

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

October 28, 1985
WASHINGTON HILTON HOTEL
Dupont Room
7:00am-9:00am

- I. CALL TO ORDER
- II. CONSIDERATION OF MINUTES
September 12, 1985
- III. NOMINATING COMMITTEE REPORT
- IV. OTHER BUSINESS
- V. ADJOURNMENT

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Mr. Rice

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
September 12, 1985

PRESENT

Sheldon King, Chairman
C. Thomas Smith, Chairman-Elect
Haynes Rice, Immediate Past Chairman
Robert J. Baker
Jeptha W. Dalston, PhD
Gordon M. Derzon
Gary Gambuti
Glenn R. Mitchell
James J. Mongan, MD
Eric B. Munson
David A. Reed
Thomas J. Stranova
Deal Brooks, AHA Representative

ABSENT

J. Robert Buchanan, MD
Spencer Foreman, MD

GUESTS

Kimberly Dunn, OSR Representative, University TX
Richard Janeway, MD
Kirk Murphy, OSR Representative, Hahnemann

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Paul R. Elliott, PhD
Thomas J. Kennedy, Jr., MD
Richard M. Knapp, PhD
Karen L. Pfordresher
Nancy E. Seline
Kathleen Turner

COTH ADMINISTRATIVE BOARD
Meeting Minutes
September 12, 1985

I. CALL TO ORDER

Mr. King called the meeting to order at 8:15am in the Cabinet Room of the Shoreham Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the June 20, 1985 COTH Administrative Board Meeting.

Prior to moving to the agenda, Mr. King welcomed two members of the OSR Administrative Board who would be joining the meeting, and asked that they introduce themselves. He reminded the Board that Mr. Gambuti will chair the committee to plan next year's COTH Spring Meeting in Philadelphia. Other members of the committee are: Chuck Buck, Hospital of the University of Pennsylvania; Jim DeNiro, Veterans Administration Medical Center (Palo Alto); Bob Johnson, District of Columbia General Hospital; Gerry Mungerson, Illinois Masonic Medical Center; and Ed Schwartz, University of Minnesota Hospitals and Clinics. The Committee is to have its first meeting on October 1 to begin its work.

The Chairman reported that there had been established an AAMC Committee on Faculty Practice Plans. That Committee had its first meeting on September 11. The Committee is chaired by Dr. Ed Stemmler, Dean at the University of Pennsylvania. COTH representatives to the Committee are Robert Heyssel, MD, The Johns Hopkins Hospital; John Ives, Shands Hospital; and Raymond Schultze, MD, UCLA Medical Center. A committee also has been established to study the MCAT. Andrew Wallace, CEO at Duke University Hospital, is the COTH representative.

The House Budget Committee is reviewing the Medicare Prospective Payment System. Charles Buck, CEO at the Hospital of the University of Pennsylvania, will be appearing on behalf of COTH/AAMC before that Committee on October 7. Mr. King reminded the Board that Congressman Gray from Philadelphia chairs the House Budget Committee. He also indicated that Dr. Foreman presented a keynote luncheon address to a crowd of over 300 people at the AAMC National Invitational Conference on Clinical Education of Medical Students. Mr. Rice, who was present at that conference, reported that Dr. Foreman carried the COTH flag with brilliance.

Mr. King then reported on an activity in which he was engaged entitled, "Counsel 2000" sponsored by the American Podiatric Association. He reported that there are six schools of podiatry that are graduating approximately 600 students per year, and that those students have a less than 3.0 grade point average. There are only 400 residency positions available and he reported that it would be expected that many more residencies would be requested. He also indicated that there was little in the way of standards for residencies and they varied in the

length of training period. Finally he indicated that the whole question of the scope of service activity of podiatrists was in a state of flux with a fair amount of variation by state concerning the definition of the foot and the various procedures that were permitted to be performed by podiatrists.

As a last matter, Mr. King reminded each of the Board members that there would be a Board meeting on the morning of Monday, October 28, during the AAMC Annual Meeting, and urged that those who had not yet registered for the meeting do so.

At this point Mr. King called on Dr. Knapp for any additional matters he might have to report to the Board. Dr. Knapp indicated that he had called the chief executive officer of Rochester Methodist Hospital in Rochester, MN, and that Mr. Winholtz indicated no displeasure on any policy or other matters related to the hospital's membership in the Council of Teaching Hospitals, but indicated that since most of the policy and other such matters at the Mayo Clinic with regard to education and other service matters were decided by the executives at the Mayo Clinic, the hospital had decided to save the dues which would be spent on the Council of Teaching Hospitals. Dr. Knapp also reported that as requested by the Board, he had asked for a copy of the AHA Survey of Board Chairmen and CEO's on their views concerning relationships with respective associations. The results of that survey were not yet available, and there was some question as to how useful the survey results would be. He then indicated that in discussions with Mr. Smith and Mr. King, it was agreed that discussion of the role of the Council of Teaching Hospitals as well as the AAMC and new directions that should be charted, should come to a close. The staff believes they have appropriate direction based on recommendations of the Board, and that until such time as a leadership change takes place at the AAMC, there would be no need to discuss the matter further. He did indicate the following activities were taking place. The staff is writing for journals that are outside the general readership that teaching hospital directors might read on a regular basis. An article on financing graduate medical education will appear shortly in a journal entitled, Physician Practice Management; a manuscript has been submitted to Business and Health; and a manuscript is under development to appear in a Florida medical journal. In addition, Dr. Knapp indicated that the staff was doing its best to improve and strengthen relationships with staff members of American Healthcare Systems and the Consortium of Jewish Hospitals. Similar efforts are underway with the University Hospital Consortium and Voluntary Hospitals of America.

The AAMC is planning four regional seminars entitled, "Academic Medical Centers and the Challenges Posed by Alternative Delivery Systems." Individuals important to policy making concerning hospital and medical practice matters will be invited to these seminars. The staff is also developing a survey to identify work that is under way within the teaching hospital community to identify problem "DRG's." If sufficient results are identified, a conference on this subject may be held in the late spring or summer of 1986.

Finally, the item on the Board agenda devoted to "Medicare Outpatient Surgery Savings, Access, and Quality Act" points to a direction of establishing a competitive price for free standing facilities and services with which teaching hospitals are going to have to compete. The staff is working on activities the

AAMC could undertake to assist major teaching hospitals in a uniform pricing system.

III. MEMBERSHIP

Following discussion and appropriate consideration, the following action was taken:

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

NAVAL HOSPITAL, Bethesda, Maryland for full membership.

IV. THE INDEPENDENT STUDENT ISSUE

Paul Elliott, PhD, Director, AAMC Division of Student Programs, joined the Board to describe the controversy surrounding the issue of when a student should be declared independent for the purpose of student financial assistance under Title IV. The AAMC has been working with a coalition of other educational associations under the leadership of the American Council on Education (ACE) to develop a consensus position on the upcoming reauthorization of the Higher Education Act. In all but one instance, the positions taken by the ACE coalition are consistent with positions taken previously by the AAMC. The one instance is the definition of what constitutes an independent student. The question is when a student is independent of his or her parents for determination of need under the Federal Student Loan and Work Study Programs. The coalition has proposed automatic emancipation for all graduate and professional students. This would mean medical students would not be required to provide information on parental resources in order to be eligible for the Guaranteed Student Loan or National Direct Student Loan programs. In the past, the AAMC has stressed that students and their families bear primary responsibility for financing medical education. This past spring, the AAMC's Group on Student Affairs Committee on Student Financial Assistance had a thorough discussion of the issue and unanimously voted against the ACE's proposed stance. Dr. Elliott noted that the ACE's proposal was not consistent with the AAMC's policy that Federal aid to medical students should create and maintain access to the profession for all qualified students. He said that the public was already beginning to question the need for Federal financial aid for students destined to enter a highly remunerative profession. Allowing students of affluent parents to gain access to scarce Federal funds is likely to increase public skepticism. Dr. Elliott asked that the Board support the staff recommendation that the AAMC oppose the ACE consortium position on independent student status.

ACTION: It was moved, seconded, and carried to approve the staff recommendation to oppose the ACE's proposed expansion of the definition of independent student.

V. HEALTH PLANNING

Dr. Bentley reviewed the discussion of health planning, and the recommendation that was voted upon at the June COTH Administrative Board meeting. He stated that the issue had been placed on the agenda once again for two reasons: (1) the Council of Deans' request for further background information, and (2) the need to verify the phrasing of the recommendation made at the June Board meeting. The June recommendation reads as follows:

- o That the Association support state-wide CON review of construction projects which result in new bed capacity or construction projects or new facilities which replace existing beds;
- o That the Association oppose CON review of major medical equipment or new institutional health services that do not result in increased capacity.

Clarification was requested concerning the CON review for renovations (i.e., whether the Board intended that a dollar threshold or some criteria for review be added to the language). Mr. Gambuti stated that in the June discussion, he had alluded to a dollar amount of \$5 million before renovations would be reviewed. Mr. Reed suggested that some dollar figure should be included, perhaps based on a percentage of a hospital's total physical plant. Mr. Smith suggested that the recommendation should refer to "new" rather than "increased" bed capacity, and that criteria defining "expanded bed capacity" as some percentage increase would be more workable than an open-ended requirement. He questioned whether an absolute dollar figure wouldn't be too rigid and suggested the use of some proportional increase in an institution's annual budget as the trigger for CON review. Mr. Munson stated such a concept might discriminate against the smaller, rural hospital. Discussion followed with further consideration of whether specific thresholds might force inequity into the review process. Mr. King stated that the emphasis should be on review of increased bed capacity whether it be new construction or renovations irrespective of the cost. Mr. Mitchell pointed out that it may be best to be silent on the requirement for review of renovations because in that case the institution places itself at risk and is perforce affected by the marketplace and considerations of competition.

The Administrative Board voted unanimously to revise its recommendation as follows:

- o That the Association support state-wide CON review of construction projects which result in increased bed capacity;
- o That the Association oppose CON review of major medical equipment or new institutional health services.

ACTION: It was moved, seconded, and carried to recommend that the Executive Council adopt the revised position on health planning recommended September 12, 1985 by the COTH Administrative Board.

VI. COMMENTARY ON GPEP REPORT

Dr. August Swanson, Director, AAMC Department of Academic Affairs, presented the Executive Council's revised commentary on the GPEP Report. Mr. King questioned conclusion #5 which appears to avoid dealing with the promotion problems of those faculty who do not produce scholarly papers. Dr. Swanson referred to a later entry in the document which does emphasize the need for a high degree of recognition and reward for effective teaching. Mr. Rice noted that the report neglected to allow credit to be given for service and administrative functions in the teaching hospital...activities that are necessary and deserving of attention and reward. Dr. Dalston, although agreeing in principle, stated that the academic system does not readily accommodate such activities which are divergent from the recognized aspirations of the academic environment. Kim Dunn, a representative from the Organization of Student Representatives, argued that medical schools were established to be service institutions and therefore service activities in the teaching hospitals should be recognized and rewarded, as they provide a needed balance to the emphasis on scholarly pursuits. Dr. Dalston stated universities historically do not give equal weight to service activities. Mr. King agreed that recognition of service is lacking in the university environment, and since medical schools must provide community and patient care services, there is an inherent problem with this issue. Dr. Swanson stated that this commentary is to address the GPEP Report itself and not that Report's omissions. The Board agreed to bring these unresolved concerns before the Executive Council for a broader-based discussion.

VII. RESEARCH FACILITIES CONSTRUCTION LEGISLATION

Dr. Thomas Kennedy, Jr., Director, AAMC Department of Planning and Policy Development, presented the research facilities construction legislative proposal to the Board. Dr. Kennedy requested general advice and guidance on behalf of the AAMC, as it negotiates within the program area of research facilities construction. This issue has become particularly relevant to the academic medical community in light of the deterioration of institutional research infrastructure.

The bill under discussion would set aside 10% of the budget of six major Federal research funding agencies - NSF, DOD, HSS, DOE, USDA, and NASA - for university-based research and development devoted to laboratory construction and renovation projects. Dr. Kennedy stated that the AAMC on the whole would prefer a traditional construction program, with funding as part of an NIH authorization appropriated by committees.

In support of the set-aside concept, Mr. Rice pointed out the current imbalance in the allocation of NIH research dollars, with 20% of the nation's medical schools receiving 80% of such funding. Dr. Dalston emphasized the amount of research taking place in the teaching hospital, to which Dr. Knapp suggested that language could be added to include such hospitals under this bill. Mr. Smith questioned whether the Federal government's response to this bill would be to clarify that payment for research-related renovation and construction was historically covered by overhead payments awarded as part of the institution's awarded grants. He also wondered if the bill would be considered a "budget

neutral" proposal with funding for the set-aside coming from the total NIH grant funds. Dr. Kennedy said no one is arguing at this time that overhead payments were to cover these costs, but agreed that "budget neutrality" is a legitimate concern.

Mr. Baker agreed that the AAMC should work to define the institutions to be included in the bill, and especially questioned whether investor-owned institutions would be eligible for these funds. Dr. Kennedy believed all eligible projects would be reviewed. Mr. Rice reiterated that it is important for the AAMC to support activities that are equitable, and not support a continuation of the old style of funding for a few, large institutions at the expense of the smaller institution.

ACTION: It was moved, seconded, and carried by a six vote endorsement that the AAMC support H.R.2823 as modified by the staff recommendations on page 62 of the September Executive Council agenda book, with three Administrative Board members opposing and two members abstaining.

VIII. REPORT OF THE COMMITTEE FOR THE GOVERNANCE AND MANAGEMENT OF INSTITUTIONAL ANIMAL RESOURCES

Dr. John Sherman, AAMC Vice President, described the recommendations of the Committee for the Governance and Management of Institutional Animal Resources as guidelines for improving procedures for the use of animals in research. The guidelines intend to ensure institutional priority for efforts to maintain high standards for the humane care of research animals. He stated that such guidelines are useful because they illustrate both institutional sensitivity to this highly publicized issue, and responsible and accountable use of public funds. Dr. Sherman informed the Board of several text changes that would amend the document to include teaching hospitals by adding the words "and hospitals" on page 73 and changing "university" to "institutions" throughout the document.

Mr. Smith expressed concern with the language on page 74 that states that a high ranking official responsible for the animal resources program should report "directly to the chief executive officer" as possibly interfering with an institution's prerogative to determine organizational responsibilities.

ACTION: It was moved, seconded, and carried to endorse this document pending discussion with the Executive Council on whether or not it would be appropriate to dictate internal institutional organization by including specific reporting requirements in such a document.

IX. TRANSITION TO GRADUATE MEDICAL EDUCATION: ISSUES AND SUGGESTIONS

In order to generate a thoughtful discussion of the problems with selection into residency training programs, Arnold Brown, MD, Chairman of the Council of Deans, requested that the AAMC staff, officers of the Group of Medical Education and the Group on Student Affairs officers develop an agenda item to be discussed at the September Administrative Board meeting. The problems include early match and

early commitment of medical students to particular residency slots, increasing competition among medical students for particular residency slots, and disruption of the normal medical education process by students taking certain electives in their upper class years in order to obtain access to a residency position they believe to be desirable. The agenda item contained numerous suggestions to improve the transition to graduate medical education, but the list is not exhaustive. Dr. Elliott commented that perhaps the most useful thing to come of the exercise of preparing the agenda item was to realize that there were really three separate sets of issues: (1) the selection process, (2) the clinical curriculum, and (3) the counseling process. Among the many recommendations included in the agenda item, Dr. Elliott suggested that four were very straightforward and achievable. They were:

- o Tighten up the third and fourth year elective restrictions that already exist in each of the medical schools;
- o Hold to the October 1 date for the deans submitting a letter of recommendation;
- o Develop a single application process for the residency training positions, similar to that which was developed by the AAMC for medical schools, which would give a structural basis for a single organization to gain control of the process;
- o Create handbooks for each specialty training program.

Dr. Elliott suggested that some action was necessary by the AAMC because the voluntary effort to control early admissions to residency training programs was not working, and students were getting panicky about getting into a program as quickly as possible.

The Board discussed this item, expressing some concern about the recommendation that the hospital directors should assume authority over the admissions to the residency training programs, but it did acknowledge that the institution should have a role in determining what students are admitted to its programs.

Dr. Elliott did not request a specific action from the Board other than expression of their general concerns.

X. MEDICARE OUTPATIENT SURGERY SAVINGS, ACCESS, AND QUALITY ACT

Dr. Knapp began the discussion with a brief description of the bill introduced by Senator David Durenberger (R-MN), which proposes establishing a single rate for the Medicare payment for ambulatory surgical service regardless of whether that service is provided in a hospital outpatient department or in a free-standing ambulatory surgical center. Dr. Knapp briefly described a conversation he had had with the chief executive officer of Manhattan Eye and Ear Hospital, in which the chief executive had alerted Dr. Knapp to the concerns of the eye and ear hospitals. Subsequently, the AAMC sent out a memo to its member institutions asking their reaction to this bill. In addition, Dr. Knapp had discussed this legislation with several congressional staff members. He asked the Board for its

reaction to the bill as currently written. Dr. Knapp did note that in his meetings with congressional staff, there seemed to be a general acceptance of the proposal that the residency training costs allocated to the outpatient services should be passed through just as they are on the inpatient side.

Dr. Cooper noted that the support services offered by hospitals were in excess of those offered by free-standing ambulatory surgery centers, and therefore the hospitals should be able to command a higher price for the surgeries they do. Mr. Smith passed out copies of his letter to Senator Durenberger (included in these minutes as Appendix A). The Senator has made specific reference to charges and costs at Yale-New Haven Hospital in proposing his bill, and Mr. Smith's letter was designed to refute the allegations that Yale-New Haven had extraordinarily high charges. Mr. Smith did concur with Dr. Cooper that there were costs to the backup services that are provided by hospitals. He suggested altering the bill to set fixed payment rates for hospital-based ambulatory surgery based on hospital-specific reasonable costs, but limited to no more than the amount paid for the same procedure on an inpatient basis. Mr. Baker commented that the hospital-specific cost based rates would be essentially cost-based payments, which might be a difficult concept to sell in the current political environment. He suggested an alternative of creating an average hospital rate for similarly situated hospitals. There was some concern expressed among Board members that because appropriate data were lacking, there would be an inability to identify problems that would be caused by such a reimbursement proposal.

After further discussion there was consensus that the AAMC should support the following policies:

- o For all procedures, payment for surgery performed in a hospital outpatient department should not exceed payment for a comparable inpatient DRG;
- o Where the coefficient of variation in current payments for a surgical procedure to hospitals is less than half the average price paid, the price paid for the service should be limited to the average payment to hospitals in the region for similar outpatients;
- o Where the coefficient of variation in current payments for a surgical procedure to hospitals is greater than half the average price paid to hospitals, it is not reasonable to assume patients are sufficiently similar to set limits using an average regional price; and
- o In all cases where a price limit or fixed price payment is established for outpatient services, teaching hospitals should be allowed to claim direct medical education costs on a passthrough basis separate from the fixed price or limit.

A copy of the letter sent to Senate Finance Committee Chairman Packwood is included in these minutes as Appendix B.

XI. ADJOURNMENT

There being no further business, Mr. King adjourned the meeting at 12:00noon.

Yale New Haven Hospital

20 York Street, New Haven, CT 06504

September 10, 1985

The Honorable David Durenberger
U.S. Senator for Minnesota
United States Senate Office
Washington, D.C. 20510

Dear Senator Durenberger:

I am writing in response to your proposed legislation, S.1489, "Medicare Outpatient Surgery Savings, Access, and Quality Act of 1985", and your comments included as part of the Congressional Record of July 24, 1985. While I share the philosophical intent of the legislation to establish a fixed rate reimbursement system for outpatient surgery, I take strong exception to your remarks about the cost of Hospital-based ambulatory surgery and particularly your erroneous statement of cataract surgery charges by Yale-New Haven Hospital.

In the Congressional Record you cited beneficiary co-payments in excess of \$900 based on charges of \$4500 by Yale-New Haven Hospital. This overall charge figure is far in excess of the actual \$1602 average Yale-New Haven charge for this outpatient procedure. Moreover, your statement is particularly misleading since Medicare reimburses reasonable costs rather than charges for the hospital component of outpatient surgery which is exclusive of professional fees.

The actual reimbursement from the Medicare Part B Trust Fund to Yale-New Haven Hospital for outpatient cataract surgery is less than the corresponding inpatient reimbursement rate for the Hospital. Based on the data submitted to the Department of Health and Human Services on Yale-New Haven Hospital's Medicare Cost Filing for 1984, the computed reimbursement to Yale-New Haven Hospital for Ambulatory Cataract Surgery is as follows:

FACILITY SERVICE	AVERAGE HOSPITAL CHARGE	COST TO CHARGE RATIO 1984 FILING	REASON-ABLE COST	REASONABLE COST-REIMBURSE. BY MEDICARE (80%)	BENEFICIARY CO-PAY (20% CHARGE)	ACTUAL MEDICARE REIMBURSE. FROM PART B TRUST FUND
Hospital Anesthesia	\$ 272	42.582%	\$ 116	\$ 93	\$ 54	(Difference of reasonable cost less beneficiary co-payment)
Ambulatory O.R. Fee	531	73.535%	390	312	106	
Lens	552	76.912%	425	340	110	
Eye Pathol.	113	71.767%	81	65	23	
Medications	110	52.610%	58	46	22	
Gen. Med/Surg	24	76.912%	18	14	5	
TOTAL:	<u>\$1602</u>		<u>\$1088</u>	<u>\$870</u>	<u>\$320</u>	

As you can see, the Hospital recovers only the "reasonable" cost of the procedure through Medicare payment of \$768 plus the beneficiary co-payment of \$320, for a total of \$1088. The \$768 Medicare payment represents the facility fee component paid to Yale-New Haven specifically addressed in the Congressional Record and is considerably less than \$4500.

When this facility fee for outpatient cataract surgery is compared to the Yale-New Haven Hospital inpatient reimbursement level (excluding indirect medical education) your hypothesis that hospital outpatient rates exceed inpatient rates is proven to be incorrect for Yale-New Haven Hospital. Our current inpatient DRG reimbursement rate is:

DRG 39 - Lens Implantation	
DRG 39 Weight	.4958
Hospital Reimbursement	<u>\$1939.15</u> (maximum allowable)
Assume 80% Part B Payment	<u>\$1551</u>

There are other elements of the legislation on which I would like to comment. The overall purpose of the proposed legislation is to establish a reimbursement system for Ambulatory Surgery based on a fixed fee "...regardless of setting". Such a reimbursement system would probably cause the erosion of Hospital Ambulatory Surgery programs due to the inability to recover reasonable costs, and at the same time, encourage the rapid proliferation of freestanding surgical centers. The impact of this proliferation on the frequency of unnecessary surgical procedures must be considered.

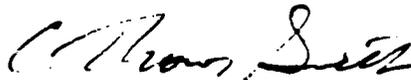
It is clear that costs in a complex full service hospital with all of the sophisticated equipment, service, technology and emergency capabilities operated twenty-four hours per day, seven days per week are higher than a freestanding operation without the same level of sophistication, emergency capability or unlimited hours of operation. Although freestanding surgical centers have demonstrated an ability to successfully perform outpatient surgery for routine cases, they are not prepared, to the same extent as an acute hospital, to manage emergencies that may arise during an ambulatory surgical case. If an emergent situation should arise during a procedure, immediate response and full service are necessary, and hospital-based ambulatory surgery provides a full range of emergency and back-up support. Staff are fully experienced in the management of life threatening situations. To reimburse these substantially different facilities at the same rate regardless of total costs, would be inequitable and illogical. In addition, it is very important to note that the very technological advancements in surgical technique that have created the opportunity for freestanding outpatient surgical centers were developed in and by hospitals. Financial support for the continued advancement of technology as an appropriate hospital-based expense must remain available so as to encourage further cost effective innovations in surgical practice.

In summary, I would encourage your consideration of the following sections as amendments to the original bill.

- o Establish fixed reimbursement rates for hospital-based Ambulatory Surgery based on hospital specific reasonable costs.
- o Limit Hospital-based Ambulatory Surgery reimbursement to a rate not to exceed inpatient DRG rates.
- o Maintain a separate fixed rate reimbursement schedule for freestanding outpatient surgery and update the freestanding Ambulatory Surgery prospective rate at least annually.

I would be more than happy to meet with you in your Washington office to further review the implications of the proposed legislation.

Sincerely,



C. Thomas Smith
President



association of american medical colleges

September 16, 1985

The Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chairman Packwood:

In the past few weeks, the price Medicare pays for ambulatory surgery in hospital outpatient departments has received considerable attention. The Association of American Medical Colleges, whose 375 non-Federal major teaching hospitals are major providers of outpatient services, has reviewed this issue carefully and found the most widely discussed proposals:

- o are based on incomplete and inaccurate data;
- o have compared only a very few procedures, primarily cataract surgery; and
- o have compared outpatient departments costs including related laboratory, radiology and prosthetic devices with free-standing surgery center prices excluding laboratory, radiology, and prosthetic devices.

In this situation, the AAMC does not believe it is appropriate or reasonable to use a single payment rate for both hospital outpatient departments and free-standing surgical centers. The Association believes Congress must act with prudence and caution to ensure that beneficiary access to care is protected while better data is collected and analyzed to make future payment decisions. Therefore, the AAMC strongly recommends that any legislation to modify payment rates for ambulatory surgery in hospital outpatient departments incorporate the following principles:

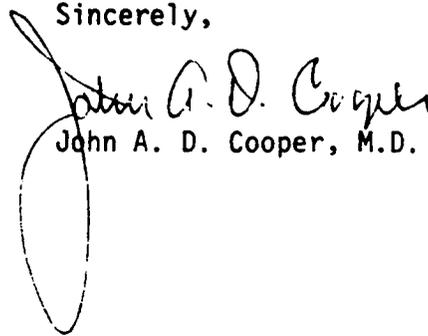
- o for all procedures, payment for surgery performed in a hospital outpatient department should not exceed payment for a comparable inpatient DRG;
- o where the coefficient of variation in current payments for a surgical procedure to hospitals is less than half the average price paid, the price paid for the service should be limited to the average payment to hospitals in the region for similar outpatients;
- o where the coefficient of variation in current payments for a surgical procedure to hospitals is greater than half the average price paid to hospitals, it is not reasonable to assume patients are sufficiently similar to set limits using an average regional price; and

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- o in all cases where a price limit or fixed price payment is established for outpatient services, teaching hospitals should be allowed to claim direct medical education costs on a passthrough basis separate from the fixed price or limit.

The AAMC believes legislation reflecting these principles will balance Congressional interest in improving hospital efficiency with the obligation to protect beneficiary access to services required.

Sincerely,


John A. D. Cooper, M.D.

cc: Members, Committee on Finance