AAMC

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

AGENDA

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

October 30, 1989
7:30-9:00a
Washington Hilton Hotel
Cabinet 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

October 30- The Washington Hilton Hotel, Washington, DC

COTH SPRING MEETINGS

May 9-12, 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

AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

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WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

AGENDA

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

WASHINGTON HILTON HOTEL
Cabinet Room
October 30, 1989
7:30-9:00a

I.	Call to Order	
II.	Consideration of the Minutes	Page 1
III.	Discussion of 1990 COTH Spring Meeting Program	Page 15
IV.	1989-90 COTH Nominating Committee Report	Page 19

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
September 28, 1989

Present
Calvin Bland
J. Robert Buchanan, MD
Gary Gambuti
Jerome Grossman, MD
Leo Henikoff, MD
John Ives
Sister Sheila Lyne
James Mongan, MD
Max Poll
Raymond Schultze, MD
Edward Schwartz
Barbara Small

Guests
Richard Averill
D. Kay Clawson, MD
David Cohen, PhD
John Colloton
Julie Jones

Staff
Ivy Baer
James Bentley, PhD
Joanna Chusid
Linda Fishman
Leslie Goode
Joan Hartman-Moore
Joyce Kelly, PhD
Joseph Keyes
Richard Knapp, PhD
Elizabeth Martin
Herbert Nickens, MD
Robert Petersdorf, MD
Edward Stemmler, MD
August Swanson, MD
Kathleen Turner
Melissa Wubbold
Stephen Zimmermann

SEPTEMBER 28, 1989
COTH ADMINISTRATIVE BOARD
MINUTES

I. CALL TO ORDER

Mr. Gambuti called the meeting to order at 7:30a in the Map Room of the Washington Hilton Hotel, and introduced the breakfast speaker for the meeting, Mr. Richard Averill, Vice Chairman of Health Systems International. Mr. Averill is one of the developers of the Diagnosis Related Groups (DRGs) classification scheme and was instrumental in the design and implementation of the New Jersey Prospective Reimbursement System.

Mr. Averill's presentation addressed the HSI Yale Complication and Comorbidity Revision Project (also known as the Yale DRG refinement study), a study commissioned by the Health Care Financing Administration (HCFA) that concluded six months ago. Mr. Averill began by illustrating the problems with the current Medicare DRGs and describing several alternative "grouper" programs currently in use among various locales and payors. These classification systems, such as the New York State Grouper and a pediatric grouper developed by the National Association of Children's Hospitals and Rehabilitation Institutions (NACHRI), use newly created DRGs and modifications of the HCFA DRGs to improve the accuracy of the systems.

The refined DRGs use the secondary diagnosis in addition to the primary diagnosis to classify patients by different levels of resource use. For medical diagnoses, the complications and comorbidities (CC) list was expanded into three classes, ranging from classes of patients for whom the CCs are expected to have a minor or no effect, a moderate effect, or a major effect on resource use. The same categories were used for surgical procedures, with the addition of a class to represent CCs that are expected to have a catastrophic effect on resource use. To obtain these categories each DRG was divided separately by the additional classes, not just the DRGs with CCs. The system uses a hierarchical model to classify patients within DRGs: patients are assigned to a CC class based on their most severe secondary diagnosis. Multiple secondary diagnoses do not change the assignment to a CC class. The DRG refinement results in approximately 1200 DRGs, compared to the 477 FY 1989 DRGs. Mr. Averill stated that HCFA is in the process of evaluating the HSI report and will then conduct an impact analysis to determine the classification system's effect on the redistribution of hospital payments.

He then addressed the issue of severity and its relationship to hospital payment, pointing out that if a hospital treats a disproportionate share of severely ill patients, the hospital will be underpaid based on DRGs. HCFA is studying this issue and will make a report to Congress. He compared classification of patients into DRG 148 (major bowel procedures with cc) using both the Yale refined DRGs and the Computerized Severity

Index (CSI) developed at Johns Hopkins. The refined DRGs could not classify patients in the "major" and "catastrophic" categories as well as the CSI system. However, CSI is a costly system to implement because it uses detailed clinical information from the patient's medical record.

Mr. Averill also mentioned the progress toward a payment system for ambulatory services and HSI's research on Ambulatory Visit Groups (AVGs) which are the DRG equivalents for ambulatory patients. Their report is due to HCFA in June 1990. HCFA will issue its report on a prospective payment system for the facility component of ambulatory services by January 1, 1991.

He concluded his presentation by emphasizing that DRGs will continue to serve as the basis of payment for the next decade, and modifications of the DRG system, such as the Yale refinement, New York State and NACHRI projects, will continue. Finally, he predicted government will expand DRG payment amounts to include capital and physicians' fees for hospital services. He noted that Congress is exerting pressure on HCFA to come up with an aggressive proposal for bundling physicians' fees into a service component.

Dr. Schultze asked Mr. Averill how the refined DRGs would classify a patient whose severity increases during a hospital stay. Mr. Averill noted that the refined DRGs cannot distinguish among levels of quality of care, i.e. if a CC occurs in the hospital and costs increase, the system will not pick up whether the increase was due to poor care. In response to a question from Dr. Grossman, Mr. Averill cautioned that payment and quality issues should not be mixed.

Dr. Buchanan asked Mr. Averill about the refined DRGs' ability to distinguish among levels of nursing within the DRG mix. He responded that like the current Medicare DRGs, the Yale refined DRGs treat all nursing days as being of equal intensity. No progress has been made on constructing per diem nursing weights for individual DRGs. Several Board members pointed out that nursing requirements can vary tremendously within a hospital stay and some hospitals, prompted not by Medicare payment policy but by the need to allocate wisely internal resources, have restructured their nursing services. Dr. Schultze pointed out that the frail elderly consume a disproportionate share of services. In the near future, UCLA hospital will bill patients on the basis of nursing severity.

Dr. Bentley asked Mr. Averill about the necessity of special provisions for outlier cases under the new system. Mr. Averill stated that some cases are so atypical they defy classification, e.g., multiple trauma cases. Additionally, HCFA is constrained at present by legislation that mandates payment for outlier cases.

Following a full discussion, Mr. Gambuti thanked Mr. Averill for meeting with the Administrative Board, and expressed the Board's interest in continuing to follow DRG developments.

II. CONSIDERATION OF MINUTES

ACTION: It was moved, seconded, and carried to unanimously approve the minutes from the June 15, 1989 COTH Administrative Board meeting in full.

III. WAXMAN AMENDMENT ON MEDICARE PAYMENTS FOR GRADUATE MEDICAL EDUCATION

Dr. Bentley gave a brief overview of the direct medical education payment (DME), noting that at the start of prospective payment, direct medical education payments stayed on a cost passthrough basis. In 1985, COBRA legislation, as a result of Congress' dissatisfaction with the passthrough, put a per resident payment system in place. Under this system, a resident is weighted as 1.0 FTE for the resident's initial residency period plus one year (not to exceed five years), and thereafter as .5 FTE. The Waxman amendment proposes two changes to the 1985 legislation as follows: primary care residents as defined by family medicine, general internal medicine, and general pediatrics will be increased to a 1.25 FTE weight; residents in internal medicine and pediatrics other than primary care residents will be assigned a weight of 1.10. Under the Waxman amendment, funding of these increases should come out of the direct medical education payments themselves. This would be achieved by placing a cap on the range of cost per resident payments, and costs above that limit would not be recognized. The expenditures saved above the limit would be used to fund the proposal. The four preliminary staff recommendations on this amendment are listed on pages 82-83 of the Executive Council agenda. Recommendation four recognizes the danger that the amendment could go into effect before institutions with high costs per resident and the reasons for these costs were identified. Dr. Bentley pointed out that one of the tables in the COTH academic medical center survey is a cost per resident table, and distributed copies of this table as a handout (Attachment A); the amendment does not specify how the costs per resident will be calculated, nor how they will relate to the yet undetermined threshold. Mr. Gambuti pointed out that this table does not account for the fact that a certain percentage of these costs will be disallowed because of the 1984 base.

Discussion ensued on the Association's policy on reimbursement driven manipulation of the physician manpower supply. Dr. Buchanan pointed out that the budget neutral component of this proposal differentiates it from other AAMC supported recommendations by the fact that the increases in some programs will be paid for by others.

Dr. Mongan felt that this approach to the increase in production of primary care physicians would not be effective. He did not believe that this proposal would be an incentive to either the hospital or the physician, and suggested that increasing the Medicare Part B fee schedule would have a more desirable outcome. Dr. Bentley discussed two alternatives to the current proposal he had been asked to explore; 1/ a flat tax that would affect all

programs equally and 2/ a progressive tax in which those programs at the low cost per resident end of the scale would contribute a proportionally smaller amount to the needed pool, and those at the higher end would contribute a larger amount (Attachment B).

A motion was made to oppose this amendment on the basis that the incentive, which switches monies from one institution to the other for the purpose of increasing primary care physicians, is proposed at the hospital level rather than the student level. Primary care residencies today are going unfilled, and Dr. Buchanan recommended that the incentive be directed at the individual, not the institution or program. The motion was modified to suggest alternate incentives such as increased stipends, re-examination of fee schedules, and the retirement of student loans for those physicians going into primary care.

Following this discussion, Dr. Petersdorf joined the Board. He supported the position stated in the Executive Council agenda, and asked that the Board reconsider their position on the amendment on the basis that it may not be the ultimate incentive to bring more physicians to the primary care arena, but that it was a workable beginning. He noted that flat opposition to the amendment could result in the Association being perceived as a proponent of the status quo and anti-primary care. He, therefore, believed it would be an error not to support Congressman Waxman in this earnest endeavor after staff has finally strengthened the Association's tenuous relationship with his office and the House Subcommittee on Health and the Environment which he chairs. Further dialogue ensued, and the Board recognized that funding of this endeavor will come from the highest cost per resident programs regardless of incentives. The motion was amended to reflect the following:

ACTION: It was moved, seconded, and carried to sincerely applaud Mr. Waxman's efforts on behalf of primary care, to emphasize the COTH Administrative Board's support of primary care, and to strongly recommend Mr. Waxman's staff consider the propositions noted above as alternatives to the hospital-based incentive currently being proposed. It was further recommended that Dr. Petersdorf and Dr. Knapp visit Mr. Waxman and his staff for the purpose of instituting a meaningful and cooperative dialogue.

IV. DRAFT REVISION OF THE GENERAL REQUIREMENTS OF THE ESSENTIALS OF ACCREDITED RESIDENCIES AND GRADUATE MEDICAL EDUCATION

Dr. Swanson gave a brief history of the general requirements and their most recent update in 1980. The bylaws of the Accreditation Council for Graduate Medical Education (ACGME) require that any change in the general requirements be approved by each of the parent organizations, making revision of the requirements an arduous process. Two

years ago a committee was appointed to revise the general requirements on the "basis that because of their nonspecificity, the current requirements are not sufficiently specific to be enforceable." Significant changes are addressed on page 85 of the Executive Council agenda. Dr. Clawson concurred as former chair of the ACGME Function and Structure Committee that the nonspecificity of the requirements made them impossible to support legally, and concurrently the special requirements were becoming more and more prescriptive. He felt that as they stand now the requirements are not useful. Dr. Buchanan cautioned the need to keep in mind that other groups besides the ACGME, such as resident staffs, will seek to use these revised amendments for their respective purposes. Additionally, he expressed concern over the specificity being applied to such areas as laboratory and x-ray retrieval systems.

ACTION: It was moved, seconded, and carried to recommend that the AAMC appoint an ad hoc committee to review the draft ACGME essentials, and that the committee pay particular attention to essentials which impose detailed management, organizational, and financial requirements on the hospitals which are not essential for quality graduate medical education programs.

V. PRESIDENT'S REPORT

Dr. Petersdorf welcomed Dr. Stemmler who has joined the Association as a "scholar in residence" on a six month sabbatical. He announced staff of the AAMC and the American Medical Association (AMA) have been working to assure an orderly transition and transfer of the medical students to other medical schools from Oral Roberts University, an institution scheduled to close its medical school at the end of this academic year. He gave special credit to Loma Linda University in this endeavor. He also announced that staff is busily engaged in preparations for the upcoming AAMC Annual Meeting. This will be the 100th Annual Meeting and the theme is "Physician Education: Our Heritage and Future." Department of Education Secretary Lauro Cavazos and HHS Secretary Louis Sullivan will be key speakers.

The AAMC is about to enter the second year of its medical school visit program; twenty visits were made in 1989 and about three dozen schools have requested visits in the coming year. The purpose of these visits is to allow AAMC staff to become more familiar with a broader range of member institutions, and Dr. Petersdorf felt they were also a helpful means of educating the school staffs about the AAMC and its programs and resources.

He noted this year marked the tenth anniversary of the temporary restraining order the Association received in its efforts to challenge the New York State testing legislation, and a hearing on the AAMC's MCAT suit has been scheduled for November 21.

Dr. Petersdorf expressed the increasing AAMC concern about the Veterans Administration and its programs. He noted that Dr. Gronvall has been asked to step down as chief medical director for political reasons, and that a search committee for his replacement is underway. Dr. Petersdorf stated he would like to see several strong candidates come forward and that the AAMC has ample input into the committee through Dr. William Butler and Dr. Ted Cooper, as well as the support of Dr. James Sammons of the AMA. It will be next summer before the appointment is made. He noted that the deans have been very effective in presenting the case for increased funding on behalf of the VA, and Dr. Hutton of the University of Cincinnati is scheduled to testify in the near future.

A drop of only 20 hospitals has been attributed to the 1989-90 dues increase; attrition of 40 hospitals had been calculated in the budget projections. None of the institutions that have dropped membership is a major academic medical center, and Dr. Petersdorf did not feel that present drop in membership was cause for alarm. He noted that negotiations on the future AAMC headquarters site were progressing satisfactorily and that the majority of the hurdles faced at the time of the June Board meetings had been overcome. He hoped to be able to make a public announcement at the Annual Meeting.

Mr. Gambuti thanked Dr. Petersdorf.

VI. REPORT OF THE TASK FORCE ON PHYSICIAN SUPPLY

Mr. Keyes summarized the findings of the draft document that had been distributed as a handout, noting that it represents a consensus that the specialty mix in academic medicine does not warrant drastic measures on the part of the AAMC, and that the problems of dealing with foreign medical graduates do not warrant setting up an international accrediting mechanism. The report identifies the problem of declining interest in a career in medicine, and concomitantly recognizes the need to ensure a strong and viable applicant pool. It also identifies the problems of inadequate access to health/physician services and the disappointing level of interest in primary care, and stresses the need to ensure completion of a residency program as an essential component in every physician's training. Though the report does not call for a cutback in the number of physicians trained at this time, it discusses the dangers of such an oversupply. And, finally, it recognizes that member institutions can play an appropriate role world-wide in training physicians who will return to their own countries and in that regard endorses the recently established International Medical Scholars Program.

Dr. Schultze noted the alarming trend of the increasing number of physicians per 100,000 population presented in Table 17 of the report. He believed that the data did not support the conclusions drawn on physician supply, and suggested that the report not be distributed. There was agreement at the table that the report did not take a credible position on this subject. Additionally, Mr. Gambuti objected to the weak stance taken on primary care.

Dr. Mongan suggested that perhaps the supply of physicians needs to be redistributed rather than controlled, and indicated he was not willing to concede that the aggregate number is as out of line as is being suggested.

ACTION: It was moved, seconded, and carried to recommend these remarks go on record, and recommend that the Executive Council remand the report to the Task Force for further study.

VII. COTH MEMBERS INSTITUTIONS HAVING DROPPED MEMBERSHIP AS A RESULT OF DUES INCREASE

Dr. Bentley noted that the majority of those institutions having dropped membership were long time members, remembering that the non-home plate institutions only had the opportunity to be in COTH in the early 1970s. He noted 89 non-federal COTH members have yet to pay their dues; however, it is expected that this is an internal accounting factor in most cases, and not a reluctance to renew membership. The attrition rate is still well within the expected course, though Dr. Bentley did express concern for some of the larger public hospitals and indicated some thought might be given to phasing in the dues increase for certain groups of hospitals to avoid losing a particular segment of membership. Dr. Buchanan raised the issue of stratifying membership in a different way than at present. He indicated that it may be necessary to re-examine classes of membership in COTH and stratify the charges as well as the services. Mr. Gambuti submitted that this issue be discussed at a future Board meeting, and suggested individual Board members call the CEOs of the dropped hospitals to encourage them to reconsider membership in the Council.

VIII. MEMBER PARTICIPATION IN COTH

Dr. Bentley asked the Board to consider the Alliance for Independent Academic Medical Centers' request to become more involved in the Association. This alliance is composed vice presidents of academic affairs or for medical education in the larger community hospitals who feel they have no direct relationship to or involvement in COTH/AAMC. Possibilities for including these individuals in the Association are presented in the COTH agenda on page 79. In response to a question from Mr. Gambuti, Dr. Bentley indicated the negative factor in establishing a freestanding AAMC Group of Hospital Educators is that it may directly conflict with the Association of Hospital Medical Educators (AHME), a group composed primarily of representatives from the smaller community teaching hospitals. He did not perceive any problem in permitting each COTH member hospital to designate representative(s) to a hospital educators' group, but it was important to understand that formation of such a group would not comprise a governance entity. Dr. Henikoff suggested that if these individuals did not find a home within the Association they were likely to form their own group.

ACTION: It was moved, seconded, and carried to recommend that an AAMC Group of Hospital Educators be formed.

IX. DISCUSSION OF 1990 COTH SPRING MEETING PROGRAM

Dr. Bentley requested ideas for speakers and topics from the Administrative Board, as well as scheduling advice. After discussion, the following recommendations were made.

- The meeting would commence Wednesday evening with a dinner and speaker;
- Thursday evening would be free;
- The local constituent-hosted event would take place on Friday evening, providing incentive to stay for the Saturday morning session.

The following was proposed as an alternative plan.

- The local constituent-hosted event would take place on Thursday evening in the form of a reception only, allowing registrants to then go out for dinner on their own;
- A keynote speaker followed by a reception would take place on Friday evening.

Mr. Gambuti noted that Mr. Averill would make an excellent speaker, and Dr. Buchanan suggested Karen Ignani from the AFL/CIO. Mrs. Small supported the suggestion of Joann Lynn from the George Washington Center for Aging. Mr. Bland indicated he would be interested in hearing more about Dr. Grossman's example of accountability and control of products from the evening before. Dr. Henikoff expressed an interest in the corporate arena and the PPOs' increasingly dramatic effect on hospital rates; Dr. Schultze indicated Joseph Califano had a good presentation on this.

Dr. Bentley then asked for suggestions for an opening night speaker, noting that it would most likely be very difficult to get a high ranking political speaker on a Wednesday evening in mid May. Dr. Buchanan described John Silver, President, Boston University, as an exciting and provocative speaker on the public education system as it ties in to the health care system's responsibility for the student body.

Dr. Schultze, in response to Dr. Bentley's call for negative comments, indicated that he had heard John Benson speak. Dr. Bentley indicated he would incorporate these suggestions into a proposal for the October Annual Meeting Board session.

X. NIH RESEARCH FACILITIES CONSTRUCTION AUTHORIZATION

The consensus of the Board was to use NIH funds for grants rather than facilities "and let the universities pursue other means of building their buildings, including using the overhead on those grants to fund the buildings on a long term capital basis rather than cutting into the grants themselves." Additionally, it was felt that the special laws that are passed to support a specific university should also be eliminated.

XI. A SINGLE EXAMINATION FOR MEDICAL LICENSURE

The consensus of the Administrative Board was to support the single examination for medical licensure which was made more plausible by the emphasis on both clinical and didactic experience.

XII. AAU DRAFT REPORT ON INDIRECT COSTS

A revised letter of the one presented on pages 66-71 of the Executive Council agenda to Dr. Rosenzweig of the AAU was distributed as a handout. The additions are in italics and the deletions are underlines, but Dr. Bentley felt it was little changed. Dr. Buchanan commented that the letter was very technical and expressed his hope that the Deans will give this letter to their financial staff. Dr. Bentley confirmed that there are two different circulars, an OMB (A-21) circular that applies to universities and then the HHS document (OASC-3); this letter pertains primarily to the OMB circular and its regulations, though for the sake uniformity Dr. Petersdorf suggested that consideration be given to amending the OASC-3 circular as well. The Board had no further comments on this letter and the consensus was that it be approved by the Executive Council.

XIII. ADJOURNMENT

Mr. Gambuti thanked the Board for their participation; the meeting was adjourned at 12:30p.

TABLE 49

Total Allowable Graduate Medical Education (GME) Expenditures*
Per FTE Resident and Clinical Fellow
Most Recently Completed Fiscal Year

Hospital Name	Total Allowable GME Expenditures Per Hospital Funded FTE Resident and Fellow	Total Allowable GME Expenditures* Per Total FTE Resident and Fellow
ALABAMA	$ 31,348.84	$ 26,960.00
ALBANY	46,291.65	40,976.88
ARIZONA	31,334.18	31,334.18
ARKANSAS	N.A.	N.A.
BARNES	28,824.34	22,224.26
BETH ISRAEL	89,135.03	89,135.03
BRIGHAM	35,060.93	35,060.93
CHICAGO	N.A.	57,180.28
CINCINNATI	57,625.51	56,702.18
CLEVELAND METRO	59,348.58	58,284.98
COLORADO	64,080.88	45,583.66
CONN	49,529.78	20,362.24
CRAWFORD LONG	51,470.87	51,470.87
DUKE	43,432.44	29,633.59
EMORY	25,871.16	25,871.16
FROEDTERT	75,905.94	75,905.94
GEORGETOWN	38,451.59	23,518.39
GRACE	84,405.80	84,405.80
GRADY	51,120.31	50,723.00
GWU	65,405.66	65,405.66
HAHNEMANN	44,881.03	43,612.31
HARBOR-UCLA	73,481.46	67,001.54
HARBORVIEW	74,379.55	57,541.11
HARRIS CO.	N.A.	30,906.44
HERMANN	29,007.97	20,862.47
HERSHEY	123,420.60	67,682.26
HITCHCOCK	39,542.23	36,906.08
HOPKINS	47,668.59	28,567.10
HOWARD	191,883.09	180,985.50
HUMANA	N.A.	N.A.
HUP	85,729.10	74,017.44
INDIANA	38,674.78	25,357.02
IOWA	49,254.47	35,773.48
JACKSON	57,149.45	57,149.45
JEFFERSON	80,500.92	68,140.55
KANSAS	22,708.15	22,708.15
KENTUCKY	44,111.08	40,117.09
KINGS CO.	N.A.	N.A.
LA COUNTY	52,952.75	52,115.97
LOMA LINDA	47,549.87	44,662.91
LSU	28,456.58	25,108.75
MARYLAND	53,158.96	35,722.99
MASS. GEN.	56,308.14	55,808.95
MASSACHUSETTS	61,891.91	51,754.44
MCGAW	64,908.92	51,538.17
MED. COL. GA.	40,616.48	39,428.49
MED. COL. OH.	33,880.99	33,802.97
MED. COL. PA.	65,195.98	64,547.26

* Total allowable GME expenditures include hospital expenditures, related organization costs and other adjustments, and allocated overhead less nonreimbursable costs.

Note: Costs per FTE resident and fellow are not reported where trainees are supported by institutional funds.

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Most Recently Completed Fiscal Year

Hospital Name	Total Allowable GME Expenditures Per Hospital Funded FTE Resident and Fellow	Total Allowable GME Expenditures* Per Total FTE Resident and Fellow
MED. COL. VA.	$ 53,952.87	$ 47,825.88
MEMPHIS	.00	57,980.63
METHODIST	37,063.48	32,486.31
MICHIGAN	86,970.97	60,291.61
MILWAUKEE CO.	59,074.67	54,525.68
MINNESOTA	79,402.82	57,222.55
MISSISSIPPI	68,162.82	34,081.41
MISSOURI	80,031.93	57,842.28
MONTEFIORE	117,793.46	111,570.41
MT. SINAI	117,901.40	95,771.81
N. CAROLINA	64,902.30	49,543.95
NC BAPTIST	86,113.63	66,358.15
NEBRASKA	37,527.47	32,232.18
NEMC	90,872.25	77,841.51
NEW MEXICO	96,450.78	79,430.06
NEW YORK	110,933.42	110,933.42
NORTHWESTERN	57,915.04	57,915.04
NY PRESBY	68,356.45	68,356.45
NYU-TISCH	59,087.03	59,087.03
OHIO STATE	119,744.74	70,005.66
OKLAHOMA	42,256.89	42,256.89
OREGON	60,175.58	60,175.58
PARKLAND	36,782.51	36,782.51
PITT CO.	94,634.39	93,320.03
PRESBY-UNIV	53,835.16	45,639.33
RUSH	40,857.79	40,857.79
RWJ	87,843.51	84,008.75
S. ALABAMA	53,065.76	51,838.80
S. CAROLINA	.00	47,768.13
SAINT MARYS	N.A.	N.A.
SCOTT & WHITE	63,854.07	63,276.15
SF GENERAL	51,218.10	42,818.33
SHANDS	75,087.58	48,371.09
ST. JOSEPH	82,161.48	55,950.45
ST. LOUIS	80,228.67	80,228.67
STANFORD	78,238.56	63,594.98
STONY BROOK	51,526.58	37,631.77
STRONG	62,501.13	62,501.13
SUNY-BROOKLYN	280,689.01	110,681.79
SUNY-SYRACUSE	59,022.70	47,873.97
TEMPLE	51,036.59	45,912.44
TEXAS	57,098.84	51,883.08
TRUMAN-WEST	45,443.45	45,443.45
TULANE	68,241.22	68,241.22
U. VIRGINIA	60,754.35	49,460.47
UC DAVIS	45,254.04	36,912.28
UC IRVINE	65,516.58	39,309.95
UCLA	77,209.10	34,139.26

* Total allowable GME expenditures include hospital expenditures, related organization costs and other adjustments, and allocated overhead less nonreimbursable costs.

Note: Costs per FTE resident and fellow are not reported where trainees are supported by institutional funds.

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UCSD	$ 63,747.13	$ 54,054.58
UCSF	40,377.18	30,253.11
UMDNJ	43,972.91	43,972.91
UNIV-CLEVELAND	39,450.06	34,368.36
UTAH	33,477.75	26,266.25
VANDERBILT	83,706.09	50,575.39
VERMONT	31,763.69	25,946.72
W. VIRGINIA	33,214.49	28,743.31
WASHINGTON	78,611.07	45,395.12
WESTCHESTER	112,428.57	91,459.75
WISCONSIN	36,373.68	32,506.71
WISHARD	55,119.41	55,119.41
YALE	45,402.99	36,973.75
MEAN	58,583.80	56,535.20
MEDIAN	57,915.04	50,575.39

* Total allowable GME expenditures include hospital expenditures, related organization costs and other adjustments, and allocated overhead less nonreimbursable costs.

Note: Costs per FTE resident and fellow are not reported where trainees are supported by institutional funds.

Alternative Proposals for Financing the Waxman Proposal

The Waxman proposal to use Medicare funds to encourage primary care training contains three separable components: (1) the increase in FTE weights for primary care residents, (2) the increase in the FTE weights for all other internal medicine and pediatrics residents, and (3) a source of financing. This paper addresses only the last issue--financing--to facilitate discussion at the COTH Administrative Board.

Within the current Medicare budget reconciliation process, there are three possible sources for funding the increased FTE weights proposed by Waxman:

limit the DRG rate of increase for all hospitals,

reduce the indirect medical education adjustment, and

redistribute the present medical education payments.

It is unlikely that Congress will expand medical education payments at the expense of all hospitals and it is unlikely that teaching hospitals would support reducing the IME payments to increase the direct medical education payments. Therefore, the most likely source of funding in the current budget process is to redistribute the existing medical education payments.

The Waxman proposal would redistribute existing funds by decreasing the amounts paid to hospitals with above average per-resident costs. This approach is opposed by COTH members with the above average costs. They argue that many of the hospitals with lower per-resident costs benefit from state appropriations, while many of those with high per-resident costs have no appropriations. Moreover, they believe that the reduction in payments necessary to fund the expanded FTE weights will severely damage their residency programs. For example, if a hospital has 200 residents with an average cost of $100,000 per resident and if the per resident limit is set at $75,000, the hospital will experience a reduction in allowable costs of $5,000,000. Hospitals in this situation request that the Administrative Board consider other approaches to redistributing the payments offer two suggestions:

Impose a uniform percentage reduction in the payments made to all hospitals in order to establish a pool of funds necessary to pay the increased FTE weights. Using the impact estimates on page 81 of the Executive Council agenda, the reduction would be about 4.4% if only primary care

residents are funded and about 6.5% if both primary care and categorical internal medicine/pediatrics residents are funded.

Impose a sliding scale reduction in the payments made to hospitals with the percentage reduction increasing with the amount of the per-resident cost. For example, hospital in the lowest cost quartile might have payments reduced to equal 10% of the pool while hospitals in the highest cost quartile might have payments reduced to equal 40% of the pool.

The COTH Administrative Board is requested to consider these options in its discussion of the Waxman proposal.

1990 COTH Spring Meeting

At the September Administrative Board meeting, a discussion of topics for the 1990 COTH Spring Meeting was held. Based on that discussion, the attached draft program has been prepared for further discussion at the Board's October breakfast.

Draft Program
1990 COTH Spring Meeting
Boston, Massachusetts

Wednesday, May 9

3:00 - 5:00	AAMC Orientation (Optional) with COTH Board and AAMC Executive Staff
4:00 - 6:00	Registration
6:00 - 7:00	Opening Address
	"Educational Institutions -- Reaching Beyond our Walls"
	John R. Silber, Ph.D. President, Boston University
7:00 - 8:00	COTH Chairman's Reception
8:00 - 9:30	Dinner

Thursday, May 10

7:30 - 8:30	Continental Breakfast
8:30 - 10:00	Plenary Session
	"National Health Care System: New Proposals"
	Karen Ignani/Bert Seidman AFL-CIO
	Stuart Butler Heritage Foundation
10:00 - 10:30	Coffee Break
10:30 - 12:00	Discussion Groups
	"Implications of New Proposals for Teaching Hospitals"
12:15 - 1:30	Lunch
	AAMC Chairman's Address
	David Cohen AAMC Chairman

1:30 - 6:30	Free Time
6:30 - 8:00	COTH Membership Reception Sponsored by Boston COTH Members

Friday, May 11

7:30 - 8:30	Continental Breakfast
8:30 - 10:00	Plenary Session

"New Hospital Management Structures: Looking Back and Assessing the Changes"

Robert M. Heyssel, M.D.
President
The Johns Hopkins Hospital

Jerome Grossman, M.D.
Chairman/CEO
New England Medical Center

James Block, M.D.
President
University Hospitals of Cleveland

10;00 - 10:30	Coffee Break
10:30 - 12:00	Discussion Groups

"Organizational Developments at COTH Hospitals"

12:15 - 1:30	Luncheon

"President's Report"
Robert G. Petersdorf, M.D.

1:30 - 6:00	Free Time
6:00 - 7:00	Keynote Speaker

"Health Policy in the 1990s"

George Mitchell, D-Maine
Jay Rockefeller, D-West Virginia

7:00 - 8:00	Reception

Saturday, May 12

7:30 - 8:00	Continental Breakfast

8:00 - 9:00	Government Relations Update Richard M. Knapp, Ph.D.
9:00 - 9:30	Chairman's Report Raymond Schultze, M.D.
9:30 - 10:30	"The New DRGs and Teaching Hospitals" Richard Averill Vice Chairman Health System International
10:30 - 12:00	Discussion Group Reports
12:00	Adjourn

Nominating Committee Report

Council of Teaching Hospitals

October 30, 1989

On behalf of the committee -- which consisted of Bob Buchanan, Gary Gambuti, and myself -- I am pleased to report the following nominations. The Committee met several times by telephone conference call and considered a large number of individuals for the position available. In our deliberations, we considered both the personal qualities of the individuals being considered and, to obtain balance and diversity, the institutional characteristics of the hospitals where they serve as CEO. After due deliberation, the Committee presents the following nominations:

- COTH Chairman, Raymond Schultze, M.D., Director, UCLA Medical Center
- Chairman-Elect, Jerome Grossman, M.D., Chairman/CEO, New England Medical Center, Inc.
- COTH Secretary, William Kerr, Director, Medical Center, University of California, San Francisco

For three year terms on the COTH Administrative Board:

Jose Coronado
Hospital Director
Audie Murphy Memorial VA Hospital
San Antonio, TX

R. Edward Howell
Executive Director
Medical Codllege of Georgia Hospitals and Clinics

Gail Warden
President and CEO
Henry Ford Health Care Corporation

For three year terms on the AAMC Assembly:

Three Year Term

Belsey, George W.
Executive Director
University of Utah Hospital
Salt Lake City, Utah 84132

Breitenbach, Thomas G.
President/CEO
Miami Valley Hospital
Dayton, Ohio 45409

Carson, John T.
Medical Center Director
Veterans Administration Medical Center
St. Louis, Missouri 63125

DeNiro, James C.
Medical Center Director
Veterans Administration Medical Center
Palo Alto, California 94304

Dickler, Robert M.
General Director
The University of Minnesota
Hospital and Clinic
Minneapolis, Minnesota 55455

Dooley, James S.
Medical Center Director
Veterans Administration Medical
Center
Bronx, New York 10468

Eldredge, Clifford M.
Chief Executive Officer
Baystate Medical Center
Springfield, Massachusetts 01199

Forsyth, John
Executive Director
University of Michigan Hospitals
Ann Arbor, Michigan 48109

Fuentes, Miquel. A., Jr.
President/CEO
The Bronx Lebanon Hospital Center
Bronx, New York 10456

Gilbert, Albert F., Ph.D.
President
Akron City Hospital
Akron, Ohio 44309

Griner, Paul F., M.D.
General Director
Strong Memorial Hospital
Rochester, New york 14642

Halpern, Kevin G.
President/CeO
Cooper Hospital/University
Medical Center
Camden, New Jersey 08103

Handel, David J.
Director of Hospitals
Indiana University Hospitals
Indianapolis, Indiana 46223

Mathies, Allen W., Jr., M.D.
President/CEO
Huntington Memorial Hospital
Pasadena, California 91105

Metts, Paul E.
Chief Executive Officer
Shands Hospital
Gainesville, Florida 32610

Moore, Joseph L.
Medical Center Director
Veterans Administration Medical
Center -- Lakeside
Chicago, Illinois 60611

Silver, Richard A.
Hospital Director
Veterans Administration Medical Center
Tampa, Florida 35612

Skinner, David, M.D.
President
The New York Hospital
New York, New York 10021

Taylor, James H.
President
Medical Center Hospital of
Vermont
Burlington, Vermont 05401

Ummell, Stephen L.
President/CEO and President
Memorial Health Services
Memorial Medical Center at
Long Beach
Long Beach, California 90801

Gail Warden
President and CEO
Henry Ford Health Care Corporation

For Two Year Terms on the AAMC Assembly

<u>Two Year Term</u>

Doughty, Clark R.
Medical Center Director
Veterans Administration Medical Center
Kansas City, Missouri 64128

For one year terms on the AAMC Assembly:

<u>One Year Term</u>

Wallace, Andrew G., M.D.
Vice President for Health Affairs
Duke University Hospital
Durham, NC 27710

Westerman, John H.
President/CEO
The Hospital of the Good Samaritan
Los Angeles, California 90017