COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 (202) 828-0490

SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

NOVEMBER, 1979 – OCTOBER, 1980

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OUTLINE OF SELECTED ACTIVITIES

INTRODUCTION

The Department of Teaching Hospitals is the staff component of the Association of American Medical Colleges (AAMC) responsible for representing the interests and concerns of teaching hospitals in AAMC activities and with other organizations and agencies. Each year, the Department prepares a summary of its activites during the past year. This annual report is distributed at the Annual Meeting every fall. The following document covers Department activities from November, 1979 through October, 1980. Those interested in knowing more about Department activities are encouraged to read this report and to contact us for any information you need throughout the year. Staff members of the Department and their phone numbers are listed in Appendix A.

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 needs, concerns, and opportunities facing major teaching hospitals in the United States. The Council of Teaching Hospitals has input into overall Association policy and direction through two formal bodies: the Executive Council, which includes four members of the COTH Administrative Board, and the AAMC Assembly -- the highest legislative body of the AAMC. During the past year, Charles B. Womer, President of the University Hospitals of Cleveland, has been Chairman of the AAMC Executive Council.

COTH Membership

There are two categories of COTH membership: teaching hospital full membership and corresponding membership. To qualify for either type of membership, the applicant institution must have a written 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.

The major criteria for teaching hospital membership are:

- The hospital must sponsor or significantly participate in at least four approved, active residency programs.
- At least two of the approved residency programs must be in internal medicine, surgery, obstetrics-gynecology, pediatrics, family practice, or psychiatry.

In addition to these two criteria, consideration will be given to a hospital's participation in medical education activities such as undergraduate clerkships, the presence of full-time chiefs of service, the proportion of residents which are foreign medical graduates, and the significance of the hospital's educational programs to the affiliated medical school. In the case of specialty hospitals, such as children's hospitals, exceptions may be made to the four residency programs requirement as long as the hospital meets the membership criteria within the framework of the specialized objectives of the hospital.

Institutions not meeting the criteria for full 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 423 teaching hospital members and 25 corresponding members. There are presently 349 not-for-profit, municipal, and state COTH member hospitals. The remaining 74 members are Veterans Administration hospitals. Sixty-four members are university-owned hospitals.

COTH Administrative Board

The Administrative Board of the Council of Teaching Hospitals sets the policy for the Council and provides representation to the Executive Council of the Association. 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. There are nine regular members of the Board, each serving a three year term. In addition, the Immediate Past Chairman, the Chairman, the Chairman-elect, and the Secretary are members of the Administrative Board. For the coming 1980-1981 year, Stuart J. Marylander, President of the Cedars-Sinai Medical Center in Los Angeles, will be serving as the COTH Chairman. Other present members and officers of the COTH Board are listed in Appendix B of this report. COTH Officers, Administrative Board members, and new representatives to the AAMC Assembly are elected annually by all COTH members at the AAMC Annual Meeting.

AAMC STUDY OF TEACHING HOSPITALS

A significant part of the 1979 COTH Spring Meeting was spent in workshops discussing the term teaching hospital in light of reimbursement, planning, and national health insurance issues. Each workshop concluded that the problems facing teaching hospitals in the future resulted 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 each of these costs among teaching hospitals. Because of the variation among teaching hospitals, discussion groups concluded 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.

The 1979 Spring Meeting recommendation was supported by the COTH Administrative Board and the AAMC Executive Council at their June, 1979 meetings. As a first step, staff were directed to develop a state-of-the-art paper on approaches to quantifying patient intensity and an annotated bibliography on educational costs.

The first version of the intensity paper, "Case Mix Measures and Their Reimbursement Applications," was provided to the AAMC Executive Council at its September, 1979 meeting. Upon reviewing the paper, the COTH Administrative Board recommended: that the AAMC distribute the preliminary report to all COTH members

and to other interested hospitals and hospital associations, and that the AAMC prepare a second paper summarizing the case mix research activity of others and suggesting several possibilities for COTH/AAMC sponsored activities.

In December, 1979 the AAMC established an Ad Hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals to guide the Association's special project on the patient intensity of care in teaching hospitals. The Ad Hoc Committee, which is being chaired by Mark Levitan, Executive Director of the Hospital of the University of Pennsylvania, includes seven chief executive officers from COTH member hospitals, one medical school dean, one medical school department of surgery chairman, one hospital chief of medicine, and one chief resident. The Ad Hoc Committee has held two meetings, one in January and the second in March. At the January meeting, four recommendations were adopted:

- that AAMC staff continue to monitor and, where appropriate, visit case mix researchers, state and federal reimbursement experiments, and developers of management information systems focusing on patient diagnosis;

- that the AAMC sponsor a workshop to acquaint the constituents with present developments and issues in case mix measurement, reimbursement, and management information systems;

- that the Association obtain appropriate data to evaluate the HCFA assumptions that a 20 percent sample of Medicare discharges is adequate to describe a hospital's case mix, that hospitals produce cases at similar relative prices, and that year-to-year changes in case mix are significant; and

- that the Association staff develop a comprehensive workplan for a study of the characteristics and costs of teaching hospitals.

In formulating the plan for a study of the COTH membership, significant questions were raised about the case mix and financial data that should be used in the study. Therefore, seven hospitals with significant past experience in merging patient specific clinical and financial data were convened as an advisory panel to the larger committee. It was the consensus of these hospitals that a case mix project involving the COTH membership should begin with a limited number of hospitals, use the Yale Diagnosis Related Groups to categorize case mix, and use "charges adjusted by costs to charge ratios" to compare the costs of cases across teaching hospitals.

These recommendations and staff proposals for the Ad Hoc Committee's other priorities were the subject of the Ad Hoc Committee's March meeting. The Ad Hoc Committee approved further development and initial implementation of an 18 month study which would develop three profiles for a sample of teaching hospitals: a case-mix profile, a program and services profile, and a financial profile. A comprehensive description of teaching hospitals will be derived from the data in these three profiles.

Following the March meeting of the Ad Hoc Committee, a survey was mailed to all non-federal COTH members to determine which institutions had the patient

clinical and billing data necessary to participate in the study. From the group of hospitals which indicated they had the required data, a sample of 34 hospitals was selected based primarily on geographic location and level of educational involvement. On August 1, 1980, a letter requesting participation in the study was sent to the chief executive officer of each of the 34 hospitals, and 22 institutions responded positively. In September, an additional 14 hospitals were invited, with the expectation of achieving a final sample of approximately 30 hospitals.

On September 5, 1980, an initial meeting of the participating hospitals was held in Chicago to review the case mix data requirements and drafts of questionnaires to be used for the study. As a result of the meeting, a final uniform computer tape format has been developed for the patient case mix data. Detailed diagnostic, procedural and charge data will be collected on all patients discharged in fiscal year 1978. The data will be used to classify patients by Yale's DRGs as well as by a severity measure, disease staging. The analysis will also include replication of HCFA's case mix index which is being developed for possible application in constructing Section 223 limits. The AAMC has contracted with SysteMetrics of Santa Barbara, California to perform the data processing for the case mix data. In addition, staff is finalizing questionnaires on educational activities, patient services, research, hospital staff, and contract arrangements. Finally, each hospital is submitting a copy of its 1978 Medicare cost report, annual report, audited financial statements, and patient origin study. Participating hospitals are expected to submit the case mix data tapes to SysteMetrics by the end of this year. The questionnaires on the other characteristics of teaching hospitals are being sent to hospitals this fall. It is anticipated that preliminary study data will be available by the 1981 COTH spring meeting in Atlanta with final reports available by late summer.

As a result of the Association's response to member interest in patient intensity measures and educational costs, two special reports were published during the year: "Describing and Paying Hospitals - Developments in Patient Case Mix," and "Medical Education Costs in Teaching Hospitals - An Annotated Bibliography."

COTH SPRING MEETING

On May 14 through 16, 1980, the Council of Teaching Hospitals held its third annual Spring Meeting in Denver, Colorado. The meeting opened with a keynote address by Paul Ellwood, President of Interstudy and an advocate of price competition in the health care industry. His presentation was titled "Can Teaching Hospitals Survive in a Price Competitive Medical Care World?" He urged teaching hospital executives to assess the implications of competition for their institutions and to enter the marketplace now, because price competition among hospitals is coming, "like it or not".

The morning session on May 15 featured five presentations. Christopher Fordham, Chancellor of the University of North Carolina, attributed the nation's potential oversupply of physicians and shortage of nurses to the lack of collaboration between state and federal decision-makers in the health manpower area and the lack of adequate goal setting. To address the oversupply, Dr. Fordham called for development of a national policy for reduction in health

manpower over time; development of new approaches to medical curriculum; and directly addressing the nursing supply issue within national policy. Edward Stemmler, Dean of the University of Pennsylvania School of Medicine, described medical schools' growing dependency on organized faculty practice plan revenue for the financial support for medical education and emphasized the decreasing support from other traditional sources of funds. D. Kay Clawson, Dean of the University of Kentucky College of Medicine, described faculty practice plans as an effective mechanism for service, education, and research in a competitive market and emphasized "flexibility, accountability, and incentives" as the keys to their success. Richard Moy, Dean and Provost of the Southern Illinois University School of Medicine, recounted the establishment of the new medical school and discussed its effects on area hospitals and communities. The final speaker, Julius Krevans, Dean of the School of Medicine of the University of California, San Francisco presented a philosophical discussion on the current and prospective state of the nation in his speech on "Living in the 80's; Where do we Fit?"

The afternoon began with an informative technical discussion of "Physician Reimbursment Issues in the Hospital-Based Group Practice Setting," by Jack Wood, attorney with the firm Wood, Lucksinger and Epstein of Houston, Texas. The session concluded with four concurrent meetings on special topics of current interest: Lawrence Klainer, Program Manager of the Veterans Administration Central Office, discussed "Health Care Information Systems within the VA," and Thomas Watt, Deputy, Planning and Program Development of the Central Office, spoke on "Multi-level Care: What, Why, How, and When in the Veterans Administration;" Myron Wegman, Dean Emeritus, School of Public Health, University of Michigan, discussed "Bed Reduction Under State Legislation: the Michigan Experience;" "Third Party Pressure on the Academic Medical Center: The Stanford Story" was the topic Peter Levin, Executive Director of Stanford University Hospital, reviewed, and Jerome Grossman, President of the New England Medical Center, presented "An Enterprise Approach to Managing the Hospital Outpatient Department."

The final day of the meeting was primarily devoted to a discussion of case mix reimbursement and the application of Diagnosis Related Groups (DRGs): Mark Levitan, Executive Director of the Hospital of the University of Pennsylvania and Chairman of the Association's Ad Hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, commented on the AAMC's study of teaching hospitals. James Bentley, Associate Director of the Department of Teaching Hospitals, reviewed staff activity to date in designing the study. These introductory remarks were followed by three presentations: Judith Lave, Director of HCFA Office of Research, spoke on "Fitting Payments to the Hospital's Products: The Medicare Perspective;" J. Joel May, Executive Vice President, Health Care Research and Education Trust of New Jersey, discussed "Case Mix Reimbursement: New Jersey's Approach to Assessing the Impact;" and Robert Fetter, Professor at Yale University and one of the original developers of the DRG concept, addressed the subject of "Diagnostic Grouping and Management: Changing the Questions Faced."

SURVEYS/PUBLICATIONS

The Department of Teaching Hospitals has five regular publications that are distributed to COTH members at no charge. In addition, the Association, from time to time, publishes special reports on various issues of current interest which are also distributed to COTH members. All of these publications are described below.

COTH Report

The COTH Report, which is published ten times a year, reports Washington developments and AAMC activities of concern to COTH members. It also summarizes important findings of studies focusing on current health policy issues. The COTH Report is provided at no charge to COTH member hospitals. A subscription fee of $30 is charged to non-COTH members wishing to receive the publication.

COTH Directory of Educational Programs and Services

Annually, a directory of all COTH members is prepared and distributed to all COTH members. The Directory provides a profile of each COTH member hospital, including selected operational and educational programs statistics. Questionnaires for the 1981 Directory were mailed in July and September, depending on the hospital's fiscal year. The 1981 Directory will be published early next year.

COTH Executive Salary Survey

Each year, the Department of Teaching Hospitals collects and publishes information on the salaries of all chief executive officers of COTH member hospitals. The tables in the report present data on salaries, fringe benefits, and hospital compensation policies by hospital ownership, regional location, type of affiliation, and bed size. In addition to the chief executive officer salary information, salary figures are presented for department heads and other types of administrative personnel. Distribution of the COTH Executive Salary Survey is limited to COTH chief executive officers. However, COTH Administrative Board policy does permit COTH hospital board members to 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 University Owned Teaching Hospitals' Financial and General Operating Data

This survey is prepared annually for the 64 university owned hospitals in the country. Information presented in the tables includes detailed hospital data on hospital income sources, expenses, utilization of services, and staffing. Distribution of this report is restricted to those institutions participating in the survey.

COTH Survey of House Staff Stipends, Benefits, and Funding

For the past 12 years, COTH members have been surveyed on the stipends, benefits, and funding of house staff at their institutions. Preliminary findings from this survey are published annually in June and a final report is published in the Winter. The tables in the report include data on house staff stipends by hospital region, ownership, bed size, and affiliation. Fringe benefits for house staff and sources and amounts of funding per hospital are also presented by these categories. This report is distributed to all COTH member hospitals.

Toward a More Contemporary Public Understanding of the Teaching Hospital

In preparation for the 1979 COTH Spring Meeting, staff prepared a paper describing the evolution and general characteristics of teaching hospitals. A copy of the paper was mailed to all chief executive officers of COTH member hospitals following that meeting. Additional copies are still available for those who did not receive the paper at that time.

Describing and Paying Hospitals: Developments in Patient Case Mix

The Department of Teaching Hospitals has spent considerable time during the past year following developments in patient case mix reimbursement and applications. Their findings have been summarized in this 115 page report. The report was sent to COTH member hospitals in June, 1980. Additional copies are available for $3.75. Address requests to Attention: Membership and Subscriptions, AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

Medical Education Costs in Teaching Hospitals: An Annotated Bibliography

This paper provides a comprehensive annotated bibliography of all articles and studies that have been written on the assessment of educational costs in teaching hospitals. Each annotation includes a summary of the objective of the study, the methodology used, and any important findings. A total of 30 studies are reviewed.

MEDICARE REIMBURSEMENT REGULATIONS

The Health Care Financing Administration (HCFA) underwent a change in leadership this year when Leonard Schaeffer resigned on June 1st as Administrator of HCFA. He was replaced by Howard Newman on July 17th, who for the past six years was President of the Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire. Mr. Newman is the third Administrator of HCFA since its conception in 1976. During the past year several important regulations have been published affecting Medicare reimbursement policy. Those most important to teaching hospitals are summarized below.

Section 223

Section 223 of the 1972 Social Security Amendments, P.L. 92-603, authorized Medicare to impose limitations on hospital costs reimbursed by the program's Part A coverage. Since 1974, limits have been set on Medicare per diem routine operating costs under Section 223. In the past, these limitations have disproportionately penalized the teaching hospital community. In July, 1979, more than 100 members of the Council of Teaching Hospitals met with then HCFA Administrator Leonard Schaeffer and other members of his staff to express their concerns about the limits. Last November, the AAMC Executive Committee met with HHS Secretary Harris to discuss Association concerns, and specific attention was given to the adverse impact of Medicare Section 223 reimbursement limitations on COTH members. As a result of these meetings, the regulations for setting limits on fiscal year 1981 per diem costs were substantially changed.

The proposed limits for fiscal year 1981 routine operating costs were published on April 1, 1980 in the Federal Register. The proposed methodology for this year's limits contained five significant features: (1) the per diem limit for each hospital group was changed from the 80th percentile to 112 percent of the means for the labor and non-labor components of routine costs; (2) in adjusting labor costs by the local wage index, the definition of labor-related costs was expanded to include 79.5 percent of total cost compared to 60 percent last year; (3) capital-related costs and medical and nursing education costs continued to be excluded; (4) an adjustment for each teaching hospital's limit was made based on the ratio of the number of residents to beds in the hospital (the limit was adjusted upward by 4.7 percent for each .1 resident per bed); and (5) limits for hospitals in states that have a lower Medicare hospital utilization than the national average were adjusted upward as was done last year.

To assess the impact of the proposed regulations, a survey was sent to all Council of Teaching Hospitals' non-federal members in April. In addition, AAMC staff obtained data arrays from HCFA that were used to construct the limits. The analysis of the HCFA data suggested that about 23 percent of the responding COTH members exceeded the proposed limits, compared to almost one third that were projected to exceed the 80th percentile limits under the previous methodology. Nationwide approximately 18 percent of all hospitals were expected to be impacted under the new proposed methodology. Thus, it appeared that the major teaching hosital would be better off under the new limits than they were last year but would still be penalized more frequently than others. Projections also indicated that teaching hospitals in the midwest and the west would be disproportionately penalized.

Based on the HCFA data, the COTH survey and individual comments from COTH members, a letter of comment on the proposed schedule of limits was sent to acting HCFA Administrator Earl Collier on June 2, 1980. The Association's letter supported the new educational adjustment for teaching hospitals and the expanded definition of labor-related costs, but opposed the 112 percent limits. As has been stated in previous years, the Association objected that the methodology used to construct the limits is simplistic, arbitrary and not consistent with Section 223 Congressional intent which was to exclude from reimbursement only those costs "found to be unnecessary in the efficient delivery of needed health services." The letter also stated that regional inequity still exists; the adjustment for education needs modification and clarification; energy and malpractice costs which are highly variable should be excluded from the definition of routine

operating costs; the limits do not recognize the cost associated with the provision of complex tertiary care to intensely ill patients; and the exception process is inadequate.

HCFA published the final schedule of limits on hospital inpatient and routine operating costs on June 20th. The final limits were very similar to the proposed limits but several minor modifications and clarifications were made. First, the inflation projections were revised upward so that group limits were several dollars higher than they were in the proposed limits. Second, a technical change was made in the way the number of residents are to be counted for the new educational adjustment. Third, it was clarified that because of new regulations relating to reimbursement of malpractice insurance costs, these costs would be excluded from the definition of routine operating costs. Finally, the previously inaccurate wage index for Minneapolis was increased resulting in slightly lower indexes for all other SMSAs. These final limits became effective for hospitals with cost reporting periods beginning on or after July 1, 1980.

Section 227

Section 227 of the 1972 Social Security Amendments (P.L. 92-603) governs the payment by Medicare of physician services rendered at teaching hospitals. The first set of proposed regulations addressing this issue was published in 1973. To date, implementation of this payment provision has yet to be achieved, despite extensive study and additional proposed regulations. At the 1978 Annual Meeting of the AAMC, former HEW Secretary Joseph Califano publicly agreed to delay further implementation of Section 227 so that HCFA and the AAMC could work together to develop equitable and workable regulations. In the interim, several bills have been introduced to delay Section 227 beyond its legislatively-mandated October 1, 1978 implementation date. There have also been legislative efforts to repeal Section 227. These developments are reported below.

On October 22, 1979 the Subcommittee on Health and the Environment of the House Interstate and Foreign Commerce Committee held hearings which addressed the Section 227 issue, as well as other Medicare and Medicaid provisions under consideration for amendment. Edward N. Brandt, Jr., M.D., Vice Chancellor for Health Affairs of the University of Texas System, accompanied by John A. D. Cooper, M.D., President of the AAMC, appeared before the Subcommittee on behalf of the Association and as part of a five member panel on Section 227.

Dr. Brandt covered three main points in his testimony: (1) when a professional fee for medical services is appropriate if residents are involved in the care of the patient; (2) how the amount of the professional fee is calculated; and (3) what so-called "double billing" is. The last point was covered first because Dr. Brandt stated, "... it is so frequently raised and is so frequently, in my opinion, misunderstood." The Association expressed strong opposition to double billing where a single service is reimbursed under both Medicare Part A and Part B benefits.

The Association testified that the 1969 Intermediary Letter #372 for the most part outlines reasonable criteria for determining whether personal and identifiable services were performed and merit a professional fee. However, the AAMC strongly objected to the previous draft regulations for Section 227 which

said that unless a given percentage of all patients met private patient criteria, no fees for professional services could be billed at that hospital.

The method used to determine the amount of the professional charge a teaching physician could receive was of equal concern to the Association in its testimony. Dr. Brandt pointed out that the July, 1978 draft regulations for Section 227 required that a majority of non-Medicare patients pay at least 80 percent of the charges in order for HCFA to recognize and make equivalent payment on charges claimed to Medicare. Similar collection requirements are not made of physicians admitting patients to non-teaching hospitals. The Association stressed that repeal of Section 227 would not resolve the fee payment controversy, for it is already a part of Intermediary Letter #372. To resolve this issue the AAMC urged the Subcommittee to include language in its report which prohibits the inclusion of token charges for charity patients and substandard charges for welfare and other low-income patients when determining fee levels for personal, identifiable services.

In his summary remarks, Dr. Brandt recommended the following actions to the Subcommittee:

- that an amendment be passed delaying the implementation date of Section 227 until a period of 180 days has expired subsequent to the issuance of proposed implementing regulations in the Federal Register;
- that the Committee report accompanying the amendment clearly indicate Congressional intent on the issues of when professional fees for teaching physicians are appropriate, how the fee level is determined, and what constitutes "double billing;"
- that the Subcommittee and its staff monitor HEW's regulations on these issues.

On January 31, 1980 the House Subcommittee on Health and the Environment reported out H.R. 4000 with an amendment sponsored by Representative David E. Satterfield, III (D-Va.) that would, in effect, repeal the teaching physician payment provisions of Section 227. Subsequent to that vote, the parent Interstate and Foreign Commerce Committee completed their markup of H.R. 4000 which retained the Section 227 repeal amendment. Although no separate action on H.R. 4000 has been taken by the full House of Representatives, it did pass a Budget Reconciliation Bill (H.R. 7765) on September 3, which includes the Section 227 repeal effort, and that bill is now in conference with the Senate version of the reconciliation bill. The Senate version does not address the Section 227 issue, so it is not yet known in what form the repeal effort will be included in the conference report, or whether Congress will even be able to agree on a final reconciliation bill prior to adjournment in December.

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. On May 16, 1979, HCFA proposed regulations that would more stringently define special care units. The

purpose of the regulations was to reclassify some special care units that are presently being reported as special care units but should be classified under 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 special care units were published on August 18, 1980 in the Federal Register. The regulations become effective for cost reporting periods beginning on or after October 1, 1980. In the final rule, the term "intensive care type units" replaces "special care units" which was used in the May 16, 1979 proposed regulations. The change was made because HCFA believes that "special care units" may suggest that subintensive care and intermediate care units be included in the definition. Thus, the new term is intended to reinforce HCFA's position that only units furnishing care equivalent to that furnished in intensive care units qualify for separate reimbursement as described in 42 CFR 405.452(d)(8). The final rule has modified several of the criteria that must be met to be considered an intensive care type unit. For example:

- Intensive care type units must be physically identifiable and separate from general routine patient care areas, including subintensive care units, intermediate care units, and ancillary service areas, but two or more intensive care units need not be separate from each other to meet the intensive care type unit criteria. These units could concurrently share nursing staff, although the units would be considered one unit for reimbursement purposes.

- Nurse staffing requirements have changed. The provision that registered nursing care must be present on a continuous 24 hour basis has been retained but in place of the other hourly nursing requirements in the proposed regulations, the final rule requires a minimum nurse-patient ratio of one nurse to two patients per patient day. Registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants may be included in this calculation.

- The provision that staffing may not be decreased during night shifts, weekends or periods when it is commonly decreased in other patient areas has been dropped.

- The word "permanently" has been deleted from the requirement that an intensive care type unit be permanently equipped with life-saving equipment. Thus, portable equipment that is readily available for immediate use may qualify a unit as an intensive care type unit.

Reimbursement for Costs of Approved Internship and Residency Programs

In determining net allowable costs for Medicare reimbursement, hospitals have been required to offset any grants or donations for approved educational programs when calculating educational costs allowable for Medicare reimbursement.

On August 10, 1979 in the Federal Register, HCFA proposed new regulations which would make an exception to this general rule for grants and donations for primary care residency care programs. The intent of the change was to insure that Medicare reimbursement policy would not thwart the purpose of primary care training grants which encourage the development of programs designed to train physicians in primary care specialities. Specifically, the proposed rule stated that providers would not be required to offset grants in three primary care areas: family medicine, general internal medicine, and general pediatrics.

The final rule for these regulations was published on Tuesday, August 5, 1980 in the Federal Register. The final regulations are similar to the proposed rule. Providers would not be required to deduct grants and donations for primary care residency training when determining net allowable educational costs for Medicare reimbursement. However, providers receiving grants will have to comply with the following reporting requirements:

- The provider will be required to report to its intermediary total revenues and total direct and indirect costs for each of the above primary care residency programs which received a grant or donation. The methodology for arriving at costs and revenues will be outlined in forthcoming instructions that will accompany HCFA cost reporting forms.

- The provider will be required to report to its intermediary the name and address of the donor of each grant and donation, and the amount given by each donor.

- If the provider reports a surplus of revenues over expenses that is equal to or less than the amount received by a Public Health Service (PHS) grant, HCFA will notify PHS which may recover the surplus or redesignate it for the succeeding year.

- If the provider reports a surplus that exceeds the amount of the PHS grant, HCFA will notify PHS and other donors of the surplus.

- If the provider reports a surplus but did not receive a PHS grant, all other donors will be notified.

- If the provider did not have a surplus, no donors would need to be notified. This rule will be applied retroactively to January 1, 1978.

Hospital-Based Physicians

In the March 11, 1980 Federal Register, HCFA published a final notice announcing its intention to apply and enforce uniformly Medicare regulations for services performed by "hospital-based" physicians beginning on July 1, 1980. The announcement was intended to reaffirm the Medicare regulation which states that charges for physician services will only be allowed if such "services require performance by a physician in person" and contribute to the diagnosis or treatment of the patient. All other services performed by a hospital-based physician, according to the regulations, should be reimbursed on a reasonable cost basis. Thus, HCFA wanted to clearly state that: (1) professional medical services personally performed by an individual physician for an individual

patient can be reimbursed under Part B, and (2) professional services performed for the general benefit of patients should be reimbursed under Part A. Significantly, all of the examples used in the HCFA notice were for clinical pathology services.

Under the rule, pathologists would have been paid for clinical pathology services in only one of three ways:

- on a fee-for-service basis if and only if (1) the pathologist personally performed the service and (2) the service required performance by a physician. If the pathologist did not personally perform the work, his services would be viewed as supervisory or quality control and payment would be made on a reasonable cost basis through the hospital's cost report.

- on a reasonable charge basis where the pathologist leased the laboratory from the hospital and where the pathologist paid laboratory operating costs from his revenue.

- through the hospital as a Part A cost of inpatient services.

Significantly, the notice stated that hospitals permitting pathologists to use arrangements other than these three would be in violation of the Medicare participation agreement and might be terminated from the program.

The final rule for this issue has not been implemented. A preliminary injunction to block implementation of the March 11 notice was issued on June 4, 1980 by a Federal District Court in Arkansas. Claiming that the notice represented a "reinterpretation" of the original regulations, the plaintiffs - the American College of Pathologists, the Arkansas Hospital Association, the Arkansas Society of Pathologist and others - charged that the HCFA policy: (1) had violated the Congressional intent of the Medicare law to reimburse pathologist under Part B of Medicare for the professional component of their services; (2) had violated the HHS Secretary's own regulation against influencing contractual agreements between hospitals and physicians; (3) constituted a major policy change with respect to reimbursement of "hospital-based" pathologists and violated the Administrative Procedures Act; and (4) would seriously affect the hospital/physician agreements in the state of Arkansas.

In response to the court action, HCFA issued a notice in the June 20 Federal Register announcing that "pending further action in court, Part B charged payment for the alleged professional component of clinical laboratory services furnished in a hospital setting may be continued." On August 26, a Federal District Court judge in Little Rock, Arkansas rejected a motion by HHS to dismiss the preliminary court injunction. Thus, HCFA is still prohibited from implementing the reimbursement changes.

OTHER MEDICARE-RELATED REGULATIONS

The Annual Hospital Report

The Health Care Financing Administration (HCFA) continued to push for a uniform reporting system for hospitals during 1980. A new hospital uniform reporting system was proposed on March 19, 1980 in the Federal Register. The newly-proposed system, which was mandated by the Medicare-Medicaid Anti-fraud and Abuse Amendments of 1977, is intended to enable HCFA to (1) compare the costs of services among hospitals for reimbursement purposes and policy analysis, (2) develop ways to hold down costs through alternative reimbursement mechanisms, and (3) detect abuse in the public financing programs.

Now called "The Annual Hospital Report" (AHR), the proposed system would, according to HCFA, be "more economical and easier to implement" than its highly criticized predecessor - the System for Hospital Uniform Reporting (SHUR) - which was proposed in January, 1979 and was never implemented due to extensive opposition throughout the hospital industry, as well as criticism from insurers and Congressional leaders. HCFA's claims that the newly-proposed system reduces the reporting burden of the previously proposed system by at least 20 percent, and the pages of forms and manual material by 45 percent, have been met with considerable skepticism by hospital groups.

In its letter of comment, the Association opposed implementation of AHR. The letter stated that the AAMC opposes the proposed AHR system because it is an excessive use of the Secretary's authority, requires excessive information, combines reporting and reimbursement, and fails to provide necessary additional revenues for system introduction and maintenance. In lieu of AHR, the Association recommended a reporting system which uses audited financial statements, consolidated cost centers, statistically reclassified entries and sampling procedures, and a more liberalized concept of materiality. Finally, the AAMC recommended that data from any uniform reporting system be considered confidential unless the particular item of data is necessary for the efficient operation of another government agency and formal, written consent has been obtained from the identified hospitals.

Final regulations for the AHR have not been published. Implementation of the AHR cannot be done without formal review and approval by appropriate health committees in both the Senate and the House. Thus, hospitals may still be months away from having to comply with uniform reporting requirements.

Clinical Lab Regulations

On October 12, 1979, the Health Care Financing Administration and the Center for Disease Control jointly published proposed changes in the standards for supervisory personnel in clinical laboratories subject to regulation under the Medicare program and the Clinical Laboratory Improvement Act of 1967. The existing rules would be replaced by a single set of requirements for laboratory directors, technical supervisors, bench supervisors, technologists, and cytotechnologists.

The proposed program is designed to have three major interdependent components of review: (1) personnel standards, (2) quality control, and (3) standards for performance based upon proficiency testing. In its letter of comment, the Association challenged the proposition that credentialing is an effective and reasonable approach to assure accuracy and reliability of test results. The Association was particularly troubled by the establishment of a single set of standards for the entire range of laboratories that will be subject to these regulations and thus, the failure to take into account the special needs of clinical research laboratories. Finally, the AAMC criticized the arbitrary and inflexible qualifications proposed, which it believes will have a negative impact on the quality of laboratory testing.

The AAMC proposed an alternative approach to assuring the quality of laboratory testing which included: (1) an expanded program of proficiency testing in laboratory certification under the aegis of the Center for Disease Control, the College of American Pathologists, the National Committee for Clinical Laboratories Standards, and other professional organizations or state agencies at the option of the individual laboratories; (2) limiting the proficiency testing to the most frequently performed tests; and (3) for those laboratories that do not meet the certifying criteria of the programs mentioned above, the establishment of standards for full-time laboratory directors and technical supervisors only and certification of the quality of these laboratories by on-site and blind output testing, as well as by inspection as needed.

On June 9-10, 1980 the Center for Disease Control held a public meeting at its headquarters outside Atlanta to discuss the standards for laboratory personnel which were proposed last October. More than 7,000 letters had been received in response to the proposed regulations, prompting the Center for Disease Control to hold the meeting. At that meeting, many statements were made about the ineffectiveness of the credentialing approach and the potentially large impact on rural and teaching hospitals and specialty laboratories. Nevertheless, it appeared from the meeting that the Department of Health and Human Services is still pursuing a policy of laboratory regulation based on personnel credentialing. To date, no final regulations have been published.

Activity on establishing standards for clinical labs has not been limited to the regulatory efforts. Two legislative proposals which would make changes in clinical lab standards were introduced and approved by two health subcommittees in the House of Representatives. Each was a part of H.R. 4000, the Medicare-Medicaid Amendments Bill. However, the subcommittees differed dramatically in their approach to the clinical lab problem. Because of the sensitivity and complexity of this issue and an inability to reach a consensus, provisions related to clinical lab standards have been deleted altogether from H.R. 4000. It is likely that Congress will have additional hearings on this issue in the future.

Provider Reimbursement Review Board Regulations

Proposed regulations that would significantly change the procedures under which the Provider Reimbursement Review Board (PRRB) operates were published in the February 14, 1980 Federal Register. The five member board was established by law to resolve Medicare payment disputes involving $10,000 or more. The AAMC

gave a "mixed review" of the proposed regulations. The Association approved proposed revisions that would expedite traditional review, make "final decisions" of the PRRB reviewable only by the courts, clarify the deadlines for health care providers to seek judicial review in cases where the Secretary or her designated reviewer declined to review a PRRB decision, and prohibit "ex parte" communications between any of the parties to a case and the Secretary or her designated reviewer during a review of a PRRB decision. The AAMC also agreed with a provision in the proposed regulation that would designate HCFA, rather than the Medicare intermediary as is current practice, as the party representing the Medicare program in most PRRB cases. However, the AAMC strongly opposed allowing the HCFA administrator to continue to be the final appeals authority for PRRB decisions within HHS since the agency would now be a party to the PRRB proceedings. To prevent any question of bias or conflict of interest in the appeals process, the AAMC advocated returning the final appeals authority in HHS to the HHS Secretary.

The AAMC also opposed: (1) allowing the HHS Secretary or her designated reviewer the power to remand appeals of PRRB decisions back to the board for further consideration, (2) binding the PRRB to adhere to HCFA notices of policy as if they have the "stature and weight" of codified regulations when these notices have not gone through the rulemaking process specified in the Administrative Procedures Act, (3) binding the PRRB to precedents set by the appeals decisions of the HHS Secretary even though the policy set by these decisions has not been sent through the formal rulemaking process, (4) giving the Medicare intermediary or the other decision-making authorities, including intermediaries' hearing officers or panels, the PRRB, or the HCFA Administrator, the prerogative to reopen Medicare cost reports to consider issues not previously in controversy, and (5) opening PRRB proceedings to the public except when the board itself determines proceedings should be closed. Final regulations on these changes have not yet been published.

Provider Nomination of Medicare Intermediaries

In the June 23, 1980 Federal Register, HCFA issued final regulations authorizing the HCFA Administrator to assign or reassign a provider to a particular intermediary and to designate a national or regional intermediary to serve a class of providers. The regulations, which implement provisions of the Medicare-Medicaid Anti-fraud and Abuse Amendments (P.L. 95-142), established criteria and statistical standards for evaluating the performance of intermediaries. The assignment or reassignment of providers to an intermediary or the designation of a regional or national intermediary may result from an intermediary's failure to satisfy these criteria and standards. However, this need not occur for such action to take place if improvement in the administration of the Medicare program would result.

For the designation of a national or regional intermediary to serve a class of providers, classes may be established on the basis of the type of provider or on such common characteristics as size or type of ownership. The regulations require that the Administrator furnish affected providers and intermediaries a full explanation of the reasons for taking any action authorized by the regulations prior to taking such action. Opportunity for a hearing would be made for any adversely affected intermediary. Judicial review may be obtained for

final determinations and providers may present testimony. The Administrator's authority to refuse to renew an intermediary agreement upon its expiration has been left unchanged by these regulations. Additionally, consideration of the criteria and statistical standards established by the new regulations is not a precondition to renewal.

Medicare-Medicaid Conditions of Participation for Hospitals

The June 20 Federal Register contained a notice of proposed rulemaking revising the hospital conditions for participation under Medicare and Medicaid. The current conditions have been in effect since 1966, without any major changes. The revised conditions were over two and a half years in the making and are intended to simplify the regulatory requirements which hospitals must meet to be certified for participation in Medicare and Medicaid.

On August 18, the Association submitted comments on the proposed regulations. The AAMC was pleased with HCFA's efforts to simplify the regulations and was generally supportive of their potential for allowing hospitals greater flexibility in performing administrative and managerial functions under conditions of participation. However, the Association submitted more than 50 specific technical comments and identified a number of areas with which it had concern. Among these were:

- the definition of "medical staff", as proposed, was unnecessarily repetitive due to the inclusion of the expression "and other practitioners" after the titles "physicians, dentists, podiatrists." Since the term "practitioner" was separately defined in the proposed rule as "an appropriately licensed physician, dentist, or podiatrist who may be granted clinical privileges in the hospital," the Association recommended that the phrase "and other practitioners" in the "medical staff" definition be deleted as duplicative and unnecessary.

- the Association noted several instances where the certifying bodies specifically cited may not be the only accrediting agencies performing this function. The Association emphasized that specifying only a limited number of certifying bodies throughout the section on personnel qualifications would not only preclude qualification of certain personnel certified by other valid groups, but also would not accommodate the introduction of new sources for official endorsement of a health professional's qualification. Therefore, in order to provide needed flexibility, the Association recommended the addition of the phrase "or other appropriate certifying body" wherever such accrediting bodies are specifically referenced in the personnel qualifications section of the proposed rule.

- with regard to the proposed requirement for annual review of membership and clinical privileges, the Association argued that the Joint Commission on Accreditation of Hospitals' (JCAH) requirement for biennial review provides greater flexibility for hospitals and would satisfy the HCFA objective for this condition.

- the Association noted the absence in the qualifications of definitions for a "pharmacist, laboratory technologist, laboratory director," and other personnel categories. The Association stated the rationale for the inclusion of some and exclusion of others of major importance to containing health care costs and to delivering health care in rural and teaching hospitals was a serious omission.

As is the case with many of the HCFA regulations, no final rule has been published on this issue.

BUDGET RECONCILIATION BILL

The economic problems in the country in 1980 coupled with a call to achieve a balanced federal budget have prompted Congress to spend considerable time on a budget reconciliation bill for fiscal year 1981. If passed, the budget reconciliation bill would be the first ever under the 6-year-old Congressional budget process. The reconciliation provisions under the Budget Act require that various Congressional committees report to their respective budget committees, specifying spending reductions to meet the reconciliation requirements. To date, the Senate and House have passed their versions of the reconciliation bill, S. 2885 and H.R. 7765. The bill is now being considered by a Conference Committee to reconcile the substantial differences between the two bills.

The Senate bill has adopted many of the provisions of H.R. 934, Senator Talmadge's Medicare-Medicaid Administrative and Reimbursement Reforms Act, to achieve the required spending cuts. Passed on June 30, 1980 by a unanimous vote of 89 to 0, the bill contains the following important provisions relating to health expenditures:

- Establishment of a new method of reimbursement for routine operating costs, effective July 1, 1980, replacing the current Section 223 classification system with one that would provide incentive payments for below average costs and penalize hospitals with costs substantially above average. Of concern is the fact that the new system would build a ratcheting system into the reimbursement formula. The "ratchet effect" would result from the fact that (a) the method of establishing the maximum limits for the second and subsequent years of this program would utilize the constant dollar difference between the first year's average and 115 percent of the first year's average, rather than setting the limits at 115 percent of the average for each year of the program; and (b) only one-half of any hospital's costs in excess of the limits in any year of the program would be included in the calculation of the group's average for the following year. The net result of this formula would be to screw down reimbursement so that the maximum limits in future years would be progressively and substantially smaller than the initial 115 percent of the groups' means.

- Deferring payments of the 8 1/2 percent nursing cost differential during the second half of fiscal year 1981 until the General Accounting Office (GAO) reports the results of a study addressing this issue.

- Giving states more discretion in arranging for care and services for Medicaid recipients through competitive bid contracts thereby limiting the "freedom of choice" that Medicaid patients presently have in selecting providers. States would be required, however, to assure that Medicaid recipients generally have reasonable access to services.

- Establishment of limitations on hospital outpatient and clinic costs. The Secretary of HHS would be required to give high priority to implementation of such limits.

- Reduction in reimbursement rates for hospitalized long-term care patients. Hospitals would be paid for services at the skilled nursing facility/extended nursing facility rate if the PSRO determined that the patient did not need acute hospital services, even if long-term care beds were unavailable in the community.

- Deferral for one month of the Periodic Interim Payment (PIP) program under Medicare, which would normally make payment during September, 1981, until Fiscal 1982, which begins October, 1981.

The House version of the reconciliation bill differs dramatically from the Senate version, and a complicated conference of the two bills is underway. The House reconciliation bill includes some provisions from H.R. 3990 and H.R. 4000, two bills which address Medicare and Medicaid reimbursement reform. Among the provisions in the House bill are:

- A provision that if a hospital's occupancy rate is 80 percent or more and if it cannot obtain a certificate of need for the provision of long term care, Medicare-Medicaid reimbursement would be made at the acute care rate for as long as the patient required skilled nursing care services and a long-term care bed was unavailable. If hospitals did not have an 80 percent occupany rate, or could obtain the certificate of need, payment would be at the same rate otherwise payable for "swing beds."

- A provision that would, in effect, repeal Section 227 of P.L. 92-603, relating to the payment of teaching physicians for professional services rendered to Medicare patients. Under this provision, physicians in teaching hospitals would continue to be reimbursed on a charge basis under Part B. In addition, the provision would authorize payment of physician services in teaching hospitals on the basis of costs under Part A if a hospital and all its physicians elected such a method.

Because this year is the first time Congress is attempting to pass a budget reconciliation bill, the likelihood of its final approval is unclear. However, the Conference Committee is expected to resume their efforts following the election recess with numerous controversial issues ahead of them.

HOUSE STAFF UNIONIZATION

Since the National Labor Relations Board (NLRB) decided in the Cedars-Sinai case in 1976 that house staff are primarily students rather than employees for purposes of coverage under the National Labor Relations Act (NLRA), there has

been considerable legislative and legal activity surrounding this issue. 1980 was no exception. There was an important Congressional vote in the House of Representatives and a decision by the U.S. Court of Appeals for the District of Columbia.

Legislative Activity

H.R. 2222, a bill which would have defined house staff as employees for purposes of collective bargaining under the National Labor Relations Act (NLRA), was defeated in the House of Representatives on November 28, 1979 by a vote of 167 yeahs to 227 nays. Although reported favorably by the House Committee on Education and Labor, the bill, cosponsored by Representative Frank Thompson (D-New Jersey) and Representative John Ashbrook (R-Ohio), was soundly defeated following one hour of intensive debate. Proponents of the bill argued that its passage was justified as a matter of equity and was necessary to rectify the March 1976 Cedars-Sinai decision of the National Labor Relations Board (NLRB), which ruled that house staff were primarily engaged in education and should be considered students.

Representative John Erlenborn (R-Illinois) led the opposition to the bill. He contended that the NLRB decision was not a mistake but rather a finding of fact that, under the particular circumstances before it, the house staff were primarily students and thus not within the meaning of "employee" within the NLRA. He noted that under different facts where the house staff were primarily employees, the NLRB could, and undoubtedly would, reach that conclusion and authorize collective bargaining. He suggested that the proponents of the bill would have the Congress ignore the facts, remove the discretion of the Board to find that "apples are apples and oranges are oranges, and define by legislative fiat that all the fruit are oranges." Mr. Erlenborn also cited demands made by the house staff of Cook County Hospital (Illinois) as illustrative of what could be expected in private hospitals should this bill pass. The extensive list of expensive demands provided sound evidence of his contention that the adoption of H.R. 2222 would be inconsistent with the Congress' concern for hospital cost containment. It would also be extremely disruptive of the collegial relationship normally expected between mentor and student and would have a deleterious effect on the process of graduate medical education.

Congressmen Mickey Edwards (R-Oklahoma), Richardson Preyer (D-North Carolina), Arlen Erdahl (R-Minnesota), Edward Derwinski (R-Illinois), and Barry Goldwater, Jr. (R-California) also spoke in opposition, reiterating the theme struck by Erlenborn. After the debate, amendments were called for but none were offered. A voice vote was ruled by the chair to have carried the bill (contrary to the perceptions of those observing), a tally vote was demanded and H.R. 2222 was decisively defeated. No similar legislation has been introduced in the Senate.

Judicial Activity

The judicial history of the house staff unionization issue is more complex than the legislative history. As noted, the Cedars-Sinai case of 1976 brought a great deal of attention to house staff unionization. That decision ruled in favor of Cedars-Sinai by declaring that house staff were primarily students. In

1978, the U.S. District Court dismissed an action brought by the Physicians National House Staff Association (PNHA) which was appealing the 1976 NLRB determination in the Cedars-Sinai case. In 1979, the U.S. Court of Appeals for the District of Columbia reversed, by a split decision of 2 to 1, the District Court decision of 1978. In this case, PNHA identified a narrow exception to the general rule and argued that the exception created jurisdiction for purposes of this action. The three man Appellate Court panel found that the exception applied to the case and remanded it to the District Court for further proceedings.

Following that court action, the NLRB petitioned the U.S. Court of Appeals for the District of Columbia Circuit to rehear the case before the full court, not just the three judge panel. On June 5, 1979 the court granted the NLRB's petition for a rehearing by the entire court. The rehearing by the full court of appeals was held on October 9, 1979 with oral arguments on the case. On Friday, July 11, 1980, the court of appeals ruled that the NLRB acted within its statutory authority in the Cedars-Sinai decision. The AAMC was amicus curiae in the case supporting the NLRB's position. Writing the majority decision for the nine-member court of appeals, Judge Roger Robb stated, "In this case the NLRB carefully analyzed the facts and reached the 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 of employees; that the programs in which they participate were designed not for the purpose of meeting the hospital's staffing requirements, but rather to allow the student to develop, in a hospital setting, the clinical judgement and the proficiency in clinical skills necessary to the practice of medicine in the area of his choice. In making this determination, the Board acted within its jurisdiction." The decision of the court was by a vote of 5 to 4. PNHA has asked the Supreme Court to grant it a delay in the time requirement for filing an appeal to the decision.

NATIONAL HEALTH INSURANCE

Legislative Activity

During the past year a great deal of attention has been devoted to national health insurance proposals which vary dramatically in approach. In late 1979, the emphasis was on plans extending comprehensive health insurance coverage to the entire population. Senator Edward Kennedy (D-Massachusetts) offered a national health insurance proposal that 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. In addition, drugs, home health, nursing home care, and mental health care would all be partially covered. In contrast to Kennedy's plan, President Carter proposed a less comprehensive approach that would incrementally increase the health benefits of various seqments of the population. Senator Russell Long (D-Louisiana) led the activity on a program of catastrophic national health insurance coverage, although a number of other Congressmen introduced catastrophic plans as well.

In 1980, the debate shifted from issues related to amount of coverage and schedule for implementation to issues relating to the financing structure and cost containment, with particular emphasis on price competition. In fact, virtually all of the proposals introduced during this year advocated some form of

price competition among insurers and among providers in the health care industry. Some of these proposals would not need to be implemented within a national health insurance program. However, most have been linked in some way to national health insurance, if only at the catastrophic level.

The pro-competition bills would encourage comparison of provider and health insurance plan costs by (1) encouraging or requiring employers to offer multiple health plans to their employees, (2) by changing tax laws relating to allowable deduction for health expenditures, (3) by encouraging HMO growth, and/or (4) by encouraging the development of plans offering coinsurance and deductibles.

In the House of Representatives, Representative James Jones (D-Oklahoma), Representative James Martin (R-North Carolina), Representative Al Ullman (D-Oregon) and Representatives Richard Gephardt (D-Missouri) and David Stockman (D-Michigan) have all introduced bills that would encourage competition in the health care industry. The bill receiving the most attention in the House at this point is Stockman and Gephardt's "The National Healthcare Reform Act of 1980." This bill would go beyond the others by advocating tax law changes and discontinuing PSROs, health planning, and cost-based reimbursement. States would have the option of participating in a federalized Medicaid program, and Medicare beneficiaries would be given the option of selecting alternatives to the traditional Medicare benefit package. Of particular interest to COTH constituents is that the bill would provide separate, federal funding for "not more than" 70 percent of the direct costs of graduate medical education and for the training of nurses and other health care professionals to the extent the Secretary finds such compensation is necessary.

In the Senate, two bills have been introduced encouraging competition: Senator David Durenberger's (R-Minnesota) "Health Incentives Reform Act" (S. 1968) and Senator Richard Schweiker's (R-Pennsylvania) "Comprehensive Health Care Reform Act" (S. 1590). On March, 1980, John Colloton, Director of the University of Iowa Hospitals and Clinics and Assistant to the University President for Health Affairs, and Richard Knapp, Ph.D., Director of the Association's Department of Teaching Hospitals, testified before the Senate Finance's Subcommittee on Health on these competition proposals. Colloton stated that making several health plans available to all employees is intuitively appealing. Injection of competition among insurers at this level is easily understood. What is not clear is how competition would manifest itself over time among hospitals and physicians.

Strikingly absent from the literature and public discussions of these issues are the effects the competitive approach may have on teaching hospitals, Colloton pointed out. Underlying the competitive models being proposed is the assumption that hospitals provide a single, relatively standardized product which is easily identifiable in terms of cost and quality. This assumption raises several issues for teaching hospitals which have multiple products benefiting not only the individual patient, but society as a whole. Because these activities are expensive, result in higher costs for teaching hospitals, and are presently financed to a large extent through patient care revenues, competitive pricing could jeopardize the ability of teaching hospitals to meet their multiple responsibilities. He then went on to describe these contributions in the areas of charity care, quality of care, medical education, research, technology development, and tertiary care services. In summary, Colloton urged that long-term effects of competition be more carefully assessed so that the intended worthy objectives of the legislation do not result in unintended consequences that are inconsistent with the nation's health care priorities.

While it is highly unlikely that any legislation encouraging competition will be passed in this session of Congress, it is almost certain that considerable attention will be given to this issue when the 97th Congress convenes in January, 1981. At that time, the AAMC will have further opportunity to comment on the proposals being developed.

AAMC Activity on National Health Insurance

Due to the renewed and intensified Congressional interest in national health insurance in 1979, the AAMC appointed a National Health Insurance Review Committee in August, 1979. The Committee was charged to review and recommend appropriate revisions in the Association's November, 1975 policy statement on national health insurance. The Committee was chaired by John Gronvall, Dean of the University of Michigan Medical School. The Committee, whose report was adopted on June 26, 1980 by the AAMC Executive Council, identified three major problems: (1) the total absence or incompleteness of basic health insurance coverage for many low income Americans; (2) the lack of adequate health insurance protection for many against the high cost of catastrophic illness; and (3) the need for a consensus on a minimum standard for basic health benefit plans. The Committee concluded that the Association's policy should be directed at the "need for expansion and improvement of health insurance in the United States."

The specific recommendations of the AAMC National Health Insurance Review Committee were: (1) the Medicaid program should be expanded and improved through the provision of federal incentives to the states to foster broader eligibility for low income people and to standardize the scope of benefits offered; (2) a program should be developed which would provide incentives for employers to make catastrophic health insurance more widely available; and (3) an independent certifying body or commission, composed of representatives and insurance carriers, providers and consumers, should be created to establish a minimum standard basic health insurance benefits package. The commission would review all basic health plans and provide its "seal of approval" only to those meeting the minimally acceptable standard. The Committee believed that the approval of health plans by a voluntary body would provide a powerful incentive to insurers to offer at least minimally acceptable basic benefit packages.

In addition to the above proposals, the Committee concluded that the Association should recommend that the following issues be addressed within the context of an expanded and improved health insurance system: (1) the appropriate use of cost-sharing mechanisms in financing the nation's health insurance system; (2) the fair and reasonable reimbursement of physicians and institutional providers of service; (3) the appropriateness of financing graduate medical education through the patient service revenues of hospitals; and (4) the encouragement of philanthropic contributions to health care providers.

In addition to the AAMC Ad Hoc Committee on National Health Insurance, an Ad Hoc Committee on Competition was appointed and had its first meeting in June, 1980. This committee, which is chaired by Robert Tranquada, Chancellor/Dean of the University of Massachusetts Medical School, was appointed to assess the implications of price competition for medical schools and teaching hospitals. The Committee is working under the assumption that price competition will increase and that to respond to these developments, the Association should:

- develop policy recommendations with regard to the generic issue of price competition and responses to specific legislative proposals;

- identify specific activities institutions might undertake in response to price competition; and

- identify specific activities beyond the Committee's work the AAMC might undertake to support institutional initiatives.

Based on the June, 1980 meeting, a preliminary document is being drafted that will be reviewed by the Ad Hoc Committee members at a fall meeting.

HEALTH PLANNING

On October 4, 1979, President Carter signed into law the "Health Planning and Resources Development Amendments of 1979." This legislation amended and extended the National Health Planning and Resources Development Act of 1974 for three years through September 30, 1982. In connection with this legislation, proposed regulations have been published relating to appropriateness review and certificate of need. In addition, President Carter has called for limits on federal funds for hospital construction.

Appropriateness Review

Under the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) and continued under the recently enacted Health Planning and Resources Development Amendments of 1979 (P.L. 96-79), Health Systems Agencies (HSA) and State Health Planning Agencies (SHPA) are required to review the appropriateness of all existing institutional health services within their areas and states at least every five years, make public their findings, and make recommendations for remedial actions when a service is found to be inappropriate. Unlike other forms of review in the health planning act, appropriateness review does not require the application of sanctions for a finding of inappropriateness. However, the Secretary of HHS has not prohibited the application of sanctions. Addressing numerous comments received on regulations originally published May 16, 1978 and incorporating technical changes produced by the new planning legislation, HEW issued final regulations governing appropriateness reviews in the December 11, 1979 Federal Register. The regulations require that the review process consider the following issues of particular importance to the AAMC constituency:

- the special needs and circumstances of those entities which provide a substantial proportion of their services or resources or both to individuals not residing in the immediate health service area. These entities may include medical and other health professions schools, multi-disciplinary clinics, and speciality centers.

- the special needs and circumstances of biomedical and behaviorial research projects which are designed to meet a national need and for which local conditions offer special advantages.

- the effect of competition on the supply of health services being reviewed and the need for improvements or innovations in the financing and delivery of health services which foster competition.

Certificate of Need Regulations

In the March 26, 1980 Federal Register, HEW issued a notice of proposed rulemaking (NPRM) which would amend the current regulations governing certificate of need (CON) reviews by State Health Planning and Development Agencies (SHPDAs) and Health System Agencies (HSAs). The proposal was intended to provide guidance to state legislators in modifying their CON statues to conform with changes made by the Health Planning and Resources Development Amendments of 1979. Under this legislation, planning agencies are required to review and determine the need for proposed capital expenditures, new institutional health services, and major medical equipment. These statutory amendments, which are primarily technical in nature, (1) expand the procedural requirements for CON programs, (2) add several criteria to those that health planning agencies must consider in their review of applications, and (3) clarify, with some changes, the projects for which CON approval must be obtained.

On May 23, 1980 the Association submitted its comments and recommendations regarding the proposed regulations. The Association was pleased that the HHS Secretary had followed strictly the substance of the statutory provisions requiring that the criteria for HSA and state agency CON reviews include consideration of the clinical and access needs of health professional training programs, and the special needs and circumstances of those entities providing a substantial proportion of their services and resources to individuals residing outside of their immediate health service areas. However, the AAMC was particularly concerned about an issue not specifically addressed by the regulations -- Congressional intent with regard to the need to review proposed training and research capital expenditure projects, facilities and medical equipment that do not have a major impact on the availability or delivery of health services in a health service area. The Association noted that Congress expressed itself clearly on this subject in amending Section 1513 (e)(1)(B) of the Planning Act. Congress specifically provided that both research and training projects under the Public Health Service Act should not be reviewed by HSAs under their "review and approval of proposed uses of federal funds" responsibility when the training project would not alter health service availability, or when the research project would not change the delivery or availability of services to those in an area who are not direct participants in research. Regardless of whether such projects were made "by or on behalf of a health facility," Congress simply deemed such reviews to be unnecessary by virtue of their lack of significant patient service impact. Since the above citation is the only acknowledgement in the statute which clearly states Congressional opinion on the issue, the AAMC called for the exemption of such projects (and their accompanying facilities and equipment) from the CON review process as a more accurate interpretation of legislative intent.

The Association also submitted detailed comments relative to specific provisions in the proposed regulations, which addressed: procedures for CON review, scope of CON review programs, access to services, criteria for CON

review, and effective dates of implementation. Final regulations on CON requirements have not yet been published.

Limits on Federal Funds for Hospital Construction

In a June 10, 1980 press release from the Council on Wage and Price Stability, Alfred Kahn, President Carter's advisor on inflation, announced that the President has directed federal agencies to limit the use of federal funds and tax subsidies to finance the construction of unnecessary new hospital capacity and renovation of existing hospital capacity in areas where there are already too many hospital beds. The Department of Health and Human Services estimates that the nation now has about 130,000 unneeded hospital beds which cost the economy $4 billion and the Federal government $1.1 billion each year. The limits would affect (1) all hospitals built, owned, and operated by the federal government; (2) federal programs that subsidize both private and public construction through grants, loans, and loan guarantees; (3) programs that aid hospital construction through federal tax subsidy; and (4) federal reimbursement for patient care (depreciation and interest on capital expenditure projects which are being reimbursed under Medicare and Medicaid). The directive was issued in the format of an Office of Management and Budget (OMB) memorandum in the June 17 Federal Register.

A 30 day comment period to the OMB memo was provided. The Association, in a letter of comment, expressed concern that this new directive disregarded the responsibilities and capabilities of the current health planning system to monitor non-federal hospital construction. The Association argued that the proposed memorandum was unnecesary and recommended that it be withdrawn entirely. It was the Association's firm belief that, if allowed, the present health planning structure could achieve the objectives of the memorandum, and that the proposed OMB program would undermine this system by federalizing local health planning and exceeding Congressional intent with regard to the federal government's role in health planning. To address unnecessary expenditures for federal hospitals, the Association recommended that an Executive Order to federal agencies requiring the careful review of direct hospital construction needs as part of the federal government's budget development process would meet the objectives of the proposed memorandum. Further details on the implementation of this directive have not yet been made publicly available.

Health Planning Technical Amendments

In August, 1980, several technical health planning amendments, introduced by Representative Henry Waxman (D-California), were attached to H.R. 7036, "The Health Research Act of 1980", which has been passed by the full House. Of particular interest to the teaching hospital community is a provision which would establish an exception for health research under Certificate of Need requirements for capital expenditures. Under current law, capital expenditures exceeding $150,000 made by or on behalf of a health care facility would be subject to Certificate of Need review. The proposed provision amends the definition of the term "capital expenditure" to exclude "an expenditure made by or on behalf of a health facility for health research at the facility if the application of the

Certificate of Need review. The proposed provision amends the definition of the term "capital expenditure" to exclude "an expenditure made by or on behalf of a health facility for health research at the facility if the application of the expenditure or the operating costs of the research will not affect the charges of the facility for the provision of medical or other health services, if the research will not involve the provision of such services to patients of any health care facility, and if the person making the expenditure files a notice with the state agency of the state in which the facility is located describing the nature of the research and providing assurances satisfactory to the state that the expenditure or operating costs will not affect such charges and the research does not involve the provision of medical or other health services to patients at any health care facility." In the Senate, a companion health research bill, S. 988, introduced by Senator Kennedy has passed the full Senate. It does not include Waxman's technical amendments to the planning law. A conference committee for these two bills has not yet resolved the differences in the two bills, and it may not be passed before the end of this Congressional session.

FINANCIALLY DISTRESSED HOSPITALS

With an increasing number of hospitals facing severe financial problems, Congress has begun to consider measures for remedying the plight of these institutions, particularly large, urban hospitals. Numerous hearings across the country have been held during 1980 on this subject. Four bills in Congress have been introduced which would provide assistance to financially distressed hospitals: two bills in the Senate introduced by Senator Jacob Javits (R-New York) ("The Financially Distressed Hospitals Assistance Act" and "The Hospital Ambulatory Services Reimbursement Reform Act"), one bill by Representative Charles Rangel (D-New York) ("The Hospital Financing Experiment and Demonstration Act"), and one bill offered by Lewis Stokes (D-Ohio) ("Medical Care Facilities Protection Act of 1980").

The Association has taken the opportunity to write two letters on this issue: one to Senator Kennedy, Chairman of the Senate's Labor and Human Resources Subcommittee on Health and Scientific Research, and one to Representative Rangel, Chairman of the Health Subcommittee of the House Ways and Means Committee. Of particular concern to the Association is the effect of the fiscal stringencies being faced by these hospitals on their graduate medical education programs. In many cases, it was noted, the residency training programs in such institutions have been able to attract only foreign medical graduates, a phenonenum which in tandem with the financial crisis jeopardizes standards of education and patient care. The AAMC agreed that federal action was necessary if this dilemma was to be adequately addressed. Without such action, the AAMC warned, the continued fiscal deterioration of these hospitals can only lead to erosion of the quality of care provided to a significant segment of the population, the discontinuance of medical education and community programs in areas where they are of greatest need, the loss of countless jobs among hospitals' personnel in areas where levels of unemployment are among the highest already, and ultimately the demise of essential services and facilities due to bankruptcy.

Section 223 limitations, Medicare and Medicaid participation in hospital bad debts, special projects to modernize facilities, and special project grant programs for hospital operations. While some members of Congress believe this issue should be given high priority, it appears that the full agenda of Congress may not permit passage of any of these bills this fall.

HEALTH CARE TECHNOLOGY

Technology assessment is gaining attention at both the state and federal levels. The National Council on Health Care Technology (NCHCT) is now in its second year. The Council, created under mandate of federal law, is an advisory body to the National Center for Health Care Technology. The NCHCT was established to assess high priority health care technologies; coordinate all research and evaluation relating to health care technology assessment within HHS; support, through grants and program centers, research and assessment of health care technologies outside HHS; and make recommendations to the Secretary of HHS with respect to reimbursement policy on both new and existing technology.

Last fall a statement was submitted to the Council by the AAMC in response to the Council's request for public comment about the focus HHS should take in the field of health care technology and technology assessment. In its statement, the Association stressed the need for the Council to facilitate "research on research" in order to foster a better understanding of high technology assessment in the health care field. The statement recommended that the Council act to reduce duplication in the efforts to advance health care technology and to encourage more cooperation and coordination among the various parties involved in technology development and dissemination. The AAMC also advocated that the Council play an active role in determining priority areas for technological research, clarifying federal government patent policy, and extending public participation in decision-making processes affecting health care technology.

Increasingly, it is apparent that Medicare will begin to be more stringent about reimbursement for new or expensive health care technology. On August 6, 1980 HCFA gave an official ruling to discontinue Medicare coverage of heart transplantation procedures. On November 2, 1979, HCFA tentatively authorized payment for heart transplant patients at Stanford University Medical Center, pending development of final criteria for coverage of heart transplantations at Stanford and other institutions. However, HCFA's continuing review of the question of coverage has disclosed the existence of a number of important issues such as patient selection and potential social and economic implications, and insufficient information to support development of generally applicable coverage criteria. Consequently, Medicare coverage of heart transplantation procedures is being discontinued retroactively as of June 13, 1980. The exclusion is based on Section 1862(A)(1) of the Social Security Act, which prohibits payment for services which are not "reasonable and necessary." Exempt from the new policy are patients who were accepted as candidates for heart transplants at Stanford University and the University of Arizona Medical Centers by June 12, 1980. Following the completion of a broad study of the social, ethical, economic, and scientific implications of heart transplants, HCFA will issue a final policy on Medicare coverage of them.

Appendix A

STAFF
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Richard M. Knapp, Ph.D.
Director
202/828-0490

James D. Bentley, Ph.D.
Associate Director
202/828-0493

Joseph C. Isaacs
Senior Staff Associate
202/828-0496

Peter W. Butler
Senior Staff Associate
202/828-0493

Mary Eng
Administrative Resident
202/828-0496

Melissa H. Wubbold
Administrative Secretary
202/828-0490

Melody J. Bishop
Secretary
202/828-0493

Donna R. Greenleaf
Secretary
202/828-0496

Appendix B

COUNCIL OF TEACHING HOSPITALS
OFFICERS AND ADMINISTRATIVE BOARD
1979-80

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Director and Assistant to the
President for Health Services
University of Iowa Hospitals
and Clinics
Iowa City, Iowa

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*Stuart J. Marylander
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Los Angeles, California

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General Director
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Term Expiring 1982

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Philadelphia, Pennsylvania

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* Representative to AAMC Executive Council