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SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

NOVEMBER, 1980 - OCTOBER, 1981

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036

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 the activities of the Association and in interaction with other organizations and agencies. Each year, the Department prepares a summary of its activities during the past year. The yearly report is distributed at the AAMC's Council of Teaching Hospitals (COTH) Annual Membership meeting held each fall. This current document summarizes Departmental activities from November, 1980 through October, 1981. Those interested in knowing more about these activities are encouraged to read this report and to contact Departmental staff for any pertinent information you may need throughout the year. Staff members and their phone numbers are listed in Appendix D.

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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 -- which includes 63 COTH members and is the highest legislative body of the AAMC.

COTH Administrative Board

The Administrative Board of the Council of Teaching Hospitals establishes the policy of the Council and provides representation to the Association's Executive Council. There are nine regular members of the Board, each serving a three-year term. In addition, its membership includes the Chairman, Chairman-Elect, Immediate Past Chairman, and Secretary. For the coming 1981-82 year, Mitchell T. Rabkin, M.D., President of the Beth Israel Hospital in Boston, will serve as the COTH Chairman, succeeding Stuart J. Marylander, President of Cedars-Sinai Medical Center in Los Angeles. Other members and officers of the Administrative Board are listed in Appendix A. COTH officers, Administrative Board members, and new representatives to the AAMC Assembly are elected each year by the COTH membership at the AAMC Annual Meeting. COTH representatives to the AAMC Assembly are listed in Appendix B and COTH committee appointments during 1980-81 appear in Appendix C.

The COTH Administrative Board met five times during the year to conduct the Council's business and to review and discuss all items on the agenda of the AAMC Executive Council. A topic of discussion emphasized throughout the year

was health care competition. The Administrative Board examined the various "pro-competition" proposals that have been introduced, their potential impact on teaching hospitals, and alternatives for addressing the issues. In other deliberations, the Administrative Board focused on a wide variety of topics including: the report of the Association's ad hoc Committee on Competition, the Association's project to describe and quantify the case mix and service characteristics of teaching hospitals, the potential impact on teaching hospitals of various Medicare and Medicaid proposals contained in the budget reconciliation acts which were enacted during the past year, Medicare's revised reimbursement policy on resident moonlighting, the revised General Requirements Section of the Essentials of Accredited Residencies in Graduate Medical Education, and interaction with the Commission of Professional and Hospital Activities (CPHA).

Preceding four of its meetings, the Administrative Board held informal discussions with various governmental officials and allied health organization executives: Howard Newman, then Administrator of the Health Care Financing Administration (HCFA) discussed his agency's objectives under the Carter Administration; Gail Warden, Executive Vice President of the AHA, and Howard Berman, AHA Group Vice President discussed the future of the CPHA and other health care topics of mutual interest; Shiela P. Burke, R.N., professional staff member of the Senate Finance Committee, discussed the budget reconciliation process and the various Medicare and Medicaid spending reduction proposals to be considered by the Committee; and Carolyne Davis, Ph.D., current Administrator of HCFA, discussed her agency's activities under the Reagan Administration.

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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 twQ 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 410 full teaching hospital members and 28 corresponding members. These are private not-for-profit, municipal, state-owned or operated, and Veterans Administration hospitals. Sixty-four members are university-owned hospitals.

SURVEYS AND 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. Those available for purchase are also listed separately in Appendix E.

COTH Report

The COTH Report is the newsletter of the Association's Council of Teaching Hospitals. It is published approximately 10 times annually and distributed to more than 2,600 subscribers. The newsletter, which took on a "new look" with its August-September, 1981 issue, provides a comprehensive review of: Association and Council activities; federal legislative and regulatory issues of relevance to the academic medical/teaching hospital community; pertinent surveys, studies, reports and other publications; and other current health care and medical education topics of interest. A subscription fee of $30 is charged to non-COTH members wishing to receive this 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

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hospital, including selected operational and educational program data. Questionnaires for the 1982 Directory were mailed in July and October, 1981, depending on the hospital's fiscal year. The 1982 Directory will be published early next year. Additional copies of the Directory are priced at $6.00 per copy and may be obtained from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

COTH Executive Salary Survey

Each year, the Department of Teaching Hospitals collects and publishes, on a personal and confidential basis, information on the salaries and fringe benefits of all chief executive officers of COTH member hospitals. The report presents 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 and fringe benefit information 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. COTH Administrative Board policy does permit COTH hospital board members to receive the survey upon request. However, 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

For the past decade, this survey has been prepared annually for the university owned members of COTH. The information is presented on a personal and confidential basis and includes detailed data on hospital revenue sources, expenses, capital expenditures, utilization of services, staffing, and other

general operating data. Distribution of this report is restricted to those institutions participating in the survey.

COTH Survey of Housestaff Stipends, Benefits, and Funding

For the past 12 years, COTH members have been surveyed on the stipends, benefits, and funding of housestaff at their institutions. Preliminary findings from this survey are published annually in June and a final report is published in the Fall. The tables in the report include data on housestaff stipends by hospital region, ownership, bed size, and affiliation. Fringe benefits for housestaff and sources and amounts of funding per hospital are also presented by these categories. This report is distributed to all COTH member hospitals. Additional copies are available for $5.00 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

COTH Hospital Construction Survey

In the latter part of June, 1981, Departmental staff completed an analysis of construction projects begun in 1979 among COTH non-federal member hospitals. It was found that 68 percent of the funding of such projects was financed by the incurrence of some form of debt. The situation had dramatically changed from 1969, the first year in which the AAMC monitored COTH construction projects, when only 20 percent of such capital was borrowed or financed through debt. Results of the latest survey, which were compared with the pattern of funding for construction projects begun in 1974 and those completed in 1969, were presented in the June-July 1981 issue of the COTH Report.

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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 recently revised and updated version of the paper was mailed to all AAMC members in May 1981. Additional copies are available for $3.00 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W. Washington, D.C. 20036. In addition, an abbreviated version of this paper appeared in the October 1980 issue of the Annals of Internal Medicine.

Price Competition in the Health Care Marketplace: "Issues for Teaching Hospitals"

Price competition has been advocated by many as an alternative to regulation and mandatory controls on health care costs. To explore the implications of price competition for teaching hospitals, an AAMC Ad Hoc Committee on Competition was appointed and met on two occasions last year. Their draft report was reviewed by the Executive Council last January. A number of changes were made subsequent to that review, and the final report was approved by the Executive Council at its March meeting. The document is not intended to be a definitive AAMC policy statement on competition, rather it raises important issues that must be understood and addressed regardless of what form of competition legislation is being considered. It was mailed to all AAMC members in May, 1981. Additional copies are available for $3.00 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

Describing and Paying Hospitals: Developments in Patient Case Mix

The Department of Teaching Hospitals has spent considerable time following developments in patient case mix reimbursement and applications. Its 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 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

Medical Education Costs in Teaching Hospitals: An Annotated Bibliography

This recently updated paper provides a comprehensive annotated bibliography of the major 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 35 studies are cited. Copies of the bibliography were mailed to all COTH members. Additional copies are available for $3.00 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

AAMC STUDY OF TEACHING HOSPITALS

On May 8, 1981, at the COTH Spring Meeting held in Atlanta, a progress report was given on the major descriptive study of teaching hospitals initiated by the Association last year. With guidance from the Ad Hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, the Association's staff developed a methodology for the study. A sample of 33 COTH member hospitals agreed to participate. Each hospital was asked to submit a computer tape of its 1978 fiscal year patient discharge abstracts and bills. In addition, each hospital supplied a copy of its 1978 fiscal year Medicare costs report, audited financial statement, annual report, and patient origin study. Finally, three questionnaires--on educational programs, hospital staffing and patient services--were completed by the study hospitals.

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During 1980-81, staff completed a major portion of the analysis of the data received. The patient abstracts and billing information has been analyzed using two case mix measures: diagnosis related groups and disease staging. This data, which has been processed by SysteMetrics of Santa Barbara, California, includes over 500,000 patient records. Data from the three questionnaires and other hospital reports have been tabulated and are being prepared for a final report. Staff are now in the process of drafting the final report, which is expected to be available for distribution in 1982. It will present findings in several chapters including those on: facilities and services, educational programs, hospital staffing, financial characteristics, and patient case mix.

THE BUDGET RECONCILIATION ACTS OF 1980 & 1981

The 1980 Budget Reconciliation Process and the Repeal of Medicare Section 227

For the first time under a six-year-old Congressional budget process, a House-Senate conference committee began work in mid-September, 1980, to iron out differences between two versions of a budget reconciliation bill aimed at trimming the federal government's budget for Fiscal Year 1981. On September 19, 1980, the Association wrote to each of the conferees, expressing its views on six issues addressed in the health section of the proposed legislation.

The AAMC supported a provision in the House bill that would, alter substantially Section 227 of P.L. 92-603, the Medicare Amendments to the Social Security Act, the highly controversial provision dealing with teaching physicians' reimbursement. The Association contended that Section 227 inherently discriminates against physicians caring for patients in teaching hospitals and noted that two sets of draft implementing regulations have been unworkable, inequitable and harmful to existing patterns of medical education.

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Five provisions in the Senate bill were opposed by the AAMC. These would have: (1) established a retroactive limitation on hospital reimbursement using a mandated, inflexible statistical formula with a "ratcheting" effect; (2) undermined the authority of fiscal intermediaries to establish equitable apportionment of costs by limiting all payments to the Medicare patient's proportional share and by requiring federal review of the justifications for a higher payment; (3) penalized hospitals financially under Medicare for the absence of adequate long-term care facilities in their communities by paying lower long-term care reimbursement rates when acute care beds may be in use necessarily; (4) required the HHS Secretary to implement outpatient cost limitations prior to appropriate Congressional examination of the implications of such limitations; and (5) permitted Medicaid programs to limit a beneficiary's choice of hospitals and thereby potentially create a two-class system of medical care.

The Final 1980 Statute

On December 5, 1980, President Carter signed into law the "Omnibus Reconciliation Act of 1980," P.L. 96-499. This first-time-ever use of the budget reconciliation process contained 58 Medicare-Medicaid reimbursement reforms, including the AAMC-supported provision which altered Section 227 of the 1972 Social Security amendments and added new guidelines for paying teaching physicians. However, the amendment, Section 948, did retain the original provision allowing cost reimbursement when elected by all physicians in the hospital. While the list of Medicare-Medicaid amendments was extensive, the House-Senate conferees dropped from the final measure four of the five controversial provisions strongly opposed by the AAMC. The conferees included the provision related to paying hospitals lower long-term care facility reimbursement rates when patients do not require acute hospital care.

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The 1981 Budget Reconciliation Process and the Proposed Medicaid Federal Payment "Cap"

On March 11, 1981, President Reagan sent Congress his Fiscal Year 1982 budget request. The Administration's proposed budget called for the imposition of an "interim cap" to limit federal payments under the Medicaid program to a level of $100 million less than the current spending estimate for Fiscal Year 1981, with only a five percent increase above this amount in Fiscal Year 1982. Increases beyond that fiscal year would simply be adjustments of the base by the increase in inflation. This initiative would have required legislative enactment and was expected to save nearly $1.1 billion in FY 1982 and a total of $15.0 billion through FY 1986. In return for the reduction in federal support, states would be given increased control over Medicaid eligibility, benefits and reimbursement policies.

To assist in the development of its position, strategy, and testimony concerning the Administration's Medicaid proposal, and to help substantiate the significant role teaching hospitals have in caring for Medicaid patients and the importance of adequate payment for these services, the Association sent its teaching hospital members a "Medicaid Activity Questionnaire" on March 18, 1981. On March 31, citing preliminary statistics from the survey responses, Charles Womer, President of the University Hospitals of Cleveland and immediate past chairman of the AAMC, testified on behalf of the AAMC on the proposed Medicaid cap before the Senate Committee on Finance.

Mr. Womer emphasized that the Administration's proposal would have several adverse hospital outcomes: increased hospital bad debts and charity requirements, increased hospital financial distress, increased hospital prices for charge-paying patients, a reversal of hospital accomplishments in providing a one-class standard of care, and creation of a serious barrier to the

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Administration's interest in competition. The Association urged the Committee to reject the proposed Medicaid budget reductions and examine other areas of the proposed federal budget where reductions would not have the devastating impact of Medicaid program cutbacks. In addition, the AAMC strongly opposed a denial-of-choice provision which would amend the law to give the HHS Secretary the authority to permit states to madate, on a least cost basis, a Medicaid recipients's physician and hospital.

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Proposed Medicare Reimbursement Limits

During April 1981, the Association's efforts to oppose the proposed Medicaid cap, as well as several Medicare payment reduction proposals, continued. The Association wrote to Senator Robert Dole (R-Kans.) Chairman of the Senate Finance Committee, and to Rep. Andrew Jacobs, (D-Ind.), Chairman of the Subcommittee on Health of the House Ways and Means Committee, urging their Congressional panels to oppose proposals to limit Medicare payments for hospital-based outpatient services, hospital-based renal dialysis, and the 8 1/2 percent inpatient care nursing differential. The Committees were considering these proposals in their efforts to develop budget recommendations.

Medicaid and Medicare Provisions Targeted for Opposition by the Association

Throughout May and June, 1981, the AAMC continued to convey to members of Congress its opposition to various proposed Medicaid and Medicare budget cuts. On June 5, 1981, the Association submitted written testimony to the Health Subcommittee of the House Energy and Commerce Committee on the Medicaid component on the Administration's proposed "Health Care Financing Amendments of 1981," which contained the legislative language necessary to implement the proposed federal cap. The AAMC presented it opposition to the cap on the same grounds it argued earlier before the Senate Finance Committee. By the latter

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part of June, each chamber of Congress had approved its own version of a Fiscal Year 1982 budget reconciliation bill. After careful consideration of the provisions of both bills, the AAMC Executive Council concluded that the House bill was preferable in most respects to the Senate bill. However, the Association targeted the following Medicare and Medicaid provisions in the House version for opposition: (1) eliminating of reasonable cost payment for hospitals under Medicaid; (2) setting Medicare Section 223 limits at no more than 108 percent of the group mean; (3) requiring interest on funded depreciation to be offset against interest paid on capital indebtedness in determining Medicare payments; (4) limiting Medicare payment for hospital outpatient services to the reasonable cost or charges for such services provided in physicians' offices in the same area of location; and (5) reducing the routine nursing salary cost differential.

The Final 1981 Statute

In July, a record number of House-Senate conferees arrived at a single reconciliation package which later was signed into law as P.L. 97-35 by President Reagan on August 13, 1981. Although the proposed Medicare offset of interest on funded depreciation against interest paid on capital indebtedness was dropped, other provisions opposed by the Association were incorporated in the new statute in somewhat milder forms. The Administration's proposed Medicaid cap was replaced by reductions of 3 percent in federal Medicaid funding in Fiscal Year 1982; 4 percent in Fiscal Year 1983; and 4 1/2 percent in Fiscal Year 1984. These reductions could, however, be minimized or eliminated entirely if certain specified criteria are met by the state. The requirement that Medicaid pay for hospital services on a Medicare reasonable cost basis was deleted. Instead, states will be required to determine reasonable and adequate hospital payment rates that permit efficient and

economical hospital operations. By July 1, 1982, the Secretary of HHS is required to develop a model prospective payment methodology for inpatient hospital services to be used under Medicaid and Medicare. Medicaid beneficiary freedom-of-choice requirements were waived to allow states to purchase laboratory services and medical devices through a competitive bidding process. Moreover, a state may apply to the Secretary for a waiver of freedom-of-choice requirements to enable the state to establish cost-effective arrangements for medical care (i.e., placing restrictions on the use of certain providers) as long as such services are consistent with standards for access, quality, and efficient and economic provision of covered care.

The major Medicare provisions enacted include: (1) reduction of the 8 1/2 percent routine nursing salary differential to a rate not to exceed 5 percent; (2) reduction of the Section 223 ceiling for reimbursement of inpatient routine hospital costs from 112 to 108 percent of the group mean; (3) limitation of the reasonable costs or charges for hospital-based outpatient services to the reasonable charges for comparable services provided in physicians' offices in the same area: (4) prospective rate payments for renal dialysis services at hospital-based facilities based on single composite weighted formulas which take into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings; and (5) requirement that Medicare payments be secondary for end stage renal disease services covered under certain group health policies.

In addition, major amendments affecting both the Medicare and Medicaid programs (1) repealed the 80% occupancy rate test for determining whether payment to a hospital for a patient (no longer needing acute hospital services, but who remains hospitalized because no long-term care bed is available) will be reduced to a long-term care rate in favor of a new occupancy test based on

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whether there are excess beds in the hospital and the area, and (2) provided for payments to hospitals for capital-related and increased operating costs associated with closing or converting (to approved use) underutilized beds.

HEALTH CARE COMPETITION

AAMC Ad Hoc Committee on Competition

Since the defeat of President Carter's hospital cost containment legislation in 1979, an increasing amount of attention has been given to ways of injecting price competition into the health care marketplace as a means of stimulating cost consciousness among providers (hospitals and physicians) and consumers (individuals enrolling in health plans and patients seeking care). Many of its advocates see the competitive approach as an alternative to regulations and mandatory controls on health care costs. To explore the implications of price competition for teaching hospitals, an AAMC Ad Hoc Committee on Competition was appointed and met on two occasions. Its draft report was reviewed by the AAMC's Executive Council in January, 1981. A number of changes were made subsequent to that review and a final report, which has been disseminated widely, was approved by the Executive Council as a discussion paper at its March, 1981 meeting. The document, titled "Price Competition in the Health Care Marketplace--Issues for Teaching Hospitals," was not intended to be a definitive AAMC policy statement on competition, rather it raises important issues that must be understood and addressed regardless of what form of competition legislation is considered.

Consumer Choice and Price Competition Concepts

One approach to competition in the health care marketplace is designed to influence "consumer choice." It has three underlying principles: employers would be mandated or encouraged to offer multiple choices among health plans to

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would be mandated or encouraged to offer multiple choices among health plans to their employees; employers would be required to make the same dollar contribution to an employee's premium regardless of the plan selected; and a dollar limit would be placed on the amount of the premium that could be treated as a deduction for tax purposes. This "consumer choice" level of competition is explicitly articulated in proposed legislation.

A second approach is directed at increasing "price competition" among providers. It assumes that the consumer choice principle coupled with the repeal of existing regulations, such as health planning, PSRO's and cost-based reimbursement, would encourage individuals and health insurance plans acting in behalf of their beneficiaries to give greater consideration to hospital costs and physician fees when purchasing or contracting for health care services. As a result, those providing the services -- hospitals, HMO's, physicians -- would be stimulated to provide their services at the lowest possible cost. Although quality of care, access, and other factors might influence consumer decisions, it is presumed that an overriding concern for the price of medical services would bring about major cost savings.

<u>Implications of Competition for Teaching Hospitals</u>

Because there has been no wide-scale experience with consumer choice and price competition, there is little known regarding the potential of these approaches to achieve their objectives. To date, far too little attention has been given to the potential implications of this approach for certain types of providers, patient populations, and the nation's supply of trained health manpower. Teaching hospitals must be concerned about price competition because their costs are generally higher than those of non-teaching hospitals. The higher costs derive from their multiple, related products not generally provided by non-teaching hospitals. These include, but are not limited, to:

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--The provision of clinical education for medical students, residents nurses, and other allied health professionals;

--The translation of biomedical research into more effective methods to prevent, diagnose, and treat medical illnesses;

--The provision of regional, tertiary care services to seriously ill patients;

--The provision of large amounts of uncompensated inpatient and outpatient care for disadvantaged patients; and

--The provision of emergency and outpatient care to patient populations otherwise unable to obtain access to health care services.

These activities are presently funded primarily by patient care revenues. Under competitive pricing, individual consumers and third parties, HMO's and IPA's may be unwilling to pay the cost of programs which do not provide short-term, indentifiable medical care benefits for their subscribers. Thus, teaching hospitals may be placed at a distinct disadvantage, and their unique contributions threatened.

Some advocates of price competition recognize that teaching hospitals have multiple products which benefit not only individual patients, but society as a whole. The commonly offered solution is to identify and publicly fund these additional activities based on their own merits. However, the AAMC has emphasized that any attempts to segment the unique characteristics of teaching hospitals into measurable units run the risk of ignoring the fact that their contributions are the products of inter-related programs, which together provide the environment and resources required for teaching future health manpower and advancing medical knowledge and practice.

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"Pro-Competition" Legislation

To ensure that competitive approaches to reforming the health care system continue to be debated, one House and two Senate "pro-competition" health plans introduced last year were resubmitted early in the 97th Congress. On January 5, 1981, Rep. Richard Gephardt (D-Mo.) introduced "The National Health Care Reform Act." The legislation, H.R. 850, is essentially the same bill he and now OMB Director David Stockman authored last year. On January 15, Senate Labor and Human Resources Committee Chairman Orrin Hatch (R-Utah) reintroduced the "Comprehensive Health Care Reform Act," S. 139, legislation that he cosponsored with now Secretary of HHS Richard Schweiker. On February 5, Senate Finance Health Subcommittee Chairman David Durenberger (R-Minn.) reintroduced his "Health Incentives Reform Act." The measure, S. 433, was originally introduced in 1979 and was again cosponsored by Senators John Heinz (R-Pa.) and David Boren (D-Okla.).

Reagan Administration Activities on Health Care Competition

To develop the Administration's pro-competition bill, Secretary Schweiker appointed a HHS intradepartmental task force on competition legislation chaired by Robert Rubin, M.D., HHS Assistant Secretary for Planning and Evaluation. A private sector task force on competition health legislation also was created at the direction of the Secretary by David Winston, Vice President of Blyth, Eastman, Paino, Webber Health Care Funding Inc., in Washington, D.C. The task force, which is chaired by Winston, is intended to serve as a reactor panel or sounding board for the HHS Secretary and other Administration officials on proposals for competition health legislation. The Administration's bill is expected to be introduced in late December, 1981.

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AAMC Testimony on Pro-Competition Proposals

In testimony presented on behalf of the Association before the House Ways and Means Health Subcommittee, Earl Frederick, President of the Children's Memorial Hospital of Chicago, emphasized that there has been no wide-scale experience with any of the "pro-competition" approaches proposed. He noted that this is particularly significant because the proponents of hospital price competition have not addressed the potential implications of these approaches for certain types of providers, patient populations, and the nation's supply of trained health manpower. Although price competition will influence decisions of consumers and groups with purchasing power, he stressed, there are no assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet reasonable needs of all its citizens.

The Association's testimony explained that for the teaching hospital to be competitive in a price dominated marketplace, two broad issues have to be addressed: funding for charity care patients and funding for the unique societal contributions of teaching hospitals. To permit hospitals to care for patients unable to pay for the services they need, proposals to restructure the medical care system must include full payment for the costs of caring for the poor. This is contrary to recent Administration and Congressional decisions to decrease the federal financial commitment to the poor, the medically indigent, and the aged. Mr. Frederick emphasized that the trend begun in the recent budget reconciliation process must be reversed if all hospitals are to compete even-handedly on a price basis.

The testimony further explained that the second issue of major concern for teaching hospitals derives from the added costs teaching hospitals incur in meeting their obligations to society as a whole rather than to individual

patients. Presently, these activities are financed through patient care revenues. Price competition among hospitals raises questions about the future ability of teaching hospitals to finance these responsibilities. One commonly proposed solution is to identify and separately fund these activities on their own merits. In effect, this approach argues for centralization and regulation of decisions for these activities, but decentralization, through price influenced market mechanisms, of all other decisions relating to patient care services. Mr. Frederick cautioned that efforts to carve out and separately fund unique, socially desirable attributes of teaching hospitals should recognize the potentially negative impacts of this approach:

- Separate funding of graduate medical education may limit the ability of medical schools and teaching hospitals to make local decisions about their residency programs.
- Federal support for graduate medical education may be subject to the budget and appropriations process which could make such a fund vulnerable to any major efforts to cut federal spending.
- The administration of the fund could be extremely complex. How would the necessary funds be collected? How would those responsible for distributing the funds decide which hospitals would get support and what that level of support should be?

As a result of these problems, Mr. Frederick stated, teaching hospitals have been unable to identify a solution to the problems their societal missions create in a price competitive environment. "Nevertheless," he concluded, "a solution must be found."

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HEALTH PLANNING

Certificate of Need Review

On October 21, 1980, final regulations were issued establishing the minimum requirements for satisfactory certificate of need (CON) review programs under the health planning act. The regulations implemented revisions made to the original law (P.L. 93-641) by the "Health Planning and Resources Development Amendments of 1979" (P.L. 96-79). A major concern conveyed in the AAMC's May 23, 1980 comments on the proposed regulations was addressed in the final issuance. The Association had requested clarification of the status of proposed capital expenditures or major medical equipment acquisitions for research and training under CON review. It cited statutory language in the Act which it believes demonstrated that Congress did not intend that such proposals be reviewed where there was no major impact on the availability or delivery of inpatient health services in a health service area. In the final CON regulations, the Secretary of HHS emphasized that: "Only clinically related services are included in the definition of institutional health services; consequently, research services *per se* are not required to be subject to review. Capital expenditures are required to be reviewed only if they are made by or on behalf of the health care facility. Major medical equipment acquired for research purposes need not be subject to review if the equipment will not be used to provide services to inpatients of a hospital."

On the same subject, the "Health Programs Extension Act of 1980" (P.L. 96-538), enacted on December 17, 1980, contained several health planning amendments. The AAMC worked closely with Congressional staff in development of an amendment in Title III of the law that provides an exception to the existing CON requirements for the acquisition of major medical equipment, provision of institutional health services, or the obligation of capital expenditures solely

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undertaken for purposes of research. The term "solely for research" is defined to include patient care provided on an occasional and irregular basis outside the research program. A research project would not, however, be exempt from review if it would substantially change the bed capacity of the facility, the medical or other patient care services of the facility, or effect the charges for services other than the services included in the research.

Also related to certificate of need review were the major modifications made during this year to the review thresholds by the "Omnibus Reconciliation Act of 1981." They have been increased from $75,000 to $250,000 for operational costs associated with new services, from $150,000 to $400,000 for major medical equipment acquisitions and from $150,000 to $600,000 for mandated review of capital expenditures.

National Health Planning Goals

On December 8, 1980, the Association sent its members copies of the complete text of proposed regulations issued by HHS on November 25, 1980 to establish national health planning goals (as required by the health planning act). The proposed goals were broad in nature and were divided into three categories: (1) those related to health status outcomes; (2) those related to disease prevention and health promotion; and (3) those related to institutional and personnel resources in systems of care. Most were expressed in quantified terms, while the remainder were qualitative in nature. Under the planning law, health systems agencies (HSAs) must give "appropriate consideration" to these goals in development of their health systems plans and must justify any inconsistencies with them.

In mid-February, 1981, the AAMC submitted its comments on the proposed planning goals, viewing them as broad statements from the federal perspective

to assist the state and local planning agencies in establishing their own goals and priorities. As such, the Association strongly criticized the goals for lacking a sense of realism and consistency. There was no discussion of the cost and funding implications of pursuing such lofty goals, information which planning agencies must take into account in relationship to resources available in their communities. The Association also recommended that the preamble to the regulations explicitly state recognition that the "Health Planning Amendments of 1979" eliminated the statutory requirements for consistency with the national guidelines for health planning, of which the proposed goals are a part. HHS was reminded that it was the expressed intent of Congress that decisions about the applicability of the goals and standards be made at the local level, where they will be effected. The Association also addressed six specific areas of concern within the text of the proposed goals. A final version of these goals has yet to be published.

The Future of the National Health Planning Program

Regarding the future of the current health planning structure, the AAMC's Executive Council approved a statement in January, 1981 which identified several critical deficiencies of the national program and its implementation. The Council did not make the planning act a priority for further Association action. The major issues of concern, many of which had been reiterated throughout the implementation of the planning section, were:

- Academic Medical Center Applications - An ongoing concern has been the failure of health planning decision-makers to adequately recognize and accommodate the unique roles of the academic medical center in (1) the regionalization of highly specialized, referral health services, (2) the education and training of health care professionals at all levels

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of the health sciences, and (3) the conduct of its research and development mission.

- An Excessive Federal Role and Overemphasis on Regulation - The process that has evolved from P.L. 93-641 is not the "bottom-up," autonomous grassroots planning system originally envisioned by Congress, but is instead a "top-down" federal decision-making process emphasizing the regulation and reduction of the capacity of the health care system at the institutional level. Constructive planning has become an incidental secondary component to an excessive regulatory function. National guidelines are applied rigidly despite their explicit flexible nature to reflect adjustments for local conditions and circumstances.

- The Certificate of Need (CON) Review Program As The Principal Instrument of Regulation - Although the mandated CON review process was designed to foster health planning, planning has become instead generally characterized as a vehicle to support CON regulation. Increasingly, adversarial relationships between planners and providers have developed due to inequities and inefficiencies in the review process. As a result, providers have had to assume all the burden of proving need (including provision of data that was originally assumed to be the responsibility of planners) and must often accept other unrelated responsibilities to obtain a certificate. Moreover, it is felt that: (1) the applicant's time and expense to provide all required CON material often is overly burdensome; (2) the minimum dollar threshold for capital expenditure review is too low and minor non-health care expenditures are often unnecessarily reviewed; and (3) the CON review and decision-making process often adds to the cost of health care due to costly delays by the planning bodies.

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- The Influence of Federal Program Funding - The regulatory emphasis of the planning program is not likely to change as long as the federal government substantially funds local agency operation. Participation in the financing of these agencies through a variety of sources needs to be explored to permit greater independence of the program from excessive federal bureaucratic control.

- Failure to Address Essential Factors for Effective Planning - Consideration of geographic and other variables are believed to be key components for effective health planning which have been lacking in the current health planning structure and its implementation. Additionally, it is felt that more thought should be directed to the role of physicians in the planning of institutional services.

- Inadequate Representation of Affected Parties on Health Systems Agency (HSA) Boards - It is felt that HSA governing boards lack adequate representation from key parties of interest such as hospitals, physicians, third-party payers, business and labor, local governments, and other types of health care providers. These Boards are required to be dominated by consumer members who often are just gaining the knowledge and experience to make effective decisions when their terms expire. Moreover, State Health Planning and Development Agencies (SHPDAs), the final decision-making authorities under CON, have no composition requirements and often exclude representatives of significantly affected parties, including hospitals.

- Appropriateness Review Viewed As An Unnecessary Evil - Provider groups (including the AAMC) have constantly sought the elimination of the appropriateness review requirement because: (a) it simply represents another layer of excessive regulation for the purpose of capacity

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control; (b) planning agencies have neither the expertise or resources to perform such reviews; (c) considerations upon which a funding of appropriateness rests are economic, not medical quality or need-related; and (d) ultimate sanctions for findings of inappropriateness are as yet unclear and are feared will be aimed at preventing payment for services rendered in a service labelled inappropriate (without due process provisions for the provider).

HMO DEVELOPMENT AT ACADEMIC MEDICAL CENTERS

Interest in the development of health maintenance organzations (HMOs) at academic medical centers prompted the Association to cosponsor a national conference with the Kaiser Family Foundation in October 1980, and publish the conference proceedings. The publication, which will be available from the Kaiser Family Foundation in the Fall, 1981, will include summaries of discussions of the conference attendees on issues such as the cost of conducting educational programs in prepaid practices, the compatibility between the service objectives of prepaid practices and the educational and research objectives of academic medical centers, and the effect of prepaid practice on faculty practice plans. These summaries, the papers presented by major speakers, and the case histories of academic medical center/prepaid affiliations provide many insights into successfully developing relationships between academic medical centers and prepaid practices.

HOUSESTAFF UNIONIZATION

On July 11, 1980, by a vote of 6-4 the U.S. Court of Appeals for the District of Columbia Circuit ruled that the National Labor Relations Board (NLRB) acted within its statutory authority in its March 1979 Cedars-Sinai decision. This decision declared that interns and residents are primarily

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students rather than employees for purposes of coverage under the National Labor Relations Act (NLRA). The AAMC was amicus curiae in in the case supporting the NLRB's position, and submitted a friend-of-the court brief in the original Cedars-Sinai case as well. The Court of Appeals case was brought by the Physicians' National Housestaff Association (PNHA) after an earlier U.S. District Court decision concluded the court had no jurisdiction to review the NLRB's Cedars-Sinai decision. The case, PNHA v. John H. Fanning et al., was then appealed by the PNHA to the U.S. Supreme Court. The PNHA argued that the legislative history of the 1974 amendment to the NLRA was clear with regard to Congressional intent that housestaff be covered by the Act and that the Board should not have declined to recognize them. On February 23, 1981, the nation's highest court denied the motion of PNHA and thereby left standing the lower court determinations.

During the past year, the AAMC participated as amicus curiae before the Federal Labor Relations Authority in two cases in which PNHA sought to represent housestaff enrolled in graduate medical education programs at the Veterans Administration Medical Centers in Long Beach, California and Brooklyn, New York, respectively. The Association also submitted amicus curiae briefs before: (1) the California Public Employment Relations Board, in a case in which the issue of unionization for housestaff enrolled in graduate medical education programs at hospitals owned and operated by the State of California was under consideration; and (2) the NLRB, in the case of Children's Hospital of Los Angeles v. Interns and Residents Association of Children's Hospital. The outcomes of these various cases are still pending.

LONG TERM CARE PROJECT

In October 1980, the Association undertook a project on aging and long term care. Under a cooperative agreement with the Administration on Aging

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(AoA), the AAMC is providing technical assistance to institutions that have received grants from AoA to plan or operate multidisciplinary long term care gerontology centers (LTCGCs). It is intended that these centers, which are funded under Title IV-E of the Older Americans Act of 1965 as amended, become a national resource for needed services, research, and education and training in long term care.

The primary role of the Association is to act as a facilitator to the long term care centers and projects in obtaining their goals. The Association, therefore, acts to promote an exchange of information on programs and organization at each of the centers and projects and provides the services of experts in organizational development and long term care issues to the new and advanced planning centers. In addition, the Association is developing a management information system that will be used to collect, analyze, and report data on the accomplishments of the operational centers.

To ensure that the project activities incorporate the views and concerns of the many different disciplines that are involved in long term care centers and projects, the Association established a multidisciplinary project advisory committee. The committee members met in January, 1981 to review AAMC's planned activities and to express their views on the major long term care issues to be addressed in the 1980s. It will meet again in October, 1981, to review progress to date, to advise the AAMC of future directions, and to discuss ways in which interest in long term care can continue to be fostered in the nation's academic medical centers.

The AAMC has also conducted two workshops. The first, held on January 12-13, 1981, focused on organizational and program planning issues that centers must address. THe second, conducted on May 6-7, 1981, concentrated on specific substantive areas such as research on the impact of the environment on the

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frail elderly, training of professionals who supply long term care in different settings and at different levels of intensity, long term care policy analysis and assessment, and approaches to developing innovative models of service. A third workshop is scheduled for May 1982. In addition, the exchange of information on long term care is further enhanced by the publication of a newsletter on the LTCGC program. The first issues were published in April and July, 1981. Three more issues will be published next year.

MEDICARE REIMBURSEMENT REGULATIONS

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. Last year, the Health Care Financing Administration (HCFA) attempted to address this inequity in the final schedule of limits on hospital inpatient and routine operating costs for fiscal year 1981. An adjustment for each teaching hospital's limit was based on the ratio of the number of residents to beds in the hospital, with the limit being adjusted upward by 4.7 percent for each .1 resident per bed. In addition, the Section 223 limits included the following 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) capital-related costs, approved medical and nursing education program costs, and malpractice insurance were excluded; (3) limits for hospitals in states that have lower than average covered days of care per 1000 Medicare beneficiaries were adjusted upward; (4) 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 for fiscal year 1980; and (5) there were seven hospital groupings.

When the above schedule was first proposed, the Association supported the new educational adjustment for teaching hospitals and the expanded definition of labor-related costs. However, it opposed the 112 percent limit and reiterated its long-held objection that the methodology used to construct the limits is simplistic, arbitrary and inconsistent with Congressional intent to exclude from reimbursement under Section 223 only those costs "found to be unnecessary in the efficient delivery of needed health services."

The final notice for Medicare Section 223 limits on hospital per diem inpatient general routine operating costs for cost reporting periods beginning on or after July 1, 1981 was published in the June 30, 1981 Federal Register. These fiscal year 1982 limits were never issued as a proposed rule so no opportunity for comment was provided by HCFA. However, the new limits used essentially the same methodology that was employed the previous year (as described above). Minor technical modifications were made in two areas. First, the method used to construct the market basket index was modified, and second, the data used to estimate the wage index information was altered.

As described earlier in this report, the limits on reimbursement to hospitals under Section 223 were modified by the "Omnibus Reconciliation Act of 1981." The new statute provides that the Secretary of HHS may not recognize as reasonable (in the efficient delivery of health services) routine operating costs for the provision of general inpatient services by a hospital to the extent these costs exceed 108 percent (down from 112 percent) of the mean of such costs per diem for hospitals in the same grouping. However, the Secretary may provide for exemptions to the limitation as he deems appropriate. The new limit applies to cost reporting periods ending after September 30, 1981. In

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the case of a cost reporting period beginning before October, 1981, any reduction in payments shall be imposed only in proportion to the part of the period that occurs after September 30, 1981.

Section 227

As previously discussed in this activities statement, the "Omnibus Reconciliation Act of 1980," P.L. 96-499, contained a provision significantly altering Section 227 of the 1972 Medicare amendments to the Social Security Act which established special provisions for Medicare payment of physicians' professional services provided in a teaching hospital. Essentially, Section 227 had required physicians in teaching hospitals to be paid on a reasonable cost basis for professional medical services unless the services were provided to a private patient (as defined by the Secretary of HHS) or the hospital met the billing and collection provisions of a "grandfather" clause.

In the eight years since enactment of Section 227, HHS had not been able to produce implementing regulations that would allow effective administration and be equitable to physicians treating patients in teaching hospitals. On two occasions, discriminatory and harmful draft regulations were vigorously opposed by the medical education community and the AAMC. To redress this situation, Section 948 of the 1980 Reconciliation Act repealed Section 227, except for the provision allowing cost reimbursement when elected by all physicians in the hospital, and added new guidelines for paying teaching physicians.

Part (a) of Section 948 repealed the provisions of Section 227 which presumed physicians in teaching hospitals should be paid on a reasonable cost basis through the hospital, while those in nonteaching hospitals are paid the reasonable and customary fee. The new provisions presume that physicians in teaching hospitals, like their colleagues in non-teaching hospitals, are to be

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paid on a reasonable charge basis when they have provided a billable service. Section 948(a) does, however, permit physicians in a teaching hospital to be paid on a cost basis, without the 20% patient copayment requirement, if all physicians in the hospital elect to accept cost payments for Medicare patients.

Section 948(b) contains provisions which define when a physician in a teaching hospital may bill for the services performed or personally supervised for Medicare beneficiaries and outlines the policy that will be followed in determining the amount of the fee that the Medicare program will pay. Conditions (I) and (II) of Section 948(b) essentially require the physician to meet the criteria of the present Intermediary Letter (IL) #372 to be eligible to bill a fee for services performed. Under IL #372, physician charges are allowed when (a) the physician renders sufficient personal and indentifiable physician services to exercise full control over the management of the protion of the case for which the payment is sought and (b) the services are similar to those the physician furnished to patients not entitled to benefits under Medicare. Condition (III) goes beyond IL #372 by requiring that Medicare pay fees only where 25% of the hospital's non-Medicare patients paid a substantial part of their charges (other than nominal charges). Significantly for condition (III), payments received from Medicaid agencies would be defined as "substantial" regardless of the actual amount of the payment. In general, the Congressional Conferees on this legislation intended that "a substantial part of charges" be interpreted as at least 50%.

When the above three conditions are met, the customary charge for fee-for-service payments shall be determined in one of three ways. In the case of a physician who has a substantial practice outside the teaching setting, Medicare carriers would use the fee profile for similiar services provided in the physician's outside practice. In the case of physicians practicing

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primarily in teaching hospitals, the fee profile would be determined by using the most frequently collected charges for each service, excluding from calculation patients paying nominal or no fees. Finally, if the average fee paid is greater than the most frequently collected charges, physicians practicing in teaching hospitals would have their fee profiles determined using the mean charge collected for each service excluding from the calculation patients paying nominal or no fees. The fee-for-service provisions of Section 948(b) were scheduled to become effective with hospital cost reporting periods beginning on or after January 1, 1981. However, final regulations to implement the provisions have yet to be promulgated.

In the report accompanying the reconciliation bill, the final paragraph under the section on "Reimbursement of Physicians' Services in Teaching Hospitals" directs the Secretary of HHS to study the relationship between existing reimbursement practices of the Medicare program and DHHS programs assigned to stimulate primary care residency programs. The Secretary is to provide Congressional committees with recommendations for administrative and statutory changes to remove possible conflicts between the reimbursement and manpower development policies.

The AAMC, which supported the Section 227 repeal contained in Section 948(a) did not support Section 948(b) because the provisions violate a number of principles that have guided AAMC policy during its negotiations over this issue. However, the Association believes that the vast majority of its constituent institutions can function satisfactorily within the statutory provisions, and that any problems that might arise can be addressed during the development of implementing regulations. Therefore, these provisions were not formally opposed by the AAMC.

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Medicare officials are now in the process of developing the regulations to implement Section 948. While the Association has had no reason to oppose generally the service requirements and medical record documentation necessary to substantiate them, some recent Medicare audits have retroactively disallowed fees by applying documentation criteria which had not been used previously and were not understood to be required by IL #372.

To assess the significance of Medicare service and documentation problems, the AAMC conducted a survey of its member schools and hospitals. In addition to the findings of past Medicare Part B audits, the questionnaire (which was mailed on July 10, 1981) requested information on vague or unreasonable service and documentation requirements and identification of situations and issues not covered by current Medicare directives. The survey data received is now being analyzed by Departmental staff.

Incentive Reimbursement for Outpatient Dialysis and Self-Care Dialysis Training

On November 21, 1980, the AAMC submitted comments to the HCFA Administrator on proposed regulations to establish incentive reimbursement for outpatient dialysis and self-care dialysis training. The Association was pleased to note that the proposed regulations recognized and provided for different reimbursement rates for hospital-based and independent (free-standing) dialysis services. The AAMC strongly urged HCFA to retain this distinction in developing final regulations. The AAMC was concerned, however, that the proposed regulations included a detailed statistical methodology for calculating the incentive reimbusement rate in the admitted absence of adequate data. The Association asked HCFA to delay promulgation of incentive reimbursement rates until appropriate data could be collected and the impact of the rates on beneficiaries and providers could be analyzed. The final version of these regulations has yet to be issued.

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The "Omnibus Reconciliation Act of 1981" addressed this issue and required the Secretary of HHS to promulgate regulations setting forth a method determining prospectively the amounts of payments to be made for renal dialysis services furnished in dialysis facilities or at home. This method is to provide for the prospective determination of a rate for each mode of care based on a single composite weighted formula (which takes into account the mix of patients who receive dialysis services at a facility or at home and the relative costs of providing such services in these settings) for hospital-based facilities and other renal dialysis facilities. This amendment applies to services furnished on or after October 1, 1981.

Provider Reimbursement Manual Revision on "Cost to Related Organizations"

The Association submitted comments on June 10, 1981 on a Medicare Intermediary Manual revision proposed by HCFA on the issue of the "Cost To Related Organizations." On January 26, 1979, HCFA published proposed changes in its related organization regulations. On January 19, 1981, the notice of proposed rulemaking (NPRM) was withdrawn because "we (HCFA) have found that Medicare intermediaries, that interpret and apply the regulation with respect to specific provider expenditures, appear to be able to resolve most of the issues equitably." In its comments to HCFA, the Association emphasized that it failed to understand how regulations judged to be effective and interpretable in January 1981 could necessitate a significant proposed manual revision three months later. Moreover, the Association objected to the attempt to incorporate a significant regulatory change in a proposed manual revision when similar changes were rejected in withdrawing the NPRM. To promulgate and implement these new policies without a NPRM was, in the AAMC's view, a violation of the Administrative Procedures Act. If HCFA intended to implement the policy

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changes, the AAMC strongly urged that a NPRM first be published for public comment.

COTH SPRING MEETING

On May 6-8, 1981, the fourth annual Spring Meeting of the AAMC's Council of Teaching Hospitals (COTH) was held at the Peachtree Plaza Hotel in Atlanta Georgia. A record number of COTH-member chief executive officers (and their associates) attended the two-day meeting, which is conducted to provide these executives with an opportunity to personally interact and discuss major current isues of common interest and concern. To stimulate the discussion, a number of distinguished speakers were on the program to present various points of view on these issues.

Health Care and the American Economy in the Eighties

The keynote speaker was Ralph S. Saul, Chairman and Chief Executive Officer of INA Corporation, a major insurance company. Mr. Saul addressed the topic of "Health Care and the American Economy in the Eighties." He asserted that the principal task for both health care providers and consumers will be "how to make do with less." He noted that the pervasive public assumption that health care is an entitlement has been weakened by a growing consensus that health care costs are too high and cannot be permitted to continue to rise as rapidly as at present. He felt that there were two principal pressures motivating this current drive to control health care costs: (1) the productive work force increasingly is becoming aware of the relationship between government spending and taxation and inflation, and (2) employers, the largest private purchasers of health care, are increasingly resisting the heavy burden placed on them by the cost of employee coverage. As evidence of the latter, he pointed out the Ford Motor Company's health expenditures increased 240% between

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1970 and 1978, and that in 1975 the firm was paying $520 million toward health care coverage (or $3,200 per employee). He also noted that for the first time in many years, employee fringe benefits are growing less rapidly than wages.

Mr. Saul emphasized that increased recognition must be given to the fact that funds for health care are a finite resource and improved management will be needed to get more for the dollars expended. He felt that proprietary hospitals and management services are "here to stay" and have fostered improved management techniques in the health care industry. To contain health care costs in the 1980's, Mr. Saul believes some form of competitive approach will be injected into the delivery system and regulation of the industry will be reduced. In this competitive environment, he thought changing conditions would include:

- government regulation would be directed at the support of creative competition and away from rewarding inefficiency as under the current reimbursement system;
- there will be a shift from the current cost-based reimbursement system to a fee-based system with first dollar coverage;
- potential recipients of capital financing will be scrutinized more heavily by the sources of such funding;
- greater experimentation by providers in the delivery of health care will be fostered and multi-hospital systems will become an increasingly important delivery mode;
- reasonable consumer cost-sharing will be instilled into the payment system; and

- greater price sensitivity and cost consciousness by providers and consumers will be encouraged.

Mr. Saul alerted the teaching hospital executives that "competition in the health care marketplace is coming" and had better be faced squarely. He felt the challenge for teaching hospitals would be to examine their patient care cost to find areas for reductions. "With a federal policy shift from paternalism to greater independent responsibilities," he stated, "it will be left to managers to make the right decisions. Teaching hospitals will continue to be supported by both the public and business as major intellectual resources for the nation. However, if teaching hospitals are to compete on an acute care basis, teaching and research costs will have to be distinguished and separately funded because the cross subsidization of these costs from patient care revenue cannot continue in a competitive environment."

Caring for a Wounded President

Following dinner on the same evening, Dennis S. O'Leary, MD, Dean for Clinical Affairs at the George Washington University (GWU) Medical Center in Washington, DC, recounted the hospital's experiences in the aftermath of the attempt on March 30 to assassinate President Reagan. It may be recalled that it was Dr. O'Leary who provided a sense of order and reassurance on national television during press conferences after the tragic event. He was equally impressive at the Spring Meeting in his depiction of the unique medical, security, and public relations problems faced by the hospital during this episode.

Health Care and the Growing Aged Population

The morning session on May 7 featured a presentation by Dorothy P. Rice, Director of the National Center for Health Statistics, on "Morbidity, Mortality

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and Population Trends in the United States." The implications of these trends were then discussed by three other speakers. Mr. Rice distributed a handout which presented detailed tables and charts demonstrating that the phrase the "Graying of America" is aptly used to describe the increasing percentage of the elderly in the total U.S. population. However, she emphasized that the phrase lacks the urgency needed to meet the medical care and social needs of this growing population segment. She stressed that the "Geriatric Imperative," coined by Anne R. Somers, Professor of Community Medicine at CMDNJ-Rutgers Medical School in New Jersey, is occurring now and demands that the nation rethink and plan future health policy for the elderly. She noted that the nation's mortality rate decreased nearly 20 percent between 1953 and 1978. Assuming that the current mortality rate remains constant, the aged population will increase by 38 percent by the year 2003. If a continuation of declining mortality rates is assumed, it is projectd that the aged population will triple by the year 2003.

Ms. Rice then suggested a three-prong approach to improving medical care for the elderly in the future:

--more research to provide a better psychosocial understanding of the elderly;

--more and better education for the elderly in the areas of self and preventive care; and

--the inclusion of specific geriatric and gerontology training in the medical education curriculum and those of other health professions.

The first speaker to react to Ms. Rice's presentation was J. Alexander McMahon, President of the American Hospital Asociation, who discussed "The Implications for Traditional and Emerging Services." He first noted that

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whether one looks at the Carter Administration's cost containment proposal or the current Administration's inclination toward a pro-competitive approach to health care, the intent is similar--the reduction of federal health expenditures. Therefore, Mr. McMahon foresees less money for health services coming from the government, as well as from the business community which is dissatisfied with the growth in its expenditures for employee health insurance. He hoped that the hospital industry would recognize that "its world is undergoing long-term changes that will have to be accomodated if today's hospitals are to survive under tomorrow's free-market regulation."

Discussing the growth of the aged population, Mr. McMahon predicted that the Medicare program would face the same types of financial problems which have jeopardized the continued existence of the Old Age and Survivors Disability Insurance and Social Security programs. To address this, he believed Congress would look at ways of "restructuring Medicare, limiting payments to providers, and making providers the rationers of health care in the nation." In general, he predicted that the more expensive modes of the health care delivery would become unaffordable and therefore hospital utilization by patients at all age levels would be reduced in the future in favor of less costly modes of ambulatory care. In addition, though he was unsure where the financing for new services would be found, he thought that emerging programs, particularly in the geriatric area, would be permitted to develop. He also expected that hospitals would find themselves more involved in the areas of retirement housing, hospices and nursing homes in reaction to the population growth patterns.

Discussing "The Implications for Educational and Research Objectives" was Saul J. Farber, MD, Acting Dean of the New York University School of Medicine. Dr. Farber called the aging of the nation's population a reflection of our successes both in medical care and environmental development. He presented a

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review of the history of medical specialties and described the movement for the creation of the geriatric specialty as unique because the clinical need precedes a strong academic-research base to support it. He too saw the needs of the elderly becoming more urgent and felt health professions training would need to increase education in the psychosocial and biomedical concerns of aging. He noted that a number of the medical specialties boards (e.g., American Board of Internal Medicine) are already emphasizing geriatrics in their training standards.

In the area of research, Dr. Farber declared that gerontology must be added to the family of biomedical sciences. "The questions," he stated, "are numerous and new vistas would be open on understanding the basis of life and death." He noted particularly that research on incontinence, a major factor in decisions to admit older persons to nursing homes, is greatly needed. He closed by indicating that there was still time to plan for the steep rise in the growth of the aged population which he believes will occur around the year 2000. However, he asserted, the effort must begin now and would require a strong commitment from the teaching hospitals of the country.

The final presentation during the Thursday morning session was presented by Loretta Ford, E. D., Dean of the School of Nursing at the University of Rochester. She discussed the population trends in relation to the "The Implications for the Spectrum of Nursing Services" and began by discussing the current problems in maintaining and recruiting an adequate supply of nurses. Citing a prediction that there would be 100,000 nursing vacancies by the year 1985, she attributed the current nursing shortage to: (1) non-competitive salaries and benefits; (2) the availability of better career opportunities;

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(3) the limited respect and role given nurses in patient care planning and decision-making; (4) working conditions which are often substandard; and (5) the lack of professional advancement in the field.

Ms. Ford indicated that currently there are only 1,000 nurses in geriatric nursing, a figure which is insufficient at present and portrays an even dimmer picture for elderly care in the future. To remedy this situation, she recommended that academic nursing retrain and retool faculty toward elderly care. She emphasized that these directions must be taken despite the shortage problem, for which solutions would have to be economic and professional in nature. She called for demonstration projects in hospitals that would foster the growth of clinical geriatric teams, on which hospital administrators and nurses would play significant roles. She also called for more research on the nursing center concept which may provide the future day care centers for the elderly.

Physician Performance in Prepaid Medical Plans

The afternoon session on May 7 began with an informative technical discussion presented by William C. Richardson, Ph.D., Associate Dean at the School of Public Health at the University of Washington, on the subject of "Physician Performance in Prepaid Medical Plans." He described the results of a study done in the State of Washington which compared the Group Health Cooperative prepaid medical plan and independent community practitioners in the Seattle area on such variables as technical and economic efficiency, case mix, patient care and related costs, and other factors. The study demonstrated that greater efficiencies and physician performance were achieved in the prepaid medical plan.

Later that afternoon, four individual workshops were conducted to enable

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small group discussions on the subjects of consumer choice and competition and their potential effects on teaching hospitals. In addition, a concurrent session was held in which Veterans Administration (VA) medical center directors met with representatives from the Office of the VA's Chief Medical Director.

Social Security, Medicare and Medicaid: Likely Developments in the Eighties

The Spring Meeting concluded with four presentations on the morning of May 8. The first speaker was Rep. Barber B. Conable (R-N.Y.), ranking minority member of the House Ways and Means Committee, who spoke on "Social Security, Medicare and Medicaid: Likely Developments in the Eighties." It was a particularly opportune time to hear from the Congressman since the House of Representatives voted in impressive numbers to support the Administration's federal budget proposal the prior day. Describing the vote as an easy task, Rep. Conable admitted that moving from the general to the particular on the budget would be a painful and difficult time for Congress, particularly on the Administration's proposed tax cuts.

For the Social Security, Medicare and Medicaid programs, Rep. Conable indicated the "the picture is dark." To stabilize the growth of the Social Security program he explained that three major options are being looked at: (1) suppress the growth of welfare-related benefits to produce modest savings; (2) reallocate payroll taxes to divert health insurance money to the Old Age and Survivors Disability Insurance program; and (3) provide incentives for people to work longer.

On the Medicaid program, the Congressman stated that there was considerable support for the proposed federal expenditure cap as a preliminary measure through 1983, when it would be expected that a more comprehensive proposal for Medicaid program reform would be introduced by the Administration.

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For the Medicare program, he noted that the adopted budget resolution calls for a $1.1 billion spending reduction by fiscal year 1982. Clearly, he emphasized, the various Congressional committees with jurisdiction over health programs will have a great deal of work ahead of them to implement the resolution.

<u>Acquiring Capital in the Eighties</u>

The next speaker was J. Ira Harris, general partner of Salomon Brothers, a major investment firm in Chicago. Mr. Harris spoke on the subject of "Acquiring Capital in the Eighties." He described the health care industry as a "fat cat," which has over the years built up resources but now faces considerable financing and capital access problems because a system devoted to universal accessibility and quality care could not be afforded in this inflationary time. He contended that the health care industry is ripe for "catastrophic change" and agreed with earlier speakers that the future held the introduction of competition into the health care marketplace and increased accountability. During a period of govenment deregulation, he felt that the strategy for

investment in the health care industry would be based on profitability versus risk, an approach he called "returning back to basics." He predicted that the current approach to financing by long-term debt through fixed rate 25-30 year bonds is "on its way out" and that a rationing process will occur between hospitals with similar credit ratings in order to raise institutional credit worthiness. He also felt that the introduction of competition in health care would produce greater risk and raise the threshold on rate of return on investment in the industry. Therefore, he anticipated that capital decision-making would be based on market demand and that consumers would have more input into convenience versus cost decisions in choosing among providers.

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Mr. Harris warned the teaching hospital executives that these drastic changes in capital financing would have to be met by major changes in hospital management philosophy. He then recommended the following corporate strategy for health care institutions:

- health care institutions must diversify risk through such management approaches as vertical organizations and shared arrangements;
- health care institutions must diversify their funding alternatives;
- equity capital needs to be developed regardless of non-profit or proprietary orientation;
- quality management talent must be nurtured in order that appropriate resource allocation decisions are made and new capital markets are found; and
- it must be accepted that investor-owned hospitals will have no intrinsic advantage over voluntary institutions if appropriate corporate strategies are instituted.

American Industry: The New Tough Buyer of Health Care

The third speaker was Henry E. Simmons, MD, a pricipal with the accounting/management consulting firm of Peat, Marwick, Mitchell and Company. Dr. Simmons' address was entitled "American Industry: The New Tough Buyer of Health Care." He began by declaring that the control of inflation will include an effort to contain health care expenditures as a major domestic issue of the 1980's. He estimated that government and big business are convinced that one third to one half of the health care they purchase is either unnecessary, inadequately provided, or inefficient. He further noted that business is being shown evidence that: (1) the cost-benefit and quality of the health care they

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purchase is not commensurate with the increasing amounts being expended on it; (2) there may be more benefit from non-traditional sources of care; (3) providers have directly influenced the reduced quality of care by unnecessary utilization of services for diseases and ailments that are iatrogenic in nature; (4) there are marked differences in inpatient utilization rates regionally without adequate explanations for these variations; and (5) health maintenance organizations (HMOs) and other health care delivery modes offer adequate services at lower rates of utilization and cost than more traditional settings.

Because business is becoming a more knowledgeable consumer and sees tremendous waste in the health care systems, Dr. Simmons sees a growing belief among major corporations that increased quality of care will come only from major system reform. This reform will see business and labor more and more deciding to work together to relieve the problems of higher health care costs, with corporations increasingly bargaining with the least cost quality provider and reducing the freedom of choice employees have in selecting the setting for health care services. Dr. Simmons believes that the future will hold increased corporate committment to HMO development, as well as continued growth of the corporate practice of medicine. He warned that business will become an extremely prudent buyer. If hospitals ignore this they will probably not survive in the competitive environment that he believes will come with or without legislation.

In closing, Dr. Simmons declared that "competition is the future" and "the traditional hospital setting is dead." He predicted that the major buyers will seek new systems of health care and that the coming environment can offer remarkable new opportunities to hospitals if they choose "to move with the flow, respect trends and react to them." To do this, he believes hospitals

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will have to "make do with less" and cut away waste without reducing the level of care. In relation to teaching hospitals specifically, he believes there would be enough of a market for their high quality care once there "houses were in order and efficiencies were achieved." He stated that he could even see the banding together of centers of excellence in franchising arrangements and the patenting of higher technology services.

<u>Progress Report on AAMC Teaching Hospital Study</u>

The meeting's last session provided a report on the status of the COTH study on diagnostic case mix and other distinctive features of teaching hospitals. Mark S. Levitan, Executive Director of the Hospital of the University of Pennsylvania and Chairman of the AAMC Ad Hoc Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, provided an overview, describing some of the problems that have been experienced with the data and its collection, and preliminary statistics that have been compiled.

The 1982 Spring Meeting will be held May 12-14 at the Colonnade Hotel in Boston.

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APPENDICES

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APPENDIX A

COTH OFFICERS AND ADMINISTRATIVE BOARD
1980-1981

Officers:

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Chairman-Elect: Mitchell T. Rabkin, MD * .... Beth Israel Hospital, Boston

Immediate Past Chairman: John W. Colloton * .... University of Iowa Hospitals and Clinics, Iowa City

Secretary: James W. Bartlett, MD .... Strong Memorial Hospital of the University of Rochester

COTH Administrative Board Members:

Terms Expiring 1981:

Dennis R. Barry .... Moses H. Cone Memorial Hospital, Greensboro

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

Robert K. Match, MD .... Long Island Jewish-Hillside Medical Center, New York

Terms Expiring 1982:

Fred J. Cowell .... Jackson Memorial Hospital Miami

Robert E. Frank .... Barnes Hospital St. Louis

Earl J. Frederick .... The Children's Memorial Hospital, Chicago

John A. Reinertsen * .... University of Utah Medical Center, Salt Lake City

Terms Expiring 1983:

Spencer Foreman, MD .... Sinai Hospital of Baltimore Baltimore

Haynes Rice .... Howard University Hospital Washington, D.C.

John V. Sheehan .... Veterans Administration Medical Center, Houston

* COTH Representatives to the AAMC Executive Council.

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APPENDIX B

COTH REPRESENTATIVES TO AAMC ASSEMBLY
1980-1981

Term Expiring 1981:

Dennis R. Barry .... Moses H. Cone Memorial Hospital
Greensboro, N.C.

James W. Bartlett, MD .... Strong Memorial Hospital
Rochester, N.Y.

B. Fred Brown .... Veterans Administration Medical
Center, Durham, N.C.

J. Robert Buchanan, MD .... Michael Reese Hospital & Medical
Center, Chicago, Ill.

John W. Colloton .... University of Iowa Hospital &
Clinics, Iowa City, Iowa

Fred J. Cowell .... Jackson Memorial Hospital
Miami, Fla.

Edward J. Dailey .... Muhlenberg Hospital
Plainfield, N.J.

Samuel Davis .... The Mount Sinai Hospital
New York, N.Y.

Felix E. Demartini, MD .... Presbyterian Hospital
New York, N.Y.

John F. Harlan, Jr. .... University of Virginia Hospital
Charlottesville, Va.

William F. Hejna, MD .... Rush-Presbyterian-St. Luke's
Medical Center, Chicago, Ill.

Paul B. Hoffmann .... Emory University Hospital
Atlanta, Ga.

William B. Kerr .... University of California Hospitals
& Clinics, San Francisco, Cal.

Sheldon S. King .... University of California Medical
Center, San Diego, Cal.

Mark S. Levitan .... Hospital of the University of
Pennsylvania, Philadelphia, Pa.

Robert K. Match, MD .... Long Island Jewish-Hillside Medical
Center, New Hyde Park, N.Y.

Glenn R. Mitchell .... Medical Center Hospitals
Norfolk, Va.

John J. Peters .... Veterans Administration Regional
Director

John A. Reinertsen .... University of Utah Medical Center
Salt Lake City, Utah

Carlton M. Smith .... Veterans Administration Regional
Director

Terms Expiring 1982:

Jess E. Burrow .... Veterans Administration Medical
Center, Sepulveda, Cal.

Laurance V. Foye, Jr., MD .... Veterans Administration Medical
Center, San Francisco, Cal.

Louis M. Frazier, Jr. .... Veterans Administration Medical
Center, Shreveport, La.

APPENDIX B

COTH REPRESENTATIVES TO AAMC ASSEMBLY, 1980-1981

Continued

1982: Continued

Earl J. Frederick .... The Children's Memorial Hospital
Chicago, Ill.
William H. Gurtner .... Mt. Zion Hospital & Medical Center
San Francisco, Cal.
Warren G. Harding .... Bexar County Hospital District
San Antonio, Tex.
Roger S. Hunt .... Indiana University Hospitals
Indianapolis, Ind.
John E. Ives .... Shands Teaching Hospital
Gainesville, Fla.
Donald G. Kassebaum, MD .... University of Oregon Hospital
Portland, Oregon
James Malloy .... John Dempsey Hospital
Farmington, Conn.
Stuart J. Marylander .... Cedars-Sinai Medical Center
Los Angeles, Cal.
G. Bruce McFadden .... University of Maryland Hospitals
Baltimore, Md.
Joseph Moore .... Veterans Administration Lakeside
Medical Center, Chicago, Ill.
Charles O'Brien .... Georgetown University Hospital
Washington, D.C.
David R. Pitts .... Ochsner Foundation Hospital
New Orleans, La.
Ruth M. Rothstein .... Mt. Sinai Hospital Medical Center
Chicago, Ill.
Jerome R. Sapolsky .... The Miriam Hospital
Providence, R.I.
Richard L. Sejnost .... The Harper Hospital
Detroit, Mich.
Robert J. Taylor .... Hennepin County Hospitals
Minneapolis, Minn.
David S. Weiner .... Children's Hospital Medical Center
Boston, Mass.
Bernard B. Weinstein .... Westchester County Medical Center
Valhalla, N.Y.

Terms Expiring 1983:

Peter Baglio .... Veterans Administration Medical
Center, East Orange, N.J.
Robert J. Baker .... University of Nebraska Hospital
Omaha, Nebraska
Michael O. Bice .... University of Massachusetts Medical
Center, Worcester, Mass.
David M. Bray .... University of Chicago Hospital
Chicago, Ill.
Daniel E. Cooney .... Veterans Administration Medical
Center, Minneapolis, Minn.
Carl R. Fischer .... University of Arkansas Hospital
Little Rock, Ark.

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APPENDIX B

COTH REPRESENTATIVES TO THE AAMC ASSEMBLY, 1980-1981

Continued

1983: Continued

Spencer Foreman, MD .... Sinai Hospital of Baltimore, Inc.
Baltimore, Md.

Robert E. Frank .... Barnes Hospital
St. Louis, Mo.

James G. Harding .... Wilmington Medical Center
Wilmington, Del.

Henry L. Hood, MD .... Geisinger Medical Center
Danville, Pa.

William A. McLees, Ph.D. .... Medical University of South Carolina
Hospital, Charleston, S.C.

Frederick C. Meyer .... Presbyterian Hospital of the Pacific
Medical Center, San Francisco, Cal.

Charles B. Mullins, MD .... Parkland Memorial Hospital
Dallas, Tex.

Mitchell T. Rabkin, MD .... Beth Israel Hospital
Boston, Mass.

David A. Reed .... Good Samaritan Hospital
Phoenix, Ariz.

Haynes Rice .... Howard University Hospital
Washington, D.C.

John D. Ruffcorn .... Loma Linda University Medical
Center, Loma Linda, Cal.

John V. Sheehan .... Veterans Administration Medical
Center, Houston, Tex.

Richard A. Silver .... Veterans Administration Medical
Center, Tampa, Florida

C. Thomas Smith .... Yale- New Haven Hospital
New Haven, Conn.

Richard L. Stensrud .... St. Louis University Hospital
St. Louis, Mo.

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APPENDIX C

COTH COMMITTEE APPOINTMENTS 1980-1981

The following individuals are COTH representatives to AAMC standing and ad hoc committees.

AUDIT COMMITTEE

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

LIAISON COMMITTEE ON MEDICAL EDUCATION

Edward C. Andrews, Jr., MD, Maine Medical Center, Portland

FINANCE COMMITTEE

Charles B. Womer, University Hospitals of Cleveland, Cleveland
John W. Colloton, University of Iowa Hospitals and Clinics, Iowa City

FLEXNER AWARD COMMITTEE

Edward C. Andrews, Jr., MD, Maine Medical Center, Portland

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David S. Weiner, The Children's Hospital Medical Center, Boston

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David L. Everhart, Northwestern Memorial Hospital, Chicago
J. Robert Buchanan, MD, Michael Reese Hospital and Medical Center, Chicago

RESOLUTIONS COMMITTEE

James M. Ensign, Creighton Omaha Regional Health Care Medical Center, Omaha

AAMC NOMINATING COMMITTEE

John W. Colloton, University of Iowa Hospitals and Clinics, Iowa City
David L. Everhart, Nortwestern Memorial Hospital, Chicago

COTH NOMINATING COMMITTEE

Chairman - John W. Colloton, University of Iowa Hospitals and Clinics, Iowa City
Stuart J. Marylander, Cedars-Sinai Medical Center, Los Angeles
Don L. Arnwine, Charleston Area Medical Center, Charleston, West Virginia

COTH SPRING MEETING PLANNING COMMITTEE

Chairman - James W. Bartlett, MD, Strong Memorial Hospital, Rochester
J. Robert Buchanan, MD, Michael Reese Hospital and Medical Center, Chicago

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APPENDIX C

COTH COMMITTEE APPOINTMENTS 1980-1981

Continued

COTH SPRING MEETING PLANNING COMMITTEE (Continued)

John R. Fears, Veterans Administration Medical Center, Hines, Illinois
John E. Ives, Shands Teaching Hospital, Gainesville, Florida
Sheldon S. King, University Hospital, University of California - San Diego

AAMC AD HOC COMMITTEE ON COMPETITION

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David M. Brown, MD, University of Minnesota Medical School, Minneapolis
Paul W. Hanson, The Genesee Hospital, Rochester
Robert M. Heyssel, MD, The Johns Hopkins Hospital, Baltimore
Harold H. Hines, Marsh & McLennan, Inc., Chicago
Ronald P. Kaufman, MD, The George Washington University Medical Center, Washington, D.C.
William B. Kerr, University of California Hospitals, San Francisco
Richard H. Moy, MD, Southern Illinois University School of Medicine, Springfield
Hiram C. Polk, Jr., MD, University of Louisville School of Medicine

AAMC AD HOC COMMITTEE ON THE DISTINCTIVE CHARACTERISTICS
AND RELATED COSTS OF TEACHING HOSPITALS

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Arthur E. Baue, MD, Yale University School of Medicine, New Haven
Donald A. Bradley, Morristown Memorial Hospital, Morristown, New Jersey
David R. Challoner, MD, St. Louis University School of Medicine
Fred J. Cowell, Jackson Memorial Hospital, Miami
David Dolins, Beth Israel Hospital, Boston
Earl J. Frederick, The Children's Memorial Hospital of Chicago
William B. Kerr, University of California Hospitals, San Francisco
James R. Kleinenberg, MD, Cedars-Sinai Medical Center, Los Angeles
Robert K. Match, MD, Long Island Jewish-Hillside Medical Center, New Hyde Park, N.Y.
Hamilton Moses, MD, The Johns Hopkins Hospital, Baltimore

AAMC AD HOC COMMITTEE ON MEDICARE SECTION 227

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Irwin Birnbaum, Montefiore Hospital, New York
Frederick J. Bonte, MD, The University of Texas Southwestern Medical School, Dallas
David M. Brown, MD, University of Minnesota Medical School, Minneapolis
William R. Bowdoin, Trust Company of Georgia, Atlanta
Thomas A. Bruce, MD, University of Arkansas College of Medicine, Little Rock
James M. Colwill, MD, University of Missouri- Columbia School of Medicine
Martin G. Dillard, MD, Howard University Hospital, Washington, D.C.
Fairfield Goodale, MD, Medical College of Georgia, Augusta
Robert W. Heins, The University of Texas Southwestern Medical School, Dallas
William N. Kelley, MD, The University of Michigan Medical School, Ann Arbor
Richard Littlejohn, University of California School of Medicine, San Francisco
Jerome H. Modell, MD, University of Florida, Gainesville
Elliot C. Roberts, Sr., Cook County Hospital, Chicago
Marvin H. Siegel, J.D., University of Miami School of Medicine
Eugene L. Staples, West Virginia University Hospital, Morgantown

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APPENDIX D

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Director
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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

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Administrative Secretary
202/828-0490

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Secretary
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Dahlia S. Parry
Secretary
202/828-0496

AoA LONG-TERM CARE PROJECT

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Project Director
202/828-0423

Ann M. Vengrofski
Research Associate
202/828-0422

Stephanie A. Tames
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APPENDIX E

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Price Competition in the Health Care Marketplace: Issues for Teaching Hospitals	$ 3.00
Medical Education Costs in Teaching Hospitals: An Annotated Bibliography	$ 3.00
Describing and Paying Hospitals: Developments in Patient Case Mix	$ 3.50
COTH Directory of Educational Programs and Services - 1981	$ 6.00
COTH Survey of Housestaff Stipends, Benefits and Funding - 1981 (not available until late Fall 1981)	$ 6.00
COTH Report (monthly newsletter)	$ 30.00 per annum

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