association of american medical colleges

AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS

ADMINISTRATIVE BOARD MEETING

June 19, 1986
8:00 a.m.
Washington Hilton Hotel
Farragut Room

one dupont circle, n.w./washington, d.c. 20036

COTH ADMINISTRATIVE BOARD

Chairman: C. Thomas Smith
Yale New Haven Hospital

Chairman-Elect: Spencer Foreman, MD
Sinai Hospital of Baltimore

Immediate Past Chairman: Sheldon S. King
Stanford University Hospital

Secretary: John E. Ives
Shands Hospital

Robert J. Baker
University of Nebraska Hospital and Clinics

J. Robert Buchanan, MD
Massachusetts General Hospital

Gordon M. Derzon
Univeristy of Wisconsin Hospital and Clinics

Gary Gambuti
St. Luke's-Roosevelt Hospital

Larry L. Mathis
The Methodist Hospital

James J. Mongan, MD
Truman Medical Center

Eric B. Munson
North Carolina Memorial Hospital

Charles M. O'Brien, Jr.
Georgetown University Hospital

Raymond G. Schultze, MD
UCLA Hospitals and Clinics

Barabara A. Small
Veterans Administration Medical Center

William T. Robinson
AHA Representative

COTH MEETING DATES

COTH ADMINISTRATIVE BOARD MEETINGS

June 18-19, 1986	Washington Hilton Hotel Washington, DC
September 10-11, 1986	Same

COTH SPRING MEETING

May 13-15, 1987	Fairmont Hotel Dallas, TX
May 11-13, 1988	The Hilton Hotel New York, NY

AAMC ANNUAL MEETINGS

October 25-30, 1986	The Hilton Hotel New Orleans, LA
November 7-12, 1987	Washington Hilton Hotel Washington, DC
November 12-17, 1988	The Marriott Hotel Chicago, IL

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

June 18-19, 1986
Washington Hilton Hotel
Washington, DC

WEDNESDAY, June 18, 1986

6:00p	JOINT ADMINISTRATIVE BOARD RECEPTION AND DINNER FOR JOHN A. D. COOPER, MD Lincoln and Monroe Rooms

THURSDAY, June 19, 1986

8:00am	COTH ADMINISTRATIVE BOARD MEETING Farragut Room
12:00noon	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Hemisphere Room
1:00pm	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Military Room

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

June 19, 1986
WASHINGTON HILTON HOTEL
Farragut Room
8:00am-12:00noon

I.	CALL TO ORDER	
II.	CONSIDERATION OF MINUTES	Page 1
III.	MEMBERSHIP	Page 28
	Veterans Administration Medical Center Salem, Virginia	
IV.	REVIEW OF COTH SPRING MEETING IN PHILADELPHIA	Page 37
V.	COTH AS A VEHICLE TO PROVIDE COMPETITIVE ECONOMIC SERVICES	Page 38
VI.	ROLE OF THE AAMC IN PROMOTION OF ACADEMIC MEDICAL CENTERS TO THE PUBLIC	Executive Council Agenda - Page 27
VII.	REVISION OF THE GENERAL REQUIREMENTS SECTION OF THE ESSENTIALS OF ACCREDITED RESIDENCIES	Executive Council Agenda - Page 18
VIII.	GME TRANSITION COMMITTEE REPORT	Page 43
IX.	FOLLOW-UP ON COD SPRING MEETING RESOLUTIONS	Executive Council Agenda - Page 45
X.	HEALTH CARE INNOVATION ACT OF 1986	Page 57
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XIII.	ADJOURNMENT	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
April 10, 1986

PRESENT

C. Thomas Smith, Chairman
Sheldon S. King, Immediate Past Chairman
Spencer Foreman, MD, Chairman-Elect
Robert J. Baker
John E. Ives
Larry L. Mathis
James J. Mongan, MD
Charles M. O'Brien, Jr.
Raymond G. Schultze, MD
Barbara A. Small
William T. Robinson, AHA Representative

ABSENT

J. Robert Buchanan, MD
Gordon M. Derzon
Gary Gambuti
Eric B. Munson

GUESTS

Richard Janeway, MD
Robert G. Petersdorf, MD
Edward J. Stemmler, MD
Virginia V. Weldon, MD

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Richard M. Knapp, PhD
Nancy E. Seline
August G. Swanson, MD
Judith L. Teich
Kathleen Turner
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MINUTES
Meeting Minutes
April 10, 1986

I. CALL TO ORDER

Mr. Smith called the meeting to order at 8:00am in the Hamilton Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the January 23, 1986 COTH Administrative Board meeting.

III. MEMBERSHIP

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

HOLY CROSS HOSPITAL, Silver Spring, MD for full membership;

HUMANA HOSPITAL-UNIVERSITY, Louisville, KY for full membership (with two dissenting votes); and

TORONTO GENERAL HOSPITAL, Toronto, Ontario, Canada for full membership.

IV. GENERAL DISCUSSION

Before moving directly to the agenda, the Chairman indicated he had a few items he wished to report.

First, he welcomed Larry Mathis, President, The Methodist Hospital in Houston, Texas, who was unable to attend the first 1986 meeting of the Administrative Board in January.

He then noted that AAMC testimony had been given twice since the January meeting. On March 14, George Middleton, Chairman, Board of Trustees, Alliance Health System in Norfolk, Virginia, appeared before the Health Subcommittee of the Senate Finance Committee to outline AAMC views on, "Medicare Payments for Hospital Capital." On March 6, Mr. O'Brien appeared before the Subcommittee on Health of the House Ways and Means Committee to present AAMC views on the Administration's FY87 budget proposals for Medicare. Mr. Smith expressed specific appreciation to Mr. O'Brien for his willingness to take the time to prepare and appear.

Dr. Foreman will be in the chair presiding at the COTH Annual Meeting in New Orleans; thus, it has been his task to work with the staff on the program for the Annual Meeting. Mr. Smith also noted that Dr. Foreman was keynote speaker at the Council of Deans meeting in Florida the previous week, and asked him to give a preview of what he planned for the New Orleans meeting and a review of his presentation to the Deans in Florida. Dr. Foreman indicated that in working with the staff an individual by the name of Jack Jackson had been identified.

Mr. Jackson is a former executive with American Airlines who has spoken widely on the new competitive environment and executive and employee motivation. He has been asked to speak on, "The Margin of Success: New Management Roles in a Competitive Environment." It has also been agreed that there will be no Administrative Board meeting on the Monday morning of the Annual Meeting, and a reception is being planned for that afternoon following Mr. Jackson's presentation at the COTH General Session. Dr. Foreman indicated that as a result of his remarks at a discussion at the AAMC Officers' Retreat in December, he had been asked to serve as the keynote speaker for the Council of Deans annual Spring Meeting on, "The Attractiveness of Medicine as a Profession." He indicated that he had given his own views concerning the ways in which medicine continues to be a profession which should attract first-class students and outlined the opportunities that would be available to them in the future, regardless of the doom and gloom that has been preached in some quarters of the medical profession.

At this point, Mr. Smith called upon Dr. Bentley who reported on a survey of the membership to identify the extent to which AIDS patients were being served and a variety of financial and other characteristics surrounding the treatment of these patients; and a survey on Medicare educational costs related to the size of faculty supervision budgets, as well as budgets for nursing and allied health education. The Chairman then called on Dr. Knapp who distributed a Government Accounting Office (GAO) study on malpractice which had been identified at the January Administrative Board meeting. At this point, Dr. Knapp indicated Dr. Bentley had recently celebrated his tenth anniversary as an AAMC employee. He indicated that an internal staff event had been held to celebrate this occasion, but he wished to take a moment to express his sincere appreciation personally and on behalf of the staff and the Administrative Board to Dr. Bentley for his ten years of service with the AAMC. He then presented Dr. Bentley with a gift which was symbolic of the contributions he has made and the best wishes of the COTH Administrative Board.

Mr. Smith then reported on the meeting of the AAMC Executive Committee with HHS Secretary Otis Bowen, MD. He indicated that three items formed the agenda for the meeting with Dr. Bowen:

- o HCFA regulations to severely limit educational costs,
- o Indirect costs on research grants, and
- o Availability of student loans.

With regard to the draft HCFA regulations, the Secretary indicated that as a result of the comprehensive Omnibus Budget Reconciliation Act which called for a study of allied health and nursing education costs and set forth a formula for the payment of graduate medical education costs, these regulations were being withdrawn from consideration. The other two issues formed the basis for the remainder of the discussion; while the Secretary made no commitments, he listened patiently and the meeting was a cordial one.

V. COTH/AAMC AS A VEHICLE TO PROVIDE COMPETITIVE ECONOMIC SERVICES

Dr. Knapp called attention to the item in the COTH Administrative Board agenda book that outlined the history of this issue since it had first been discussed in May 1982. In one form or another, this issue has continued to occupy the attention of the staff and in many respects it can be viewed as a review of the overall objectives of the AAMC Council of Teaching Hospitals and a redefinition of what the COTH is all about. The question before the Administrative Board at its January 1986 meeting was, "What role can the AAMC staff members play if asked

to participate in the development of insurance products of any one of the alliances or consortia?" Dr. Bentley had been asked to participate as a member of the National Health Care and Insurance Delivery Council of the University Hospital Consortium. Mr. Baker, UHC President, outlined the activities of that Council as exploring the various options of networking for academic medical centers and the type of insurance products that might be useful to academic medical centers. Drs. Foreman and Buchanan had questioned Association staff involvement in the basic economic interests of COTH members. They indicated they believed it would be a mistake for the staff to be identified as "advocates" of any one of the various groups that are beginning to emerge. To tap the staff for one organization and not to make the same service available to all could lead to some difficult problems. In addition, if the staff were made available to all such organizations, there would be problems with conflicts of interest. The question of whether or not this was a wise way for the staff to spend its time also arose.

The fundamental question in the two most recent policy debates within the Board on this subject has been, "Should the COTH/AAMC directly initiate service programs which provide economic advantages to its members?" In reviewing this matter, it is important to know the alliances or consortia in which constituents maintain current membership. A list of the COTH constituents which belong to each of the consortia or alliances which are emerging appears as Appendix A to these minutes. Three basic questions were identified in the agenda as needing full discussion by the Administrative Board.

> SHOULD THE COTH/AAMC INITIATE SERVICE PROGRAMS AND ACTIVITIES TO MEET THESE NEEDS? IF SO, SHOULD THEY BE OFFERED TO ALL COTH/AAMC CONSTITUENTS?

If the answer to the first question is no, then the next issues are:

> WHAT ROLE SHOULD THE AAMC PLAY IN THE EMERGING SERVICE ARRANGEMENTS IN THE NEW COMPETITIVE ENVIRONMENT?
>
> WHAT RELATIONSHIP(S) SHOULD THE AAMC HAVE WITH THE ORGANIZATIONS EMERGING PRIMARILY TO PROMOTE ECONOMIC BENEFITS TO HOSPITALS?

Dr. Foreman initiated the discussion by indicating that his views had not changed from the first time he heard discussion of this issue. He believed the role of the COTH/AAMC in this area needs to be carefully limited. He cited two reasons for this view. First, there are many, many meetings and many, many arguments that take place before these business arrangements to achieve a competitive advantage can be solidified. It takes a great deal of time and a different set of skills, and it should not be viewed as an activity which can be easily performed and grafted onto the AAMC as a new small function. In addition, the basic purpose of achieving a competitive advantage is to pit one member against the other. He did not believe it would be wise to place the COTH/AAMC in the middle of such warfare. He indicated that he wasn't as concerned about the role of the AAMC staff members as private or individual consultants as he was about having AAMC staff as formal members of task forces or committees of these consortia.

Mr. King indicated that it might be time to re-evaluate earlier decisions. A limited role in this area would not be unrealistic although it may be too late to enter into the service business in this fashion. If a business venture were to be initiated, perhaps a subsidiary corporation of the AAMC would be an appropriate option. Mr. O'Brien indicated that he had a different view on

representation than he had on the matter of whether or not it would be wise to set up a subsidiary corporation and enter into business arrangements. He believed that staff members of the AAMC should be represented in these various consortia activities, but stated that he believed that it was too late for the AAMC to enter into the economic service environment. Mr. Mathis indicated that he did not believe it was too late. He stated that there seemed to be constant fluctuation in the commitment which various shareholders and members expressed to the consortia and other alliances, and indicated that all these activities must be viewed as ventures which may or may not succeed. Their success is still something to be identified. Mr. Ives indicated that he felt that it would be inappropriate given the mission of the COTH/AAMC to get into this service activity business. He stated that COTH/AAMC "stands on higher ground." He indicated that there is plenty of opportunity to pursue economic advantage through one of the organizations that is presently offering the opportunity to do so. Mr. King indicated that he wasn't so sure that we should give up so easily on the opportunity to be a major player in the service business. Dr. Stemmler indicated that to create one more service organization did involve some risk; he asked whether there was a possibility that one may emerge with whom we may wish to align ourselves. Dr. Foreman indicated that he would not be in favor of spending the large amount of money it would take to do a feasibility study to determine whether or not it would be worthwhile to get such an enterprise off the ground. Dr. Schultze indicated that, "None of these consortia or alliances are fixed in stone." He indicated, as had Mr. Mathis, that a shake-out will occur and relationships with none of these organizations should be foreclosed. We need to stay as close as possible to these organizations in every way we can.

Mr. Smith reaffirmed his belief that the Board is not in a concrete decision mode. The question is being revisited. It is a difficult question and the politics of the relationship do need to be understood. Mr. Baker indicated that he didn't think that there are many who feel we should initiate service programs at this time, but concerning the representation issue it would be in the interest of everyone for the AAMC and its staff to keep their eyes and ears open to all consortium activities. He indicated the question was, "How can we create a relationship which is complimentary and not divisive?" Dr. Knapp indicated that there are various ways in which the staff can participate: observer, periodic consultant, staff consultant, member of a committee or council. Dr. Mongan indicated that he wasn't so sure that specific rules or guidance could be given regarding how the staff ought to behave. The UHC represents 33 members of the 117 so-called medical center hospitals. Whether the staff gets to know more about this particular organization and its relationship to its environment, or gets to know more about how one hospital feels about another competing hospital really isn't something about which groundrules can be outlined. Mr. Mathis indicated that there was intense competition between Hermann Hospital and The Methodist Hospital and that in dealing with these two constituents, one needs to keep their COTH hat on, not some competitive economic hat which may take a different form. Mr. Baker indicated that he felt that this discussion was causing the group to look at what can cause trouble rather than how can the COTH/AAMC play a constructive role. At this point Mr. Smith asked Mr. Robinson how the American Hospital Association deals with these issues. Mr. Robinson indicated that the decision regarding staff opportunities to participate in such activities are made on an ad hoc basis. Each request requires the approval of the AHA president; "Many ask, few are granted." In addition, he indicated that when there is financial remuneration for such activities, such dollars revert to the American Hospital Association. He indicated that the basic question that is asked by the AHA president is, "Would participation confuse other elements of the AHA?" The same question is asked with regard to participation on boards of other

organizations. The question needs to be, and is, asked, "How will this benefit the AHA?"

ACTION: It was moved, seconded, and carried unanimously to recommend that AAMC staff members be permitted to serve as observers or periodic consultants in activities of organizations such as those indicated as currently evolving consortia or alliances when such participation does not compromise the purpose of the AAMC. It was further agreed such activity only be undertaken subject to approval of the AAMC president.

Mr. Baker indicated that the University Hospital Consortium is dedicated to the academic medical center even though UHC represents only 33 such entities. He asked what additional role the AAMC should play. He believed there is an active role rather than a passive role. There was general consensus, Dr. Foreman dissenting, that there might be an additional role. There was general agreement that the Department of Teaching Hospitals staff should work to identify the activities that are occurring in the other alliances and consortia, and make every effort to keep informed. It was suggested the AAMC make an effort to serve as a convener to bring all these organizations together. Mr. Mathis indicated he felt such a possibility did not exist at the present time; the majority of Board members agreed with his assessment.

VI. REPORT OF THE AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

Dr. Knapp initiated the discussion of the draft final report of the AAMC Committee on Financing Graduate Medical Education by reminding the Administrative Board of why the Committee was initially formed. He recalled the growing tension in the medical education community resulting from changes in teaching hospital patient care payments which prompted the question, "In a price driven market, to what extent can teaching hospital revenues be looked to for support of graduate medical education?" It seemed clear that a continuation of the open-ended commitment was not feasible, and radical changes, such as the creation of a separate national fund for graduate medical education were considered. However, the Committee realized that while radical changes might solve the financing problem, they had disadvantages as well. One major disadvantage was the potential loss of control over the educational process. After careful consideration, the members of the Committee concluded that the disadvantages of radical change outweighed the discomfort felt regarding the uncertainty of hospital financing. The Committee then turned its energy to determine what financing could reasonably be expected from teaching hospitals in the future, setting limits on what had previously been open-ended funding. After a great deal of deliberation and compromise, the Committee reached the decision reflected in the report.

Dr. Foreman noted the Executive Summary was missing recommendation #15, and Ms. Seline promised to correct the error. Mr. Smith then asked how non-Medicare payers were to be convinced to continue paying for graduate medical education. A discussion ensued of how health care insurers acting in a price competitive market would react to the Committee's document exhorting them to continue paying for residency and some fellowship training. Questions were raised regarding the possibility that the federal government might require support to be forthcoming from all health care payers. It was also noted that there is a strong

relationship between the presence of residents and fellows and the hospital's ability to offer a wide variety of patient care diagnostic and treatment services. The Board recommended that careful monitoring of the reactions to this report should be undertaken. The issue is important and the financial environment is volatile. While the report was accepted, there were several members who believed the recommendations did not go far enough, and the report was too much a "status quo" document.

ACTION: It was moved, seconded, and carried to approve the recommendation that the Committee report be adopted and distributed widely.

VII. REVISION OF THE GENERAL REQUIREMENTS SECTION OF THE ESSENTIALS OF ACCREDITED RESIDENCIES

Dr. August Swanson presented the two revisions of the General Requirements which were adopted by the ACGME in February. ACGME requirements stipulate that the changes must be approved by all five members of the ACGME.

The first change adds a sentence to section 1.3, stating that, "Further, adequate financial support for residents' stipends is an essential component of graduate medical education." Dr. Swanson stated that there appears to be a "growing trend" toward unpaid residents. This proposed change would make stipends for residents an "essential component" of graduate medical education.

Dr. Foreman began the discussion by stating that this change was designed to ensure that residency programs facing financial difficulties don't slash residents' salaries in half in order to support a full component of residents. Mr. Ives stated that doing exactly that may be a survival mechanism for some residency programs. Mr. Mathis suggested that perhaps some procedure could be set in motion to require residents to provide an amount equal to stipends and benefits to some fund; the result being an unfunded residency position. Dr. Foreman stated that the proposed change was designed to prevent just that to which Mr. Mathis was referring; i.e., the trend towards residents being required to fund their own training expenses. It was designed to tell institutions that if they cannot afford to pay residents, then they should not have a program nor the ensuing benefits of having residents. Dr. Swanson stated that access to medical education should not be contingent on financial resources. Mr. Ives pointed out the difficulty in determining what constitutes an "adequate" stipend. Mr. O'Brien commented that an accrediting body should not concern itself with financial matters. Drs. Schultze and Mongan both stated they felt the sentence should be dropped, that it was a bad idea, and that the word "adequate" was unclear. Dr. Foreman pointed out that according to the table on page 90 of the Executive Council agenda book (Report of the Committee on Financing Graduate Medical Education), indebtedness of medical students has increased tremendously in recent years. If a resident is not paid for his residency position, it may further add to this level of debt. Additionally, the relative burden of debt is significantly larger than it was years ago. Dr. Mongan stated that the table on student indebtedness indicates that the medical schools cause the student to go into debt, and that teaching hospitals are then asked to deal with the consequences.

Dr. Schultze stated that the "system is coming to a crunch," and that it is unreasonable to take away the discretionary power of residency programs. He stated the level of the stipend has little to do with the quality of program. Dr. Swanson stated that quality <u>is</u> related to this issue. Dr. Bentley commented

on the balance of power; i.e., the more removed a hospital is from the "orbit" [of university-affiliated institutions], the higher the stipend this hospital usually offers. Many good quality residents are willing to accept lower stipends for the benefits of better training, but what mechanisms can be put in place to ensure that powerful institutions don't take advantage of relatively powerless young people? Mr. Smith pointed out that programs should be evaluated on the "reasonableness" of what they offer. Mr. Ives asked whether any programs had been put on probation or otherwise censured because of unreasonable demands or conditions. Dr. Foreman replied that to his knowledge this has not happened, but that in the accreditation process, the "Essentials" have not been literally interpreted.

Dr. Swanson then asked for guidance for the ACGME. Would a revision of the language in the proposed change be sufficient? He stated that there is no urgency regarding this issue. Dr. Foreman stated that the groups which have voted in favor of this change are not the ones which will have to "pay the freight." Mr. Robinson commented that the AHA has no objection to this provision. Dr. Schultze stated that housestaff in California will now be unionized, and he felt that the introduction of such language into the General Essentials would hamper the negotiating process if it occured. Mr. King reiterated that quality and stipends are unrelated issues. A motion was made by Dr. Foreman that the language of the proposed change be adopted. This motion was defeated with only Dr. Foreman expressing support. Mr. Ives stated that financial considerations do not belong in accreditation requirements. Mr. Smith agreed, stating this issue belongs under "terms and conditions of employment."

The second proposed change involves the replacement of an existing sentence regarding the teaching of the socioeconomics of health care and the importance of cost containment. The new sentence reads, "Instruction in medical ethics, in the socioeconomics of health care, and in the importance of cost containment should be part of all programs." Mr. King objected to the phrase "cost containment," and suggested using "cost-effective medical practice" instead. Dr. Bentley observed that the section was beginning to resemble a curriculum review paragraph. There was discussion on whether the group's mandate is to react to proposed changes, or whether it is their prerogative to suggest changes if they wish. Dr. Schultze suggested that the sentence should read, "Programs should foster an understanding of medical ethics ....," rather than "require instruction."

ACTION: It was moved, seconded, and carried unanimously to recommend that the sentence should be combined with the preceding sentence to read, "All training programs should foster the development of residents' teaching abilities and interpersonal abilities, and should foster an understanding of medical ethics, of the socioeconomics of health care, and of the importance of cost-effective medical practice."

VIII. CHANGES IN GRADUATE MEDICAL EDUCATION TRAINING REQUIREMENTS

Dr. August Swanson presented for discussion the issue of a new policy which was adopted by the American Board of Medical Specialties which would require that when a member board changes its training requirements, an open forum for discussion and review will be held. This change had been prompted by the

American Board of Pathology's decision to require an additional year of clinical training. The procedures for proposing changes and for the review forum are outlined on p. 167 of the Executive Council agenda book. The immediate reason for concern was a proposed change which the Residency Review Committee (RRC) in Anesthesiology presented to the February 1986 meeting of the Accreditation Council for Graduate Medical Education (ACGME). The change would lengthen training programs by one year, eliminating the current option of two years of practice experience which can be used instead of an additional year of clinical training. The change would require all candidates to have one broad clinical year and three years of anesthesiology training in an accredited program. This would necessitate approximately 1,000 additional positions in accredited anesthesiology programs. The ACGME deferred action, and asked that definitive data on the impact of the changes on educational resources be presented at its meeting in June of 1986. The formal position of the Society of Anesthesia Chairmen on this issue appears as Appendix B to these minutes.

Five options were presented for consideration by the Executive Council:

1. Take no further action until the open forum procedure has been tried;

2. Introduce a change in the ABMS procedure that would require an open forum to be held before a board makes any decision about changes in training requirements;

3. Reintroduce the amendment to the ABMS bylaws at the September 1986 ABMS meeting;

4. Issue a public statement that the COD and COTH will not consider changes in training requirements that require additional resources to be provided by medical schools or teaching hospitals to be binding unless approved by the AAMC Assembly;

5. Require that changes in special requirements be ratified unanimously by the five sponsoring organizations of the ACGME. This can be accomplished by declaring that changes approved by the ACGME are policy issues. This declaration could be selectively invoked by the AAMC.

Dr. Foreman stated that option 5 would cause great disruption to the accreditation process. He felt that it would provide an effective veto but that the boards would be resentful. Option 4 was also considered to be divisive, and it is doubtful that the ABMS amendment mentioned in option 3 would pass now. The discussion centered on option 2 as an interesting and viable alternative which might create opportunities for graceful compromise.

ACTION: It was moved, seconded, and carried unanimously to recommend adoption of option 2.

IX. AAMC FINANCE COMMITTEE REPORT

A copy of the interim report of the AAMC Finance Committee appears as Appendix C to these minutes.

Drs. Weldon, Janeway, Stemmler, and Petersdorf joined the Administrative Board meeting for this discussion. Dr. Weldon indicated that this report was a set of principles and indicated that to some degree the attention to this matter at the present time resulted from the falloff in MCAT test takers and student applicants

using the AMCAS program. It should be understood that these programs have served to keep the teaching hospital and medical center dues at the current low level. It was pointed out that the current COTH institutional dues are $2,580/year for full COTH membership. The following points were made in the discussion:

- o There needs to be a fuller discussion of the balance sheet;
- o Departmental activities of the AAMC need to be better related to revenue sources;
- o The reserves and their sizes need to be related to the operating income;
- o The reserve fund needs to be in a position where it at least keeps pace with the consumer price index;
- o Competing views were expressed with regard to the Annual Meeting registration fees. One view was that an annual increase of $25.00 was too much to ask; a second view was that given the registration fees that are being asked by other organizations, a continuing escalation was not out of line;
- o While there was no resolution with regard to the differentiation of dues payments for various types of COTH members, if or when a dues increase or change is contemplated, such a policy does need to be considered.

Dr. Weldon thanked the group for their discussion and observations, and indicated that Dr. Petersdorf had requested that this report and the consideration of a dues increase not be moved ahead on a fast track and indicated that the Finance Committee would meet once again before any proposal was brought to the Administrative Boards and Executive Council for action.

X. MARKETING AND ADVERTISING: THE ROLE OF THE AAMC

Included in the Executive Council agenda was an unsolicited proposal from David Barton, Sr., President, The Barton Gillet Company, advocating a joint AAMC/AAHC marketing program. After a brief review of the history of this proposal by Dr. Bentley, Dr. Foreman stated his three major concerns with the proposal. First, the proposal calls for "distinguish(ing) the difference between the real and the pretenders among 'medical centers.'" In an inclusive organization such as the AAMC/COTH, Dr. Foreman was concerned that this approach would split the membership and weaken the organization. Secondly, the proposal called for "confront(ing) directly the extremist views of the doomsayers now worshipping at the alter of 'managed care.'" Dr. Foreman acknowledged that "managed care" may not be all its advocates had hoped for, but he expressed concern about the AAMC advocating a full return to fee-for-service when some of our constituents are beginning to market managed care. Lastly, the proposal called for "defin(ing) medical quality, once and for all." While this is a worthy goal, Dr. Foreman questioned its possible achievement. In the general discussion which followed, Administrative Board members supported Dr. Foreman's observations and noted that the teaching hospital expenditures of the AAMC were significantly smaller than the present advertising budgets of individual member hospitals. Thus, a national campaign by the AAMC was likely to be too small to have a significant impact. Board members did feel, however, that the AAMC could serve in a useful role by assembling advertising developed and used by COTH members. In a clearinghouse capacity, generic advertisements could be distributed to the membership with permission of the originator. Even if individual members had to pay royalty or

user fees, such payments could be less than the costs of developing new ads. The Board did not favor further exploration of the Barton Gillet proposal, but recommended the issue be reviewed once again at the June Administrative Board meeting.

XI. TAX REFORM UPDATE

Prior to adjournment, Dr Bentley reviewed the Executive Council summary of pending tax legislation as a follow-up to the Administrative Board's January discussion. A number of Board members expressed interest in particular provisions, especially salary reduction agreements and deferred compensation. With the Senate Finance Committee actively considering possible alternatives, it was recommended that individual members seek the advice of independent tax counsel before entering into any long-term agreements.

XII. ADJOURNMENT

There being no further business, the meeting was adjourned at 12:50p.

ALLIANCE PARTICIPATION: COTH MEMBERSHIP

ALLIANCE	# of COTH Members	Academic Medical Center Hospital
Voluntary Hospitals of America		
Shareholders	35	6
Affiliates and Regional Partners	22	3
University Hospital Consortium	34	34
Premier Health Systems	24	4
American Health Care Systems	13	2
Sun Health Affiliates	11	4
Adventist Health System Affiliates	2	1
Major Catholic Health Alliance	3	1
American Medical International	2	1
Hospital Corporation of America	3	2*
Humana	1	1

*These are management contracts

VOLUNTARY HOSPITALS OF AMERICA
SHAREHOLDERS

1. Baptist Medical Centers
   Birmingham, Alabama

2. Tucson Medical Center
   Tucson, Arizona

3. Memorial Hospital of Long Beach
   Long Beach, California

4. Cedars-Sinai Medical Center
   Los Angeles, California

5. Pacific Presbyterian Medical Center
   San Francisco, California

6. Hartford Hospital
   Hartford, Connecticut

7. Yale-New Haven Hospital
   New Haven, Connecticut

8. Orlando Regional Medical Center
   Orlando, Florida

9. Evanston Hospital Corporation
   Evanston, Illinois

10. Memorial Medical Center
    Springfield, Illinois

11. Ochsner Foundation Hospital
    New Orleans, Louisiana

12. Maine Medical Center
    Portland, Maine

13. The Johns Hopkins Hospital
    Baltimore, Maryland

14. Massachusetts General Hospital
    Boston, Massachusetts

15. Henry Ford Hospital
    Detroit, Michigan

16. Butterworth Hospital
    Grand Rapids, Michigan

17. St. Luke's Hospital of Kansas City
    Kansas City, Missouri

18. Barnes Hospital
    St. Louis, Missouri

19. Mary Hitchcock Memorial Hospital
    Hanover, New Hampshire

20. United Health Services
    Johnson City, New York

21. Akron General Medical Center
    Akron, Ohio

22. The Christ Hospital
    Cincinnati, Ohio

23. Riverside Methodist Hospital
    Columbus, Ohio

24. Miami Valley Hospital
    Dayton, Ohio

25. The Toledo Hospital
    Toledo, Ohio

26. Lehigh Valley Hospital Center
    Allentown, Pennsylvania

27. Pennsylvania Hospital
    Philadelphia, Pennsylvania

28. Allegheny General Hospital
    Pittsburgh, Pennsylvania

29. Baptist Memorial Hospital
    Memphis, Tennessee

30. Baylor University Medical Center
    Dallas, Texas

31. Medical Center Hospital of Vermont
    Burlington, Vermont

32. Norfolk General Hospital
    Norfolk, Virginia

33. Charleston Area Medical Center
    Charleston, West Virginia

34. Madison General Hospital
    Madison, Wisconsin

35. St. Luke's Hospital
    Milwaukee, Wisconsin

VOLUNTARY HOSPITALS OF AMERICA
AFFILIATES AND REGIONAL PARTNERS

1. Bridgeport Hospital
   Bridgeport, Connecticut
2. The Danbury Hospital
   Danbury, Connecticut
3. New Britain General Hospital
   New Britain, Connecticut
4. The Stamford Hospital
   Stamford, Connecticut
5. The Waterbury Hospital
   Waterbury, Connecticut
6. MacNeal Memorial Hospital
   Berwyn, Illionis
7. Children's Memorial Hospital
   Chicago, Illinois
8. Northwestern Memorial Hospital
   Chigicao, Illinois
9. Lutheran General Hospital
   Park Ridge, Illinois
10. Francis Scott Key Medical Center
    Baltimore, Maryland
11. Oakwood Hospital Corporation
    Dearborn, Michigan
12. St. John Hospital
    Detroit, Michigan
13. Muhlenberh Hospital
    Plainfield, New Jersey
14. Aultman Hospital
    Canton, Ohio
15. Crozen-Chester Medical Center
    Chester, Pennsylvania
16. Hamot Medical Center
    Erie, Pennsylvania
17. Harrisburg Hospital
    Harrisburg, Pennsylvania
18. Conemaugh Valley Memorial Hospital
    Johnstown, Pennsylvania
19. Episcopal Hospital
    Philadelphia, Pennsylvania
20. Frankford Hospital
    Philadelphia, Pennsylvania
21. Shadyside Hospital
    Pittsburgh, Pennsylvania
22. West Virginia University Hospital
    Morgantown, West Virginia

UNIVERSITY HOSPITAL CONSORTIUM

1. University of Alabama Hospitals
   Birmingham, Alabama

2. University Medical Center
   Tucson, Arizona

3. UCLA Hospital and Clinics
   Los Angeles, California

4. University Hospital
   San Diego, California

5. University of California Medical Center
   San Francisco, California

6. Stanford University Hospital
   Stanford, California

7. University Hospital
   Denver, Colorado

8. John Dempsey Hospital
   Farmington, Connecticut

9. Georgetown University Hospital
   Washington, D.C.

0. Shands Hospital
   Gainesville, Florida

1. Medical College of Georgia Hospital
   Augusta, Georgia

2. University of Illinois Hospital
   Chicago, Illinois

3. Indiana University Hospitals
   Indianapolis, Indiana

4. University Hospital
   Lexington, Kentucky

5. University of Massachusetts Hospital
   Worcester, Massachusetts

6. St. Louis University Hospital
   St. Louis, Missouri

7. University of Minnesota Hospital
   Minneapolis, Minnesota

18. University of Missouri Hospital
    Columbia, Missouri

19. University of Nebraska Hospital
    Omaha, Nebraska

20. University Hospital
    Brooklyn, New York

21. Presbyterian University Hospital
    New York City, New York

22. University Hospital
    Stony Brook, New York

23. North Carolina Memorial Hospital
    Chapel Hill, North Carolina

24. Ohio State University Hospitals
    Columbus, Ohio

25. Medical College of Ohio Hospital
    Toledo, Ohio

26. Oklahoma Teaching Hospitals
    Oklahoma City, Oklahoma

27. Hahnemann University Hospital
    Philadelphia, Pennsylvania

28. Thomas Jefferson University Hospital
    Philadelphia, Pennsylvania

29. Presbyterian University Hospital
    Pittsburgh, Pennsylvania

30. Hermann Hospital
    Houston, Texas

31. University of Virginia Hospitals
    Charlottesville, Virginia

32. Medical College of Virginia Hospital
    Richmond, Virginia

33. University of Wisconsin Hospital
    Madison, Wisconsin

34. University of Utah Hospital
    Salt Lake City, Utah

PREMIER HEALTH SYSTEMS

1. Mt. Zion Hospital and Medical Center
   San Francisco, California
2. Mount Sinai Hospital
   Hartford, Connecticut
3. Mount Sinai Medical Center
   Miami Beach, Florida
4. Michael Reese Hospital and Medical Center
   Chicago, Illinois
5. Mount Sinai Medical Center/Schwab Rehabilitation Center
   Chicago, Illinois
6. Methodist Hospital of Indiana
   Indianapolis, Indiana
7. Touro Infirmary
   New Orleans, Louisiana
8. Sinai Hospital of Baltimore
   Baltimore, Maryland
9. Beth Israel Hospital
   Boston, Massachusetts
10. Sinai Hospital of Detroit
    Detroit, Michigan
11. The Jewish Hospital of St. Louis
    St. Louis, Missouri
12. St. Louis University Hospital
    St. Louis, Missouri
13. Newark Beth Israel Medical Center
    Newark, New Jersey
14. Long Island Jewish Medical Center
    New Hyde Park, New York
15. Beth Israel Medical Center
    New York, New York
16. Long Island College Hospital
    Brooklyn, New York
17. Montefiore Medical Center
    New York, New York
18. The Mount Sinai Medical Center
    New York, New York
19. Akron City Hospital
    Akron, Ohio
20. The Mount Sinai Medical Center
    Cleveland, Ohio
21. Albert Einstein Health Care Foundation
    Philadelphia, Pennsylvania
22. Montefiore Hospital Association
    Pittsburgh, Pennsylvania
23. The Miriam Hospital
    Providence, Rhode Island
24. Mount Sinai Medical Center
    Milwaukee, Wisconsin

AMERICAN HEALTH CARE SYSTEMS

1. Good Samaritan Medical Center
   Phoenix, Arizona

2. Washington Hospital Center
   Washington, D.C.

3. Christ Hospital
   Oak Lawn, Illinois

4. Lutheran General Hospital
   Park Ridge, Illinois

5. Iowa Methodist Medical Center
   Des Moines, Iowa

6. Berkshire Medical Center
   Pittsfield, Massachusetts

7. Baystate Medical Center
   Springfield, Massachusetts

8. Harper-Grace Hospitals
   Detroit, Michigan

9. Greenville Hospital System
   Greenville, South Carolina

10. Methodist Hospital of Memphis
    Memphis, Tennessee

11. Presbyterian Hospital of Dallas
    Dallas, Texas

12. The Methodist Hospital
    Houston, Texas

13. Fairfax Hospital
    Falls Church, Virginia

SUN HEALTH AFFILIATES

1. Crawford W. Long Memorial Hospital
   Atlanta, Georgia
2. Emory University Hospital
   Atlanta, Georgia
3. Union Memorial Hospital
   Baltimore, Maryland
4. Charlotte Memorial Hospital
   Charlotte, North Carolina
5. Moses H. Cone Memorial Hospital
   Greensboro, North Carolina
6. North Carolina Baptist Hospital
   Winston-Salem, North Carolina
7. Erlanger Medical Center
   Chattanooga, Tennessee
8. Methodist Hospital of Memphis
   Memphis, Tennessee
9. Vanderbilt University Hospital
   Nashville, Tennessee
10. Methodist Hospital of Dallas
    Dallas, Texas
11. Fairfax Hospital
    Falls Church, Virginia

ADVENTIST HEALTH SYSTEM AFFILIATES

1. Loma Linda University Medical Center
   Loma Linda, California
2. Kettering Memorial Hospital
   Kettering, Ohio

MAJOR CATHOLIC HEALTH ALLIANCE

1. Foster G. McGaw Hospital
   Maywood, Illinois
2. St. Vincent Hospital and Health Care Corporation
   Indianapolis, Indiana
3. St. Francis Medical Center
   Pittsburgh, Pennsylvania

AMERICAN MEDICAL INTERNATIONAL

1. Presbyterian-St. Luke's Medical Center
   Denver, Colorado
2. St. Joseph's Hospital
   Omaha, Nebraska

HOSPITAL CORPORATION OF AMERICA

1. Wesley Medical Center
   Wichita, Kansas

2. University of Medicine and Dentistry of*
   New Jersey-University Hospital
   Newark, New Jersey

3. University Hospital, University of*
   Mississippi Medical Center
   Jackson, Mississippi

HUMANA

1. Humana Hospital-University
   Louisville, Kentucky

*These are management contracts

CHANGES IN GRADUATE MEDICAL EDUCATION TRAINING REQUIREMENTS

At the February 1986 meeting of the ACGME, the RRC in Anesthesiology requested approval of changes in its special requirements that would make a fourth year of formal training mandatory and eliminate the current alternative option of two years of practice as an equivalent for board certification. The issues raised by this action led AAMC to support a motion for ACGME to defer action and ask that definitive data on the impact of the proposed change on educational resources be presented at its June 1986 meeting.

The Society of Academic Anesthesia Chairmen supports the proposed change in board requirement and submitted a statement by Dr. Robert M. Epstein, their representative at the CAS Spring meeting on March 27, 1986 (Attachment I). The CAS representative of the Association of University Anesthetists, Dr. Philip Larson, Jr., has written a letter from their society urging AAMC to support the proposed change in residency training requirements which has the support of the academic anesthesia societies as well as their Board and RRC (Attachment II). CAS members urged that AAMC separate decision on the merits of this specific case from a general discussion of the merits of tightening the procedure by which Boards alter training requirements for certification.

Statement by Robert M. Epstein, M.D. from
the Society of Academic Anesthesia Chairmen

As one of the representatives to the Council of Academic Societies from the Society of Academic Anesthesia Chairmen, I wish briefly to address the Council concerning the publication in the President's Weekly Activities Report for February 20, 1986, of an item headed "ACGME Defers Action On Increased Anesthesiology Training."

The report indicated that the ACGME considered that proposed revisions of the Special Requirements for training programs in anesthesiology would increase the required length of residency programs from three to four years. This is a misinterpretation of the proposals for a change in the Special Requirements. For more than twenty years the American Board of Anesthesiology has offered credit toward its basic certificate for a fourth postgraduate year of formal residency, giving the candidate an opportunity to achieve certification one year sooner than without it. In the late 1960's the Special Requirements were changed to provide that no program could be newly approved after 1970, nor reapproved after 1973, unless that program had demonstrated that it had in place such an acceptable fourth year of training, thus providing a residency program of three years' duration (following the PGY-1 Year).

In 1976 the American Board of Anesthesiology adopted, and in 1977 its Booklet of Information (page 5) reported that "The Continuum of Education in Anesthesiology consists of four years of training after receiving the M.D. or D.O. degree." -- i.e. the PGY-1 Year and three anesthesiology residency years. Provisions were made, however, to accept two alternate pathways at the discretion of the Board, on a case by case basis. One of these was the presentation of two years of practice in the field of anesthesiology acceptable to the Board; the other was a Ph.D. degree in a scientific discipline related to anesthesiology. In the past ten years

large numbers of candidates preferred to submit an alternate pathway credential in lieu of the fourth year of residency, thereby continuing to accelerate their entry into practice while delaying their admission to the oral examination portion of the Board's examination system.

There followed internal discussions over the period of a decade, two formal meetings for discussions with directors of residency programs (consisting of members of the Society we represent here), and the collection of questionnaire data, all of which indicated a growing need for additional educational time for graduate education in our discipline. I think it important to emphasize that members of the Society of Academic Anesthesia Chairmen were intimately involved in these discussions and that they resulted in consensus on the need for the additional period of required graduate education. Therefore the American Board of Anesthesiology in 1983 announced its intention to eliminate the alternate pathway which had permitted the shortening of the residency program by the submission of practice credit. In effect, this will require most of the candidates for certification to submit the full four year continuum of education mandated by the Board's published rules since 1977. In 1984, after an additional 15 months of discussions as to the content of the revised four year residency curriculum, the Board announced the required new curriculum requirements. It also gave ample lead time to programs by indicating a starting date of May 1, 1986 on which those entering the programs would be subject to the new requirements.

Since the new graduate educational curriculum differs from the old in its outline of content, sequence, and progression, revised Special Requirements covering the new pattern are appropriate and have been recommended by the Residency Review Committee in Anesthesiology to the

meeting this requirement and obtaining satisfactory experiences for the residents. The impact of recognizing the need to provide this education by mention in the Special Requirements will therefore be negligible.

The Report refers to the change in the length of training programs as a "unilateral action by the American Board of Anesthesiology." The Boards, as stated in the Report, do have final responsibility for adopting needed changes in their requirements. However, given the history of consultation outlined above, the decision of the Board in our discipine is not considered by this Society to have been unilaterally taken or arbitrary. The Report further stated that the American Board of Medical Specialties had adopted a requirement of public hearings to permit review and criticism of proposed changes in certification requirements. This proposal was not in fact adopted until last week, some four weeks following the publication of the Weekly Activities Report in question, and more than three years following the action of the American Board of Anesthesiology. The Board did inform the ARMS in March, 1984, of its intention to alter its curriculum. To imply that the Board is now somehow culpable for not arranging in 1983 a public forum of interested parties other than program directors seems an ex post facto application of rules which would not be acceptable in any other of our other democratic forums, and strikes this Society as an unseemly suggestion.

Members of the Society of Academic Anesthesia Chairmen are responsible for the administrative and fiscal soundness of academic departments as well as forthe educational integrity of their programs. We are well aware of the many concerns for the impact of educational decisions on academic medical centers and health care delivery systems. At the same time we

ACGME for adoption. I wish to emphasize, however, that these revisions do not in any way extend the training period which programs are required to offer, since the availability of PGY years 2, 3, and 4 has been in the existing Special Requirements for the past 17 years and has been mandated for all programs, as stated above, since 1973.

The Weekly Activities Report indicates that it was the impression of the ACGME that an additional 1,000 residency positions would be required nationally to support the revised certification requirement. This is simply not correct. Since the purpose of the revised curriculum is to enhance the clinical education and experience of the resident, and since this experience is gained in a clinical setting, to a first approximation the same total resident pool will be meeting the existing patient care needs remaining in residency status for a longer period of required education. Predictably, given the times, residency directors are in no position to expect augmentation of authorized positions simply to meet an extended training period, even if such were desirable and intended by the Board -- which it is not. Two surveys indicate that perhaps 250 to 300 additional positions will be added by 1990, mostly to meet growing requirements for anesthetic care. A formal survey by the RRC is currently under way.

A second reason for deferral was stated to be the addition of a requirement that anesthesiology residents be assigned for a minimum of two months to an intensive care unit. This requirement has been in effect since 1983 and the problem of providing this educational opportunity has already been solved by almost every program in the country. Members of the Society of Academic Anesthesia Chairmen are simply not having difficulty in

believe that the Board system is charged with establishing educational standards for the protection of the public, and that its independence in doing so is the best remaining safeguard of quality in health care in an era of tightening resources.

The AAMC is of course a parent member of the ACGME. It does appear to members of the Society of Academic Anesthesia Chairmen that the AAMC has not been fully informed in its action to publish its report and presumably in considering its vote. We have no doubt that the publication in the WAP will at a minimum create the need for an extensive task of reeducation of the academic administrations with whom we must work. We hope that at the next vote on the issue in the ACGME we may have the support of the AAMC for one of its member societies which concurs with the recommended actions in its discipline. We express the hope that other members of the CAS may help to support this position as the opportunity arises.

Robert M. Epstein, M. D.

Society of Academic Anesthesia Chairmen

ATTACHMENT 2

STANFORD UNIVERSITY MEDICAL CENTER
STANFORD, CALIFORNIA 94305 • (415) 497-5439

STANFORD UNIVERSITY SCHOOL OF MEDICINE
Department of Anesthesia

C. Philip Larson, Jr., M.D.
Professor of Anesthesia and
Surgery (Neurosurgery)

February 30, 1986

David H. Cohen, Ph.D.
Chairman, Dept. of Neurobiology
SUNY at Stony Brook
Stony Brook, L.I., NY 11794

Dear David:

I am writing you as a representative of the Association of University Anesthetists to urge the Council of Academic Societies Administrative Board to support the change in training requirements implemented by the American Board of Anesthesiology. With the strong support of the CAS, the AAMC should be willing to approve the training requirements and urge the ACGME to do likewise.

The issues surrounding this matter were presented accurately and clearly by Bob Epstein at the recent CAS meeting. The ABA is not lengthening the total training requirement, but rather redefining what is acceptable training for entry into the ABA examination system. Extensive analysis by the ABA has demonstrated that most programs should be able to revise their curriculum from two to three years of clinical training without increasing the total numbers of residents in the program. In other words, the national impact on costs for training in anesthesiology should be minimal. More importantly, the additional training will greatly increase the skills and competence of future trainees in the specialty.

Congratulations on your effective chairmanship of the recent CAS meeting. The program was well planned and focussed on issues of importance to academic faculty, with ample opportunity for input from those in attendance. I and my colleagues felt that it was a productive meeting.

Sincerely yours,

C. Philip Larson, Jr., M.D.

INTERIM REPORT OF THE FINANCE COMMITTEE

The Association's Finance Committee met on March 14 to begin its work as charged by the Executive Council. The Finance Committee requests discussion of the following principles by each Administrative Board:

1. The operating budget should fully fund depreciation, build reserves as necessary, and have an operational margin of 4-5%. Meeting this goal would result in a projected shortfall in revenue beginning in fiscal year 1987 and growing to $1,782,643 in Fiscal Year 1990.

2. The Association should develop a methodology for adding a portion of the income from the endowment (currently managed by Sanford Bernstein) to the operating revenues to support the Association's programs and activities and to modulate any needed increase in dues.

3. Member dues will need to be increased to generate the added revenue needed to meet principle 1. Some concerns of the Finance Committee follow, which underlie the recommendation that the necessary dues be allocated only to the medical school and teaching hospital categories, in proportion to their existing total participation.

   a. Medical Schools: currently all but one institutional member pay the maximum amount, so that the dues curve is essentially flat, and the rate paid is the same by both large and small schools.

   b. Teaching Hospitals: there should be a consideration of a differentiation in dues payments among this category of member.

   c. CAS: the CAS organizations with whom the Association has its closest ties are the chairmen's groups, and these groups are least likely to be able to support an increase

   d. Individual: this category of membership is decreasing, which reduces number of Journal of Medical Education subscribers and jeopardizes advertising revenue from that source.

   e. Staff should provide information on the development of a new annual inflator. For example, the CPI appears less appropriate than the higher education inflator.

4. The annual meeting registration fee is set at $100 for 1986, with no recommendation for future years. The Committee recommends an annual increase of $25 with yearly review.

5. The Finance Committee should make an annual reevaluation of income and expense projections in view of newly developing

programs (such as MEDLOANS) and their potential for additional income.

6. Any changes in dues structures must be accompanied by a full explanation of facts and reasoning in support of such a decision.

7. The revenue needed to offset shortfalls anticipated through FY90 should be generated disproportionately more in the early years (FY 87, 88) to provide flexibility for the new president.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations 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
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Veterans Administration Medical Center

Hospital Address: (Street) 1970 Boulevard

(City) Salem (State) Virginia (Zip) 24153

(Area Code)/Telephone Number: (703) 982-2463

Name of Hospital's Chief Executive Officer: Hugh E. Davis, L.L.B

Title of Hospital's Chief Executive Officer: Director and Assistant Dean, University of Virginia School of Medicine

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	727	Admissions:		7,235
Average Daily Census:	605	Visits:	Emergency Room:	22,497
Total Live Births:	N/A	Visits:	Outpatient or Clinic	133,468

B. Financial Data

Total Operating Expenses: $63,283,553

Total Payroll Expenses: $42,428,095

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $873,043
Supervising Faculty: $3,307,368

C. Staffing Data

Number of Personnel: Full-Time: 1,513
Part-Time: 147

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 64
With Medical School Faculty Appointments: 38

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

Medicine	Nuclear Medicine	Nursing	Dental
Surgery	Psychiatry	Social Work	Dietetic
Laboratory	Rehab Medicine	Audiology & Speech Path.	Pharmacy
Radiology	Psychology	Recreation	

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	1 Elective + 1 Required	94	Both
Surgery	1 Elective + 1 Required	28	Both
Ob-Gyn	N/A		
Pediatrics	N/A		
Family Practice	None		
Psychiatry	1 Elective + 1 Required	44	Both
Other: Cardiology	1	9	Elective
MICU	1	2	Elective
Infectious Disease	1	2	Elective
Nephrology	1	1	Elective
Acute Medicine	1	4	Elective

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	0			
Medicine	23	21	2	1973
Surgery	5	5	0	1968
Ob-Gyn	0			
Pediatrics	0			
Family Practice	0			
Psychiatry	1	0	1	1984
Other:				
Cardiovascular	2	2	0	1985
Gastroenterology	1	1	0	1985
Infect. Disease	1	1	0	1984
Pulmonary	2	2	0	1984
Ophthalmology	1	1	0	1979
Orthopedics	1	1	0	1968
Urology	1	1	0	1968

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: University of Virginia School of Medicine

Dean of Affiliated Medical School: Robert M. Carey, M.D.
James Carroll Flippin
Professor of Medical Science
and Dean

Information Submitted by: (Name) Hugh E. Davis, L.L.B.
Director and Assistant Dean,
(Title) University of Virginia School of Medicine

Signature of Hospital's Chief Executive Officer:

H. E. Davis (Date) May 9, 1986

H. E. DAVIS, Director

Veterans Administration

April 24, 1986 In Reply Refer To: 658/00

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 Dick:

A few years ago we had an exchange of correspondence regarding the eligibility of our institution for full COTH membership. At that time, I think we had some 15 or 20 medical residents. You felt that the corresponding membership would be the appropriate membership at that stage of our development; therefore, we did not pursue our application for full membership.

As reflected by the enclosed VA reports, our residencies have expanded significantly since that time. The same is true for the undergraduate clerkships. Almost all of the 3rd year class rotate here for clerkships in medicine, surgery, and psychiatry. Many return for electives in the 4th year. Our residency in psychiatry is just beginning, and both the VA and the School expect it to expand very quickly. About forty of our permanent physicians have full academic appointments at the school.

I would appreciate your advice as to whether we should apply for full COTH membership. If you desire further information, please write or call me (703-982-2463).

Sincerely,

H. E. DAVIS
Director and
Assistant Dean
University of Virginia
School of Medicine

Enclosures

Veterans Administration

FACILITY NAME: VAMC Salem, Va.

MEDICAL HOUSE STAFF POSITION BY SPECIALTY

RCS 10-0145

July 1, 1986-Sep. 30, 1987

	SPECIALTY/SUBSPECIALTY		POSITIONS ALLOCATED	HOUSE STAFF RECRUITED FOR VA COMPONENT OF PROGRAM AS OF 4/28/86 — POST GRADUATE LEVEL								DIFFERENCE BETWEEN POSITIONS ALLOCATED AND RECRUITED
				1	2	3	4	5	6	7	TOTAL	
(1)	PM&R											
(2)	PSYCHIATRY		1				1				1	0
(3a)	ANESTHESIOLOGY	3. SUPPORT SERVICES										
(3b)	NUCLEAR MEDICINE											
(3c)	PATHOLOGY											
(3d)	NEUROLOGY											
(3e)	DIAGNOSTIC RADIOLOGY											
(3f)	THERAPEUTIC RADIOLOGY											
(4a)	NEUROLOGY	4. MEDICINE										
(4b)	GENERAL INTERNAL MEDICINE		23	2	10	10	1				23	0
(4c)	ALLERGY & IMMUNOLOGY											
(4d)	CARDIOVASCULAR DISEASE		2				1	1			2	0
(4e)	DERMATOLOGY											
(4f)	ENDOCRINOLOGY & METAB											
(4g)	FAMILY PRACTICE											
(4h)	GASTROENTEROLOGY		1				1				1	0
(4i)	HEMATOLOGY											
(4j)	COMBINED HEMATOLOGY/ ONCOLOGY											
(4k)	INFECTIOUS DISEASES		1					1			1	0
(4L)	NEPHROLOGY											
(4m)	ONCOLOGY											
(4n)	PULMONARY DISEASES		2				1	1			2	0
(4o)	RHEUMATOLOGY											
(5a)	GENERAL SURGERY	5. SURGERY	5		4		1				5	0
(5b)	COLON AND RECTAL SURGERY											
(5c)	NEUROLOGICAL SURGERY											
(5d)	OPHTHALMOLOGY		1				1				1	0
(5e)	ORTHOPEDIC SURGERY		1				1				1	0
(5f)	OTOLARYNGOLOGY											
(5g)	PLASTIC SURGERY											
(5h)	THORACIC SURGERY											
(5i)	UROLOGY		1					1			1	0
(5j)	VASCULAR SURGERY											
(6)	OTHER											
(7)	TOTAL		38	2	14	10	8	4			38	0

VA FORM FEB 1986 **10-7934**

SUPERSEDES VA FORM 10-7934, FEB 1985, WHICH W

1

0 SUMMARY OF DM&S TRAINEES FOR FY 1985 BY MAJOR PROGRAMS

RCS 10-0161
COIN DMS 51

REGION NUMBER 2
MEDICAL DISTRICT NUMBER 07

A	B	NUMBER OF TRAINEES TOTAL C	PAID D	WOC E
0652	RICHMOND, VA			
0		7	7	
40	ADMIN. TRAINEES ENTRY & MID LEVEL	5	5	
41	ADMIN TRAINEES ADVANCED LEVEL	2	2	
42	ADMIN TRAINEES SPECIAL PROGS			
0	FACILITY TOTAL	1,353	250	1,103
0658	SALEM, VA			
0		109	70	39
01	MEDICAL HOUSE STAFF	187		187
03	MEDICAL STUDENTS	6		6
05	DENTAL STUDENTS	1	1	
07	AUDIOLOGY AND SPEECH PATHOLOGY	17		17
08	BIOMED. INST. & MACHINE OPERATION	19		19
10	DENTAL AUXILIARIES	13		13
11	DIETETICS	1		1
17	MEDICAL RECORDS	183		183
19	NURSING PROFESSIONAL	69		69
20	NURS. AUX.	4		4
24	REHABILITATION	13	8	5
27	PSYCHOLOGY	31		31
28	RADIOLOGY	20		20
29	REHAB. COUN.	5	5	
30	SOCIAL WORK	2		2
34	RECREATION	4	4	
40	ADMIN TRAINEES ENTRY & MID LEVEL			
0	FACILITY TOTAL	684	88	596
0	MEDICAL DISTRICT TOTAL	3,411	541	2,870

UNIVERSITY OF VIRGINIA
SCHOOL OF MEDICINE
CHARLOTTESVILLE, VIRGINIA 22908

DEAN'S OFFICE
BOX 395, McKIM HALL
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May 9, 1986

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

Dear Dr. Knapp,

I am pleased to support the application by the Veterans Administration Medical Center, Salem, Virginia, for teaching hospital membership on the Council of Teaching Hospitals.

Our informal affiliations with this Center date back several years. In 1968, the Departments of Surgery, Orthopedics, and Urology began rotation of house staff to Salem, the Roanoke Memorial Hospitals, and Community Hospital of Roanoke Valley. In 1972, a formal Deans Committee relationship was established with the V.A.M.C., as residency training expanded to Medicine and its subspecialties; and, as our enlarging class of medical students required more and better clinical experiences, this was accomplished by adding the "Roanoke Program" for required clerkships based at these three Centers. Recently, the Salem program was further expanded to include residency training in Psychiatry.

Most of the third year class rotate to Salem for clerkship training in Medicine, Surgery, and Psychiatry. Many return for electives in the fourth year. Our annual evaluations of this program and its comparison with its counterparts in Charlottesville reveal equal degrees of excellence in student accomplishment and of satisfaction with their experiences. In fact, in certain areas improvements in the management of clerkships at the V.A.M.C. have been adopted at the University Medical Center, to the benefit of the School.

I have been a consultant and have participated in student and house staff education there for several years, and I can attest to the devotion of the Charlottesville faculty to providing this liaison between the two Centers. Many of the VA faculty are intimately involved with clinical, teaching, and research activities here in Charlottesville.

The Deans Committee meets in Salem, with the regular attendance of faculty based in both Centers. The Director, Mr. Hugh Davis, at the V.A.M.C., and Dr. Charles Crockett at Roanoke Memorial Hospitals, serve as Assistant Deans to coordinate the Roanoke Program on behalf of the School. Dr. Norman Knorr, immediate past Dean, and I have been gratified and encouraged by the responsiveness of the V.A. Medical Center to meet

our needs. The School and the Center mutually support each other, to the end of providing the highest possible quality of present and future medical care.

The Salem teaching program has grown steadily over recent years, and I think it has reached a level that would justify full membership in the Council of Teaching Hospitals; therefore, I recommend favorable consideration of Salem's application.

Sincerely,

Robert M Carey

ROBERT M. CAREY, M. D.
James Carroll Flippin
Professor of Medical Sciences
and Dean

REVIEW OF COTH SPRING MEETING IN PHILADELPHIA

All indications are that the meeting in Philadelphia was very successful. In the interest of continued efforts to improve the meeting, the staff would appreciate suggestions and/or observations to consider for the 1987 SPRING MEETING in Dallas. Themes, speakers, logistics, amenities, and any other matters are open for review and discussion.

The following questions should receive specific discussion:

- Is the current Wednesday evening through Friday noon format appropriate, or should the meeting be shortened or lengthened?
- Is the current policy of meeting in a business hotel in a major city preferable to the alternative of meeting in a resort, but still conveniently accessible, setting?

Additionally, thought should be given at this time to a timely meeting site for the 1989 SPRING MEETING. Listed below are the past cities in which this meeting has been held since its inception in 1978.

1978	St. Louis, MO
1979	Kansas City, MO
1980	Denver, CO
1981	Atlanta, GA
1982	Boston, MA
1983	New Orleans, LA
1984	Baltimore, MD
1985	San Francisco, CA
1986	Philadelphia, PA

The 1987 SPRING MEETING as noted above is scheduled for Dallas, TX, May 13-15, and the 1988 meeting is scheduled for New York City, NY, May 11-13. Staff recommends that consideration be given to the following cities for the 1989 COTH SPRING MEETING; other suggestions are welcome.

Chicago, IL

San Diego, CA

Orlando, FL

COTH/AAMC AS A VEHICLE TO PROVIDE COMPETITIVE ECONOMIC SERVICES

The characteristics and role of the AAMC Council of Teaching Hospitals and Department of Teaching Hospitals have been discussed and debated since the formal establishment of COTH in 1966. A recent comprehensive review was completed in April 1984 entitled, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals." In January 1985, these matters were revisited by the COTH Administrative Board. A copy of the agenda item which served as the basis for that review of the issues follows as Attachment A.

As a result of the discussion at the January 1985 meeting, respective Board members outlined the goals and services of VHA, CJH, UHC, and AHS at the April Administrative Board meeting. In addition, VHA president, Don Arnwine, set forth service and advocacy programs of VHA on the evening preceding that Board meeting.

The history of the specific question of whether or not the COTH/AAMC should become involved in specific service programs for its members is as follows.

In early May 1982, Dick Knapp received the attached memorandum from Chuck O'Brien concerning exploration of the establishment of a capital purchasing group (Attachment B). The issue was placed on the agenda of the June 24 COTH Administrative Board meeting. Chuck O'Brien and Eric Munson joined the Board for its discussion of the issue. In that discussion, the following points were raised:

- Is the AAMC's role and mission to organize or sponsor service programs for its constituents? While it can be pointed out that the centralized medical application service and the medical college admission test fall in such a category, these are without a doubt very distinctive activities;

- The question of the extent to which such a service program might be the first of a series of such programs which could divert the energies of the staff away from the primary mission of the organization was discussed;

- A number of individuals questioned whether or not there were not existing groups that could be joined by interested hospitals;

- There were questions concerning the real savings of such efforts on large big ticket items. The latter point was that in many cases major teaching hospitals have been able to obtain or negotiate discounts on their own.

The COTH Administrative Board recommended to the AAMC Executive Council that a small ad hoc committee be appointed to explore the issue with particular reference to the points made in the discussion. The Executive Council approved the appointment of such an ad hoc committee.

The ad hoc committee was asked to review, discuss, and make recommendations on the following questions:

- Is there a need for group purchasing of major capital equipment which is currently not being met?

- o If yes, what are the options available?

- o Is there any initiative the Association of American Medical Colleges should take?

Members of the committee were James W. Bartlett, MD, Chairman; Robert E. Frank; Richard Janeway, MD; Glenn Mitchell; Eric Munson; and Charles O'Brien.

The ad hoc committee met on September 8, 1982 and Dr. Bartlett reported the discussion at the meeting of the COTH Administrative Board meeting the following 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 (e.g.; nuclear magnetic 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.

At that Administrative Board meeting, a number of Board members emphasized that placing the AAMC in the role of a shared services contractor (or some similar relationship) would be a substantial departure from its traditional role. In addition, some Board members noted such an activity would place the COTH/AAMC in competition with state and local hospital associations with which COTH/AAMC needs to maintain cooperative relationships for advocacy purposes. In addition, management of these service programs in some associations was perceived to have begun to detract from the principal mission of the association. Finally, some of these services initiated and operated by state and local hospital associations were activities by which some hospitals and multi-hospital systems wished to create their own diversification programs.

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 to 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 Administrative 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 participants at the AAMC Officers' Retreat in December 1982, reviewed and discussed the recommendations of the ad hoc Committee on Joint Major Equipment Purchasing. The report recommended and the AAMC Executive Council concurred on September 9, 1982 that:

- AAMC staff should be requested to assess the access of teaching hospitals and medical schools to currently operating group purchasing activities for major capital equipment; and

- AAMC staff should examine what group services are needed by teaching hospitals and medical schools.

At the December 1982 AAMC Officers' Retreat, it was agreed upon review that with the growth and potential of regional and national group purchasing activities and other developments, it would be unwise for the AAMC to develop such a program. In addition, it was agreed that such a program to serve medical schools is not warranted based on any expression of interest thus far.

With respect to the second recommendation, there was extensive discussion of the fact that in some respects, multihospital systems are taking on associaton functions and objectives, and some associations are assuming essentially service functions of multihospital systems. It was recognized that these hospital systems as well as other organizations will be competitors for the time, effort, and loyalty of AAMC hospital constituents. It was agreed that thus far excellent communication and participation by leaders of these organizations in the activities and programs of the AAMC has served the AAMC well. There was also an awareness that this is a matter that will require constant attention in the future. At the same time, it was agreed that the AAMC should not engage in service programs as a method of competing with these other organizations. Service programs should be developed only if there is a clearly expressed constituent desire for them and only then if the service is a unique one, or one which the AAMC is uniquely qualified to provide.

In January 1983, the following recommendation based on the report from the Officers' Retreat was approved by the COTH Administrative Board and the AAMC Executive Council.

> The AAMC staff should monitor constituent service needs and be alert to changing relationships of members of newly developing organizations or

consortia with the AAMC. No formal service program should be initiated at this time.

During 1984 and 1985, networks and consortia such as VHA, AHS, CJH (now Premier Alliance), and UHC have intensified their activities and broadened the scope of their efforts. The COTH Administrative Board and AAMC staff of the Department of Teaching Hospitals have had informal and formal discussions of the emerging issues as the roles of consortia and alliances have begun to take clearer shape. For the most part, the discussions have focused on exploring the role and function of COTH/AAMC with regard to matters of education programs, information and data collection, research, service, and advocacy as these evolving organizations initiate new activities.

As these alliances and consortia have begun to mature, they are beginning to develop and market various types of insurance products as joint ventures with insurance company partners. These products are designed as "patient acquisition strategies" to provide market share advantages to their sponsors. This is a type of service activity, but one which is quite different from group purchasing, shared insurance pools, or other activities which lead to economic advantage but don't directly deal with specific competition for patients.

The question before the Administrative Board at its January 1986 meeting was, "What role can the AAMC staff members play if asked to participate in the development of insurance products of any one of the alliances or consortia?" Jim Bentley had been asked to participate as a member of the National Health Care and Insurance Delivery Council of the University Hospital Consortium. Mr. Baker, UHC President, outlined the activities of that Council as exploring the various options of networking for academic medical centers and the type of insurance products that might be useful to academic medical centers. He indicated that he feels strongly that the AAMC and the Association of Academic Health Centers (AAHC) have a role in the development of these linkages and a vital role in exploring the networking possibilities. Mr. Derzon, who is chairman of that UHC council, indicated that the initial effort of the council is an analytical one and is not yet at the point where he would call it a product development activity, although he didn't foreclose the possibility that this might in fact develop. Mr. Ives made the point that 1/3 of the core membership of the Council of Teaching Hospitals - that is the so-called "medical center hospitals" - are members of the consortium, and viewed this as a high priority agenda item. He further indicated that seven members of the University Hospital Consortium are members of the COTH Administrative Board, and that there was a relationship between the consortium and the staff of the Department of Teaching Hospitals which was based on trust and competence.

Drs. Foreman and Buchanan questioned whether the Association staff should be involved in the basic economic interests of COTH members. They indicated that it would be a mistake for the staff to be identified as "advocates" of any one of the various groups that are beginning to emerge. To tap the staff for one organization and not to make this same service available to all could lead to some difficult problems. In addition, if the staff were made available to all such organizations, there would be problems of conflicts of interest and also the question of whether or not this was a wise way for the staff to spend its time. If the AAMC has a policy (as it does) with regard to the consulting time of its staff members, it could be possible that a staff member might work with one of these groups as a paid consultant. However, even this arrangement should be approached cautiously. Mr. Munson indicated that he thought there might be a difference between open and full communication as an observer with the activities

of these newly emerging organizations versus membership on a specific committee of one of these organizations. He felt that it is important to the AAMC that its staff stay up-to-date on key issues of member concerns, and felt that open communication was necessary to achieve this. Mr. Baker indicated that he felt that the basic question was, "What role does the AAMC play in the emerging service arrangements in the new competitive environment?"

In reviewing this issue, it is important to know the alliances or consortia in which COTH constituents maintain membership. These data are being gathered, and will be available for Board review at the April 10 meeting.

The fundamental question in the two most recent policy debates has been, "Should the COTH/AAMC directly initiate service programs which provide economic advantages to its members?" In reviewing the matter, the question of whether services should be made available to all COTH/AAMC members needs attention. As the competitive environment has intensified, local and regional competition between medical centers has intensified as well. This appears to be particularly true with regard to "patient acquisition strategies" of teaching hospitals and faculty practice organizations. This issue is particularly relevant to multiple medical center cities and cities where relationships between medical center hospitals and faculty physicians, and affiliated hospitals and physicians are less than fully cooperative in the new environment.

SHOULD THE COTH/AAMC INITIATE SERVICE PROGRAMS AND ACTIVITIES TO MEET THESE NEEDS? IF SO, SHOULD THEY BE OFFERED TO ALL COTH/AAMC CONSTITUENTS?

If the answer to the first question is no, then the next issues are:

WHAT ROLE SHOULD THE AAMC PLAY IN THE EMERGING SERVICE ARRANGEMENT IN THE NEW COMPETITIVE ENVIRONMENT?

WHAT RELATIONSHIP(S) SHOULD THE AAMC HAVE WITH THE ORGANIZATIONS EMERGING PRIMARILY TO PROVIDE ECONOMIC BENEFITS TO HOSPITALS?

AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY

Preliminary Report

Following is the Preliminary Report of the Ad Hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency.

Recommendation:

That the Council adopt the report as a working document, distribute it to all institutions and organizations involved with medical student and resident education and convene the meetings recommended by the committee.

June 4, 1986

MEMORANDUM

TO: Virginia V. Weldon, M.D., Chairman
AAMC Executive Council

FROM: Spencer Foreman, M.D., Chairman
Ad Hoc Committee on Graduate Medical Education and the Transition from Medical School to Residency

SUBJECT: Preliminary Committee Report

The committee met on May 13-14. All members were in attendance. The attached report is preliminary.

The committee recommends that it receive wide circulation, that it be discussed at the Annual Meeting, and that final action on the report be taken in January 1987. This recommendation is made in the belief that solving the problems at the transition can only be achieved by mutual agreement among all parties that are concerned with improving medical students' general professional education. Unilateral dicta will not resolve the complex issues that must be discussed openly and rationally.

The committee had the benefit of a preliminary analysis of an addendum to the 1986 Graduation Questionnaire that provided quantitative information about the effect on students of the residency selection process. A final report of this study will be available in the early fall and will be a useful contribution to both local and national deliberations.

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

AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY

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President
Sinai Hospital of Baltimore, Inc.

Members:

Arnold Brown, M.D.
Dean
University of Wisconsin
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D. Kay Clawson, M.D.
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University of Kansas
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Mark L. Dyken, M.D.
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School of Medicine

AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY

Preliminary Report

Preamble:

The committee was asked to examine the effect of the selection process for residency positions on medical students' education and to recommend to the Executive Council of the AAMC what steps should be taken to lessen any disruptive effects on students' general professional education. The committee finds that the undesirable effects on medical students' education of competitive pressures at the transition between medical school and residency are due to systemic, organizational defects that result in communication failures, misunderstandings, and even mistrust among members of the academic community. These defects have an overall deleterious effect on the education of our students that must be rectified. The committee is convinced that both medical school and graduate program faculties are devoted to providing the finest quality education to both students and residents, and believes that faculty members' strong, personal commitment to students' education is a foundation upon which needed changes can be built.

Institutional Responsibility

Clinical medicine has evolved into a loose coalition of disciplines and subdisciplines with specialists in each principally identifying with and sharing the values and goals of their peers. This allegiance to specialties detracts from common understanding among disciplines and fragments our

institutions. No where is fragmentation more evident than in the organization and conduct of graduate medical education.

The committee considered the question: "If there were greater institutional responsibility for graduate medical education, would problems at the transition be more readily solvable?" It was concluded tha if each sponsoring institution had a system of academic governance for graduate medical education in place, solving problems generated by the selection process would be facilitated. A functioning governance structure could bring all of an isntitution's programs together to establish common policies and procedures for the selection of residents.

At present, who, how, and when students are selected for residency positions are the prerogative of each specialty program. The selection practices of each specialty are attuned to the national practices of the specialty rather than to institutional policies and procedures. Thus, if nationally the programs in a specialty begin to use certain selection practices, each program follows the national practice. Reinforcement of these practices by internal consultation within a specialty makes it very difficult for programs to accept arguments for changing how and when their candidates are selected. The committee believes that institutional policies and procedures should govern who, how, and when residents are selected, rather than having them determined *de facto*, according to the national practice of each specialty.

It is recognized that establishing common institutional policies and procedures is not sufficient unless each sponsored program abandons nationally determined practices and adheres to institutional rules. Therefore, the committee recommends:

- That each institution providing graduate medical education develop common policies and procedures for all of its programs; and

- That each institution establish a central administrative system for the receipt of applications and the announcement of selection decisions. This system should ensure that all programs adhere to institutional policies and procedures.

In its deliberations about the need for an academic governance structure for graduate medical education, the committee reviewed the *General Requirements Section of the Essentials of Accredited Residencies* that was adopted by the Accreditation Council for Graduate Medical Education and ratified by its five sponsors in 1981. The committee believes that the General Requirements provide a foundation upon which an institution can build an academic governance structure for graduate medical education. The finding that five years after their adoption the General Requirements are rarely, if ever, applied in accreditation decisions by residency review committeees is strong evidence that graduate medical education remains fragmented and specialty specific.

Compliance by an institution with the General Requirements should be a first order accreditation determination. Lack of compliance should jeopardize the accreditation of all of an institution's programs. The committee does not believe that each residency review committee can be expected to make a uniform decision about whether an institution is in compliance with the General Requirements. The committee recommends:

- That the ACGME establish an institutional review committee empowered to determine institutional compliance with the General Requirements;

- That the committee be composed of program directors, medical school deans, and teaching hospital directors;

- That a system be established to survey institutions periodically and independently of program surveys;

- That for institutions accredited by the Liaison Committee on Medical Education (LCME), these surveys be coordinated with LCME surveys; and

- That the accreditation decisions of the institutional review committee be communicated to, and be binding upon, each residency review committee.

Specific Problems and Recommendations

Specific problems must be solved to ameliorate educational disruption at the transition. Some of these are largely within the control of the medical schools and should concern the Liaison Committee on Medical Education, which is responsible for determining the quality of medical student programs. Others are problems that must be solved by the mutual efforts of both medical school and graduate medical education authorities.

Medical School Problems:

Medical schools deans and their faculties have the ethical responsibility to ensure that graduates have attained a general professional education that imparts the knowledge, skills, values, and attitudes expected of all physicians. The intrusion of external forces that impair the accomplishment of this responsibility must not be permitted.

Some students, intent on making themselves competitive for selection in certain specialties and programs, have sought to interrupt their junior year's

required sequence of clerkships to take electives, either at their own or other institutions. The committee recommends:

- That all students take the clerkships required by the Liaison Committee on Medical Education (internal medicine, surgery, pediatrics, obstetrics/gynecology, psychiatry, and, in some schools, family practice), only in the institution in which they are matriculated; and

- That the satisfactory completion of an institution's required clerkship sequence precede the privilege of taking electives.

Many students increasingly devote their electives in the senior year to the pursuit of a residency position. The committee does not believe that a uniformly structured senior year should be imposed upon all students. But, it strongly recommends that students' elective programs should be tailored to their completion of a general professional education that is consonant with their specialty choices and career plans. The committee recommends:

- That each school establish an authoritative system to review and approve each student's elective sequence; and

- That the Liaison Committee on Medical Education adopt accreditation policies to ensure that these recommendations are implemented.

Mutual Problems:

The pressures on medical schools, medical students, and graduate medical education programs imposed by the doubling of the number of medical school graduates and a consequent reduction in the ratio of residency positions per graduate are responsible for many problems that can be solved only by mutual

effort and cooperation. These can be divided into criteria problems and procedural problems.

Criteria Problems:

Program directors are intent upon selecting the most qualified graduates that they can. Their selection criteria are based upon students' knowledge, skills, and personal qualities. Medical school faculties responsible for evaluating students' achievement in these areas communicate their evaluations through deans' letters and transcripts. Some programs evidence a low regard for these evaluations, even doubting their candor. As a result, a large number of programs require students to submit National Board of Medical Examiners scores, and some are even requesting Medical College Admission Test scores. To obtain what are perceived to be more reliable evaluations, informal networks of communication between clinical departments and program directors about candidates have evolved within disciplines. To observe candidates' performance, it is often suggested that they take an elective in a specialty at the institutions to which they are applying. This practice has led some students to take multiple electives in the specialty that they hope to pursue in their residencies.

The committee believes that these selection criteria problems can be solved and recommends:

- That every medical school faculty inform their students at matriculation that their ultimate evaluation will consist of a balanced appraisal of their weaknesses and their strengths;
- That those responsible for assembling evaluations and communicating them to graduate medical education programs adopt the principle that their

responsibility is to provide a candid appraisal of students' weaknesses as well as their strengths;

- That programs only require the submission of standardized test scores that have been demonstrated to have a significant correlation with clinical performance; and

- That all programs abandon the practice of suggesting that candidates take an elective at an institution for the purpose of improving their chances for selection.

Procedural Problems:

The procedural problems at the transition are largely related to timing. They are complicated by the large number of applications that must be processed both by the medical schools and by graduate medical education institutions and their programs. The committee believes that changes in the timing of the application and selection process and institutional systems to assist programs to process large numbers of applications can ameliorate the procedural problems.

The National Resident Matching Program (NRMP) is governed by all the parties concerned with medical students' and residents' education. Since its establishment, the NRMP has sought to adapt its policies and procedures to serve the needs of both students and graduate medical education programs. All graduate medical education programs should select senior students only through the matching program. The committee is convinced that further modifications to improve the program can be accomplished. A high priority for change is the schedule for submitting rank order lists and releasing match results.

The crucial dates in the NRMP schedule are in the second week in January, when students and programs must submit their rank order lists, and in the second week in March, when the match results are released. NRMP uses the two month period between these dates to computer code rank order lists and to obtain confirmation of their accuracy from both students and programs. The committee recommends:

- That medical schools, teaching hospitals, and programs work together to ensure that senior medical students are selected for residency positions only through the NRMP;
- That the NRMP explore every possible way to shorten the time between the submission of rank order lists and the release of the match results to one month;
- That, if this shortening is accomplished, the rank order list deadline be moved to March 1; and
- That the match results be released on April 1.

The lengthening of the period before rank order lists must be submitted from the present two weeks to two months after the December holidays will provide significantly more time for decisions by both candidates and programs. This schedule will also permit medical schools to incorporate evaluation of a portion of students' senior year performance into their communications to programs. The committee recommends:

- That, if a March 1 rank order deadline is achieved, all medical schools and programs mutually agree on November 1 as the earliest date evaluations will be released by the schools.

The establishment of separate matching programs that occur in advance of the NRMP schedule by five specialties has contributed to the time pressures on both schools and students. The committee believes that these early matches, which were conceived before NRMP had adapted its programs to the needs of students applying to these specialties, are no longer necessary. The Committee therefore recommends:

- That negotiations be undertaken to incorporate early matching specialties into the NRMP.

The committee considered the proposition that a national centralized application service be established to permit candidates to file only one application for distribution to all the programs to which they are applying. Such a service is not considered feasible. However, the committee believes that both the burden of filing applications by candidates and processing them by programs must be reduced as much as possible.

For candidates, the burden of filing applications can be reduced by the general acceptance of the universal application form developed by the AAMC and distributed by the NRMP. This four-page form has two pages for academic and demographic information that all programs require. It can be filled out once and reproduced. The other two pages are for information that is specific for a particular program or specialty and are completed for each program to which a student applies.

The burden of processing a large number of applications can be alleviated by central institutional systems for this purpose. While selection decisions must reside with the programs, they can be relieved of much of the paperwork and record-keeping involved in the application process. At academic medical

centers, the experience of the medical school admissions office in processing a large number of applications can be applied. The committee recommends:

- That medical schools promote their graduates' use of the universal application form for graduate medical education;
- That all graduate medical education institutions and their programs accept the universal application form as at least the first step in the application process; and
- That institutions develop central systems for handling the paperwork and record-keeping for applications.

Health Care Innovation Act

In an effort to help ensure that Medicare's prospective payment system does not hinder the introduction of new technology or clinical procedures, Senators Durenberger (R-MN) and Bentsen (D-TX) have introduced the "Health Care Innovation Act of 1986," S.2474. (Copy included as Attachment A). Under the bill, Medicare would be required to partially support the extra costs of new technologies or procedures for which the Food and Drug Administration has approved a premarket approval application. As proposed, technologies covered by the bill would exclude those medical devices the cost of which (in whole or part) are Medicare capital-related costs. The Medicare supplementary payment would equal 60% of the cost above a threshold of 110% of the DRG payment. In teaching hospitals, the 110% calculation is determined before the resident-to-bed adjustment is calculated. The total supplementary payments to a single hospital are limited by a formula based 40% on the hospital's share of national Part A payments and 60% on the hospital's share of indirect medical education payments. Total supplements payable to all hospitals cannot exceed 1% of Medicare prospective payments. To obtain the added payments, hospitals would have to furnish Medicare with clinical and financial data on the innovation.

Board members are requested to discuss:

- how active the AAMC should be in seeking supplementary payments for new technologies and procedure,
- the acceptability of the proposed payment formula and limits, and
- the acceptability of furnishing utilization and cost data as a quid pro quo for supplementary payments.

Attachment A

By Mr. DURENBERGER (for himself and Mr. BENTSEN):

S. 2474. A bill to amend title XVIII of the Social Security Act to encourage the availability of new technologies and new procedures which are not recognized by the Medicare prospective payment system, to collect data to determine whether such technologies and procedures should be so recognized on a permanent basis, to provide for annual recalibration of diagnosis related groups, and for other purposes; to the Committee on Finance.

HEALTH CARE INNOVATION ACT

Mr. DURENBERGER. Mr. President, I rise to introduce today the Health Care Innovation Act of 1986. I am joined in introducing this proposal by my distinguished colleague the Senator from Texas [Mr. BENTSEN].

The Health Care Innovation Act of 1986 amends title 18 of the Social Security Act to encourage the continued diffusion of new medical technologies and procedures not now recognized under the Medicare prospective payment system, to collect data to determine whether such technologies and procedures are useful and should be paid for by Medicare on a permanent basis, and to require the Secretary of Health and Human Services to adjust annually the Medicare prices set by diagnosis related groups to advance medical technology and procedures.

Mr. President, last Sunday I had the privilege of spending Mother's Day with my parents at their home in Avon, just west of St. Cloud, MN.

I consider myself incredibly lucky—at almost 52 years of age—to have two living parents.

And, because I have a 75-year-old mother and an 80-year-old father, I have a very personal interest in the subject I'm discussing here today.

STRETCHING OUT THE LIFESPAN

A lot of us don't want to admit it, but America is an aging nation. We're living longer, but also fuller lives.

I like to think one reason we're all living longer stems from the fact that we're taking better care of ourselves—jogging more, smoking less, and all the rest. I can't imagine in Minneapolis and St. Paul, MN how there could be anyone left who drinks and drives, or rides in a car without a seatbelt, after the media deluge we've had from "Project Lifesaver" over the past couple of weeks.

But, we're living longer due to more than healthier habits. We are also living longer because medical science has continued to provide new and better ways of keeping us going, new procedures and technologies that extend lives and improve the quality of lives for millions of Americans.

Pacemakers represent one such example.

Something like a half-million Americans—more than the total population of St. Paul—are now walking around, leading relatively normal lives with pacemakers implanted in their chest. Medical experts tell us that as many as 5 percent, or 25,000 people, would die within minutes without them.

Thousands of other Americans have had their lives extended by innovations in surgical procedures, like bypass operations, for example. While all of these new technologies and procedures are subject to abuse and overuse, the fact is that they have contributed immeasurably to extending and improving the quality of our lives.

The kind of emphasis on quality and innovation in our health care system which has produced the pacemaker, heart by-pass surgery, and other examples of new technology and procedures does not exist everywhere in the world.

Last summer I had the privilege of visiting relatives in Poland. I went to a well-respected children's hospital in Cracow and spent some time there with the physicians and medical director. And, I heard them wish over and over again that they had access to the kind of advances in medical science many of us in this country simply take for granted. The kind of technology which would bring those Polish doctors past a point at which they now seem almost frozen in time—a time which resembled this country when my parents were my age.

TECHNOLOGY AND HEALTH SYSTEM REFORM

Over the years, Americans have taken the lead in pushing out the frontiers of medical science and extending and improving our lives in the process. But now, while we are in the midst of a very necessary effort to contain the health care cost explosion which threatens to bankrupt us all, we need to stop, look around, and make sure the kinds of technological advances we've seen take place in the past are encouraged to continue.

I say this as one of those who has argued most often and most forcefully in behalf of the marketplace reforms in health care which are now sweeping this country.

In fact, I've published a new book on the subject—"Prescription For Change," which I commend to my colleagues.

Those reforms have been necessary, and they are working largely as intended to halt the dramatic increases in health care costs we had been experiencing while, at the same time, retaining the kind of quality which Americans demand and deserve.

But, despite generally favorable reviews, there are some troubling side effects of health care reform which need to be addressed.

And, S. 2474 I am introducing today in the Senate is one of the midcourse corrections which now needs to be made.

A key part of recent reforms in health care has been the new Medicare hospital prospective payment system which Congress set in place in 1983. This new payment system encourages more conservative practices

in hospitals by setting prices in advance for some 468 different categories of illness.

Hospitals are no longer paid, in other words, for each test or procedure they perform on Medicare patients—regardless of price. They are rewarded for staying within the predetermined prices set on each illness or injury.

While this new payment system is an important step forward in controlling costs, it will discourage the use and development of many advanced medical treatments or technologies—it will unless it permits a normal market for new product research and development to function.

Because the new Medicare payment system pays a set price for each illness, for example, it encourages hospitals to use the lowest cost or efficient treatment available. This means that two types or technologies are at a disadvantage; those that improve quality, but cost more; and those that have a higher price up front but may actually save money in the long run by reducing the need for return visits to the hospital.

Mr. President, this problem with the prospective payment system must be rectified. I am introducing S. 2474 to provide medical technology researchers and manufacturers with proper market incentives to continue the kind of work which has made possible an ever longer and better quality life for millions of Americans.

This is particularly relevant in a State like Minnesota which has spawned medical technology geniuses like Lloyd Cherne, the developer of the Cherne coronary artery disease detector, and others to continue the kind of breakthroughs in medical science we have come to expect and depend on.

In fact, I've made the point of highlighting the leading role Minnesota has assumed in the health technology field as well as starting the health care policy revolution now sweeping the country, by yesterday announcing the introduction of this bill in my home State of Minnesota.

I should also note that this legislation is part of a series of mid-course adjustments which I and my colleagues in the Congress have or will make in this health policy revolution.

Before the health policy revolution, before competition and consumer choice took hold on the health care system, hospital charity care, physician training, and medical research were subsidized with the surplus revenue generated from patients who paid for services. In the new environment consumers and third-party payers have little incentive to pay for anything more than they receive in direct services, and they, therefore, balk at paying for the old cross-subsidies.

My colleagues on the Senate Finance Committee, particularly the Senators from Kansas [Mr. DOLE] and Texas [Mr. BENTSEN], share this concern that explicit policy needs to be set concerning the cross-subsidies. The reform of payment for health services by Medicare and other payers must continue. But, at the same time the indigent care, physician training and medical technology advancement should not be left out.

Last year Senators DOLE and BENTSEN joined me in promoting changes in Medicare payments to teaching hospitals. Those initiatives were incorporated in the fiscal year 1986 reconciliation bill which passed the Congress. Those changes made a clear commitment from Medicare to fund appropriate physician training which enhances the care for Medicare beneficiaries.

In the area of indigent care, care for those who lack health insurance and cannot pay for services, I have also made a number of proposals. With my colleague the Senator from Massachusetts [Mr. KENNEDY] and others, I introduced the Alleys to Health Care Act of 1986, S. 2403, and I will introduce other measures to refine the tax code to provide incentives for all Americans to obtain health insurance coverage.

These measures will not help all of the 37 million Americans who lack health insurance. But, should enable many to obtain a health plan and reduce the financial pressure on hospitals from those who cannot pay.

Today, however, my purpose is to focus on assuring Americans, continuing access to the best medical care we can offer. Senator BENTSEN is joining me today in an important next step in this process. In proposing S. 2474, the Health Care Innovation Act of 1986, we are providing explicit Medicare policy on the development and diffusion of new medical advances. The bill is consistent with Medicare's prospective pricing system, and it reflects our commitment to continue reform while adjusting it to assure the American people that they will receive quality as well as efficient health care services.

Briefly, S. 2774:

First, requires Medicare to pick up a part of the extra cost of new technologies or procedures prior to their full approval. Only technologies and procedures which have been approved by the Food and Drug Administration as safe and effective would qualify. Under this provision of S. 2474 Medicare would agree to share the risk for the early introduction of new technologies and procedures with hospitals. Only part of the marginal cost above the per case payment would be covered.

In the old cost-based environment, innovators in medical technologies and procedures could afford to wait until Medicare decided to cover a medical advance because they knew they could recover their full cost. Today, under the per case, diagnosis related group [DRG], payment system even if Medicare decides to cover a new technology or procedure, the innovator cannot be assured that the payment structure will be adjusted to meet their full costs. The risk is increased so innovators will shy away from marketing a medical advance for which costs are greater than the respective DRG that advance would fall into.

S. 2474 provides a financial bridge in which Medicare shares the risk with the hospital and innovator for the medical advance while it decides whether or not to permanently cover an advance and how much to pay for it.

Second, requires hospitals which use this provision to cooperate with Medicare in collecting data on the medical advance. In the past, Medicare has frequently had to make decisions on covering medical advances based on scanty data. Also, cost information, so important to setting the right price, is hard to come by. This provision would enable Medicare the flexibility to collect the information needed to decide whether or not an advance is truly useful and what the price should be.

Third, requires Medicare to recalibrate the DRG's annually rather than every 4 years as now required by law. Changes in medical practice should be reflected in the DRG prices as fast as possible. The current 4-year lag time freezes medical practice in time for no medical or scientific reason. The 4-year period for adjusting the price was set arbitrarily and does not reflect the capacity of Medicare to adjust more rapidly.

Mr. President, older Americans deserve access to the best quality and most up-to-date health care treatments available. And, they deserve assurance that the health care industry will continue to seek out new and better ways of treating illnesses such as cancer, heart disease, and Alzheimer's disease.

These kinds of advances can not only extend the length and qualilty of life for older Americans, but also continue the strong role which this country's advances in medical technology have played in improving the quality of health care worldwide.

S. 2474 moves us in that direction.

Mr. President, I ask unanimous consent that the text of S. 2474 be printed in the RECORD at this point, followed by the bill summary, steps in approving and paying for projects and procedures, and example technologies inhibited by Medicare.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 2474

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Care Innovation Act of 1986".

SEC. 2. INTERIM FINANCING AND DATA COLLECTION.

(a) IN GENERAL.—Section 1886 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i)(1)(A) Notwithstanding sections 1813 and 1814(b), the Secretary shall make payment under this subsection to a subsection (d) hospital (as defined in subsection (d)(1)(B)) for the qualified new technology or procedure costs incurred with respect to an inpatient hospital discharge.

"(B) Payments made under this subsection shall be in addition to payments made under subsection (d).

"(2) The Secretary shall make payments for qualified new technology or procedure costs as follows:

"(A) DETERMINING QUALIFIED NEW TECHNOLOGY OR PROCEDURE COSTS.—A 'Qualified new technology or procedure cost', as used in this subsection, is the incremental operating cost associated with the use of a new technological advance or a new procedure (as determined in accordance with paragraph (3)) with respect to a hospital discharge.

"(B) DETERMINING INCREMENTAL OPERATING COSTS.—'Incremental operating cost', as used in this subsection, is the amount by which charges, adjusted to cost, with respect to a hospital discharge, exceed 110 percent of the amount payable under subsection (d) with respect to such discharge (as determined prior to the adjustment under subsection (d)(5)(B) for indirect costs of medical education).

"(C) PAYMENT AMOUNT.—The Secretary shall pay to a subsection (d) hospital, with respect to a hospital discharge, an amount equal to 60 percent of the qualified technology or procedure costs for which the requirements of this subsection are satisfied and for which the hospital submits a claim for payment.

"(3) The new technological advances and new procedures with respect to which payment may be made under this subsection shall be determined as follows:

"(A) DETERMINING NEW TECHNOLOGICAL ADVANCES AND NEW PROCEDURES.—

"(i) A 'new technological advance', as used in this subsection, is a medical device (as defined in subparagraph (F)(i))—

"(I) for which the Food and Drug Administration has approved a premarket approval application under section 515(a) of the Federal Food, Drug, and Cosmetic Act (other than a device which is or may be subject to section 515(a)(1) of such Act);

"(II) which is used during the interim data collection period (as determined under subparagraph (B)) for such device; and

"(III) which is not a capital technology (as defined in subparagraph (C)).

"(ii) A 'new procedure', as used in this section, is a medical or surgical procedure (as limited by subparagraph (F)(ii)) which is used during the interim data collection period (as determined under subparagraph (B)) for such procedure.

"(B) DETERMINING INTERIM DATA COLLECTION PERIODS.—With respect to a medical device or a medical or surgical procedure, the 'interim data collection period', as used in this subsection, is the period which—

"(i) begins on—

"(I) in the case of a medical device, the date such medical device receives approval of a premarket approval application under section 515(a) of the Federal Food, Drug, and Cosmetic Act; and

"(II) in the case of a medical or surgical procedure, the date that is the earlier of the date on which an ICD-9-CM code is assigned to the procedure or the date on which the Secretary makes a final determination (as defined in subparagraph (F)(iii)), that the procedure is not excluded under section 1862(a); and

"(ii) ends on the date, subject to subparagraph (D), that is the earliest of—

"(I) the first October 1 which occurs at least 24 months after the date on which such period begins;

"(II) the effective date of a reweighting (as defined in subsection (d)(4)(C)(iv)(II)) or a classification adjustment (as described in subsection (d)(4)(C)(i)) which directly affects a diagnosis related group with respect to which such medical device or procedure is used; or

"(III) the effective date of a final determination (as defined in subparagraph (F)(iii)) by the Secretary that such medical device or procedure (or a service employing such medical device or procedure) is excluded under section 1862(a).

"(C) EXCLUDING CAPITAL TECHNOLOGIES.—A capital technology, as used in this subsection, is a medical device, the costs of which (in whole or in part) are capital related costs as defined by the Secretary under subsection (a)(4).

"(D) LIMITING FOR SPECIFIC USES.—In determining the date on which an interim data collection period ends under subparagraph (B)(ii)(II) or (III), a reweighting, classification adjustment, or final determination which applies with respect to a specific use of a medical device or procedure operates to end such period only with respect to such use.

"(E) EXEMPTIONS FROM COVERAGE REQUIREMENT.—Notwithstanding section 1862(a), and except as provided in subparagraph (B)(ii)(III), payment may not be denied by reason of section 1862(a)—

"(i) if such payment is under this subsection and is for qualified new technology or procedure costs; or

"(ii) if such payment is under subsection (d) and is for expenses incurred for items or services for a discharge with respect to which an amount is payable under this subsection.

"(F) DEFINITIONS.—The term—

"(i) 'medical device', as used in this subsection, means a medical device as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act;

"(ii) 'procedure', as used in this subsection, does not include a procedure using a medical device for which an investigational exemption under section 520(g) of the Federal Food, Drug, and Cosmetic Act is in effect; and

"(iii) 'final determination', as used in subparagraphs (B)(i)(II) and (B)(ii)(III), means a determination which—

"(I) applies with respect to all subsection (d) hospitals; and

"(II) in the case of a determination described in subparagraph (B)(ii)(II) is not based, in whole or in part, on insufficiency of data with respect to a medical device or procedure or a service employing such medical device or procedure.

"(4) The Secretary shall collect data on new technological advances and new procedures and use such data as follows:

"(A) DATA COLLECTION AND REPORTING.—A subsection (d) hospital which elects to claim a payment under paragraph (2)(C) with respect to an inpatient hospital discharge shall report, in such form and in accordance with such procedures as the Secretary may prescribe—

"(i) the amount of reasonable operating costs of inpatient hospital services (as defined in subsection (a)(4)); and

"(ii) such other financial or clinical data as the Secretary determines to be necessary to carry out subparagraph (B).

"(B) USE OF DATA FOR REWEIGHTING AND RECLASSIFICATION.—The data reported under subparagraph (A)—

"(i) shall be used by the Secretary to carry out clauses (i) and (ii) of subsection (d)(4)(C);

"(ii) shall be made available by the Secretary to the Prospective Payment Assessment Commission and used by such Commission to carry out subsection (d)(4)(D); and

"(iii) shall be made available by the Secretary, upon request, to the National Institutes of Health, National Center for Health Services Research and Health Care Technology Assessment, Office of Technology Assessment, Food and Drug Administration, Veterans' Administration, and Department of Defense.

"(5) In addition to the limitations imposed by paragraphs (2) and (3), the Secretary shall limit payments under this subsection as follows:

"(A) EXCLUDING OUTLIER PAYMENTS.—No payment may be made under this subsection for a cost or charge which qualifies for an additional payment under subsection (d)(5)(A).

"(B) LIMITING ANNUAL PAYMENTS TO INDIVIDUAL HOSPITALS.—The amount of payments available under this subsection to a subsection (d) hospital for a fiscal year shall not exceed a share of the total amount available under this subsection for such fiscal year (as determined under subparagraphs (D) and (E)). Such share for any hospital shall be a fraction of the total amount available, equal to—

"(i) 40 percent of a fraction—

"(I) the numerator of which is the amount of payments to such hospital under part A of this title for operating costs of inpatient hospital services (as defined in subsection (a)(4)), as estimated by the Secretary for the immediately preceding fiscal year; and

"(II) the denominator of which is the amount of all payments under part A of this title for operating costs of inpatient hospital services (as defined in subsection (a)(4)), as estimated by the Secretary for the immediately preceding fiscal year; plus

"(ii) 60 percent of a fraction—

"(I) the numerator of which is the amount of payments to such hospital under subsection (d)(5)(B) for indirect costs of medical education, as estimated by the Secretary for the immediately preceding fiscal year; and

"(II) the denominator of which is the amount of all payments under subsection (d)(5)(B) for indirect costs of medical education, as estimated by the Secretary for the immediately preceding fiscal year.

"(C) LIMITING CARRY FORWARD OF PAYMENTS.—Payments available to a subsection (d) hospital under subparagraph (B) for a fiscal year, but not claimed under paragraph (2)(C) with respect to a qualified new technology or procedure costs incurred in such year, may not be claimed for a succeeding fiscal year.

"(D) LIMITING AGGREGATE ANNUAL PAYMENTS.—Subject to subparagraphs (E) and (F), the total amount available under this subsection for all hospitals for any fiscal year shall be the amount equal to 1 percent of the total payments made under subsection (d) for the immediately preceding fiscal year, as estimated by the Secretary.

"(E) ADJUSTMENT FOR EXCESS AGGREGATE ANNUAL PAYMENTS.—The amount determined under subparagraph (D) for any fiscal year shall be reduced by the amount (if any) by which the total payments made under this subsection for the preceding fiscal year exceeded the amount determined under such subparagraph for such preceding fiscal year.

"(F) REQUIREMENT OF TRUST FUND BALANCE.—Payments under this subsection for any fiscal year—

"(i) shall be payable from the Federal Hospital Insurance Trust Fund (and shall not be subject to appropriations); and

"(ii) shall be available under subparagraph (D) only to the extent an asset balance (as described in the 'Annual Report of the Board of Trustees of the Federal Housing Insurance Trust Fund') exists in such Fund at the beginning of such fiscal year, as estimated by the Secretary after consulting with the other Trustees for such Fund.".

(b) REPORT.—The Secretary of Health and Human Services shall report to Congress not later than one year after the date of the enactment of this Act on methods by which payments could be made under section 1885(i) of the Social Security Act (as added by this Act) to any health maintenance organization or competitive medical plan that has a risk-sharing contract under section 1876 of the Social Security Act.

(c) CONFORMING AMENDMENTS.—(1) Section 1862(a)(1)(A) of the Social Security Act is amended by inserting "or which are new technologies or procedures to which section 1886(i) applies," after "(C), or (D),".

(2) Section 1886(d)(5)(B) of such Act is amended by adding at the end thereof the following: "The adjustment under this subparagraph shall be made on the basis of the payment amount to such hospital without taking into account any payments under subsection (i) for qualified new technology or procedure costs.".

(d) EFFECTIVE DATE.—(1) The amendments made by this section shall apply with respect to qualified new technology or procedure costs (as defined in section 1886(i)(2)(A) of the Social Security Act) made after the date of the enactment of this Act.

(2) Notwithstanding section 1886(i)(3)(A) of the Social Security Act, a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) or procedure shall not be a new technological advance or procedure for purposes of such section 1886(i)(3)(A) if, before the date of the enactment of this Act, there occurs with respect to such device or procedure or a specific use thereof—

(A) a reweighting or classification adjustment (as described in section 1886(i)(3)(B)(ii)(II) of the Social Security Act and as limited by section 1886(i)(3)(D) of such Act); or

(B) a final determination (as described in section 1886(i)(3)(B)(ii)(III) of the Social Security Act, as defined in section 1886(i)(3)(F)(iii) of such Act, and as limited by section 1886(i)(3)(D) of such Act).

SEC. 3. ANNUAL RECALIBRATION.

(a) ADJUSTMENTS OF DRG CLASSIFICATIONS AND WEIGHTING FACTORS.—Section 1886(d)(4)(C) of the Social Security Act is amended to read as follows:

"(C)(i) The Secretary shall adjust the classifications established under subparagraph (A) for discharges in fiscal year 1986 and at least once every four fiscal years thereafter.

"(ii) The Secretary shall adjust the weighting factors established under subparagraph (B)—

"(I) through a recalibration for discharges in fiscal year 1986 and once every fiscal year thereafter; and

"(II) through reweighting for discharges in any fiscal year.

"(iii) The Secretary shall make the adjustments under clauses (i) and (ii) to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

"(iv) As used in this subparagraph, the term—

"(I) 'recalibration' means a weighting factor adjustment which is based on a methodology applied uniformly to all weighting factors, which reflects the relative hospital resources used for each weighting factor compared to all other weighting factors, and which becomes effective with respect to all weighting factors simultaneously; and

"(II) 'reweighting' means a weighting factor adjustment which reflects the relative hospital resources used for a weighting factor compared to all other weighting factors, but which does not apply to all weighting factors.".

(b) PUBLICATION.—(1) Section 1886(e)(5)(A) of the Social Security Act is amended by inserting "and proposed recalibration under subsection (d)(4)(C)(ii)(I)" after "paragraph (4)".

(2) Section 1886(e)(5)(B) of such Act is amended by striking out "proposal" and inserting in lieu thereof "proposals" and by inserting "(4) and final recalibration under subsection (d)(4)(C)(ii)(I)" after "such paragraph".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective on the date of the enactment of this Act.

BILL SUMMARY: HEALTH CARE INNOVATION ACT OF 1986

1. Why do we need this legislation?

In 1983, Medicare's hospital payment system was changed to a DRG—or "diagnosis-related group"—system. Now, each illness is placed in a DRG that has a flat payment rate. A hospital treating a patient gets the DRG rate for the patient's illness, regardless of the treatment used, the length of the hospital visit or the expense to the hospital. This system encourages only treatments that lower costs per hospital visit. Many treatments do that.

Others, however, raise today's costs, but either decrease costs over time or greatly improve care at a higher cost. These treatments often face long delays—even after safety and effectiveness approval from the Food and Drug Administration—in being fully incorporated into the DRG system. Thus, Medicare patients lack access to some of the most promising new technologies, and manufacturers are discouraged from developing them.

2. What does the legislation do?

It provides partial funding for certain cost-increasing medical treatments used for Medicare patients until Medicare makes necessary DRG adjustments. In addition, the DRG rate would be adjusted annually, rather than every four years.

3. What qualifies?

New products and procedures would qualify if they increase costs at least 10 percent above the price of the Medicare DRG. In addition, new products must have premarket approval for safety and effectiveness by the Food and Drug Administration, while new procedures must have already started to enter the DRG system. Specifically, that means when Medicare has decided which DRG seems most appropriate for the new procedure.

4. How long do payments last?

The legislation would provide funding only until Medicare adjusted the individual DRG price. Payment for a technology could never last more than two years.

5. Why was this length of time for funding chosen?

It permits enough time to generate data to help Medicare decide whether to incorporate the treatment into the DRGs on a permanent basis.

6. How would the payments work?

Medicare would pay the hospital part of the cost of using a product or procedure that's covered by the bill. Medicare's share would be the DRG rate, plus 60 percent of the amount that exceeds 110 percent of the DRG level. The hospital would pay the extra 40 percent above that level.

For example, a profoundly deaf patient could not currently receive a cochlear implant under Medicare, since it is not covered. With this bill a hospital could install an implant that has FDA approval in a Medicare patient. The DRG for ear surgery pays only $1,835. If the cochlear implant cost $20,000, the hospital would receive $12,624. Here's how:

Cost of implant	$20,000
110 percent of $1,800, which is the DRG payment for surgey	−2,028
Amount by which implant exceeds 110 percent of DRG	17,982
The percent that the bill will pay above 110 percent of the DRG price	×.60
60 percent of amount exceeding 110 percent	10,789
DRG payment level	+1,835
Amount Medicare pays	12,624

7. Do any other limits apply?

Limits would be set each year on the amount of funding each hospital could receive. The limit would be based on a formula which reflects, in part, the percentage of Medicare payments a hospital receives overall.

8. Once a technology qualifies, how does the legislation actually work?

A hospital will be paid for any technology which qualifies. As it does with any other technology, it must merely charge Medicare for repayment.

9. What else is required of hospitals that offer technologies paid for under the bill?

A hospital offering a product or procedure eligible under the bill would be required to provide data which Medicare needs to assess the usefulness of the product or procedure and to establish an appropriate DRG rate for the new treatment.

STEPS IN APPROVING AND PAYING FOR PRODUCTS AND PROCEDURE

Current law	Changes resulting from Health Care Innovation Act of 1986
1. Investigational device exemption for products: Food and Drug Administration approves clinical tests of device in humans.	
2. (a) Premarket approval for products: FDA finds device safe and effective and approves for general use. or (b) Classification of new procedures: The procedure is placed in the payment category that best fits the new treatment.	3. Once steps 2(a) or 2(b) occur, Medicare will pay for the use of a technology on patients. This legislation pays part and the hospital pays part. Payment lasts for two years or until step 5, whichever comes first.
4. Medicare approval: Medicare agrees to pay for the product or procedure. Without this, patients would not receive Medicare payment for their treatment and, thus, would not be candidates for the technology. For the cochlear implant, the lag from FDA to Medicare approval has already been over one and one-half years.	Payment would also end it Medicare reviewed the technology and decided it is not approved (step 4).

5. Medicare adjusts prices to account for new products and procedures. This often takes several months after Medicare approves the technology.

EXAMPLE OF TECHNOLOGIES INHIBITED BY MEDICARE

COCHLEAR IMPLANT

A sophisticated electronic device that gives a sense of hearing to people whose deafness is caused by damage to the cochlea (inner ear). Some people who have been told that they have "nerve deafness" may benefit from a cochlear implant.

In the normal hearing process, sound waves enter the ear and strike the eardrum, setting off a chain of vibrations that pass from tiny bones in the middle ear to the cochlea. In the cochlea, hair cells convert the vibrations into electrical impulses that travel along the hearing nerve to the brain. The brain, decoding these impulses, "hears" the sound.

In contrast, the cochlear implant bypasses the eardrum and tiny bones and sends electrical signals directly into the cochlea. Then, as in normal hearing, the signals go from the cochlea to the hearing nerve and then to the brain, which provides meaningful sound.

Status: The cochlear implant was approved as safe and effective by the Food and Drug Administration in November 1984. As yet, Medicare has not agreed to pay for its use by Medicare patients.

DRUG ADMINISTRATION DEVICE

The drug administration device (DAD) is a pump and reservoir implanted into the body to dispense a drug. The pump can be programmed without surgery via radio signals to dispense a drug to a specific point with precise timing and dosage.

It is under clinical study for delivery of analgesics for pain control, chemotherapy for cancer, agents for controlling spasticity and medications for treating congestive heart failure. Since the pump can direct drugs to the brain, it can have uniquely valuable uses—for example, it is already being tested as a method of administering a drug to control Alzheimer's Disease, if such a drug were developed. Since the pump is completely implanted, the patient's daily activities are not affected and a high quality of life can be maintained.

Status: The pump was approved by FDA in 1982, but was not made available to Medicare patients until 1984. The Medicare payment rate has yet to be increased to cover the cost of this technology.

VENTRICULAR ASSIST PUMP

A device designed to help people with certain types of severe heart problems, implanted temporarily to supplement the pumping action of a weak heart. The device is used only when other, more conventional treatments do not work. For example, it can be used with patients who are awaiting a heart transplant, or to boost the pumping power of a heart after open-heart surgery (such as bypass surgery) or a heart attack. It is placed outside the body and powered by bursts of air generated by compressor.

Status: The device is still in the experimental stage, but has been implanted during clinical trials in dozens of patients. Once the device receives FDA approval, it appears that the Medicare payment rate will be insufficient to cover its cost.

● Mr. BENTSEN. Mr. President, I am pleased to join my distinguished colleague, Senator DURENBERGER, in introducing S. 2474, the Medical Equal Access to Technology Act. The purpose of this legislation is to amend title XVIII of the Social Security Act to ensure that Medicare beneficiaries have access to new medical devices and procedures.

Introduction of the Prospective Payment System [PPS] in 1983 has resulted in significant reform of the health delivery system used by hospitals across this country. Dramatic changes in length of stay, use of outpatient surgery, and increased competition among providers of care have helped curb major increases in the cost of services. However, as my colleagues know, PPS uses the Diagnostic Related Group, or DRG, to determine rates of hospital reimbursement. DRG's are based on national averages associated with the delivery of care or services. In order to obtain average rates of payment, a service must already be available and accessible to patients.

A system based strictly on DRG's is therefore inherently dependent on existing technologies and procedures for which there is a history of payments and for which an average rate can be derived. But what of new technologies and procedures? PPS is, by definition, biased against introducing the most advanced, state-of-the-art health services. This bill, Mr. President, is designed to overcome the disincentives built into the DRG system and thereby ensure that elderly and disabled beneficiaries have access to the full range of devices and technologies needed to improve their health status.

Specifically, the bill provides partial funding for certain costly medical treatments until DRG's are recalibrated to account for those costs. New devices and procedures would qualify for coverage if they increase Medicare costs at least 10 percent above the payment rate of the DRG that most nearly approximates the diagnosis. In addition, new products must have approval for safety and efficacy by the Food and Drug Administration, and new procedures must have received a recommendation for coverage under the International Classification of Diseases [ICD9-CM].

This bill provides funding only until such time as the Health Care Financing Administration adjusts the DRG's to accommodate the new technology. Moreover, Medicare's share of the payment would be the closest DRG rate plus 60 percent of the amount that exceeds 110 percent of the DRG level—the hospital would be liable for the remaining 40 percent. Requiring that institutions share in the cost of the new techology is designed to ensure that the hospital has a sufficient stake in the cost of the device or technology to make a prudent coverage decision.

Total expenditures for the implementation of this proposal may not exceed 1 percent of the trust funds, and funds may only be expended in years when the trust fund has a surplus. This year, the amount that could be utilized would therefore amount to approximately $400 million; however, preliminary projections place this year's cost at no more than $100 million.

Mr. President, I should like to take a moment to highlight an example of the type of procedure that could be made more widely available to the elderly and disabled with enactment of this bill. Dr. Stanley Crawford, a heart surgeon who practices at the Methodist Hospital in Houston, pioneered a complex resection and graft replacement known as a thoraco-abdominal aortic aneurysm resection (Thoraco-AAA). Half of the procedures performed annually are done at the Methodist Hospital, and the remainder are carried out at fewer than six other institutions.

Prior to the development of this technique, nearly 60 percent of the persons with the medical problems leading to a Thoraco-AAA died within 2 years, and 80 percent died within 5 years. Today, Dr. Crawford's innovative approach to treating these patients has turned those statistics around, making a longer more normal life possible for dozens of heart patients and their families.

The clinical efficacy of the procedure was established after the most recent modifications to the ICD-9CM, yet the PPS structure does not capture this new surgical technique, which has resulted in a loss of nearly $2½ million to the Methodist Hospital over the last year.

Because of a commitment to clinical research and a firm desire to maintain the hospital's reputation as a world class institution, the president and members of the Methodist Hospital board have allowed Dr. Crawford to operate while they awaited recalibration of the DRG's. Not all institutions have the financial resources to enable them to carry out such a decision. More importantly, elderly and disabled persons in communities across this country are being denied access to a lifesaving technique, simply because of a lag in recoding.

Mr. President, our bill is not designed to pay for all the costs of new technology, but rather to recognize the incremental costs associated with that technology. We do not propose to eliminate all losses, but to reduce them. We do not intend to create Medicare financial incentives for new medical advances, but rather to remove what, in this budget-driven environment, is a powerful financial disincentive which works against our common interest in pushing back the frontiers of medical science for the benefit of all.

I urge my colleagues to join with us in support of this modest, but necessary, modification of the Prospective Payment System.●

By Mr. HUMPHREY (for himself, Mr. LUGAR, Mr. HATCH, Mr. NICKLES, Mr. LEAHY, Mr.