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, 1976 - October, 1977

The Association of American Medical Colleges authorized the formation of a Council of Teaching Hospitals in November, 1965. Organized as one of three governing councils in the AAMC, the purpose of the Council of Teaching Hospitals is to provide activities and programs relating to special problems and opportunities in medical school affiliated or university-owned teaching hospitals. Membership in COTH presently stands at 406 teaching hospitals.

The Department of Teaching Hospitals is the staff component of the Association 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 report 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.

LIMITING HOSPITAL REVENUES

No activity has consumed more staff time in the past year than have responses to national efforts to limit hospital revenues. While many of the proponents of such efforts have argued that their particular program would contain hospital costs, the common denominator of all proposals has been that they would directly limit payments to hospitals without directly reducing the rate of increase in hospital costs. In response to these proponents, the AAMC -- while recognizing the legitimate national interest in reducing the rate of increase in hospital costs -- has attempted to explain the multiple and interrelated factors contributing to hospital cost increases, has opposed legislative proposals which do not recognize the unique contributions and financial requirements of teaching hospitals, and has favored proposals which use regional planning and utilization review to redirect hospital activities and costs.

National Citizens Advisory Committee

The National Citizens Advisory Committee for the support of Medical Education -- chaired by former I.R.S. Commissioner Mortimer M. Caplin -- was formed to provide a layman's view of the problems confronting the nation's medical centers. In February, 1977, the Committee issued a statement setting

forth its views concerning hospital cost containment, a statement developed with the support and assistance of the Department of Teaching Hospitals.

The Citizens Advisory Committee statement, "Cost Containment and the Reimbursement of Teaching Hospitals," reviewed trends in health and hospital expenditures and factors responsible for hospital expenditures. It concluded with the recommendation that hospital reimbursement programs attempting to contain hospital costs should adopt the following principles in paying teaching hospitals:

- Reimbursement programs should assure hospitals payment for the justifiable costs of patient care and medical education services. In determining justifiable costs, reimbursement programs should:
  - recognize the impact of a hospital's approved scope of services and its patient mix on operating costs.
  - calculate operating costs on a "going concern" basis with full recognition of bad debts, working capital requirements, and depreciation.
  - recognize physician costs for personal medical services and for medical program supervision and administration.
  - recognize capital expenditures which are reviewed and approved by appropriate planning authorities.
  - recognize costs resulting from manpower training programs which are accredited by an appropriate organization. Costs recognized should include faculty costs for educational instruction and supervision, costs for student stipends where provided, and costs for program support and institutional overhead.
  - the efficient allocation of facilities, capital equipment, and services should be supported in determining justifiable costs; however, resource allocation decisions based solely on patient service requirements may increase total health costs by creating inefficiencies which increase expenses for student training, faculty participation, and program coordination. Therefore, reimbursement programs which determine justifiable costs in hospitals with accredited educational programs should give consideration to both patient care and educational program efficiencies.

Copies of the Committee's statement were sent to all COTH members.

The Carter Administration Proposal

In his February budget message, President Jimmy Carter indicated that he would propose a hospital payment program which would reduce hospital revenues from an anticipated fourteen percent increase to a nine percent increase. Following the President's message, Association officials, including staff from the Department of Teaching Hospitals, met with HEW officials to discuss the Administration's thinking in this area and to advocate special consideration for the costs incurred by teaching/tertiary care hospitals.

On April 25th, President Carter, stating that "the cost of (health) care is rising so rapidly it jeopardizes our health goals and our other important social objectives," announced his proposed "Hospital Cost Containment Act of 1977." The proposed program, which was to begin October 1, 1977, had four major purposes:

-- to contain the rate of increase in hospital inpatient revenues,

-- to establish a system of capital allocation for hospital facilities and services,

-- to provide for the publication and disclosure of selected hospital charges, and

-- to provide for permanent reforms in hospital reimbursement.

The President's proposal was introduced in the Congress by Senator Kennedy (D-Mass.), S. 1391, and by Representatives Rogers (D-Fla.) and Rostenkowski (D-Ill.), H.R. 6575.

To develop the Association's position on the Administration's proposal, an Ad Hoc Committee was appointed. The Committee -- chaired by COTH Chairman-Elect David Everhart, President of the Northwestern Memorial Hospital -- consisted of David D. Thompson, COTH Chairman and Director of the New York Hospital; Robert Heyssel, Executive Vice President and Director of the Johns Hopkins Hospital; Lawrence Hill, Executive Director of New England Medical Center Hospital; David Hitt, Executive Director of Baylor University Medical Center; Robert Rhamy, Chairman of the Department of Urology, Vanderbilt University; Elliot Roberts, Director, Charity Hospital, New Orleans; Edward Stemmler, Dean, the University of Pennsylvania School of Medicine; and Charles B. Womer, President of the University Hospitals of Cleveland. Working from a comprehensive outline prepared by Department staff, the Ad Hoc Committee developed a policy outline for testimony on the revenue limitations (Title I) and capital expenditure limitations (Title II) of the Administration's proposal.

Hearings on the Administration's cost containment proposal were held by House and Senate Committees in May and June. On May 12th COTH Chairman David Thompson and Chairman-Elect David Everhart appeared before a joint hearing of the Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce and the Subcommittee on Health, House Committee on Ways and Means to present the Association's position on

hospital cost containment. The Association objected to the arbitrary nature of the flat percentage cap and the inherent inequity of capping only one industry in the economy. Specific problems that the proposal would create for teaching hospitals -- such as the absence of a case mix adjustment and the inclusion of hospital based educational costs in the cap -- were discussed and highlighted. In lieu of the President's revenue cap proposal, the AAMC suggested that one alternative might be reimbursement limitations based on comparing the costs of similarly grouped hospitals and the full implementation of PSRO and health planning programs. The Association also objected to the arbitrary provisions of the President's limitation on hospital capital expenditures -- a $2.5 billion annual ceiling on capital expenditures, a national standard of 4 beds/1,000 population, and a national standard for hospital occupancy of no less than 80 percent -- because they are insensitive to local needs and conditions and to inter-area migration of patients for tertiary level care. In place of the President's proposal, the AAMC testimony recommended full implementation and financial support of an amended National Health Planning and Resources Development Act. Copies of the AAMC testimony were distributed to all COTH members.

On July 17th, the Association of American Medical Colleges (AAMC) testified before the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee on the Carter Administration's "Hospital Cost Containment Act of 1977." The Association's testimony was presented by David D. Thompson, COTH Chairman and Director of the New York Hospital and Robert M. Heyssel, member of the COTH Administrative Board and Executive Vice President and Director of the Johns Hopkins Hospital. In lieu of the revenue limitations proposed by the President, the AAMC recommended a six point program to moderate hospital costs:

(1) Uniform Cost Reporting: a uniform hospital cost reporting system must be developed and implemented immediately;

(2) Publication of Financial Data: hospital financial statements and charge data should be published and made available to the general community;

(3) Promoting Legislative Consistency: every bill or regulation affecting hospital operations should be accompanied by a cost impact statement;

(4) Promotion of Existing Programs: the PSRO and health planning programs must be fully implemented with expansion of the former to cover all inpatients and of the latter to cover non-institutional capital expenditures under Certificate-of-Need;

(5) Prospective Payment Limitations: reimbursement limitations could be derived from cross-classification schemes which remove atypical and uncontrollable costs and include an effective exceptions process; and

(6) State Rate and Budget Reviews: consideration should be given to permitting Medicare to pay state-determined rates where the state system applies to all hospitals and all revenue, bases rates on full financial requirements of hospitals, is

an independent agency with appropriate staffing, includes formal procedures including public hearings, and provides due process and judicial review.

At the present time, the outcome of Congressional action on the Administration's proposal is most uncertain. In the House, it was referred to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means. While a Subcommittee of Interstate and Foreign Commerce has endorsed an amended version of the President's proposal, the Health Subcommittee of Ways and Means has not convened a quorum on this issue for several months. Recently, Representative Rostenkowski, Chairman of the latter Subcommittee, indefinitely suspended further attempts by his Subcommittee to hold mark-up sessions on the bill. Both House Committees, and their Subcommittees, must act before any cost containment bill is considered by the House as a whole. In the Senate, the proposal was similarly referred to two Committees: Human Resources and Finance. In August, the former adopted an amended version of the President's proposal which was previously reported out by its Subcommittee on Health and Scientific Research chaired by Senator Kennedy (D-Mass.). The Subcommittee on Health of the Finance Committee, however, has only held hearings on the proposal in conjunction with hearings on the Talmadge Bill (see below). Thus, legislation appears unlikely this year.

The Talmadge Bill

In 1976, Senator Herman Talmadge, Chairman of the Subcommittee on Health of the Senate Finance Committee, introduced legislation to revise the Medicare and Medicaid programs, including their provider payment provisions. On February first, an Ad Hoc Committee to review the Talmadge Bill on Medicare and Medicaid Reform was appointed. Chaired by Irv Wilmot, Executive Vice President of NYU University Hospital, the Committee was composed of Daniel Barker, Administrator of Crawford W. Long Memorial Hospital, Atlanta; Ellis Benson, Chairman of Laboratory Medicine and Pathology, University of Minnesota Medical School; Stuart Bondurant, President and Dean, Albany Medical College; John Colloton, Director, University of Iowa Hospitals and Clinics; Marvin Cornblath, Chairman of Pediatrics, University of Maryland Medical School; John M. Dennis, Dean, University of Maryland, and Jerome H. Modell, Chairman of Anesthesiology, University of Florida College of Medicine. The Committee carefully and thoroughly reviewed the testimony presented by the Association in 1976, paying special attention to the positions taken on hospital reimbursement and physician payment. The Committee's report was reviewed and amended by the COTH Administrative Board and then adopted by the Association's Executive Council at its April first meeting.

Senator Talmadge re-introduced his Medicare and Medicaid reform proposal (S. 1470) on May 5th, and on June 8th COTH Chairman David Thompson testified on the proposed legislation before the Subcommittee on Health of the Senate Finance Committee. Acknowledging that hospital payment limitations derived from cross-classification are one legitimate approach to containing expenditures for hospital services, the Association's testimony recommended modifying the bill to provide more flexible provisions so that learning acquired through experience would not require new legislation to change the payment provisions. It was also recommended that the Secretary of HEW initiate studies to adequately define "tertiary care/teaching" hospitals and to examine the impact of establishing a special payment category for these hospitals. In discussing

the proposed physician payment provisions, the AAMC recommended amending the bill to ensure that faculty physicians could be paid for either professional or educational services when providing care in the presence of students and opposed payment mechanisms which would inhibit the development of any discipline.

In opening the June hearings on his bill, Senator Talmadge promised that an expanded version, covering all inpatient costs and all payors, was being developed by Subcommittee staff. In mid-July Department staff learned that Subcommittee staff was examining the impact of an expanded Talmadge bill on teaching hospitals. Following direct discussions with Subcommittee staff and the review of a Congressional Research Service study of the impact of the bill on 102 medical centers, Department staff conducted an evaluation which explored the reimbursement impact of some alternative groupings of tertiary care/teaching hospitals. Copies of the paper, "Classifying COTH Members for Determining Reimbursement Limitations: An Empirical Examiniation," were provided to Subcommittee staff.

In early October, Senator Talmadge announced the long awaited expansion of his "Medicare-Medicaid Administrative and Reimbursement Reform Act." The revision, published as an outline rather than a fully-drafted bill, uses separate routine and ancillary service revenue ceilings to cover all hospital inpatient services and payors, effective with accounting periods beginning on or after July 1, 1978. As drafted, the routine revenue limitation would be applied on a per diem basis while the ancillary revenue limitation would apply on a per admission basis. Separate revenue limits would be calculated for the hospital's routine services (bed, board, routine nursing and supplies, etc.) and for its ancillary services (X-rays, laboratory tests, drugs, etc.).

To obtain initial reaction to Senator Talmadge's revised approach, the Subcommittee on Health of the Senate Finance Committee held three days of hospital cost containment hearings beginning on October 12th. Charles B. Womer -- Immediate Past Chairman of the Council of Teaching Hospitals and President of University Hospitals of Cleveland -- presented oral and written testimony on behalf of the Association of American Medical Colleges (AAMC). He restated the AAMC's opposition to the Administration's proposed cost containment proposal, including the amended verison adopted by the Senate Human Resources Committee. Reviewing the revised Talmadge Bill, Mr. Womer supported several principles contained in the outline:

1. The effort made to recognize differences among institutions and geographic regions in the control mechanism.

2. The effort which is being made to compare costs which should be most similar among institutions and to exclude those costs which are uncontrollable or for very good reasons vary widely among institutions.

3. The recognition that the costs of goods and services purchased by hospitals often vary from the changes in costs in the overall economy and the intention to recognize these differences.

4. The intention to include an enlightened exceptions process and the provision for increases resulting from changes in patient mix and the intensity of care provided.

5. The recognition of the cumulative effect of year-to-year cost increases.

6. The inclusion of incentives for those hospitals in a group which have below average costs.

7. The requirement for uniform reporting of hospital costs.

8. Recognition that all admission increases have costs associated with them.

9. Recognition of the operating cost increases of approved expansion of patient care services.

10. The collective, rather than separate, application of the routine and ancillary revenue ceilings.

11. The recognition of regional variation in wage levels.

Mr. Womer then described AAMC concerns about the classification system to be used to group hospitals, the price indices to be used to calculate ancillary service limits, the lack of a definition for "revenue," the absence of a method for incorporating excluded routine service costs into the revenue limit, and the question of whether special care units will be treated as ancillary or routine services. Last, the AAMC expressed caution against establishing a long-range approach to hospital cost containment which would fractionalize hospital management and operations by calculating separate revenue ceilings for individual revenue or cost centers.

Medicare's Routine Service Cost Limitations

Federal regulations establishing per diem routine service cost limitations for hospital payments under the Medicare program became effective for accounting periods beginning after June 30, 1974. In May, 1975, the Association of American Medical Colleges filed suit in the U.S. District Court seeking relief from the regulations, arguing that the regulations were arbitrary, capricious, in excess of the HEW Secretary's authority, inconsistent with the 1972 Amendments to the Social Security Act, and would cause irreparable harm to teaching hospitals.

The initial court decision was in favor of the Department of Health, Education and Welfare. Therefore, the AAMC appealed the decision. While oral briefings on the appeal were presented on September 16, 1976, the U.S. Court of Appeals -- on April 1, 1977 -- requested a supplemental brief from the Association concerning the jurisdictional authority of the courts in this matter.

On May 2nd, the AAMC filed the court-requested supplementary brief taking the position that, while individual claimants seeking judicial review of specific benefit determinations must follow prescribed administrative procedures before turning to the courts, the court has direct and immediate jurisdiction to review agency regulations implementing legislation. Since that supplemental brief was filed, no court action on the appeal has been announced.

To develop quantitative support for the Association's concerns regarding the impact on COTH members of the Medicare program's routine service cost

limitations, postcard surveys of non-Federal COTH members were conducted in the Spring of 1976 and 1977. The surveys requested member hospitals to indicate: (1) the inclusive date of the hospital's cost reporting periods for the current and past year and (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 routine service costs. Thus, in the past two years, the Department of Teaching Hospitals has collected information on the Section 223 status of COTH members as follows:

(1) Fiscal Year 1975 Actual Status -- collected as past year data on the Spring 1976 survey.

(2) Fiscal Year 1976 Estimated -- collected as current year data on the Spring 1976 survey.

(3) Fiscal Year 1976 Actual -- collected as past year data on the Spring 1977 survey, and

(4) Fiscal Year 1977 Estimated -- collected as current year data on the Spring 1977 survey.

The surveys supported the following conclusions: (a) approximately twenty percent of the responding hospitals had costs exceeding or expected to exceed the routine service cost limitation; (b) a large majority of hospitals exceeding their Section 223 ceilings in one fiscal period also expect to exceed the ceiling in the subsequent fiscal period; (c) hospitals exceeding the ceiling in the current year are generally over the ceiling by a larger amount than were those hospitals which exceeded the ceiling in past years; and (d) COTH hospitals exceeding the ceiling tend to be located in the west, university-owned, under 410 beds, controlled by a state or county, and spending over $7.75 per adjusted patient day for house staff stipends.

A schedule of payment ceilings for Medicare limitations on routine service costs for cost reporting periods beginning on or after October 1, 1977 was proposed by the Health Care Financing Administration in the August 12th Federal Register. The schedule -- consistent with the one published on July 8th for hospitals with reporting years beginning in July, August, or September -- is based on essentially the same methodology as that used in previous years. In proposing this Section 223 schedule, DHEW included the following statement on future payment limitations: ". . . the Secretary hereby serves notice of his intention to review these limits from time to time and make such changes in the limits as circumstances may warrant to assure that costs which are reimbursed are reasonable. Any such changes will be prospective in nature but will apply to all hospital inpatient general routine service costs incurred after the effective date of the changes."

The Association's critical comments on this proposed schedule were submitted to the Administrator of the Health Care Financing Administration on September 9th. The comments objected to establishing a payment limitation using a methodology which equates statistically atypical costs with excessive or unnecessary costs; requested the establishment of a viable and timely exceptions process; asked for a clearer statement that prospective changes in the limitations will not affect a hospital's current cost reporting period; and recommend that DHEW provide hospitals with payment limitations at least 120 days prior to the start of a hospital's cost reporting period.

HOUSE STAFF UNIONIZATION

In March, 1976, when the National Labor Relations Board (NLRB) declared, in its Cedars-Sinai and similar decisions, that house staff are primarily students rather than employees for purposes of coverage under the National Labor Relations Act (NLRA), many anticipated a reduction in Association activities on this issue. Subsequent legislative and judicial actions, stimulated by house staff unions, have not supported the original expectation.

Legislative Activities

Representative Frank Thompson, Jr., (D-NJ) -- Chairman of the House Subcommittee on Labor-Management Relations -- introudced a bill on October 1, 1976 which would amend the National Labor Relations Act to define house staff, and certain other post-baccalaureate students, as employees for purposes of coverage under the Act. Following the Congressional adjournment, Representative Thompson held labor relations oversight hearings on November 29th in San Francisco. Because witnesses for the oversight hearings were specifically asked to address the Cedars-Sinai decision, Stuart Marylander -- Executive Vice President of the Cedars-Sinai Medical Center and a COTH Administrative Board member -- and Robert Tranquada, Associate Dean for Postgraduate Medical Education at UCLA, testified at the hearing in favor of the NLRB's decision and in opposition to Representative Thompson's bill.

On January 19th, Representative Thompson re-introduced his legislation to define house staff as employees under the NLRA. The bill, known as H.R. 2222, was the subject of hearings before Thompson's Subcommittee on Labor-Management Relations on April 4th and 25th. Lead-off witness at the April 4th hearings was John A. D. Cooper, President of the Association of American Medical Colleges. Dr. Cooper presented the AAMC's position that residency programs are an integral part of the medical education process and that the resident is primarily a student whose relationship with the hospital should be based on an educational rather than an industrial model. Other witnesses -- including the American Medical Association -- supported Representative Thompson's bill. The April 25th hearing, held at the request of the Subcommittee minority members, accented witnesses opposed to Thompson's bill, including hospital attorneys, hospital association representatives, medical educators, and present and former residents.

No additional legislative activity on house staff coverage under the NLRA occurred until July 19th when Senators Donald W. Riegle, Jr. (D-Mich.) and Alan Cranston (D-Calif.) introduced legislation in the Senate to define house staff as employees under the Act. To date, that bill, S. 1884, has been referred to the Senate Committee on Human Resources where hearings have not been scheduled. Responding to letters from AAMC members opposed to his bill, Senator Riegle has repeatedly stated the position that educational issues can be separated from employee issues and the former declared non-bargainable. Therefore, Department staff and AAMC counsel are presently preparing an analysis which demonstrates the impossibility of this contention under the National Labor Relations Act.

Judicial Activities

As a direct result of the Cedars-Sinai decision, house staff unions in the State of New York petitioned the New York State Labor Relations Board to accept jurisdiction over house staff labor relations in the State's not-for-profit hospitals. When the State Board relied on an NLRB advisory opinion to dismiss a house staff request for certification as an exclusive bargaining agent, the Committee of Interns and Residents of New York filed suit challenging the State Board's decision. Following a State court decision that the State Board had jurisdiction over house staff, the National Labor Relations Board filed a Federal Court suit seeking to establish the NLRB's pre-emptive authority over state labor boards.

On January 31st, Judge Charles Stewart of the U.S. District Court for the Southern District of New York ruled that the National Labor Relations Act did not pre-empt state labor boards from asserting jurisdiction over house staff representation petitions. The National Labor Relations Board appealed Judge Stewart's decision and subsequently a three judge panel from the U.S. Court of Appeals for the Second Circuit, headed by former Connecticut Governor Meskill, heard the appeal in July.

On September 21st, in a unanimous opinion, the Appeals Court ruled that the jurisdiction of the NLRB over house staff in voluntary, non-profit hospitals pre-empts state labor boards from asserting jursidiction over house staff in these hospitals. Arguing that the wisdom of the NLRB decision that house staff are primarily students was not before the Appeals Court, the decision states: "Thus, it is clear from (the) Cedars-Sinai and Kansas City II (decisions) that the NLRB has not ceded jurisdiction over housestaff. Rather, the NLRB concluded that, although it has jurisdiction, it would be contrary to national policy to extend collective bargaining rights to housestaff because they 'are primarily students.'"

In both the U.S. District and Appeals Courts, the AAMC submitted amicus curiae briefs supporting the NLRB's position that house staff are primarily students and arguing that the NLRB's decision should pre-empt contrary state action.

On March 3rd, the Physicians National Housestaff Association (PNHA) and four housestaff associations brought suit against the National Labor Relations Board in the U.S. District Court for the District of Columbia. PNHA argued that the NLRB had exceeded its authority in the Cedars-Sinai decision. While the AAMC requested permission from the Court to file an amicus curiae brief supporting the NLRB in this suit, that request was denied by the presiding judge in October. In making his denial, the judge noted that the AAMC's position was a part of the NLRB's records in this case. A court date for this suit is expected shortly.

MEDICARE REIMBURSEMENT PRACTICES

Teaching Physician Payment

In March of 1976 the Congressionally chartered study of the payment of physicians in teaching hospitals, under Section 227 of the 1972 Medicare Amendments to the Social Security Act, was published by the NAS Institute

of Medicine. Since there was not sufficient time between March and July, 1976 to consider the results of the study, legislation (P.L. 94-368) was passed and signed by the President on July 14, 1976 which further deferred implementation of Section 227 until September 30, 1977.

The original legislation which authorized the study by the Institute of Medicine required that the Social Security Administration review and analyze the IOM report and submit its analysis to the authorizing Congressional committees 90 days subsequent to the completion of the IOM report. To date, the Social Security Administration has never submitted its required report. By letter on September 20, 1977, Robert Derzon, Administrator of the Health Care Financing Administration, recommended -- to the respective Chairmen of the Senate Finance Committee and the House Ways and Means Committee -- a further deferral of Section 227 implementation until September 30, 1978. In his letter, Mr. Derzon stated that during this interim period HCFA will publish regulations and issue instructions to Medicare carriers and intermediaries that will allow Section 227 to become operational by September 30, 1978. He wrote that, "These reguations which are now in the early stage of preparation, should lead to a strengthening of the private patient-physician relationship explicit in Section 227, while at the same time modifying 'the fiscal test' requirement contained in the proposed regulations published in July, 1973." He also expressed his concern about current reimbursement by Medicare and Medicaid for administrative services provided to teaching hospitals by medical schools and has advised that the new regulations should clarify existing ambiguities which in his view could be currently providing excessive reimbursement.

As a result of Mr. Derzon's letter, Department staff are working to have legislation introduced which would delay the effective date of Section 227 until October 1, 1978.

Family Practice Grants

Existing Medicare regulations (section 405.421 of Title 20, C.F.R.) provide that "an appropriate part of the net cost of approved educational activities is an allowable cost" under the program where "the net cost means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs) less any reimbursement from grants, tuition, and specific donations." Under these regulations, the Bureau of Health Insurance (BHI) has taken the position that federal and state grants for medical education are restricted grants which must be deducted from the costs of education program prior to determining allowable costs for services provided to Medicare beneficiaries. The result of this reimbursement policy is clear: the actual dollars received in federal grants are accompanied by a reduction in Medicare reimbursement. The consequences of this reimbursement reduction are similarly clear: (1) grant funds provide a lessor stimulus than that intended by the granting agencies; (2) state funds unintentially support a federal social insurance program; and (3) provider incentives to respond to government programs are substantially reduced.

This reimbursement issue received increased visibility in 1977 because of developments and policy changes made by the Region IV (Atlanta) office of the Bureau of Health Insurance. In Intermediary Letter 3-75 of January 22, 1975, the Regional BHI office specified that ". . . grants from HEW for the

establishment of residency programs in family practice" are to be classified as "seed money" grants which are not offset against provider costs in determining Medicare reimbursement. On July 14, 1976, the Regional office issued Intermediary Letter 12-76 stating that its prior Intermediary Letter was in error. As a result of this change in policy, intermediaries attempted to retroactively recover funds approved under the original Regional Intermediary Letter. In at least one case, this retroactive recovery has the potential to amounting to over one million dollars.

During the Spring of 1977, Department staff worked with COTH members in HEW Region IV to clarify the reimbursement and public policy issues raised by the treatment of family practice grants. In April, the Association sent a letter to HEW Secretary Califano strongly recommending (1) that Section 405.421 of the Medicare regulation (20 C.F.R.) be revised, at the earliest possible date, to provide that graduate medical education grants are not to be deducted from program costs in determining Medicare reimbursement to the extent that such grant funds do not result in a net operating gain (total program revenue less total program cost > 0) for the program supported by the grant and (2) that the federal government not seek retroactive recovery of Medicare funds where graduate medical education grants were treated, under Regional BHI instruction, as "seed money" grants.

As a result of provider, Association, and Bureau of Health Manpower concerns over Medicare's treatment of grants for graduate medical education, HEW held a one day conference on this issue in September. Teaching hospital staff were included in that conference. Shortly thereafter, Secretary Califano wrote the Association that he had directed HCFA Administrator Robert Derzon and Assistant Secretary Richmond to develop a consistent HEW policy on this matter. Further, Califano stated, "our objective is to find a solution to the problems which have arisen in the past, which is both equitable to health care providers in their capacities as teaching institutions and grantees, and consistent with our longer term position towards the support of primary care residency programs."

Allowable Interest Expense

In an advisory opinion from the Commissioner of the Social Security Administration, a private University was advised that the Medicare program would not recognize, as an allowable cost, interest expense on external borrowings when the University had unrestricted endowments which it is not applying to the costs of constructing a new University hospital. This advisory opinion was based on three related lines of argument some of which could be applied more generally to non-university hospital endowments.

> Since (the) Hospital is a teaching hospital which is owned, operated, and a part of the corporate entity of (the) University, the university and hospital must be treated as related organizations under program policy. As such, the funds which the university advances to its teaching hospital, which is a part of the university complex, cannot be considered loans under the Medicare since they are merely a transfer of funds between two components of the same organization. Accordingly, the interest payments on funds generated from within the organization cannot

be considered allowable interest expense in determining provider reimbursement under the program.

We do not think it is unreasonable to consider funds which are unrestricted funds of the university to also be funds of the hospital. To do otherwise would result in the reimbursement of unreasonable cost if provider organizations were permitted to transfer such funds between their operating activities in order to maximize Medicare reimbursement.

It would also be erroneous to allow interest expense on external borrowings when existing funds are currently available within the corporate entity. Where a university and a hospital are operating components of the same corporation, the revenues and unrestricted funds generated from either corporate operation represent corporate moneys which are available to meet any corporate requirement. Accordingly, revenues derived from the university's operation (student fees, tuition, etc.) are corporate revenues which may be used to satisfy expenditures incurred by the hospital component.

Department staff have worked with the University's legal counsel to identify other university-owned hospitals that could be denied interest payments under the same arguments and to arrange a meeting of these university hospital officials with the involved University and its counsel. Staff have also assisted the University's legal counsel in identifying and preparing background materials for the University's formal request for a reversal of SSA's advisory opinion.

The issues raised in this particular university-owned situation may extend to hospitals more generally. In the SSA Commissioner's letter, the statement is made that ". . . there is no basis under existing Medicare policy for allowing interest expense on internal or external loans when funds are available within the organization to meet such requirements." Conceivably, the Medicare position underlying this statement could require any hospital with an unrestricted endowment to exhaust such funds prior to obtaining external funds such as bank loans. Teaching Hospital staff are monitoring Medicare actions to determine if this more general interpretation is being employed by program authorities.

Malpractice Insurance Alternatives

The rapid rise in premiums for commercial malpractice insurance has stimulated many hospitals, singularly or collectively, to develop alternative forms of professional liability coverage. Last year, the Bureau of Health Insurance issued the first public draft of a policy that would permit reimbursement for some alternative forms of professional liability coverage, and staff commented extensively on it. In the past year, BHI published both a second draft and a change in the Provider Reimbursement Manual which recognized alternative malpractice coverage arrangements. Staff, once again, commented on the draft version: the AAMC strongly recommended (1) that BHI

include as an allowable hospital cost those costs incurred to include house staff, hospital-based, and salaried physicians as named insureds in the hospitals' malpractice coverage; (2) that BHI permit state and municipal government treasurers to serve as a self-insurance trust fund agents; (3) that BHI allow costs for self-insurance funds to include expenses for administering risk management programs; (4) that BHI deny reimbursement for losses exceeding coverage only in instances where the coverage limits were not representative of prudent business practices; and (5) that BHI eliminate the use of the term "general patient liability" and use only general liability and professional liability in describing hospital insurance programs. Since the manual change was published, staff have worked with American Hospital Association staff and the AHA's Advisory Panel on Malpractice to obtain clarification of several issues, especially the separation of general patient liability and professional liability coverages.

Uniform Hospital Accounting

The Office of Research and Statistics of the Social Security Administration, for the past several years, has been working to develop a uniform hospital accounting manual. In January, SSA officials requested a meeting with Department staff to discuss SSA's viewpoint on uniform accounting for outpatient, ambulatory, and emergency services. Staff arranged a meeting with SSA which included representatives from COTH member hospitals. Upon review, members and staff expressed serious concern: (1) that an accounting system was being developed prior to development of a reporting system, (2) that the proposed accounting system allowed no flexibility in its chart of accounts, and (3) that the proposed system could not be sufficiently expanded to meet managerial, as distinct from third-party payor, needs. Following several additional technical comments, the Association offered to continue working with SSA to evaluate outpatient accounting proposals.

HEALTH PLANNING

The National Health Planning and Resources Development Act of 1976 (P.L. 93-641) was due to expire on June 30, 1977, but received a one-year extension when President Carter signed into law in August the Health Services Extension Act of 1977 (P.L. 95-83). The extension was approved in order to provide the Administration and Congress an opportunity to review the planning law's implementation and other health related authorities. During the past year, activities at DHEW related to implementation of P.L. 93-641 have been largely devoted to making the 212 Health Systems Agencies (HSAs) or HSA-type agencies and 56 State Health Planning and Development Agencies (SHPDAs) operational. However, health planning activities at the federal level have intensified in recent months and the AAMC's Department of Teaching Hospitals has been involved in a number of these.

In September, the AAMC submitted its comments in response to HEW's request, published in the August 9th Federal Register, for comments or suggestions for improvement of the "Draft Guidelines for the Development of the State Medical Facilities Plan (SMFP)". Particular emphasis in the Association's response was placed on the failure of the draft guidelines to accomodate the unique role of the academic medical center/teaching hospital; the total lack of any exceptions language in the guidelines;

the arbitrariness of the national bed supply and occupancy standards established; the questionable way in which these standards were promulgated; the inadequacy of the formulae using the optimal occupancy method for setting bed ceilings; the lack of clarity in the relationship of the SMFP to other required plans; and the possible inappropriateness, in relation to the law, of the SMFP serving to guide in performing Certificate-of-Need and other project reviews. The Association is also now in the process of developing comments and recommendations on the proposed "National Guidelines for Health Planning" which were published by HEW on September 23rd. In addition, Senator Richard S. Schweiker (R-Pa.), ranking minority member on the Senate Human Resources Health and Scientific Research Subcommittee, has written to the AAMC requesting its views on a series of questions related to the structure and functioning of the nation's health planning program as it is presently constituted. The Association is currently developing its response to the Senator's correspondence.

Maintaining its involvement in health planning activities at the Congressional level, AAMC staff, together with representatives from other national hospital associations, met on October 18th with health care specialists from the staffs of Senators Jacob Javits (R-N.Y.), Edward Kennedy (D-Mass.) and Richard Schweiker to discuss issues pertinent to the renewal of the health planning act. Topics discussed included composition of HSA governing bodies, HSA staffing patterns, the functions of the National Council on Health Planning and Development, coverage of non-institutional providers under certificate-of-need, and the legal implications of service decertification. Of particular interest to the Association were lengthy discussions concerning the role of the HSA in review of federal grant awards for manpower programs and clinical research; the role, within the framework of the recently proposed Health Planning Guidelines, of tertiary care centers which often serve more than one health service area; and efforts to avoid costly duplication of specialized services. These were early stage discussions that will undoubtedly continue as the legislators move closer to addressing the future of the planning law.

In March, the AAMC engaged the services of Eugene J. Rubel, former director of HEW's Bureau of Health Planning and Resources Development, and provided a grant to him to visit a number (approximately eight) of teaching hospital, medical school and HSA executives to determine the current and future implications of the implementation of P.L. 93-641 as it pertains to the academic medical center. He also specifically examined the extent to which teaching hospital directors and medical school deans are involved in the decision-making process of HSAs. Mr. Rubel has completed a preliminary report of his findings and observations, which will be helpful to the staff in its efforts to act on behalf of COTH/AAMC constituents.

The past year also saw the development of a new cooperative relationship between the AAMC and the American Health Planning Association (AHPA), with Joe Isaacs of the Department of Teaching Hospitals' staff being designated as the Association's liaison person to the AHPA for involvement in activities of mutual concern and attendance at meetings of interest.

CLINICAL LABORATORY IMPROVEMENT ACT

Congressional interest in establishing revised standards for clinical laboratories was strong in 1976; however, no single bill passed both the House and Senate. Legislation to control clinical laboratories was re-introduced

in both houses in 1977 and hearings were held. The Association's testimony, in addition to requesting special consideration for clinical research laboratories, took the position that Congress should not force hospitals to comply with mandatory personnel credentialing provisions which markedly increase the costs of hospital laboratory operation without a concomitant increase in the reliability and accuracy of clinical laboratory tests. Therefore, the Association strongly recommended deleting proposed provisions permitting the Secretary of HEW to prescribed personnel qualifications for laboratory personnel below the level of directors and supervisors.

NATIONAL HEALTH INSURANCE

Responding to HEW Secretary Califano's request for views and opinions on national health insurance, the Association recommended general policy positions in several areas which must be considered in evaluating any national health insurance plan. Specifically, the AAMC stated: (1) that national health insurance is an appropriate mechanism for financing graduate medical education, (2) that hospitals cannot expand their ambulatory educational and service programs without adequate reimbursement, (3) that payment for physicians' services should be on an equal basis irrespective of the setting in which services are provided, (4) that hospital payment mechanisms must recognize the distinctive characteristics and costs of teaching hospitals, and (5) that recognition and encouragement be given to private philanthropy.

MANAGEMENT ADVANCEMENT PROGRAM

The Management Advancement Program, instituted for medical school deans in 1971, was expanded in 1976 to include administrators of COTH hospitals and a five day session was attended by twenty-six COTH executives. In 1977, a redesigned five day seminar was held for twenty-four COTH member executives. Because of the favorable responses provided for both seminars, another Management Advancement Program for COTH executives is being planned for June, 1978.

JCAH STATEMENT OF HOSPITAL GOVERNANCE

University-owned hospitals have repeatedly had difficulty with JCAH governing board standards. A draft statement, designed to provide surveyors with background information on university hospital governance, was provided to COTH and reviewed by the COTH Administrative Board. A revised version was then returned to the Commission where it was adopted with one minor change.

FOREIGN MEDICAL GRADUATES

The Health Professions Educational Assistance Act, P.L. 94-484, significantly altered government policies and procedures for admitting foreign trained physicians, interns and residents included. During the winter and spring of 1977, Department staff met repeatedly with officials from the State Department, HEW, and the Immigration and Naturalization service to comment on and monitor proposed government policies and to provide COTH members with direct access to appropriate authorities.

COTH REPORT

For several years, the COTH Report has been published monthly using an eight page format. With the increased activity of Federal agencies in all aspects of the hospital industry, this format limited the background information which could be published on any policy issue, bill, hearing, or regulation. Therefore, beginning with this year's January issue, Joseph Isaacs, Managing Editor, expanded the newsletter so that issues from eight to twenty pages may be used as needed to cover stories of particular interest to teaching hospitals. In addition, he has attempted to broaden the COTH Report's range of in-depth coverage and to make it more comprehensive.

SURVEYS

The Department has maintained its program of continuing membership surveys and expanded its special membership surveys.

Regular Surveys

The 1976 Executive Salary Survey, published in November of 1976, was compiled from the responses of 282 COTH members. For chief executive officers, the survey describes salaries, fringe benefits, and hospital compensation policies. For departmental executives, salary and fringe benefit data was published. Questionnaires for the 1977 survey will be mailed to COTH members in November, and it is anticipated that findings from the survey will be published in February, 1978. At its meeting in September, the COTH Administrative Board requested that this year's survey include questions concerning the confidentiality of the salary survey report and questions directed at learning what use COTH members make of the report.

The sixth annual COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data, covering fiscal year 1975, was published in April, 1977. The report, based on responses from 61 hospitals, provides comparative and detailed hospital data on hospital income sources, expenses, utilization of services, and staffing. The next report, for fiscal years ending in 1976, will be published in January of next year.

The 1977 COTH Survey of House Staff Policy and Related Information was mailed to members in October. As in previous surveys, the 1977 edition describes house staff stipend increases, fringe benefit programs, and recent trends in these areas. Information is published by geographic region, type of hospital control, bed size, and type of affiliation. This year's survey included new questions on the anticipated impact of new immigration procedures for foreign medical graduates, external actions to limit the number of house staff in training, and the definition of clinical fellows.

In April of this year, COTH published its ninth annual Directory of Educational Programs and Services. The Directory provides a profile of each COTH member hospital, including selected operational and educational program statistics. Questionnaires for the 1978 Directory were mailed in August. Because the COTH Administrative Board has requested that staff review the membership eligibility of COTH hospitals, members have been requested to include copies of affiliation agreements and selected residency program data.

Special Surveys

Four special surveys of the COTH membership were conducted during this past year.

(1) As described earlier, a survey of member experience under Section 223 was conducted in May.

(2) In June, the Council of Teaching Hospitals published a Survey of Professional Liability Insurance in University-Owned Hospitals. Based on forty responses to a questionnaire completed in late summer of 1976, the report presented findings on physician coverage, commercial insurance coverage, and self-insurance programs.

(3) A special report was prepared based on data supplied by the American Hospital Association which set forth the source of construction funds for projects begun in 1975 by COTH hospitals. Results showed the pattern of financing for hospital construction in COTH hospitals and hospitals generally has undergone a decided shift during the past seven years. Federal as well as state and local grants and appropriations, plus the use of hospital's own earnings have considerably diminished in importance. Collectively, these sources now account for only one-third of the construction funds, whereas earlier they had accounted for two-thirds of it. The slack has been taken up by borrowing, which now accounts for over one-half of the funds for construction among COTH institutions.

(4) In October, a questionnaire was mailed to members seeking information on the costs of JCAH-required capital expenditure projects. Responses to this survey will be used to provide House and Senate committees with hard data on the impact of the President's proposed capital expenditure ceiling and to discuss the financial impacts of present standards with JCAH officials.

Association Studies

Under a contract with the Bureau of Health Manpower, the Association is presently conducting several studies of medical education and its related institutions and organizations. Department staff have served as consultants to two of these studies: the Medical School-Clinical Affiliation Study and the Medical Practice Plans study. As consultants, staff have assisted with study design, data gathering and analysis, and report preparation. A copy of the final report of the affiliation study was sent to all COTH members.

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 and through staff membership on three committees of the American Hospital Association.

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