association of american medical colleges

AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS

ADMINISTRATIVE BOARD MEETING

September 10, 1987
8:00 am
Washington Hilton Hotel
Map Room

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

COTH ADMINISTRATIVE BOARD

Chairman: Spencer Foreman, MD
Montefiore Medical Center

Chairman-Elect: J. Robert Buchanan, MD
Massachusetts General Hospital

Immediate Past Chairman: C. Thomas Smith
Yale-New Haven Hospital

Secretary: John E. Ives
St. Luke's Episcopal Hospital

Gordon M. Derzon
University of Wisconsin Hospital and Clinics

Gary Gambuti
St. Luke's-Roosevelt Hospital

Jerome H. Grossman, MD
New England Medical Center, Inc.

William H. Johnson,Jr.
University of New Mexico Hospital

Larry L. Mathis
The Methodist Hospital

James J. Mongan, MD
Truman Medical Center

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

Raymond G. Schultze, MD
UCLA Hospitals and Clinics

C. Edward Schwartz
Hospital of the University of Pennsylvania

Barbara A. Small
Veterans Administration Medical Center

Alexander H. Williams
AHA Representative

COTH MEETING DATES

COTH ADMINISTRATIVE BOARD MEETINGS

September 9-10, 1987	The Washington Hilton Hotel Washington, DC

COTH SPRING MEETINGS

May 11-13, 1988	The New York Hilton Hotel New York, NY
May 10-12, 1989	The Hotel del Coronado San Diego, CA

AAMC ANNUAL MEETINGS

November 7-12, 1987	The Washington Hilton Hotel Washington, DC
November 12-17, 1988	The Marriott Hotel Chicago, IL
October 28-November 2, 1989	The Washington Hilton Hotel Washington, DC

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 9-10, 1987
Washington Hilton Hotel
Washington, DC

WEDNESDAY, September 9, 1987

6:30p	JOINT ADMINISTRATIVE BOARDS SESSION Guest Speaker: Fortney (Pete) Stark Chairman, House Ways and Means Health Subcommittee Georgetown West Room
7:00p	JOINT ADMINISTRATIVE BOARDS RECEPTION AND DINNER Jefferson East/West Rooms

THURSDAY, September 10, 1987

8:00a	COTH ADMINISTRATIVE BOARD MEETING Map Room
12:30p	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Hemisphere Room
1:30p	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Military Room

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

WASHINGTON HILTON HOTEL
Map Room
September 10, 1987
8:00am-12:30pm

I.	CALL TO ORDER	
II.	CHAIRMAN'S REPORT	Dr. Foreman
III.	CONSIDERATION OF MINUTES, June 18, 1987	Page 1
IV.	COTH AGENDA ITEMS	
	ACTION: Membership Applications	
	St. Luke's Episcopal Hospital Houston, Texas RECOMMENDATION: Full Membership	Page 8
V.	EXECUTIVE COUNCIL AGENDA ITEMS	
	A. ACTION: Paper on Housestaff Hours	Separate Attachment
	B. ACTION: Report of the ad hoc Committee on Housestaff Participation	Executive Council Agenda - Page 17
	C. ACTION: Repeal of Policy on Paying Capital Costs in COTH Hospitals	Executive Council Agenda - Page 23
	D. ACTION: Proposed Policies for Jointly Sponsored AAHC/AAMC Group of Government Relations Representatives	Executive Council Agenda - Page 34
	E. ACTION: Full Funding of Research Project Grants	Executive Council Agenda - Page 39
	F. ACTION: ACCME Guidelines for Accrediting Enduring Educational Materials	Executive Council Agenda - Page 52
VI.	INFORMATION ITEMS	
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	B. Membership and Minutes of the July 20, 1987 Meeting of the AAMC ad hoc Committee to Review the Academic Medical Center Survey	Page 14

VII. OLD BUSINESS

VIII. NEW BUSINESS

IX. ADJOURN

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
June 18, 1987

PRESENT

Spencer Foreman, MD, Chairman
C. Thomas Smith, Immediate Past Chairman
Gordon M. Derzon
Gary Gambuti
William H. Johnson, Jr.
Larry L. Mathis
James J. Mongan, MD
Charles M. O'Brien, Jr.
Raymond G. Schultze, MD
Barbara A. Small
Alexander H. Williams, AHA Representative

ABSENT

J. Robert Buchanan, MD
Jerome H. Grossman, MD
John E. Ives
C. Edward Schwartz

GUESTS

John W. Colloton
Joanne Fruth, OSR Representative
Thomas Sherman, OSR Representative
Edward J. Stemmler, MD

STAFF

David S. Baime
James D. Bentley, PhD
Robert L. Beran
Linda E. Fishman
Joseph A. Keyes, Jr.
Sonia M. Kohan
Robert G. Petersdorf, MD
James R. Schofield, MD
John F. Sherman, PhD
August G. Swanson, MD
Judith L. Teich
James G. Terwilliger
Kathleen S. Turner
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MEETING
MINUTES
June 18, 1987

I. Call to Order

Dr. Foreman called the meeting to order at 9:30a in the Caucus Room of the Washington Hilton Hotel.

II. Control of Resident Hours

Dr. Petersdorf began the discussion by describing the resident supervision and working hours changes recently recommended to the Commissioner of Health for New York State, Dr. David Axelrod. The changes would limit the number of hours that residents are assigned and require 24 hour per day ER coverage by attending physicians. There was some confusion regarding when and how these changes would be implemented. There was also some uncertainty expressed as to the exact limits to be placed on the number of consecutive hours assigned to residents. Dr. Petersdorf asked how the AAMC should respond to this issue and how its position should be communicated. He suggested the possibility of writing an "op ed" article for the New York Times or a letter to the editor, but felt that any such piece would need to be too brief and too simplistic. He suggested the AAMC needed to examine housestaff working conditions more carefully. The Board discussed mounting a data gathering effort to examine differences in resident hours among geographic areas and the variety of experiences in different types of hospitals. The Arthur Young study of 45 hospitals was suggested as a good starting place for such data. There was some concern expressed about creating a "standard" number of hours which could then be used against the hospital in malpractice cases.

It was pointed out that the requirement for 24 hour attending/faculty coverage in the emergency room was not a precipitous change, as most teaching hospitals have coverage already, for at least two out of three shifts.

Several comments were made by Board members concerned that the financial and educational implications of these proposed changes have not been thought through. For example, if more residents are assigned for the shorter shifts, will the oversupply of physicians become greater, and how will the proposed rules affect a resident's ability to participate in long procedures such as liver transplants. Dr. Foreman noted that community hospitals without faculty would also be required to have 24 hour coverage in the emergency room.

There was agreement that a thorough examination of the implications of the proposal is needed, but that hospitals could no longer expect PGY-1s and 2s to be assigned for 36-hour periods.

ACTION: It was moved, seconded, and carried that the AAMC should take a position regarding the educational and financial implications of any decision regarding housestaff hours. The position should be developed on hard data, and staff should develop a policy framework for discussions at the next Executive Council meeting.

III. Change in Executive Council Meeting Schedule

Dr. Petersdorf also briefly outlined his proposed plan to change the dates for the Executive Council/Administrative Board meetings in the upcoming year (1988),

replacing the traditional January and April meetings with a February meeting, thereby lessening the work load on the Board members and AAMC staff.

ACTION: It was moved, seconded, and carried to approve the plan to change the current Executive Council and Administrative Board meeting schedule as follows:

February 24-25, 1988
June 22-23, 1988
September 7-8, 1988

This agenda would not affect the COTH Spring or AAMC Annual Meeting schedules.

IV. Consideration of the Minutes

ACTION: It was moved, seconded, and carried to approve the minutes of the April 16, 1987 COTH Administrative Board meeting.

V. Chairman's Report

Dr. Foreman briefly recapped the 1987 COTH Spring Meeting in Dallas, congratulating Dr. Mongan, chairman of the Spring Meeting Planning Committee, on a fine program, and thanking Mr. Mathis for cosponsorship of the Thursday evening reception with the Methodist Hospital of Dallas. He noted the relatively low attendance at the meeting and hoped that this was not a precursor of future Spring Meetings. He reported that staff had researched the two Spring Meeting sites recommended by the Board for 1990. While an exciting and unique city, Charleston is inconvenient for most travelers from cities other than Washington or Atlanta. Boston is a lovely and innovative city, but an expensive and often used meeting site. After some discussion, the following action was taken.

ACTION: It was moved, seconded, and carried that the 1990 COTH Spring Meeting be held in Boston, Massachusetts and that staff initiate the appropriate negotiations.

Dr. Foreman reminded the Board of the upcoming AAMC Annual Meeting, noting that the topic for the COTH General Session, scheduled this year for 3:00p, Monday, November 9, will be "AIDS--Important Lessons for Teaching Hospitals." Dr. Bentley noted that speakers are being contacted now for that session.

In conclusion, Dr. Foreman reported that as a result of Administrative Board discussions at the April 16 meeting, AAMC staff is working on a new AAMC Directory format which will consolidate membership data. He also reviewed recent committee appointments, noting that Tom Smith and Eric Munson have been named to the AAMC committee on housestaff participation and that a committee to revise the "Survey of Academic Medical Center Hospitals", chaired by Dave Witter of the Oregon Health Sciences University, has been established.

VI. Membership

It was noted that during the meeting of April 16, the Board had taken the following action which had not appeared in the minutes.

ACTION: It was moved, seconded, and carried on April 16 to approve:

CHILDREN'S MEDICAL CENTER, Dayton, Ohio for full membership.

DANA-FARBER CANCER INSTITUTE, Boston, Massachusetts for continued corresponding membership.

The Board concluded that the Dana-Farber Cancer Institute's characteristics, including its highly limited inpatient role, were similar to those present when the institution was made a corresponding member in 1976.

It was moved, seconded, and carried on June 18 to approve:

GEORGIA BAPTIST MEDICAL CENTER, Atlanta Georgia for full membership,

THE STATEN ISLAND HOSPITAL, Staten Island, New York for full membership.

VII. ACGME Policy Matter

During its previous meeting, the Executive Council had postponed discussion of the proposed revision in the General Requirements of Residency Training Programs. The revision would prohibit graduates of unaccredited U.S. medical schools from being accepted into ACGME accredited training programs. It would affect only one medical school, in Puerto Rico, which is chartered and whose graduates are licensed by Puerto Rico. Dr. Schofield reported that San Juan Batista is an entreprenurial school with about 80 students. The LCME visited the school three times, but it did not meet minimum standards for accreditation. Another school in Puerto Rico has recently been chartered but does not have any students yet. There is some concern that the second school will try to get its students into ACGME residency programs. Mr. Keyes pointed out that the Board needs to ratify this change in order to prevent schools in Puerto Rico and the Virgin Islands from bypassing the LCME accreditation requirements.

ACTION: It was moved, seconded, and carried that the Board accept the proposed change in the General Requirements. It was noted that this decision may be helpful in ensuring that more doctors remain in practice in Puerto Rico, which was one of the goals the Puerto Rican government had in establishing this school.

VIII. Possible AAMC Activities Related to AIDS

Dr. Petersdorf requested input from the Board on possible AAMC activities related to AIDS. He then turned the discussion over to Dr. Sherman who reviewed the four

areas of effort in which the Association could become involved. The AHA's representative, Mr. Williams, described that organization's efforts. It was decided that in an attempt to reduce duplication of effort, the AAMC should communicate with other organizations regarding their activities on AIDS.

It was suggested that the AAMC concentrate its efforts in areas of particular interest to its members, such as the effect of AIDS on medical education programs, medical staff education programs, and the financial burden on hospitals of treating AIDS patients. In summary, the Board decided that teaching hospitals will be looked to as authorities on AIDS treatment; thus, the AAMC should also work to identify precautions against transmission of the disease and models for delivering care.

ACTION: It was moved, seconded, and carried to establish an AAMC AIDS task force to examine these issues in more depth.

With respect to legislative proposals to provide money for AIDS education and research, the Board agreed that the legislation was moving in the right direction and that teaching hospitals have an obligation to see that the large amounts of research dollars are not ill-spent. There was no further action taken by the Board.

IX. AAMC Statement on Medical Education of Minority Group Students

A proposal was placed before the Board to modify the AAMC's current policy statement on minority education, which was adopted in 1970, to reflect the current issues for minority students in medical schools. The new statement acknowledged the progress made in expanding opportunities for minority students in medical school and reaffirmed the commitment of the AAMC and its member institutions to the education of underrepresented minorities for the practice of medicine.

ACTION: A motion was made, seconded, and carried to approve the proposed change in the statement.

X. Mandatory Health Benefits

Dr. Bentley described recently introduced federal legislation mandating health insurance coverage and suggested that there are two approaches to assuring greater health care coverage: 1) expanding Medicaid, and/or 2) mandating that every employer provide health insurance. The AAMC has supported the concept of health insurance coverage for everyone, but has not specifically addressed how to pay for it. He suggested that the AAMC support the concept embodied in the proposed legislation since it will help the hospitals combat the growing problem of uncompensated care. During discussions by the Board, it was stated that great care should be taken to ensure that the question of who pays for the care of the poor - employer or hospital - is clearly defined.

ACTION: It was moved, seconded, and carried that the AAMC support the concept of employer-paid mandatory health benefits.

XI. Medicare Payments for Capital

Dr. Bentley described the Administration's current proposal for Medicare to reimburse hospital capital expenses on a prospective basis. This proposed regulation is opposed by the hospital industry which favors cost reimbursement, even though Congress is unwilling to provide full cost. In the absence of an adequate supply of resources, the industry believes equity is paramount. Recently, a letter was sent to Congress declaring strong opposition to the inclusion of capital payments in the Prospective Payment System. The AAMC participated in this effort. However, in light of AAMC's 1984 policy statement supporting prospective payment for capital, Dr. Bentley questioned how the AAMC should proceed in the future.

The Board reaffirmed the position it took in September of 1986, which stated the AAMC should not be a leader in the debate on Medicare capital, but should be a participant acting in accordance with the rest of the industry. Board members were not confident that prospective capital payment would benefit hospitals. In light of increasing budgetary constraints, there was concern that the proposal may not be implemented as proposed. In an area such as capital, where resource predictability is critical, the Board elected to support the current system of payment.

ACTION: It was moved, seconded, and carried that the 1984 policy statement be rescinded and that staff rewrite the AAMC's current capital policy statement and work with the AHA to bring the policy to fruition.

XII. Organizing the Group on Faculty Practice

Dr. Bentley reviewed the major reasons for developing a Group on Faculty Practice and the Council of Deans' recommendations about the organization of the group. In light of these discussions, Dr. Bentley requested that the Board approve the following staff recommendations:

1) the Group on Faculty Practice be established as a professional development and educational organization within the AAMC;

2) membership in the Group would be limited to plans representing full-time faculty;

3) representatives to the Group would be limited to a single president or chairman and a single plan administrator in each LCME accredited medical school, and;

4) any action on group bylaws, rules, or regulations be reserved until a staff report on AAMC groups is acted upon and the Group has had at least one organizational meeting.

ACTION: It was moved, seconded, and carried that the staff recommendations be approved.

XIII. Defining a COTH Member

Board members were asked to approve the appointment of a small membership committee to review and recommend criteria and categories for COTH

membership. As COTH hospitals have merged, consolidated, reorganized, and formed multi-hospital systems, these new arrangements have been handled on an ad hoc individual basis. Dr. Bentley gave examples of different arrangements and mentioned the recent request of the Mayo Foundation to act as the COTH member for St. Mary's (a COTH member) and for Rochester Methodist (formerly a COTH member).

ACTION: It was moved, seconded, and carried to appoint a small membership committee to review and recommend critiera and categories for COTH membership.

XIV. Release for Dean's Letters

Dr. Beran joined the meeting to describe the events surrounding the establishment of November 1 as the uniform release date for deans' letters for 1987. He reminded the Board that the Council of Deans, Council of Academic Societies, and the Executive Council called for the uniform release date for deans' letters at its April 15 meeting as a means of minimizing the disruption of the fourth year of undergraduate medical education. The original recommendation emerged from the COD Spring meeting. The Executive Council feared that the early recruitment efforts were hampering students' education and forcing them to make career selection decisions prior to having an adequate opportunity to assess the various specialty options. November 1 was the date recommended by the COD or the release of the letters.

Dr. Beran reported on discussions held on this issue during the June meeting of the Group on Student Affairs Steering Committee. After reviewing the progress reports, the steering committee was becoming concerned that some schools were leaning toward sending deans' letters early because of pressure from program directors, particularly those participating in the early match. The steering committee was of the strong opinion that a letter from Dr. Petersdorf to the deans reaffirming the November 1 release date was important at this juncture. Since the establishment of the uniform deans' letter release date was voted upon by the Executive Council, Dr. Beran was asking each of the administrative boards to endorse the concept of the letter.

Mr. Gambuti noted the importance of compliance by all schools to the November 1 release date to prevent differential treatment of students by program directors. Dr. Foreman echoed Mr. Gambuti's comments, noting this concern had been raised by the AAMC Committee on the Transition to Residency, which he chaired.

After some discussion, Dr. Foreman noted a consensus of the Board to recommend that the Executiive Council reaffirm the November 1 release date, and that Dr. Petersdorf send a letter to all deans informing them of the Executive Council's reaffirmation.

XV. Adjournment

ACTION: There being no further business, it was moved, seconded, and carried that the meeting adjourn at 12:15p.

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: St. Luke's Episcopal Hospital

Hospital Address: (Street) 6720 Bertner

(City) Houston (State) Texas (Zip) 77030

(Area Code)/Telephone Number: (713) 791-2011

Name of Hospital's Chief Executive Officer: John A. Burdine, M.D.

Title of Hospital's Chief Executive Officer: President and Chief Executive Officer

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

Patient Service Data (Year ending September 26, 1986)

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	931	Admissions:		33,205
Average Daily Census:	558	Visits:	Emergency Room:	18,559
Total Live Births:	4,313	Visits:	Outpatient or Clinic	176,492

B. Financial Data

Total Operating Expenses: $ 144,682,000

Total Payroll Expenses: $ 78,706,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 3,643,450
Supervising Faculty: $ ---

C. Staffing Data

Number of Personnel: Full-Time: 3,525
Part-Time: 557

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 405
With Medical School Faculty Appointments: 320

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

Family Medicine, Nuclear Medicine, Physical Medicine, Newborn & Premature, Obstetrics/Gynecology

Does the hospital have a full-time salaried Director of Medical Education?: No

VI. 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	73/yr	73	Required
Surgery	48/yr	48	Required
Ob-Gyn	58/yr	Info not available	Required
Pediatrics	0		
Family Practice	120/yr	Info not available	Required
Psychiatry	12/yr	Info not available	Required
Other:			

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	38	*	*	1948
Surgery	10	*	*	1948
Ob-Gyn	5	*	*	1948
Pediatrics	2	*	*	1948
Family Practice	11	*	*	1973
Psychiatry	2	*	*	1955
Other: Physical Med.	2	*	*	1955
Urology	5	*	*	1948
Thoracic Surg.	6	6	0	1971
CV Anesthesia	9	9	0	1975
Pathology	8	7	0	1962

Gen. Surg. 4
Hand Surg. 2
Eye 1
Plastic 1
Orthopedic 2

[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: Baylor College of Medicine

Dean of Affiliated Medical School: William T. Butler, M.D.

Information Submitted by: (Name) John E. Ives

(Title) Executive Vice President and Chief Operating Officer

Signature of Hospital's Chief Executive Officer:

John E. Ives (Date) 8/19/87

BAYLOR
COLLEGE OF
MEDICINE

Texas Medical Center
Houston, Texas 77030

William T. Butler, M.D.
President
(713) 799-4846

August 20, 1987

James D. Bentley, Ph.D.
Vice President for Clinical Services
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Jim:

I am pleased to submit a letter recommending the St. Luke's Episcopal Hospital for membership in the Council of Teaching Hospitals. This hospital is affiliated with Baylor College of Medicine, and, in addition to housing our Departments of Obstetrics/Gynecology and Family Medicine, provides teaching facilities for the vast majority of our clinical departments.

You may recall that until a year or two ago, the Hospital shared a common administration with Texas Children's Hospital, and that the membership in the COTH was arbitrarily assigned to Texas Children's Hospital. Now that the hospitals are under separate management, it is entirely appropriate for each to have separate memberships.

If you need any additional information, please give me a call.

With personal regards,

William T. Butler, M.D.

WTB:hd

association of american medical colleges

August 12. 1987

M E M O R A N D U M

TO: AAMC ad hoc Committee to Review the Academic Medical Center Survey

David Witter. Jr.. Chairman
Michael Bradley
Irvin Kues
Jacqueline Kuhn
Howard Peterson
Mark Richards
Peter Van Etten
Kenneth Yerington

FROM: Linda Fishman
Research Associate
Division of Clinical Services

SUBJECT: Minutes From the July 20 Meeting

Attached is a summary of the discussion on ways to improve the academic medical center survey. You will note that the charts created during the meeting are reproduced as Attachments A through D.

I am currently designing the revised survey instrument based on your suggestions and hope to send it to you during the last week in August. If you have any amendments or revisions to the minutes or additional comments about the revised survey, please call me at (202) 828-0490.

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

MINUTES

AAMC ad hoc Committee to Review the
Academic Medical Center Hospital Survey
July 20, 1987

Attendees

DAVID WITTER, Jr., Chairman
Director
Oregon Health Sciences
University Hospital

MARK RICHARDS
Assistant Executive Director for
Planning and Reimbursement
Thomas Jefferson University
Hospital

IRVIN KUES
Vice President, Management Systems
and Finance
The Johns Hopkins Hospital

JACQUELINE KUHN
Associate Director, Medical Center
and Director of Finance
The Medical Center at the University
of California, San Francisco

HOWARD PETERSON
Director, University Hospital
The Milton S. Hershey Medical Center

PETER VAN ETTEN
Chief Financial Officer
New England Medical Center

KENNETH YERINGTON
Director, Financial Management
University of Iowa Hospitals
and Clinics

AAMC Staff
James D. Bentley, Ph.D.
Vice President
Division of Clinical Services

Linda E. Fishman
Research Associate
Division of Clinical Services

I. Welcome and Introduction of Committee Members and Staff

Dr. Bentley began the meeting in the conference room at the AAMC by welcoming Mr. Witter and the members of the Committee, explaining the nature of the Commonwealth Fund teaching hospital database, and asking for their help in improving the Association's survey of academic medical center (AMC) hospitals. He

then turned the meeting over to Mr. Witter, who asked Committee members and staff to introduce themselves. Mr. Witter noted that the Committee included both CEOs and CFOs in an effort to have the recommendations reflect both perspectives.

II. Review of Committee Charge

Mr. Witter reviewed the charge to the Committee, pointing out that the data needs of AMC hospitals are similar to the data needs of the Commonwealth Fund project and the AAMC. He directed the Committee to focus its deliberations on several major topics: (1) the types of financial and operating data members need and want to share; (2) the usefulness of collecting data on governmental appropriations, residency counts and educational costs by training program; and (3) the possibility of identifying and collecting data on hospital-based research activities. Mr. Witter also asked the Committee to discuss an appropriate schedule for the AMC survey and to formulate publication and distribution policies.

III. Background on COTH Data Activities

For those Committee members who were not familiar with the range of COTH's current data collection activities, Mr. Witter described and made available copies of the annual Housestaff Survey and the Executive Salary Survey. Participants were also given a description of the Commonwealth Fund project, Better Policy Analysis Capability for Teaching Hospitals. Dr. Bentley emphasized the need to make all COTH data collection efforts and publications timely and accurate.

IV. Academic Medical Center Data

A. COTH ROLE/CAPABILITY

The question of defining the audience for the AMC survey was raised at the beginning of the day's discussion. There are two users of the survey: (1) academic medical center hospitals and (2) the AAMC. The AMC survey provides a unique opportunity for the AAMC to collect teaching hospital data in areas of national concern. These data are the basis for policy analysis and formulation and help the AAMC educate government leaders and the public about teaching hospitals.

Several Committee members pointed to the difficulties of collecting comparable data and cautioned staff against attempting a detailed examination of departmental level data. Individual hospital accounting and management practices affect the comparability of data and such a data collection effort requires regular work group meetings and agreement by all participants on a set of very detailed definitions. Academic medical center groups such as the Western University Hospital Council (WUHC) and the eastern "original" Council of Teaching Hospitals group have been collecting and analyzing departmental level data for many years. Members believe that these groups and COTH play different roles. COTH does not have the resources to produce a report of departmental level data for 121 academic medical centers. Even for the fifteen Western hospitals that have been longtime participants in the WUHC survey, three-to-four person-months are required to produce their report.

Mr. Van Etten suggested that since teaching hospitals are more different than alike, COTH should concentrate its efforts on a limited number of issues of interest to all 121 academic medical centers. Appropriate topics might be government appropriations, graduate medical education including faculty support, and indigent care. All members of the Committee agreed that a routinely published, relatively simple and straightforward report with reasonably accurate data would be very desirable.

B. EXISTING DATA COLLECTION ACTIVITIES

Committee members were asked to comment on the usefulness of the previous AMC survey and to describe the types of data collection activities in which their institutions participate. Committee members thought the AMC survey was useful to varying degrees. Some individuals used the data to perform additional analyses; Mr. Yerington passed out a series of tables his staff had constructed from the most recent AMC survey.

All Commmittee members participate in a variety of data collection efforts, ranging from the American Hospital Association's Annual Survey to regional work group surveys (addressed to fifteen or fewer members) to state regulatory submissions (See Attachment A). All AMC hospitals respond to the AHA's Annual Survey and Committee members were interested, whenever possible, in using the data that the AHA collects rather than responding to the same questions twice. Dr. Bentley pointed out, however, that data on many of the highly sophisticated technology and clinical programs are not collected by the AHA until the devices/programs are relatively common throughout the United States.

C. KINDS OF DATA ACADEMIC MEDICAL CENTERS WANT TO SHARE

Mr. Kues suggested five areas in which academic medical center hospitals have needs for data: REVENUES, EXPENSES, OPERATING STATISTICS, CASE MIX, and ISSUES (See Attachment B). The participants then discussed each area:

1. REVENUES

Members agreed to eliminate the question on net patient revenue by payer source and collect only gross patient revenues by payer and total net patient revenue. At most institutions gross to net revenue by payer is only estimated and depends to some extent on the accounting policies of hospital management. While members

were interested in payer source data, Mr. Peterson pointed out that payers, e.g. Blue Cross and Medicaid differ across regions and states, making comparisons difficult. One way of getting around this, however, would be to re-phrase questions to focus on national issues, such as hospitals' percentage collections on Medicare and Medicaid.

Members agreed that the income statement table (Table 18) in the AMC survey was useful, but needed to be redesigned for easier reading. Mr. Van Etten requested that the survey obtain income statement data for two years so that trend comparisons can be made. Committee members' most and least useful tables in the current survey report are shown in Attachment C.

2. EXPENSES

Committee members agreed that some of the questions asking for expense/cost data need to be revised or made more detailed. For example, Mr. Richards suggested that the survey separate interest and depreciation expenses into plant/fixed equipment and movable components. The Committee agreed that definitions need to be more specific, especially in questions asking about education costs.

As with revenues, members were interested in obtaining expense data to analyze trends. One question might ask the institution's percentage change in expenses and then rank the institutions by percentage change. Members wanted to know the percentage of total operating expenses in various departments such as lab or radiology.

3. OPERATING STATISTICS

Members were interested in obtaining workload and program data to develop a profile of the institution. (See Attachment D for examples.) Mr. Kues suggested

that admissions and length of stay are more important variables than beds and days.

Many of the program data elements can be taken from the hospital's response to the AHA Annual Survey. Other elements such as bone marrow and helicopter programs will be collected in the AMC survey. Looking at the presence or absence of some of these programs may provide insight into the variation in costs across hospitals.

4. CASE MIX

Committee members thought data on case mix were very desirable in the AMC survey. There was a discussion about the feasibility of hospitals submitting computer data tapes in order to calculate case mix by payer, and whether to use Medicare weights in the calculations. The group concluded that the process would require a level of resources beyond those likely to be available. It was suggested that staff look at a relatively simple area such as length of stay by DRG, aggregate case mix by payer (using Medicare weights), and aggregate case mix, thus enabling the report to present case mix adjusted (and wage adjusted) cost per case.

Volume data by DRG might be another simple, yet interesting measure. Ms. Kuhn directed the group's attention to a table produced by the Western University Hospital Council (WUHC), showing the top twenty Medicare DRGs by volume, gain and loss. She pointed out that the gain/loss data were not useful due to the WUHC's difficulty in defining costs, but the volume data are not a problem.

5. ISSUES

Committee members and AAMC staff identified several issues of interest to all academic medical centers: prospective payment, government appropriations,

education and research. Much of the discussion, however, centered on specific data issues, i.e. how to "get at the data," such as receipt and reporting of appropriations, defining the hospital, and identifying and collecting data on hospital-based research activities.

Committee members recommended that information about the impact of the prospective payment system on academic medical centers should be routinely collected in the revised survey. This is especially important for the Commonwealth Fund project. A proposed question, similar to the one asked by the WUHC in their survey, will include data on Medicare inpatient costs and payments, passthrough payments and the indirect medical education adjustment. These data will improve the AAMC's ability to represent its hospital members.

Dr. Bentley informed the Committee that in past years appropriations data and how they're reported on the survey instrument have contributed to the delay in the study's timely publication. Therefore, staff requested the Committee's view on a separate appropriations survey. Committee members expressed little interest in a separate appropriations survey, although they are very interested in which hospitals receive governmental appropriations and for what purpose. Standard definitions for the uses of appropriations should be developed, thus encouraging consistent responses from hospitals.

The group agreed that in light of the various ways in which hospitals report appropriated funds (sometimes for political reasons), the AAMC should simply report the stated amount and not reclassify it in an effort to achieve consistency. To avoid double counting, members felt strongly that appropriations should not be reported as gross patient revenue except under very special circumstances. The Committee recommended a table of appropriation amounts, purposes and in the case of multiple purpose funds, an estimated distribution of

how they are spent. Appropriations should be clearly labeled as to how they are classified on the financial statements.

Committee members recommended limiting the survey to hospital operations only. As hospitals merge and consolidate to form systems and move services to other sites within the system (e.g., a laboratory corporation at the Johns Hopkins Health System), tracking purchased services and related party transactions will become even more complex. In the future the AMC survey may want to develop both hospital and system profile data. For the upcoming survey, questions will refer to hospital data only.

Of the triad of teaching hospital activities--research, education, and patient care--the least is known about hospital- based research. Therefore, the Committee was asked to attempt to identify data that could provide some measure of research conducted in teaching hospitals. Aside from data on clinical research centers (CRCs) such as the number of beds, protocols and classes of patients, the Committee reported data on hospital-based research are difficult to collect. Research activity is comingled with patient care and the flow of research dollars to the hospital is in most instances through the university or the medical school and therefore difficult to trace.

V. Project Schedule

Committee members were very concerned about insuring the accuracy and timeliness of the data. Several participants acknowledged that clerical staff who are responsible for completing the survey often do not supply accurate data. In addition, the survey requires the efforts of several individuals in different departments. This results in a long, involved routing process and AAMC staff sometimes have difficulty in tracking down the preparer when they must call to confirm data.

To rectify these problems, the committee recommended that the survey instrument be redesigned to include spaces for the preparers' names and telephone numbers. They also recommended that the chief financial officer at each institution be asked to certify the completed questionnaire.

Dr. Bentley and Committee members agreed that a timely survey is critical to make the report useful to the academic medical center members and to the AAMC. Publication of a timely survey is complicated by the various fiscal year ends of the respondents. An analysis of fiscal year ends of AMC hospitals showed that about 70 percent of the institutions end their fiscal years between March 31 and August 31.

The Committee recommended that staff plan to send the survey questionnaire to all academic medical centers in early October, and that the survey collect FY 1987 data from institutions with fiscal years ending between March 31 and August 31. Hospitals with September year ends will be asked in a separate cover letter to complete the form in a timely manner using FY 1987 data. Hospitals with October through December year ends will provide FY 1986 data.

The Committee suggested that an abbreviated preliminary report on some data such as government appropriations sometime in early January 1988 would be useful. Several members offered their assistance in contacting colleagues to speed the data collection process. Some participants expressed an interest in submitting and receiving raw data on diskettes. Such an option might be time-saving for both AAMC and hospital staff.

VI. Publication Policies

Committee members agreed that copies of the survey results should go only to participants. The confidential nature of the study i.e. that the document is for internal use and permission must be obtained to use institutionally identifiable

data elsewhere, should be described in the questionnaire and in the preface of the document. All participants agreed that hospital identification is a necessary and important part of the study.

As for sharing these data with the Johns Hopkins' Center for Hospital Finance and Management under the Commonwealth Fund project, Committee members concluded that the matter is between the Center and the AAMC. Dr. Bentley assured members that hospital-specific data would not be published or released for general distribution by either organization.

VII. Adjournment

Dr. Bentley stated that the next step would be the design of a new questionnaire. It will be mailed to Committee members during August. Telephone conference calls will be arranged to discuss the revised instrument.

Mr. Witter adjourned the meeting at 3 p.m.

File Name: Minutes

LF/ML/081087

Attachment A

Data Collection Activities of COTH
and Other Organizations

Organization	Survey	Types of Data
Council of Teaching Hospitals	Academic Medical Center	financial, general operations
	Housestaff	salaries, funding
	Executive Salary	salaries, fringes
	Directory - Educational Programs	programs, services
American Hospital Association	Monitrend	departmental operations
	Annual Survey	workload
Western University Hospital Council (WUHC)	15 Western Hospitals	financial operations, reimbursement, staffing, DRGs
University of California Health Information Network	5 Univ. California Hospitals	DRG comparative profiles
"Original" COTH Members	8 Eastern Hospitals	DRGs, departmental operations
University Hospital Consortium (UHC)	50 University Hospitals	operations, capital, materials management
State Agencies	Annual Reports	workload, operations
Baxter/Travenol		operations analysis

Attachment B

Types of Data That Might be Collected Through the Academic Medical Center Survey

Revenue:	gross/net by payer, profit, inpatient/outpatient
Expense:	operating expenses, percentage change in expenses from year to year
Operating Statistics:	overall, key departments, e.g., operating room program profiles, hospital vs. system profiles
Case Mix:	DRGs by volume, length of stay by DRG
Issues:	uncompensated care, appropriations, research and related activities, education/faculty costs (direct medical education, indirect, other), hospital/university relations

Attachment C

Most Useful and Least Useful Tables in the TEFRA Year Academic Medical Center Survey

	Most Useful Tables (#)	Least Useful Tables (#)
A	2, 5, 7, 9-11 (combine) 16, 17, 23, 25, 27, 32	29, 37, 38, 40
B	11, 18, 22, 24, 27, 28, 32	30, 33, 37, 38
C	11 (poor validity), 12 (if accurate for purchased services), 31 39, 41	All other tables
D	18, 27, 34, 35	
E	18, 27, 34	11 (net), 38, 39, 40, 41
F	1-8 (in different form), 20, 21, 22, 23, 32, 33 34, 36	capital, debt

Attachment D

Examples of Profile Data

Workload	Program
Admissions	Transplants by Type (bone marrow, heart)
Discharges by Service	Lithotripsy by Type
Inpatient Days	Burns
LOS	Neonatal
Number of Surgical Cases, Hours	MRI, PET
Licensed Beds by Service (5-6 categories)	Helicopter
Set-up and Staffed Beds by Service	Special Care Units by Type
FTEs	Trauma
Number of ER Visits, Including Number and Level of Traumas	Psych
Number of Burn Cases	Rehab
Number of Ambulatory Surgery Cases	

LETTERS OF COMMENT

Between Administrative Board meetings, the Division of Clinical Services and the Office of Government Relations prepare letters on proposed legislative and regulatory proposals of particular interest to teaching hospitals. These letters are regularly summarized in the COTH Report. To ensure you are fully informed of the positions taken, however, the comment letters written during the interval between Administrative Board meetings will appear at the back of the COTH Administrative Board agendas in the future.

Since the last Administrative Board meeting, the AAMC has commented on four regulatory proposals: 1/ Medicare payments for capital, 2/ Medicare payments for ambulatory surgery, 3/ CHAMPUS payments for inpatient hospital services, and 4/ proposed changes to Medicare's prospective payment system (PPS). Copies of these letters follow.

association of american medical colleges

July 1, 1987

Office of Civilian Health and Medical
Program of the Uniformed Services
Policy Branch
Aurora, Colorado 80045

Re: Proposed Rule on Implementation of a CHAMPUS DRG - Based Payment System

Dear Sirs:

The Association of American Medical Colleges, which includes among its members 127 medical schools, 85 societies of faculty physicians, and more than 450 teaching hospitals, commends the Department of Defense for proposing a DRG-based payment system that recognizes differences between the resources utilized in caring for CHAMPUS beneficiaries and Medicare beneficiaries, as well as the additional costs for educational programs and severely ill patients that are not included in the basic DRG payments. The pass through of direct medical education expenses and the indirect medical education adjustment will help teaching hospitals meet the costs of caring for CHAMPUS patients.

There are four issues in the proposal rule on which the AAMC urges CHAMPUS to change its initial policy decision:

- The lack of an area wage adjustment factor;
- The lack of separation between urban and rural hospital payment rates;
- The exclusion of a "disproportionate share" adjustment; and
- The phasing-in of payment rates.

In addition, the AAMC will comment on the proposed methodology for:

- Standardizing for the indirect medical education adjustment;
- Payments for outliers; and
- Updating the DRG weights.

COMMENTS ON POLICY DECISIONS

Lack of an Area Wage Index

In the computation of payment rates for hospitals, the proposed CHAMPUS regulations do not provide for an adjustment to account for the differences in wages that must be paid by hospitals in different locations throughout the

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country. Under Medicare's DRG-based system, area wage indices vary from .5349 in San Juan, Puerto Rico to 1.0014 in Trenton, New Jersey to 1.4945 in San Francisco. In other words, a hospital worker that is paid $10.00 per hour in Trenton would be paid $5.35 per hour in San Juan and $14.95 in San Francisco to reflect differences in the cost of living in each of those locations. Since nearly 80% of a hospital's cost is composed of labor expenses, this difference creates large, legitimate differences in hospital costs that must be considered in establishing any type of payment system. Area wage indices are used in the Medicare Prospective Payment System to standardize the hospital's cost in preparation to calculating the national average rate, and to determine each hospital's payment amounts. It is imperative that wage variations be recognized in the CHAMPUS payment system to allow for appropriate differences in cost incurred by hospitals in different labor market areas. If such an adjustment is not included, hospitals in low cost labor regions will receive a windfall, while hospitals in more expensive labor market areas, such as inner cities, would be underpaid.

Urban-Rural Hospital Distinctions

The preamble to the proposed rule states that CHAMPUS will not distinguish between urban and rural hospitals in determining payment rates because "recent evidence indicates there is not a substantial basis for such a distinction." On the contrary, Medicare's latest proposed rates for hospitals beginning with the fiscal year starting on or after October 1, 1987 are $2346 for the labor portion and $831.43 for the non-labor portion of the rates for urban hospitals and $2124.82 for labor and $588.42 for the non-labor portion for rural hospitals. This is a difference of 10.4% for the labor costs, even after adjusting for area wage differences, and 41.3% for the non-labor portion of the rate. This distinction in rates is significant and plays an integral role in accounting for the variation in costs reported by hospitals. If it were excluded from the calculation of Medicare payment rates, it is highly likely other factors intended to account for some of the legitimate differences in patient care costs, such as the indirect medical education adjustment, would have to be larger. In keeping with the Congressional intent that the CHAMPUS payment system be constructed "to the extent practicable" in accordance with Medicare rules, CHAMPUS should separate hospitals into urban and rural categories in determining its payment rates.

The "Disproportionate Share" Adjustment

Since 1986, the Medicare Prospective Payment System has included a factor known as the "disproportionate share adjustment." It benefits hospitals providing care to an unusually, or disproportionately, large share of low income or indigent individuals. This adjustment is meant to recognize costs incurred in providing care, not the lack of revenue generated in caring for poor patients. Some health researchers have speculated that the additional cost may result from the multiple complications or advanced stages of illness with which patients in these hospitals are often admitted. Others believe that because many of these patients do not have their own physician, they must be completely worked up upon admission, resulting in the hospitals bearing costs for procedures or tests that might otherwise have been performed in a private physician's office. Regardless

of the reason for the costs, the Health Care Financing Administration analysis has clearly shown that higher costs are incurred by those hospitals qualifying as "disproportionate share providers." The DOD should analyze its data to determine if the costs of caring for its patients in disproportionate share providers is greater, and if it is, this distinction should be manifested in the the CHAMPUS DRG-based payment system.

Phasing-In of Payment Rates

The preamble to the CHAMPUS proposal suggests that it is unnecessary to gradually move from the charge-based payment system of the past to the proposed DRG system because hospitals have already adjusted to a DRG system under Medicare. It is true that one of the objectives of phasing-in the Medicare system over a five-year period was to give hospitals time to adapt, but there were other objectives as well. For example, the data used to calculate the original weights and rates were somewhat unreliable. Similarily, the CHAMPUS data used to calculate weights and payment rates may be flawed. The uncertainty of the data puts the financial status of the CHAMPUS program as much in jeopardy as the hospitals'. CHAMPUS should phase in its payment system over 2 or 3 years to allow time to correct the data and prevent unintended financial hardships.

COMMENTS ON METHODOLOGY

Standardizing for the Indirect Medical Education Adjustment

The proposed rule uses Medicare's formula for determining the indirect medical education adjustment to standardize the DRG weights, but not the national average price. There are two major flaws in this approach. First, the Medicare formula for the indirect medical education adjustment is a regression formula that explains variation in the costs of treating Medicare patients in non-teaching versus teaching hospitals. The variation that this formula attempts to explain is what remains after the other variables Medicare uses in its rate determination have accounted for as much of variation as possible. These variables include area wage rate adjustments, the distinction between urban and rural rates, and the disproportionate share adjustment. If, as the proposed rule states, CHAMPUS beneficiaries have very different resource utilization patterns than Medicare patients, and if CHAMPUS is going to exclude the aforementioned variables from the determination of its payment rates, then a distinct indirect medical education adjustment formula should be developed for CHAMPUS.

Secondly, this separately determined adjustment should be used to standardize the teaching hospital charges for calculation of the of the DRG weights and the national average prices. Under section "(iii)(A) calculation of DRG weights" (page 20748), the proposed rule states that teaching hospital charges will be divided by its indirect medical education adjustment to standardize for the cost effects associated with this factor. However, under Section "(iii)(C) calculation of the adjusted standardized amount," no mention is made of standardizing the charges for this factor before computation of the non-teaching standardized amount. Such standardization should be performed to ensure that the prices paid to hospitals are not excessive.

Payment for Outliers

Outliers are identified as those patients whose length of stay is abberrant or whose costs greatly exceed the expected amount. This is similiar to the way in which Medicare identifies outliers. However, unlike Medicare, the CHAMPUS proposal identifies low length of stay outliers as well as high length of stay outliers. Given the CHAMPUS population of beneficiaries, which is largely younger and relatively healthy, it is appropriate that low length of stay outliers be treated separately. DOD should be commended for including this in the proposal.

With regard to the payments for long length of stay outliers and cost outliers, the proposed rule recognizes that a patient could exceed both thresholds. It is proposed that when this occurs, the patient would be treated as a length of stay outlier. Medicare made the same decision during its initial years of implementation of its payment system but will be changing to allow cost outlier status to take precedence over day outlier status if the proposed change in the July 10 Federal Register is adopted. (Federal Register, pg. 22089-22090). HCFA studies show that this will result in more equitable payment for services rendered to resource intensive patients. Similiarily, CHAMPUS should consider how patients who qualify as both length of stay and cost outliers should be treated. For the sake of consistency and ease in administration, CHAMPUS should follow Medicare's decision on the treatment of these patients.

Updating the DRG Weights

The proposed rule indicates that changes in the DRG weights adopted by Medicare will result in a proportional change in the DRG weights used by CHAMPUS. Since the reason CHAMPUS DRG weights were created in the first place was that there was substantial disparity between the resources used by CHAMPUS beneficiaries and the Medicare patients, proportionately adjusting the CHAMPUS DRGs to account for changes in Medicare weights would be inconsistent and illogical. Separate analysis of the effect of the change Medicare has adopted on resource use by CHAMPUS patients should be employed to determine what the appropriate or estimated change in the CHAMPUS payment should be. Perhaps, the DOD can elicit cooperation from the Prospective Payment Assessment Commission (ProPAC) to make this determination.

The AAMC appreciates this opportunity to comment.

Very sincerely yours,

Robert G. Petersdorf, M.D.

aamc association of american medical colleges

ROBERT G. PETERSDORF, M.D.
PRESIDENT

(202) 828-0460

July 20, 1987

Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-403-P
P.O. Box 26676
Baltimore, Maryland 21207

Dear Sir:

The Association of American Medical Colleges which represents 127 U.S. medical schools, 85 academic societies, and over 350 major teaching hospitals participating in the Medicare program, appreciates the opportunity to comment on the proposed regulations to incorporate hospitals' capital expenses into the Medicare prospective payment system. At the outset, the Association states its belief that it is inappropriate for a major methodological change in the payment of Medicare capital costs to occur by regulation. Such a change should result from Congressional action to reflect the diverse and competing interests of hospitals in different capital circumstances. Only through careful study and open deliberation can sound public policy be developed.

Comments on Regulatory Provisions

The AAMC would like to commend HCFA for standardizing the federal capital rates by the indirect medical education and disproportionate share adjustments as well as including them in the calculation of hospital payments. Tertiary care hospitals have increased capital needs because they treat the more seriously ill patients. These patients require the latest in medical technology. Additionally, many teaching hospitals provide a disproportionate share of care to the aged poor. The Association strongly encourages the continued use of these adjustments in any payment plan to adequately compensate teaching hospitals for their distinctive and above average capital costs.

The proposal establishes a ten-year transition period for incorporating capital payments for plant and fixed equipment into the prospective payment system and a two-year transition for movable equipment. This schedule was based on an assumption that 60 percent of a hospital's capital is plant and fixed equipment and 40 percent is movable equipment. If the ratio of hospital's capital equipment varies, the hospital's ability to adjust within the transition period will be reduced. The proposal failed to provide an analysis of this impact and the subject warrants further study.

The AAMC questions the conclusions of the proposal's impact statement. HCFA's analysis suggests that payments for teaching hospitals will increase above costs an average of three percent per year. This estimate was based on reported capital-related costs in FY 1984. The figures were adjusted for inflation but did not take into consideration projects underway or the future costs of capital. Teaching hospitals tend to have older physical plants and be in greater need of

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modernization. These hospitals have projects presently underway which will be inadequately reimbursed by the provisions of this proposal.

The "lumpy" nature of capital expenditures means that a single, average payment will not meet the varying needs of hospitals. The proposal fails to take into consideration a hospital's place in the capital life cycle. An exceptions process should be developed which would ensure that hospitals are not penalized for appropriate capital investments.

Comments on Regulatory Omissions

The AAMC believes the May 19 notice in the Federal Register lacks a clear explanation of several essential topics needed for proper evaluation of the proposal. Four subjects not adequately addressed are:

- o Updates after 1990
- o Directly assigned costs
- o System refinements
- o Construction cost index

If Congress does not act on the capital issue, the AAMC strongly recommends that the proposed regulations be revised and republished before implementation.

The proposal lacks a clear explanation of the subject of rate increases and the methodology for calculating the rates after the year 1990 when OBRA regulations are no longer in effect. Furthermore, the proposed regulations state that after 1990 the rates will be updated by the annual PPS factor. The PPS factor should be amended to contain a component in the market basket calculation that reflects changes in the quantity and price of capital. These are major issues for participating hospitals and must be clarified before the proposal can be adequately evaluated. Capital investments have long term effects on hospital costs. Hospitals and the investment community must have sufficient information to realistically assess the hospital's ability to repay its bonds.

The proposal also leaves numerous methodological questions unanswered. For example, the proposal states that data is still being analyzed to determine the appropriate reporting of directly assigned costs as fixed or movable equipment (pp. 18846). The difference in how costs are reported has a signficant effect on the total payment to be received for capital by hospitals. Hospitals can not assess the adequacy of the regulation without a definite decision regarding the categorization of these expenses. Additionally, the proposed rule refers to undescribed methodologies for refining the system and apportioning ancillary equipment into both fixed and movable as well as inpatient and outpatient services (pp. 18846).

Finally, on page 18848 of the regulations, HCFA states that they are still investigating the calculation of the Construction Cost Index. This index, which is included to adjust prices for geographic variation, has a significant effect

on hospitals' capital payments. The absence of adequate prior studies of alternatives for construction indices demostrates that HCFA's proposal is incomplete.

A change in any of these four points still being deliberated -- post 1990 updates, directly assigned costs, methodologies for refining the system and the construction cost index -- can materially affect the payments to a hospital. The long term nature of financing capital and the importance that capital acquisition plays in the life of a hospital dictates the need for a predictable capital payment system. Hospitals must be able to assure investors of loan repayment to maintain access to financial markets. The current proposal has a significant amount of uncertainty associated with it and as a result could reduce hospitals' access to capital. The inability to access financial markets could force hospitals to close. These issues warrant HCFA's republishing the rule so that affected parties truly have the opportunity to review and evaluate the proposal.

Conclusion

In light of the regulations' weaknesses, the AAMC favors a system that appropriately distributes available funds in an equitable and predictable manner. The system should recognize individual hospital's capital-related costs and pay them accordingly. It should not create instability in financial markets. Therefore, the AAMC supports preservation of the current cost reimbursement system for capital costs.

Very sincerely yours,

Robert G. Petersdorf, M.D.

association of american medical colleges

August 3, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Attention: BERC-428-P
P.O. Box 26676
Baltimore, Maryland 21207

Dear Dr. Roper,

The Association of American Medical Colleges, which represents the 127 U.S. medical schools as well as 85 societies of faculty physicians and 470 teaching hospitals, would like to express its concern about the proposed rule regarding Medicare payment for facility services related to ambulatory surgical procedures performed in an outpatient hospital setting. The AAMC has three primary concerns with the proposed regulations: the unrealistic implementation schedules, the failure to recognize severity within ambulatory procedures, and the lack of recognition of medical education costs in hospital outpatient departments.

Implementation Schedule

The Association believes that the reporting requirements imposed by the proposed regulations are substantial, and that there is very little time for hospitals to adapt their billing and data collection systems prior to implementation. Together, these two factors would have a potentially negative impact on many hospitals.

The Association recognizes that the legislation was quite detailed. As a result, HCFA has little discretion in numerous areas. HCFA does have considerable discretion, however, in implementing the new policy. The AAMC is particularly concerned with the implementation approach HCFA is planning. HCFA points out that "hospitals will incur substantial administrative costs in implementing HCPCS (HCFA common procedure coding system) for reporting outpatient services." Further, "so as to conform to this requirement, hospitals will need to change certain elements of their accounting systems." By proposing a rigid and hurried schedule, HCFA is not giving adequate recognition to provider requirements to install new coding systems, revise patient billing systems, and develop new cost reporting procedures.

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This creates problems for most hospitals, but it will impose severe implementation problems on hospitals with cost reporting years beginning from October 1, 1987 through April 1, 1988. Consequently, the AAMC recommends HCFA adopt a transition period which permits fiscal intermediaries to exercise substantial flexibility in implementation when a hospital is making a "good faith" effort to comply with final regulations.

Adjusting for Case Mix

Hospitals, which have already complied with the intent of the Prospective Payment System in moving many surgical procedures from the inpatient setting to the outpatient clinic, should not be penalized by receiving a payment based on comparison with facilities which are acknowledged to have lower fixed costs and which are more selective in the range of procedures they offer and the types of patients they treat. Patients treated in hospital outpatient departments tend to have more serious and complex illnesses than those treated in ASCs; this requires not only more intensive procedures, but a greater range of backup services. This difference in outpatient case mix is not currently recognized in the procedure codes for payment. The AAMC recommends immediate efforts by HCFA to develop suffixes for the procedural codes, which would recognize the intensive services provided to more frail patients or those with more complex needs in hospital outpatient departments.

Medical Education Costs

For teaching hospitals, since patients and procedures have been moved to outpatient settings, a significant proportion of the education of interns and residents must now take place in the ambulatory setting. This medical education component is currently recognized in payments for outpatient services. However, the proposed payment methodology, using the standard overhead amount for ASCs, would not recognize this important aspect of hospital services. The AAMC recommends that HCFA pass-through and pay medical education costs before computing ASC payments to hospital outpatient departments.

Conclusions

In HCFA's own view, the proposed regulations would decrease payments to hospitals, although it is recognized that hospitals have higher fixed costs than do free-standing

ASCs, and that teaching hospitals also incur greater costs because of their medical education obligations. In addition to decreasing payments, the regulations would also increase administrative costs because of conversion to the new coding system. The Association believes that these negative implications for hospitals, which HCFA itself points out in its analysis, mitigate against a hurried implementation of the proposed regulations. HCFA's statement that "(these changes) could generally benefit the development of a healthy market for the delivery of ASC surgical services" must be balanced against this array of negative considerations.

Sincerely,

John F. Sherman, Ph.D.
Executive Vice President

association of american medical colleges

August 6, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Attn: BERC-400-P
BERC-452-NC
P.O. Box 26676
Baltimore, Maryland 21207

Dear Dr. Roper:

The Association of American Medical Colleges -- which represents the nation's major teaching hospitals, medical schools, and faculty societies -- welcomes the opportunity to comment on prospective payment regulations published in the Federal Register on June 10, 1987 (BERC-400-P) and June 11, 1987 (BERC-452-NC). The AAMC focuses its comments on four major concerns with the draft regulations: the proposed increase in DRG prices, the absence of public data on significant changes proposed in numerous areas, DRG classification, and the proposed revision in the outlier payment policy.

Proposed Increase in DRG Prices

In the June 10 notice, HCFA states, "the most recent forecasted hospital market increase for FY 1988 is 4.7%." HCFA then notes that under the provisions of the Omnibus Reconciliation Act of 1986, a DRG price increase of 2.0% less than inflation is required. While current law requires hospitals to absorb 42.6% (2% of 4.7%) of the estimated inflation in goods and services, HCFA proposes in its June 11 notice to increase DRG prices only 0.75%. Thus, HCFA is proposing that hospitals absorb inflation increases of 3.95%. This means hospitals would be denied 84% (3.95% of 4.7%) of the increase in the cost of goods and services.

Hospitals are incurring real increases in the costs of purchasing goods and services. HCFA's 4.7% estimate understates the current inflation increase because it does not reflect the rapid increases in nursing salaries necessitated by the growing nurse shortage, malpractice insurance premiums, and petroleum products. To meet these increased costs, the AAMC recommends that HCFA increase DRG prices by the full 2.7% increase published in the June 10 Federal Register.

Absence of Data

In the June 10 regulations, HCFA proposes to establish new DRGs for alcohol and drug abuse, to modify surgical hierarchies in determining DRGs, and to adopt a wage index based on combined 1982 and 1984 data. In each case, HCFA asserts these proposals are based on sound analysis of available data. It is laudable that HCFA has conducted such research in an effort to improve the Prospective Payment System. Thoughtful studies need to be continued to provide some assurance that PPS appropriately and equitably compensates hospitals for caring for Medicare beneficiaries. In the current proposed rule, however, HCFA does not publish or provide the data underlying these decisions. Thus, there is no effective way for hospitals or their associations to assess these proposals. By withholding the data, HCFA has denied the right of the regulated parties to comment in an informed manner. Therefore, the AAMC recommends that HCFA make its data publicly available in the form used to determine the proposed policies and

allow hospitals a thirty day comment period commencing with the public availability of the data.

DRG Classification

In two areas, the AAMC believes HCFA should modify its proposal to incorporate suggestions made by ProPAC. First, ProPAC suggested involving physicians in designating surgical hierarchies. HCFA rejects this proposal with the position that physicians do not have a detailed understanding of hospital resource utilization. Even if HCFA's assertion were true, the DRG's were developed to categorize patients within medically meaningful groupings. Therefore, the AAMC believes it remains important to involve physicians in changes in the DRGs, including changes in surgical hierarchies.

Secondly, HCFA has rejected the ProPAC recommendation proposing a special payment adjustment for patients receiving an MRI. HCFA bases its position on the alleged profitability of hospitals. The HCFA statement misses the point. Prices for individual services need to be regularly adjusted to reflect real resource utilization. Otherwise, payment amounts send false signals of the economic viability of specific services. Therefore, the AAMC supports the ProPAC recommendation that MRI services should be recognized and the prices recalculated to reflect their use.

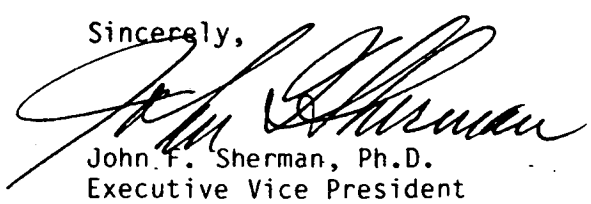
Outlier Payments

The June 10 regulations propose a major change in Medicare's present outlier policy. In essence, the present policy favors paying patients as day outliers; the proposed policy favors paying cost outliers and increasing the rate of cost outlier payments. While the AAMC supports the concept of using outlier payments to cushion the risk of high cost patients in an average price payment system, the Association finds the current HCFA proposal has generated substantial confusion. In addition, several private efforts to model the impact of the proposal have shown payment reductions in the hospitals with the largest numbers of high cost outliers. The current confusion and the unexpected impacts suggest that HCFA should make any changes in outlier policy gradually and only following publication of substantial data assessing the impacts of the proposed changes. Therefore, instead of the dramatic redistribution of outlier payments proposed, the AAMC recommends a gradual policy change accompanied by extensive and publicly available analysis of policy options.

Conclusions

Medicare's prospective payment system has major financial implications for hospitals. Policy changes must be carefully considered and fully documented before they are made. Year-to-year disruptions should be minimized. The AAMC comments are based on these principles. If more information on the recommendations is needed, please call James Bentley at (202) 828-0490 or Richard Knapp at (202) 828-0410.

Sincerely,



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