



**association of american  
medical colleges**

**SELECTED ACTIVITIES  
DEPARTMENT OF TEACHING HOSPITALS  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES**

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**ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
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## INTRODUCTION

The Department of Teaching Hospitals is the staff component of the Association of American 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, 1981 through October, 1982. 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 C.

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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 represents the Council in the deliberations and policy making process of the AAMC. There are nine regular members of the Board, each serving a three-year term. In addition, membership includes the chairman, chairman-elect, immediate past chairman, and secretary. For the coming 1982-83 year, Mark S. Levitan, executive director of the Hospital of the University of Pennsylvania, Philadelphia, will serve as the COTH chairman, succeeding Mitchell T. Rabkin, M.D., president of Beth Israel Hospital in Boston. 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. COTH committee appointments during 1981-82 appear in the AAMC 1981-1982 Annual Report.

The COTH Administrative Board met five times to conduct the Council's business and to review and discuss Executive Council Agenda items. A major agenda item continued to be the various "pro-competition" legislative proposals that have been introduced, their potential impact on teaching hospitals, and alternatives for addressing the issues. After numerous discussions on the subject, the Board neither formally endorsed or opposed such legislation. Instead, the Board examined relevant issues such as: Medicare and Medicaid participation, charity and uncompensated care, pricing of plans, a special fund for the societal contributions of teaching hospitals, and an evaluation commission. The Administrative Board also examined the American Hospital Association's (AHA's) proposed Medicare prospective payment system. Essentially, the proposed system would be limited to four years' duration and would establish, in the first year, a fixed price for each Medicare discharge for each hospital based on the hospital's actual costs in the previous year. Payments in each subsequent year would be adjusted to reflect increased prices in the goods and services purchased by hospitals. Hospitals able to provide care for less than the fixed payment would be allowed to retain the resulting profit, while those with costs greater than the payments would incur a loss. In addition, hospitals, under defined conditions and with specific changes in the fixed payment, would be allowed to charge Medicare patients up to \$1,000 per discharge above the government payment. In June, the Administrative Board endorsed the AHA proposal in concept. In late summer, the AHA announced its intention to revise the proposal as a result of the comments it had received from its members and from the government. That effort is currently underway. The Board discussed the potential effects of proposed Medicare cutbacks on teaching hospitals during each meeting. During the November 1981 meeting, the Board was informed of the Reagan administration's possible proposals for reductions in Medicare spending, and during the January meeting, the board discussed a new proposal from the Reagan Administration that would have limited

Medicare reimbursement to 98 percent of allowable costs. The Board concluded that this proposed reduction to 98 percent of allowable costs was less desirable than the previously proposed plans for reducing Medicare expenditures. During the other Board meetings, the staff informed the Board of developments in the Medicare reimbursement limits.

In other deliberations, the Administrative Board focused on several topics: the AAMC's study of teaching hospital characteristics, the report of the Association's ad hoc Committee on Health Planning, the impact of proposed tax-exempt financing restrictions, the Health Care Financing Administration's (HCFA's) regulatory proposal for prospective reimbursement of dialysis services, the declining availability of graduate medical education positions at teaching hospitals, the status of nurses, and COTH/AAMC sponsorship of a capital purchasing program. The Administrative Board held informal discussions with a director of a state hospital rate setting program, a representative of business and industry health care interests, and an official from the Congressional Budget Office (CBO) as prologues to three of its meetings. Harold Cohen, Executive Director of Maryland's Health Services Cost Review Commission, discussed the evolution and success of hospital rate setting in his state. Willis Goldbeck, Executive Director of the Washington Business Group on Health, reviewed developments in the area of business coalitions, employer self-insurance, and preferred provider arrangements. Paul Ginsberg, CBO Deputy Assistant Director for Income Security and Health, discussed his agency's evaluation of the proposed Medicare and Medicaid budget reductions and its assessment of the American Hospital Association's prospective Medicare payment proposal.

#### 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 full membership are:

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

In addition to these two criteria, consideration will be given to a hospital's participation in medical education activities such as undergraduate clerkships, the presence of full-time chiefs of service, the proportion of residents that 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 sent to institutions in the full membership category. The present membership of the Council of

Teaching Hospitals includes 421 full teaching hospital members and 29 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. Information on how to purchase those of these publications that are available to the public is contained in Appendix D.

### 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 reviews: Association and Council activities; federal legislative and regulatory issues of relevance to the academic medical and teaching hospital communities; 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 to receive this publication.

### COTH Directory of Educational Programs and Services

Annually, a directory containing a profile of each COTH member hospital is prepared and distributed to all COTH members. The Directory includes selected operational and education program data on each member. Questionnaires for the 1983 Directory were mailed in July and September, 1981, depending on the hospital's fiscal year. The 1983 Directory will be published early next year. Copies of the Directory are priced at \$7.00 per copy.

### COTH Executive Salary Survey

Each year, the Department of Teaching Hospitals collects information on the salaries and fringe benefits of 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 eleven years, 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 \$7.00 each.

### Case Mix Studies of Teaching Hospitals

Two technical reports, one entitled "The DRG Case Mix of a Sample of Teaching Hospitals" which was released in December of 1981, and the other entitled "The Disease Staging Case Mix of a Sample of Teaching Hospitals" which was published in February of 1982, reported on significant observations from COTH's on-going study to describe the teaching hospital. These companion reports examined data from a sample of teaching hospitals, including on the diagnosis and conditions of patients, the costs of treatment, and the charges for the patients. In the diagnosis related group (DRG) study, the patient classification system developed at Yale University was used to categorize 556,150 patients discharged during 1978 from 24 of the study hospitals. This study lists the most common DRGs and the most costly DRGs, calculates expected lengths of stay and expected costs-per-case for the hospitals based on their case mix, and computes case mix indices for the hospitals using different factors to assign relative values to each DRG. This report is available at a cost of \$6.00.

In the second report, the recently developed "disease staging" approach is used to classify patients. This approach subdivides each of 400 major disease categories (grouped based on diagnoses) into four stages of acuity ranging from a condition with no complications to death. This study also computes expected lengths of stay, expected charges per case, and expected estimated costs per case using disease staging. It examines the diversity of diagnoses and stages of acuity within those diagnoses of patients in teaching hospitals. This document is available at a cost of \$8.00.

### Quality Assurance and Cost Containment

The teaching of quality assurance and cost containment to undergraduate and graduate medical students and allied health professionals was the focus of two AAMC prepared publications released in October, 1982. The texts, Teaching Quality Assurance and Cost Containment in Health Care: A Faculty Guide and Principles of Quality Assurance and Cost Containment in Health Care: A Guide for Medical Students, Residents, and Other Health Professionals, are the first books to appear in the Association's Series in Academic Medicine to be published by Jossey-Bass Inc. The books offer faculty and curriculum planners numerous suggestions on how to facilitate the introduction of cost containment and quality assurance instruction into medical education and provide excellent materials for self-instruction. They also provide a systematic five-stage approach to conducting quality assurance and cost containment studies, using a methodology analogous to the stages of the clinical management of patients. In addition, the

detailed case histories presented on quality assurance and cost containment studies conducted in actual delivery settings illustrate how the concepts and theories presented in the two texts can be applied in practice. These books are available from Jossey-Bass Publishers, 433 California St., San Francisco, Calif. 94104, at a cost of \$19.95 for the Faculty Guide and \$14.95 for the Guide for Medical Students, Residents, and Other Health Professionals.

### ACTIVITIES OF THE DEPARTMENT OF TEACHING HOSPITALS

The Department of Teaching Hospitals worked on several major projects during 1981-82. These projects were a study of teaching hospital characteristics; the Budget Reconciliation Acts of 1981 and 1982; proposed tax-exempt financing restrictions; health care competition; health planning; legislative and regulatory analyses; and surveys and publications.

#### Study of Teaching Hospital Characteristics

For the past two years, AAMC staff has been conducting a study of the characteristics of 33 members of the Council of Teaching Hospitals (COTH) in an effort to describe the characteristics common to a majority of teaching hospitals. Under the guidance of the AAMC Committee on the Distinctive Characteristics and Related Costs of Teaching Hospitals, chaired by Mark S. Levitan, chairman-elect of the COTH Administrative Board, the first two in a series of study reports were published during the 1981-1982 year.

"The DRG Case Mix of a Sample of Teaching Hospitals: A Technical Report," was published in December. It presented data on patient case mix in 24 of the study hospitals using the "diagnosis-related groups" (DRGs) methodology developed at Yale University. This study showed that based on a sample of teaching hospitals, COTH members provide significant amounts of tertiary care in addition to, but not instead of, care for relatively routine types of patients. The report is useful to teaching hospitals wishing to compare their own costs, charges, and lengths of stay for all patients or just for Medicare patients with a given diagnosis to that of a sample of their peers. It also provides case-mix indices, which are measures of the relative complexity of a hospital's mix of patients, and describes many of the difficulties encountered in trying to classify patients into DRGs and then trying to match those records to billing data.

In February 1982, "The Disease Staging Case Mix of a Sample of Teaching Hospitals: A Technical Report," was published and presented data on patient case mix in the same study hospitals using the "disease staging" methodology developed by Joseph Gonnella of Jefferson Medical College and others. This methodology separates each major disease category, of which there are 400, into four levels of severity ranging from an uncomplicated condition to death. Using this classification scheme, the sample of teaching hospitals were shown to have 14 percent of their patients in the most severe category of illness next to death. This report also provides useful comparison data on the costs, charges, lengths of stay and case-mix indices as calculated using disease-staging of the sample of teaching hospitals.

The department continues to work on two final documents which will describe and present data on the patient care, research, and teaching missions of COTH member institutions. One of these documents is being written for dissemination to



a wide audience which has limited familiarity with teaching hospitals. This audience includes congressmen, members of the press, and community and business leaders interested in teaching hospitals. The second document is designed to be used by COTH members only. It contains more detailed data on services provided, patients seen, and the costs of care in teaching hospitals. These documents are expected to be published shortly.

### 1983 Budget Reconciliation Activities

The federal government's Fiscal Year 1983 budget was developed through the budget reconciliation process. Working from the President's FY 1983 budget requests, a First Concurrent Budget Resolution was approved by Congress in June 1982 after months of struggle and heated partisan debate.

Early in the FY 1983 federal budget process, the AAMC wrote President Reagan to strongly oppose his proposals to achieve over \$950 million in entitlement program cuts from across-the-board reductions of two percent in Medicare hospital reimbursement and three percent in federal payments for optional services under Medicaid. The Association argued: "These proposals will have a particularly adverse impact on the nation's academic medical centers and their teaching hospitals, which provide a large proportion of care for the poor and the elderly. Cutbacks in Medicare, Medicaid and social welfare programs disproportionately increase the financial burden on the teaching hospitals that already are facing fiscal difficulties in maintaining their unique role in the education of medical students, residents and other students in the health professions, the advancement of knowledge through bio-medical research, and the provision of complex care at the cutting edge of medicine." Responding to such opposition and particularly to concerns about the potential for increased cost-shifting to private paying patients, Congressional committees abandoned both proposals.

In place of the President's proposals, Congress adopted Medicare, Medicaid, and tax changes as part of the "Tax Equity and Fiscal Responsibility Act of 1982." These changes were the result of work by the Senate Finance Committee, the House Ways and Means Committee, and the House Energy and Commerce Committee. The major changes to Medicare in this Act are expansion of the Section 223 limits on reimbursement for routine costs to include ancillary costs; the addition of a "target rate" limit on hospital expenditures; elimination of the Medicare routine nursing cost differential; and the imposition of new reimbursement limits on pathologists, radiologists, and other hospital-based physicians. The law also mandates that Health and Human Services draft a prospective reimbursement system by December 31 of this year.

The Association wrote to the House and Senate committees during the developmental stages of this legislation to encourage them to set the Section 223 limits at 120 percent of the mean cost-per-admission for each hospital group, rather than at the 110 percent that the Senate committee advocated, and to urge that the limit include provision for case-mix and resident-per-bed adjustments. The AAMC Executive Council had adopted a policy earlier in the year that called for the Association to actively pursue explicit recognition of hospital patient mix (including differences in diagnosis, intensity of illness, and type of patient) in all hospital payment limitations and prospective payment systems.

The AAMC advocated the adoption of the three-year "target rate" reimbursement concept developed by the House Ways and Means Committee. It urged adoption of the provision requiring HHS to report prospective payment proposals by December 31 and provide an appropriate opportunity for full debate and legislative action on any

future prospective payment system. The AAMC favored retention of the routine nursing salary differential (i.e., an additional five percent) as adopted by the House Ways and Means Committee. One provision prohibits reimbursement for assistants at surgery in hospitals where a training program exists in that specialty, except under exceptional medical circumstances. The AAMC had strongly recommended that conference report language include the following statement to ensure that hospitals with integrated or affiliated residencies are not penalized for cases where a resident is not included on the operating team: "The Committee does not intend this provision to apply in surgical cases where the operating surgeon does not involve residents in the care of patients." This language was not incorporated in the committee report. One provision originally considered by the Senate was the elimination of the physician fee economic index for FY 1983. To help retain physician acceptance of "assignment" patients, the AAMC opposed this freeze on physician fees. This provision was eliminated. To assist financially distressed hospitals, the AAMC urged approval of language providing exceptions to such institutions from proposed delays in Medicare Periodic Interim Payments (PIPs).

#### Action Necessary to Preserve Tax-Exempt Bond Status

In its correspondence to the conferees, the AAMC also urged adoption of a Senate-approved provision which exempted 501(c)(3) organizations (e.g., non-profit hospitals and universities) and student loans from all of the tax-exempt bond use restrictions proposed other than a bond registration requirement. The AAMC's efforts to oppose tax-exempt bond limits had begun when Treasury Secretary Donald Regan indicated that the Administration planned to introduce a legislative proposal to eliminate or limit significantly the availability of federal tax-exempt bond financing for non-profit hospital construction, according to the January 12, 1982 New York Times. On the basis of the Secretary's statements which described misuse of industrial development bonds by "hamburger stands and unneeded hospitals," the AAMC presumed legislation would be designed to prevent construction of excess hospital beds financed with tax-exempt bonds. Taking issue with the Secretary's contention, the Association wrote Secretary Regan to request that the Administration continue to make available the use of tax-exempt bonds by non-profit hospitals. The Association recommended that the Administration consider: (1) there is no evidence linking tax-exempt financing to hospital overbedding; (2) governmental and marketplace mechanisms exist to monitor need for hospital capital expenditures and need not be duplicated or displaced; (3) the Treasury's estimated revenue loss due to tax-exempt hospital bond issues is overstated; and (4) tax-exempt financing for non-federal, non-profit hospitals is both appropriate and necessary in the public interest. A similar letter was sent to all members of the House and Senate Budget Committees, the Senate Finance Committee, and the House Ways and Means Committee.

Subsequently, it was learned that the proposed legislation would apply to all 501(c)(3) organizations, including hospitals and educational entities and would require that: (1) after 1985, the bond user receive a contribution or commitment equal to one percent of total project costs from the government issuer by means of a tax credit or abatement, provision of service, insurance or guarantee of the bond, payment of the bond issuance expense or cash; (2) each bond issuance be approved by the highest elected official or legislative body of the government unit issuing the bond, effective upon enactment; (3) each bond be registered with the Internal Revenue Service; (4) a restriction be placed on the arbitrage income derived from the short-term investment of bond proceeds; and (5) straight-line depreciation be used for assets financed with such bonds. The AAMC joined with the Association of American Universities, the National Association of State

Universities and Land-Grant Colleges, the National Association of Independent Colleges and Universities, and other higher education organizations to oppose application of the restrictions to both hospitals and educational entities. Key Congressmen were alerted about the devastating impacts that the proposed bond restrictions would have on non-profit hospitals, higher education and students. They were urged to reject the Administration's position and endorse existing law regarding 501(c)(3) organizations and student loans in relation to tax-exempt bond use. The Association and other organizations were successful in getting Congress to exclude 501(c)(3) organizations from this legislation except for the registration requirement.

#### Testimony Given on Concerns Over Competition Proposals

Several proposals designed to stimulate competition in the financing and delivery of health care were introduced in Congress during the past year. These included H.R. 850, the "National Health Care Reform Act," sponsored by Representative Richard Gephardt (D-Mo.); S. 433, the "Health Incentives Reform Act," introduced by Senator David Durenberger (R-Minn.); and S. 139, the "Comprehensive Health Care Reform Act," introduced by Senator Orrin Hatch (R-Ut.). Although revenue savings from a health care competition proposal have been projected in the budget request submitted by the President both this year and last, no such formal legislation has been proposed by the Administration.

In October 1981, Earl Frederick, president of The Children's Memorial Hospital in Chicago, testified on behalf of the Association before the House Ways and Means Health Subcommittee at hearings on the major "pro-competition" bills. Mr. Frederick emphasized that, "it is important to remember that there has been no wide-scale experience with these approaches. This is particularly significant because the proponents of price-competition among hospitals 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." For the teaching hospital to be competitive in a price-dominated marketplace, the Association explained that two broad issues must be addressed: funding for charity care patients and funding for the unique societal contributions of teaching hospitals. These societal activities include the clinical component of undergraduate and graduate medical and allied health education, technology transfer and dissemination, community-wide tertiary care services with high stand-by costs, and primary care ambulatory services in medically underserved areas. 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. However, the Association's testimony described the potentially negative impacts of this approach and the resultant inability of teaching hospitals to identify a solution to the problem their societal missions create in a price competitive environment.

Throughout the year, AAMC staff worked closely with the staff of Rep. Gephardt to find means by which to address the teaching hospital's unique societal contributions within his "pro-competition" measure. At the request of the Congressman's staff, the AAMC obtained from the American Hospital Association's 1981 Annual Survey of Hospitals an analysis of the charity and bad-debt deductions for the nation's short-stay, non-federal hospitals. The results were startling. Of the total number of such hospitals nationwide in 1980, 5.6 percent (or 327) were non-federal members of the Association's Council of Teaching Hospitals (COTH). These COTH hospitals incurred 47 percent (\$601 million) of the charity

care deductions and 35 percent (\$1.2 billion) of the bad-debt deductions of all short-term non-federal hospitals nationally in 1980. These data provided a clear measure of two of the special societal costs borne by teaching hospitals and support the Association's position that consumer choice/price-competition proposals for restructuring health services pose a special risk for teaching hospitals unless improved financing is obtained for patients who are unable to pay for their care. This concern as well as others presented in the Association's testimony before the House Ways and Means Health Subcommittee were reiterated by Mark Levitan, the COTH chairman-elect, at hearings conducted in March 1982 by the National Council on Health Planning and Development. Although Mr. Levitan extensively discussed the potential effects of competition on teaching hospitals, his testimony could not specifically address the role of health planning because an AAMC ad hoc committee was still in the process of developing a position on health planning.

#### Role for Health Planning Advocated by Association, Debated by Congress

A position statement on health planning was approved by the Association's Executive Council in April, 1982. It stated that the Association supports the concept of community-based health planning. It called for repeal of PL. 93-641 and enactment of an entirely new streamlined federal health planning law that would encourage the continuation of local health planning on a voluntary basis and mandate state-level certificate of need (CON) review. The Association decided not to oppose limited federal technical assistance funding for the voluntary local planning component. Compliance with the CON mandate would require establishment of state legal authority for CON review and development of a State Health Plan, and would be enforced through withholding of federal payments under certain health block grant programs. In addition, the Association believed the federal government should make funds available to assist in the ongoing operation of the state programs, but its contribution must not exceed one-third of the yearly state CON program costs incurred. The position statement advocated that CON review authority should: cover all providers but be restricted to proposed capital expenditures which involve only direct patient care projects that exceed a dollar threshold of \$600,000; provide for expeditious reviews; index the dollar value for proposed projects to inflation; and provide due process protection for applicants. The revamped program must continue to give special consideration in planning activities to the unique roles and needs of medical schools and teaching hospitals in fulfillment of their patient care, education and research missions, according to the Association's position. The statement was sent to all members of the Senate Labor and Human Resources and House Energy and Commerce Committees, which have primary jurisdiction over planning.

In late April 1982, the Senate Labor and Human Resources Committee rejected an amendment offered by Senator Lowell Weicker (R-Co.) that would have extended the current health planning program through 1985 with small modifications. On the House side, three bills had been introduced -- H.R. 4554 by Representative Richard Shelby (R-Al.) to repeal PL. 93-641 immediately without replacement, H.R. 6084 by Representative Henry Waxman (D-Ca.) which would have revamped and streamlined the existing program, and H.R. 6173 by Representative Edward Madigan (R-Ill.) which would have created an optional block grant to states for health planning.

By May, the AAMC had become a member of a coalition representing health care providers, health insurers, health planners, state and local governments and business and industry who wished to promote a revised health planning program. Recognizing the bipartisan support demonstrated in the House for health planning

by Representatives Waxman and Madigan, the coalition worked closely with the Congressmen's staffs in order to develop compromise legislation that would have broader Congressional support and be acceptable to the Administration. After extensive negotiation, Representatives Madigan and Waxman devised a compromise measure which the full House Energy and Commerce Committee agreed to support on the House floor. Committee chairman John Dingell (D-Mi.) and Representatives Shelby and James Broyhill (R-N.C.) were also instrumental in these negotiations. The compromise measure would repeal the current planning law and establish a health planning block grant in its place that would be authorized for two years (through Fiscal Year 1984). The block grant would provide authorizations of \$32 million for voluntary state-level health planning in 1983. Another \$32 million would be authorized as "pass-through" matching grants for local health planning activity. This funding would be optional to the states and could be met with the assistance of private sector funding. The matching funds would receive 100 percent federal support in FY 1983 and 85 percent in FY 1984.

States choosing to receive block grant funds for state-level health planning would be required to develop State Health Plans and perform certificate of need (CON) review. CON review thresholds under the compromise bill would be established in ranges from \$1 million to \$5 million in capital expenditures (up from \$600,000 at present) and from \$500,000 to \$1 million for the operating costs of new or expanded "institutional health services" (up from the current \$250,000). CON reviews of capital investments would include coverage of major medical equipment, which is specifically required under present law at a \$400,000 threshold. Only acute inpatient and long-term care facilities would be subject to review. This measure passed the House by an overwhelming margin shortly before Congress adjourned for the November elections.

In July, a health planning bill entitled "The Health Planning Deregulation Act of 1982," S. 2720, was introduced by Senators Dan Quayle (R-In.), Orrin Hatch and Paula Hawkins (R-Fl.). The "bare bones" measure would authorize for one year only \$20 million in block grant funds. These federal funds would be optional to the states but could not be used for certificate of need or other regulatory programs. States choosing to take part in the program would be permitted to use the funds to assist in meeting "not more than 75 percent of the costs of activities relating to (a) state or local health planning and (b) experiments designed to demonstrate non-regulatory strategies to promote competition in the financing and delivery of health care." In addition, the bill would prohibit the use of federal funds for "any state or local activity that regulates the planning, allocation, financing or delivery of health care resources or services, including a certificate of need program or a program regulating the amounts charged by providers of health care."

The Association wrote to each of the co-sponsors of S.2720, requesting revision of the legislation to achieve greater compatibility with the House compromise measure. Specifically, the AAMC advocated that at least \$65 million be authorized in S. 2720 and split evenly between a block grant for state level planning activities and matching grants to encourage grassroots, local planning efforts. It also recommended that block grant funds be permitted to be used for CON programs in states opting to receive such funds and believed that this approach would be in accord with the Administration's efforts to augment state discretionary authority. In addition, the Association recommended that the length of program authorization in the Senate bill be extended to at least two years and that the unique roles and needs of academic medical centers/teaching hospitals continue to be accommodated in the health planning process. The Senators appear reluctant to allow any amendments to their bill on the floor of the Senate, but

have indicated that they may be willing to compromise on several issues that are of concern to the Association during the conference with the House. Further action is expected on the Senate measures after the November elections.

#### Association Responds to Proposed Changes in Regulations, Policies

During the year, the Association responded on several occasions to proposed regulations or policy changes that would affect teaching hospitals participating in the Medicare and Medicaid programs. In September 1981, the AAMC commented to the Health Care Financing Administration (HCFA) in opposition to a proposed rule that would eliminate a regulation requiring states to announce reimbursement changes under Medicaid 60 days in advance of their implementation. It was feared that the proposal would permit states to change Medicaid reimbursement without requiring them to notify providers prior to the change. The AAMC noted that the proposed rule overlooked an important reason for having the 60-day notification rule: the opportunity for institutions and the public to offer constructive evaluation and advice. The Association felt it would be unfortunate if this opportunity were eliminated solely because states desire to expedite their administrative affairs and relieve short-term budget constraints.

In January 1982, the Association commented on a proposed revision to the Medicare Provider Reimbursement Manual regarding the treatment of seed money contributions. The Association took issue with proposed language that would redefine "seed money grants" to include contributions only when they pertain directly to patient care services and establish a new provider or enable an existing provider to furnish a type of health care service it previously did not furnish. The Association urged that seed money contributions be allowed to assist any hospital operation in which Medicare shares in the allowable costs. Thus, it was emphasized that seed money contributions should be allowed not only for the addition of new patient care services, but also for establishing new residency programs and the expansion of existing patient care services.

In March 1982, the Association commented on a proposed "clarification" issued by HCFA for sections of the Provider Reimbursement Manual. The so-called clarification was believed to actually constitute a major substantive change in HCFA policy by eliminating payment to hospital associations for start-up monies invested in new membership service programs designed to reduce hospital costs. It was noted that such programs have included centralized purchasing services, group warehousing, management engineering consulting, combined laundry, and malpractice insurance activities. In order to avert a substantial barrier to such cost-effective innovations, the AAMC strongly recommended that HCFA withdraw its proposed changes entirely.

In April 1982, the Association responded to regulations proposed by HCFA to establish a prospective payment rate for maintenance dialysis under Medicare's End-Stage Renal Disease (ESRD) program. These prospective payment rates would apply for such dialysis, whether furnished at home or in a hospital-based or independent dialysis facility. However, the rates paid to hospital-based facilities would be slightly higher. In comments submitted to the HCFA Administrator and the House Ways and Means Subcommittee on Oversight, the AAMC emphasized five points on the impact of the proposed payment regulations on teaching hospitals: (1) the ESRD program is not a cost-ineffective program, rather it is one which is providing services for an ever-increasing population of patients at similar average cost to previous years; (2) an increase in the use of home dialysis will actually be undermined by the regulations, penalizing hospital-based facilities, the chief source of patients dialyzing at home; (3) the

rate structure is grossly deficient as it is based on old, inadequate data used to establish a methodology which fails to carry out the Congressional directive for a dual rate structure (instead, there is evidence that it was constructed to generate a predetermined savings, rather than reflect an objective analysis of facility cost); (4) the proposed regulations fail to recognize that hospital-based facilities care for a population of dialysis patients who are sicker and have greater potential for complications on dialysis than those dialyzed at free-standing facilities; and (5) the exceptions process established by the proposed regulations is one that looks with disfavor on the granting of exceptions and would be inadequate to provide hospital-based facilities relief from the adverse effects of the proposed rates. The Association urged the Oversight Subcommittee to recommend that HCFA suspend its plan to implement the proposed regulations until it develops a methodology for hospital-based dialysis which uses up-to-date, accurate data and which accounts for the particular needs of hospitals and their patients.

In July 1982, the Association wrote to HCFA to express its views on proposed revisions to the rules governing Medicare and Medicaid survey and certification of health care facilities. While applauding HCFA's efforts to simplify and streamline these regulations, the AAMC identified three areas in the proposed regulations where changes could further avoid unnecessary regulation, duplication and expense. These were: (1) survey cycles should not be different for hospitals and their extended care facilities and nursing homes; (2) the protection provided to maintain the confidentiality of hospital accreditation survey information should be extended to their intermediate care and skilled nursing facilities; and (3) Joint Commission on Accreditation of Hospitals (JCAH) accreditation of providers who participate in both Medicare and Medicaid should be accepted for certification in both programs.

In August, the AAMC wrote to the Department of Health and Human Services advocating that it not abridge or revoke its commitment to allow public comment on proposed rules. The AAMC was writing to comment on a proposed rule appearing in the June 22 Federal Register that would have absolved the Department of Health and Human Services of its obligation to elicit public comments on all proposed rules relating to public property, loans, grants, benefits, and contracts. This would include rules on the Medicare and Medicaid programs. According to the notice in the Federal Register, HHS intended to allow public comment in most instances; however when, in its judgement, the delay in issuing final rules would prevent the implementation of a beneficial program or when the rules were so minor and technical in nature that public comment could not be anticipated, the Department would have the option to forego the usual public comment. Previously, HHS had used the Federal Register to notify the public of proposed changes in the rules that govern its many programs and to invite public comment on these proposed changes. The Administrative Procedure Act provides that an agency may waive the 30-day public comment period where "good cause" for such waiver exists. The Department's proposed rule change would go beyond this authority to waive the public comment period by allowing the Department the sole judgement on when it should or should not allow time for comments. "This could lead to arbitrary and capricious use of the waiver of the comment period since it means that only the Department will be judging itself on when to use the comment period," wrote the AAMC. The Association advocated that HHS withdraw its proposed change and continue to allow the public to participate in the rule making of the Department. The Congress, press and others also opposed this change. No action has been taken on this proposed rule as of this writing.

## Long Term Care Project

During the past year, under a two-year cooperative agreement with the Administration on Aging (AoA), the AAMC continued to provide technical assistance to a group of Long Term Care Gerontology Centers (LTCGCs) nationwide. The Centers are based in or affiliated with medical schools, and have been awarded grants for research, development of education and training programs and service models, information dissemination and technical assistance to address many of the problems identified in long term care.

Under the AoA-sponsored project, AAMC staff has identified field consultants to assist centers in both early and advanced stages of planning, conducted three workshops to address common organizational problems and develop strategies for improving coordination among the centers, and developed a management information system for use in gathering aggregate data on the centers' activities for AoA internal management and public accountability purposes. Through newsletters, workshop reports and ad hoc informational memos, the AAMC staff has also disseminated information on the types of research, education and training, and service models in which the LTCGCs are engaged. In addition, a two-volume annual report was produced which described the collective accomplishments of the first five operational Long Term Care Gerontology Centers in the country. These facilities have been monitored and assisted by the AAMC project staff.

## HMO Relationships

During the past year, the proceedings were published for a national conference cosponsored in late 1980 by the AAMC and the Henry J. Kaiser Family Foundation on the subject of affiliations between academic medical centers (AMCs) and health maintenance organizations (HMOs). The benefits and risks to both AMCs and HMOs of these affiliations were explored. Case histories were used to describe various forms of prepaid practices, the different types of relationships that can exist between AMCs and HMOs, and the organizational, financial and educational considerations associated with these associations.

The publication, Health Maintenance Organizations and Academic Medical Centers, is available from the Kaiser Family Foundation. It contains the major presentations made at the conference, as well as summaries of the discussion of issues raised by participants. The conference proceedings add substantially to the body of knowledge on affiliations between prepaid plans and academic medical centers. In addition, three broad conclusions are made: (1) there is a need to find resources to support medical education in prepaid practice settings; (2) large tertiary care hospitals will increasingly be competing with secondary care community hospitals for patients referred by physicians in prepaid practice; and (3) relationships in which AMCs and HMOs retain a high degree of independence are advantageous to both types of organizations.

In related activity, the Association, in conjunction with the Department of Community Health of the Tufts University School of Medicine, currently is conducting a survey to identify: (1) the extent of undergraduate clinical medical education involvement at prepaid health care plans (i.e., HMOs and IPAs) and, (2) the methods and data being used to analyze the costs associated with medical education in these settings. This information is being sought in light of the pressures to expand prepaid health care plans and the growing interest of academic medical centers in this method of delivering medical services.

Among ad hoc hospital activities during the past year, the Association



conducted a survey of the Medicare documentation experiences of COTH members in relation to complying with the requirements of section 227 of the 1972 Medicare amendments. This section established special payment provisions for physicians' services provided in teaching hospitals. Additionally the AAMC evaluated proposed revisions to the Medical Staff chapter of the Joint Commission on Accreditation of Hospital's Accreditation Manual for Hospitals.

#### COTH SPRING MEETING

The fifth annual Council of Teaching Hospitals (COTH) Spring Meeting was held on May 12-14 in Boston. The two-day session is designed to bring together the CEO's of member hospitals to discuss the health care issues facing them and to interact informally. Attracting a record of 225 chief executive officers and their associates, the meeting sessions focused on the increasing competition among and between hospitals and other providers for patients, new programs and services, community support and financial resources.

#### Projections for 1983 and Beyond

The meeting began with three papers describing major environmental features faced by hospitals. The keynote speaker at the opening session was John Iglehart, special correspondent for the New England Journal of Medicine, who addressed "The Washington Perspective: Political and Budgetary Expectations For 1983 and Beyond." Iglehart noted that the trends under the Reagan Administration have been: (1) encouraging competition and permitting the free market to take its toll; (2) a reexamination of the limits of public benevolence; and (3) less government regulation and reduced taxation. In health care, he felt that the primary target in attacking the growth in government spending is the Medicare program.

Iglehart described these trends as a societal phenomenon, not a Republican one and predicted the process of decreasing government size would continue regardless of who is in office. Regarding teaching hospitals, he suggested that Washington policymakers perceive such institutions, particularly those which are publicly-owned, as having "weak managements" with "insufficient control" over their operations. He cautioned that teaching hospitals can no longer live in yesterday's resource rich world and would face increasing pressure to downsize and identify their component costs more specifically.

#### Effect on Physician Manpower

The second speaker was J. Robert Buchanan, M.D., president of Michael Reese Hospital and Medical Center. Dr. Buchanan addressed the topic of: "Regulation, Competition and Physician Manpower Projections: The Issues Before Us." Dr. Buchanan described the evolution of present national health policies and the potential impacts of increased physician supply. He described the past three decades in medicine as a "superb response to increasing demand and the need to democratize health care in the U.S. by achieving a single standard of health care through equal access." However, he noted, that achieving this has been costly - health care spending now equals 10 percent of the Gross National Product (GNP) and personal health care spending has risen in the past decade from \$212 to \$1,200 per person. While federal regulation has offered a "blanket of security: which has increased access to care without loss of quality, he felt that such regulation has provided insufficient incentives to control costs.

Dr. Buchanan emphasized that the health care industry cannot prosper under the Reagan Administration in the "same old way." He described the

Administration's competition orientation and its potential for success as dubious because the health care system does not fit into the classical model of supply and demand. He predicted that "competition would beget more regulation, not more competition." He suggested that currently proposed competition strategies fail to account for the unpredictability of the consumer and the protection of teaching hospitals and their charity care, education and research functions. If such factors are not addressed, Dr. Buchanan foresaw a return to a two-tier system of medical care, reduced access for those most in need, and a painful period for teaching hospitals. He suggested a more desirable system would: (1) be perspectiveally financed; (2) provide for consumer participation in the payment process; and (3) provide for care of the poor. He closed by warning that the nation should not "enact social Darwinism and destroy the values of the current system through vigilante actions, for a social deficit will lead to a greater economic deficit."

### State Rate Setting

Bruce C. Vladeck, Ph.D., assistant vice president at the Robert Wood Johnson Foundation and former assistant commissioner of health responsible for the New Jersey State Rate Setting Commission, then spoke on the subject of "State Rate Review and Health Planning: Regulatory Alternatives to Competition." Dr. Vladeck began by stating that "the evidence accumulated has demonstrated that state rate regulation of hospitals works." He then cited reports by the U.S. General Accounting Office and Congressional Budget Office which found that the rate of hospital cost increase in the six states with mandatory state regulation has been 2 to 3 percent lower than in other states. He felt that two factors about state rate review promote this slower rate of increase: (1) the need to justify costs and needs in a public forum and (2) the treatment of a productivity (net intensity) factor and allowance for growth and improved quality. He cited the Maryland and New Jersey systems as the best examples of the success of rate review. These programs, he explained, are based on true prospective reimbursement in which all payers participate and there is a uniform system of payment in which providers share the costs of charity care. Therefore, under these systems, those institutions with large non-paying populations have a better opportunity to recover their costs of operation.

After further extolling the virtues of state rate review, despite what he called the "problem of New York" and its excessively stringent regulatory program, Dr. Vladeck warned that policymakers believe that federal and state governments are paying more for health care than they can afford and that revenues will become increasingly unavailable at the state and local levels. He suggested that one of two directions could be followed: (1) replacing reduced public support by subsidization from private patients or (2) moving to a prospective financing system involving reduced Medicare and Medicaid payments at the federal level or all payers at the state level. He felt that there would be a growing consensus that state level rate review would be preferable as money decisions are made increasingly at that level, with only basic ground rules from Washington. He also believed the cross-subsidization approach would be unlikely to maintain itself over an extended period of time as payers become increasingly resistant to cost shifting.

### Not-For-Profit Chains

Scott S. Parker, president of Intermountain Health Care, Inc., of Salt Lake City, Utah, spoke on the subject of "Not-for-Profit Chain Operations: Assessing Their Impact and Looking to Their Future." Mr. Parker began with some growth

indicators for hospital systems. He noted that in 1950, there were 261 hospitals in systems - in 1979 there were 1500. In the decade 1970-79, 900 hospitals joined systems. In 1965, three percent of all hospital beds belonged to systems; in 1980, the figure was 30 percent. In his home state of Utah, Parker stated, only four of more than 50 hospitals are not part of a systems.

Mr. Parker reviewed the theoretical rationale for hospitals to develop systems: (1) the ability to respond more effectively to cost containment pressures (e.g., through shared services and improved management systems); (2) the ability to attract management specialists and develop career paths within the organization for hospital managers; (3) the ability to improve quality through modernization, internal peer review, reduced duplication and innovative technologies; and (4) the ability to develop the political stature to deal as an equal partner in the political processes affecting hospitals.

Looking to the future, Parker saw regional systems, like Intermountain's not-for-profit system continuing to grow through mergers, acquisitions and management contracts and leases. They would also extend their services to other hospitals on contractual bases for insurance, data processing, management engineering and quality assurance. He went on to say: "There will be stronger national alliances through organizations such as Associated Hospital Systems, and then there will begin to be the coming together of the regional not-for-profit systems into organizations of national profile. In the beginning, this will occur through loose affiliations, later through joint ventures, and finally through consolidations."

#### The VHA Collective Approach

The next speaker was Allen M. Hicks, chairman of the board of Voluntary Hospitals of American (VHA) and president of Community Hospital of Indianapolis. Mr. Hicks agreed with Mr. Parker's projections for the consolidation of regional not-for-profit systems in the future. He then described the background of VHA, a four-year old voluntary, not-for-profit system of 30 hospitals, averaging 700 beds in size, with 70,000 employees and about \$2.5 billion worth of business yearly among them. He described eight essentials that VHA was working towards: (1) strong corporate institutional management; (2) a productivity and quality control program; (3) a human resources program for executive development; (4) a financial system with central reporting; (5) a national purchasing agreement; (6) a corporate capital financing plan; (7) its own insurance company and programs (for retirement, health, etc.); and (8) a public image building program. He emphasized strongly that the system's success is highly dependent on capital formation and commitment from the individual hospitals to the total system. He believed that VHA was exemplary of the ability of voluntary not-for-profit hospitals to remain viable and strong in an environment of increasing competition from proprietary organizations.

#### Governance at University Hospitals

Myles P. Lash, executive director of the Medical College of Virginia Hospitals and Fred Munson, Ph.D., associate professor at the University of Michigan's Graduate Program in Hospital Administration, addressed the subject "Competition Confronting University Hospitals: Its Impact on Patterns of Governance." After reviewing the various health care competition proposals under consideration by policymakers and the impact of competition already felt by his institution in Richmond, Mr. Lash described his views on what academic medical

centers would have to do to adapt. He felt they would have to "step away from their rather mundane, routine operational problems and develop comprehensive strategic plans to cope." Inevitably, he asserted, "the competition will force academic health centers and their present universities to review the effectiveness of their decision-making processes, particularly the issue of governance for the university-based teaching hospital." He warned, "if our institutions do not adapt, ...there may be selected institutional failures."

Dr. Munson then described preliminary findings from research funded by the Consortium for the Study of University Hospitals, which focuses on the management and governance of such institutions. Professor Munson explained that the basic study objective is "to understand the impact of the local environment in helping or hurting the university hospital's capacity to respond to the larger environment it shares with other teaching hospitals." He described an early observation which found a weak relationship between internal structural clarity (as defined by a clear executive leadership role and decision structure) and hospital viability as measured by common financial ratios.

#### Non-Hospital Based Competition

A presentation entitled "Non-Hospital Based Competition: An Entrepreneurial View" was then given by Karl G. Mangold, M.D., president of The Fischer Mangold Group of Emergency Physicians. Dr. Mangold began by claiming that his network of neighborhood clinics located in several locations nationwide can deliver the same acute care emergency services as teaching hospitals for half the cost, in half the time and by courteous people. He predicted that his and other types of competition to hospitals would force many of the chief executives in attendance to look for new jobs in 1986 or 1987 unless they adapt to the changing environment by: (1) acquiring and effectively utilizing the services of top notch marketers; (2) establishing a negotiating strategy with their medical staffs; (3) encouraging creativity in the management and delivery of their services; and (4) reassessing the composition and knowledge base of their hospital's board of trustees.

For teaching hospitals to compete, Dr. Mangold felt that an exceptional public relations effort would be needed to neutralize their "ivory tower" image of being excessively expensive, insensitive to patients and overly concerned about their reputations among the elite. Without a successful marketing program, he warned that his and other health care alternatives would skim the hospital's paying patients by offering a pleasant non-hospital environment with human contact and ambience, as well as convenience for both patients and physicians.

#### Corporate Reorganization

J. D. Epstein, principal in the Houston-based law firm of Wood, Lucksinger and Epstein, began his discussion of "Reorganizing for Operating and Financial Flexibility" by stating that use of such terms as "corporate reorganization" and "corporate restructuring" within the hospital industry has become almost faddish. While he felt strongly that such reorganization or restructuring is not appropriate for every health care institution, he did recommend that every hospital undergo a financial, operational, planning and legal reassessment of itself in light of the growing pressures on hospitals. He further noted that restructuring is a long-term measure and should not be viewed by hospitals as a short-term problem solution or means of quickly maximizing revenues or minimizing disallowances.

Mr. Epstein then reviewed the steps in doing an organizational assessment:

(1) develop a sound marketing plan; (2) assess the financial feasibility of the plan; (3) assess the legal and other ramifications of the plan; and (4) if the first three steps are met favorably, sell the plan to the hospital's board of trustees, involving certain board members early in the process where obstacles arise. He closed by emphasizing that successful organizational change must not forget the mission of the institution and is dependent on the existence of a strong management team and the operational flexibility to become part of a system in the future.

### Marketing the Teaching Hospital

"Marketing the Teaching Hospital's Products" was the topic of the presentation given by Jeff Goldsmith, Ph.D., director of Planning at the University of Chicago Hospitals. Dr. Goldsmith believes that "we are moving toward a system of brokered care where the purchasers will dictate the terms" of the arrangements made. These brokers will include state governors, private industry, insurers, Medicare and health maintenance organizations (HMOs). He viewed the hospital industry as extremely vulnerable to competition. Thus, he explained, strategic planning must precede marketing.

Dr. Goldsmith outlined those actions that would improve teaching hospitals' position:

- o increase organizational flexibility;
- o eliminate governance obstructions;
- o become preferred provider organizations (PPOs).
- o reduction of graduate medical education program size;
- o heal the breach between academic and community physicians;
- o foster training in ambulatory care and the provision of ambulatory services in the community;
- o further the hospital's understanding of its organization and market;
- o alter the institution's internal rewards system.

### Relationships With HMOs

Robert L. Biblo, president of the Health Insurance Plan of Greater New York, spoke on the subject of "Negotiating With Teaching Hospitals: An HMO Point of View" and reviewed some current examples of teaching hospital/HMO relationships. He noted that there are conflicting dynamics that motivate the two organizations, including: hospitals seek increased income, while HMOs seek to reduce hospital expense; HMOs try to satisfy the direct needs of their consumers, while hospitals have traditionally seen their major public as the physician; the cost reimbursement behavior pattern of hospitals versus the HMOs annual budget dynamics; and the hospital's need to fill beds versus the HMO's need to control utilization.

Mr. Biblo then reviewed the positive aspects of HMO affiliations: (1) possible willingness to share in the cost of teaching programs; (2) the ability of HMO physicians to get involved in teaching; (3) use of the HMO's ambulatory care

settings as teaching environments; (4) HMO physicians would participate actively in the professional committees of the hospital; (5) strong monitoring of admissions, length of stay and alternatives to hospital care; (6) mutually advantageous relationship in which a HMO centralizes its admissions at a particular institution; (7) HMO presence can help make marginal services more stable; (8) HMOS can assist in the marketing of the hospital; and (9) sharing of staff and equipment.

The COTH Spring Meeting concluded with a summary and analysis of the presentations and some personal commentary from Robert Zelten, Ph.D., associate professor at the Wharton School of the University of Pennsylvania.

APPENDIX A

COTH OFFICERS AND ADMINISTRATIVE BOARD

1981 - 1982

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James W. Bartlett, M.D. .... Strong Memorial Hospital of the Univ. of  
Rochester, N.Y.

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Terms Expiring 1982:

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

Earl J. Frederick ..... The Children's Memorial Hospital, Chicago,  
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John A. Reinertsen\* ..... University of Utah Medical Center, Salt  
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Terms Expiring 1983:

Spencer Foreman, M.D. .... Sinai Hospital of Baltimore, Md.

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

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

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\*COTH Representatives to the AAMC Executive Council.

Terms Expiring 1984:

Jeptha W. Dalston, Ph.D. ....	University Hospital, Ann Arbor, Mich.
Irwin Goldberg .....	Montefiore Hospital Association of Western Pennsylvania, Pittsburgh, Pa.
Sheldon S. King .....	Stanford University Hospital, Stanford, Cal.



APPENDIX B

COTH REPRESENTATIVES TO AAMC ASSEMBLY

1981 - 1982

Terms Expiring 1982:

Jess E. Burrow .....	Veterans Administration Medical Center, Sepulveda, Cal.
Laurance V. Foye, Jr., M.D. ....	Veterans Administration Medical Center, San Francisco, Cal.
Louis M. Frazier, Jr. ....	Veterans Administration Medical Center, Shreveport, La.
Earl J. Frederick .....	The Children's Memorial Hospital Chicago, Ill.
David W. Gitch .....	St. Paul-Ramsey Medical Center, St. Paul, Mn.
William H. Gurtner .....	Mt. Zion Hospital & Medical Center, San Francisco, Cal.
Roger S. Hunt .....	Indiana University Hospitals, Indianapolis, Ind.
John E. Ives .....	Shands Teaching Hospital, Gainesville, FLa.
Donald G. Kassebaum, M.D. ....	University of Oregon Hospital, Portland, Or.
James Malloy .....	John Dempsey Hospital, Farmington, Ct.
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.
David S. Weiner .....	Children's Hospital Medical Center, Boston, Mass.
Janice B. Wyatt .....	University of Massachusetts Medical Center, Westchester, Ma.

Terms Expiring 1983:

Peter Baglio .....	Veterans Administration Medical Center, East Orange, N.J.
Robert J. Baker .....	University of Nebraska Hospital, Omaha, Ne.
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.
Spencer Foreman, M.D. ....	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, M.D. ....	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, M.D. ....	Parkland Memorial Hospital, Boston, Ma.
Boone Powell, Jr. ....	Baylor University Medical Center, Dallas, Tx.
Mitchell T. Rabkin, M.D. ....	Beth Israel Hospital, Boston, Ma.
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, Tampa, Fla.
C. Thomas Smith .....	Yale-New Haven Hospital, New Haven, Conn.
Richard L. Stensrud .....	St. Louis University Hospital, St. Louis, Mo.

Terms Expiring 1984:

James W. Bartlett, M.D. ....	Strong Memorial Hospital, Rochester, N.Y.
Donald A. Bradley .....	Morristown Memorial Hospital, Morristown, N.J.
A. Sue Brown .....	University of Medicine and Dentistry Hospital of New Jersey, Newark, N.J.
Robert B. Bruner .....	The Mount Sinai Hospital, Hartford, Ct.
Thomas J. Campbell .....	State University Hospital, Upstate Syracuse, N.Y.
Jack M. Cook .....	Memorial Medical Center, Springfield, Ill.
Jose R. Coronado .....	Audie L. Murphy Memorial Veterans Administration Hospital, San Antonio, Tx.
Fred J. Cowell .....	Jackson Memorial Hospital, Miami, Fla.
Jeptha W. Dalston, Ph.D. ....	University of Michigan Hospital, Ann Arbor, Mich.
James C. DeNiro .....	Veterans Administration Medical Center, Palo Alto, Cal.
William J. Downer, Jr. ....	Blodgett Memorial Hospital Center, Grand Rapids, Mich.
John R. Fears .....	Veterans Administration Medical Center, Hines, Ill.
Sidney M. Ford .....	Veterans Administration Medical Center, St. Louis, Mo.
Irwin Goldberg .....	Montefiore Hospital, Pittsburgh, Pa.
William I. Jenkins .....	Wishard Memorial Hospital, Indianapolis, Indiana
Sheldon S. King .....	Stanford University Hospital, Stanford, Cal.

James T. Krajeck .....	Veterans Administration Medical Center, Albany, N.Y.
Mark S. Levitan .....	Hospital of the University of Pennsylvania, Philadelphia, Pa.
Glenn R. Mitchell .....	Medical Center Hospitals, Norfolk, Va.
John A. Reinertsen .....	University of Utah Hospital, Salt Lake City, Ut.
Vito F. Rallo .....	University of Cincinnati Hospital, Cincinnati, Oh.

APPENDIX C

STAFF OF THE  
DEPARTMENT OF TEACHING HOSPITALS  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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AoA LONG-TERM CARE PROJECT

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Fred Strebe  
Secretary  
202/828-0420

APPENDIX D

LISTING OF COTH PUBLICATIONS

AVAILABLE FROM THE AAMC

The following publications may be purchased from the Association should be of American Medical Colleges. Orders addressed to: s, Suite 200, One Dupont AAMC, Attn: Membership and Subscription Circle, N.W., Washington, D.C. 20036.

<u>TITLE</u>	<u>PRICE PER COPY</u>
Toward A More Contemporary Public Understanding of the Teaching Hospital	\$ 3.00
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
The DRG Case Mix of a Sample of Teaching Hospitals	\$ 6.00
The Disease Staging Case Mix of a Sample of Teaching Hospitals	\$ 8.00
COTH Directory of Educational Programs and Services - 1982	\$ 7.00
COTH Survey of Housestaff Stipends, Benefits and Funding - 1982 (available late Fall 1982)	\$ 7.00
COTH Report (monthly newsletter)	per annum \$30.00

All orders of \$25.00 or less for publications available from riptions must be the AAMC Office of Membership and Subspaid in ot prepaid must be accompanied ease advance. All orders above \$25.00, if ndo not send cash. by an institutional purchase order. Pl