AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

AGENDA

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

February 23, 1989
7:30a-12:30p
Washington Hilton Hotel
State Room

1989 COTH ADMINISTRATIVE BOARD

Chair: Gary Gambuti
St. Luke's-Roosevelt Hospital Center

Chair-Elect: Raymond G. Schultze, MD
UCLA Medical Center

Immediate Past Chair: J. Robert Buchanan, MD
Massachusetts General Hospital

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

Calvin Bland
St. Christopher's Hospital for Children
Jerome H. Grossman, MD
New England Medical Center, Inc.
Leo M. Henikoff, MD
Rush-Presbyterian-St. Luke's Medical Cente
William H. Johnson, Jr.
University of New Mexico Hospital
Sister Sheila Lyne
Mercy Hospital & Medical Center
James J. Mongan, MD
Truman Medical Center
Robert H. Mullenburg
University of Washington Hospitals
Max Poll
Barnes Hospital
C. Edward Schwartz
Hospital of the University of Pennsylvania
Barbara A. Small
Veterans Administration, Durham
Alexander H. Williams
AHA Representative

COTH MEETING DATES

COTH 1988 ADMINISTRATIVE BOARD MEETINGS

February 22-23- The Washington Hilton Hotel, Washington, DC
June 14-15- Same
September 13-14- Same

COTH SPRING MEETINGS

May 10-13, 1989
The Hotel del Coronado, San Diego, CA
May 9-11, 1990
The Lafayette Hotel, Boston, MA

AAMC ANNUAL MEETINGS

October 28-November 2, 1989
The Washington Hilton Hotel, Washington, D
October 20-26, 1990
The San Francisco Hilton Hotel, San Francisco, CA

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

February 22-23, 1989
Washington Hilton Hotel
Washington, DC

WEDNESDAY, February 22, 1989

6:30p	JOINT ADMINISTRATIVE BOARDS SESSION Guest Speaker: Senator David Durenberger (R-MN) Senate Committee on Finance, Subcommittee on Health; Special Committee on Aging Hemisphere Room
7:30p	COTH ADMINISTRATIVE BOARD RECEPTION/DINNER Thoroughbred Room

THURSDAY, February 23, 1989

7:30a	COTH ADMINISTRATIVE BOARD BREAKFAST MEETING Guest Speaker: Bruce Steinwald Deputy Director, Prospective Payment Assessment Commission (ProPAC) State Room
12:30p	JOINT ADMINISTRATIVE BOARDS LUNCHEON Thoroughbred Room
1:30p	EXECUTIVE COUNCIL BUSINESS MEETING Military Room

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COTH ADMINISTRATIVE BOARD MEETING
February 23, 1989
7:30a-12:30p

State Room
Washington Hilton Hotel
Washington, DC

I.	CALL TO ORDER	
	Guest Speaker:	Bruce Steinwald Deputy Director ProPAC
II.	CONSIDERATION OF THE MINUTES	Page 1
III.	COTH CHAIRMAN'S REPORT	Mr. Gambuti
IV.	AAMC PRESIDENT'S REPORT A. "AAMC Strategic Plan"	Dr. Petersdorf
V.	ACTION ITEMS A. AIDS Committee Report	Executive Council Agenda - Page 46
	B. AAMC Framework Document for Institutional Policies and Procedures to Deal with Misconduct in Science	Executive Council Agenda - Page 74
	C. Ethics in Patient Referrals Act	Executive Council Agenda - Page 63
	D. Recommendations for the Format and Contents of the 1991 MCAT	Executive Council Agenda - Page 24
	E. Group on Faculty Practice Rules and Regulations	Executive Council Agenda - Page 20
VI.	INFORMATION ITEMS A. AAMC Letter to ProPAC on Indirect Medical Education Payments	Page 4

Continued...

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
November 14, 1988

PRESENT

J. Robert Buchanan, MD
Spencer Foreman, MD
Gary Gambuti
Jerome H. Grossman, MD
Leo M. Henikoff, MD
John E. Ives
William H. Johnson, Jr.
Larry L. Mathis
James J. Mongan
Charles M. O'Brien, Jr.
Max Poll
Raymond G. Schultze, MD
C. Edward Schwartz

ABSENT

Barbara A. Small
Alexander H. Williams

GUESTS

Carol M. McCarthy, PhD, JD

STAFF

Ivy Baer
James D. Bentley, PhD
Joanna Chusid
G. Robert D'Antuono
Linda E. Fishman
Richard M. Knapp, PhD
David Moore
Melissa H. Wubbold
Stephen C. Zimmermann

COTH ADMINISTRATIVE BOARD
MEETING MINUTES

Marriott Hotel
Chicago, Illinois
November 14, 1988

I. CALL TO ORDER

Dr. Buchanan called the meeting to order at 7:30a in the Wisconsin Room of the Chicago Marriott Hotel. He welcomed the Board and indicated that the traditional format of the Administrative Board meeting would defer to a presentation on the American Hospital Association (AHA)'s proposal to reform Medicare's prospective payment system (PPS) by Carol McCarthy, PhD, JD, President of the American Hospital Association.

The purpose of Dr. McCarthy's presentation was to gain AAMC support for the AHA proposal that supports elimination of the urban-rural differential in the proposed Medicare adjustment to reimbursement of hospitals under PPS. At its September 1988 meeting, the Executive Council took the position that the AAMC does not endorse elimination of the differential until adequate severity of illness and non-labor price indices are developed.

According to Dr. McCarthy, the AHA is seeking fair payment for hospitals and believes the appropriate course is through rebasing the DRG rates. The AHA would like to see the urban-rural difference in rates closed while at the same time adjusting the remaining single rate by a non-labor wage index and a proxy for severity. The cost of the AHA proposal will be $2.9 billion, but the proposal will not be advocated unless hospitals receive Medicare increases above full market basket rate of increase.

After a lengthy discussion of the AHA presentation, COTH Administrative Board members agreed that the AAMC should keep the door open for further discussion with the AHA, but at this time the AAMC will continue to support the Medicare policies adopted by the AAMC Executive Council in September.

The AAMC will attempt to become involved with the AHA as it works to develop indices for the severity of illness and non-labor wage costs. To that end, Dr. Bentley was invited by Dr. McCarthy to attend a meeting of the Allied Hospital Associations in Chicago on November 29; Dr. Bentley accepted the invitation.

The meeting was adjourned at 9:00a with the intention of reconvening at 3:30p that afternoon.

The meeting reconvened at 3:30p on the afternoon of November 14 in the Minnesota Room of the Chicago Marriott Hotel for the purpose of dispensing with the original Administrative Board meeting agenda.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the September 8, 1988 COTH Administrative Board meeting.

III. MEMBERSHIP

ACTION: It was moved, seconded, and carried to approve the following institutions for full membership in the AAMC Council of Teaching Hospitals.

HARRIS COUNTY PSYCHIATRIC CENTER
Houston, TX; and

MEDICAL CENTER OF CENTRAL GEORGIA
Macon, Georgia

IV. 1989 COTH SPRING MEETING PROGRAM

Discussion ensued on revision of the traditional Spring Meeting format and it was agreed that if possible, within the confines of hotel space availability, to extend the meeting an additional day to reflect a May 10 arrival, May 13 departure. This revised format would be a compromise between the traditional Spring Meeting model and interest in a more resort-oriented agenda, and would permit registrants several blocks of free time in which to enjoy the surrounds.

It was agreed that discussion of a move to a resort based meeting and selection of the 1991 COTH Spring meeting site would be postponed until success of the 1989 San Diego meeting site could be evaluated.

Staff was instructed to consider pending developments in hospital regulation, development in patient care assessment and information technology, and a broader overview on future personnel related issues as possible topics for the 1989 Spring Meeting. A brief discussion of suitable speakers ensued.

V. COTH READERSHIP SURVEY

Joanna Chusid gave a brief summary of the readership survey that had been sent to all COTH member CEO's in an attempt to evaluate the COTH Report. She indicated that the general consensus of the 111 surveys returned favored monthly publication dealing primarily with federal activities, data analyses, and medical education.

Results indicated little interest in bibliographies, literature, or AAMC activities. Additional comments specified lack of interest in photographs and minimal interest in graphics, as well as the opinion that the current COTH Report is not timely. Staff will work to meet these preferences and correct these deficiencies.

VI. ADJOURNMENT

The meeting was adjourned at 5:00p.

AAMC Letter to ProPAC on the Indirect Medical Education Adjustment

The following is a copy of the letter sent by the AAMC over Dr. Petersdorf's signature to Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). This letter was in response to the Commission's request for the hospital industry to share its financial data in its effort to evaluate the certain elements of the indirect medical education (IME) adjustment.

association of american medical colleges

ROBERT G. PETERSDORF, M.D.
PRESIDENT

(202) 828-0460

January 25, 1989

Stuart H. Altman, Ph.D., Chairman
Dean, Florence Heller School
Brandeis University
Waltham, Massachusetts 02154

Dear Dr. Altman:

The "indirect medical education (IME) adjustment" is an integral, yet misunderstood, part of the Medicare Prospective Payment System (PPS). While its title has led many to believe that this adjustment to the Diagnosis Related Group (DRG) prices is to compensate for education and related program costs, its purpose is clear:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, March 11, 1983).

The Association of American Medical Colleges (AAMC), which represents the nation's 127 medical schools, over 435 major teaching hospitals and 83 academic medical societies, is greatly concerned that recent analyses have led some to conclude that the indirect medical education adjustment could be cut substantially without undermining the financial viability of teaching hospitals. AAMC data suggest a cut in the IME adjustment will harm substantially teaching hospitals.

At the January 10 ProPAC meeting, Commissioners were asked to consider and make recommendations on three decision elements concerning the indirect medical education adjustment:

(1) the level of the adjustment itself;

(2) whether a change in the IME should be phased in over time; and

(3) whether a change in the IME should be budget neutral.

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During a discussion of the decision options, several Commissioners expressed the need to examine total hospital margins in addition to Medicare PPS margins, and called upon the hospital industry to share its financial data. In response to the Commission's request, the AAMC submits the attached analysis of PPS and total margins for a group of academic medical center hospitals belonging to the Council of Teaching Hospitals (COTH).

Data and Findings

The attached four tables use the financial data of thirty-four hospitals that responded by January 20 to the FY 1988 COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data. The survey is mailed annually to 121 academic medical center hospitals and has a return date of February 10. These data are collected from the hospital's most recently completed fiscal year, which for most of the thirty-four institutions ended in June or September 1988. In general, PPS data reported in these tables are from the hospitals' "as submitted" Medicare cost reports. Operating and total margin data are reported from audited financial statements.

Because AAMC policy prohibits the release of hospital-specific data without permission of the hospital chief executive, we have masked the identity of individual institutions in all tables. However, an alphabetical list of the responding hospitals is included as part of the analysis.

Table 1 shows that average PPS margins for this group of hospitals dropped dramatically in FY 1988 to 4.8 percent. The PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, indirect medical education and outlier payments) less Medicare inpatient operating costs, divided by PPS revenue. Of 31 hospitals reporting PPS margin data in both 1987 and 1988, 24 (77 percent) had lower margins in 1988. While only one hospital had a negative PPS margin in 1986, by 1988 ten hospitals reported PPS margins less than zero.

Table 2 uses 1988 data to demonstrate the impact of the various types of PPS payments on hospital margins and the effect of cutting the IME adjustment in half. This period represents the first year these hospitals received a per case DRG price based 100 percent on the national average. A striking finding in Table 2 is the significant contribution of the payment adjustments (IME and disproportionate share) to reducing the large losses that would result if payment were limited to the DRG rate plus outliers. The fully phased-in national rate does not

recognize important differences in hospital costs, including the range of services offered by these hospitals and the socioeconomic mix of their patients.

During the reporting period shown in Table 2, hospitals received an IME payment at the 8.1 percent level; therefore, a reduction of the payment by one-half pays hospitals at the 4.05 percent level, assuming no change in the FY 1988 intern and resident to bed ratio. On average, PPS margins calculated without disproportionate share but with all other components fall from about 1 percent to -10 percent when the IME payment is cut in half. The addition of the disproportionate share payment allows some hospitals to achieve positive PPS margins, but the average PPS margin is still negative at -5.5 percent.

Table 3 shows that for this group of hospitals the IME and disproportionate share payments constitute a significant portion of their total PPS payments. Between one-fifth and one-fourth of these hospitals' total PPS payments can be attributed to these adjustments. However, a high percentage of these payments relative to the total payment does not necessarily guarantee a large positive margin.

Table 4 shows both operating and total hospital margins for all payers for three years. As with PPS margins, there is a definite downward trend in both margins. The average operating margin was negative in 1988. It is important to recognize, however, that some of these hospitals receive state or county/municipal appropriations to finance operations; the funds may be treated as non-operating revenue on the financial statement. When a government appropriation is recognized in the hospital's operating statement as non-operating revenue, it may result in a positive total margin. Total margins, which include government appropriations, were cut in half, falling from 6.6 percent in 1986 to 3.3 percent in 1988.

Discussion

In the initial years of PPS, major teaching hospitals' PPS margins were high relative to some other types of hospitals. The determination of the hospital-specific DRG price was a major contributor to these profits. In the early years of PPS, when DRG prices were based 75 percent on the hospital-specific price component, major teaching hospitals earned their largest margins. Since the IME adjustment was applied only to the 25 percent federal portion of the rate, it made a relatively small contribution to teaching hospitals' PPS margins. Today, with DRG prices based 100 percent on the national rate, teaching hospital

margins are generally low and the adjustments, including the IME adjustment, are increasingly important to teaching hospitals.

Teaching hospitals will be unable to withstand further reductions in the IME payment, particularly since margins on both Medicare and non-Medicare patients are dropping dramatically. The indirect medical education payment is an important equity factor in the Medicare prospective payment system, compensating teaching hospitals for the severity of their patients' illnesses, the scope of services provided and the impact of teaching hospital programs on hospital operating costs. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must fulfill their unique educational and service missions.

A major and/or sudden reduction in the IME adjustment would constitute a severe economic hardship for teaching hospitals and hinder their future capability to support adverse patient selection within DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. The AAMC urges the Commissioners to consider carefully the impact of a reduction in the indirect medical education adjustment on teaching hospitals.

Very sincerely yours,

Robert G. Petersdorf, M.D.

cc: ProPAC Commissioners
Donald Young, M.D., Executive Director

TABLE 1: PPS MARGINS IN SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986-FY 1988 RANKED BY FY 1988 PPS MARGIN

HOSPITAL	PPS MARGINS FY 86	FY 87	FY 88
A	25.20%	20.27%	30.03%
B	19.26%	12.42%	28.66%
C	28.15%	26.91%	27.84%
D	26.22%	21.31%	21.25%
E	7.09%	12.37%	18.58%
F	22.27%	15.39%	16.48%
G	34.98%	20.17%	16.46%
H	20.74%	19.50%	15.22%
I	23.68%	18.66%	12.53%
J	N.A.	N.A.	11.61%
K	14.27%	16.07%	10.78%
L	20.72%	16.78%	10.66%
M	39.17%	31.25%	9.89%
N	24.06%	15.93%	9.69%
O	8.52%	-22.79%	6.75%
P	23.40%	21.39%	5.05%
Q	19.35%	12.07%	3.88%
R	20.33%	12.86%	2.76%
S	13.82%	18.05%	2.48%
T	23.06%	15.55%	2.42%
U	25.64%	14.02%	1.80%
V	24.74%	14.81%	1.62%
W	8.60%	-1.33%	1.24%
X	15.92%	8.03%	0.09%
Y	16.74%	10.13%	-0.59%
Z	10.07%	7.17%	-1.39%
AA	24.68%	10.02%	-3.37%
BB	15.48%	N.A.	-3.93%
CC	18.80%	15.21%	-4.94%
DD	N.A.	N.A.	-8.76%
EE	-0.16%	1.73%	-9.10%
FF	14.94%	9.50%	-14.08%
GG	14.65%	0.68%	-14.57%
HH	7.06%	-4.76%	-20.66%
MEDIAN	19.84%	14.81%	3.32%
AVERAGE (WEIGHTED)	19.81%	14.76%	4.79%

PPS MARGIN= PPS REVENUE (WHERE PPS REVENUE= DRG PAYMENT, DISP. SHARE, INDIRECT MED. ED. AND OUTLIER PAYMENTS) LESS MEDICARE INPATIENT OPERATING COSTS, DIVIDED BY PPS REVENUE.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 2: PPS MARGINS FOR SELECTED ACADEMIC MEDICAL CENTER HOSPITALS RANKED BY PAYMENT WITH OUTLIERS, DSH, AND 1/2 IME: FY 1988

HOSPITAL	DRG PAYMT LESS OPER COSTS	PAYMENT WITH OUTLIERS ONLY	PAYMENT WITH OUTLIERS & FULL IME	PAYMENT WITH OUTLIERS & 1/2 IME	PAYMENT WITH OUTLIERS & DSH & 1/2 IME
B	0.00%	3.87%	20.74%	13.12%	22.54%
C	-4.67%	-0.22%	21.53%	11.98%	19.84%
A	-6.67%	-3.10%	25.48%	13.49%	19.55%
D	-7.40%	0.59%	17.78%	10.00%	14.14%
E	-17.70%	-11.86%	10.64%	0.65%	10.37%
H	-20.46%	-16.05%	6.81%	-3.37%	6.87%
G	-35.41%	-23.11%	8.64%	-4.89%	5.29%
F	-19.32%	-16.59%	12.42%	-0.02%	5.24%
J	-18.48%	-10.84%	6.80%	-1.26%	4.39%
N	-30.71%	-16.13%	3.56%	-5.37%	1.90%
K	-19.88%	-14.79%	7.73%	-2.31%	1.43%
I	-25.46%	-20.38%	8.89%	-3.72%	0.97%
M	-15.77%	-11.59%	9.89%	0.30%	0.30%
L	-32.41%	-22.68%	5.96%	-6.47%	-0.48%
O	-45.00%	-30.40%	1.50%	-12.23%	-5.46%
S	-31.96%	-17.30%	2.48%	-6.50%	-6.50%
P	-31.89%	-27.01%	1.74%	-10.80%	-6.60%
W	-29.29%	-22.00%	-2.57%	-11.44%	-6.96%
U	-34.23%	-24.34%	-1.89%	-12.00%	-7.56%
R	-44.24%	-30.47%	-1.75%	-14.34%	-8.66%
T	-38.11%	-29.41%	-0.67%	-13.25%	-9.35%
BB	-36.35%	-20.47%	-7.27%	-13.48%	-9.75%
V	-41.33%	-32.30%	-2.38%	-15.43%	-10.38%
AA	-27.13%	-19.94%	-3.37%	-11.04%	-11.04%
Q	-44.22%	-32.64%	3.26%	-11.88%	-11.05%
Z	-49.83%	-38.24%	-9.69%	-22.33%	-12.08%
X	-55.00%	-40.72%	-7.72%	-22.03%	-12.10%
Y	-49.70%	-38.03%	-7.10%	-20.61%	-12.43%
DD	-28.59%	-23.44%	-8.76%	-15.64%	-15.64%
GG	-34.11%	-26.78%	-20.86%	-23.75%	-17.16%
CC	-53.33%	-38.47%	-4.94%	-19.39%	-19.39%
EE	-51.41%	-42.54%	-15.03%	-27.31%	-20.09%
FF	-42.18%	-34.23%	-14.08%	-23.34%	-23.34%
HH	-61.95%	-50.60%	-25.04%	-36.63%	-31.42%
MEDIAN	-32.19%	-22.90%	1.62%	-11.24%	-6.78%
AVERAGE (WEIGHTED)	-33.60%	-24.28%	0.99%	-10.22%	-5.52%

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 3: DISPROPORTIONATE SHARE AND INDIRECT MEDICAL EDUCATION ADJUSTMENTS AS PERCENTAGES OF TOTAL PPS PAYMENTS RANKED BY FY 1988 PPS MARGIN

HOSPITAL	DSH AS OF TOTAL PPS PAYMT	IME AS % OF TOTAL PPS PAYMT	DSH & IME AS % OF TOTAL PPS PAYMT	FY 88 PPS MARGIN	FY 88 IRB RATIO
A	6.10%	26.04%	32.13%	30.03%	0.6506
B	9.99%	15.80%	25.79%	28.66%	0.5000
C	8.03%	19.96%	27.99%	27.84%	0.5775
D	4.22%	16.56%	20.78%	21.25%	0.5468
E	8.89%	18.33%	27.21%	18.58%	0.4449
F	4.63%	23.73%	28.36%	16.48%	0.7018
G	8.56%	23.58%	32.14%	16.46%	0.5978
H	9.02%	17.92%	26.94%	15.22%	0.5195
I	4.00%	23.34%	27.34%	12.53%	0.8091
J	5.16%	15.09%	20.25%	11.61%	0.5000
K	3.31%	18.97%	22.27%	10.78%	0.4853
L	5.00%	22.18%	27.18%	10.66%	0.6978
M	N.A.	19.25%	19.25%	9.89%	0.4805
N	6.36%	15.87%	22.23%	9.69%	0.3878
O	5.34%	23.16%	28.49%	6.75%	0.5490
P	3.37%	21.87%	25.24%	5.05%	0.5735
Q	0.65%	26.89%	27.53%	3.88%	0.5631
R	4.44%	21.03%	25.47%	2.76%	0.4308
S	N.A.	16.86%	16.86%	2.48%	0.4278
T	3.07%	21.53%	24.60%	2.42%	0.5612
U	3.62%	17.40%	21.02%	1.80%	0.4502
V	3.90%	21.73%	25.64%	1.62%	0.6501
W	3.72%	15.34%	19.05%	1.24%	0.4073
X	7.25%	21.75%	29.00%	0.09%	0.7506
Y	6.07%	21.05%	27.12%	-0.59%	0.5851
Z	7.57%	19.09%	26.66%	-1.39%	0.6172
AA	0.00%	13.81%	13.81%	-3.37%	0.3078
BB	3.11%	10.62%	13.73%	-3.93%	0.3462
CC	0.00%	24.22%	24.22%	-4.94%	0.4308
DD	N.A.	11.90%	11.90%	-8.76%	0.3810
EE	5.15%	18.31%	23.46%	-9.10%	0.5397
FF	N.A.	15.01%	15.01%	-14.08%	0.3251
GG	5.21%	4.42%	9.63%	-14.57%	0.1014
HH	3.50%	16.38%	19.88%	-20.66%	0.4685
MEDIAN	4.82%	19.03%	24.92%	3.32%	0.5098
AVERAGE (WEIGHTED)	3.85%	19.55%	23.40%	4.79%	N.A.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 4: OPERATING AND TOTAL MARGINS FOR SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986-FY 1988

HOSPITAL	OPERATING MARGINS FY 86	FY 87	FY 88	*	TOTAL MARGINS FY 86	FY 87	FY 88
A	7.47%	-4.05%	-4.16%	*	11.77%	0.46%	0.77%
B	11.58%	6.10%	-10.99%	*	13.41%	7.86%	9.87%
C	19.85%	18.96%	14.45%	*	19.85%	19.51%	14.83%
D	2.90%	10.05%	5.49%	*	3.08%	8.42%	5.92%
E	9.29%	8.37%	9.37%	*	8.37%	9.29%	9.37%
F	6.90%	5.17%	3.99%	*	6.99%	5.34%	3.79%
G	-40.36%	-34.84%	-43.40%	*	-1.19%	-0.81%	-0.77%
H	-7.86%	-11.98%	-13.05%	*	-7.86%	-11.98%	-13.05%
I	5.00%	5.34%	7.42%	*	5.01%	5.32%	7.89%
J	N.A.	N.A.	0.27%	*	N.A.	N.A.	1.52%
K	6.36%	5.87%	2.03%	*	6.16%	5.64%	3.31%
L	8.02%	1.91%	-0.66%	*	8.43%	6.39%	3.52%
M	10.92%	10.69%	10.00%	*	15.48%	13.99%	12.56%
N	10.73%	4.58%	3.64%	*	10.73%	4.58%	7.03%
O	14.00%	8.41%	7.72%	*	16.55%	11.38%	10.21%
P	2.47%	0.15%	-1.47%	*	6.63%	4.37%	2.30%
Q	2.26%	0.84%	0.89%	*	5.33%	3.95%	3.65%
R	2.59%	-0.85%	-4.76%	*	4.84%	1.85%	-2.13%
S	-2.31%	-1.71%	-3.35%	*	0.36%	0.01%	-0.46%
T	7.66%	2.64%	0.65%	*	12.72%	4.62%	2.89%
U	3.72%	1.55%	1.22%	*	5.31%	3.60%	3.47%
V	8.67%	5.61%	5.43%	*	9.18%	10.09%	6.06%
W	7.77%	2.24%	2.71%	*	10.55%	2.55%	3.04%
X	3.61%	0.47%	1.81%	*	5.35%	1.87%	2.38%
Y	-13.23%	-17.58%	-16.95%	*	1.47%	2.00%	1.16%
Z	5.06%	3.14%	3.36%	*	5.06%	3.14%	3.36%
AA	10.40%	6.26%	1.96%	*	10.63%	6.96%	2.59%
BB	0.89%	3.53%	2.24%	*	1.82%	4.47%	3.05%
CC	0.81%	0.24%	-1.10%	*	0.98%	0.75%	-0.42%
DD	N.A.	N.A.	-24.17%	*	N.A.	N.A.	1.57%
EE	3.18%	0.31%	3.82%	*	3.18%	0.31%	3.82%
FF	7.03%	8.32%	1.64%	*	8.33%	9.37%	2.44%
GG	11.67%	10.47%	4.34%	*	13.54%	19.62%	6.12%
HH	6.83%	4.70%	2.15%	*	7.53%	5.68%	4.24%
MEDIAN	6.59%	3.34%	1.89%	*	6.81%	4.60%	3.34%
AVERAGE (WEIGHTED)	2.73%	0.79%	-1.42%	*	6.57%	4.87%	3.32%

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

ACADEMIC MEDICAL CENTER HOSPITALS PROVIDING DATA
FY 1986-FY 1988

CRAWFORD LONG
DUKE UNIVERSITY
EMORY UNIVERSITY HOSPITAL
GEORGETOWN
HAHNEMANN
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
INDIANA
KENTUCKY
LA COUNTY-USC MEDICAL CENTER
LOUISIANA STATE UNIVERSITY
MASSACHUSETTS GENERAL
MEDICAL COLLEGE OF GEORGIA
MEDICAL COLLEGE OF OHIO
MEDICAL COLLEGE OF VIRGINIA
NORTH CAROLINA BAPTIST
NORTH CAROLINA MEMORIAL
REGIONAL MEDICAL CENTER AT MEMPHIS
ST LOUIS UNIVERSITY
TEMPLE
UNIVERSITY OF CALIFORNIA, DAVIS
UCLA
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
UNIVERSITY HOSPITAL (COLORADO)
UNIVERSITY OF MARYLAND
UNIVERSITTY OF MICHIGAN
UNIVERSITY OF MISSISSIPPI
UNIVERSITY OF NEBRASKA
UNIVERSITY OF NEW MEXICO
UNIVERSITY OF UTAH
UNIVERSITY OF VIRGINIA
UNIVERSITY OF WASHINGTON
VANDERBILT
VERMONT
YALE-NEW HAVEN

NOTE: HOSPITALS ARE LISTED ABOVE IN ALPHABETICAL ORDER. HOSPITAL ORDER HAS BEEN CHANGED IN THE ACCOMPANYING TABLES.

COTH Support (Letter) for C. Thomas Smith's Nomination as AHA Chair-Elect

The following is a letter from Gary Gambuti, current COTH Administrative Board Chair, to AHA Nominating Committee Chair, Jack Skarupa. The letter is in support of Tom Smith's (President, Yale-New Haven Hospital and former COTH Administrative Board Chair) nomination as AHA Chair.

Included is a copy of Jim Bentley's January 30 statement before the AHA Nominating Committee also on behalf of Mr. Smith's nomination.

ST. LUKE'S\ROOSEVELT

Hospital Center

Amsterdam Avenue at 114th Street, New York, NY 10025

Gary Gambuti
President

January 18, 1989

JAN 2[illegible] 1989

Mr. Jack Skaggaupa
Chairman
Nominating Committee
American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611

Dear Jack:

As chairman of the Council of Teaching Hospitals, I am writing to support the candidacy of C. Thomas Smith, President of Yale-New Haven Hospital, for the Chairman-Elect of the American Hospital Association. Tom is an exceptional and dedicated hospital CEO who has demonstrated a strong commitment to the leadership of national, state and regional hospital associations by holding numerous positions at all levels. As a leader, Tom has used his strong analytical skills to guide boards and committees through the thicket of conflicting policy views in order to develop shared solutions. He has then advocated the resulting position to affected parties with clear and concise presentations which have earned him respect and admiration. In addition to his many accomplishments in hospitals and hospital associations, Tom is a strong leader of his community who has given extensively of himself to charitable, educational and civic organizations.

I believe Tom Smith would be an outstanding chairman-officer of the AHA. His skills, experience and personal integrity enable him to provide leadership and inspiration to our field. I, therefore, encourage your committee to nominate C. Thomas Smith for Chairman-Elect of the AHA.

Sincerely,

Gary Gambuti
COTH Chairman

GG:gc
cc: James D. Bentley, M.D.

AHA Nominating Committee
COTH Support for C. Thomas Smith

Thank you, Mr. Chairman.

My name is James Bentley; I am the Vice President for Clinical Services of the Association of American Medical Colleges with responsibilities for its Council of Teaching Hospitals.

This afternoon, I am pleased to appear on behalf of the Council to recommend that you nominate Tom Smith, President of Yale-New Haven Hospital, as Chairman-elect of the American Hospital Association.

Tom has been an active member in the life and governance of the Council of Teaching Hospitals and in its parent organization, the Association of American Medical Colleges. He was elected by his colleagues to the Council's board in 1982. After serving a three-year term, he was elected a chairman-officer in 1985 and served as both the Council's chairman and as a member of the AAMC's Executive Committee in 1986. Tom has also chaired our Committees on Health Planning, on Prospective Payment for Hospitals, on the Review of JCAHO Standards, on the Council's annual professional development conference, and on nominations.

In all of these responsibilities, Tom has demonstrated that he is an exceptional and dedicated hospital CEO who has a strong commitment to the leadership of hospital associations. He used his strong analytical skills to guide our boards and committees through debates of conflicting views in order to develop positions the whole Council and the AAMC could support. He then advocated the positions with clear and concise presentations which earned him the respect and admiration of his colleagues, the broader community of hospital leaders, and both legislators and government administrators. Having emphasized Tom's capability to objectively analyze and lead the policy development process, I would not want you to overlook his warm, personal relationship with his colleagues or his enthusiasm for humor and entertainment.

Finally, I wish to address those who may be concerned that Tom's experience in the field may lead him to emphasize major teaching hospital interests above those of other hospitals. Without reservation, I can attest to Tom's ability to rise above the personal and parochial. While the members of the Council of Teaching Hospitals are often characterized as large, urban hospitals, they are not homogeneous. The Council has members in both rural and urban areas, with from 25 to 500 residents, and with under 100 to over 1,500 beds. The members are owned by universities, municipalities, state and federal governments, non-profit community corporations, and investor owned corporations.

As a board member and officer, Tom demonstrated his ability to open-mindedly consider the needs and interests of this diversity. Perhaps this ability has been strengthened by the dual community and university roles of his own institution, the Yale-New Haven Hospital.

In closing, I believe Tom Smith has the skills, experience and personal integrity necessary to provide leadership and inspiration for our nation's hospitals. Therefore, on behalf of the Council of Teaching Hospitals, I am pleased to encourage you to nominate C. Thomas Smith for Chairman-elect of the AHA.

Thank you.

UPDATE ON MEDICARE PAYMENT POLICIES

At its September 1988 meeting, the Executive Council was asked to consider draft positions on Medicare policy issues for 1989. Led by the COTH Administrative Board, the Executive Council adopted the policy positions shown in Attachment A.

As a result of these positions, Carol McCarthy, Ph.D., J.D., president of the American Hospital Association met with the COTH Administrative Board during the AAMC Annual Meeting to express her concern that the AAMC emphasis on maintaining a tiered payment (large/urban, urban/rural) approach until adequate adjustments for non-labor costs and severity are available could undermine the AHA's position of a single rate. After substantial debate, the Board continued to express concern about endorsing a single rate, especially because the AHA's single rate proposal is contingent upon receiving Medicare funding in excess of the current services budget.

During the Board meeting, Dr. McCarthy invited Jim Bentley to attend a November 29 briefing for state, metropolitan, and allied associations. Jim attended the meeting and participated in the discussion emphasizing (1) the significance of advocating a single rate without completed adjustments and (2) the importance of an increase in outlier funds.

Subsequent to the November 29 meeting, the following actions have occurred and they are attached for your information:

- Letter from Carol McCarthy to James Bentley (December 1, 1988) regarding COTH members on AHA committees -- Attachment B.
- Letter from James Bentley to Carol McCarthy (January 5, 1989) encouraging AHA to include academic medical center hospitals as well as community hospitals on AHA committees -- Attachment C.
- Letter from Carol McCarthy to James Bentley (January 27, 1989) indicating AHA interest in including COTH members on AHA committees -- Attachment D.
- AHA Position on Medicare Prospective Pricing Reform as approved by Board of Trustees on January 28, 1989 -- Attachment E.

POLICY POSITIONS ON MEDICARE ISSUES
Adopted by AAMC Executive Council
September 8, 1988

1. The AAMC supports a tiered rate structure for Medicare PPS payments which recognizes cost differences between urban and rural hospitals until adequate and tested indices for both wage and non-labor components of hospital cost are available.

2. The AAMC supports, as a floor, the October, 1988 formula (yielding 7.7% per 0.1 resident per bed) for the indirect medical education adjustment. This is in recognition of the multiple roles and accompanying costs teaching hospitals have in the nation's health care system, including caring for the most severely ill patients, introducing new diagnostic and treatment services, caring for patients in the high cost core cities of urban areas, and providing clinical education programs in the health professions.

3. The AAMC supports increasing the percentage of Medicare PPS payments used to compensate hospitals for high cost and long stay outliers as a means of more fully recognizing differences in patient severity of illness.

4. The AAMC supports the inclusion of a disproportionate share adjustment in the Medicare PPS and supports efforts to develop better measures of the impact of treating the poor, including the aged poor, on a hospital's overall costs and financial status.

5. The AAMC supports rebasing PPS prices, but only when rebasing includes full, public documentation and release of methodology and data; contemporary hospital cost data; and a rulemaking process with comment and appeal. If these conditions are not met, the AAMC Executive Council supports an annual increase in PPS prices at least equal to the annual increase in the price of goods and services purchased by hospitals.

6. All health care payers, including Medicare, should continue to provide their appropriate share of support for graduate medical education. Medicare may be a keystone in assuring this support since Medicare policies are determined by Congress and the Department of Health and Human Services, bodies which are supposed to guard the public interest. Accordingly, the AAMC supports the following policies:

   - residents in approved training programs should be funded largely by payments to teaching hospitals by patient care payers at least through the number of years required to achieve initial board eligibility in their chosen discipline.

   - one additional year of funding beyond initial board eligibility should be provided from teaching hospital revenues for fellows in accredited training programs to the extent that the hospital funded such training in 1984.

- an individual should be supported from patient care payers' payments to teaching hospitals for a maximum of six years of graduate medical education.

- while public and private organizations may adopt positive financial incentives to encourage physicians to train in particular disciplines they should not adopt financial disincentives for a particular discipline during the period of its initial board eligibility.

Attachment B

American Hospital Association

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6622

C. M. McCarthy, Ph.D., J.D.
President

DEC 09 1988

December 1, 1988

Dear Jim

In response to your request, I asked for a breakdown of the affiliations of those represented on the American Hospital Association's ad hoc committees on resource price adjustment and severity adjustment.

Fourteen individuals serve on the committee concerned with resource price adjustments:

Four represent allied hospital associations, with one of the four regularly represented by the senior vice president of a teaching hospital in Rochester, NY, which is a COTH member (Genesee Hospital).

Two represent teaching hospitals, one of which is a COTH member (Frankford Hospital in Philadelphia) and one of which is ACGME-approved and medical school-affiliated (Research Medical Center in Kansas City).

Five represent urban, non-teaching facilities.

Three represent rural facilities.

Of the 15 individuals who, in turn, serve on the severity adjustment committee:

Four represent allied hospital association.

One represents a consortium of facilities.

Four represent teaching hospitals, three of which are COTH members (Rush-Presbyterian-St. Luke's in Chicago, Presbyterian Hospital in New York City and the New England Medical Center in Boston) and one of which is ACGME-approved and medical school-affiliated (Virginia Beach General Hospital).

One represents urban non-teaching facilities.

Three are drawn from rural facilities.

Three represent systems with an admixture of urban, rural, teaching and non-teaching facilities.

In sum, I would say the AHA Speaker of the House did a rather good job of naming representative groups. Your comments, of course, are welcome.

I also look forward to hearing from you regarding the AAMC board's assessment of the centrality of an outlier adjustment to their support for AHA's Medicare reform package.

Best regards

Carol

Carol M. McCarthy, Ph.D., J.D.

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

association of american medical colleges

January 5, 1989

Carol M. McCarthy, Ph.D., J.D.
President
American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611

Dear Carol,

Thank you for your letter of December 1 describing the composition of the committees on resource price adjustments and the severity adjustment. I am pleased that the severity adjustment committee includes COTH members from three academic medical centers, Rush-Presbyterian St. Luke's, Presbyterian Hospital in New York City and the New England Medical Center.

However, while teaching hospitals, including COTH members, are part of the resource price adjustments committee, only community teaching hospitals are represented. Community hospitals are an important part of the American medical education system, but in many instances their needs and concerns are very different from those hospitals that are classified as academic medical centers. To have no academic medical centers on the committee is a major omission and one that I hope will be corrected. I have included a list of the academic medical center members of COTH and would be happy to suggest several hospitals to be appointed to the committee.

Also raised in your letter is the issue of the AAMC's support for the AHA's Medicare reform package. Following its November meeting with you in Chicago, the COTH board decided that the AAMC should: actively support industry-wide efforts to prevent reductions in Medicare payments to hospitals, recognize that the AAMC and AHA positions are consistent if both new money and adequate adjustment measures are available, continue the present AAMC policy of a tiered rate structure in light of AHA analysis which shows comparable financial impacts on all categories of hospitals if a tiered structure is retained in the absence of an adequate adjustment, and work with the AHA to aid in developing adjustments which would make the AAMC and AHA positions the same. The Board also expressed its continuing belief that an enlarged and more adequate outlier pool is essential for payment equity. The major difference between the AAMC and AHA positions is that the AHA supports elimination of the three-tiered hospital rate now while the AAMC wants to retain the three-tiered system until severity of illness and resource price adjustments can be made part of the prospective payment system.

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

If you have any questions, or would like more information, please do not hesitate to call.

Sincerely,

James D. Bentley, Ph.D.
Vice President for
Clinical Services

JDB/nrr

Attachment

cc: Gary Gambuti
J. Robert Buchanan, MD
Raymond G. Schultze, MD
Robert G. Petersdorf, MD

American Hospital Association

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6622

C. M. McCarthy, Ph.D., J.D.
President

January 27, 1989

Dear Jim

Thanks for your follow-up letter of January 5, providing a listing of academic medical centers and an update on the Association of American Medical Colleges' positions on Medicare PPS policies.

The American Hospital Association's ad hoc committees on severity adjustment and resource price adjustments are likely to be discharged when the AHA Board adopts positions on Medicare PPS reform at the end of this month, and thus the issue of additional ad hoc committee appointments is essentially moot. Nevertheless, I do want to indicate that academic medical centers are significantly represented on the various AHA policy bodies (e.g., governing councils of constituency sections, Regional Policy Boards) which reviewed the analyses and recommendations of both ad hoc committees.

Based on the AHA Board's actions at the end of this month, staff will be preparing a follow-up workplan, which is likely to include convening technical panels to develop further details on DRG refinement and resource price reforms. When the rosters for such technical panels are being assembled, we will make every effort to accommodate your suggestion that academic medical centers be represented.

On the matter of the difference between AHA and AAMC positions, please be advised that AHA does not support elimination of the differential without adjustments for severity and resource price inputs. We do support simultaneous movement on all three sides. Further, later this week the AHA Board will debate a position that would support increasing outlier funds along with

narrowing the differential in the likely event that less than $2.9 billion is appropriated for Medicare reform; the outlier funds would improve adequacy, the narrowed differential, equity.

Following the AHA Board meeting, we will be in touch to further review and discuss our respective positions and how we can work effectively together in the months ahead.

Sincerely

Carol

Carol M. McCarthy, Ph.D., J.D.

James D. Bentley, Ph.D.
Vice President for Clinical Services
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, DC 20036

AMERICAN HOSPITAL ASSOCIATION POSITION ON MEDICARE PROSPECTIVE PRICING REFORM*
Approved by Board of Trustees
January 28, 1989

The American Hospital Association believes that significant reforms are needed in the Medicare prospective pricing system to ensure that the prices set are both adequate and equitable. Adequate and equitable payment is essential to realizing the incentives in the system to improve efficiency while assuring beneficiary access to needed, high quality hospital care.

ADEQUACY REFORMS

For payment to be considered adequate, it must cover the full economic cost of providing needed hospital care to Medicare beneficiaries. Over time, Medicare payments must bear a reasonable relationship to the cost of services used by Medicare patients. To achieve this goal, the prices established under the prospective pricing system should be recalculated every four years using an expanded definition of the cost of caring for Medicare patients. Between these quadrennial recalculations, prices should be updated by the percentage increase in the price of the goods and services hospitals must purchase to provide care. The "hospital market basket " to be used in updating prices should be based on the prices hospitals must pay for the resources they use, particularly labor.

For providers exempt from the prospective pricing system, a more timely means of adjusting payment limits of individual providers for changes in case mix and treatment is needed.

To insulate the Medicare program from pressures to arbitrarily reduce payment levels, Medicare should be exempted and removed from the Gramm-Rudman-Hollings budget deficit reduction measures and removed from the consolidated budget of the United States.

EQUITY REFORMS

Equity is best achieved through the establishment of a single "base" rate which is adjusted for patient characteristics and for differences between hospital markets in prevailing resource prices and variations in use of resources that are beyond the control of hospital management. Movement to a single rate system must be accompanied by a hold harmless provision which protects hospitals from a reduction in payment resulting simply

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* This statement updates the American Hospital Association's position on Medicare prospective pricing reform, incorporating actions approved by the AHA Board of Trustees on January 28, 1989. All of pages two, three, and four of this statement represent a summary of the January 28, 1989 Board actions.

from the movement to a single rate. Individual hospitals, whether urban or rural, would not be protected from any reductions in payment resulting from changes in the DRG system or the updating and expansion of the resource price/use adjustment. The current indirect medical education and disproportionate share adjustments should be continued.

DRG Refinement and Severity Adjustment The DRG system is the principal means of adjusting hospital payments for patient characteristics. To improve the sensitivity of the prospective pricing system to differences in patient characteristics, the DRG system should be refined as quickly as possible.

Efforts should focus on the refinement of "problem" DRGs. Initially, an effort should be made to identify modifications in those DRGs which account for more than one percent of Medicare admissions and which show substantial differences in costs between hospitals, which contain individual diagnoses (or groups of related diagnoses) or procedures which differ substantially from the average of other diagnoses or procedures included in the DRG, or which include diagnoses or procedures that have been identified as incorrectly classified by hospitals or physicians.

Rationale The DRG system has been widely criticized for its failure to capture the "severity" of a patient's condition, and considerable resources have been expended in developing "severity measurement systems" to either replace the DRG system or to be used alongside it. The available severity systems offer little improvement over the DRG system in defining groups of patients using similar resources. DRG refinement is consistent with the basic structure of the DRG system and is consistent with the need to continuously improve the payment system to reflect changes in medical practice and to identify truly similar patients. Any improvements that might be realized by the introduction of a severity index or add-on can be realized through the DRG refinement. The continued development and evaluation of these systems, however, may identify important patient characteristics which could be used to improve the DRG system.

Resource Price and Use Adjustments The current adjustment for resource price variation is inadequate, and should be replaced with a more comprehensive index reflecting variation in the prices paid by hospitals for all types of resources, both labor and nonlabor. This index should include, on a selective basis, adjustments for resource use, and must be combined with a flexible exceptions process to identify and make corrections in the treatment of individual hospitals or groups of hospitals when appropriate. While a comprehensive index is being developed, steps should be taken to update the data used to measure differences in wage levels and to add components measuring regional differences in energy/utilities and liability insurance costs.

Rationale An index based on all types of resources would result in adjustment for all variations in resource prices whenever such variations are present, and would allow the validation of inflation as measured by the hospital market basket. Including all types of resources would avoid the need to periodically assess whether various types of resources are traded in local or national markets . Although significant problems with the use of MSAs to define hospital resource markets have been encountered, alternative definitions have proven to be equally unsatisfactory. MSAs offer a viable starting point for the definition of such markets, provided a means of redefining market areas on an exceptions basis is created.

Exceptions Process However refined the adjustments for patient mix and resource price, an exceptions process will be needed to take into consideration the unique circumstances of individual hospitals that cause them not to fit a general rule. All routine adjustments make the assumption that hospital are "average," and will work well for the majority of hospitals. Some hospitals will simply not fit into such a system of "averages." Hospitals should have the option of seeking exceptions through either binding arbitration or through adjudication before a regional appeals boards.

The determination of the boards should be final, subject only to appeal to the courts. All hospitals should be permitted to request exceptions, whether or not financially distressed. The issues subject to appeal should include: inappropriate assignment to a local market, errors in data or in calculations, variation in resource prices, and variation in resource use. Priority could be given to hospitals incurring losses as a result of inequities.

Rationale At the present time, opportunities for appeal or exceptions are extremely limited. By law, most decisions concerning payment under the prospective pricing system cannot be reviewed by the courts. Moreover, because the system is "prospective" a premium needs to be placed on the timely adjudication of exception requests . Under a prospective pricing system, an exceptions process that is not timely is of little or no use. Creating several regional review boards speeds the process by allowing more cases to be heard simultaneously across the country. Limiting further review to direct appeal to the courts also streamlines the process, as does providing hospitals with the option of binding arbitration. Access to judicial review is the best assurance of neutrality. The exceptions process should extend to all hospitals the opportunity to seek a fair price. Restricting appeals to hospitals in financial distress would preclude correction of inequities for many hospitals, including competitive inequities that, over time, may jeopardize the ability of hospitals to compete fairly with one another. At issue is whether payment is fair, not whether payment is simply adequate.

Treatment of Small Rural Hospitals Small rural hospitals have experienced sharp reductions in utilization and operating margins since the implementation of PPS. They also appear to experience substantial fluctuations in both average costs and payments from year to year. To address these concerns, hospitals operating fewer than 50 Medicare certified acute care beds should be offered the option (reviewable every four years) of being paid according to traditional Medicare cost-reimbursement principles . Criteria should be developed for granting the same option to larger hospitals (including urban hospitals) that are the sole source of care for their communities.

Rationale Payment under a prospective pricing system can be unsuitable for many small rural hospitals because they lack the volume needed to reliably predict either revenues or costs. Exempting small hospitals would provide assurances of continued access to hospital services for the communities served, although it would not guarantee a hospital's survival. Development of criteria to provide the same option to larger hospitals (including urban hospitals) that are the sole source of care for their communities would help to ensure that access to needed hospital care is also maintained in selected other communities where the hospital's bed size and/or geographic location do not precisely conform to the small, rural hospital criteria.