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, 1978 - OCTOBER, 1979

OUTLINE OF SELECTED ACTIVITIES

THE COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges was formally established in 1965. Its purpose is to provide representation and services related to the special problems, concerns, and opportunities of medical school-affiliated and university-owned hospitals. As one of the three governing councils of the Association, COTH also serves an important role in determining overall Association policy and direction.

COTH Membership

There are two categories of COTH membership: teaching hospital membership and corresponding membership. Both membership categories require the applicant institution to have a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education and a letter recommending membership from the dean of the affiliated medical school. Teaching hospital membership is limited to not-for-profit IRS 501(c)(3) and publicly-owned hospitals which sponsor or significantly participate in at least four approved residency programs. At least two of the approved residency programs must be in the following speciality areas: internal medicine, surgery, obstetrics/gynecology, pediatrics, family practice, or psychiatry. In the case of specialty hospitals -- such as children's, rehabilitation, and psychiatric institutions -- the COTH Administrative Board is authorized to make exceptions to the requirement of four residency programs provided that the specialty hospital meets the membership criteria within the framework of the specialized objectives of the hospital. Hospitals qualifying for teaching hospital membership receive the full range of AAMC and COTH services and publications and are eligible to participate in the AAMC's governance, organization, and committee structure.

Non-profit and governmental hospitals and medical education organizations (e.g., consortia, foundations, federations) not eligible for teaching hospital membership may apply for corresponding membership. Corresponding members are eligible to attend all open AAMC meetings and to receive all publications forwarded to institutions in the teaching hospital membership category. The present membership of the Council of Teaching Hospitals includes 409 teaching hospital members and 20 corresponding members. Three hundred and thirty-one of the members are not-for-profit, municipal, and state hospitals. The remaining 78 members are Veterans Administration hospitals. Sixty-four members are university-owned hospitals.

COTH Administrative Board

There are nine members on the COTH Administrative Board, each serving a three year term. Three new members are elected annually. In addition, the Immediate Past Chairman, the Chairman, the Chairman-elect, the Secretary, and the COTH Representatives to the AAMC Executive Council are members of the

Administrative Board. COTH Officers and Administrative Board members are listed in Appendix A of this report. The Administrative Board meets four times a year and is authorized to conduct business of the Council of Teaching Hospitals between the annual meetings of the membership.

The Council of Teaching Hospitals reports to the AAMC Executive Council and is represented by four Administrative Board Members. Creation of standing committees and any major actions by the COTH Administrative Board are taken only after recommendation to and approval by the AAMC Executive Council. COTH Officers, new Administrative Board members and new representatives to the AAMC Assembly -- the highest legislative body of the AAMC -- are elected annually by all COTH members at the AAMC Annual Meeting. For the coming 1979-1980 year, John W. Colloton, Director of the University of Iowa Hospitals and Assistant to the University President for Health Services, will take over as Chairman of the COTH Administrative Board. It is also of special note that for the coming year the Chairman of the Executive Council will be Charles B. Womer, President of the University Hospitals of Cleveland. Mr. Womer is the third COTH representative to serve as the AAMC Executive Council Chairman.

Department of Teaching Hospitals

The Department of Teaching Hospitals is the staff component of the Association responsible for representing interests of the teaching hospital community in AAMC activities and with other organizations and agencies. The following report summarizes the major activities undertaken by the staff since our last annual meeting in October, 1978. Individuals seeking more detailed and supplementary information on any of the activities described are encouraged to contact the Department of Teaching Hospitals. A list of staff and their phone numbers is provided in Appendix B of this report.

MEDICARE REIMBURSEMENT ISSUES AND REGULATIONS

Section 227 - Payments to Physicians and Teaching Hospitals

Background

Section 227 of the 1972 Medicare Amendments to the Social Security Act established special provisions for payment of physicians' professional medical and surgical services in teaching hospitals. On July 19th, 1973, the Department of Health, Education, and Welfare (DHEW) published proposed regulations for the implementation of Section 227. The proposed regulations were widely criticized by the medical education community as unworkable, inequitable, harmful to existing patterns in medical education, and punitive to physicians practicing in teaching hospitals. Those proposed regulations were withdrawn before implementation and Congress chartered the Institute of Medicine to conduct a study of the payment of physicians in teaching hospitals. The IOM

published its findings in March, 1976, but new regulations were not available for the scheduled implementation date on October 1, 1977. Therefore, the Administrator of the Health Care Financing Administration, Robert Derzon, 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 October 1, 1978. Senator Robert Dole (R-Kansas) sponsored legislation which accomplished the one-year delay.

Draft Regulations

Last year, the draft regulations for Section 227, which were informally circulated in July, 1978, were highly criticized by the teaching hospital community. The October 1 implementation date passed by without publication of regulations. At the AAMC Annual Meeting in October, 1978, then HEW Secretary Joseph A. Califano publicly stated his agreement to further delay implementation and to provide the medical education community with an opportunity to comment on any regulations that would be forthcoming.

Subsequent to last year's Annual Meeting, the Association's Ad Hoc Committee on Section 227 was expanded and reconstituted with Hiram C. Polk, Jr., Chairman of the Department of Surgery at the University of Louisville School of Medicine, as its Chairman. The purpose of this committee was to review the Association's position on Section 227 and to evaluate any future proposed regulations. The initial meeting of this group was held on January 4th, 1979. The Committee conducted an intensive review of last year's AAMC position on the draft 227 regulations. In developing Association strategy for Section 227, the Committee discussed HEW Undersecretary Hale Champion's letter to Senator Dale Bumpers (D-Arkansas) agreeing to a one year delay in the implementation of 227 regulations. The Committee also discussed meetings scheduled with Champion and Health Care Financing Administration Administrator Leonard Schaeffer for January, 1979. While the Committee decided to initially emphasize the development of acceptable regulations under the present law, it appointed a subcommittee, chaired by Edward M. Brandt, Jr., Vice Chancellor for Health Affairs of the University of Texas to develop legislative recommendations for use if HEW failed to develop appropriate changes in the draft regulations.

Following the January 4th Ad Hoc Committee meeting, Association staff met with Leonard Schaeffer, Clifton Gaus and Al Diamond of the Health Care Financing Administration on January 15th to discuss Section 227. The purpose of the meeting was to describe concerns with the draft regulations and to discuss the process by which differences of opinion hopefully could be resolved. Mentioned as primary concerns were the private patient test, the fiscal test for fee level, supervision of residents, and determination of the cost for physicians' services. On January 17th, members of the Association's Executive Committee, together with Stuart Bondurant, Chairman of the Association Task Force on Support for Medical Education and Hiram Polk, Chairman of the Ad Hoc Committee on Section 227, met with then HEW Undersecretary Hale Champion. This meeting included a discussion of health manpower legislation and concerns with Section 227. Also present at this meeting were Assistant Secretary for HEW, Julius Richmond; Deputy Assistant Secretary for Planning and

Evaluation, Karen Davis; Health Resources Administration Administrator, Henry Foley; and Leonard Schaeffer. Both of these meetings included candid and open discussions of the critical issues that need to be resolved.

In an effort to get widespread comments from the Association members, the Association held four one-day, regional workshops on Section 227 during January. The primary objectives of the workshop were to: have attendees clarify whether or not the July 19th, 1978 draft regulations would have an adverse impact on their school, hospital or physicians; clarify the critical issues of the draft regulations by examining their impacts on individual hospitals and schools; and develop consensus positions, if possible, on critical issues. The workshops were organized in two sessions. During the morning, descriptions of differing adverse impacts of the draft regulations were presented to provide workshop participants with examples with which they could assess their own situation. During the afternoon, critical issues identified in the morning and the previous Association analysis of the regulations were discussed and debated to develop recommended policy positions. In total, the regional workshops provided almost 350 AAMC members, representing broad geographic, institutional, and professional organizations with an opportunity to help formulate the Association's positions on Section 227 implementation.

The January meetings were followed by three half-day sessions between HCFA officials and a five member subcommittee of the AAMC Ad Hoc Committee on Section 227, which included: Hiram Polk, Chairman of the Ad Hoc Committee, Martin Dillard of Howard, Edward Brandt of the University of Texas, Marvin Siegel of Miami, and Irwin Birnbaum of Montefiore Hospital. In the sessions, HCFA presented tentative recommendations on the major issues. Dr. Polk stated that the recommendations were partially responsive to the Association's concerns, but that a discriminatory fiscal test remained and that the cost based method of payments resulted in payments less than cost.

Since last Spring, there has been little word from HCFA as to when new regulations might be published. It remains unclear what priority is presently being given to publishing new regulations. Leonard Schaeffer, HCFA Administrator, has publicly stated on several occasions that HCFA is actively addressing this issue, but he has not stated when new guidelines can be expected.

Legislative Activity

While Secretary Califano at last year's AAMC Annual Meeting agreed to delay implementation of Section 227, no legislative action was taken to officially postpone implementation beyond the October 1, 1978 deadline. There have been several efforts this year in both the House and the Senate to pass legislation that would delay Section 227 to October 1, 1979. Senator Dale Bumpers (D-Arkansas) and Representative Tim Lee Carter (D-Kentucky) introduced legislation to delay the date of implementation until October, 1979. The delay provision was also in the Talmadge-Dole Medicare and Medicaid Reform provisions, which were passed by the Senate Finance Committee on July 12, 1979. More recently, Representative David Satterfield (D-Virginia) has introduced a bill (H.R. 1821) that would, in effect, repeal Section 227.

In order to address the Section 227 issue and other Medicare and Medicaid amendments up for consideration, the Health and the Environment Subcommittee of the House Interstate and Foreign Commerce Committee recently held hearings. On Monday, October 22, Edward N. Brandt, Jr., Vice-Chancellor for Health Affairs of the University of Texas System, and John A. D. Cooper appeared before the Subcommittee to testify on Section 227. In his summary remarks, Dr. Brandt specifically recommended: 1) that an amendment be passed delaying the implementation for Section 227 until a period of 180 days has expired subsequent to the issuance of proposed implementing regulations in The Federal Register; 2) that the committee report accompanying the amendment clearly indicate Congressional intent on the three issues raised in our testimony; and 3) that the Subcommittee and its staff monitor HEW's regulations on these issues.

The members of the Subcommittee present at the hearing had great interest in the issues surrounding Section 227 and related matters. There was extensive questioning following the oral presentation. It is not clear what action will be taken by the Subcommittee. Developments will be reported in Dr. Cooper's Weekly Activities Report.

Section 223 - Limitations on General Routine Operating Costs

Section 223 of the 1972 Social Security Admendments authorized Medicare to impose limitations on the costs paid for services provided under the program's Part A coverage. Since 1974 and until this year, Medicare had annually promulgated limitations on routine service costs based on a hospital's bed size, its geographic location, and the per capita income of its surrounding community. This year, HCFA made a series of significant changes in the methodology used to set the limits. These changes resulted in a great deal of controversy and were the focus of much of the staff's time.

In the March 1 Federal Register, the Health Care Financing Administration proposed a new schedule of limits on payments to hospitals for routine inpatient services furnished to Medicare beneficiaries. The proposed regulations differed from those in previous years in several important respects. First, the limitations on inpatient routine service costs were replaced by a limitation on general routine operating costs. In determining general routine operating costs, capital related costs and the costs of approved medical education programs were excluded. Second, the hospital classification system was reduced from 35 categories to seven categories by deleting the variable of per capita income and using only bed size and rural/urban location. Third, a wage index derived from service industry wages was used to adjust the portion of the limitations which represent wages paid. Fourth, the proposed regulations used a "market basket" price index to update historical data and set projected ceilings. The market basket index is designed to measure and adjust for price changes in the goods and services purchased by the hospitals. Fifth, group limits were set at the 80th percentile rather than the 80th percentile plus 10% of the mean.

In responding to these proposed regulations, the Association expressed concern for the following reasons: the grouping scheme used to classify hospitals failed to recognize the distinctive characteristics of specialty and tertiary care hospitals; several costs which varied between hospitals were not removed; trending factors failed to reflect the hospital labor markets and the increasing intensity of the production inputs in tertiary care hospitals; and the use of the 80th percentile rather than the previously used 80th percentile plus 10% of the mean automatically forded twenty percent of the hospitals to be inefficient by arbitrary definition.

On June 1, 1979, HCFA published the final regulations for setting routine service limitations for all cost reporting periods beginning on or after July 1, 1979. The final regulations differed from the March 1st proposed rule in two significant respects: hospitals in states that use less than the national average of bed days for Medicare patients were provided an upward adjustment in their ceilings, and the limitation threshold was set at 115% of the mean cost for each group of hospitals rather than at the 80th percentile. The final regulations also replaced the service industry wage index with a more specific hospital wage index.

Based on a mailgram survey completed by AAMC's Council of Teaching Hospitals in May and on the changes from the March 1st proposed regulations to the June 1st final regulations, it appeared that COTH members would be disproportionately penalized by the new payment limitations. Moreover, it appeared that midwestern and western COTH members and medical centers would be particularly hard hit. Because of the adverse impact on COTH members, the COTH Administrative Board recommended and the AAMC Executive Council approved holding a national meeting on Section 223: 1) to allow HCFA to describe the present limitations and exception methodology; 2) to provide HCFA with a sense of the financial devastation the regulations create for the nation's major hospitals and medical centers; and 3) to provide COTH members with an opportunity to explain to their Congressional representatives the adverse financial and operational impacts resulting from these limitations.

The meeting was held on July 10th at Georgetown University Hospital in Washington, D.C.. Three officials from HCFA addressed the approximately 100 individuals in attendance from COTH institutions. Leonard D. Schaeffer, HCFA Administrator, first provided an overview of the history of HCFA and the rationale for its current policies. Mr. Schaeffer was followed by Robert O'Connor, Director of HCFA's Bureau of Program Policy. Mr. O'Connor described Section 223 regulations issued on June 1 as the product of a slow evoluation which has taken place since initial implementation of routine service costs approach in 1974. Finally, Dr. Clifton Gaus, then Director of HCFA's Office of Research, Demonstrations, and Statistics, outlined HCFA's plans for changing the methodology for setting payment limits beginning July 1, 1980. Dr. Gaus indicated that HCFA would like to move to: 1) per admission limitations; 2) limits on all inpatient costs including ancillary services; and 3) adjustments in the ceilings for individual hospitals based on case mix. The case mix adjustment would incorporate the Diagnosis Related Groups methodology developed at Yale University. Dr. Gaus indicated that a "go/no-go" decision on this new methodology would be made around December of this year.

Much of the concern expressed by members at this meeting focused on the regulations scheduled to be effective for cost reporting periods on or after July 1, 1979. There was also concern expressed about the timeliness and effectiveness of the exceptions process. After the meeting, a number of COTH hospital representatives went to Capital Hill to visit their Congressional leaders and inform them of the capricious and inequitable nature of the current Section 223 regulations and their disproportionately negative impact on the nation's teaching hospitals.

Subsequent to these meetings and additional meetings between Congressmen and HCFA officials, HCFA published on August 9th in the Federal Register a Notice of Proposed Rule Making that reset the per diem limits at the 80th percentile for cost reporting periods beginning from July 1, 1979 through September 30, 1979 and invited public comments on the statistical threshold used to set the limitation. In the Association's comments on this proposed rule, the negative and inequitable impact of using 115% of the mean to set limits was outlined. The AAMC strongly recommended that HCFA return to using the 80th percentile plus 10% of the mean for determining a limit in each grouping of hospitals as was done in previous years. The closing date for receipt of comments for the proposed rule was September 10th, 1979. It was expected that the final decision on the statistical measure to use to set the limits would be published prior to the expiration on October 1 of the 80th percentile limit. However, the final regulations have not been issued.

Limitations on Reasonable Costs

In addition to establishing specific routine operating costs ceilings, Section 223 operates under general regulatory principles used to develop payment limitations. On March 15th, 1979, the Health Care Financing Administration published in the Federal Register proposed changes to these general principles. Most of the revisions addressed methods used to determine exceptions to imposed payment limitations. These included: new exceptions for hospitals with seasonal variations in population, hospitals with atypically short lengths of patient stays, and hospitals with atypical labor costs. Also included were an explicit exception for atypical costs of paramedical and medical education programs when the hospital can demonstrate that hospitals in its limitation category generally do not incur similar costs and an exception for hospitals threatened with insolvency as a result of the imposed payment limitation. The proposed regulations required that a provider requesting an exception agree to accept review of hospital operations by the Health Care Financing Administration. Moreover, continued eligibility for future exceptions would be made contingent upon adopting the recommendations made by the operational review.

In responding to the proposed changes, the Association first outlined its concerns about the manner in which the exceptions process has been handled since its inception in 1974. Specifically, the AAMC recommended that the exception and appeal process provide (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 Secretary be required to regularly publish base line data for typical costs for each group of hospitals in the classification system; and (4) that the basis on which exceptions are granted

be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties. The letter of comment also recommended that non-patient services, atypical input costs, and case mix differences be permitted as grounds for exceptions. Finally, the Association strongly recommended that the mandatory imposition of an operational review as part of the exceptions process be deleted. The March 15th proposed regulations became final on June 1st, 1979. Unfortunately, the final regulations differed very little from the proposed rule.

Apportionment of Malpractice Costs

A fourth issue that was the subject of new regulations under Medicare was a change in the determination of allowable malpractice costs. In the March 15th Federal Register, the Health Care Financing Administration released proposed regulations that would require malpractice costs incurred by a provider to be directly apportioned to Medicare based on Medicare malpractice loss experience instead of the current apportionment basis of Medicare's overall utilization of provider services. The regulations, which became final on June 1st, require a separate accumulation and direct apportionment of malpractice insurance premiums and self-insurance fund contributions. In addition, if a provider is paying uninsured malpractice losses directly, either through deductible or coinsurance provisions or as a governmental provider, or as a result of an award in excess of reasonable cost limits, Medicare will reimburse the cost of these losses and any related direct costs only as attributable to Medicare beneficiaries. The purpose of this new rule is to reimburse Medicare providers on a basis more closely related to the actual malpractice experience of Medicare beneficiaries.

In its comments to the Health Care Financing Administration, the Association strongly protested this new rule because: the policy was based on an HEW-funded study, "Medical Malpractice Closed Claims Study - 1976," which was seriously deficient in its data and findings; the new rule sets a dangerous and inappropriate, discriminatory precedent for reimbursing on the basis of direct costs rather than on average costs which has been used in the past; malpractice claims vary dramatically from year to year which could grossly misrepresent the hospitals long-term performance in this area; the policy could have a significant inflationary impact if hospitals decide to obtain separate insurance for Medicare patients; and the regulations violate the limitations linking Medicare and Medicaid rates.

Definition of Hospital Special Care Units

At the present time, Medicare sets hospital payment limits only on general routine operating costs. Payment limitations are not presently imposed on ancillary service costs or special care unit costs.

In the past several years as special care units have proliferated, hospitals and Medicare officials have increasingly debated the definition of a special care unit. In an effort to resolve this issue, the Health Care Financing

Administration proposed a new definition for special care units in the May 16th Federal Register. Under the new proposed rule, a hospital service must meet seven criteria to be classified as a special care unit: the unit must have specific written policies concerning admissions; must be in a hospital; must be physically and identifiably separate from other hospital units; must have specific written admissions and discharge policies; must have continuous registered nursing care that is not decreased during the night or during the weekends; must provide a minimum of 12 scheduled hours of direct nursing care per patient day; and must continuously provide life saving equipment to treat the critically ill.

This definition is significantly more strigent than the one used in the past, and as a result, some patient units presently reported as special care units would now be reclassified as routine service costs subject to Section 223 payment limitations.

In response to the proposed rule, the Association noted the valuable medical and social contributions special care units have made to patient care. It was recommended that because the proposed regulations do not define special care units in terms of patient needs, HCFA should withdraw the proposed input and facility-oriented regulations and develop process-oriented regulations. Final regulations on this issue have not yet been published.

Cost to Related Organizations

Under the Medicare program, a hospital's reimbursable costs for services, facilities, or supplies furnished to it by another organization are normally the charges made by the supplying organization. However, when the hospital and the supplier are related by common ownership or control, the hospital's allowable costs are limited to the supplier's costs rather than its charges. Present Medicare policy requires the presence of significant ownership or significant control for a determination that the hospital and its supplier are related organizations. Regulations proposed would replace the present concepts of significant ownership and significant control with any ownership and any control.

If the proposed rules are adopted, Medicare may take the position that a hospital and a medical school from which the hospital obtains services are related organizations when the hospital and the school have one or more common members on their governing boards. Once the medical school is determined to be a related organization, the hospital would be reimbursed for medical school services on the basis of the school's costs, not its charges for services unless the school provides at least 80% of the supplied service in "the open market." Medicare officials did state that the existence of a hospital-medical school affiliation would not necessarily provide the basis for treating the two organizations as related.

The Association responded to the proposed rule in a March 23rd letter to Leonard Schaeffer, HCFA Administrator. The Association expressed concern with six aspects of the Notice of Proposed Rule Making: failure of the notice to adequately describe its proposed impact, the assumption that a standard of "any" control eliminates subjective evaluations, the absence of a critical de-

finition in stating the open market exception, extension of Medicare cost principles to suppliers, and the potential problems created for hospitals seeking informed trustees. As is the case with the special care unit regulations, final regulations on this subject have not yet been published.

Reimbursement Changes for Grants for Primary Care Training Programs

On Friday, August 10th, 1979, the Health Care Financing Administration announced proposed rules in the Federal Register to amend regulations governing Medicare reimbursement for primary care training programs supported, in part, by grants. Under current regulations, all grants and donations specifically designated for education must be deducted from program costs in determining allowable reimbursement costs. The proposed amendments would change this rule by allowing providers not to offset grants in four primary care areas: family practice, general practice, general internal medicine, and general pediatrics.

The new rules, which would affect all cost reporting periods beginning on or after January 1, 1980, state: (1) in determining a provider's net educational costs for reimbursement, deductions would not be required for any grants the provider receives and applies to internships and residency programs in the four areas listed above; (2) in its cost report the provider would be required to identify the total program costs and total revenues applicable to its primary care residency programs. The provider would have to identify specifically the donor of any grants designated to support primary care training costs; (3) if total revenues, including patient care revenues and grants, exceeded the total costs of the program, and if the provider had a Title VII Public Health Service grant, HCFA would notify the Public Health Service which would either recover the surplus revenues or redesignate them for the succeeding year. If the provider had no Title VII grant or if the surplus exceeded the amount of the Title VII grant, HCFA would notify other grant donors. However, HCFA would make no adjustments in Medicare reimbursement.

The proposed rule also expressed general concern about interpretation of present regulations for determining net educational costs. HCFA stated that this problem is being reviewed, and a subsequent Notice of Proposed Rule Making revising the general principles for determining net educational costs could be expected in the near future.

The AAMC responded to the proposed rules by endorsing, for the most part, the changes. However, the AAMC raised issue with two specific items. First, the Association recommended that the regulations be applicable to cost reporting periods beginning on or after January 22, 1975 rather than the proposed January 1, 1978 date. The rationale for the earlier date was that confusion over this issue was created on that date by HEW's Region IV office in Atlanta which released an intermediary letter which informed providers that grants for primary care training programs would be treated as "seed grants", and thus would not be offset in determining reimbursement. A year later, a subsequent intermediary letter was sent to providers which reversed this policy and ordered the retrospective adjustment of reimbursement already permitted under the previous intermediary letter.

The second concern of the Association was the change in language for the general principle for determining cost of educational activities. Under the explanatory language in the Notice of Proposed Rule Making, it stated that the principle for reimbursement of approved educational activities had been restated, but that "there is no change intended in how the regulations are currently being implemented." Presently, the costs of educational activities include "trainee stipends, compensation of teachers, and other costs." The proposed language would delete "and other costs". The Association expressed concern that the deletion of "and other costs" could inappropriately result in disallowance of essential educational costs, including direct costs such as fringe benefits and the indirect costs appropriately allocated to the educational cost center. For this reason, the Association strongly recommended that "and other costs" be reinstated. Final regulations on this proposed reimbursement change have not yet been published.

HILL-BURTON CHARITY CARE REGULATIONS

On May 18th, HEW published final regulations governing the requirements to provide uncompensated charity care and community service in hospitals which received Hill-Burton construction funds for assistance under Title XVI of the Public Health Service Act. In spite of objections by the AAMC and numerous other organizations to the proposed rules published in October 1978, the final regulations are similar to the proposed rule. The new regulations require hospitals that have received Hill-Burton funds to provide specific minimum dollar levels of free or reduced-charge care for indigent patients. The old regulations allowed uncompensated care to be provided in two ways. The first method, the "open door" policy was eliminated. The second option, the lesser of three percent of operating costs (less Medicare and Medicaid reimbursement) or ten percent of the assistance originally provided, is retained but modified. In future years, the ten percent option would be increased each year by an inflation factor based on the medical care component of the Consumer Price Index. Facilities assisted under the old Hill-Burton program which provide less than the required amount of care will be required to make up the difference in future years. In addition, facilities will remain obligated to provide free or reduced-charge service for 20 years from the time Hill-Burton loan or grant was made, but the regulations affect only that portion of the 20-year obligation periods which begins in 1979. The effective date of the regulations was September 1st, 1979. Health facilities with fiscal years beginning after May 18th and before September 1st were required to comply with the new regulations by September 1.

SYSTEM FOR HOSPITAL UNIFORM REPORTING

Section 19 of P.L. 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977, mandated a system for uniform reporting of data for hospitals. In the January 23rd Federal Register of this year, the Health Care

Financing Administration published proposed regulations that outlined the reporting requirements for all hospitals participating in Medicare and Medicaid programs. The new reporting system is intended to be used to allow for comparisons among hospitals. The uniform reporting requirement would be effective with hospital reporting periods beginning six months after publication of final regulations. HEW has stated that it expects the new reports to be used by local health planning agencies, state hospital rate-setting agencies, and local hospital administrators, as well as federal agencies in fraud and abuse investigations.

Since the January release of proposed regulations, SHUR has been the target of a great deal of criticism by hospital and health associations as well as individual hospitals which flooded HCFA with letters of comments and concerns. The AAMC submitted its concerns to HCFA on April 23rd. The Association noted that, in the past, it has supported a nationwide system of uniform cost reporting as an important requirement for the proper measurement, evaluation, and comparison of hospital costs. In taking this position, the Association specifically opposed uniform hospital reporting as a means of mandating uniform hospital accounting. The Association emphasized that it still endorses uniform reporting, but is strongly opposed to the proposed HCFA regulations which would impose SHUR as the nationwide reporting system. The Association contended that SHUR is seriously deficient as a uniform reporting system for both policy and technical reasons and urged HCFA to withdraw the Notice of Proposed Rule Making in order to develop a reasonable and concise reporting system which minimizes compliance costs at hospital, intermediary, and federal agency levels. The AAMC also stated that it opposed the reporting system on the grounds that it is an excessive use of the HEW Secretary's authority, requires excessive information, fails to comply with existing regulatory procedures, and fails to provide necessary additional revenue for system introduction and maintenance.

In April HCFA released a nationwide study conducted under contract to HCFA by the California public accounting firm of Morris, Davis, and Company, that attempted to evaluate the cost of implementing SHUR in 50 hospitals. The results of that study suggested that it will cost hospitals an average of $11,500 to $35,000 to switch to a federally mandated system for uniform reporting. The American Hospital Association, one of the national organizations which urged that this study be undertaken, harshly criticized the study results. AHA argued that the study's figures were unrealistically low and that (1) no valid conclusions can be drawn from the results of the reporting hospitals because of the wide discrepancies of the results reported within the test site hospitals, (2) the 50 hospitals used as test sites for the study do not represent a valid statistical sample, (3) the study methodology to capture SHUR costs was inadequate, and (4) the HCFA estimate does not include, nor was the study required to examine any costs associated with non-hospital SHUR activity.

Over the summer, SHUR also surfaced on the legislative front. On June 27th, by a vote of 306 to 101, the House adopted an amendment to the fiscal 1980 Labor-HEW appropriations bill (H.R. 4389) prohibiting the use of any funds to implement SHUR. In sponsoring the amendment, Representative Douglas K. Bereuter (R-Nebraska) argued that HEW's proposed implementation

of the SHUR system goes far beyond what Congress intended in the original legislation. In addition, he stated that HEW was trying to install an accounting system when Congress had directed only a uniform reporting system.

In the Senate, the Senate Appropriations Committee endorsed HCFA's plans to create a uniform hospital reporting system, but effectively agreed with the House that the proposed SHUR regulations should not be implemented in fiscal year 1980. The Committee added report language to the Labor-HEW appropriations bill prohibiting the use of fiscal year 1980 funds for data collection pursuant to SHUR. It directed HEW to modify its proposal in order to minimize the burden it would place on hospitals and to publish "substantially revised regulations," only after appropriate consultation with Congress.

Following this activity in the Senate and the House, the joint House-Senate Conference Committee on the FY 1980 Labor-HEW appropriations bill deleted the Bereuter amendment and adopted language used in the Senate Appropriations Committee report on the legislation which expressed concern with the "unnecessary and unintended burden on health care facilities which would have resulted if the regulations originally proposed for this system had gone into effect. The conferees therefore direct that the Secretary not issue final regulations for the program until the Department's proposed revisions have been formally approved by the appropriate committee of each house designated by the Speaker of the House of Representatives and the Majority Leader of the Senate."

HOSPITAL COST CONTAINMENT

Administration's Proposal

For the third successive year, President Carter has pushed for hospital cost containment legislation. Despite the fact that the hospital industry met last year's Voluntary Effort goal of 13.6% and the excellent performance of hospitals this year relative to general inflation, hospital cost containment legislation appears to be a very real possibility. The President's "Hospital Cost Containment Act of 1979," (H.R. 2626, S. 570) was introduced in the House of Representatives on March 6th and later in the Senate. As originally introduced in Congress, this year's bill would place a 9.7% national "voluntary limit" on the increase on total hospital expenses for 1979. Failure by the hospital industry to meet the limit would trigger a mandatory standby program for some hospitals for 1980 and subsequent years which would set ceilings on total hospital inpatient revenues per admission.

The Administration based its 9.7% rate on estimates of three components of hospital costs: (1) a 7.9% inflation allowance for the costs of goods and services purchased by hospitals in 1979 which could be revised at year-end if the actual inflation rate is higher; (2) an 0.8% allowance for population growth; and (3) an allowance of 1% for new services. All of the bills now

reported out of committees have revised the 9.7% rate upward, to as high as 11.6%, which is the hospital industry's Voluntary Effort goal for 1979. This figure could be raised even higher depending on actual inflation in the costs of goods and services in 1979.

If the hospital industry as a whole fails to meet the voluntary limit, a state or even an individual hospital could still be exempt from mandatory controls in 1980, if it were under the nationwide voluntary limit which would be adjusted to take into account state population trends and local non-supervisory wage levels. The various versions of the bill also have some provisions for exemption of hospitals in states that have approved rate review mechanisms, hospitals with under 4,000 admissions, hospitals less than three years old, and hospitals with 75% of their patients enrolled in a qualified health maintenance organization. One bill would exempt children's hospitals.

For hospitals which are not exempted, a mandatory program, if triggered, would be initiated in 1980 that would set allowable rates of increase in inpatient revenues per admission for each hospital. The limit would: (1) be based on a national inflation allowance to cover the increase in the costs of goods and services purchased; (2) include an allowance for the actual rate of increase in non-supervisory wage rates experienced by that hospital; and (3) establish groups of similar hospitals and provide an efficiency bonus of up to 1% if the hospital was below the group median or an inefficiency penalty of up to 2% if the hospital was above 115% of the median of routine hospital per diem costs for its group. The bill would also take into account individual hospital performance under the voluntary program in setting a hospital's ceiling under the mandatory program.

The President's bill also provides severe penalties for hospitals that place an unequal burden on charge-based payors, who currently account for approximately 40% of hospital revenues. The legislation would require excess revenue from this class of payor to be placed in an escrow account which would be drawn on in future years only if revenue from charge payors was below the mandatory limit. The hospital refusing to comply with the escrow requirement would be assessed a federal tax of 150% of the excess revenues.

The Association testified on three occasions on the Administration's cost containment bill: Dr. David D. Thompson, Director of the New York Hospital and former Chairman of the COTH Administrative Board, testified on March 14th before the Senate Finance Committee's Subcommittee on Health; Dr. Robert Heyssel, Chairman of the COTH Administrative Board and Executive Vice President of the Johns Hopkins Hospital, testified before the Health Subcommittee of the House Ways and Means Committee on March 23rd and then again before the House Interstate and Foreign Commerce Committee's Subcommittee on Health and the Environment on May 21st. In each of the Association's statements the legislation was opposed for six main reasons: (1) overly broad policy and administrative powers for the Secretary; (2) added bureaucratic demands; (3) a modified wage pass through that is inconsistent with cost containment objectives; (4) inadequate allowance for new services; (5) a meaningless "antidumping" provision; and (6) undermining of current voluntary efforts.

A version of the President's original bill has now passed in three of the four Congressional committees with jurisdiction over the cost containment legislation. In the House, the Interstate and Foreign Commerce Committee, by a 23-19 vote, adopted an amended hospital cost containment bill offered by Representative Henry Waxman (D-California), Chairman of the Committee's health subcommittee. The bill passed by this committee was similar to that passed earlier this summer by the House Ways and Means Committee. Each bill is a watered down version of the Administration's bill introduced in February. Significantly, each bill contains a provision that would permit either House of Congress 30 days to veto standby controls for the next year if the established voluntary limit for increases in hospital expenditures were exceeded.

In the Senate, both committees with jurisdiction over cost containment legislation acted prior to the August recess. The Committee on Human Resources reported out a bill similar to the Administration's which is much stricter than those approved in the House. The Finance Committee tabled the President's bill, but did vote for Senator Herman Talmadge's (D-Georgia) alternative Medicare and Medicaid reimbursement reforms. As was the case last year, Senator Gaylord Nelson (D-Wisconsin) is expected to lead the fight for passage of the cost containment bill in the Senate. The bill, if brought to the full Senate, will most likely be offered as an amendment to the Talmadge proposal. However, it is probable that the Senate will not take up the legislation until the House acts. At this time, the House bills have been sent to the House Rules Committee to set the conditions under which the legislation will be considered by the full House.

Talmadge Bill

On March 1st, Senator Herman Talmadge (D-Georgia), Chairman of Subcommittee on Health of the Senate Finance Committee, and Senator Robert Dole (R-Kansas), ranking minority member of the Committee, introduced the "Medicare-Medicaid Reimbursement Reform Act of 1979," S. 505. The bill, essentially the same as the "Talmadge Bill" introduced in the two previous sessions of Congress, would modify Medicare and Medicaid Reimbursement practices for hospitals and physicians. Although Senator Talmadge has stated publicly that he does view the bill as being in competition with the Administration's cost containment bill, it is clear that Congress has viewed the legislation as being an alternative to the President's approach.

The bill differs from the Administration's proposal in many important respects: limits would be set initially on routine operating costs only, not on total inpatient costs; the costs of education and training, residents and non-administrative physicians, energy, and malpractice insurance would be excluded from determination of the per diem limits; the bill would apply only to Medicare and Medicaid reimbursement, not to all sources of hospital revenue; and the payment limitations set under S. 505 would be determined by establishing categories of similar hospitals and setting the limitation at 115% of a category's average routine operating per diem costs. In the grouping scheme a separate category would be established for the "primary affiliates of accrediated medical schools." Unlike past Talmadge proposals, the primary affiliates category would not be limited to one hospital per medical school.

In contrast to the Administration's proposal, the Talmadge-Dole bill, argued Dr. David Thompson on behalf of the Association before the Senate Finance's Health Subcommittee on March 14th, is "a thoughtful, careful, non-percipitous proposal which will moderate hospital cost by redefining an institution's self interest." Dr. Thompson complimented the Health Subcommittee for developing legislation that recognizes the rudimentary state-of-the-art in hospital classification schemes, and that provides for a combination of flexibility and a health facilities cost commission which can carefully monitor implementation. The Association's testimony also expressed its appreciation for the provision permitting more than one teaching hospital per medical school to be included in the teaching hospital category. While this modification is an improvement, the Association said that it remained concerned about the creation of a category for teaching hospitals because: (1) no one knows how routine operating costs in major teaching hospitals compare with routine operating costs in non-teaching hospitals; and (2) the principle source of atypical costs in major teaching hospitals results from the scope and intensity of services provided and the diagnostic mix of patients treated, not from the presence of a educational relationship with a medical school. Thus, the Association strongly recommended that the Secretary of DHEW be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals" before establishing a separate teaching hospitals category. In its written testimony, the AAMC also commented on several other of the Medicare/Medicaid reforms that are part of the bill, such as state rate review, payment to hospital-based physicians, and a provision to delay implementation of Section 227.

The Senate Finance Committee voted on July 12th by 11 to 9 to adopt Senator Robert Dole's (R-Kansas) proposal to table Senator Gaylord Nelson's (D-Wisconsin) compromise version of the President's bill. The Committee did, however, adopt provisions of Senator Talmadge's Medicare and Medicaid Reimbursement Reform legislation. Thus far, the Senate Finance Committee has been the only Congressional Committee to consider and vote favorably on the Talmadge bill.

HOUSE STAFF UNIONIZATION

It has now been over three years since 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). The NLRB rulings, however, have continued to be challenged. Once again this year, house staff unionization surfaced as a major issue in both the courts and in Congress.

Judicial Activities

The first court action in 1979 on house staff unionization occurred early this Spring when the United States Court of Appeals for the District of Columbia Circuit reversed, by a split decision of 2 to 1, a 1978 District Court decision that dismissed an action brought by the Physician's National House-staff Association (PNHA). In that case, the District Court found that it lacked jurisdiction to review the NLRB determination because of the limited role assigned to the District Courts by the Act.

In this case, the PNHA was appealing the 1978 decision. The PNHA identified a narrow exception to the general rule and argued that the exception created jurisdiction for purposes of this action. The Appellate Court found that the exception applied to the case and remanded it to the District Court for further proceedings.

The majority opinion of the three judge panel ruling on the appeal stated that the legislative history of the 1974 amendments to the Health Care Act demonstrates that Congress fully intended to include residents, interns, and teaching fellows under the jurisdiction of the NLRB. In a dessenting opinion, Associate Circuit Judge Roger Robb stated, "In this case, the Board (NLRB) carefully analyzed the facts and reached a conclusion that interns, residents, and clinical fellows are primarily engaged in graduate educational training and that their status is therefore that of students rather than employees."

Following that court action, on April 30th, the NLRB petitioned the U.S. Court of Appeals for the District of Columbia Circuit to rehear the case before the full Court. The NLRB's rehearing request was based on the importance of the case in two respects: (1) it is an unprecedented limitation on the Board's discretion, specifically granted by Congress, to determine whether certain individuals are employees within the meaning of the Act; and (2) it represents an unjustified expansion of the narrow exception to the prohibition of judicial review of such matters. In addition, the NLRB stated that the Court's interpretation of Congressional intent to cover house staff under the 1974 amendments to the Taft-Hartley Act was in error. While the NLRB has conceded that residents have some characteristics of employees, it is argued that "they participate in these programs not for the purpose of earning a living; instead, they are there to pursue the graduate medical education that is a requirement for the practice of medicine."

In a brief order issued on June 5th, which cited the "amici curiae" appeals of the AAMC and others, the U.S. Court of Appeals for the District of Columbia Circuit granted the NLRB's petition for a rehearing by the entire court in the case of PNHA vs. Murphy. In its decision, the Appellate Court took the unusual step of vacating the panel's judgment and opinions. This action, taken on the court's own initiative, suggests that the panel's decision should not be relied upon by lawyers engaged in similar litigation or be regarded as precedent by the courts.

The rehearing by the full, 10-member Court of Appeals was held on October 9th with oral arguments on the case. If at least five members of the court conclude that the court lacks jurisdiction to review the NLRB's decision, the District Court decision will be affirmed. It is not known at this time how long it will be before a decision is reached. However, final decision may not come until next year.

Legislative Activity

On February 15th, 1979, Representatives Frank Thompson, Jr. (D-New Jersey) and John Ashbrook (R-Ohio) introduced legislation which would amend the National Labor Relations Act to define interns and residents as employees for purposes of the Act. The bill, if passed, would overturn the March, 1976 Cedars-Sinai decision of the NLRB. Upon introduction into the House,

H.R. 2222 was referred to the Committee on Education and Labor where Representative Thompson is Chairman of the Subcommittee on Labor-Management Relations and Representative Ashbrook is the ranking Republican.

On July 17th, the Subcommittee on Labor-Management Relations held hearings on H.R. 2222. Testifying on behalf of the Association, John A. D. Cooper, President, reviewed the AAMC's substantive objections to the legislation: (1) the fundamental relationship between the interns and residents and the program director and his faculty would be changed from one of teacher and student to one of employer-employee; (2) the program director would no longer be able to shape each individual's training to suit individual educational needs, but would have to deal with "employees" on a collective basis; (3) hospital administrators would be expected to bargain about subjects over which they have no control; (4) the education emphasis of graduate medical education would be replaced by a new emphasis on "wages, hours, and terms and conditions of employment"; (5) as the programs at affected hospitals changed from an emphasis on education to an emphasis upon the material element of the employer-employee relationship, graduate medical education programs would face loss of accreditation; and (6) an administrative body could become the final arbitrator of the content of graducate medical education by virtue of defining the scope of collective bargaining and affected programs.

In addition, Dr. Cooper noted the large number of professional and scientific medical organizations that are strongly opposed to this legislation. Carl Vogt, AAMC legal counsel, concluded the Association's testimony by describing how the administrative, procedural, and legal structure of the NLRA would inevitably lead to the substantive concerns of the medical education and higher education communities. Additional testimony opposing H.R. 2222 was presented by Jack Myers, past President of the American College of Physicians, and Willard M. Boyd, President of the University of Iowa.

On September 20th, the House Education and Labor Committee approved, by 23 to 9, H.R. 2222. While the markup session was not lengthy, two amendments were considered. Representative John Erlenborn (R-Illinois) offered an amendment which stated that "provisions of this act shall not be construed to require collective bargaining regarding matters affecting educational policy or programs." The amendment was rejected by a vote of 12 to 21. The Committee did adopt, by voice vote, an amendment by Representative Thompson to clarify that medical house staff would be covered under the NLRA as "employees" as well as "professional employees".

The bill has now gone to the House Rules Committee with a request that it be scheduled for one hour of floor debate prior to action by the full House of Representatives. It is not known when the Rules Committee will act.

HEALTH PLANNING

Renewal of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), which has been operating under special extensions since its expiration date in 1977, was the focus of legislative activity in health planning this year. Passage of renewal legislation came only after months of debate, negctiations, and amendments. On October 4, President Carter signed into law the "Health Planning and Resources Development Amendments of 1979," P.L. 96-79.

Congressional activity on health planning legislation was initiated on March 5th, 1979 when Senator Edward M. Kennedy (D-Massachusetts), Chairman of the Senate Subcommittee on Health and Scientific Research, and seven of his colleagues on that Subcommittee, introduced renewal legislation (S. 544) that would extend the act until 1982. The bill introduced by Senator Kennedy was very similar to the planning bill which was considered and approved by the Senate in July of 1978, but was lost in the legislative log jam at the end of the Congressional session last year. Once again this year, the Senate was quick to act on the legislation. On May 1st, by voice vote and without debate, the Senate unanimously passed S. 544.

In contrast to the swift Senate action on the health planning amendments, the House version, H.R. 3917 (previously H.R. 3441), originally sponsored by Representative Henry Waxman (D-California), advanced through the legislative process at a considerably slower pace. The Commerce Health Subcommittee had attached 50 amendments to the bill before the full Commerce Committee began its deliberations. After rejecting some of the Subcommittee's amendments, the Commerce Committee reported out a bill on May 15th. On June 7th, H.R. 3917 proceeded through the House Rules Committee where it was ruled that only one hour would be permitted on the House floor for additional debate on the bill. The House did not pass its version of the health planning bill until July 19th. Following that action, the House-Senate Conference Committee on August 1st adopted a three year, $1.37 billion extension of the "Health Planning and Resources Development Act." It still took until September 21st for the full House and Senate to agree on and adopt a single piece of legislation.

The AAMC submitted written testimony on two occasions this year commenting on the proposed legislation. The Association called for: (1) consideration of the clinical and access needs of biomedical research programs in review of proposed new health services: (2) the extension of certificate of need review requirements to all major medical equipment in excess of $150,000, regardless of setting or ownership; (3) HSA's to be prohibited from conditioning approval of one health service request on an agreement to develop another health service; (4) HSA's to be permitted to approve the limited introduction of new technologies prior to development of planning guidelines for them; (5) the elimination of provisions in both bills which proposed grant support to states for development of potentially mandatory programs for decertification of institutional resources and facilities; (6) the amendment of HSA and SHCC board composition requirements to include at least one chief executive officer of a short-term, general, tertiary care/referral hospital; (7) appropriateness review to be limited to an areawide review of selected health services if it is to be maintained as a realistic component of the planning process; and (8) elimination of HSA federal grant review and approval for manpower and research grants without a significant service component.

In addition, the AAMC specifically urged health planning legislation to include provisions that would (1) require that the dean of at least one medical school be represented on an HSA board if the health service area contained one or more accreditated schools of medicine, and (2) require that HSA and state agency reviews consider the effect of proposed services on the clinical needs of health professional training programs in the area and the extent to which the health professions school in the area would have access to the services for training purposes. Both of these provisions appeared in several of the early versions of the legislation this year. Only the second provision was adopted in the final bill.

Among the other provisions included in the "Health Planning and Resources Development Amendments of 1979", those of particular interest to COTH members include:

- Membership requirements for the composition of health systems agency boards are amended so that at least one half of the members on the board will be providers and at least one of them shall be engaged in the administration of a hospital.

- HSA and the State Agency are required to carefully consider factors that preserve and improve competition in the health service area.

- Appropriateness reviews are to be made on either an areawide or institution-specific basis, as deemed appropriate locally; become more detailed in the future; and provide for hearings in the cases of institution-specific reviews.

- An HSA can establish goals that are different from the National Health Planning Guidelines in order to be responsive to the unique needs and resources of its area, but must provide a detailed statement of such inconsistencies.

- The State Agency is required to establish a period within which approval or disapproval of the application for a Certificate of Need (CON) shall be made. If a State Agency fails to approve or disapprove an application within the applicable time period, the applicant may file suit in an appropriate state court to require the State Agency to approve or disapprove the application.

- In reviewing construction projects, the HSA and the State Agency shall consider the effect of the application on the cost and charges to the public of other providers' health services. In the case of existing services, the quality of care provided by such a facility in the past must be considered. In both cases, consideration must be given to the extent to which such proposed services will be accessible to all residents of the area to be served by such services.

- Certificate of Need programs must:

  --provide for periodic review of progress on approved projects and for withdrawl of certificates in case of extended delays;
  --require coverage of all major medical equipment serving inpatients;
  --limit coverage of other uses of non-institutional major medical equipment to requirements under state laws enacted prior to September 30th, 1982;
  --exlude coverage of HMOs which singly or in combination serve at least 50,000 persons.

- Each HSA shall collect annually the rates charged for each of the 25 most frequently used hospital services in the state including the average semi-private and private room rates. HSAs are to make such information publicly available.

- Research and training under the Public Health Service Act should not be reviewed unless the grants are to be made, and entered into, or used for the development, expansion or support of health resources which would make a significant change in the health services available in the health services area.

- HSAs may review and comment on plans for Federal facilities only when specifically requested to do so by federal agencies.

NATIONAL HEALTH INSURANCE

Legislative Activity

During 1979, national health insurance has received a renewed high level of interest. Numerous bills have been introduced. Despite the number of proposals being considered by Congress, it does not appear at this time that Congress will take action on any bills before the Congressional year ends.

President Carter first unveiled his national health insurance plan on June 12th, urging Congress to "act without delay" on an annual $24.3 billion national health insurance plan to protect "all of our people" against "devastating health bills". The bill was formally introduced in the House and the Senate on September 25th as the "National Health Plan Act" (H.R. 5400, S. 1812). The proposed legislation includes three major components. The first, Employer Guaranteed Coverage, would mandate employers to provide all full-time employees and dependents with a certified package of comprehensive benefits. Employers would be required to pay a maximum of $2,500 in out-of-pocket payments per year. No cost-sharing could be imposed on prenatal, delivery and infant services.

The second major component of the plan, "HealthCare", calls for a new Federal insurance program that would consolidate Medicare and Medicaid and broaden eligibility for the poor. Employers and individuals could also purchase coverage under HealthCare if desired. Benefits would be the same as

those outlined under the employer-mandated program although out-of-pocket payment would be limited to $1,250 for most and could be much less for the low-income population.

The third portion of the bill, Health Systems Reforms, would incorporate the President's cost containment bill and an annual national limit on capital expenditures which would be allocated among the states.

Senator Edward Kennedy (D-Massachusetts) has also offered a national health insurance bill to be considered by Congress. His bill was first outlined on May 14th in front of a large press gathering in the Russell Senate Office Building where his brothers John and Robert announced their candidacies for President of the United States. The bill was formally introduced in Congress on September 6th as S. 1720 and H.R. 5191. The bill has seven co-sponsors in the Senate and 59 co-sponsors in the House where Representative Henry Waxman (D-California) is leading the effort. The Kennedy proposal has five major principles which were developed in cooperation with organized labor's Coalition for National Health Insurance. These principles include: (1) comprehensive benefits; (2) universal coverage; (3) system reform to encourage preventive medicine and prepaid group practice; (4) strict cost control; and (5) quality controls.

The plan would provide full coverage of inpatient hospital services, physician services in and out of the hospital, X-rays, lab tests, ambulance services, and medical equipment for all U.S. residents. Drugs (for the elderly), home health, nursing home care, and mental health care would all be partially covered. Financing the plan would be primarily through wage related employer/employee contributions with the employee providing up to 35% of the total cost of the premium. Medicare would continue to cover the elderly and Medicaid would be upgraded.

Individuals could choose among private insurers, but all insurers must provide at a minimum, the mandatory benefits. Thus, competition among insurers would be based on administrative efficiency and supplemental coverage. Kennedy expects that implementation of the program would not be before 1983. He said that national health care expenditures would be $40 billion greater as a result of the plan during its first year of operation. However, he argued that strict cost controls in the proposal would make the plan cheaper than existing programs by the fourth year after implementation.

It now appears that if any bill is to be passed, it would be some form of catastrophic national health insurance. Senator Russell Long (D-Louisiana) has been a leading advocate of this approach for many years. As Chairman of the powerful Senate Finance Committee and as a key individual in any national health insurance deliberations, Senator Long has expressed his intentions to take up national health insurance in his committee this fall. It appears that the Senate Finance Committee may be the only one of the four Congressional committees with jurisdiction over national health insurance that may act in this session of Congress.

There are a number of other national health insurance plans that have been introduced in Congress, most of which are variations of the three mentioned above. However, there are several plans that take a different approach to national health insurance. The primary characteristics of these plans is their emphasis on increasing free choice, market incentives, and competition into the health care system. Representative Al Ullman (D-Oregon), Chairman of the House Ways and Means Committee is supporting such an approach. According to Ullman, his plan "does not broaden health coverage; nor will it increase the layer of benefits. It costs the Government nothing, and it can be achieved this year." Rather than proposing a health insurance scheme, Ullman attacked built-in incentives to spend money that fuel inflation and health care costs. He also rejected Government regulation of the entire health care system. His approach would be based on: (1) changing tax laws to encourage greater enrollment in prepaid health plans; (2) placing a cap on the Federal tax subsidy for medical insurance; (3) requiring a choice of health plans offered by an employer; (4) requiring employers to pay equally to each plan; (5) changing Medicare law to encourage elderly patients to join HMOs; and (6) mandating a statewide demonstration project similar to Oregon's project health for the low-income population.

Senator Richard Schweiker (R-Pennsylvania), ranking minority member on the Senate Human Resources Subcommittee on Health and Scientific Research, has also introduced a national health insurance plan that addresses cost controls, catastrophic health insurance, and disease prevention by restructering tax incentives and requiring coverage by employers. While neither Senator Ullman's plan or Senator Schweiker's plan is expected to pass, there is some consensus that increased incentives for cost consciousness are likely to be a part of any national health insurance debate in the coming months.

AAMC Activity in National Health Insurance

Because of Congressional interest in national health insurance in 1979, last summer the AAMC appointed an Ad Hoc Committee on National Health Insurance. The Committee was charged to review and revise where necessary the Association's November 1975 policy statement on national health insurance. Under the leadership of John A. Gronvall, Dean of the University of Michigan Medical School and 1978-79 Chairman of the AAMC, the Ad Hoc Committee met on August 2nd, 1979. Members of that Committee include John W. Colloton, Director of the University of Iowa Hospitals and Clinics and Assistant to the President for Health Services at the University of Iowa and Chairman-elect of the COTH Administrative Board; James F. Kelly, formerly the Executive Vice-Chancellor of the State University of New York - Albany, now retired; William H. Luginbuhl, Dean of the Division of Health Sciences at the University of Vermont College of Medicine; Peter Shields, Chairman of AAMC's Organization of Student Representatives; Virginia V. Weldon, Professor of Pediatrics and Assistant to the Vice-Chancellor at the Washington University School of Medicine; and Charles B. Womer, President of the University Hospitals of Cleveland and Chairman-elect of the AAMC Executive Council.

The Committee recommended that the Association policy be directed not at national health insurance per se, but at "the need for the expansion and improvement of health insurance in the United States." The Committee noted three major disparities that exist in the Nation's health insurance system: (1)the lack or inadequacies of basic health insurance coverage for low-income Americans; (2) the inadequacy of health insurance protection against the high cost of catastrophic illness; and (3) the lack of a generally accepted minimum standard for basic health benefit plans.

Following the Ad Hoc Committee meeting, AAMC staff drafted a position paper on the expansion and improvement of health insurance in the United States. This draft was reviewed by the Ad Hoc Committee members and by the Executive Council at its September, 1979 meeting. The final position paper of the AAMC, when approved by the Executive Council, will serve as the basis for AAMC testimony on national health insurance should Congressional Committees decide to hold hearings on national health insurance.

HOSPITAL PHILANTHROPY LEGISLATION

On February 27th, 1979, Representative Tim Lee Carter (R-Kentucky) introduced "The Voluntary Hospital Philanthropic Act," H.R. 2455. The major objective of the bill is to encourage and protect philanthropy in the health care field, especially philanthropy provided to hospitals. The bill, as presently drafted, contains several specific provisions. The first provision in the bill is that in determining hospital costs and allowable reimbursement under the Medicare, Medicaid, and Crippled Childrens Programs, hospital expenses may not be reduced by any donations, gifts, grants, or endowment funds. This provision would significantly alter present practices by prohibiting federal programs from reducing hospital cost by restricted donations when determining federal payments.

The second significant provision in the bill is that it prohibits states from adopting programs for limiting hospital revenues unless such programs exclude from the revenue limitation (1) all donor restricted funds, including those restricted to operations, and (2) all other donated funds limited by the governing board to non-operating expenses. Donated funds not restricted by the donor or limited to operating purposes by the governing board are not addressed in the bill. The third major provision in the bill is that it prohibits any federal hospital cost containment program from including in the revenue limitation (1) all donor restricted funds, including those restricted to operations, and (2) all other donated funds limited by the governing board to non-operating expenses. Donated funds not restricted by the donor or limited to operating purposes by the governing board are not addressed in the bill.

The bill, which was jointly referred to the House Committee on Ways and Means and the House Committee on Interstate and Foreign Commerce, has not been the subject of any Congressional hearings or actions. AAMC staff

has expressed Association interest in the legislation to Representative Carter's staff, and is preparing comments on the bill to be submitted to the Health Subcommittee of the House Interstate and Foreign Commerce Committee.

COTH SPRING MEETING

The AAMC's Council of Teaching Hospitals held its second annual Spring Meeting in Kansas City, Missouri on May 16-18, 1979. The two day meeting, which was conducted to provide the chief executive officers (and their chief associates) of COTH member hospitals with an opportunity to meet personally and discuss common issues and concerns, attracted over 150 participants.

The meeting opened on the evening of May 16th with an address by Dr. Jack Lein, Associate Dean for Continuing Education and Development at the University of Washington School of Medicine. The topic of his discussion, was "Legislators are not Illiterate-They Just Don't Believe us Anymore." While his presentation was humurous, his message was clear with regard to the need and appropriate methods for active participation in the legislative policy decision-making processes at all levels of government.

The morning session on May 17th, featured a presentation by Richard Knapp, Director of the Department of Teaching Hospitals, on the subject "Toward a More Contemporary Public Understanding of the Teaching Hospital." Dr. Knapp reviewed the highlights of a paper on that topic prepared by the Department staff. Following his presentation, participants were assigned to discussion groups to review the paper within the context of major issues related to hospital reimbursement, health planning and national health insurance. In the afternoon, each discussion group leader presented a report on his group's morning session. The reports were followed by floor discussion.

Spring meeting activities for May 17th concluded with four concurrent sessions on special topics of interest: (1) Paul Hanson, President of Genessee Hospital in Rochester, and Dr. James Block, President of the Rochester Area Hospital Association discussed "The Maxicap Experiment: Present Status and Future Probability;" (2) Dr. Henry Zaretsky, Director of California Office of Statewide Health Planning and Development and Dr. Robert Tranquada, Associate Dean of Postgraduate and Regional Medical Education at the UCLA School of Medicine, discussed "The Manpower Component of the State Health Plan"; (3) "An Informal Session with Staff of the Voluntary Effort" was conducted by Paul Earle, Executive Director for the Voluntary Effort; and (4) a session on the "Role of Veterans Administration Medical Centers with Medical Schools" was led by Al Gavazzi, Director of the VA Hospital in Washington, D.C.; B. Fred Brown, Director of the VA Hospital in Durham, North Carolina; Turner Camp, M.D., Director of the VA Hospital in Phoenix, Arizona; and William Mayer, M.D., Assistant Chief Medical Director of the VA. The evening program included a reception hosted by the Truman Medical Center of the University of Missouri - Kansas City.

The final day of the meeting was devoted to a discussion of "State Rate Review and the Teaching Hospital". First, "The Experience in Maryland" was discussed by representatives from two COTH member institutions in metropolitan Baltimore. The sobering experiences of the University of Maryland with the state rate review were reviewed by its Director, G. Bruce McFadden, while the more favorable experiences of the Johns Hopkins Hospital were related by Irv Kues, the Hospital Vice President for Management Systems and Finance. Later in the morning, a debate was held on the question, "Should We Support Immediate Development of State Rate Review Agencies?" Both sides of the issue were argued effectively, with Dave Hitt, who recently left his post as Executive Director of the Baylor University Medical Center, taking a qualified "pro" stance, and Irwin Goldberg, Executive Director of the Montifiore Hospital in Pittsburg, Pennsylvania, arguing the "con" position.

SPECIAL PROJECTS: EDUCATIONAL COSTS AND HOSPITAL CASE MIX

In addition to routine services and activities conducted by the Department of Teaching Hospitals, the staff occasionally undertakes projects related to specific timely, important issues. This year the staff has begun two projects which are outlined below.

As was stated in the summary description of the COTH Spring Meeting, a portion of that meeting was devoted to discussion of a paper prepared by staff titled "A More Contemporary Public Understanding of the Teaching Hospital". At the workships which addressed this paper in light of national health insurance, health planning and reimbursement issues, the consensus of the members attending the meeting was that the problems facing teaching hospitals in the future result from three factors: atypical service costs resulting from the complexity or intensity of care provided patients, atypical institutional costs resulting from educational program activities, and a wide variation in these costs among teaching hospitals. Because of the variation among teaching hospitals, members suggested that methodologies were needed to quantify intensity and educational costs so that teaching hospitals could be classified into homogeneous groups or scaled into continuous distributions. More specifically, it was recommended that the AAMC/COTH sponsor or conduct a study (or studies) to quantify the intensity of patient care and the costs of educational programs.

The COTH Administrative Board at its June meeting, with Executive Council approval, directed staff to prepare a state-of-the-art paper on methods for quantifying the intensity of care and an annotated bibliography on educational program costs. When completed, these papers would serve as resources for developing and designing the member-recommended studies.

Work has begun on the annotated bibliography on educational costs in teaching hospitals. A thorough literature search has been conducted, and abstracts are being prepared for all articles and studies that have addressed the problem of identifying and documenting the costs of medical education programs in teaching hospitals.

In regards to the state-of-the-art paper on intensity of care, staff completed a preliminary report titled "Case Mix Measures and Their Reimbursement Applications," which was presented to the COTH Administrative Board and AAMC Executive Council at their September 13th meetings. Case mix measures were selected as the initial focus of staff activity because of the active attention these measures are currently receiving from several researchers, because of several reimbursement experiments presently attempting to apply them, and because of Medicare's effort to add case mix measures to next year's payment limitations methodology. The report, which was based on numerous site visits conducted by staff last summer, gives particular attention to the Diagnosis Related Groups (DRGs) developed at Yale University because this method is the most fully developed and is being used in several reimbursement experiments. The COTH Board and AAMC Executive Council accepted the report as a source of backgroud information, authorized completing the final case mix report, approved the policy recommendations in the report, and directed staff to begin expanding its activities on quantifying the intensity of patient care provided in teaching hospitals. The case mix report was forwarded to all COTH members in September.

As a next step in this project, staff is identifying data which can be used to evaluate the DRGs as an intensity measure for reimbursement, identifying researchers/consultants with expertise and interest in conducting such an evaluation, and preparing a study plan which can be used to develop an equitable method for reimbursing hospitals that specialize to varying degrees in tertiary care, medical education, supervised research, and the introduction of new treatment and diagnostic services.

SURVEYS/PUBLICATIONS

The Department of Teaching Hospitals has maintained its program of regular and special issue membership surveys. The staff has also prepared several special reports. All of these publications have been made available to COTH members.

COTH Report

The COTH Report, which expanded its format last year, is published approximately 10 times a year. In addition to reporting Washington developments and AAMC activities of concern to COTH members, increasing emphasis has been placed on summarizing major government and private studies focusing on current health policy issues. The newsletter has also initiated a new section entitled "Faces in the News". This section highlights individuals who have contributed to and influenced major health care policy decisions in the country.

COTH Directory of Educational Programs and Services

This Directory, which was published in April, has been prepared annually for the past eleven years. The Directory provides a profile of each COTH member hospital, including selected operational and educational program statistics. Questionnaires for the 1980 Directory were mailed in July and September, depending on the hospital's fiscal year.

COTH Executive Salary Survey

The 1978 Executive Salary survey was published and mailed to COTH chief executive officers last spring. Based on responses from 70% of all non-Federal teaching hospitals members, the report describes salaries, fringe benefits, and hospital compensation policies. The tables in the report present the data by hospital's type of ownership, regional location, type of affiliation, and bed size. In addition, means, medians, quartiles, and percentiles are presented for the salary information. Questionnaires for the 1979 survey were mailed in August, and it is anticipated that the findings from the survey will be published early in 1980. This year's survey, unlike the previous survey, will include all VA members in the survey results. COTH Administrative Board policy limits distribution of this report to chief executive officers of COTH member hospitals. COTH hospital board members may also receive the survey upon request, but the chief executive officer will be informed when a copy has been provided to a board member.

COTH Survey of the University Owned Teaching Hospitals

This survey, which is also prepared annually, publishes comparable and detailed hospital data on hospital income sources, expenses, utilization of services, and staffing for university owned hospitals. The eighth annual COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data was published in April. The data presented in the report is based on fiscal year's ending in 1977. Questionnaires for this year's survey were mailed in June. The responses have now been received from all but one of the 64 participating hospitals. Results of this survey will be published early in 1980. Distribution of this report is restricted to those institutions participating in the survey.

COTH Survey of House Staff Stipends, Benefits and Funding

The preliminary results of the 1979 annual survey of house staff were mailed to all COTH member hospitals in June, 1979. This survey publishes information on levels of stipends for house staff by hospital region, ownership, bed size, and affiliation. It also provides information on fringe benefits for house staff and on sources and amounts of funding per hospital. The 1979 final report, which will be published this winter, is based on responses from over 350 hospitals.

Toward a More Contemporary Public Understanding of the Teaching Hospital

In preparation for the COTH Spring Meeting this year, the Department staff prepared a paper which outlines the evolution of the teaching hospital during the past two decades; identifies characteristics which distinguish teaching hospitals from non-teaching hospitals; and attempts to describe differences among the teaching hospital population. The report was sent to all COTH members last June.

Case Mix Measures and Their Reimbursement Applications

This report was prepared by staff based on membership recommendations during the Spring Meeting and a charge from the Administrative Board in June to prepare a state-of-the-art paper on methods for quantifying the intensity of care provided in hospitals. The report was distributed to all COTH members in September.

Other Materials Available from Department Files

In addition to the above surveys and reports, the Department of Teaching Hospitals maintains a collection of materials on various topics which are available to COTH members. While some of these items contain rather lengthy documentation and unfortunately cannot be copied upon request, the Department welcomes members to write or visit our offices in Washington, D.C. to review them. These materials include:

- copies of Section 223 exception requests submitted by COTH member hospitals to HCFA:
- time and effort reporting forms used by some member hospitals and medical schools to allocate staff time to various activities;
- a file of COTH hospital-medical school affiliation agreements;
- a file of COTH hospital house staff manuals;
- job descriptions for medical staff leadership positions at COTH hospitals;
- a survey conducted this year of sources of construction funds in teaching hospitals, which was summarized in a datagram in the August, 1979 issue of the Journal of Medical Education; and
- a collection of articles and literature on topics of special interest to teaching hospitals.

The purpose of this report is to provide COTH members with a summary of the past year's activities and of the types of services, publications, and documents available to members. If you should have any questions, you are encouraged to contact the staff of the Department of Teaching Hospitals (see Appendix B).

Appendix A

COUNCIL OF TEACHING HOSPITALS
OFFICERS AND ADMINISTRATIVE BOARD
1978-79

Chairman
*Robert M. Heyssel, M.D.
Executive Vice President & Director
The Johns Hopkins Hospital
Baltimore, Maryland

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*John W. Colloton
Director and Assistant to the
President for Health Services
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Immediate Past Chairman
*David L. Everhart
President
Northwestern Memorial Hospital
Chicago, Illinois

Secretary
John Reinertsen
Executive Director
University of Utah Medical Center
Salt Lake City, Utah

Term Expiring 1981

Dennis R. Barry
General Director
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Mark S. Levitan
Executive Director
Hospital of the University of Pennsylvania
Philadelphia, Pennsylvania

Robert K. Match, M.D.
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Long Island Jewish -
Hillside Medical Center
New Hyde Park, New York

Term Expiring 1980

James Bartlett, M.D.
Medical Director
Strong Memorial Hospital
of the University of Rochester
Rochester, New York

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Hospital Director
Veterans Administration Hospital
Gainesville, Florida

Elliott C. Roberts
Director
Charity Hospital of Louisiana
at New Orleans
New Orleans, Louisiana

Term Expiring 1979

Jerome R. Dolezal
Hospital Director
Veterans Administration Hospital
Seattle, Washington

James M. Ensign
President
Creighton Omaha Regional Health
Care Corporation
Omaha, Nebraska

Mitchell T. Rabkin, M.D.
General Director
Beth Israel Hospital
Boston, Massachusetts

Ex Officio Member

*Stuart J. Marylander
President
Cedars-Sinai Medical Center
Los Angeles, California

* Representative to AAMC Executive Council

Appendix B

STAFF
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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Gail Gross
Administrative Secretary
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Melody J. Bishop
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202/828-0493

Tina D. Williams
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