association of american medical colleges

A G E N D A

COUNCIL OF TEACHING HOSPITALS
Administrative Board Meeting

November 8, 1982
Washington Hilton Hotel
Chevy Chase Room
7:30-9:00am

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH Administrative Board Meeting
September 9, 1982

PRESENT

Mitchell T. Rabkin, MD, Chairman
Mark S. Levitan, Chairman-Elect
Stuart J. Marylander, Immediate Past Chairman
James W. Bartlett, MD, Secretary
Jeptha W. Dalston, PhD
Robert E. Frank
Earl J. Frederick
Irwin Goldberg
Sheldon S. King
John A. Reinertsen
Haynes Rice

ABSENT

Fred J. Cowell
Spencer Foreman, MD
William T. Robinson
John V. Sheehan

GUESTS

Manson Meads, MD
Nancie Noie
Thomas K. Oliver, Jr., MD
Richard S. Wilbur, MD

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Melinda Hatton
Joseph C. Isaacs
Richard M. Knapp, PhD
Anne Scanley
Nancy E. Seline
Melissa H. Wubbold

I. Call to Order

Dr. Rabkin called the meeting to order at 9:00am in the Chevy Chase Room of the Washington Hilton Hotel. He introduced Manson Meads, MD, Vice President for Health affairs at Wake Forest University Medical Center which is comprised of Bowman Gray School of Medicine and North Carolina Baptist Hospital in Winston-Salem. Dr. Meads is a Distinguished Service Member representative to the AAMC Executive Council and joined the COTH Administrative Board for its discussion today. Before moving directly to the Agenda, Dr. Rabkin noted that Dr. Knapp wished to report on two matters of interest.

Dr. Knapp reported that a Management Advancement Program is being planned for September 30-October 5, 1983 to be held at the Far Horizons Hotel on Long Boat Key in Sarasota, Florida. All COTH Chief Executives who have not attended a session in the past will be invited on a first come, first serve basis and the attendance will be cut off between 45-50 individuals. Special arrangements will be made with the Veterans Administration to select those VA Chief Executives who wish to attend.

Dr. Knapp also reported that the staff is planning to expand the University-Owned and Operated Survey to include all major affiliated hospitals. He indicated that there was an awareness of the difficulty in identifying the list but that staff would be working with a variety of criteria in order to compile the list of those hospitals that should be included.

II. Consideration of the Minutes

Dr. Dalston called attention to the section of the minutes describing COTH sponsorship of a capital purchasing program and indicated that much of this discussion as expressed in the minutes carried a negative tone. He felt that a number of positive points were made in the discussion. While no change was made in the minutes, there was a consensus that all those present were aware of the positive points raised, but that the four questions with the negative tone had served well to identify issues for the Committee that was appointed to study the matter.

ACTION: It was moved, seconded and carried to approve the minutes of the June 24, 1982 Administrative Board Meeting without amendment.

III. Membership Applications

Dr. Bentley reviewed the membership application. Based on staff recommendation and Board discussion, the following action was taken:

ACTION: It was moved, seconded and carried to approve Memorial Hospital in Chattanooga, Tennessee for CORRESPONDING MEMBERSHIP.

IV. Statement on Status of Minority Students in Medical Education

Dr. Cooper indicated that despite major efforts which successfully increased black first year enrollment to a peak of 7.5% in 1974-75, the proportion of total enrollment for the under-represented minorities (blacks, American Indians, Mexican Americans and mainland Puerto Ricans) has formed a plateau at about 8%. The size of the applicant pool represented by these minority groups has remained relatively stable over a five year period. Although the percentage for blacks increased by about one percentage point from 1977-78 to 1978-79, it has remained at about that level for the following years. The proportions for American Indians and Mexican Americans and mainland Puerto Ricans showed little change over the five year period. Also for this period, the percentage of under-represented medical school graduates remained at approximately seven percent. In light of the current trend in minority application and enrollment activity and the anxiety over the current financial assistance situation, Dr. Cooper recommended that the Board approve the statement as set forth on page 53 of the AAMC Executive Council Agenda.

ACTION: It was moved, seconded and carried to approve the statement as set forth on page 53 of the AAMC Executive Council Agenda book.

V. Report of the Ad Hoc Committee on Joint Major Equipment Purchasing

Dr. Bartlett, who chaired the ad hoc Committee, described the meeting which was held on the previous day. He explained that the Committee recognized that as part of their research, patient care and education missions, AAMC constituents are high technology users for whom group purchasing could offer significant savings and market position benefits. These constituents include not only teaching hospitals, but also medical schools which often utilize high technology equipment (e.g.; nuclear magnetic tape resonators) that is not yet reimbursable for use by hospitals in patient care.

Dr. Bartlett stated that the Committee expressed some fear of being "aced out" of opportunities by other purchasing groups and determined that the AAMC should explore the major equipment

needs of its constituency and the alternative group purchasing arrangements available to them. He noted that representatives of two major equipment purchasing groups, Voluntary Hospitals of America (VHA) and the Metropolitan Associations Purchasing Service (MAPS), attended the Committee meeting. He reported that the Committee discussed the broader question of the roles of COTH and the AAMC in relation to advocacy and representation versus a service orientation. Also addressed by the Committee were the unique problems of state university hospitals which have limited purchasing flexibility and the critical concerns regarding capital formation and the difficulties in acquiring capital. Dr. Bartlett felt it was particularly interesting to note that the Committee's discussion focused almost exclusively on radiology, which apparently consumes the largest portion of most hospitals' capital equipment budgets.

Dr. Cooper emphasized that placing the AAMC in the role of an operator would be a substantial departure from its traditional role and would be a proposal that would need to be discussed more broadly among all the Councils and approved by the Executive Council. Dr. Rabkin expressed appreciation to Dr. Bartlett and Mr. Frank for their work on the ad hoc Committee and agreed with the Committee's recommendation to pursue more information on constituent needs and available alternatives prior to committing the Association on any significant new course. Both Dr. Dalston and Mr. Reinertsen were concerned that the need for urgent AAMC action on this issue was not being adequately sensed. Dr. Knapp responded that the need to do something, particularly for the Appalachian Teaching Hospital group that originally approached the Association for assistance, is fully recognized. Dr. Bartlett stated that the Committee concurred with this view, but recognized the need to first assess the situation.

Although no official action was taken by the Board, there was the consensus that the following ad hoc Committee recommendations should be presented to the AAMC Executive Council:

> "In light of the rapidly changing structure of the hospital field and market, the AAMC should examine what group services are needed by teaching hospitals and medical schools, and how such services might be effectively provided to preserve and strengthen both the individual institution and the influence of teaching hospitals and medical schools as groups of institutions.
>
> "With respect to group purchasing, the AAMC staff should be requested to assess the access of AAMC constituents (teaching hospitals and medical schools) to currently

operating group purchasing activities for major capital equipment and ascertain if the need for improved and broader access to such services is a specified need of AAMC constituents."

The COTH Board requested that a written report be prepared of the Committee's deliberations and AAMC staff findings, which would be available for review and discussion at the January Administrative Board and Executive Council meetings. Further, the AAMC should consider this matter as a possible item for discussion at the AAMC Officers' Retreat in December.

VI. Payment for Services of Provider Based Physicians

Dr. Knapp distributed background material on this issue which is attached as Appendix A to these minutes. He described Section 108 of the Tax Equity and Fiscal Responsibility Act of 1982 which is addressed to the issue of payment for services of provider based physicians. He indicated that under the terms of Section 108, the DHHS Secretary is to prescribe regulations which will distinguish between (1) professional medical services which are personally rendered to an individual patient which contribute to the patient's diagnosis and treatment and are reimbursable only under Part B on a charge basis; and (2) professional services which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. Since to a large degree such an action will be directed at physician reimbursement in the clinical laboratory, Dr. Knapp reviewed the January 24, 1980 Executive Council Action with respect to Medicare reimbursement for pathology services (also included in Appendix A to these minutes).

Following discussion it was agreed that the COTH Administrative Board recommend to the AAMC Executive Council that the current AAMC position is appropriate to deal with this issue. It was further recommended that the staff review the position taken by the College of American Pathologists and work with that organization in resolving this set of problems.

VII. Election of Distinguished Service Members

Dr. Rabkin explained the criteria for nomination to Distinguished Service membership in the AAMC which are set forth on page 24 of the AAMC Executive Council Agenda book. He indicated that the staff had reviewed the situation and recommended that Chuck Womer be recommended by the COTH Administrative Board for Distinguished Service membership.

ACTION: It was moved, seconded and unanimously carried that Mr. Charles Womer be recommended for Distinguished Service membership in the AAMC.

VIII. Relationships with the JCAH

Dr. Rabkin reported that Dr. John Affeldt, JCAH President, is very interested in hearing more on teaching hospital concerns about the Joint Commission and discussing their current and future relationships. Dr. Affeldt will be joining the Administrative Board at its January meeting. Therefore, Dr. Rabkin requested that the Board members identify issues which Dr. Affeldt could be asked to address. The following suggestions were made:

- o the current status of the appeals process -- Mr. Rice;
- o the definition of "professional staff organization" -- Mr. Rice;
- o privilege delineations for physicians who admit few patients -- Mr. King;
- o quality and attitude of surveyors and status of specialized teams for teaching hospitals -- Mr. King, Dr. Dalston and Mr. Levitan;
- o status of joint surveys (e.g.; with state licensure reviews) -- Mr. Goldberg;
- o equivalency standards that would enable teaching hospitals to demonstrate how they assure quality of care -- Mr. Goldberg;
- o teaching hospital ability to meet medical records requirements -- Mr. King; and
- o the challenges generally facing the JCAH now and in the future.

Dr. Knapp was requested to write to Dr. Affeldt and review the outcome of the Board's discussion on this agenda item.

IX. AAMC Study of Teaching Hospital Characteristics

As agreed at the June Board meeting, the original draft report on the characteristics of teaching hospitals had been revised into two reports and mailed to the Board in August. Dr. Bentley briefly reviewed each report in terms of its intended purpose, audience and tone. Board members were generally pleased with the outcome of the revision and each of the separate reports was viewed as more appropriate for its purpose that the original had been. Several members offered suggestions for re-wordings and editorial changes. The

discussion concluded with Board members agreeing to submit comments on the drafts within two weeks. Upon receipt of the comments, staff will review both reports and distribute them to the appropriate audiences.

X. Preparation for Leadership in the Teaching Hospital/ Academic Medical Center

Dr. Dalston opened his presentation on this agenda item by asking the following question; "Given the present high demand for leadership and administrative performance in teaching hospitals and the rapid intensification of the leadership requirements for teaching hospitals, how can the field enhance preparation of new careerists and ultimately increase effectiveness in office?" He defined "the field" as hospital administration, academic medicine, medical administration and medical school administration. He noted that numerous actors are already on the scene dealing with leadership preparation -- graduate programs in hospital/health administration, MBA graduate programs, schools of public health, business schools, clinical department chairmen and clinical practitioners (administrative residencies, internships, externships, fellowships, etc.).

Dr. Dalston then explained some of the major issues which he wished the Board to consider:

- Can teaching hospital management/leadership be taught academically?
- Is it within the purview of COTH to become involved in career preparation of these persons?
- Should COTH become involved in career preparation or continuing education for leadership in teaching hospitals?
- Should COTH expand its Executive Development (MAP) program?
- Should COTH get involved in post-master's clinical practitioner training?
- Should any effort be put forth to reduce the sea of confusion relative to administrative residencies, fellowships, internships, externships and management development programs?

He noted that the AUPHA, general education accreditation bodies, individual institutions and health care corporations and systems, the ACHA, individual universities and programs,

hospital trustees and university vice presidents and officers are among those who have expressed concern about this issue of hospital management development and are seeking problem resolution. In response to the question; "Should COTH get involved?", Dr. Dalston believed the answer to be yes and that COTH /AAMC should wish to exert an influence, though not necessarily as a primary player. He suggested that he would develop a background paper if the Board expressed interest in the subject.

After further discussion by the Board, there was a consensus that the issue needed more discussion. Dr. Dalston was asked to elaborate on his presentation with additional pertinent information for further Board consideration.

XI. AAMC Response to the Enactment of the Small Business Innovation Act

Anne Scanley of the AAMC's Department of Planning and Policy Development informed the Board of some of the ramifications of the recently adopted Small Business Innovation Act that set aside portions of the government research funds to go to small businesses. According to Ms. Scanley, institutions that had been considering establishing spin-off organizations to act as small businesses should be aware that the law precludes these spin-off organizations from being eligible for these set-aside funds. However, individual faculty members and physician staff can organize small businesses to apply for these funds. Such activities can detract from the physician's commitment to the institution. Possibilities for COTH members to obtain some of these funds include signing consulting, leasing or subcontract agreements with eligible small businesses.

ACTION: The Board recommended that the Association staff wait until the proposed regulations implementing this legislation are published before notifying members of the significance of the act.

XII. Graduate Medical Education Positions

A brief discussion was held in which the Board members agreed that their comments regarding the potential shortage of graduate medical education positions had been made during the previous evening's joint Board meeting with the Council of Deans and the Organization of Student Representatives. Board members had expressed concern about the ability of teaching hospitals to maintain the number of residency positions given the imposition of Medicare and other reimbursement constraints and about the desire of some groups of specialists to add years to the present length of the residency program in their specialty.

The Board agreed no action was necessary

XIII. AHA Prospective Payment Plan

As a result of the COTH Administrative Board recommendation in June that the AAMC should support the American Hospital Association's prospective payment proposal in principle, the proposal's outline was included in the Executive Council Agenda. This item required no action by the Board; however, Dr. Bentley requested Board guidance on a discussion paper of design principles prepared by the AHA for the proposal. Principle 1 stated, "Over the long term, payment for hospital services under the Medicare program should move to locally determined, market-oriented pricing systems." Dr. Bentley's question concerned the Board view of the principle's endorsement of the phrase "involving bidding and negotiations." Without formal vote, the Board instructed Dr. Bentley to seek the removal of this phrase from the draft principle.

XIV. Information Item: Hospitals Having Terminated COTH Membership, 1980-82

Dr. Knapp reported that he wished the Board to be aware of those 18 institutions that had terminated membership in the Council of Teaching Hospitals since 1980. He indicated that repeated efforts both by Mark Levitan and himself to reactivate the membership of Children's Hospital of Philadelphia had not met with success. Stuart Marylander volunteered to discuss the matter with the chief executives of Rancho Los Amigos Hospital in Downey, California and Martin Luther King, Jr. General Hospital in Los Angeles. John Reinertsen indicated he would discuss the matter with the administrator of the Veterans Administration Medical Center in Salt Lake City.

XV. Adjournment

The meeting was adjourned at 12:30pm.

PAYMENT FOR SERVICES OF PROVIDER BASED PHYSICIANS

(Section 108 of the Bill)

Present law.—Hospitals and skilled nursing facilities retain or employ various kinds of physicians, such as radiologists, anesthesiologists and pathologists, who provide numerous services for the institution itself in addition to direct patient care services. The services that these hospital-based physicians perform for the institution may include supervision of professional or technical personnel in certain hospital departments (e.g., laboratory or X-ray departments), research, teaching or administration. These practitioners negotiate a variety of financial agreements with hospitals and skilled nursing facilities regarding the services rendered by them in the provider setting.

Under current law and regulations, services furnished by a physician to hospital inpatients are reimbursed on the basis of reasonable charges under part B only if such services are identifiable professional services to patients that require performance by physicians in person and which contribute to the diagnosis or treatment of individual patients. All other services performed for the hospital (or for a skilled nursing facility) by provider-based specialists (e.g., radiologists, anesthesiologists, pathologists) are to be reimbursed as provider services on the basis of reasonable costs.

Committee amendment.—While the above policy has been established by the law and by regulation since the inception of the medicare program, it has never been uniformly implemented. As a result the amounts that the program has paid to some hospital based physicians are related to the amount of work performed by hospital employees rather than by the physician himself.

The committee amendment directs the Secretary of Health and Human Services to prescribe regulations, effective no later than October 1, 1982, which will distinguish between (1) professional medical services which require performance of the physician in person and which are personally rendered to individual patients and which contribute to the patients' diagnosis and treatment and are reimbursable only under part B and (2) the professional medical services of practitioners which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. The Secretary would be expected to prescribe specific conditions, appropriate to each of the physician specialties, to establish when a practitioner's involvement in a patient care service is adequate to justify treating it as a physician service which is reimbursable on a reasonable charge basis under the part B program.

Medicare reimbursement for the services that would be covered under the respective parts of the program would be subject to appropriate tests of reasonableness.

As in the case of other physicians, services that are reimbursable on a reasonable charge basis will be subject to the customary-and-prevailing charge limits established under Part B of medicare. Similarly the compensation for supervision, teaching, administration and other professional services that would be reimbursable on a reasonable cost basis would be evaluated in terms of time that the physician expands, compensation comparability, and such other factors as the Secretary may prescribe.

The commitee directs the Secretary to monitor changes in arrangements, patterns of service and hospital physician relationships as a result of this proposal.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1983	$63
1984	73
1985	84

REIMBURSEMENT OF PROVIDER-BASED PHYSICIANS

SEC. 108. (a) Title XVIII of the Social Security Act is amended by adding after section 1886 of the Social Security Act (as added by section 101(a)(1) of this subtitle) the following new section:

"PAYMENT OF PROVIDER-BASED PHYSICIANS

"SEC. 1887. (a)(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

"(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and

"(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis.

"(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

"(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

"(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility.".

(2) Section 1861(v)(7) of such Act, as amended by section 101(d) of this subtitle, is further amended by adding at the end the following new subparagraph:

"(C) For provisions restricting payment for provider-based physicians' services, see section 1887.".

(c) The Secretary of Health and Human Services shall first promulgate regulations to carry out section 1887(a) of the Social Security Act not later than October 1, 1982. Such regulations shall become effective on October 1, 1982, and shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act to a hospital or skilled nursing facility resulting from the such regulations shall be imposed only in proportion to the part of the period which occurs after September 30, 1982.

Conference agreement

The conference agreement includes the Senate amendment with minor modifications. The agreement directs the Secretary to prescribe regulations which will distinguish between (1) professional medical services which are personally rendered to an individual patient, which contribute to the patient's diagnosis or treatment, and are reimbursable only under part B on a charge basis; and (2) professional services which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. Reasonable cost reimbursement for provider-based services could not exceed a reasonable compensation equivalent established by the Secretary in regulations. The conference agreement directs that regulations implementing this provision be published and effective by October 1, 1982. The conferees understand that such regulations are already under preparation by HHS. The publication and timely implementation of these regulations would reflect the intent of the conferees.

Medicare Reimbursement for Pathology Services

In promulgating reimbursement policies for Medicare, HEW and Congressional policy-makers have proposed various methods to separate Part A and Part B services provided by physicians. These proposals have been of serious concern to a number of medical disciplines, particularly pathology. The Association's Executive Council policy approved in March 1977 supported reimbursement policies which recognized crucial professional services in pathology and furthered the development of the discipline and opposed payment limitations which inhibited development of the discipline. A copy of a recent draft revision of HCFA regulations was objectionable to pathologists because it required the pathologist to be personally involved in the performance of each clinical pathology service in order to receive fee-for-service payment. The Association's ad hoc Committee on Section 227 considered this issue at its October 17 meeting, and recommended a revision in the Association's current policy to make it consistent with Senate Finance Committee language supporting percentage arrangements based on a relative value scale for compensation of pathologits. It was reported that such a policy was supported by pathologists. The proposed new policy statement:

> While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the contributions pathologists make to patient diagnosis and treatment and inhibit the development of the discipline. The Association, notes, however, that Senate Report 96-471 would permit physicians to be compensated on a percentage arrangement if the amount of reimbursement is based on an approved relative value scale "...which takes into consideration such physicians' time and effort consistent with the inherent complexity of procedures and services." The Association supports such a proposal.

The Council of Deans reported some discomfort with supporting percentage contract arrangements, but recognizing the difficulty in changing funding for any department within a short period of time, by a split vote agreed that the statement should be supported as a temporary device. CAS approved the statement, citing its concern that the development of the discipline might otherwise be inhibited. COTH recommended that the statement be

amended to clarify that the percentage contract arrangement was being supported as only one option of compensation, and on that basis had approved the statement.

ACTION: On motion, seconded, and carried, the Executive Council agreed to amend the proposed policy statement to add the phrase "as one option of compensation for pathology."

ACTION: On motion, seconded, and carried, with one dissenting vote, the Executive Council approved the following policy statement on payments for pathologists services:

While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the contributions pathologists make to patient diagnosis and treatment and inhibit the development of the discipline. The Association noted, however, that Senate Report 96-471 would permit physicians to be compensated on a percentage arrangement if the amount of reimbursement is based on approved relative value scale "...which takes into consideration such physician's time and effort consistent with the inherent complexity of procedures and services." The Association supports such a proposal as one option of compensation for pathology.

Adapting to Per Case Payment Systems

The Tax Equity and Fiscal Responsibility Act of 1982 significantly changed Medicare payments to hospitals using "target rates" and expanded Section 223 limits, both of which are computed and applied on a cost per case basis. Three national organizations are presently developing educational programs to help their members adapt to payment limits set on a per case basis:

- American Hospital Association/Ernst and Whinney,
- Healthcare Financial Management Association/ Coopers & Lybrand, and
- some state hospital associations/Arthur Young and Co.

Undoubtedly, other groups will also be developing membership education programs.

A review of the programs presently being developed shows that they share several characteristics. They are oriented primarily toward understanding the conceptual rationale for the two limits, properly computing the limits, determining the financial impacts of the limits, and discussing the managerial implications of per case limits. As announced, the programs are designed for audiences of chief executive and financial officers.

The per case payment limits present hospitals with distinct financial incentives to: (1) reduce length of patient stays, (2) decrease ancillary service use, and (3) manage the balance of high cost and low cost patients. Successfully responding to these incentives requires management of the medical activity of the hospital; new management structures and techniques combining administrative and clinical decisions must be developed. This is particularly true for teaching hospitals because of their emphasis on adding new "high cost" services, their dominance in caring for "high cost" tertiary care patients, their relatively high use of ancillaries, and the large number of physicians and residents involved in patient care decisions.

While per case limits appear to meld some administrative and clinical decisions, educational programs presently being developed are directed toward administrative executives only. This seems to be a serious shortening which the AAMC could address by drawing upon the Council of Teaching Hospitals and the Council of Academic Societies. Workshops on adapting to per case limits (and payment systems) could be developed for joint administrative and clinical teams. For example, a workshop could be developed for five-member hospital teams: hospital director, chief financial officer, clinical chairperson, chief nurse, and a chief resident. A possible topical outline for the workshop could be as follows:

Living with Per Case Revenue in Teaching Hospitals

I. Workshop Introduction
   - A. Brief summary of new Medicare payment limits
   - B. Brief summary of financial and operational implications

II. Use of Ancillaries in Teaching Hospitals
   - A. A review of the literature on increased ancillary use in teaching hospitals
   - B. A review of the literature and experiences on prior efforts to reduce ancillary use in teaching hospitals--what have we learned
   - C. A presentation on the cash flow and cost impacts of reduced

ancillary use by a hospital which has experienced a reduction in ancillary use or a substantial reduction in the increase in ancillary use

III. Monitoring Performance using New Management Information Systems
- A. Approaches to categorizing patients by type of case
- B. Data collection requirements for per case classification
- C. Steps teaching hospitals have taken to improving data quality
- D. Approaches teaching hospitals have taken to projecting and monitoring practice patterns

IV. New Approaches to Making Program Decisions
- A. Methods for determining and evaluating the financial implications of program and service changes
- B. New approaches teaching hospitals have taken to joint administrative/clinical decisions
  - 1) allocating the capital budget
  - 2) allocating the operating budget
- C. New tensions and stresses that have developed as a result of joint administrative/clinical decisions

V. Revenue Management
- A. Reordering the budget process: completing the revenue budget before the expense budget--a symbolic and substantive change
- B. Projecting revenues using new methods for predicting demand

VI. Administrative/Physician/Nurse Team Building
- A. Communicating the more critical interdependence of all parties
- B. Preserving cherished values within new decision structures

VII. Implications of Per Case Limits/Payments for the Future
- A. A new step toward competition and an opportunity to learn
- B. Marketing to obtain a balanced mix of patients
- C. Controlling operations to ensure access to capital

Depending upon the final content of any workshop, it may be desirable to offer separate workshops for (1) university-owned and primary affiliates staffed primarily by faculty physicians and (2) community teaching hospitals staffed primarily by community physicians. The separation of the membership into these two groups would recognize that the community teaching hospitals have to develop approaches and responses appropriate to the town-gown split within their medical staffs.

Action

The COTH Administrative Board is requested to discuss the desirability of the AAMC developing one or more workshops on adapting to per case payments. If the Board believes the AAMC should develop such workshops, the Board is requested to discuss both the desired audience and content of the workshops.