



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

AGENDA

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

September 28, 1989
7:30a - 12:30p
Washington Hilton Hotel
Map 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 Center
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. Muilenburg
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 1989 ADMINISTRATIVE BOARD MEETINGS

September 27-28- The Washington Hilton Hotel, Washington, DC
October 30- Same

COTH SPRING MEETINGS

May 9-11, 1990
The Lafayette Hotel, Boston, MA
May 8-11, 1991
The Mills House, Charleston, SC
April 29-May 2, 1992
The Broadmoor Hotel, Colorado Springs, CO

AAMC ANNUAL MEETINGS

October 28-November 2, 1989
The Washington Hilton Hotel, Washington, DC
October 20-25, 1990
The San Francisco Hilton Hotel, San Francisco, CA
November 8-14, 1991
The Washington Hilton Hotel, Washington, DC

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 27-28, 1989
Washington Hilton Hotel
Washington, DC

WEDNESDAY, September 27, 1989

- 1:00p JOINT ADMINISTRATIVE BOARDS SESSION WITH
AAMC GOVERNANCE AND STRUCTURE COMMITTEE
Monroe West Room
- 2:00P INDIVIDUAL ADMINISTRATIVE BOARD SESSION WITH
REPRESENTATIVES FROM COMMITTEE
Mr. John Colloton, Chair
Dr. Virginia Weldon
Hemisphere Room
- 6:00p COTH ADMINISTRATIVE BOARD RECEPTION/DINNER
Thoroughbred Room

THURSDAY, September 28, 1989

- 7:30a COTH ADMINISTRATIVE BOARD BREAKFAST
MEETING
Guest Speaker: Richard Averill
Vice Chairman, Health Systems International (HSI)
Map Room
- 12:30p JOINT ADMINISTRATIVE BOARDS LUNCHEON
Thoroughbred Room
- 1:30p EXECUTIVE COUNCIL BUSINESS MEETING
Military Room

AGENDA

COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD

WASHINGTON HILTON HOTEL

Map Room

September 28, 1989

7:30a-12:30p

- | | | |
|------|--|----------------|
| I. | Breakfast Meeting with Richard Averill, HSI (7:30-8:30a)
Background Materials | Page 1 |
| II. | Call to Order | |
| III. | President's Report | Dr. Petersdorf |
| IV. | Legislative Report | Dr. Knapp |
| V. | Chairman's Report | Mr. Gambuti |
| VI. | Consideration of the Minutes | Page 24 |
| | Attachments | Page 36 |
| VII. | COTH AGENDA ITEMS | |
| A. | Initial Discussion of 1990
COTH Spring Meeting Program | Page 74 |
| B. | Finalized Arrangements for Upcoming
COTH Spring Meetings | Page 78 |
| C. | Member Participation in COTH | Page 79 |
| D. | COTH Member Institutions Having Dropped
Membership as a Result of Dues Increase | Page 80 |
| E. | AAMC Comment Letter to Mr. Hays, Acting HCFA
Administrator, on Proposed Rule, "Changes
in Inpatient Hospital PPS and FY1990 Rates" | Page 83 |

CONTINUED...

- F. AAMC Comment Letter to Mr. Gradison on HR1692, "The Medical Care Quality Research and Improvement Act of 1989" Page 86
- G. AAMC Comment Letter to US Department of Labor on Proposed Regulation, "Occupational Exposure to Bloodborne Pathogens" Page 89

VIII. EXECUTIVE COUNCIL AGENDA

- A. Waxman Amendment on Medicare Payments for GME Executive Council Agenda - Page 76
- B. Draft Revision of the General Requirements of the ACGME Essentials of Accredited Residencies and GME Executive Council Agenda - Page 85
- C. Report of the Task Force on Physician Supply Executive Council Agenda - Page 104
- D. A Single Examination for Medical Licensure Executive Council Agenda - Page 24
- E. NIH Research Facilities Construction Authorization Executive Council Agenda - Page 72
- F. AAU Draft Report on Indirect Costs Executive Council Agenda - Page 65
- G. Proposed Revision of the Rules and Regulations of the Group on Medical Education Executive Council Agenda - Page 98

IX. STAFF REPORT

X. OLD BUSINESS/NEW BUSINESS

XI. ADJOURNMENT

Richard F. Averill

Mr. Richard Averill, Vice-Chairman of Health Systems International, has been with the Company since 1972. He has over twelve years of experience in applications of information systems technology to the health care industry.

Mr. Averill has been a leader in the application of casemix technology to problems in health. He has directed many large-scale projects in hospital reimbursement, management planning and quality assurance. He is one of the developers of the Diagnosis Related Groups (DRGs) patient classification scheme and was instrumental in the design and implementation of the New Jersey Prospective Reimbursement System.

Mr. Averill received a Masters Degree in Management from Yale University and previously served as Director of health-related research for Yale's School of Organization and Management. At Yale he had overall responsibility for the management and direction of all health systems research activities including the development of the DRG casemix system. The DRG research project required the coordination of over one hundred physicians from throughout the country. Mr. Averill has published extensively in areas of health services research and information systems. Many of his publications form the basis for educational and training programs throughout the hospital industry.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
June 15, 1989

Present

Calvin Bland
J. Robert Buchanan, MD
Gary Gambuti
Jerome Grossman, MD
Leo Henikoff, MD
John Ives
William Johnson, Jr.
Robert Muilenburg
Max Poll
Raymond Schultze, MD
Edward Schwartz
Barbara Small
Alexander Williams

Absent

Sister Sheila Lyne
James Mongan, MD

Guests

John Gronvall, MD, Veterans Administration
Robert Perreault, Veterans Administration

Staff

Ivy Baer
James Bentley, PhD
Katherine Cahill
Joanna Chusid
Linda Fishman
Leslie Goode
Donald Kassebaum, MD
Joyce Kelly, PhD
Richard Knapp, PhD
Elizabeth Martin
Herbert Nickens, MD
Robert Petersdorf, MD
John Sherman, PhD
Kathleen Turner
Melissa Wubbold
Stephen Zimmermann

COTH ADMINISTRATIVE BOARD
MEETING MINUTES

Washington Hilton Hotel
June 15, 1989

I. CALL TO ORDER

Gary Gambuti called the meeting to order at 7:45a in the Map Room of the Washington Hilton Hotel. He welcomed the Administrative Board and introduced the morning's guest speaker, John A. Gronvall, MD, Chief Medical Director, Veterans Administration, and his executive assistant, Robert Perreault. Mr. Gambuti called on the members of the Board to introduce themselves to Dr. Gronvall.

Dr. Gronvall indicated that his purpose in addressing the Board was to explore Veterans Administration hospital difficulties, how they related to COTH and the industry in general, and the goal of restructuring the VA system. He pointed out that the system was severely stressed with underfunding and major increased demands projected through the year 2010/2015 (Attachment A). The VA is currently unable to compete in equipment purchases or new technology, and the current ambition is to internally restructure the Department to better fit the new funding level with quality care as the end point. This would be assured by having fewer hospitals that would be different in scope and more nursing homes as compared with acute care hospitals; these would be well funded, well equipped, and well staffed. Dr. Gronvall admitted these changes would not be easy in the face of the political system, but that a successful restructuring was their goal.

Discussion ensued on the VA's budget, current funding difficulties, and the \$340 million supplemental payment under proposal of HR2402, which would dramatically affect the personnel level of the VA. Dr. Gronvall noted that they are currently at a 191,000 personnel level, but if the supplemental is not in effect by the fiscal year end, September 30, five thousand VA employees will be dropped to comply with a 186,000 employee fiscal level. Four thousand employees have already been dropped from a base of 195,000. He added that even with approval of the supplemental, it will be impossible to make optimal use of funds in the very short time before the end of the fiscal year. Medical care monies not obligated at fiscal year end lapse. He indicated that this is a very demoralizing cycle for personnel.

Further dialogue followed on pay levels within the VA and competition with community hospitals for quality personnel. Dr. Gronvall noted that this is a huge problem for the VA, especially in the nursing area. An attempt to close the salary gap has been made with special pay agreements, but federal regulations for justification of such agreements are difficult and self-defeating. Because of the acute nursing difficulties, a legislative proposal

is being formulated to adjust professional health care staff salaries within the VA on a locality basis. Physician salaries also need restructuring.

Dr. Gronvall responded to a question on the recent furor over mortality data results within the VA, noting that the VA study could not be directly compared with nonfederal hospitals and the HCFA study because of fundamental differences in records. The VA study was self-contained and compared individual VA hospital mortality experience to the overall VA hospital experience. The study was initiated in an effort to evaluate weakness within the system, and Dr. Gronvall stated that he believed it was a worthwhile effort. He noted, however, that the follow-up phase had not yet been implemented and it is unclear how many of the cited discrepancies were actually already under evaluation in the individual institutions.

Dr. Bentley asked Dr. Gronvall to describe the projected impact of categorizing the VA as a cabinet department. Dr. Gronvall responded that on an institutional level the change will be minimal, but it does give the Secretary, Mr. Derwinski, better access to the President. Additionally, the chief medical director is no longer appointed by the VA Administrator (Secretary), but following recommendation by a mandated search commission, is nominated directly by the President and confirmed by the Senate. The positions of six new assistant secretaries for the VA, who are also Presidential nominations, have been created to head key staff areas. He felt that there will clearly be more political leadership of the VA, at least at the Washington level.

In follow-up to Dr. Harvey Barkun's (Executive Director, Association of Canadian Medical Colleges) address the previous evening, a discussion took place on global budgeting, the Canadian system, and the VA experience in this arena. Dr. Gronvall felt that the VA is as strong as it is because VA hospitals are forced to stay in the competitive market with academic medical centers, as evidenced by the fact that VA physicians are not in civil service. Additionally, he felt that if the entire system were supported from one federal appropriation, as opposed to the current pleuralistic system, it would be much less successful. Dr. Buchanan cited his experience with the Canadian system from chairing the Liaison Committee on Medical Education (LCME), noting that the Canadian medical schools are very much at the mercy of their federal government, and noting the tremendous struggles they face under global budgeting.

Mr. Gambuti thanked Dr. Gronvall and wished him well in the following weeks. He then asked Mrs. Small to describe the VA Durham experience with the publishing of the VA mortality data; the Veterans Administration Medical Center in Durham being one of the 44 hospitals to participate in the VA mortality data study. She indicated that the published results were disproportionate, creating unqualified outlier situations, and that to date the methodology of the study has not been validated. Additionally, as Dr. Gronvall noted, there has been no follow-up phase and the participating hospitals have not had the opportunity to respond to the implications of the study. Mrs. Small felt the hospitals had

been placed in the difficult position of defending themselves from the system they profess to support.

II. DISCUSSION ITEMS

A. PRESIDENT'S REPORT

Dr. Petersdorf opened his report by announcing that the Executive Council would take final action on the general funds budget for FY1990. Due to higher than expected revenues from MCAT and AMCAS, savings in projected expenditures, and realized gains from sales in the AAMC investment portfolio, the Association will end FY 1989 in financial balance. He reported on the Wyatt survey and adjustments in AAMC salaries, and gave an update on AAMC staff. Douglas Kelly, PhD will join the Association in July as Associate Vice President for Biomedical Research, August Swanson, MD will assume the position of Vice President for Graduate Medical Education, and Louis Kettel, MD will become Vice President for Academic Affairs. The Division of Academic Affairs will be reorganized and a new section for educational research created.

He reviewed the status of plans for a new building and AAMC headquarters. The Executive Council has approved entering a development and acquisition agreement with Boston Properties for the purchase of the commercial portion of a mixed-use site at 2450 N Street, NW. Application for tax exempt revenue bond financing for the project has been filed. However, two obstacles have arisen. A local citizens' group has filed a motion to reconsider the zoning commission ruling of last December, and a janitorial services union has filed a suit to appeal the zoning commission order. AAMC lawyers are monitoring the situation.

Dr. Petersdorf summarized a visit with Assistant Secretary for Health, James Mason, MD and Deputy Assistant Secretary, Audrey Manley. He described the meeting as cordial and productive, and covered such topics as the searches for Director of the National Institutes of Health (NIH), head of the Center for Disease Control (CDC), and head of the Health Services Research Administration (HRSA). Other subjects discussed were the animal issue, human fetal tissue transplantation, and NIH reprogramming requests for research training.

Additionally, he provided an update on the AAMC's challenge to the New York State testing legislation on which a hearing is expected in September. A new piece of testing legislation has been enacted which the AAMC will oppose. Lastly, the issue of the AAMC's positions on broad public policy issues was discussed. The AAMC has traditionally abstained from taking positions on such issues.

B. LEGISLATIVE REPORT

Dr. Knapp gave an update on the legislative agenda (Attachment B), and discussed the markup worksheet for Medicare (C) being used by the House Ways and Means Health Subcommittee. He pointed out the absence of any reference to the direct medical education (DME) payment issue or the indirect medical education (IME) adjustment. This means these items are off the table and not being discussed by this Committee, ostensibly at Mr. Rostenkowski's (R-IL) urging. He urged that constituents write Messrs. Rostenkowski, Stark, and Gradison expressing appreciation for their support in keeping the indirect medical education adjustment at its current level. He explained that if the Congress did nothing, capital payments would go 100%. If they extend current law at 85%, that would save \$690 million. It appears that this will be the case. Using a 5.4% market basket projection, rates for rurals will equal 4.65%, large urban (cities larger than 1,000,000) will equal 4.15, and for small urbans will equal 3.65. This will save \$520 million. Dr. Knapp felt that the Part A markup was favorable from the hospital standpoint, but that some segments of the medical community are upset with the Part B set of recommendations. He felt that the Senate side would not be as aggressive with the physicians as the House has been. He suggested that now is the time to write to those Senators not contacted previously because they are not on the Finance Committee.

Dr. Knapp reported John Forsyth of the University of Michigan Hospital was scheduled to testify on the indirect medical education adjustment before the Senate Finance Committee, but the hearing was postponed in the face of activity surrounding the VA Supplemental Appropriations bill (HR 2402) and continued controversy over the Catastrophic Coverage Act. Dr. Knapp felt that though it was imperative to be on record, the outcome outweighed any hearing, and strong influence could be generated by individual contacts.

He then noted three initiatives that promise to be prominent in upcoming legislation. One includes the patient outcome assessment bills, S702 introduced by George Mitchell (D-ME) in the Senate, and HR1692 introduced under Willis Gradison (R-OH) and Fortney Stark (D-CA) in the House. Both bills focus on research to compare effectiveness of alternative treatments for particular illnesses. The AAMC is currently supportive of these proposals. Another is the Stark Ethics in Patient Referrals Act (HR939). This bill addresses conflicts of interest arising from physician ownership of facilities to which they make referrals. The American Medical Association is opposed to legislative control in this area; the AHA has attempted to create criteria for defining conflict of interest. The AAMC applauds the AHA's efforts and is working on the exception for "group practices" to be assured faculty practice plans can be accommodated. The third issue is the bill (HR 2207) introduced by Brian Donnelly (D-MA) making 501(c)(3) hospitals with disproportionate share adjustments below ten percent subject to a \$150 million limitation on outstanding bonds. Dr. Knapp did not believe that this proposal would affect many

COTH members, but the AAMC opposes this legislation on principle.

He warned of two areas he felt were potentially dangerous to the industry and deserved careful attention. Charges and reimbursement in the outpatient area need to be carefully monitored, particularly when Part B fees are to be reduced if the hospital has outpatient expenses included in its cost report. Additionally, he expressed concern about the impact of HMOs in the Medicare arena, noting that when the 95% AAPCC payment per Medicare beneficiary is calculated, the direct medical education payment and the indirect medical education adjustment are figured in. There is currently much concern that these payments are remaining with the HMO and are not passed on to the hospital. Mr. Muilenburg noted the difficulties being encountered with Group Health Cooperative in Seattle and pointed out that the IME is in fact a severity adjustment that should be passed on to the hospitals. Dr. Henikoff provided an extreme example of a potential situation where DRGs are not considered a major hospital reimbursement issue in Minneapolis, MN because 90% percent of the Medicare patients in that area are enrolled in HMOs. Dr. Grossman stressed the need for the AAMC to set up a policy dialogue with representatives from the HMO industry.

C. CHAIRMAN'S REPORT

Mr. Gambuti reported on a meeting of the AAMC Committee on Governance and Structure the previous day. Mr. Colloton is chair of that committee which is charged to look at the total structure and governance of the Association. The committee is currently looking at 12 specific and very inclusive items ranging from housestaff participation in the AAMC to the actual name of the organization. The original goal was to complete this process in 1989, but that goal will not be realized. The revised goal is the Assembly Meeting at the 1990 AAMC Annual Meeting. In an attempt to be as thorough in its considerations as possible, the committee is scheduled to meet with the Administrative Boards, both jointly and individually, in September. A schedule of these meetings and appropriate materials will accompany the September Administrative Board agendas. Any written responses to the committee materials will be appreciated. These materials will be presented once again at the business sessions of the administrative boards at the upcoming 1989 AAMC Annual Meeting. A draft report will be compiled following the Annual Meeting. Mr. Gambuti encouraged board members to read the committee meeting materials carefully and give the committee any possible assistance.

He then noted recent AAMC/COTH committee appointments, included in these minutes as Attachment D. These committees include the 1989 COTH Nominating Committee, The Advisory Committee on Medicare Regulations for Payment of Physicians in Teaching Hospitals, the Steering Committee on Rural Health, the ad hoc Committee on Misconduct and Conflict of Interest in Research, and a planning committee for hospital CEO Management Education Programs. The latter committee attempted to evaluate reinstating and upgrading a series of programs created in the 1970s designed to provide

hospital CEOs with an opportunity to improve their managerial skills. The committee has tasked staff to investigate a program that would deal with operating efficiency in the hospital. The agenda might deal with shared services, restructuring, and downsizing in the face of low overall profit margins and impending legislative cutbacks. Dr. Bentley asked for suggestions for speakers to address such a program.

D. STAFF REPORT

Dr. Bentley referenced his letter to Mr. Thomas Gentile of the Association of Hospital Medical Educators (AHME) that appeared in the June COTH Administrative Board Agenda. This letter was generated in response to that organization's concern that the AAMC focuses its resources on the academic medical center and that the community hospital receives little specific support. This concern was strengthened by the Association's testimony on the IME adjustment before the House Ways and Means Subcommittee on Health. The testimony used data accumulated by Linda Fishman from the AAMC Academic Medical Center Survey under The Commonwealth Fund grant. Dr. Bentley's letter explains the important role of community teaching hospitals in the Association and the services they receive. His letter was presented at AHME's recent national annual meeting.

A brief summary of the reaction to the dues increase followed. Dr. Bentley noted that to date two member have officially dropped in response to this increase. He encouraged board members to assist the Association in explaining the dues increase to members they encounter who question the increase.

III. ACTION ITEMS

A. MINUTES

ACTION: It was moved, seconded, and carried to unanimously approve the minutes from the February 23, 1989 COTH Administrative Board Meeting in full.

B. COTH SPRING MEETING

Mr. Gambuti opened the floor for a general discussion, reminding the board that the 1989 COTH Spring Meeting agenda was approved by the administrative board without the process of a planning committee. He noted that the 1989 meeting was the first time this meeting had taken place in a resort-type setting, and the first time that the program had provided for a scheduled amount of free time for the registrants.

He asked Dr. Bentley to review the statistics from the meeting. Dr. Bentley noted that attendance dropped predictably due to the west coast setting, noting that individuals on the

west coast are more willing to travel east than those on the east coast are willing to travel west. The fact that the majority of COTH constituents are in the northeast makes attendance at a west coast meeting traditionally lower than those held east of the Rocky Mountains. He noted that staff was reluctant to place the meeting in the west too often for this very reason, but that he did not feel it was possible to gauge the impact of the new format on attendance from this particular meeting. Response from the individuals that did attend was generally very positive.

Dr. Schultze was impressed with the high attendance at the Saturday morning session. Mr. Gambuti noted that though he did receive some comments that the meeting was too long, he felt the discussion groups were very successful and the majority of comments he received were also positive. It was suggested that COTH was more reluctant to be away from the office the extra day provided by the new format than perhaps other councils. Additionally, it is important to realize COTH is not COD, and their respective meetings serve a different function for each group. Dr. Henikoff acknowledged that the socialization process so evident with the Deans does not exist with COTH, but felt providing the opportunity for the process is still important. Mr. Gambuti summarized that the resort setting was still desirable for future meetings providing it was convenient to an airport and not perceived as a luxury site, that the afternoon free time was still generally perceived as a worthwhile component in the agenda, that the discussion groups were received positively, and that the Wednesday-Saturday timeframe was still desirable. The orientation session was also perceived as a good option for the first day.

Melissa Wubbold was called on to discuss future Spring Meetings sites, and following discussion of the Site Suggestions listed in the Administrative Board agenda, general consensus supported investigation of the Broadmoor Hotel in Colorado Springs, and an appropriate meeting site in Charleston, South Carolina for the 1991 and 1992 meetings. The 1990 COTH Spring Meeting will be held at the Lafayette Hotel in Boston.

Content of the 1990 program was discussed; Mr. Gambuti reminded the group of the drawbacks to planning a program too far in advance, and that the Administrative Board was now operating as the planning committee in an attempt to ensure more timely issues. Dr. Bentley noted that the Board breakfast at the 1989 Annual Meeting would spend time addressing this subject in October. Patient outcome assessment, physician utilization of resources, and effectiveness research were considered topics of interest.

Mr. Muilenburg felt the leadership in this area will come from the medical school faculties, and that it would be wise to include COD in relative discussions. Dr. Henikoff noted that in his experience the leadership to date has been from administration and though the physicians have been welcome participants, they not would have initiated the effort. Dr. Schultze suggested COTH should take the lead in pursuing the issue and bring the other councils in.

ACTION: It was moved, seconded, and carried to approve staff investigating the Broadmoor Hotel in Colorado Springs for the 1991 COTH SPRING MEETING, and an appropriate site in the city of Charleston, South Carolina for the 1992 meeting. It was further agreed that discussion of the program for the 1990 Spring Meeting would be continued at the upcoming AAMC Annual Meeting.

C. SEPTEMBER ADMINISTRATIVE BOARD MEETING SPEAKER

ACTION: It was moved, seconded, and carried to approve Mr. Richard Averill of Health Systems International (HSI), New Haven as breakfast speaker at the September Administrative Board meeting. Mr. Averill will address the proposed expansion and revision of the Medicare DRG classification system.

D. AAMC POSITIONS ON PUBLIC POLICY ISSUES

The AAMC has traditionally refrained from taking an official stance in most public policy issues that do not deal directly with academic medicine. As a result of urging from certain groups in the AAMC membership, the question of whether the Association should maintain that policy is being evaluated.

Following discussion, the Board agreed that though there are important social and policy issues that the AAMC does not address, the majority of them are being followed by other organizations and deviation from the current Association policy would dissipate the energies of the staff and membership. No action was taken at this time.

III. INFORMATION ITEMS

A. AAU REPORT ON INDIRECT COSTS

Dr. John Sherman joined the group to discuss the Association of American Universities (AAU) draft paper that accompanied the Board agendas, "Indirect Costs Associated with Federal Support of Research on University Campuses: Some Suggestions for Change." Mr. Gambuti opened the discussion by saying it was one of the best reports on this subject he has read, and recommended wider distribution in the near future.

Dr. Sherman noted that the subject of indirect costs is a long standing issue and one that continues to be a significantly divisive concern, pitting university factions against each other and against the federal government. Recognizing its charter, the AAU has been especially active in attempting to seek solutions to the problem; their latest approach being to establish a study committee under the leadership of Dr. Cornelius Pings of USC. Their findings are reflected in this draft paper.

It is recommended that this paper be used by AAMC constituents in discussing the subject of indirect costs within their environment. Dr. Sherman cautioned, however, that the nature of the revenue streams involving academic medical centers may well differ in some respects from those of the other parts of the university system, and therefore special attention needs to be devoted to being certain that if those differences are substantial, or otherwise important, due recognition ought to be made in any changes that are suggested or implemented.

He noted that in response to what is perceived as the basic problem, long-term needs of academic research being underfunded with serious long-term consequences, the committee has made twelve recommendations. They ask that these recommendations be considered as a package. A discussion of the recommendations, beginning on page 43 of the draft report, ensued. In response to the first two recommendations on facilities and equipment rates, Mr. Schwartz believed that the increase in basic sciences that is going on across the country has resulted in many new facilities and universities are nervous about paying for them. The question of how funds will flow to finance these settings, whether at the university level or down at the school level, is very big.

Dr. Sherman noted that Dr. Pings had indicated in his address to the CAS/COD on the subject, that the most contentious part of dealing with the faculty in establishing the rates are those areas in which a joint product situation is involved, where some negotiation is almost certainly probable in the eventual establishment of that part of the overhead rate. Between the criticism by the faculty and the uncertainties of the negotiation in the establishment of the rate by the federal (audit) agency, it was the sense of the committee that such a serious component of the indirect cost rate probably ought to be put on the table as a compromise with some threshold value accepted by both parties rather than attempting to continue this refinement of those allocations in a fashion that never has proved satisfactory. On the other hand, those components of the rate have remained relatively stable it turns out over the past several years, and so it would seem that both parties could probably accept some arbitrary establishment of that part of the rate without doing much harm to the financial consequences of either the funding agency the research intensive institution.

Quite different was their sense of the facility part of the overhead rate, and this is why they finally decided to recommend a split rate. Those costs in contrast to the other elements of the administrative part were probably amenable to very clear documentation and justification.

Mr. Schwartz's concern was for those institutions owned by universities. He noted that if the facilities part of the equation was to be preserved, the administrative part would have to come down. As a result, administrative overhead within the university will go up to recover that cost. He believed that hospitals and other units in institutions where medical research is a large part of the total university package will suffer. Dr. Grossman noted for

those medical centers doing their own research, the blended total rate is a major problem. Dr. Buchanan noted that hospitals should be aware that with the growth of industrial support of research, the failure to get full overhead on those contracts/agreements puts hospitals in a very vulnerable spot with the federal government. When the amount of unrecovered overhead was very small, it was largely on training grants and foundation supported activities. Most of the companies with whom hospitals are now discussing research provisions are talking about big money for direct expense support of research but are not willing to talk about the kinds of overhead rates that most COTH institutions have. By not overcoming this psychological set, hospitals are leaving themselves open for criticism from the federal government. " Why should they pay full rate when we are willing to bargain for less from others?" Dr. Grossman expressed concern that this needs to be linked at some point with the more general issue of the amount of dollars being used to support research has diminished significantly as a percentage of the total healthcare pie over the last years. Dr. Bentley recommended caution on this subject; though research dollars have not increased as much as the service side, in fact the total number of real dollars for research actually increased during the Reagan administration.

The Board agreed with both staff recommendations as put forth on page 23 of the AAMC Executive Council agenda. Dr. Sherman noted that both the COD and CAS agreed with Mr. Gambuti's initial observation that the document should receive a wider distribution outside the AAU such as to AAMC constituents and federal offices. Dr. Buchanan cautioned that this subject deserves careful, balanced, and full discussion; the AAMC should carefully evaluate the subject matter and provide the AAU with the benefit of comments and recommendations.

B. A SINGLE EXAMINATION FOR MEDICAL LICENSURE

Mr. Gambuti introduced Dr. Donald Kassebaum, former hospital director at University of Oregon, former dean at Oklahoma University College of Medicine, and presently co-secretary of the Liaison Committee on Medical Education (LCME) at the AAMC. Dr. Kassebaum noted that the issue of the single examination for medical licensure will be considered in the fall at the September Board meetings, and gave a brief history of the process. The task force to study pathways for licensure began in early 1988 as an initiative by the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB), both of which were concerned by state overtures, particularly in New York, to one way or another establish a single pathway to licensure. This was of particular concern as medical licensure falls under state purview and several states were critical of what they perceived to be a nonstandard process for licensure. The above organizations empowered the task force to investigate the single pathway in the hopes of capturing the best of the existing systems, which are perceived by the medical community to be working fairly well.

A number of concerns have been expressed about the proposal; i.e., coopting the national

board examinations, intrusion of a licensure examination by state authorities into medical schools, devaluation of LCME accreditation, and degradation of quality of practice. There are, however, the checks and balances imposed by the NBME, FSMB, and the ECFMG in their review and approval system. This governance is not likely to change in the near future considering the many parties involved, and would probably only do so to satisfy all interested parties.

Dr. Buchanan, as a former chair of the LCME, noted that this is a sticky issue, cautioning that LCME approval continues to be needed for a variety of legal purposes and expressed his hope they will remain intact. He stated he believed the basic quality of medical education in this country is head-and-shoulders over medical education in many of the countries from which individuals will come seeking entrance into the mainstream of medicine in this country.

C. CONFLICT OF INTEREST IN RESEARCH

D. ANIMAL AND PLANT HEALTH INSPECTION SERVICE (APHIS)
PROPOSED ANIMAL WELFARE REGULATIONS

The Administrative Board acknowledged the importance and relevancy of these two issues to their institutions, and agreed to defer to the COD and CAS on these agenda items.

IV. ADJOURNMENT

A brief discussion ensued on the recycling of medical equipment that is still functional but no longer state of the art, and being replaced, to less economically developed nations. Dr. Grossman noted that New England Medical Center, Inc. did have avenues for recycling equipment as permitted by logistics. He pointed out that the cost of transportation and the inability by the recipients to maintain the equipment were major hindrances to this process. Mr. Muilenburg noted that the University of Washington had direct relationships with individuals practicing in a foreign country, and that the University had contributed to setting up dialysis capability in Yugoslavia. He expressed hope that the logistical difficulties would not inhibit institutions from contributing equipment and that a program based at the University of Alabama was involved in making this sort of transfer less difficult.

Mr. Gambuti adjourned the meeting at 12:30p.

COMPARISON OF KEY INDICATORS VA VERSUS COMMUNITY HEALTH SYSTEMS

June 15, 1989

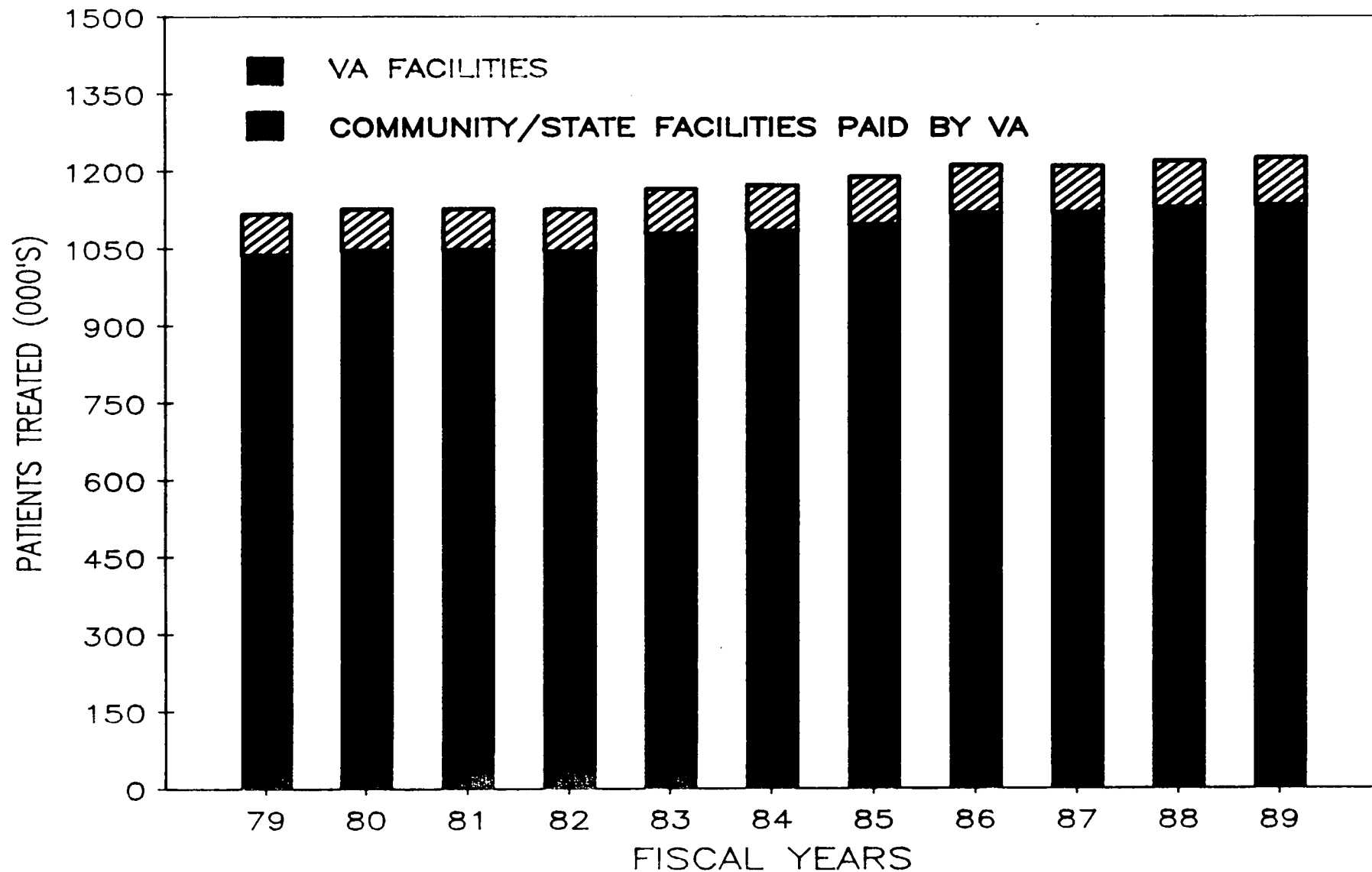
VA AND COMMUNITY HEALTH SYSTEMS
 COMPARATIVE DIMENSIONS (1987)
 (INCLUDES HOSPITAL CARE AND
 OUTPATIENT CARE ONLY)

37

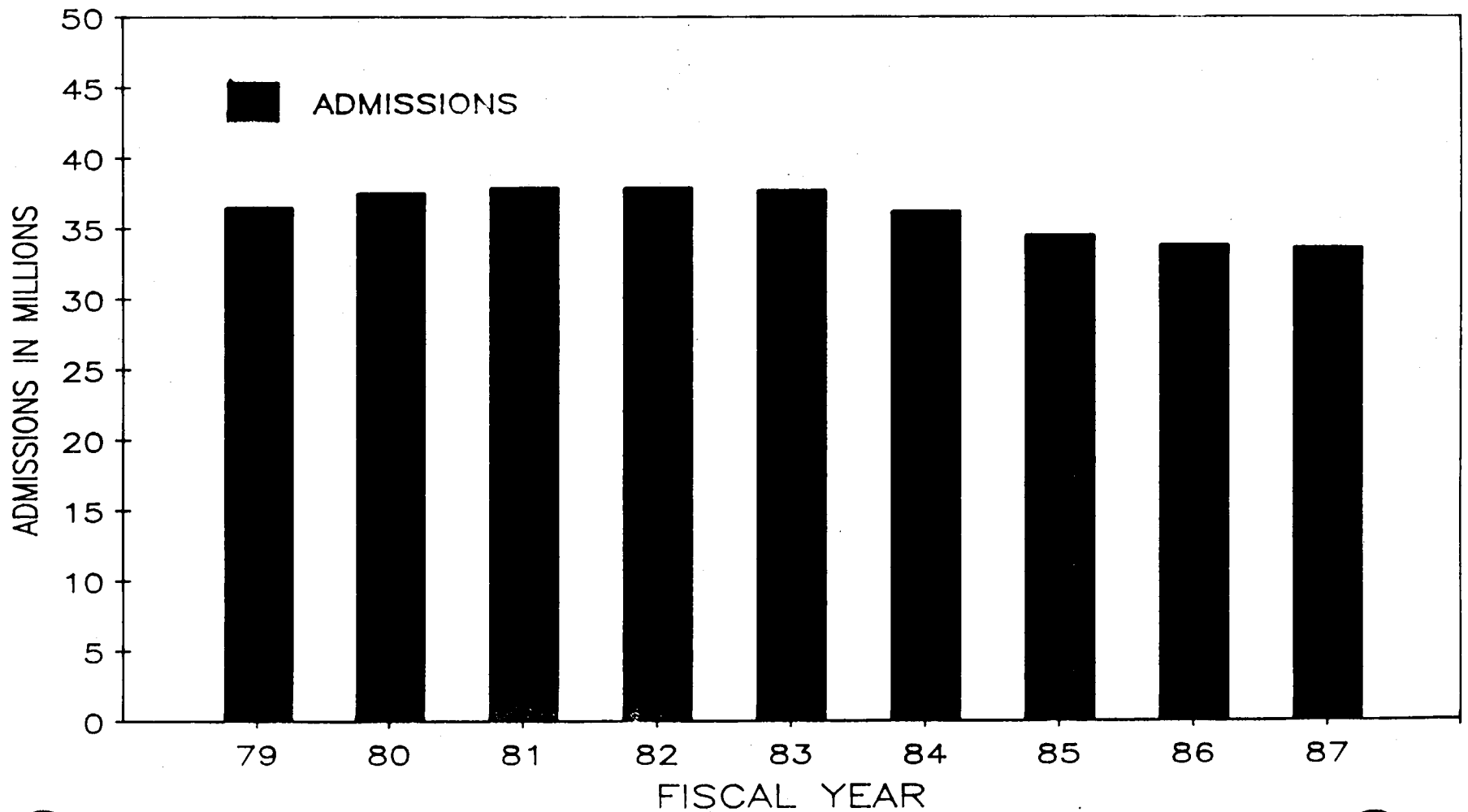
- NUMBER HOSPITALS
- HOSPITAL PATIENTS
TREATED
- OUTPATIENT VISITS
- TOTAL COSTS

VA	COMMUNITY
172	5,678
1.1 MILLION	33.6 MILLION
219 MILLION	278.9 MILLION
BILLION	161.3 BILLION

VA INPATIENTS TREATED FY 1979 THROUGH FY 1989

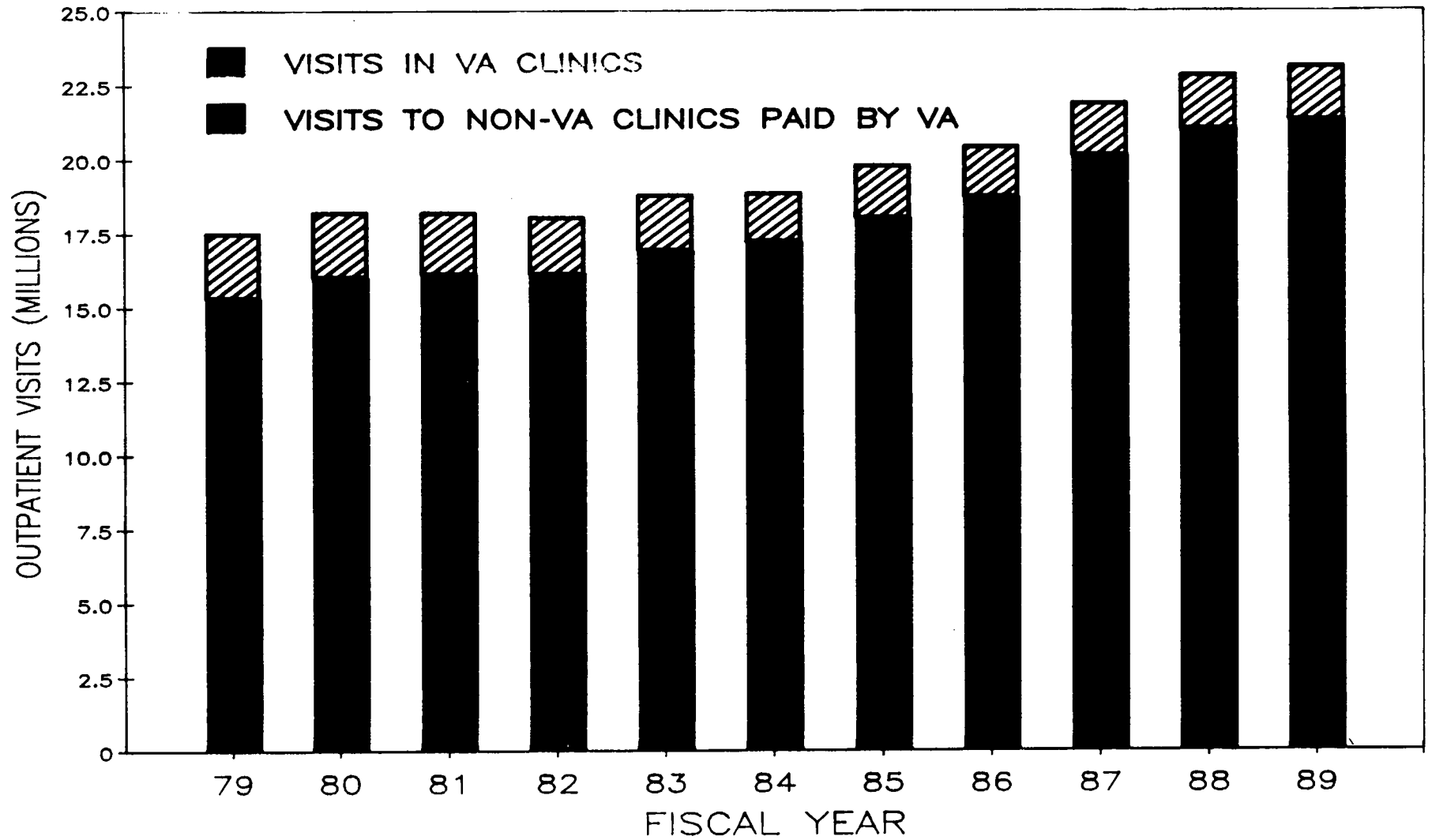


COMMUNITY HOSPITALS
FY 79 THROUGH FY 87
DATA FROM AMERICAN HOSPITAL ASSOCIATION
ADMISSIONS



VA OUTPATIENT VISITS FY 79 THROUGH FY 89 INCLUDES ONE-DAY DIALYSIS

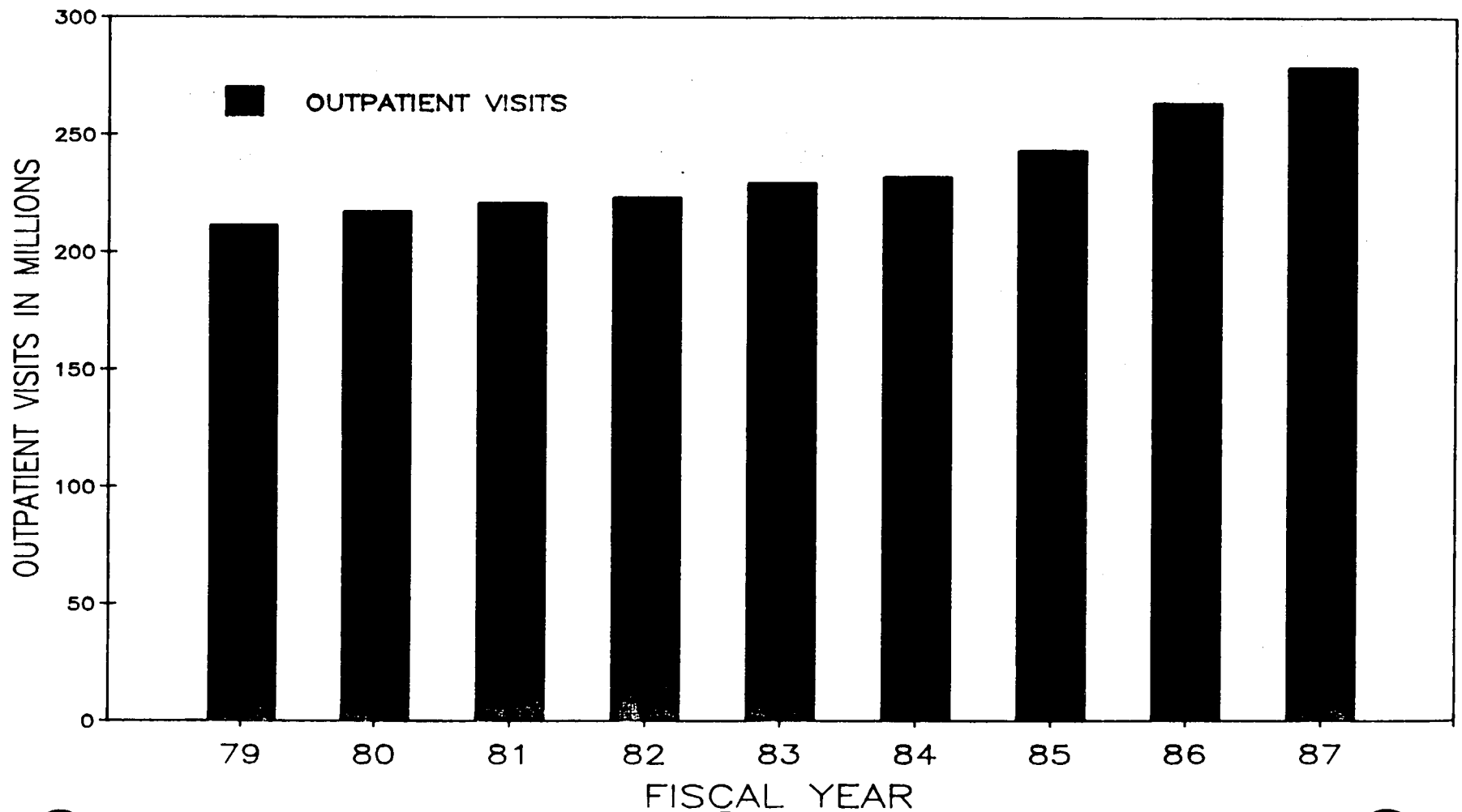
04



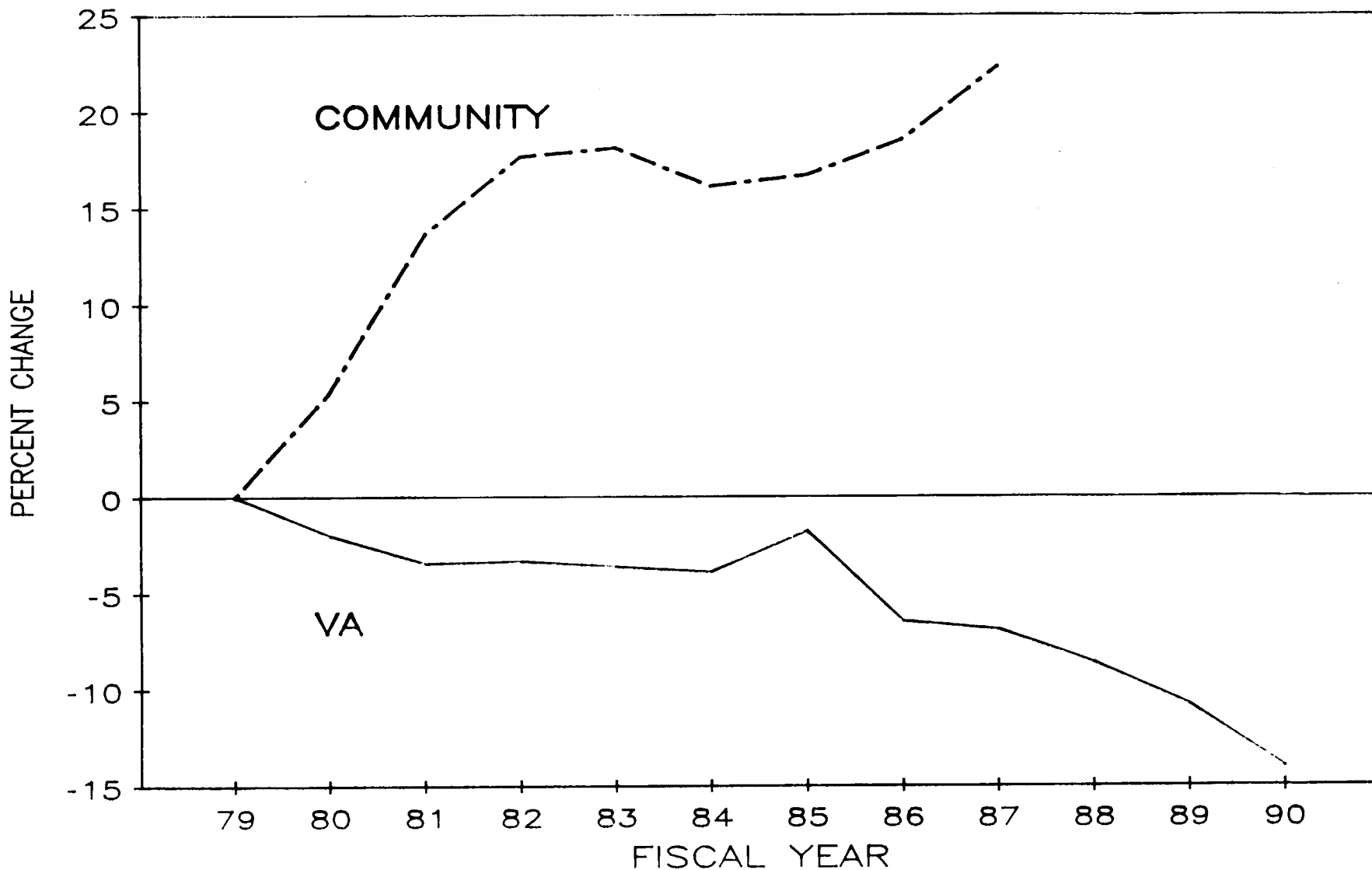
FY 88 & 89 ARE ESTIMATED

COMMUNITY HOSPITALS FY 79 THROUGH FY 87 DATA FROM AMERICAN HOSPITAL ASSOCIATION OUTPATIENT VISITS

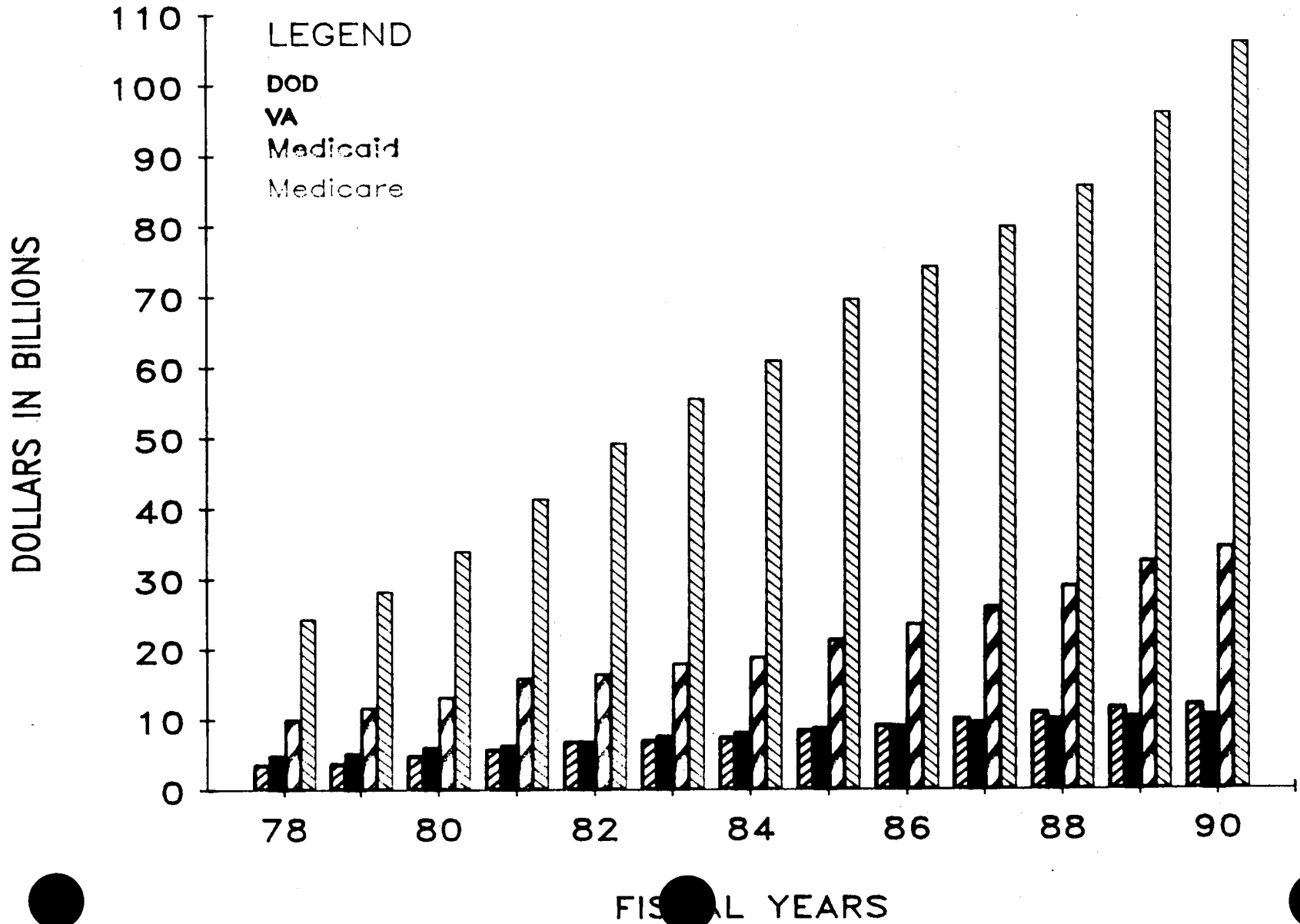
41



VA VS. COMMUNITY HOSPITAL TOTAL COSTS CUMULATIVE PERCENT CHANGE ADJUSTED FOR MEDICAL CPI



FEDERAL MEDICAL EXPENDITURES



LEGISLATION

HIGHLIGHTS: Senate began consideration of H.R. 2072, the FY 1989 emergency supplemental.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
FY 90 Budget Resolution H.Con.Res. 106 (DM)	House passed conference report 5/17 by 241-185 vote.	Senate passed conference report 5/18 by 63-37 vote.	Conferees announced agreement 5/11. Calls for \$2.3 billion in Medicare savings, 7% increase in discretionary health budget authority.
FY 1989 Emergency Supplemental H.R. 2072 (DM)	Appropriations Cmte. reported as amended, 4/18. House returned proposal to full committee 4/26, because of overall cost. House passed 5/24, after agreeing to reduce total appropriation to \$3.7 billion.	Appropriations Cmte. reported with amendments 5/31. Senate began consideration 6/1.	House version provides \$343 million for VA medical care, \$892 million to cover GSL defaults and \$822 million to combat drugs. Senate bill has no anti-drug funds. VA funding also split off as separate bill (H.R. 2402). (See below)
FY 89 VA Supplemental H.R. 2402 (LG)	Full House approved 5/18, providing \$340 million for medical care. 5/22--House rejected Senate proposal to authorize funds only through 6/15; approved instead a measure providing \$340 million through the end of FY-89.	Full Senate approved \$340 million on 5/18. Must be reauthorized before 6/15. <u>Senate re-approved VA funding as part of larger measure on 6/7.</u>	Administration requested \$304 million for medical care.
FY 90 VA Budget	Kenneth Shine, M.D. Dean of UCLA testified on the proposed VA Budget before the House VA Cmte. Richard Behrman, M.D., Dean at Case Western School of Medicine, testified 5/2 on behalf of AAMC before VA-HUD-IA Subcmte.	VA Cmte. sent recommendation to Budget Cmte. on 2/22. Deans testified at Veterans' Affairs Cmte. hearing 3/6. VA Cmte sent recommendation to Budget Cmte. on 3/8. John Dennis, M.D., Dean of U. of Maryland School of Medicine, testified at VA-HUD-IA Subcmte. hearing on 5/19.	House and Senate VA Cmtes. requested \$1.3 billion over the Administration's FY-90 proposed budget for all medical programs.
FY 90 HHS Appropriations (DM)	Aram Chobanian, M.D., Dean, Boston U. Sch. of Med., testified 5/3 on behalf of AAMC before Labor-HHS-Education Subcmte. Subcmte. hearings completed 5/4.	Kay Clawson, M.D., Executive Vice Chancellor, U. of Kansas Med. Ctr., testified 5/4 on behalf of AAMC before Labor-HHS-Education Subcmte. Subcmte. hearings completed 5/12.	AAMC supported recommendations of Ad Hoc Group for Medical Research Funding for NIH (\$8.416 billion) and ADAMHA research and research training (\$933 million) and increased funding for PHSA Title VII health manpower and student financial assistance programs.
Reprogramming of \$29 million in FY 89 Title VII funds (SC)			As part of the FY 90 budget proposal, DHHS proposed reprogramming \$29 million in FY 89 Title VII program funds to be transferred to cover HEAL defaults. DHHS has reconsidered the need for the \$29 million & does not intend to request the reprogramming.
FY 90 NSF Appropriations (DM)	VA-HUD-IA Appropriations Subcmte. held hearing 3/15.	VA-HUD-IA Appropriations Subcmte. held hearing 4/3.	
Medicare (CC)	<u>H.R. 2483 introduced 5/24 by Rep. Mazzoli (Ways & Means; Energy & Commerce).</u>		<u>Provides establishment of bipartisan Medicare Financing and Benefit Review Commission to study and make recommendations concerning financial solvency and benefit structure of the Medicare program.</u>

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
Hospitals Payments (CC)			House Ways & Means conducted hearing 5/19 to address problems of inner city and rural hospitals.
PPS Payments (CC)	H. Con. Res. 40 introduced 1/31 by Reps. Johnson, Oberstar, and Boxer (Ways & Means). "Resolution to Protect Medicare" companion to Senate resolution.	S. Con. Res. 10 introduced 1/31 by Sens. Simon, Kassebaum and Durenberger (Finance). Companion to House resolution.	Resolution to fund Medicare payments to hospitals at current law levels. Payment rates would fully reflect increases in costs of goods and services. 40 Senators and 229 Congressmen have cosponsored the companion resolutions.
	H.R. 1110 introduced 2/23 by Rep. Skelton (Ways & Means).		Would pay hospitals a blended rate (hospital-specific and national) relative to variation in costs within DRGs.
	H.R. 1026 introduced by Rep. Downey (Ways & Means).		Would maintain current distribution of day/cost outliers for hospital payment for 3 years.
	H.R. 130 introduced 1/4 by Rep. Collins (Ways & Means).		Would provide emergency financial assistance to Medicare hospitals.
	H.R. 1610 introduced 3/23 by Rep. Gilman (Ways & Means).		Would require annual updating of hospital area wage index factor to reflect the most current data, beginning FY-90.
	H.R. 2048 introduced 4/18 by Rep. Machtley (Ways & Means).		Would require HHS to use most current data available in updating the hospital wage level adjustment factor.
	H.R. 2207 introduced 5/3 by Rep. Donnelly (Ways & Means).		Would amend the internal revenue code to require that hospitals which provide insufficient service to low-income individuals will be subject to the \$150,000,000 limitation on outstanding bonds, which applies generally to section 501(c)(3) organizations.
	H.Con.Res. 125 introduced 5/16 by Rep. Fallon (Ways & Means).	S.Con.Res. 37 introduced 5/16 by Sen. Harkin (Finance).	To express sense of Congress that the differential in Medicare payments to urban and rural hospitals should be eliminated.
Capital (CC)	H.R. 712 introduced 2/2 by Rep. Stark (Ways & Means). Hearing conducted 3/13 by Ways & Means.		Would require states establish capital expenditure review plans. Review would apply to all capital expenditures over \$1 million.
	H.R. 1812 introduced 4/12 by Rep. Donnelly (Ways & Means).		Would extend current capital payment level of cost minus 15% through 1992, and provide further reductions in capital payments for low-occupancy hospitals. Would exempt hospitals serving a heavily disproportionate share of indigent patients from reductions related to low-occupancy.
Patient Dumping (CC)	H.R. 821 introduced 2/2 by Rep. Stark (Ways & Means). "Medicare Hospital Patient Protection Amendment."		Would protect against improper transfer for economic reasons.
"Hospital Indigent Care Assistance Act (CC)	H.R. 754 introduced 1/31 by Rep. Stark (Ways & Means; Energy & Commerce).		Would impose an excise tax on employer's cost of providing medical benefits to employees for support of indigent care.

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<u>ISSUE</u>	<u>HOUSE STATUS</u>	<u>SENATE STATUS</u>	<u>COMMENTS</u>
Medical Education (CC)	H.R. 2093 introduced 4/25 by Rep. Pepper (Ways & Means; Energy & Commerce).		Would require institutions to have residency training and fellowship programs in geriatric medicine as a condition for payment of direct medical education costs under Medicare.
Medical Outcome Research (CC)	H.R. 1692 introduced 4/5 by Rep. Gradison (Ways & Means). Hearing conducted 5/24 by Ways & Means.	S. 702 introduced 4/5 by Sen. Mitchell (Finance).	Would fund research to compare the effectiveness of alternative treatments for particular ailments. Senate bill would authorize \$239 million (55% Medicare funds) over 3 years; House bill would authorize \$847 million over 5 years (2/3 Medicare).
PRO Review (CC)	H.R. 2141 introduced 4/27 by Rep. Hammerschmidt (Ways & Means; Energy & Commerce).		Would grant providers and practitioners the right to reconsideration of a payment denial by a peer review organization (PRO) before the PRO notifies the Medicare beneficiary of the denial.
Physician Payments (CC)	H.R. 1271 introduced 3/2 by Rep. Slattery (Ways & Means)	S. 188 introduced 1/25 by Sen. Symms (Finance).	Would eliminate caps on physician fees.
	H.Con.Res. 83 introduced 3/23 by Rep. Slattery (Education & Labor).	S.Con.Res. 36 introduced 5/10 by Sen. Hatch (Finance).	Would eliminate increases in prevailing charge levels for certain physicians where such an increase would raise the prevailing charge level above the national median prevailing charge level for that service.
	H.Con.Res. 116 introduced 5/10 by Rep. Owens (Utah)(Ways & Means).		H.Con.Res. 83 and 116 and S.Con.Res. 36 express sense of the Congress regarding geographic variations in physician payments under Medicare.
	H.R. 1667 introduced 4/4 by Rep. Dan Glickman (Ways & Means; Energy & Commerce).		Would require adjustment of the conversion factors for anesthesia services under Medicare Part B.
	H.R. 1811 introduced 4/12 by Rep. Derrick (Ways & Means; Energy & Commerce).		Would repeal Medicare participating physician and maximum allowable charge programs (MAAC), and eliminate carrier requirements for physician to return payments for services not deemed reasonable and necessary.
	H.R. 2091 introduced 4/25 by Rep. Pepper (Ways & Means).		Would require an annual report by OTA on changes in payment amounts for certain surgical transplantation procedures.
"Ethics in Patient Referrals Act" (CC)	H.R. 939 introduced 2/10 by Rep. Stark (Ways & Means). Hearing conducted 3/2 by Ways & Means Subcommittees on Health and Oversight.		Providers of Medicare services would be prohibited from accepting referrals from physicians with an ownership interest or other compensation arrangement.
Mandatory Assignment (CC)	H.R. 155 introduced 1/3 by Rep. Donnelly (Ways & Means, Energy & Commerce).		Would require physicians to accept the assigned rate for Medicare reimbursement.
Physician Assistants (CC)	H.R. 1175 introduced 2/28 by Rep. Wyden (Ways & Means; Energy & Commerce).	S. 461 introduced 2/28 by Sen. Grassley (Finance).	Would permit Medicare payment for services of physician assistants outside institutional settings. H.R. 1175 and S. 461 are companion bills.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
Nursing (CC)		S. 115 introduced 1/25 by Sen. Inouye (Finance).	Would provide pediatric nurse practitioner or pediatric clinical nurse services under Medicare Part B, and would become a mandatory benefit under Medicaid.
	H.R. 143 introduced 1/4 by Rep. Collins (Ways & Means; Energy & Commerce).	S. 125 introduced 1/25 by Sen. Inouye (Finance).	Would provide for direct payment under Medicare for RN's as assistants in surgery.
		S. 126 introduced 1/25 by Sen. Inouye (Finance).	Would allow nurse practitioners or clinical specialists, in collaboration with a physician, to certify or recertify the need for certain services; would also provide for Medicare coverage of services by a nurse practitioner or clinical nurse specialist.
	H.R. 1140 introduced 2/28 by Rep. Roybal. "Nursing Shortage and Nurse Reimbursement Incentive Act" (Ways & Means; Energy & Commerce).		Extend coverage and reimbursement for nursing services under Medicare and Medicaid.
	H.R. 324 introduced 1/4 by Rep. Quillen (Ways & Means; Energy & Commerce).		Would permit direct payment to RNs under Medicare.
	H.R. 327 introduced by Rep. Quillen (Ways & Means; Energy & Commerce).		Would permit direct payment to LPNs under Medicare.
	H.R. 2032 introduced 4/18 by Rep. Donnelly (Ways & Means; Energy & Commerce).		Would provide payment under Medicare for demonstration programs for joint nursing undergraduate education programs. Would also expand definition of approved medical education activity.
Nursing Shortage (S)	H.R. 2111 introduced 4/26 by Rep. Ackerman (Energy & Commerce; Judiciary; Ways & Means).		H.R. 2111 would provide tuition assistance grants for nursing promotion in secondary schools; recruitment efforts in nontraditional sectors; nurse re-entry training; loan forgiveness for service in underserved areas.
Catastrophic Health Insurance (CC)	H.R. 169 introduced 1/4 by Rep. Fawell (Ways & Means; Energy & Commerce).	S. 43 introduced 1/25 by Sen. Reid (Finance).	H.R. 169, H.R. 332, H.R. 864, H.R. 697 & S. 43 would repeal Medicare Catastrophic Coverage Act.
	H.R. 332 introduced 1/3 by Rep. Ritter (Ways & Means; Energy & Commerce).		
	H.R. 697 introduced 1/25 by Rep. T. Luken (Ways & Means; Energy & Commerce).		
	H.R. 864 introduced 2/6 by Rep. McCandless (Ways & Means; Energy & Commerce).		
	H.R. 63 introduced 1/4 by Rep. Archer (Energy & Commerce; Ways & Means).	S. 335 introduced 2/2 by Rep. McCain (Finance). "Medicare Catastrophic Coverage Revision Act."	H.R. 63, H.R. 1564, S. 335, and S.1011 would delay for one year the effective dates of the supplemental premium and additional Part B benefits with the exception of the spousal impoverishment provision.
	H.R. 1564 introduced 3/22 by Rep. DeFazio (Ways & Means, Energy & Commerce). "Medicare Catastrophic Coverage Revision Act."	S.1011 introduced 5/17 by Sen. Exon (Finance).	

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ISSUE

HOUSE STATUS

SENATE STATUS

COMMENTS

S. 608 introduced 3/16 by Sen. Wallop (Finance).

Would require that catastrophic health coverage under Medicare Part B listed as a separate benefit and allow for separate election of the benefit.

H.R. 872 introduced 2/6 by Rep Sabo (Energy & Commerce) "Comprehensive Health Care Improvement Act."

Would establish state assistance program for coverage of catastrophic health care expenses.

H.R. 974 introduced 2/9 by Rep. Frank (Ways & Means; Energy & Commerce).

Would amend tax code and Title XVIII of the Soc. Sec. Act to finance increased benefits under the Medicare Catastrophic Coverage Act.

S. 445 introduced 2/23 by Sen. Nickles (Finance) "Catastrophic Coverage Delay Act."

Would delay Catastrophic Coverage Act for 2 years and establish a Commission to assess health care needs of the elderly.

S. 660 introduced 3/17 by Sen. DeConcini (Finance). "Medicare Catastrophic Coverage Refinancing Act".

Would repeal increase in Medicare Part B premium, and the supplemental premium. Would fund coverage by lifting cap on income for contribution to Social Security and Medicare trust funds, and through general revenues.

H.R. 1808 introduced 4/12 by Rep. Cardin (Ways & Means; Energy & Commerce).

Would increase excise taxes on tobacco and reduce Medicare supplementary premium under the Catastrophic Coverage Act.

H.R. 1809 introduced 4/12 by Rep Cardin (Ways & Means; Energy & Commerce).

Would permit certain disabled and spouses of government employees to elect not to receive Medicare Catastrophic coverage benefits.

H.R. 2055 introduced 4/18 by Rep. Rhodes (Way & Means; Energy & Commerce).

Would repeal Medicare Part B supplemental premium and certain benefits added by the Catastrophic legislation.

H.R. 2069 introduced 4/18 by Rep. Watkins (Ways & Means; Energy & Commerce).

Delay implementation of Catastrophic Coverage Act for 2 years.

S. 1038 introduced 5/18 by Sen. Roth (Finance).

Would repeal Medicare catastrophic coverage provisions effective after 1989 and repeal the supplemental premium.

National Health Insurance/
Minimum Health Benefits/
Mandatory Health Coverage (CC)

H.R. 16 introduced 1/3 by Rep. Dingell (Energy & Commerce).

Would create a national health insurance program to be financed by payroll deductions.

S. 494 introduced 3/2 by Sen. Durenberger (Finance).

Would increase amount and extend for 5 years the deduction of health insurance costs for self-employed individuals.

H.R. 1845 introduced 4/12 by Rep. Waxman (Energy & Commerce).

S. 768 introduced 4/12 by Sen. Kennedy (Labor & Human Resources). Hearing conducted 5/1.

Would require employer sponsored health insurance for all Americans. AAMC prepared "News Release" in support of the legislation.

H.R. 2218 introduced 5/3 by Rep. Pease (Ways & Means; Energy & Commerce).

Would make health insurance widely available to individuals, based on income and assets, under a competitive system.

H.R. 2500 introduced 5/25 by Rep. Dellums (Energy & Commerce; Armed Services; Banking; Education & Labor; Post Office; Veterans' Affairs; Ways & Means).

Would establish a U.S. Health Service to provide high quality comprehensive health care for all Americans and to overcome the deficiencies in the present system health care delivery.

Health Insurance Deduction (CC)

H.R. 1422 introduced 3/15 by Rep. Carr (Ways & Means).

H.R. 1422 and H.R. 1535 would allow income tax deduction of 100% of health insurance costs of self-employed individuals.

H.R. 1535 introduced 3/25 by Rep. McEwen (Ways & Means).

Would increase deduction allowable for health insurance costs of the self employed.

H.R. 1846 introduced 4/12 by Rep. Clay (Ways & Means).

Medicaid (CC)

H.R. 800 introduced 2/2 by Rep. Leland (Energy & Commerce).

S. 339 introduced 2/2 by Sen. Bradley (Finance). "Infant Mortality and Children's Health Act."

Would expand Medicaid services to pregnant women and infants to reduce infant mortality.

H.R. 833 introduced 2/2 by Rep. Waxman (Energy & Commerce).

Would improve basic access to health care for needy children under Medicaid program.

H.R. 751 introduced 1/31 by Rep. Stark (Ways & Means).

Would assure appropriate payment for inpatient hospital services under Medicaid.

S. 440 introduced 2/23 by Sen. Biden (Finance) "Health Care for Children Act."

Would extend Medicaid coverage to low-income children.

S. 614 introduced 3/16 by Sen. Paul Simon.

Would require states to make prompt payment for medical services under Medicaid.

H.R. 1568 introduced 3/22 by Rep. Kennelly (Energy & Commerce) "Infant & Mortality Prevention Act."

Would provide supplemental resources to enhance the delivery of health services to pregnant women and infants, through child health service block grants.

H.R. 1573 introduced 3/22 by Rep. Miller (of CA) (Energy & Commerce; Education & Labor).

Would improve and expand services for child health.

H.R. 1710 introduced 4/5 by Rep. Rowland (Energy & Commerce).

S. 708 introduced by Sen. Bradley (Sen. Finance).

H.R. 1710 and S. 708 would promote integration and coordination of services for pregnant women and infants to prevent infant mortality and morbidity.

H.R. 2216 introduced 5/3 by Rep. Michel (Energy & Commerce).

S. 902 introduced 5/3 by Sen. Dole (Finance).

H.R. 2216 and S. 902 would increase coverage for pregnant women and infants, and for childhood immunizations (companion bills).

S. 1053 introduced by Sen. Riegle (Finance).

Would provide supplemental resources to enhance the delivery of health services to pregnant women and infants.

H.R. 2505 introduced 5/25 by Rep. Panetta (Ways & Means; Energy & Commerce).

Would amend the Public Health Service Act; Medicaid; and the tax code with respect to preventative health programs.

Rural Health Care (CC) (See also "Deductibility of Student Loan Interest")

H.R. 762 introduced 2/2 by Rep. Pickle (Ways & Means). "Equity for Rural Hospitals Act."

S. 306 introduced 1/31 by Sens. Bentsen & Dole (Finance) "Equity for Rural Hospitals Act."

Would modify Medicare payments to hospitals by developing a single rate with adjustments. Would increase medical education demonstrations from 4 to 10. H.R. 762 and S. 306 are companion bills.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
	H.R. 1168 introduced 2/28 by Rep. Roberts (Ways & Means).	S. 10 introduced by Sen. Dole (Finance).	Would ensure that Medicare dependent small rural hospitals receive at least their reasonable costs for 3 years. S. 10 and H.R. 1168 companion bills.
	H.R. 804 introduced 2/2 by Rep. Michel (Ways & Means).	S. 205 introduced 1/25 by Sen. Symms (Finance).	H.R. 804, H.R. 880 & S. 205 would eliminate the payment differential between urban and rural hospitals.
	H.R. 880 introduced 2/7 by Rep. Craig (Ways & Means).	S. 227 introduced 1/25 by Sen. Moynihan (Finance).	Would exempt small rural hospitals from PPS.
		S. 366 introduced 2/7 by Sen. Baucus (Finance). "Rural Health Manpower Assistance Act."	Would make Medicare payment reforms to ensure the adequate provision of health care in rural areas.
	H.R. 1270 introduced 3/2 by Rep. Slattery (Ways & Means).		Would permit certain rural hospitals to elect to be paid on cost basis for inpatient care.
	H.R. 186 introduced by Rep. Gunderson (Ways & Means).		Would allow small rural hospitals to be paid on a reasonable cost basis.
		S. 735 introduced 4/10 by Sen. Daschle (Sen. Finance).	Would extend sole community hospital status to broader class of hospitals and increase payment rates to those hospitals.
		S.Res. 126 introduced 5/10 by Sen. Baucus (Finance).	To express sense of the Senate that PropAC does not equitably represent the proportion of Medicare beneficiaries in rural areas. Would add 4 commissioners with experience in rural health care delivery to correct the inequity.
Trauma Care (CC)	H.R. 436 introduced 1/4 by Rep. Bates (Energy & Commerce).	S. 15 introduced 1/25 by Sen. Cranston (Labor & Human Resources).	Aid to states for adopting trauma care plans set by American College of Surgeons and American College of Emergency Physicians. Would include employee guidelines with respect to infectious diseases.
	H.R. 753 introduced 1/31 by Rep. Stark (Ways & Means) "Medicare Trauma and Emergency Quality Assurance Act."		States would coordinate emergency medical services under statewide trauma and emergency care plans. Establishment of such plans would assure continued payment for Medicare trauma DRGs.
<u>Organ Transplants (CC)</u>	<u>H.R. 2490 introduced 5/24 by Rep. Walgren (Ways & Means; Energy & Commerce).</u>		<u>Would provide mechanism for taxpayers to designate any portion of any overpayment of income tax, and to contribute other amounts, for payment to the National Organ Transplant Fund.</u>
Fetal Tissue/ Tissue Transplantation Research (SC)	H.R. 1351 introduced 3/9 by Rep. Holloway & 26 cosponsors (Energy & Commerce).		H.R. 1351 would prohibit federal funding of all research that uses fetal tissue from induced abortions. Department's transplantation funding moratorium still in effect; NIH panel reports and DAC's recommendation to lift moratorium were forwarded to the ASH. NIH has released panel & DAC reports to the public. Final decision on moratorium still pending.

ISSUE HOUSE STATUS SENATE STATUS COMMENTS

Animal Welfare Protection Act (LG)	H.R. 425 introduced 1/3 by Rep. Roth (R-WI) (Agriculture).		Provides increased enforcement and stricter penalties for violations of the Animal Welfare Act.
Research Accounting for Use of Animals (LG)	On 1/19, Rep. Torricelli (D-NJ) re-introduced this legislation (H.R. 560) from the last Congress (Energy & Commerce).		
Animal Research Facility Protection (LG)		S. 727 introduced 4/7 by Sen. Heflin (D-AL)(Agriculture).	Makes theft, destruction, or unauthorized use of research animals, equipment, or data a federal crime.
Legal "Standing" for Animals	Introduced on 5/22 by Rep. Rose (D-NC) (Agricultural & Judiciary).		Would grant legal "standing" to an individual on behalf of an animal to compel enforcement of the Animal Welfare Act.
Consumer Products Testing (LG)	H.R. 1676 introduced 4/15 by Rep. Boxer (D-CA)(Energy & Commerce). 57 co-sponsors.	S. 891 introduced 5/2 by Sen. Reid (D-NV)(Commerce, Science & Transportation).Calls for elimination of Draize test, claiming "non-animal alternatives have been developed for other acute toxicity tests."	
Employee Benefit Non-discrimination Rules (LG)	H.R. 518 introduced 1/19 by Rep. Crane (R-IL) (Ways & Means).	S. 89 introduced 1/25 by Sen. Symms (R-ID) (Finance).	Would delay for 1 year implementation of Sec. 89.
	H.R. 634 introduced 1/24 by Rep. LaFalce (R-NY) (Ways & Means). 5/22--House refused to consider an amendment to repeal Section 89 during consideration of supplemental funding bill.	<u>6/6 Sen. Kasten (R-WI) proposed an amendment to the supplemental appropriations to repeal Sec. 89; Sen. Mitchell (D-ME) countered with an amendment suggesting that compliance with Sec. 89 be delayed for one year to give Congress an opportunity to revise the rules. Mitchell amendment passed unanimously.</u>	Would repeal application of Sec. 89.
	H.R. 692 introduced 1/27 by Rep. Henry (R-MI) (Ways & Means).		Would establish that the non-discrimination rules included in Tax Reform Act of 1986 would not take effect until the IRS issues appropriate guidelines and regs.
		S. 654 introduced 3/17 by Sen. Pryor (D-AR). Co-sponsors include 9 members of the Senate Finance Committee.	Designates as "Section 90" arrangements to simplify compliance with Sec. 89.
	H.R. 1864 introduced 4/13 by Rep. Rostenkowski (D-IL)(Ways & Means). This legislation to simplify Sec. 89 is co-sponsored by All Ways & Means Committee Democrats. Hearing held 5/2.	Hearing held 5/9.	

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ISSUEHOUSE STATUSSENATE STATUSCOMMENTS

Tax Free
Employer-
Provided
Insurance (LG)

H.R. 1165 introduced 2/28 by Rep. Pickett (D-VA). Would exclude from income employer-provided tuition assistance of \$5250 per year for undergraduates and \$1500 per year for graduate students.

S. 260 introduced on 1/25 by Sen. Moynihan (D-NY).

Would restore prior law regarding tax-free, employer-paid tuition benefits (Sec. 127 of the Tax Codes).

H.R. 2037 introduced 4/19 by Rep. Guarini (D-NJ)(Ways & Means).

Deductibility of
Student Loan
Interest (LG)

H.R. 747 introduced 1/31 by Rep. Schulze (R-PA). Over 270 co-sponsors.

S. 656 introduced 3/17 by Sen. Symms (R-ID).

Similar bills introduced by other House members.

H.R. 1588 introduced 3/23 by Rep. VanderJagt (R-MI) with 26 co-sponsors.

S. 840 introduced 4/19 by Sen. Boren (D-OK)(Finance).

Restores the deductibility of educational loan interest for health professionals who practice in medically underserved or health manpower shortage areas.

S. 954 introduced 5/10 by Sen. Pressler (R-SD) (Finance).

Would allow a tax deduction for principal and interest paid on a student loan by a physician who agrees to practice medicine for 2 years in a rural area.

S. 1060 introduced 5/18 by Sen. Pryor (D-AR)(Finance).

Would provide refundable income tax credits to primary health services providers who work in rural health manpower shortage areas.

H.R. 2522 introduced 5/31 by Rep. Smith (R-OR) (Energy & Commerce, Ways & Means)

National Health
Service Corps
(SC)

S. 959 introduced 5/10 by Sen. Daschle (D-SD)(Labor and Human Resources); one co-sponsor.

Restores the deductibility of student loan interest for family practice physicians in rural areas and provides a \$10,000 tax credit for each of 5 consecutive years for those who practice primary care in medically under-served areas.

Would require: preference to be given to medical students who are from health manpower shortage areas, are economically disadvantaged or minority, or are attending schools with rural training opportunities; improved communication with scholarship recipients and information dissemination about corps opportunities, needs, and requirements; allowances for Corps physicians to rotate to other facilities for continuing medical education or board certification requirements; loan repayment to provide a MINIMUM of \$20,000 per year of service; and, mandate a scholarship recruitment goal of 450 physicians.

Unrelated
Business Income
Tax (LG)

H.R. 2275 introduced 5/9 by Rep. Donnelly (D-MA)(Ways & Means).

Would classify as unrelated business income receipts tax-exempt organizations receive from affinity credit cards and sale of membership lists. Thus, tax-exempts would be taxed on revenue from such transactions.

Hospital Bonds
(LG)

H.R. 2207 introduced 5/3 by Rep. Donnelly (D-MA)(Ways & Means).

Would impose \$150 million limit on outstanding bonds to 501(c)(3) hospitals which provide "insufficient" service to low-income individuals.

Foreign Medical
Res Anti-
Termination
(SC)

H.R. 614 introduced 1/24 by Rep. Bates (Energy & Commerce).

S. 304 introduced 1/31 by Sen. Moynihan (Labor & Human Resources).

H.R. 614 and S. 304 prohibit different requirements in eligibility for residency, licensure, reimbursement, etc., and make HHS enforcer of federal licensure standards.

	H.R. 1134 introduced 2/27 by Rep. Solarz (Energy & Commerce).	S. 879 introduced 5/2 by Sen. Lieberman (Finance).	H.R. 1134 is narrower than H.R. 614. It applies only to reciprocity licensure policies and allows longer residency requirements for FMGs. Its enforcement mechanism threatens loss of Medicaid funding. S. 879 companion of H.R. 1134.
National Service Legislation (SC)	H.R. 660, introduced 1/27 by Rep. McCurdy (Education & Labor, Armed Services, and Veterans Affairs). Companion to S. 3.	S. 3 introduced 1/25 by Sen. Nunn (Labor & Human Resources).	As required by P.L. 100-607, GAO is investigating issue of discrimination in state licensure by reciprocity. Report due to Congress 8/4/89.
	H.R. 717 introduced 1/31 by Rep. Panetta (Education, Labor, and Interior & Insular Affairs).	S. 322 introduced 2/2 by Sen. Dodd (Labor & Human Resources). Companion to H.R. 717.	Legislative intent of all bills is to promote national and community service and provide educational opportunities in exchange. S. 3 & H.R. 660 would eventually replace current federal student aid program.
	H.R. 948 introduced 2/9 by Rep. Kennelly (Education & Labor, Armed Services, Veterans' Affairs).	S. 382 introduced 2/9 by Senator Graham (Labor & Human Resources).	Senate Labor Committee hearings held 3/9, 3/14, 3/20, and 4/21. House Education Subcommittees held joint hearings 3/15 and 4/19; strong opposition expressed at 4/19 hearing by members to idea of linking receipt of student aid to performance of service.
	H.R. 985 introduced 2/9 by Rep. Morella (Foreign Affairs).	S. 408 introduced 2/9 by Sen. Mikulski (Labor & Human Resources).	<u>House Education hearing scheduled for 6/28.</u>
	H.R. 1000 introduced 2/9 by Rep. Bonior (Education & Labor); Companion to S. 408.		Demonstration project; Would add educational benefits to Peace Corps program.
Stafford Student & Loan Defaults/ Restriction on Student Status Deferment (SC)	H.R. 2193 introduced 5/2 by Rep. Roukema (Education & Labor).	S. 539, 540, 541 introduced 3/9 by Sen. Bumpers (Labor & Human Resources).	Expands loan forgiveness for service in tax exempt organization of Peace Corps or VISTA.
		S. 576 introduced 3/15 by Sen. Pell (Labor & Human Resources).	\$3 million national service demonstration program.
		S. 650 introduced 3/17 by Sen. Kennedy (Labor & Human Resources).	\$100 million student community service program.
			H.R. 2193 targets schools with high default rates; includes lender risk sharing (5%) for loans made to students attending high default rate schools.

ISSUE	HOUSE STATUS	SENATE STATUS	COMMENTS
		S. 568 introduced 3/15 by Sen. Pell. Approved by full Senate 3/17.	S. 568 includes a provision restricting use of student deferments by medical residents and a 5% administrative fee on SLS loans. Senate Budget resolution assumes enactment of S. 568 as a way of saving \$70 million in outlays. House Postsecondary Education Subcmt. is not expected to introduce default legislation. Department of Education final default regulations issued June 5, 1989.
AIDS (DM)		S. 14 introduced 1/25 by Sen. Cranston (Labor & Human Resources).	Would assist eligible consortia in providing services to AIDS patients.
Federal Salary Increase (DM)	H.R. 1132 introduced 2/27 by Rep. Morella (Post Office & Civil Service).		Would provide salary increases for members of Senior Executive Service employees, including nearly 600 SES employees at HHS.
Nursing Research Facilities (DM)	H.R. 927 introduced 2/9 by Rep. Purcell and 26 co-sponsors (Energy & Commerce).		Would authorize \$5, 10 & 15 million in FYs 90, 91, 92, respectively, for grants to "acquire, construct, improve or repair" nursing research facilities. Requires 50/50 match of federal and non-federal funds. 15% set-aside for institutions with less than \$20 million in federal R&D in preceding 2 years.
Biological Warfare (DM)	H.R. 2371 introduced 5/16 by Rep. Owens (D-UT)(Energy & Commerce).		Would require all federal research, development, testing and evaluation of the medical aspects of the use of biological agents in the development of defenses against biological warfare to be conducted through NIH.
Disease	H.R. 979 introduced 2/9 by Rep. Hochbrueckner & 15 co-sponsors (Energy & Commerce).	S. 223 introduced 1/25 by Sen. Moynihan (Labor & Human Resources).	Would provide grants for research, treatment and public education.
Patient Confidentiality (DM)	H.R. 1206 introduced 3/1 by Rep. Lightfoot (Energy & Commerce).		Would prevent PHS from disclosing to Congress, without patient's consent, patient identifying information in records acquired or created by PHS.
FDA Recruitment (DM)	H.R. 1207 introduced 3/1 by Rep. Lightfoot (Energy & Commerce).		Would assist FDA in recruiting scientists and other health professionals.
FDA Revitalization Act (DM)		S. 845 introduced 4/19 by Sen. Hatch (R-UT) and 12 co-sponsors (Labor & Human Resources).	Would create a Senior Scientific Health Service within PHS; provide loan repayment for individuals joining FDA; and establish a \$500 million "funding floor" for FDA.
Transgenic Animal Patent Reform Act (DM)	H.R. 1556 introduced 3/22 by Rep. Kastenmeier (D-WI) (Judiciary).		Would recognize that the Patent Office has determined that genetically altered animals are patentable; would prohibit patents for humans; would define the scope of a patent on patented transgenic farm animals.
Transgenic Animal Regulatory Reform Act (DM)	H.R. 1557 introduced 3/22 by Rep. Kastenmeier (D-WI) (Agriculture and Science, Space & Technology).		Would provide a regulatory approach for the treatment of transgenic animals.

ISSUE

HOUSE STATUS

SENATE STATUS

COMMENTS

For more information, contact the AAMC Office of Governmental Relations. Individuals responsible for issues are indicated by initials following items.

CC = Catherine Cahill, 202-828-0526
SC = Sarah Carr, 202-828-0525

LG = Leslie Goode, 202-828-0526
DM = Dave Moore, 202-828-0525

REGULATION

IRS SECTION 89 NON-DISCRIMINATION RULES TRANSITIONAL RELIEF

The IRS issued a notice providing employers additional transitional relief until October 1, 1989 for complying with section 89. The Notice permits employers to use a partial testing year beginning on October 1, eliminates certain restriction with respect to the delayed partial testing year, and expands availability of the October 1 date to all statutory benefit plans.

5/5/89 - [Internal Revenue Bulletin 1989-24] [Notice 89-65]

Agency Contact: David Munroe or Nancy Marks (202) 535-3818

AAMC Contact: Leslie Goode (202) 828-0525

ANIMAL WELFARE ACT AMENDMENTS

The Department of Agriculture, Animal and Plant Health Inspection Service issued a proposed rule and request for comments on a portion of the Animal Welfare Act Amendments of 1985. The proposed regulations pertain to the interrelationship between Parts 1 and 3 of the Act. Specifically, USDA intends to update, clarify and expand the list of definitions in order to inform the public on the scope of the regulations and enforce them.

5/25/89 - [54 FR 10822] [9 CFR Parts 1,2,3]

Agency Contact: Dr. R. L. Crawford, USDA, Room 268, Federal Building,
6505 Belcrest Road, Hyattsville, MD 20782
(301) 436-7833

AAMC Contact: Leslie Goode (202) 828-0525

Deadline for comments: May 15, 1989 for parts 1 and 2; July 14 for part 3.

ESTABLISHMENT OF OFFICE OF SCIENTIFIC INTEGRITY

HHS amended its statement of Organization, Functions and Delegations of Authority to establish an Office of Scientific Integrity within the Office of the Director, NIH, to serve as the PHS focal point for coordinating scientific misconduct activities for intramural and extramural research programs, oversee scientific misconduct investigations of awardee institutions, investigate allegations of misconduct when necessary, and make recommendations to the Office of the Assistant Secretary for Health (OASH) regarding allegations of scientific misconduct. The OASH organizational statement is amended to establish an Office of Scientific Integrity Review, with responsibility for ensuring that PHS research agencies adequately carry out policies and procedures regarding allegations of scientific misconduct.

3/16/89 [54 FR 11080]

AAMC Contact: Allan Shipp (202) 828-0480.

GOLDEN PARACHUTE PAYMENTS

IRS issued proposed regulations relating to golden parachute payments. The regulations will provide guidance for complying with Section 280G of the IRS code of 1986.

4/5/89 [26 CFR Part 1][PS-217-84]

Agency Contacts: Stuart Wessler (202) 566-6016 or Robert Misner (202) 566-4752

AAMC Contact: Leslie Goode (202) 828-0525

Deadline for comments or request for public hearing: July 5, 1989

MINIMUM COVERAGE REQUIREMENTS OF CERTAIN BENEFIT PLANS

The IRS issued a notice of proposed rulemaking relating to the minimum coverage and participation requirements of Sections 410(b) and 401(a)(26) of the 1986 Internal Revenue Code. The regulations provide guidance to comply with the changes in the Tax Reform Act of 1986 as they affect sponsors of and participants in pension, profit-sharing, stock bonus, and certain other employee benefit plans.

5/18/89 [26 CFR Part 1] [RIN 1545-AK41]

Agency Contact: Nancy Marks (202) 343-6954

AAMC Contact: Leslie Goode (202) 8288-0525

Deadline for comments or request for public hearing: July 17, 1989

NATIONAL COMMISSIONS AND COUNCILS

Prospective Payment Review Commission (ProPAC)

ProPAC submitted its annual Report to Congress March 1. Although the reporting date required by statute is March 1, ProPAC requested additional reporting time for the technical supplement to the report. Therefore, recommendations for changes in Medicare's prospective payment system were conveyed to the appropriate Congressional committees March 31. The next meeting of ProPAC will be held June 13 and 14.

Physician Payment Review Commission (PPRC)

The annual Report to Congress was submitted April 30. Hearings to address PPRC's recommendations to Congress were held 3/17 before the Senate Finance Committee, and 3/21 before House Ways & Means. The PPRC is scheduled to meet October 26-27, and November 30 and December 1. Two new members have been appointed: Walter B. Maker of Chrysler and Gail R. Wilensky of Project HOPE. The three reappointed members are: Philip R. Lee, Jim Bob Brame, and Uwe E. Reinhardt. All five terms will end in 1992.

Prescription Drug Payment Review Commission

Appointments to the Commission have been made, but staffing for the Commission will not be complete until May. The meeting schedule has not yet been established. The first Report to Congress is due May 1, 1990.

Council on Graduate Medical Education (COGME)

Council is scheduled to meet November 2-3, 1989.

Bipartisan Commission on Comprehensive Health Care

A new Chairman has not yet been chosen to replace the late Rep. Pepper. Vice Chairman include: Rep. Gradison, Sen. Durenberger, and Sen. Buacus. Judith Fedder has been named staff director. Two reports were mandated by the Catastrophic Coverage legislation:

- o The Report on Comprehensive Long-Term Care Services for the Elderly and Disabled.
- o The Report on Comprehensive Health Care Services.

The reports will be combined and reported to Congress November 9, 1989.

Congressional Biomedical Ethics Advisory Committee

Although the Committee has scheduled meetings in May, July, September and November 1989, its set schedule is uncertain. A May meeting, originally set for May 15 and 16 in Washington, D.C., was cancelled because the Committee's fourteenth member has not been appointed.

W. J. ... 6/6/89
SUBCOMMITTEE FY 90 MEDICARE PROPOSAL

June 6, 1989

	FY 90	FY 91
PART A		
Capital at -15% in 1990	\$690 m	\$105 m
DRG creep/PropAC diff'tial	520	660
Innercity/rural hospitals		
Innercity hospitals		
Increase in disproportionate share payments including Pickle hospitals	+150	+195 p
Rural hospitals		
Additional update of +1.67%	+85	+105
Rural referral centers	+20	+35
EAC hospitals	0	+50
Hospice payment	+35	+50
TOTAL PART A	920	330

ALL FIGURES ARE PRELIMINARY CBO AND COMMITTEE STAFF ESTIMATES

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	FY 90	FY 91
PART B		
Overpriced procedures		
Reduce overpriced procedure by up to 15% using RB RVS effective 4/1/90	236	308
Reduce radiology and anesthesiology services by 8% effective 4/1/90	130	175
Reduce update from 5.3% to 2% and give primary care full MEI on 4/1/90	510	615
Three part physician payment package	0	0
Other physician		
New physician customary effective 4/1/90	25	150
Designated specialities effective 4/1/90	20	32
Physician ownership/referral	30	37
Hospital out-patient: capital at -15% in 1990	50	30
Durable medical equipment		
Limit rental agreements	20	30
Seat lift chairs	7	11
Reduce oxygen payment by 5%	35	55
Enteral equipment fee schedule	15	15
Reduce update to 2%	45	65
Clinical lab		
Cap fee schedule at 95% of natl median	55	85
Reduce update to 2%	40	60
Part B spending items		
Pay psychologists	+12	+22
CRNAs effective 4/1/90	+55	+100
Community Health Centers effective 4/1/90	+25	+100
Small blood labs	+5	+8
Mental health eliminate \$1,100 limit	+15	+37
TOTAL PART B	1,106	1,401

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	FY 90	FY 91
PART A and B		
Delay payments by 2 days	300	40
Secondary payer information from IRS	400	900
ESRD		
Limit method II payments to method I	80	140
Patient bill of rights		
Medical effectiveness/outcomes research	*	*
Part A and B spending items		
Religious orders effective 1/1/90	+12	+15
Long-term care demonstration	+5	+10
Innercity hospital demonstration	+3	+5
Disabled adult children	0	+5
Hospital dumping amendments	0	0
HMO physician incentive plans	0	0
TOTAL PART A and B	760	1,045
BENEFICIARIES		
Freeze basic Part B premium in CY 90	+310	+435
TOTAL BENEFICIARIES	+310	+435
OTHER		
State risk pools	0	0
Federal/State standard for private long-term care insurance	0	0
TOTAL	2,476	2,341

FY90-mrk

REDUCTIONS IN PAYMENTS FOR PHYSICIAN SERVICES

June 6, 1989

Proposal

1. Reduce payments for overpriced procedures
 - * Provides for reductions in the prevailing charges of procedures identified as overpriced using PhysPRC simulation of a resource based relative value scale (RB RVS).
 - Overpriced procedures are those procedures that on a national basis are more than 15% overpriced. List of overpriced procedures includes about 120 procedures.
 - * Reductions are achieved in a manner consistent with PhysPRC's recommendations for implementation of an RB RVS.
 - Procedures with fees that are more overpriced are reduced by greater percentages.
 - In areas with low prices, fees are reduced less than areas with high fees.
 - * Provides that the reductions are made such that:
 - Procedure that are more than 15% but not more than 30% overpriced are reduced half way to the RB RVS estimated fee.
 - Procedures more than 30% overpriced are reduced by a maximum of 15%.
 - Reductions are based on an RB RVS fee that is adjusted by a geographic cost of practice index (GPCI).
 - * Effective date: 4/1/90

2.. Reduce anesthesiology and radiology fee schedules

- * Provides for an 8% reduction in the conversion factor for the existing anesthesiology and radiology fee schedules.
- * Reductions to be made in a manner consistent with implementation of an RB RVS.
 - Provides that the Secretary estimate a national average anesthesiology and radiology conversion factors, reduced by 8% under the conversion factors that apply in 1989.
 - Provides that the Secretary apply a geographic cost of practice index to the overhead portion of the conversion factors to determine new local conversion factors.
 - Reductions in local conversion factors may not exceed 15%.
PP
- * Prevailing charges for radiology services that are not based on the radiology fee schedule are reduced to the local radiology fee schedule amounts.
- * Effective date: 4/1/90

3. Reduce MEI update

- * Annual update to customary and prevailing charge screens is delayed until 4/1/90.
 - 1989 participation agreements are extended through 3/31/90.
- * Provides that the MEI update for services other than primary care services is reduced to 2%.
 - Baseline = 5.3%
- * Update for primary care services is equal to the full MEI (5.3%).
 - Primary care services are defined as in OBRA of 1987.
- * Effective date: 4/1/90

Savings

	FY90	FY91
Reduce overprice procedures	\$236	\$308
Reduce anesthesiology and radiology fee schedules by 8%	\$130	\$175
Reduce MEI update to 2%, except for primary care services (4/1/90)	\$510	\$615
Total savings:	\$876	\$1,093

DURABLE MEDICAL EQUIPMENT PACKAGE

June 6, 1989

Proposal

1. Limit DME rental agreements.

- * Reduces payments for durable medical equipment under the DME rental fee schedule. The fee schedule is reduced such that monthly rental payments are based on:
 - 10% of the recognized purchase price (based on average submitted charges in the base period) for the first three months of rental (same as current law), and
 - 7.5% of the recognized purchase price for the 4th through 15th months of rental.
 - Maximum rental payments equal 120% of the recognized purchase price.
- * Effective date: 1/1/90

2. Seat lift chairs

- * Provides for use of tighter standards in determining the medical necessity of seat lift chairs.
- * Reduces the fee schedule for seat lift chairs by 15%.
- * Provides that seat lift chairs may only be billed on an assigned basis.
- * Prohibits medical suppliers from distributing medical necessity forms to Medicare beneficiaries.
- * Effective date: 1/1/90

3. Reduce payments for oxygen
- * Reduces the fee schedule for oxygen supplies, equipment and services by 5%.
 - * Effective date: 1/1/90
4. Enteral equipment
- * Provides that payments for enteral equipment be based on a fee schedule.
 - * The fee schedule amounts are determined in the same manner as the fee schedules for other durable medical equipment.
 - * Effective date: 1/1/90
5. Reduce durable medical equipment update
- * Reduces the update for the durable medical equipment fee schedules to 2%.
 - Baseline = 4.9%
 - * Effective date: 1/1/90

Savings

	FY90	FY91
Limit rental agreements	\$ 20	\$ 30
Seat lift chairs	\$ 7	\$ 11
Reduce payments for oxygen by 5%	\$ 35	\$ 55
Enteral equipment	\$ 15	\$ 15
Reduce DME fee update to 2%	\$ 42	\$ 45
Total savings:	\$119	\$156

CLINICAL LABORATORY SERVICES

June 6, 1989

Proposal

1. Cap clinical laboratory fee schedules

- * Clinical lab services currently paid under local fee schedules. The local fee schedules are subject to a national cap equal to the median of the local fee schedules.
- * Provides for reducing the national cap to 95% of the median.
- * Effective date: 1/1/90

2. Reduce lab fee schedule update

- * Reduces update to lab fee schedules to 2%
-- Baseline = 4.7%
- * Effective date: 1/1/90

Savings

	FY90	FY91
Cap lab fee schedules	\$ 55	\$ 85
Reduce lab fee update to 2%	\$ 40	\$ 60
Total savings:	\$ 95	\$145

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Initial Discussion of 1990 COTH Spring Meeting

Background

In 1989, the COTH Administrative Board decided to eliminate a Spring Meeting Planning Committee and assume direct responsibility for planning the COTH Spring Meeting program. From a staff perspective, it is important to balance advance planning activities - topic and speaker selection -- with the need to be flexible and respond to issues in a timely way. Therefore, the following schedule is proposed:

September, 1989	Hold a preliminary discussion of meeting structure and possible topics and speakers at the Administrative Board meeting
October, 1989	Select definitive topics and recommended speakers at the Board's Annual Meeting breakfast
November, 1989	Distribute preliminary meeting information, including session topics, to membership
December, 1989	Finalize speaker arrangements with COTH Chairs at AAMC officers retreat
January, 1990	Distribute formal meeting announcement to membership

Meeting Structure

Based on member responses to the 1989 Spring Meeting and Board decisions at its June meeting, the following Spring Meeting format is proposed:

Wednesday:	afternoon:	AAMC Orientation (optional) - COTH Board Members - AAMC Executive Staff
	evening:	Keynote speaker Reception Dinner
Thursday:	morning:	Continental Breakfast Plenary Speakers (8:30-10:00) Coffee Break Discussion Session (10:30-12:00)
	noon:	Luncheon Dr. Petersdorf's Report
	afternoon:	free time

- evening: Special event with Boston members or
Dinner with speaker
- Friday: morning: Continental Breakfast
Plenary speakers (8:30-10:00)
Coffee Break
Discussion Session (10:30-12:00)
- noon: Luncheon
Legislative Update - Dr. Knapp
- afternoon: free time
- evening: Reception only or
Dinner with speaker
- Saturday: morning: Continental Breakfast
Speakers with question (8:00-11:00)

The Board is requested to evaluate this format with a decision needed on Friday evening activity: reception only or dinner with speakers.

Meeting Topics and Speakers

Across the past year, your staff have tried to listen to member suggestions for speakers and topics. The following list is suggested to stimulate Board discussion:

Possible Speakers

- George Mitchell (D-ME)
Senate Majority Leader
- Stuart Altman, PhD
ProPAC Chairman
- Arnold Relman, MD
New England Journal editor
- Joann Lynn
George Washington Center for Aging
"Bioethical Dilemmas and the Law"
- Richard Cyert, PhD
Carneige Mellon University
"Management of University in Crisis--Scaling Down"
- Kristine Romdeau
Labor Organizer, Harvard
"The Twenty-First Century Work Force"
- Jack McConnel
Senior Vice President, Johnson & Johnson
"Science in the Next Century"

Emily Freidman

"Are We Abandoning the Poor"

Gary Filerman

President

Association of University Programs in Health Administration

"The Changing Focus of Health Administration Education"

Topics Suggested (sometimes with speakers)

How Do You Prepare to be CEO of a Teaching Hospital

Concepts of Quality Control

Don Berwick, MD

Harvard Community Health Plan

Corporate America's Views on Health Care Costs

Corporate Perspectives on Changing the Health Care System

Corporate Problems with Proposed Solutions

Coverage Decisions for the 1990s

Oregon's Decision to Ration Care

Massachusetts' Mandatory Coverage

Catastrophic Coverage-What Happened

Long Term Care Coverage

National Health Insurance Proposals

Affiliation Relationships in a Competitive Era

A Dean's Perspective

A Hospital CEO's View of Hospital Relationship

Foundation Perspective on Teaching Hospital

Presidents of Robert Wood Johnson

Commonwealth Fund

Pew Foundation

Hartford Foundation

Kellogg Foundation

Looking at Specialty Board Requirements

John Benson - Internal Medicine

Timothy Oliver - Pediatrics

New Research Activities/Developments

Evaluating the Social HMO Experiment

Teaching Hospital Costs

Ken Thorup, Harvard

Measuring Patient-Centered Care

Tom Delbano, Beth Israel, Boston
JCAHO's Experiment on Measuring Quality
Experiences of Involved COTH Hospitals

Research and the Teaching Hospital
Harvard's Venture Capital Approach
Establishing a Conflict of Interest Policy

Approaches to Categorizing and Paying for Ambulatory Care
Ambulatory Visit Groups
Products of Ambulatory Care and Surgery - NYS Experiment

Changing the Site of Medical Education - Implication for Teaching Hospitals

Management Information Systems -- Should COTH Members Start a Joint Venture
Software Development Firm?

Using Legal Counsel: Managing In-House and Outside Counsel
Andy Schaffer, NYU
Hospital Attorneys

Developments in On-Line Medical Information Use
William Stead, MD, Duke
David Masys, National Library of Medicine

Organizing Ambulatory Care Services
Contracting Out Management at Cleveland

Managing the Research Culture
Robert Burgelman, PhD, Stanford
Merwyn Greenlick, PhD, Kaiser Portland

The New International Health Services Market
Serving a Japanese Corporation in the U.S.
Working the Pacific Rim
Working the International Marketplace

Successful Cost Containment Experiences

Board members are requested to offer additional ideas for speakers and topics and to select the five most interesting.

ARRANGEMENTS FOR UPCOMING COTH SPRING MEETINGS

At its June meeting, the COTH Administrative Board discussed site preferences for upcoming COTH Spring meetings. Across the summer, hotel contacts were made and sites evaluated. The following meeting dates and sites are confirmed.

<u>Year</u>	<u>Dates</u>	<u>Site</u>
1990	May 9-12	Lafayette Hotel, Boston
1991	May 8-11	The Mills House, Charleston (SC)
1992	April 29-May 2	Broadmoor Hotel, Colorado Springs

Board members are requested to reserve these dates on their advance calendars.

MEMBER PARTICIPATION IN COTH

As an AAMC component, COTH is organized as an institutional membership with the CEO as the hospital representative. In many cases, this structure works well with the CEO actively involved in COTH Meetings and with the CEO's office carefully distributing AAMC mailings to the appropriate hospital staff. In a number of cases, however, the CEO, while supportive of COTH, is not heavily involved in COTH activities and no one from the institution attends COTH/AAMC meetings. In other cases, irrespective of CEO involvement in COTH, the hospital has a staff person with primary responsibility for medical education policies and issues. This person, who often is called vice president for academic affairs or vice president for medical education, has no direct relationship to or involvement in COTH/AAMC. Across the past year, approximately thirty of these individuals from affiliated community hospitals of 600 beds or more, met to discuss shared operational concerns and their dissatisfaction with their relationship with the AAMC, AHA, and AMA. Tentatively, they have formed the Alliance for Independent Academic Medical Centers. On July 7, three representatives of the group -- Ethel Weinberg, M.D., vice president for academic affairs at Baystate Medical Center; Stephen Larned, M.D., vice president for medical affairs, Maine Medical Center; and Edmond Rothschild, M.D., vice president for professional and academic affairs, St. Luke's-Roosevelt Hospital Center -- met with Dr. Petersdorf and Jim Bentley to express their interest in a more direct involvement in COTH/AAMC.

In the past few years, community hospital involvement in COTH has increased with more CEO's elected to the Board and the Assembly and with more representatives named to committees. As the current survey of academic medical center hospitals is expanded to include non-federal, general COTH members with at least 100 residents, the AAMC will be able to provide large affiliated hospitals with some useful comparative data. These steps do not, however, satisfy the need of some hospital-based educators for involvement, networking and visibility.

Given this background, the Administrative Board is requested to discuss approaches which could be undertaken by the AAMC to expand affiliated hospitals participation.

Possibilities could include:

- o establishing a COTH section for hospital vice presidents with responsibility for medical education,
- o establishing a freestanding AAMC Group of Hospital Educators
- o expanding the invitation list for the COTH Spring Meeting to include vice presidents for major functional areas -- nursing, finances, medical education, operations
- o leaving present COTH/AAMC practices intact but developing a staff liaison relationship with the Alliance of Independent Academic Medical Centers.

**COTH MEMBER INSTITUTIONS HAVING DROPPED MEMBERSHIP
AS A RESULT OF THE 1989-1990 DUES INCREASE**

Butterworth Hospital
Grand Rapids, MI
1969

Christ Hospital
Cincinnati, OH
1973

Conemaugh Valley Memorial Hospital
Johnstown, PA
1968

Emanuel Hospital & Health Center
Portland, OR
1967
Legacy Health System

Erlanger Medical Center
Chattanooga, TN
1978

Good Samaritan Hospital and Health Center
Dayton, OH
1978
Sisters of Charity Health Care Systems, Inc.

Kaiser Permanente Medical Center
San Francisco, CA
1969
Kaiser Foundation Hospitals

Memorial Medical Center
Savannah, GA
1984
Hospital Corporation of America

Continued...

**COTH MEMBER INSTITUTIONS HAVING DROPPED MEMBERSHIP
AS A RESULT OF THE 1989-1990 DUES INCREASE**
Continued...

Mt. Sinai Hospital
Hartford, CT
1976

Presbyterian Medical Center of Philadelphia
Philadelphia, PA
1966

St. Francis Medical Center
Peoria, IL
1970
Sisters of the 3rd Order of St. Francis

St. Joseph Medical Center
Wichita, KS
1983
CSJ Health System of Wichita

St. Vincent Hospital and Health Care Center, Inc.
Indianapolis, IN
1983
Daughters of Charity National Health System

St. Vincent's Medical Center of Richmond
Staten Island, NY
1970
Sisters of Charity Health Care System Corporation

UCLA Neuropsychiatric Hospital
Los Angeles, CA
1972
University of California-Systemwide Administration

Continued...

**COTH MEMBER INSTITUTIONS HAVING DROPPED MEMBERSHIP
AS A RESULT OF THE 1989-1990 DUES INCREASE**

Continued...

Veterans Administration Medical Center
Sepulveda, CA
1972

Wesley Medical Center
Wichita, KS
1970
Hospital Corporation of America

YHA, Inc.
Youngstown, OH
1970

Robert G. Petersdorf, M.D.
President



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (909) 898-0460

June 29, 1989

Louis B. Hays
Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-630-P
P.O. Box 26676
Baltimore, MD 21207

Dear Mr. Hays:

The Association of American Medical Colleges welcomes the opportunity to comment on the proposed rule, "Changes in Inpatient Hospital Prospective Payment System and Fiscal Year 1990 Rates." (54 Federal Register 19636). The AAMC represents the nation's major teaching hospitals, medical schools, faculty societies and faculty practice plans. The comments address three proposals: the reduction in DRG weights, the use of 1984 data to establish the labor wage index and outlier payment policies.

Reduction in DRG Weights

HCFA has proposed an across-the-board reduction of 1.35% in DRG weights. The proposal is based on a comparison of the case-mix values for 1988 discharges using both the FY1988 Grouper and the FY1986 Grouper. The value was found to be higher when the FY1988 Grouper was used. HCFA claims that "this demonstrates that changes we made to the Grouper program between FY1986 and FY1988, coupled with changes in hospital diagnostic and reporting practices made in response to those Grouper changes, inflated the case-mix and, therefore, program expenditures." (54 Federal Register 19645). HCFA concluded that "of the total increase in the case-mix value from FY1986 to FY1988 (that is, 6.4 percent), 1.35 percent is the result of recalibration and changes made to the Grouper program." (54 Federal Register 19646).

The AAMC objects to the proposed 1.35 percent cut for two reasons. First, HCFA offers no factual evidence to support its conclusion about the cause of the increase. There is no reason for HCFA to assume that the case-mix values under the new Grouper system should duplicate those of the old Grouper system. With better classification in the new system, one would expect some changes in distribution. The AAMC believes that the appropriate test for neutrality should be the database on which the new system is developed rather than a comparison based on two different systems.

Secondly, the AAMC sees the proposed reduction as an effort on the part of HCFA to reduce the update factor that Congress set by law. The effect of reducing the DRG weights is to reduce the payment updates, despite the fact that HCFA no longer has the discretion to set a PPS update.

Wage Index

As it did in the FY1989 proposed rule on changes to PPS (53 Federal Register 19498), HCFA is proposing that the wage index be computed using only 1984 data rather than the current blend of 1982 and 1984 data. The previous proposal was withdrawn when HCFA published the final rule so that the agency could "evaluate the relationship between changes in the wage index and aggregate prospective payments." (53 Federal Register 19498). However, HCFA has supplied no more information this year than last, so it is impossible to assess any evaluation HCFA may have done.

In the current proposed rule HCFA states that "our current analysis indicates that moving from a blended wage index to one based solely on 1984 data does not significantly impact aggregate prospective payments" (54 Federal Register 19646). The distributional effects are as important as the aggregate payment effect; thus, the AAMC believes that this is an inadequate basis on which to evaluate the impact.

A further problem is that since the method used for the analysis has not been published, it is impossible to assess the impact of the proposed change. AAMC recommends, as it did last year when this same proposal was made, that HCFA make its data and methodology publicly available and allow hospitals a 30 day comment period commencing with the publication of the wage indexes. More information is also needed to make a determination of whether this proposal is done in a budget neutral manner.

Also of concern is that the 1984 data used for the wage index are currently five years old. Much has happened within the health care industry during that time, including shortages in nursing and allied health professions, which have caused a huge escalation in salaries. The 1984 data do not reflect such significant changes. The AAMC is encouraged that HCFA is developing a survey to collect more current data and urges HCFA to wait until the survey methodology can be reviewed and the data are available before making changes in the wage index.

Outliers

There are two areas of concern regarding HCFA's proposals for changes in outlier payments. The first is that HCFA is keeping the total outlier pool at 5.1% and thus increasing outlier thresholds; the second is the reduction in the marginal cost factor from 90% to 60% for burn cases that are day outliers.

Research at Boston University, the University of Michigan and Johns Hopkins University has shown that at present the most practical method of recognizing severely ill patients and compensating hospitals for their care is an increase in the outlier pool. This would be accompanied by a reduction in outlier thresholds. The AAMC supports increasing the outlier pool, although recognizing that since changes in outlier payments must be accomplished in a budget neutral manner, it would be necessary to offset the increase by reductions in other PPS payments.

The AAMC is also concerned about the precipitous drop in payments for burn cases that are day outliers. If the proposed reduction is implemented it should be done over a period of several years to give those hospitals that will be most affected time to adjust to payment changes.

If you have any questions or need further information, please call James Bentley, Ph.D., Vice President for Clinical Services or Ivy Baer, J.D., M.P.H., Staff Associate, on my staff at 202-828-0490.

Very sincerely yours,



Robert G. Petersdorf, M.D.



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0460

June 15, 1989

The Honorable Willis D. Gradison, Jr.
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Gradison:

The Association of American Medical Colleges (AAMC) expresses its support for H.R. 1692, "The Medical Care Quality Research and Improvement Act of 1989," and the national program of research on the outcomes, effectiveness, and appropriateness of medical care it would establish.

The AAMC has as its purpose the improvement of the nation's health through the advancement of academic medicine. As an association of 127 medical schools, 435 teaching hospitals, and 87 academic societies, the AAMC works with its members to set a national agenda for medical education, biomedical research and health care. In pursuing its purpose, the Association works to strengthen the quality of medical education and training, to enhance the search for biomedical knowledge, to advance basic, clinical, and health services research, and to integrate education and research into the provision of effective health care.

The development of outcome research would represent a major shift in emphasis from academic medicine's traditional role in basic and clinical research, that has led to so many advances in health care technology. In fact, the very growth of this technology will place great, and possibly conflicting, demands on the medical schools that comprise the AAMC constituency. However, if appropriately funded, the addition of an agenda that includes research on outcomes would broaden and make more comprehensive academic medicine's institutional missions.

Certainly the time has come for the development of "outcome, effectiveness and appropriateness research" as defined within H.R. 1692. But this innovative and necessary initiative should not supplant the continuing need and the current momentum of basic medical research that keeps our country foremost in health care treatment and technology. Therefore, conflicting demands on funding should be avoided. The AAMC notes that two-thirds of the appropriations to fund H.R. 1692 are to be derived from the Federal Hospital and Supplementary Medical Insurance Trust Funds. This approach to funding will avoid the perception that this program will have a negative impact on the funds traditionally available for the continuation of basic and clinical research.

As stated by DHHS Secretary Sullivan and others, the development of patient outcomes research and the eventual development of practice guidelines will be a time consuming project. However, the fundamental premises on which the proposal is based are sound and the long-term benefits can be enormous for patients as well as the medical community.

A significant need for this form of research can be seen in the substantial regional variations in medical practice. As demonstrated in research by John Wennberg, M.D., and Robert Brook, M.D., presented during the hearing, there are significant differences in medical practice, including the choice of procedural therapy. This variation in frequency continues to be unexplained. Outcome assessment research would provide a mechanism for assuring that treatment decisions are based on the best information available. Outcome assessment research would also provide a means of maintaining and improving the quality of patient care. The AAMC believes then through the development of practice guidelines as described in the proposed legislation that these goals would be accomplished.

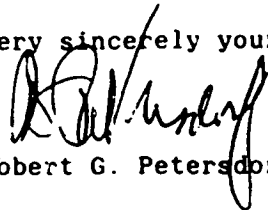
Physicians are faced with many diagnostic alternatives and therapeutic options, and choosing the appropriate test or the most beneficial treatment becomes more complex as technology continues to grow. The development of practice guidelines would provide a dynamic basis for response by the health care system in an environment of rapidly changing health care technology. However, practice guidelines must be kept fluid to accommodate a constant re-evaluation and feedback of information. Flexibility is necessary for the practice guidelines to continue to serve their intended purpose of synthesizing the best available information from research so that they may influence physicians in clinical practice. It is equally necessary for advancements in information sciences and decision analysis to keep pace with changes in medical technology.

With respect to practice guidelines, the AAMC:

- o Recognizes the validity of condition-specific, or treatment-specific practice guidelines as a means of enhancing quality of medical care by providing physicians with a range of appropriate tests and/or procedures for a given clinical situation;
- o Endorses the recommendations of the Physician Payment Review Commission which urges federal government funding and private sector development of practice guidelines;
- o Supports a strong leadership role for academic medical centers because these institutions can provide an appropriate setting for the clinical research required for the development of practice guidelines;
- o Encourages the representation of medical schools and teaching hospitals on any national governing body or council established to oversee the research and development of practice guidelines.

In summary, the AAMC strongly supports H.R. 1692. The initiative provides a framework for assessing the effectiveness and appropriateness of medical tests and procedures to facilitate the greater goal of improved medical practice.

Very sincerely yours,



Robert G. Petersdorf, M.D.

Robert G. Petersdorf, M.D.
President



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0460

August 10, 1989

Docket Officer
Docket No. H-370
Room N-2625
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Dear Department of Labor Representative:

The Association of American Medical Colleges, representing the nation's major teaching hospitals, medical schools and faculty societies, welcomes the opportunity to comment on the proposed regulation, "Occupational Exposure to Bloodborne Pathogens," 54 Federal Register 23042. The AAMC's comments will focus on the expected impact of the proposed regulation on educational institutions, particularly teaching hospitals.


AAMC member institutions train most of the physicians and other health professionals in the United States; most also house research laboratories. It is the nature of the educational process for the health professions that students rotate in and out of many institutions during the course of their professional training. As proposed, the regulation would require training about the hazards of bloodborne pathogens each time an individual rotates to a new institution and each institution would be required to retain records of the training. The AAMC recognizes the importance of training in increasing workplace safety, but believes that OSHA did not consider the implications of the provisions of the regulation on teaching institutions. Since the intent of the proposed regulation is that training be given once annually, the Association urges OSHA to allow interns, residents, medical and other health profession students also to receive training once annually. It should be provided by the individual's sponsoring institution, i.e., the institution that has accepted the individual into a program that, if completed, will award a degree or other certificate of completion; that institution should also retain all pertinent records.

The AAMC believes that the estimate of the cost of compliance of \$33,000 for each hospital greatly underestimates what it will cost teaching hospitals to comply. While on average hospitals have 530 employees, teaching hospitals have an average of 2,500 employees. Just in terms of the amount of personal protective equipment that must be made available and the employee training that must be provided, most teaching hospitals could be expected to spend far more than non-teaching hospitals. The AAMC notes that no costs of compliance have been assigned to medical schools.

Since many teaching hospitals are large institutions where there are almost innumerable opportunities for occupational exposure, putting together an infection control plan that documents each task and procedure where there is the potential for exposure, will be a monumental, if not impossible, job. In addition, research is continually being done at teaching hospitals. One consequence of the research is that new tasks are being developed that may have the potential for occupational exposure, so the infection control plan will require frequent updating. OSHA should recognize that the level of documentation called for is not necessary to ensure employee safety. The AAMC urges OSHA to allow institutions greater flexibility in devising workplace safety plans and procedures. Institutions should not risk being found in violation of a regulation that has a requirement that may be virtually impossible to meet.

If you have any questions or would like more information, please contact Ivy Baer on my staff at 202-828-0490.

Very sincerely yours,


Robert S. Petersdorf, M.D.