorities.

The urban hospitals, the public-general hospitals, the teaching hospitals, the children's hospitals, the small and rural hospitals, the suburban hospitals all have different concerns and priorities. It is the AHA's job, as a national association representing all of these institutions, to identify truly national priorities and positions. It is not an easy task. We need as much discussion, as much thinking, and as much open and candid observation on these issues as possible. If we turn deaf ears to minority opinions, questions, or concerns, we are not doing our job. This House through the RABs must deal with these issues in a forthright and direct manner.

CONTROVERSY ALREADY GENERATED

It would be nice if we could say that these are issues on which all men good and true would agree. Frankly, they are not. Wherever we have discussed them, there has been controversy.

I want to share with you some of the comments I heard expressed at the General Council and the Board meetings, because they indicate the extent and the depth of concern that has been expressed.

Overall, there was some concern about considering these issues within the framework of the cost containment issue. The alternative we heard was to think about them within the context of the hospital's role in serving the public, and the growing fear that some people--particularly the poor--are being pushed out of the health care financing system. From this, a vast variety of philosophic and practical issues grow.

Some voiced the view that the preamble should assert AHA's commitment to providing essential health care services to all. Others thought that if society is unwilling to pay for "optimal care," then perhaps we should go about the business of defining "minimal" levels of care to which people are entitled. And this brought up the whole issue of "entitlement" and what--if anything--the term means in today's economic and political scene. Others think we are going in the direction of a "two-tiered" health care system, and AHA must decide its position on this.

Additional basic concerns addressed the role of AHA on these issues. Should AHA be seeking a consensus position? Do we have an obligation to identify the "right" thing to do--our guiding principle--and make decisions that flow from that rather than from pragmatic political reality. Should AHA be identifying short-term solutions or long-term directions--and what are the implications of this decision on how we view the issues.

And, then there are some who are not at all convinced that the so-called era of limits really applies to health care when you get down to the level of individuals--if you or your family is sick, you want the best care regardless of the price.

These are only a few of the general concerns about the analysis. If we look at the eight individual points, we get more specific and even contradictory concerns. For example, on consumer choice we heard from some that we should go further in encouraging competition, and from others we heard a concern that consumer choice may be a mask for disenfranchising the poor and the elderly from our health care system.

We heard extensive concern and questions about changing the reimbursement system. Should we go further and faster on changes? Can prospective payment really address the problem of paying the adequate financial requirements of hospitals? Does the Association realize that some hospitals may not make it under a different reimbursement system? Is it meaningful to address the payment issue without considering the role of the medical staff? And there was the view that whatever AHA is in favor of--it ought to allow maximum flexibility for individual hospitals.

Some voiced the concern that AHA should go further on the issue of cutbacks in federal funding for Medicare and Medicaid--opposing all cutbacks regardless of other factors--as a strategy if not as a policy. And, indeed, many recognized that despite AHA's policy and statement on health care planning, the field still is not settled on this issue.

These are the concerns I have heard over the past couple of days. I have little doubt that each of you can add to the list, and I urge you to do so at your RAB [and council] meetings. We need the best thinking from each of you in considering these issues.

Developing Principles or Guidelines For Effective
Hospital Payment Systems:
Progress Report

Background

Based on the comments provided by several RABs and others with respect to the Shortfalls Report, it is vital that the payment mechanism issue be put into proper context.

The principle point in this regard is that payment systems, regardless of how well designed, cannot in and of themselves eliminate underfinancing. Therefore, if payment systems are to be effective they must operate within a context where:

- Neither government nor private purchasers of health care promise more benefit coverage to more people than they are willing and able to adequately finance.
- When faced with limitations in resources, government at all levels recognizes as its first obligation the financing of care for those population groups least able to purchase adequate private health benefit coverage or to pay directly for health care services. (Where government's resources are insufficient to provide the above level of support, it should provide assistance and incentives for the private sector to help meet these needs.)
- Both government and private purchasers of care should design their health benefit programs in ways that will help to increase the cost-consciousness of the insured population, and eliminate demands for unnecessary, inappropriate and/or avoidable health care services.

Hospital Payment Systems

Within the foregoing context, the following are presented as possible principles for the design of effective hospital payment systems.

1. In the interests of pluralism and innovation, payment systems should be locally determined to the maximum extent possible. Under federally financed programs, this may be best accomplished through consumer choice approaches, competitive bidding by private carriers to underwrite and administer such programs in a region, demonstration and waiver opportunities, and/or other means.
2. Hospital payment rates should be set in advance for some minimum period of time (e.g., annually) and thereby provide reasonable degrees of predictability for both the hospital and the payer.
3. The basis for determination of rates should be non-elemental and output-oriented (i.e., should not be founded in definitions, or standards regarding the appropriate level, of specific elements of allowable costs or financial requirements) in order to minimize administrative burdens for both the hospital and payer and to ensure that hospital management prerogatives are maintained.

4. Payment systems should provide a balance of financial risks and rewards for efficient and effective hospital management.
 - a) As sound management includes efforts to help ensure that only medically necessary and appropriate services are provided, payment systems at a minimum should avoid disincentives for effective utilization and quality assurance mechanisms and at a maximum, should reward hospitals for such mechanisms.
 - b) Hospital performance in relation to prospective rates set for one time period should not affect the rates determined for a subsequent period, in order to avoid a "ratcheting-down" effect whereby the individual hospital over time loses the ability to be rewarded for continued management-effectiveness and to generate reasonable levels of operating income from the payer on an on-going basis.
 - c) The payment system should be coordinated with other external financing mechanisms to assure that well-managed hospitals are not financially penalized/disadvantaged for providing charity care or for conducting medical education, research and medical-technology testing programs. In other words, a well-managed hospital should not have to utilize net operating income derived from the provision of direct patient services to the payer's beneficiaries or subscribers to subsidize the costs of these socially responsible efforts, thereby eroding its capital.
5. In order to achieve a better balance in the bargaining powers of hospitals and payers in negotiating effective payment systems and in determining rates under those systems, and to help moderate consumer demand for services, hospitals should have the option of billing the patient for amounts that exceed the pre-determined rates.
6. Given the critical role of physicians in influencing patient demands for and use of hospital services, the incentives inherent in systems for paying hospital medical staff members should complement and reinforce those inherent in hospital payment systems.