COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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Selected Activities
Department of Teaching Hospitals
Association of American Medical Colleges
November, 1975 - October, 1976

The Department of Teaching Hospitals is the staff component of the Association of American Medical Colleges responsible for representing the interests of the teaching hospital community in AAMC activities and with other organizations and agencies. To ensure that COTH members have a comprehensive description of staff activities, this statement presents a review of activities in-progress and completed during the past year. Individuals seeking more detailed and supplementary information on any of the activities described are encouraged to contact the Department of Teaching Hospitals.

## HOUSE STAFF COLLECTIVE BARGAINING

### National Labor Relations Board

In June 1974, the National Labor Relations Act was amended (P.L. 92-360) to include under the Act all non-public health care institutions. While the amendments did add provisions to the Act to facilitate the application of federal labor law to health care providers, the issue remained as to whether house staff were to be treated as employees covered by the Act or as students excluded from the provisions of the Act.

In 1975, regional offices of the National Labor Relations Board (NLRB) transferred five cases in COTH hospitals concerning the application of the Act to house staff to the National Labor Relations Board. Because the Board's decision would have a significant impact upon graduate medical education, the AAMC Executive Council decided that the Association would not be fulfilling its obligation to maintain the standards of medical education unless it asserted the educational nature of intern and residency positions and opposed any action which would make the structure and function of graduate medical education subject to an adversary process of labor negotiations. The Executive Council authorized the submission of an amicus curiae brief to the NLRB: the Association petitioned the NLRB for leave to participate as an amicus; filed its written brief regarding house staff recognitional petitions on April 14th and 21st, 1975; and presented its oral brief before the NLRB in September, 1975.

On March, 1976, the National Labor Relations Board ruled on the Cedars-Sinai and St. Christopher's cases. The Board held (with one member dissenting) that house staff are primarily engaged in graduate educational training programs and, therefore, the Board further held that house staff were to be considered students rather than employees for purposes of coverage under the National Labor Relations

Act. In his lone dissent, Board member Fanning asserted that the house staff perform a service for the hospital and receive compensation. Challenging the majority opinion, he noted that the key element ". . .has always been whether students were also employees."

As a result of the Board's decision, house staff cannot claim the protection of the Federal Labor Relations Act in disputes with teaching hospitals, although house staff may seek to organize and bargain outside the framework provided by the Act. The Association provided copies of the Board decisions and dissents to all COTH members and recommended that members review the decision carefully because the Physicians' National Housestaff Association (PNHA) announced its intention to fight the decision "on all fronts."

New York State Labor Relations Board

On April 20th, the Committee of Interns and Residents (CIR) at Misericordia Hospital Medical Center in New York City petitioned the New York State Labor Relations Board for certification as the exclusive bargaining representative for house staff. Because the New York State Labor Relations Board has jurisdiction where the National Labor Relations Board does not, CIR argued the State Board had jurisdiction because the NLRB, in earlier cases, declared housestaff were primarily students and not employees covered under the National Labor Relations Act.

On June 15th, acting upon a petition filed by the hospital, the NLRB issued an Advisory Opinion expressing the position that the NLRB did have jurisdiction over labor relations situations at Misericordia. With the NLRB Advisory Opinion, the hospital argued before the State Board that the NLRB had jurisdiction over the CIR petition and requested that the State Board dismiss the petition.

On July 15th, the New York State Labor Relations Board, citing the NLRB Advisory Opinion, dismissed the petition of the Committee of Interns and Residents. In the Memorandum accompanying the order, the Labor Relations Board stated: "The question of possible state jurisdiction here is certainly not free from doubt. Cogent arguements can be, and have been made on both sides of the issue. On balance, we have concluded that further processing of this matter before this Board is not warranted at this time. Accordingly, we shall dismiss the petition."

At present CIR is challenging the State Labor Board's jurisdiction decision in a New York State Court. The AAMC is evaluating this as well as other actions to determine its proper role in the resolution of this issue.

## MEDICARE'S ROUTINE SERVICE COST LIMITATIONS

Section 223: AAMC Suit

Federal regulations establishing per diem routine service cost limitations for hospital reimbursement under the Medicare program became effective for accounting periods beginning June 30, 1974. In May of 1975, the Association filed suit in the U.S. District Court for the District of Columbia seeking relief from the regulations arguing that they were arbitrary, capricious, in excess of the HEW Secretary's authority, and inconsistent with the Act, and that they would cause irreparable harm to teaching hospitals. The initial decision -- rendered on June 30, 1975 --

was in favor of HEW. AAMC's request to the District Court Judge to reconsider his decision was rejected, and the Association filed a notification to appeal the decision on August 4, 1975.

The AAMC's written Appeal Brief was submitted to the U.S. District Court of Appeals for the District of Columbia Circuit on October 21, 1975. The Appeal Brief argued that the District Court Judge had erred in four ways: in finding the regulation to have been lawfully promulgated, in relying on the HEW Secretary's unexplained reason for failing to utilize pertinent variables in establishing the regulation, in regarding the "exception process" as curing defects inherent in the schedule, and in its interpretation of a precedent case. HEW's written response brief was filed on December 1, 1975.

On September 16, 1976, oral arguments on the appeal were presented by AAMC and government attorneys before a three-judge panel from the U.S. District Court of Appeals. A decision by the Court is expected in late November or December. Given the uncertainty of the outcome of that decision, the Department is actively sharing its written briefs with other hospital associations -- including the Hospital Council of Northern California and the Hospital Council of San Diego and Imperial Counties -- that are considering attacking the regulations using different issues from those used in the AAMC suit.

Section 223: Impact on COTH Members

To assess the impact of Federal regulations regarding per diem routine service cost limitations under the Medicare program on COTH members, the Department conducted a survey of non-Federal COTH members from March 22, 1976 to May 24, 1976. The survey requested member hospitals to indicate:

1. the inclusive date of the hospital's cost reporting periods for the current amd immediate past years;

2. the Medicare cost ceiling for routine service costs for the past and current year as well as the past year's actual and current year's projected costs for routine service costs;

3. whether the hospital is in a standard metropolitan statistical area, a standard consolidated statistical area, or neither type of statistical area.

Completed surveys were received from 274 of the 329 hospitals surveyed for an 83% response. Hospitals reporting 1975 routine service costs above their Section 223 limitation were contacted to verify the data.

Survey findings show:

- For 1975, 56 responding hospitals (20%) exceeded the routine service cost ceiling. For 1976, 66 responding hospitals (24%) expected to exceed the Section 223 ceiling.

- Hospitals expecting to exceed the ceiling for 1976 are generally over the ceiling by a larger amount than were those hospitals which actually exceeded the ceiling in 1975. For example, in 1975, 43% of the hospitals exceeding the ceilings did so by $10 or more per patient day; in 1976 60.5% of the hospitals projecting costs above the ceilings expect to exceed it by $10 or more per patient day.

- When compared with all responding COTH hospitals, COTH hospitals disproportionately over the Medicare ceiling tend to be university-owned, under 410 beds, controlled by a state or county, and spending over $7.75 per adjusted patient day for house staff stipends.

- As housestaff stipends per adjusted patient day increase, the percentage of responding hospitals exceeding the Medicare ceiling increases. The present classification scheme and its resulting cost limitations are working to the disadvantage of COTH members with relatively high house staff expenditures.

The results of this study were provided to AAMC attorneys for their use in the oral brief used in the Association's 223 appeal hearing.

Section 223: Exceptions Procedures

The Medicare process for reviewing and evaluating exception requests by hospitals incurring atypical routine service costs has been a source of frustration for hospitals. It has been especially frustrating for COTH hospitals that find the atypical costs result from an atypical case mix or scope of services.

In September, 1975, the Bureau of Health Insurance published "advance copies" of Intermediary Letter 75-50 presenting a methodology for use in adjusting routine service costs to reflect atypical intern and resident costs. Copies of I.L. 75-50 were distributed to all COTH members. In spite of concerted efforts by Department staff encouraging BHI officials to prepare and distribute specific methodologies for use in requesting exceptions in other areas of concern to COTH members, BHI has only added a methodology for atypical nursing education costs during the past year. Copies of this methodology were distributed to all COTH members.

In the absence of adequate methodologies specifying exception procedures, the Association, on May 17th, requested BHI, under the Freedom of Information Act, to provide a listing of each institution which had been granted an exception, a listing specifying the reasons individual institutions had been granted exceptions, and a count of the number of institutions that had submitted exception requests. BHI's response was incomplete and of little use because it reported aggregate, rather than institutional, data for exceptions. As a result of this uninformative exchange, subsequent Association testimony on the Medicare program and on cost containment proposals have recommended that any such legislation include provisions for an exception and appeal process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or reduction in the per-admission costs.

To provide COTH members with assistance in filing exception requests, Department staff contacted all hospitals responding to the post card survey that had actual or projected costs over the routine service cost limitation. These

COTH hospitals were asked to provide the Department of Teaching Hospitals with complete documentation of exception requests and intermediary and BHI responses. Copies of these materials have been furnished to COTH hospitals upon request.

## TEACHING PHYSICIAN REIMBURSEMENT

### Institute of Medicine Report

In 1973, Congress called upon the Institute of Medicine (IOM) of the National Academy of Sciences to conduct a study of certain facets of the Medicare and Medicaid reimbursement policies. Specifically, the study was to examine the five following elements:

1. Methods of reimbursement for physicians' services under Title XVIII and XIX of the Social Security Act in hospitals which have teaching programs;

2. The extent to which funds expended under these Titles are supporting the training of medical specialities which are in excess supply;

3. How funds could be expended in ways which would support a more rational distribution of physician manpower;

4. The extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates; and,

5. The existing and appropriate role that part of such funds which are expended meet in whole or in part the cost of salaries of interns and residents.

On March 1, 1976, the Institute of Medicine released the long-awaited report entitled Medicare-Medicaid Reimbursement Policies. Among the more significant recommendations contained in the report were the following:

- Section 227 of P.L. 92-603 should not go into effect on July 1, 1976. Until new legislation can be enacted, authority to continue cost reimbursement for physician services under Section 15 of P.L. 93-233 should be extended.

- A fee based method of payment is appropriate for teaching physicians only when they provide personal and identifiable services to program beneficiaries or directly supervise the provision of such services by house officers. With one exception, the physician role test as described in the proposed Section 227 regulations is appropriate as a test of whether personal and identifiable services are provided. The exception is the requirement for pre-admission relationship between the physician and patient. Under this method, after two years, the IOM recommends that no cost reimbursement be allowed for supervisory and teaching services in teaching hospitals.

- A unified method of payment is appropriate to institutions where there is a physician team approach to patient care and graduate medical education. Under this method, all services of licensed physicians would be paid out of Part B, except house officers who have not completed the first year of residency training. Such house officers would be paid on a cost reimbursement basis to the hospital.

- Financing mechanisms should be changed to provide more equitable support for ambulatory care services so that medical schools and teaching hospitals would find it easier financially to support primary care training programs.

- A permanent quasi-public independent physician manpower commission should be established to monitor the specialty distribution of physicians and to determine the appropriate number of residency slots for each specialty.

- With the exception of the category "contact physicians," post-graduate specialty training slots, available as of July 1, 1977, should be frozen at the level of residency positions filled as of July 1, 1975.

Department staff worked extensively with the COTH Administrative Board, the AAMC Exceutive Council, and with a special AAMC Task Force on the IOM Study in preparing the Association's response to the IOM recommendations which was presented to the Subcommittee on Health of the House Ways and Means Committee on September 16th. Because this one-day hearing was limited to the IOM recommendations on teaching physician reimbursement, the Association's official evaluation of all IOM recommendations was submitted for the record and oral testimony -- presented by Dr. David Thompson, COTH Chairman-Elect, and Dr. Robert Buchanan, Council of Dean's Chairman-Elect -- concentrated on the teaching physician reimbursement recommendations. As the Dean of the Cornell University Medical College, Dr. Buchanan opened the testimony by presenting the teaching hospital's legitimate need for professional medical as well as educational and supervisory services. He also pointed out that both services are dependent for their financial support on the health care dollar and that discussion of reduced reimbursements must recognize this interdependence. Arguing that the "double billing" allegations underlying the Section 227 provisions are a managerial control and reporting problem rather than a public policy problem, Dr. Thompson, Director of the New York Hospital, advocated both fee-for-service and cost-based reimbursement for teaching physicians under the Medicare program. Stating that a single physician should not be allowed to receive charges for professional medical services and be reimbursed for education and supervision on the same patient, the testimony urged Congress to permit both Part A and Part B payments for teaching physicians, but with a record keeping procedure which can be audited to ensure that no "double billing" is supported. Dr. Thompson also called for a clarification of the term "cost" as used in the cost-based reimbursement recommendation of the Institute of Medicine's study

Copies of the IOM study and copies of the Association's written response and oral testimony have been furnished to COTH hospitals.

Law Delaying Section 227 Implementation

In the 1972 Social Security Amendments, Congress included Section 227 to simplify payment of teaching physicians under the Medicare program. As Congress itself recognized, "adoption of this provision, brought forth expressions of serious concern from the medical education community about whether the legislation established a workable and equitable reimbursement policy for the teaching hospital setting." To resolve this issue, Congress suspended the implementation of Section 227 until July 1, 1976 and chartered the Institute of Medicine (see above) to study teaching physician reimbursement.

Because only ninety days were available between publication of the IOM recommendations and the scheduled implementation of Section 227, Department of Teaching Hospitals staff met with Congressional staff to request a further delay

in the implementation of Section 227. This additional delay would allow Congress, the AAMC, and Association constituents to evaluate alternative methods of reimbursement for physicians in teaching hospitals. On July 14th, the President signed into law (P.L. 94-368) the bill which postponed the effective date of Section 227 of the 1972 Medicare Amendments from July 1, 1976 to October 1, 1976.

## THE TALMADGE MEDICARE/MEDICAID BILL

### The Talmadge Bill

Senator Herman Talmadge (D-Ga.) has been actively concerned with developing legislation to reform the Medicare and Medicaid programs for over a year. During that time, Department staff met repeatedly with the Health Subcommittee staff of the Senate Finance Committee to discuss general concepts and tentative provisions being considered by Senator Talmadge.

On January 14, 1976, the staff of the Senate Finance Committee reviewed the essence of its proposed bill with the COTH Administrative Board. Subsequent to that session, the Administrative Board recommended that:

- language should be incorporated into the bill which would require the Secretary to examine the implications for reimbursement to various definitions of the terms "teaching/tertiary care hospitals" to determine which definitions most accurately reflect the teaching hospital's role as a referral center for tertiary patient care services, and as an educational institution;

- hospitals should be classified by size and type, and that the system should provide for the establishment of an "advisory body" to evaluate alternative classifications of size and type, to review progress and monitor implementation, and to examine problems encountered and make recommendations regarding solutions; and,

- malpractice insurance premiums be added to the list of exclusions from routine operating cost which are contained in the proposal.

On March 25th, Senator Talmadge introduced his "Medicare and Medicaid Administrative and Reimbursement Reform Act," S. 3205. The bill, similar to the earlier draft outlined before the COTH Administrative Board, proposed significant changes in the hospital and physician payment systems as they now exist under the Medicare and Medicaid programs. Among the significant provisions of the bill are proposals for:

- the centralizaton of federal health care financing,
- the implementation of uniform hospital accounting and reporting,
- the establishment of a revised routine service cost limitation to replace Section 223 of P.L. 92-603,
- the establishment of a special cost limitation category for the "primary affiliates of accredited medical schools" limited to one hospital per school, and
- the elimination of Medicare/Medicaid recognition of percentage contracts for hospital-associated physicians.

Senate Hearings on Talmadge Bill

The Subcommittee on Health of the Senate Finance Committee held five days of hearings on Senator Talmadge's Medicare and Medicaid reform bill, S. 3205, beginning on July 26th. Charles B. Womer -- COTH Chairman and then President of the Yale-New Haven Hospital-- presented the testimony of the Association of American Medical Colleges. The Association concentrated its testimony on the classification scheme for hospitals and the routine operating cost limitation procedure. For the hospital classification provisions, the AAMC:

- recommended more flexible legislation providing that hospitals be classified "by size and type" with guidance in the Committee report,
- recommended appointment of a "National Technical Advisory Board" to recommend and evaluate classification systems,
- opposed the establishment of a specific classification for "primary affiliates of accredited medical schools," and
- recommended that the Secretary, DHEW be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals."

For the provisions on determining routine operating costs limitations, the AAMC:

- recommended providing Executive Agencies with flexibility to specify the ceiling with guidance in the Committee Report;
- supported exclusion of capital costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and medical personnel and energy costs associated with heating or cooling the hospital plant,
- recommended exclusion from routine operating costs of malpractice premium costs and energy costs for lighting and facility operations;
- recommended wage rate changes reflect regional costs for technical and professional personnel in academic medical centers;
- supported case mix provisions;
- recommended a strengthened exceptions procedure; and
- recommended advance notification of 120 days for the cost limitation.

Copies of the testimony were distributed to all COTH members.

House Hearings on Medicare and Medicaid

Hearings on changing the hospital reimbursement system of the Medicare program were held on August 3rd by the Subcommittee on Health of the House Ways and Means Committee. Charles B. Womer -- Chairman of the Council of Teaching Hospitals and

then President of the Yale-New Haven Hospital -- presented the Association of American Medical Colleges' testimony. In the written testimony, the Association discussed six factors as significant contributors to hospital cost increases: general economy inflation; government-mandated programs; new benefits, services and technologies; population size and composition; per capital utilization; and some excesses and duplications in our increasingly complex health care system. Conflicting health service policies which contribute to costs by providing the industry with inconsistent guidance were discussed using the following examples:

- Some seek to increase the number of physicians, but the consequences are most likely contrary to the intent of others who advocate cost reduction or containment.

- Just compensation for patients with adverse clinical outcomes is sought, while large awards increase malpractice premiums and stimulate defensive medicine.

- "Excess" beds and staff are condemned while hospital closures are prevented by public opposition seeking, in part, to retain full employment.

- Certification and licensure of health occupations is advanced while over-specialization and its cost are attacked.

- Biomedical researchers are encouraged to strive for breakthroughs providing "completed technologies" and chastized for not actively and and immediately applying each partial finding.

- Primary and ambulatory care are encouraged while funding increases are more readily obtained for catastrophic and terminal care.

- Excellence as a standard of care is to be attained but costs are to be minimized.

The Association opposed any arbitrary percentage cap as a means of limiting Medicare expenditures and advocated changes in Representative Duncan's legislation on Medicare Reform. The Duncan legislation, H.R. 13080, is the House version of the Senate's "Talmadge bill," S. 3205. In his oral statement, Mr. Womer discussed cost increases at Yale-New Haven Hospital to provide the Subcommittee with illustrations of the uncontrollable cost factors faced by chief executive officers and Boards of Trustees.

Copies of Mr. Womer's oral and written statements were provided to all COTH members.

## NATIONAL HEALTH INSURANCE

Last November 6th, the Subcommittee on Health of the House Ways and Means Committee held hearings on national health insurance issues and proposals. In testifying on behalf of the Association, COTH Chairman Charles B. Womer then emphasized the following points:

- national health insurance is an appropriate mechanism for financing graduate medical education as a means of replenishing health manpower;

- the reimbursement system for physicians' services should provide payment for high quality health services irrespective of the setting in which they are delivered, and it should not impede the training and education of medical students and residents;

- payments to providers must reflect valid cost differences arising from differences in case mix, scope of service, and teaching programs; and

- national health insurance should recognize and encourage the continuation of philanthrophy to the health care system.

Mr. Womer's oral statement was supported and extended by submission for the record of the Report of the AAMC's Task Force on National Health Insurance.

## COST CONTAINMENT PROPOSALS

### President Ford's Medicare Proposal

In setting forth the Federal Budget for 1977, President Ford's Medicare proposals included a seven percent limitation on per diem reimbursement increases, a four percent limitation on customary and prevailing physician charges, and a copayment equal to ten percent of hospital charges subject to a maximum of a $500 beneficiary expenditure. On February 10, 1976, Dr. David Thompson -- COTH Chairman-Elect and Director of the New York Hospital -- testified on these proposals before the Subcommittee on Health of the House Ways and Means Committee. In testifying on behalf of the Association, Dr. Thompson argued that the President's proposals:

- failed to address the real factors behind hospital expenditure increases such as increased services and increases in the cost of hospital purchases,

- would increase non-reimbursable costs associated with Medicare which must be applied to non-Medicare patients,

- would reduce physician acceptance of Medicare payments on an assignment basis, and

- would increase the medical care costs of program beneficiaries.

Copies of Dr. Thompson's statement were provided to all COTH hospitals.

### SSA's HIBAC Panel

On September 16, 1976, James Bentley -- Assistant Director of the Department of Teaching Hospitals -- appeared on a panel discussing hospital reimbursement issues, before the Health Insurance Benefits Advisory Council, an advisory body to the Bureau of Health Insurance of the Social Security Administration. Other panel participants represented the Blue Cross Association, the American Hospital Association, and the Federation of American Hospitals. In the Association's testimony, Jim reviewed factors contributing to hospital expenditure increases under the Medicare Program; outlined contradictory policies and expectations faced by hospitals which increased operating costs; opposed proposals, such as President Ford's to impose an arbitrary percentage cap on hospital payments under Medicare; and suggested modifications to improve the "Talmadge Bill," S. 3205.

## NATIONAL CITIZENS ADVISORY COMMITTEE

The National Citizens Advisory Committee for the Support of Medical Education -- chaired by Gustave Levy, a prominent New York City investment banker -- was formed to provide a layman's view of the problems confronting the nation's medical centers. In October, 1975, the Committee released a statement setting forth its views concerning health manpower training legislation.

In the Spring of 1976, the Committee decided its second major policy statement would address critical issues in cost containment and the reimbursement of teaching hospitals. Recognizing that cost containment programs must include teaching hospitals, the Committee's current draft argues that cost containment programs must be carefully designed and implemented to recognize the unique contributions and requirements of teaching hospitals, lest the financial integrity of these institutions be undermined. In developing position statements and drafts of this proposed report, Department staff have provided the Committee with essential support and assistance.

## HEALTH PLANNING

The Department of Teaching Hospitals has responsibility for monitoring development and implementation of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) and responding, in light of their impact on teaching hospitals, to the various policy statements, guidelines, and proposed regulations concerning the health planning law. The AAMC Task Force on Implementation of Health Planning Legislation, chaired by Dr. Charles Sanders, General Director of Massachusetts General Hospital, assisted the Department's staff in making these responses providing advice and guidance as necessary.

During the past year, comments and recommendations were submitted concerning Health Systems Agency (HSA) designation regulations, the interpretation of Section 1522(b)(c)(3) of P.L. 93-641 which deals with minimum membership composition of a HSA governing body and executive committee, and the proposed regulations regarding State Health Planning and Development Agencies (SHPDAs), Statewide Health Coordinating Councils (SHCCs), Review of New Institutional Health Services, and Capital Expenditures Review. In addition, the Department of Teaching Hospitals has had the opportunity, on a number of occasions during this past year, to express the views of the AAMC regarding the proposed uniform accounting system being developed under Section 1533(d) of P.L. 93-641.

The Association has also repeatedly expressed concern over Section 1513(e) of the national health planning law which deals with "Planning Agency Review of Proposed Uses of Federal Funds" under Title IV (National Institutes of Health) and Title VII (Health Research and Teaching Facilities of Professional Health Personnel). In a position paper formulated by the Task Force on Implementation of Health Planning Legislation, the AAMC submitted its interpretation of and comments on Section 1513(e) with regard to planning agency responsibility and authority for programs designated for funding under Titles IV and VII.

The Association also plans to comment on the "National Guidelines for Health Planning" as they are proposed and developed. HEW's initial statement of these guidelines is expected to be published by the latter part of November, 1976.

## MANAGEMENT ADVANCEMENT PROGRAM

Since its inception in 1971, the Management Advancement Program (MAP), directed by the Association's Department of Institutional Development, has been an educational effort for senior administrators from academic medical centers. The objective has been approached through the presentation of didactic lectures and through an open exchange between program participants and lecturers throughout the course of the various seminars. This year, the seminar programs, which have traditionally concentrated on medical school personnel, were expanded to include a five-day session especially designed for administrators of COTH hospitals. The MAP/COTH seminar was attended by twenty-two hospital administrators, one dean and one department chairman. The seminar, conducted in June of 1976, is currently being evaluated to determine its acceptance and usefulness and to arrange possible future offerings for COTH hospital administrators.

## STANDARDS FOR PERSONNEL IN CLINICAL LABORATORIES

While the Clinical Laboratory Improvement Act (H.R. 14319 and S. 1737) died in the final rush for Congressional adjournment, HEW held hearings on its "Proposed Standards for Personnel in Clinical Laboratories" on July 21st. In a written statement submitted for the hearing record the Association stressed that, while the quality of tests needs to assured, the proposed standards for laboratory personnel promulgated by HEW exceed that which is needed to assure good laboratory performance, are unnecessarily restrictive, and specify internal management and operations requirements for clinical labs. The Association's statement recommended:

- deleting personnel requirements below the level of laboratory supervisor or director;
- establishing less restrictive qualifications for the laboratory director and technical supervisor categories;
- proceeding with caution in the adoption of regulations which would inadvertently constrain the clinical research laboratory.

Lastly, the Association offered to assist HEW in the development and evaluation of new regulations.

## SURVEYS

The Department has maintained its program of continuing and special membership surveys during the year. The 1975 Executive Salary Survey, published in November of 1975, was compiled from the responses of 293 COTH members. For chief executive officers, the survey described salaries, fringe benefits, and hospital compensation policies. For departmental executives, salary and fringe benefit data was published. Questionnaires for the 1976 survey were mailed to COTH members in September, and it is anticipated that findings from the data will be distributed shortly after the Annual Meeting.

The fifth annual Survey of State Appropriations, Income and Expense Analysis for university-owned hospitals was published in April, 1976. The report, which included fifty-six institutions for fiscal year 1974, differed from previous surveys in two ways: first, income data was requested on an accrual rather than a cash basis and, second, expense data was keyed to the Medicare cost reports to improve data comparability. Questionnaires for the survey covering fiscal year 1975 were mailed in May, 1976 with publication of the report scheduled for January, 1977.

The 1976 COTH Survey of House Staff Policy and Related Issues was mailed to members in October. As in the previous house staff surveys, the 1976 edition describes house staff stipend increases and house staff fringe benefit programs and trends. Information is organized by geographic region, type of hospital control, and type of affiliation. This year's survey included new questions on outpatient psychiatric insurance coverage, paid leave, notification of appointments, moonlighting, rotation schedules, and the distribution of ethnic minorities and women as house staff.

In February of this year, COTH published its eighth annual Directory of Educational Programs and Services. This 1976 Directory provided a profile of COTH member hospitals with selected statistics related to the operational characteristics and educational programs of each institution. Questionnaires for the 1977 Directory were mailed in August and included a new question designed to ascertain the number of residents and fellows in training in each program at COTH hospitals.

In addition to the special survey on the impact of Section 223 ceilings on COTH members (see page 3), the Department conducted a special Survey on Professional Liability Insurance in University Hospitals in the fall of 1976. The questionnaire sought information on the source of coverage for professional personnel and the source of premiums for that coverage. In addition, information on professional liability insurance and claims was requested. Because of the complexity of the information obtained, it is anticiapated that results of this survey will be published in January, 1977.

## MEDICAL SCHOOL-HOSPITAL AFFILIATION STUDY

The Association has contracted with the Bureau of Health Manpower of the Health Resources Administration to study the relationships between medical schools and their affiliated hospitals. The study is designed to develop a means of describing the complexity of medical school-clinical affiliate relationships and to investigate, from a management perspective, problems in these relationships.

The study design includes questionnaires to describe the program activities and resources of the affiliated institutions, and site visits to examine dynamic aspects of the relationship including:

- assignment of medical students to clerkships;
- assignment of residents by specialty;
- initiation of new patient care programs;

- allocation of resources for sponsored programs;
- selection of educational officers in affiliated hospitals;
- participation of volunteer faculty in medical school affairs.

In developing and conducting this study, staff of the Department of Teaching Hospitals have worked with staff in the Department of Institutional Development with study and analysis design, questionnaire construction and site visits. Copies of the study will be made available when the effort is completed early in 1977.

## STAFF CHANGES

### Resignations

Effective July 15th, Steve Summer, Assistant Director of the Department, resigned to accept a position as Vice President for Professional Activities of the Maryland Hospital Association. Steve joined the Department in July, 1974 as a Staff Associate, and in addition to his other responsibilities, was the Managing Editor of the COTH REPORT.

Robert Carow, Staff Associate in the Department, resigned October 8th to take a position with the Advisory Committee on Federal Pay. In addition to general duties, Bob was specifically responsible for the financial survey of university-owned hospitals and prepared a bibliography on the economics of teaching hospitals.

### Appointments

James D. Bentley, Ph.D., joined the Department as the Assistant Director on March 1, 1976. Jim earned a Bachelor's degree from Michigan State University where he majored in health facilities management. He was awarded the doctoral degree from the University of Michigan's Program in Medical Care Organization in 1971. For the past five years, he has been the Assistant Research Director at the Naval School of Health Care Administration, Bethesda, Maryland.

On October 11th, Joseph C. Isaacs joined the Department as a Staff Associate. Joe earned a B.A. in psychology at the City College of New York and a Master of Science in Public Health in 1975 from the University of Missouri's Graduate Program in Health Services Management. Prior to joining the AAMC, Joe was a Health Care Consultant in the Government Services Office of Arthur Young and Company, Washington, D.C.

## MISCELLANEOUS

In addition to the program of activities described in this report, Department staff have submitted numerous comments on proposed regulations published by federal agencies and have distributed key government regulations and policy documents to COTH members.

Coordination with other hospital associations has been maintained through regular participation in meetings of the Allied Hospital Association Executives.

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# 1975-1976

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CHAIRMAN-ELECT
David D. Thompson, M.D.*
Director
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IMMEDIATE PAST CHAIRMAN
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