association of american medical colleges

SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

NOVEMBER, 1982-OCTOBER, 1983

one dupont circle, n.w./washington, d.c. 20036

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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 document summarizes Departmental activities from November, 1982 through October, 1983. Those interested in knowing more about these activities are encouraged to read this report and to contact Departmental staff for additional information. 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 represents the Council in the deliberations and policymaking process of the AAMC 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 1983-84 year, Haynes Rice, Director of Howard University Hospital in Washington, D.C., will serve as the COTH Chairman, succeeding Earl J. Frederick, President of Children's Memorial Hospital in Chicago. Mr. Frederick assumed the chairmanship during the past year from Mark S. Levitan who left his post as Executive Director of Hospital of the University of Pennsylvania to become the President of Shared Medical Systems (SMS). 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 1982-83 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 items on the agenda of the AAMC Executive Council. Two major topics of discussion emphasized throughout the year were the Medicare reimbursement changes adopted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Social Security Amendments of 1983 which created the Prospective Payment System for Medicare inpatient hospital services. An ad hoc Committee on Prospective Payment for Hospitals was established to guide the AAMC response to the interim final regulations and to address the impacts and implications of Medicare's new per case pricing system based on diagnosis related groups (DRGs). In other deliberations, the Administrative Board focused on a wide variety of subjects including: payment for physician services in a teaching setting; an assessment of the Department of Teaching Hospitals' activities and future initiatives; issues related to trends in graduate medical education positions; regulations on "Nondiscrimination on the Basis of Handicap" (also referred to as the "Baby Doe" regulations); the role of the AAMC in providing constituent service programs (e.g., group purchasing services); and the controversial proposed revisions to the medical staff chapter of the Joint Commission on Accreditation of Hospitals' (JCAH's) Accreditation Manual for Hospitals.

Preceding two of its meetings, the Administrative Board held informal discussions with staff of an accrediting organization and a key Congressional committee: John E. Affeldt, M.D., President of the JCAH, and two of his associates, Mr. Hill and Dr. Roberts, provided background on the rationales

behind the controversial revisions of the medical staff chapter of the Accreditation Manual for Hospitals and described the JCAH's organization generally; and Shiela P. Burke, R.N., deputy staff director for the Senate Finance Committee, discussed her sense of where Congress, and particularly Finance Committee Chairman Robert Dole (R-Kans.), stood on various issues related to health care spending. She also reviewed some of the implications for academic medical centers of the Medicare prospective payment program, which had been signed into law that same day.

COTH Membership

There are two categories of COTH membership: teaching hospital full (voting) membership and corresponding (non-voting) membership. To qualify for full membership, the applicant institution must be an IRS 501(c)(3) organization and must have a written affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education and a letter recommending membership from the dean of the affiliated medical school.

The major criteria for teaching hospital membership are:

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

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

Institutions not meeting the criteria for full teaching hospital membership may apply for corresponding membership. Corresponding members do not have a vote within the AAMC assembly, but are eligible to attend all open Association meetings and receive all publications forwarded to institutions in the full teaching hospital membership category. The present membership of the Council of Teaching Hospitals includes 420 full teaching hospital members and 35 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, including all members of the U. S. Congress. The newsletter, which is typically between 8 and 12 pages in length, provides comprehensive coverage 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. An annual 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 hospital, including selected operational and educational program data. Questionnaires for the 1984 Directory will be mailed in December, 1983. The 1984 Directory will be published early next year. Additional copies of the Directory are priced at $7.00 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 benefits 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 Hospital's Financial and General Operating Data

For the past twelve 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 13 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 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, 1983, Departmental staff completed an analysis of construction projects begun in 1981 among COTH non-federal member hospitals. It was found that 74 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. About 87 percent of the debt financing in 1981 was acquired through the issuance of state and local tax-exempt bonds. Results of the latest survey, which were compared with the pattern of funding for construction projects begun in 1974 and 1979 and those completed in 1969, will be presented as a Datagram in an upcoming issue of the Journal of Medical Education. The results also were discussed briefly in the July-August, 1983 issue of the COTH Report.

Selected Data on a Small Sample of Teaching Hospitals

"Selected Data on a Small Sample of Teaching Hospitals," the third in a series of four reports which were produced during the three-year AAMC Study of Teaching Hospital Characteristics, was sent to all COTH members in November, 1982. The report is designed to permit AAMC members to compare their own hospital's patient care, research and teaching characteristics with those of a diverse group of the membership of COTH. The report uses 1978 data from a sample of 33 non-federal COTH hospitals. Additional copies are available for $10.00 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

A Description of Teaching Hospital Characteristics

"A Description of Teaching Hospital Characteristics," the last in a series of four reports which were produced during the three-year AAMC Study of Teaching Hospital Characteristics, was published in January, 1983. It is designed as a public advocacy document describing the distinctive characteristics of teaching hospitals that will need to be addressed as health policy alternatives are considered. The report is intended primarily for government executives and their staffs, third party payers, and the interested general public. It begins by comparing the characteristics of non-federal COTH hospitals with all other community hospitals and documents teaching hospital differences in organizational and service characteristics. The second section of the report describes the special responsibilities teaching hospitals have for health manpower education, clinical research, the application of new technology, and tertiary care and the

impact these have on teaching hospitals. The report was mailed to all COTH members in January, 1983. Additional copies of the document may be purchased for $3.00 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

Survey of Undergraduate Medical Education in Prepaid Health Care Plan Settings

The AAMC's Department of Teaching Hospitals, in conjunction with the Department of Community Health at Tufts University School of Medicine, conducted surveys during the past year to identify: (1) the extent of formal undergraduate clinical medical education involvement at prepaid health care plans (PHCP's) such as health maintenance organizations (HMO's) and (2) the methods and data being used to analyze the costs associated with medical education in these settings. The results of these surveys are expected to be published in a future issue of the Journal of Medical Education and will be presented during a special program at the AAMC's 1983 Annual Meeting.

Medicare Prospective Payment: Probable Effects on Academic Health Center Hospitals Short-Term and Long-Term Options

In conjunction with the Association of Academic Health Centers, the AAMC published a staff report in April, 1983, on the proceedings of a conference on the implications of Medicare's Prospective Payment System for academic medical centers. The conferees considered the new hospital payment system against the background of the experience of several major teaching hospitals which have used various models of case-mix classifications for management and payment purposes. Copies of the report were mailed to all COTH members. Additional copies are available free from: AAMC, Department of Teaching Hospitals, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

ACTIVITIES OF THE DEPARTMENT OF TEACHING HOSPITALS

The Association's Department of Teaching Hospitals addressed several major issues during 1982-83. Key among these were the Medicare Prospective Payment System which was adopted as part of the Social Security Reform Act of 1983, and the regulations implementing the new Medicare physician payment requirements of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA). Additionally, Departmental staff played an active role in: (1) completing a major descriptive study of teaching hospitals; (2) advocating Congressional support for a revamped national health planning program; (3) opposing controversial modifications proposed by the Joint Commission on Accreditation of Hospitals (JCAH) to the medical staff chapter and other sections of the Accreditation Manual for Hospitals; (4) seeking to temper excessive Department of Health and Human Services (HHS) regulations regarding "Nondiscrimination on the Basis of Handicap," (a.k.a., the "Baby Doe" regulations) which address care for severely handicapped infants; (5) opposing legislation that would have restricted the availability of tax-exempt bond financing for use by hospitals and educational facilities for major capital projects, as well as eliminated the benefits of certain leasing arrangements; (6) drafting a report to address "Payment for Physician Services in a Teaching Setting"; (7) analyzing various legislative and regulatory proposals; and (8) publishing several surveys and reports. The

following is a brief review of Departmental activities in major areas of interest during the past year.

TEFRA Regulations

The regulations implementing P. L. 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) were published on October 1, 1982, and set forth (a) how physicians practicing in an institution would be paid for services both to inpatients and outpatients, (b) when assistants at surgery would be paid, and (c) redesigned the Medicare limits on hospital payments. The regulation establishing the limits on payments for hospital-based physicians was intended to distinguish services provided to the institution or the patient population generally (Part A Services) from services rendered directly to an individual patient (Part B Services). Once differentiated, the former services would be paid on a reasonable cost basis, while the latter services would be reimbursed on a reasonable charge basis. The regulation restricted Medicare reimbursement for physicians who did not personally retain all of the charge payments to the amount of compensation received by the physician. The Association was concerned that this could be interpreted to mean that a physician assigning fees to an entity such as a medical school or faculty practice plan and accepting a salary from that entity would have his or her fees restricted by Medicare to the amount of the salary. In response, the Association planned a Deans' March on Washington to alert Congressional delegations to the potential problems with this rule. However, the need for the March was obviated when AAMC was made aware of an internal HCFA memorandum which clarified that the rule would not jeopardize faculty practice plans.

The hospital-based physician regulation also specified changes in the way in which Medicare would pay for radiologists', anesthesiologists', and pathologists' services. In changing the radiologists' payments, HCFA sought to distinguish physicians who must pay their own overhead and operating costs out of the fee from those who practice in the hospital and do not incur these same costs. For radiologists' services generally available in a physician's office setting in the community, a hospital-based radiologist will be subject to a limit of 40 percent of the prevailing fee for the office-based services. For anesthesiologists, full fee payments are limited to services wherein no more than four concurrent procedures have been medically directed. Beyond this number, anesthesiologists will be considered to be acting in a supervisory capacity and, therefore, subject to payment on a reasonable cost basis only. For pathologists, the majority of clinical laboratory tests were defined as Part A services, and thus, subject to payment on a reasonable cost basis rather than on a charge basis.

To avoid duplicative payment to both the hospital and physician for outpatient overhead costs where such costs have been met totally or partially by the hospital, another TEFRA regulation limits physician charges for services furnished in hospital outpatient departments. Where a particular service is commonly provided in private office settings in the community, a physician performing that same service in a hospital-based clinic which claims Medicare payment of overhead costs will have his or her fee reduced to 60 percent of the Medicare prevailing fee for non-specialist physicians. Certain services are excluded from this reduction, including bona fide emergency services, ambulatory surgical services, radiology services, and services paid on the basis of compensation related charges.

In comments submitted in November, the Association objected to the way in which this regulation was written, noting particularly that overhead costs in

hospital settings may be higher than those experienced in private office settings due to the costs for graduate medical education and the Medicare cost allocation formula which consistently attributes large portions of hospital overhead costs to the outpatient settings. The AAMC recommended that the language be revised to allow physicians to earn full fees for services in hospital outpatient settings as long as the physicians reimburse the hospital an amount comparable to that paid by area office-based physicians for overhead expenses.

Additionally, the use of the phrase "routinely provided in a physician's private office" in defining which services would be subject to this limitation was criticized. The Association observed that the phrase is so vague that it permits conflicting interpretations by different carriers under identical circumstances and thus needs to be clarified. It was noted that further clarification also is needed concerning services which might be "routinely provided" in an office setting during regular office hours, but which are performed in a hospital at night or on weekends. The regulation does not address whether these services will be subject to the limitation if performed during those hours when they would not be routinely available in private office settings.

Additionally, the AAMC questioned the application of these limits in medically underserved areas where office-based services may not be available. It objected to the use of non-specialist fees to determine the limits for specialists in hospital outpatient departments, noting that this was contrary to the way in which Medicare normally treated specialist payments. Finally, the Association suggested the exclusion of services provided in organized hospital emergency departments since services in these departments are initiated based on the decision of the patient or patient's guardian that the condition warranted immediate attention rather than the decision of the physicians as to the most appropriate setting in which services would be rendered.

The regulations implementing TEFRA also preclude payment for an "assistant at surgery" when the hospital has residency programs in the surgical speciality in question and residents are availalbe to assist during the surgery. Through the efforts of the Association, this rule was amended to allow a physician practicing in a teaching hospital but not participating in the educational program to use an assistant at surgery who would be paid the allowed Medicare fee. HCFA acknowledged that residents have other duties besides performing direct patient care, and thus, may be unavailable because they are involved in educational or research activities. Thus, in such circumstances, Medicare will pay fees for an assistant at surgery. The regulation also clarified that hospitals participating in approved residency programs sponsored by other hospitals are not affected by this policy.

In addition to the rules on physician payment, TEFRA and its implementing regulations established two limits on hospital payment. The first, called "the target rate," uses the hospital's own base year cost adjusted for inflation to constrain the percentage increase in Medicare payments to each institution. The second expands the existing routine operating cost limit under Medicare Section 223 to include special care unit and anxillary service costs. The revision sets ceilings on hospital expenditures based on average costs per admission adjusted by a case mix index based on diagnosis related groups (DRGs) and area wage indices. Significantly, capital and direct medical education costs are excluded from the limit and a special adjustment, based on a hospital's resident-to-bed ratio, is provided for so-called indirect medical education costs. In commenting on these regulations, the AAMC suggested that HCFA:

- Provide detailed procedures to be used in calculating the base period and control period costs;

- Provide detailed procedures to be used in calculating any penalties to be applied to allowable costs as determined by the cost report;

- Modify the determination of the case mix categories and weights to recognize methodological shortcomings;

- Publish detailed data on the case mix index which hospitals may use to manage their operations;

- Modify the procedure used to calculate the area wage indices used in the calculation of the 223 limits;

- Alter its proposal to determine inflation rates for the year in question using data available at the time of settlement;

- Include an adjustment for hospitals serving large numbers of Medicare and low income patients; and,

- Recognize the likely effects of other regulatory changes, such as the proposed changes in payments for physician services provided in institutional providers, on hospital costs.

The Medicare Prospective Payment System for Hospitals

On December 28, 1982, as mandated by TEFRA, then Secretary of HHS, Richard S. Schweiker, sent a proposal to Congress for instituting a Prospective Payment System for Medicare reimbursement of inpatient hospital services. The proposal suggested establishing prices for each DRG and paying these rates to all but children's and psychiatric hospitals. The only adjustment to the rates would be the application of area wage index differences.

The Association expressed five broad policy concerns with this proposal in testimony presented before the Senate Finance Committee's Subcommittee on Health on February 2, 1983 and the House Ways and Means Subcommittee on Health on February 14, 1983. First, the AAMC noted that crucial details of the payment scheme were missing from the proposal including the computation of the "pass through" of direct medical education and capital costs, the treatment of cost of atypical cases, and the procedure for determining indirect medical education costs. Additionally, the AAMC asserted that methodological refinements cannot compensate for inadequate payment under the Medicare program and reminded the Congress that the Medicare payment system is a normative statement of the government's values, not just a technical issue. The Congressmen were warned that statistical averages mask appropriate differences in hospital cost.

The AAMC predicted that the burden of the reduction in Medicare expenditures would be unevenly distributed among certain types of hospitals, disproportionally harming teaching institutions because allowances were not made for: differences in hospital size and scope of service, disparties in severity of illness of patients within diagnostic groupings, inadequate information in the HHS data base with which to properly classify patients into DRGs, and methodological problems that overestimate the cost of routine care while underestimating the cost of tertiary care. A more evolutionary change in the payment mechanism was advocated

so that the higher cost in teaching institutions could be properly evaluated and not assumed to represent inefficiency, waste, or poor management. Finally, the issue of the threat to hospital-physician relationships engendered by this proposal, was raised. Clearly, the proposal put the onus on the hospital to exert strong influence on physician behavior.

The AAMC assertion that the Administration's proposal would disproportionally harm some groups of hospitals was borne out by the Congressional Budget Office, which presented projections at the Ways and Means Subcommittee hearing that showed that teaching and other large hospitals would suffer substantial losses under the proposed scheme while small and rural hospitals would reap windfall gains.

Congressional amendments to the Administration's proposal resulted in the adoption of a prospective payment scheme that included a four-year phase-in of the DRG payments; the use of regional and national rates to ease the transition; an adjustment for teaching hospitals based on their resident-to-bed ratios; a requirement that unusual cases, or "outliers" as they are called, are paid at marginal cost and constitute between 5 and 6 percent of total per case payments; and a provision for special adjustments for national and regional referral centers. These amendments tempered CBO's estimates of the adverse impact of the new payment system on teaching hospitals, although it is as yet unclear how individual institutions will be affected. This scheme was passed by Congress in late March and signed into law by the President on April 3 as part of the Social Security Amendments of 1983, P. L. 98-21.

Regulations implementing the Medicare Prospective Payment System were issued on September 1, 1983. In its comments, the AAMC took issue with: (1) the way residents are counted in calculating the "indirect medical education" adjustment; (2) how the adjustments for referral centers, and hospitals with a disproportionate number of low income and Medicare patients are defined; (3) the lack of clarity regarding payments for outlier patients; (4) how certain wage indices are calculated; (5) the blend of payment rates during the transition period; and (6) the exclusion of the medical library as an educational cost.

OMB Proposes Overall Reduction in Medicare Payments Under Prospective Payment

In August, it was rumored that the Department of Health and Human Services (HHS) was under pressure from the Office of Management and Budget (OMB) director David Stockman to reduce the Medicare payments per diagnosis related group in fiscal year 1984-85 to allow for a potential increase in hospital admissions. This brought strenuous objections from John A. D. Cooper, M.D., president of the Association of American Medical Colleges and J. Alexander McMahon, president of the American Hospital Association, who wrote jointly to the HHS Secretary. The reduction in payment rates was apparently suggested by Stockman in order to maintain the "budget neutrality" of the Medicare Prospective Payment System on the assumption that hospitals would arbitrarily increase admissions in order to "game" the system.

"We believe that such a reduction, under the guise of budget neutrality, is neither authorized by the statue nor warranted by any reasonable estimate," said McMahon and Cooper in the joint letter. They told Heckler that the results of this reduction in payments would be to unfairly lower payments to hospitals under the new system. The provisions of the Social Security Act which established this payment scheme foresaw no such adjustment, they reminded her. Heckler was told

that the Peer Review Organizations (PRO) provided a mechanism to guard against inappropriate admissions of Medicare beneficiaries. Further, McMahon and Cooper stated, it is likely Medicare admissions will increase legitimately due to the increase incidents of illness and the growing number of elderly in each successive year.

While reiterating their organizations' and the hospitals' commitment to making the new prospective system work, the two Association presidents stated, "the transition to the new payment system, which will not be easy in any case, will be made all the more difficult for the government and hospitals if arbitrary and unfair decisions undermine the basic concepts embodied in Medicare program."

Prospective Payment Assessment Commission

In adopting the new Medicare payment system for hospitals, Congress provided that a new Prospective Payment Assessment Commission be created under the auspices of the Office of Technology Assessment (OTA) to advise Congress and DHHS on several important aspects of the new payment scheme based on DRG's. Among the subjects that the Commission will be looked to for advice are: (1) the annual inflation factor for DRG payments; (2) the way in which new technology and/or new treatment protocols can be incorporated in the DRG prices; (3) what constitutes medically appropriate patterns of health resources use for certain diagnoses; and (4) the assessment of the safety, efficacy, and medical necessity of new and existing medical and surgical procedures and regional variations in treatment patterns.

OTA has estimated that between $1.5 and $2.5 million would be needed to support the Commission and its staff. However, the Administration requested no funds for the Commission in its FY 1984 Budget Request. Without the Commission, DHHS would have sole responsibility as payor, regulator, and evaluator. To present this from occurring, the AAMC actively fought for funding for the Commission. The outcome of these efforts was the approval of appropriations of $1 million and $2.5 million for the Commission by the House and Senate Labor/HHS Appropriations Subcommittees respectively. An amount somewhere in the middle of these two figures is likely to be reached when a single appropriations measure is finalized in joint conference.

While these Subcommittees were completing their deliberations, John H. Gibbons, director of the OTA, sent a letter to all of the major health care organizations and others concerned with the new Prospective Payment System requesting that they nominate candidates for the Commission. Nominees for the Commission were requested to have expertise in the provision and financing of health care; the conduct and interpretation of biomedical, health services, or health economics research; and/or in the research and development of technological and scientific advances in health care.

The Association responded by nominating John W. Colloton, Director of University of Iowa Hospitals and Clinics and Assistant to the University President for Statewide Health Services. Mr. Colloton's nomination was discussed and approved by the Association's Executive Council. The Association indicated that Mr. Colloton's stature among his colleagues was exemplified by the numerous committees on which he has been asked to serve and the many posts he has filled, including serving as Chairman of the Council of Teaching Hospitals in 1978-79 and the Iowa Hospital Association in 1977.

Medicare Payment for Physician Services in Teaching Hospitals

The AAMC's Ad Hoc Committee for Payment for Physicians' Services in Teaching Hospitals met in April, 1983, to discuss the forthcoming Medicare regulations governing payment for physician services in the teaching setting. These regulations were referenced in and will augment the TEFRA regulations on hospital-based physician payments. The Committee, chaired by Hiram C. Polk, Jr., M.D. chairman of the department of surgery at the University of Louisville, met with Donald Young, M.D. deputy director of HCFA.

The Committee concentrated on discussing the following five issues: (1) how "teaching hospital" should be defined; (2) how "teaching physician" should be defined; (3) what presumptive tests can be used in the regulation to exclude hospitals that will not be constrained by the rule; (4) the potential problem of specifying physician patient relationships in family medicine, psychiatry, and anesthesiology;; and (5) how to determine reasonable fees for physicians, especially when Medicaid is a major payor but pays only a small portion of the charges. After a lengthy discussion, the Committee directed the AAMC staff to initiate discussions with key people in HHS and on the staff of the relevant Congressional committees, and to prepare a comprehensive report for review by the AAMC Administrative Boards and Executive Council in June.

This report formed the basis of testimony presented in July by AAMC President John A. D. Cooper, M.D., before the Health and Environment Subcommittee of the House Energy and Commerce Committee. In order to focus clearly on the problem, he quoted directly from the statute:

Section 1842--

(b) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who has a substantial practice outside the teaching setting, the carrier shall take into account the amounts the physician charges for similar services in the physician's outside practice.

(ii) In the case of a physician who does not have a practice described in clause (i), if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greater of -

(i) The charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (i) and (ii) of subparagraph (A) (i), or

(ii) The mean of the charges (other than nominal charegs) which were collected in full or substantial part with respect to such patients.

In essence, he explained, the statutory requirement is that Medicare fee levels be set at the mean or the mode (whichever is more) of charges collected in full or substantial part from non-Medicare patients. This policy has major financial implications where a low payer is the more frequent payer. For example, if Medicaid pays unusually low fees on behalf of the largest group of non-Medicare patients, the low Medicaid payments would be the modal fee; it would also substantially lower the mean fee collected. He noted that there are a number of states in which the Medicaid program pays less than half of what the Medicare program pays for professional services in medicine and surgery.

He further explained that if an individual physician or a group of physicians serve a substantial number of Medicaid patients, the fees they will be paid for their services under the Medicare program will be adversely affected by the level of Medicaid fees paid in some states. There are a number of hospitals which serve upwards of 40% Medicaid patients. Physicians practicing in these institutions would have their Medicare fees substantially reduced if the statutory requirements set forth in Section 948 were implemented. Teaching physicians that provide medical care to large numbers of poor patients, and for many it is their only source of care, should not be penalized by this regulation.

Dr. Cooper stated that there are at least two alternatives that would correct this inequity. Section 1842(b) of the Social Security Act could be amended by adding to (6) (B) the following provision:

> (b) (ii) (III) However, payments made on behalf of the Medicaid program shall be excluded in determining

Another alternative to amending this language would be to repeal the entire language in (ii) and replace it with the following, "...the customary charge of a physician without an outside practice should be the lesser of the actual charge or the prevailing charge in the lociality." Efforts to achieve resolution of this issue are under active consideration as a result of recent action taken by the Health Subcommittee of the Energy and Commerce Committee in the House of Representatives.

Proposed Medicare-Medicaid Conditions of Participation

In March, the Association wrote to Health Care Financing Administration (HCFA) Administrator Carolyne Davis stating its views on the revised Medicare-Medicaid Conditions of Participation for Hospitals that were published in the January 4 Federal Register. It noted that virtually all AAMC-member hospitals are voluntarily accredited by the Joint Commission on Accreditation of Hospitals (JCAH) and, therefore, receive "deemed status" for Medicare eligibility. For nonaccredited institutions, however, the Federal conditions of participation become the standard for evaluation of the hospital's quality and ability to care appropriately for Medicare and Medicaid beneficiaries. As minimally acceptable standards for hospital care, the AAMC emphasized that these regulations must be maintained at a level where they will continue to foster quality patient care.

The Association supported HCFA's efforts to simplify the regulations and add increased management flexibility. Furthermore, it endorsed the inclusion of new conditions for Nuclear Medicine and Quality Assurance. However, it called for clarifying language regarding the expansion of the "physician" definition. The AAMC recommended language that would clearly define "physician" as licensed doctors of medicine, osteopathy and dentistry. This definition could be extended

only in relation to physician services covered by the entitlement programs the Association believes Congress had intended, and not to questions of medical staff privileges, responsibilities and supervision.

Advisory Council Recommends Elimination of Medicare Reimbursement for Graduate Medical Education

The Advisory Council on Social Security, which has focused much of its attention on seeking remedies for the impending bankruptcy of the Medicare Trust Fund, agreed preliminarily to several policy recommendations at its August 25, 1983 meeting. The recommendation of greatest concern to members of the AAMC was a statement that Medicare ought to cease reimbursing for education and training costs. The Council unanimously endorsed this recommendation. It calls for a study to "provide for the orderly withdrawal of Medicare funds from training support" to be completed within three years under HHS's supervision. "It is inappropriate for Medicare, a program designed to pay for medical services for the elderly, to underwrite the costs of training and medical education," the statement says.

On October 16, AAMC staff and Chairman-Elect Robert Heyssel, M.D., appeared before the Council in defense of continued payment for graduate medical education by Medicare. In the absence of clearly described, administratively feasible, and politically acceptable alternatives for paying clinical education costs, the Social Security Advisory Council should reconsider its decision that Medicare should stop paying for these costs, Dr. Heyssel told the Advisory Council. Dr. Heyssel, President of The Johns Hopkins Hospital, strongly objected to the Council's recommendation that a study be conducted to plot an "orderly withdrawal of Medicare funds from training support." The Association felt such a study was premature in the absence of studies describing the alternative financing sources available and the consequences of shifting to them.

Dr. Heyssel told the Council that a clear distinction should be made between clinical education costs and Medicare payments made under a clinical education label. Under the label of direct medical edcuation costs, he noted, Medicare is paying for a joint product that includes both education and service to the patient. Clinical care can only be learned through participation in the practice of medicine, he told the Committee, and thus the residents and other trainees were rendering service as well as being educated themselves. In the absence of these clinical trainees, additional service personnel would have to be hired and would be included in the Medicare costs, he reminded them.

Turning to the issue of the "indirect medical education cost", Dr. Heyssel quoted the House Report on the Social Security Act which acknowledged:

> "This adjustment is provided in the light of doubts...about the ability of the DRG case classification system to account fully for such factors as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional cost associated with the teaching of residents...the adjustment for indirect medical education cost is only a proxy to account for a number of factors which may legitimately increase cost in teaching institutions."

The Advisory Council will reconsider its recommendation on this issue as well as all others it has previously considered at its next meeting in preparation for its final report.

AAMC Study of Teaching Hospital Characteristics

For more than two years, staff of the Department of Teaching Hospitals conducted 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, the final two in a series of four study reports were published during the 1982-83 year. The documents, "Selected Data on a Small Sample of Teaching Hospitals" and "A Description of Teaching Hospitals Characteristics" are described in the Surveys and Publications section of this annual report.

Health Planning

While Congress was considering the new payment systems for hospital services, debate over the continuation of the health planning program resurfaced. The AAMC has been a proponent of health planning and had endorsed a $64.8 million compromise health planning bill introduced in the Fall of 1982 by Representatives Henry Waxman (D-Cal.), Edward Madigan (R-Ill.), Richard Shelby (D-Ala.), John Dingle (D-Mich.), and James Broyhill (R-N.C.). This measure, the Health Planning Block Grant Act of 1982, which was adopted overwhelmingly by the House of Representatives, made funds available for both state and local planning activities. States were obligated to have a certificate of need (CON) program with review thresholds in the range of $1 million to $5 million for capital expenditures (up from $600,000 at present) and between $500,000 and $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 acquisitions which are currently reviewed when their projected cost exceeds. A single designated state agency (DSA) in each state would have been responsible for conducting hearings on CON applications under this bill, and governors would have been allowed to designate regional health planning agencies in their states.

In the Senate, the "Health Planning Deregulation Act of 1982" was sponsored by Senators Daniel Quayle (R-Ind.), Orrin Hatch (R-Utah), Paula Hawkins (R-Fla.), David Durenberger (R-Minn.), and Daniel Inouye (D-Hi.). The "bare bones" bill would have authorized only $20 million for one year and been much more restrictive than its House counterpart. It precluded states from using federal funds to regulate the planning, allocation, financing, or delivery of health care resources and services. The Association wrote to each of the Senate cosponsors to request revision of the legislation to achieve greater comparability with the House measure. A House-Senate compromise resolution was worked out and passed the House of Representatives by unanimous consent on December 16. However, it failed to come to a vote in the Senate before the end of the Congressional session. Nevertheless, the current health planning program survived for another year in a continuing resolution that was passed by both houses of Congress on December 21, 1982.

Health planning advocates from both major parties in Congress resumed their efforts to obtain an authorization for a new health planning program in the Spring of 1983. However, negotiations broke down. Representatives Henry Waxman, chairman of the House Energy and Commerce Health Subcommittee, sponsored a bill

entitled, "Health Planning Amendments of 1983," (H. R. 2934) emphazing the need for a scaled-back version of the current statute at least until capital costs are included in the DRG-based Medicare prospective payment system. It was approved by the full Committee. A counter-proposal (H. R. 2935) that would have repealed the current statute and replaced it with a block grant program that was offered by Representatives Madigan and Shelby. It was defeated in the Health Subcommittee.

Staff of the Association and several other health organizations interested in achieving enactment of a new planning law created a coalition to encourage and assist House members to develop bipartisan legislation that would be pallitable to the Senate and not attract the opposition of the Administration. Although the partisan Waxman bill was believed to have many positive features, it was felt it could not attain ultimate adoption in both Houses. Therefore, the coalition worked with minority staff of the health subcommittee to draft a compromise discussion bill that would serve to reopen negotiations between the House and Senate. With some modification, the Office of Management and Budget (OMB) supported the discussion draft. At present, the Waxman bill, the discussion draft and a $40 million deregulation block grant measure (S. 1778) introduced by Senator Dan Quayle (R-Ind.) are the alternatives around which House-Senate staff negotiations are again taking place. AAMC staff continues to monitor these renewed discussions and assist in efforts to reach compromise capable of enactment.

The "Baby Doe" Regulations

An issue of concern to many teaching hospitals, especially those caring for substantial numbers of critically ill infants, was the publication of proposed regulations by HHS regarding the decision to treat or forego treatment for severely handicapped infants. Regulations entitled "Nondiscrimination on the Basis of Handicapped" were published on March 7, 1983 and became effective on March 22. Also known as the "Baby Doe" regulations because of an Indiana case cited in the preamble, the regulations required hospitals to post notices of the government's prohibition on withholding customary medical care or nutrition from an infant solely on the basis of its handicap. In addition, a toll free hot-line number was established for anonymous reporting of suspected violations of the law to the Office of Civil Rights. The rule was endorsed by President Reagan and backed by "right-to-life" groups.

The AAMC and several other organizations, including the American Academy of Pediatrics (AAP) and the National Association of Children's Hospitals and Related Institutions (NACHRI), protested that this rule interjected the Department of Health and Human Services into the sensitive and highly emotional atmosphere in which parents, physicians, and other health care personnel were attempting to make very difficult decisions about the care of seriously handicapped infants. The AAMC and other health care organizations urged HHS Secretary Heckler to delay implementation of the rule in order to address concerns that the posted notices and the toll free hot-line would needlessly add to the stress of parents and health care personnel and negatively impact the patient care process.

The request for delay went unheeded by Secretary Heckler. However, the AAP, the NACHRI, and Children's Hospital National Medical Center in Washington, D.C., filed suit in Federal District Court, where the regulation was struck down. The judge's decision was based largely upon procedural irregularities, but he expressed dissatisfaction with what he termed "a hasty and ill considered" method of addressing "one of the most difficult and sensitive medical and ethical problems facing our society."

In response to the judge's decision, Secretary Heckler announced that HHS would appeal the ruling to a higher court; however, no such appeal was made. Instead, HHS redrafted the regulations and published the revision on July 6. While the substance of the regulations had not changed significantly, the Department took the proper procedural steps in reissuing them and attempted to address several of the judge's concerns in the preamble. Unexpectedly, the Department added state child protection agencies in the enforcement of the regulations.

The inclusion of the child protection agencies parallels provisions contained in bills introduced in the House of Representatives by John Erlenborn (R-Ill.) and in the Senate by Jeremiah Denton (R-Ala.). These measures propose revising the Child Abuse Prevention and Treatment Act to require the posted notices and "hot-lines" approach taken by HHS in regulation. While continuing to express commitment to providing medically indicated treatment and nutrition to infants with life threatening conditions, the AAMC wrote to members of the appropriate House and Senate Committees urging them to reject the proposed bills. In particular, the AAMC objected to the coupling of medical treatment decisions with child abuse legislation and the use of "hot lines" to monitor compliance with the law. The Association expressed dissatisfaction with the assumption that personnel at child abuse protection agencies have the necessary expertise to properly assess or advise on the appropriateness of medical care to severely impaired infants. Furthermore, it criticized the diversion of scarce resources from the important task of investigating child abuse to the examination of complex and very difficult treatment decisions. It also objected that the need for posted notices implied that hospitals and physicians had been criticized for their treatment of infants, a false impression that would lead to an unjustifiable increase in the anxiety levels of families of critically ill infants. The AAMC advocated a solution recommended by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavior Research in its report, "Deciding to Forgo Life Sustaining Treatment." The Commisssion called for the creation of local review bodies to examine cases where life sustaining treatment is in question. The legislation has since been is still pending in both Houses of Congress.

Tax-Exempt Bond Restrictions

Again this year, the availability of tax-exempt bonds used to finance major capital projects in hospital and educational institutions appeared threatened by rumored Congressional intentions. Last year, the Tax Equity and Fiscal Responsibility Act (TEFRA) established new reporting and registration requirements on small-issue Industrial Development Bonds (IDB's). In adopting this legislation, Congress recognized that 501(c)(3) organizations, such as nonprofit hospitals and educational facilities, use tax-exempt bonds for public purposes and specifically exempted them from any major restrictions on the availability of such financing. To head off attempts to add further restrictions this year, the AAMC wrote to all members of the Senate Finance and House Ways and Means Committees on June 28, urging them to stand by the determinations made last year, based on the following facts: (1) tax exempt revenue bonds support activities with the express purpose of creating a healthier and better educated public; (2) they are needed because the traditional sources of capital for private, nonprofit hospitals and academic centers have been impaired by a variety of federal government actions; (3) the federal tax revenue lost as a result of the issuance of these bonds is miniscule; and, (4) there is no evidence linking nonprofit hospitals and educational institutions to the inappropriate use of tax-exempt financing.

Actually, IDB's are not the form of tax-exempt bonds that are widely used by 501(c)(3) hospitals and schools. However, they are they type cited as the most commonly abused by commercial or proprietary users. In September, it was rumored that House Ways and Means Committee Chairman Dan Rostenkowski (D-Ill.) intended during mark-up of pending tax legislation to offer a proposal for state-by-state volume caps on all private purpose bonds. Once again, the Association wrote to all members of both the House and Senate jurisdictional committees to reiterate the justifications for exempting 501(c)(3) organizations from any limits that may be proposed. These letters were followed-up by AAMC staff contact with many of the staff of these legislators. Additionally, certain AAMC members were requested to contact their representatives on the House Ways and Means Committee.

In October, the House Committee mark-up took place and state-by-state volume caps were approved for all private purpose bonds other than mortgage subsidy bonds and bonds issued to benefit 501(c)(3) organizations. In other words, beginning in 1984, a $150 per capita cap applied to each state's population would be set for all IDB's. Once again, the efforts of the AAMC and other organizations successfully averted the application of these restrictions to bonds issued to benefit 501(c)(3) organizations. However, the cap would include student loan bonds and those issuing these bonds would face additional restrictions on their arbitrage profits. The AAMC will continue to oppose the student loan restrictions as the debate shifts to the Senate. The Ways and Means measure will next go to the floor for a full House vote. No similar proposal has yet been considered during the ongoing efforts of the Senate Finance Committee to develop a tax package.

Lease Financing Reforms

Two bills have been introduced that attempt to address concerns about the abuses in "sale-lease back" arrangements between taxable lessors and tax-exempt entities. The bills, H. R. 3110 and S. 1564, were introduced by Rep. J. J. Pickle (D-Tex.) and Senator Robert Dole (R-Kans.), respectively. Under these sale-lease back arrangements, a nonprofit, tax-exempt organization could sell its buildings and grounds to a for-profit corporation, and subsequently lease them back. The private purchaser-lessor would then benefit from the accelerated depreciation schedule and other tax credits granted to them under such arrangements by the 1981 Economic Recovery Tax Act. The tax-exempt institution would benefit from an immediate cash inflow and "below-market rate" rents for what was formerly its own property. The House and Senate bills intend to curb the ability of nontaxable entities to sell such tax preferences through leasing.

In July, 1983, the AAMC wrote to both the House Ways and Means and Senate Finance Committees to convey concerns that the provisions of these bills may be too sweeping. The AAMC believes public purpose, tax-exempt entities should not be denied the productive use of certain tax policies designed to benefit taxable entities because of the indiscretions of a few organizations. While the Association appreciated the intent of the legislation, it feared that the bills would restrict not only sale-lease back abuse, but would also restrict legitimate and productive uses of leasing transactions and rehabilitation tax credits between tax-exempt entities and taxable lessors. Two such productive uses identified by the Association were the leasing of short-lived, expensive medical equipment and the sale-lease back of existing real property (e.g., buildings) badly in need of renovation. In the latter instance, such arrangements can provide the lessee with needed operating funds while the lessor can provide the needed capital previously not available to the lessee for major improvements. The Association distinguished these productive and beneficial arrangements from those in which the tax-exempt entity seeks only to improve its cash position.

On July 27, H. R. 3110 was reported out of the House Ways and Means Committee. Although the provisions regarding real property and the rehabilitation tax credit were made more stringent, the restrictions on leasing of high technology hospital equipment and computers were made more lenient. Such equipment would be exempt from H. R. 3110's restriction if:

- the term of the lease does not exceed five years;
- the lease is for more than 80 percent of the useful life of the property;
- it is not financed with tax-exempt Industrial Development Bonds (IDB's); and
- there was no sale-lease back involved.

If these criteria are not met, depreciation of the equipment would have to be on a five-year straight line basis. The House bill had originally proposed requiring such depreciation over 12 years.

Leasing arrangements for real property, such as buildings, owned by tax-exempt entities would be affected by the bill if they meet any of the following conditions:

- Financing of the property was achieved through tax-exempt IDB's.
- The lease contains a fixed purchase price or sale option.
- The lease term exceeds 80 percent of the property's useful life.
- The tax-exempt entity uses the property under a lease, or sale and lease-back arrangement.

Investors would have to use straight-line depreciation for such properties over 40 years or 125 percent of the lease term, whichever is greater. Under the current accelerated cost recovery system, depreciation of such properties was permitted over only 15 years. The House bill originally called for expansion to a 35-year straight-line depreciation schedule. Additionally, the special tax credit for rehabilitating old buildings would not be allowed if the taxable entity enters into a leasing arrangement with a non-profit organization or government that used tax-exempt IDB's to finance the rehabilitation.

The new restrictions would apply to leasing arrangements made after May 23, 1983, the date the bill was introduced, but organizations that had "binding contracts" to enter into leases by the end of 1983 would be permitted to continue the transaction under the current allowances.

A vote on H. R. 3110 by the full House is expected in late October. The Senate Finance Committee had yet to mark-up S. 1564 at this writing.

Proposed JCAH Manual Revisions

"The Association is deeply concerned about the proposed alterations to the chapter on medical staff," the AAMC told Dr. John Affeldt, president of the Joint Commission on Accreditation of Hospitals (JCAH) in a leter sent in February 1983. The Association critiqued proposed revisions to JCAH's Accreditation Manual for

Hospitals. The revision of greatest concern to the AAMC was a proposed change from "medical staff" to "organized staff" in defining who has the authority to admit and provide medical care to patients. Organized staff, as defined by the JCAH would have included "fully licensed physicians and may include other individuals who also qualify for clinical privileges and are licensed for independent provision of patient care services." At its January meeting, Dr. Affeldt told members of the COTH Administrative Board that this revision was proposed to avoid possible allegations of restraint of trade against JCAH.

The Association stated that the revisions would "change the long-held concept that physicians have a legitimate responsibility for insuring that high quality medical care is provided in our nation's hospitals." The proposed revisions to the JCAH manual could be interpreted to mean that a patient could be admitted to and discharged from a hospital without ever seeing a physician. The proposed revision would make hospitals vulnerable to legal actions by health professionals with limited licenses to practice who were seeking an independent and equivalent role to that of a physician, the AAMC wrote. It was pointed out that if other qualified professionals were allowed on the staff, it would be difficult to have uniformly applied eligiblity criteria, as required by the proposed revisions, given the disparity in education, training and skills between physicians and non-physicians. Similarly, it was noted that quality assurance programs would be difficult to administer.

The contributions of other, non-physician health care personnel, such as physician assistants, nurse practitioners, nurse midwives, and podiatrists, to the provision of modern medical care were acknowledged by the AAMC. However, it was suggested that patients would best be served if these other professionals worked under and were responsible to physicians. Several other suggestions were offered for amending the proposed revisions that would clarify the standards or make them more feasible.

The JCAH withdraw its proposed changes and issued another revised draft for field review in September. The AAMC submitted comments noting that the modifications were vastly improved over the previous draft. The latest draft refers again to the characteristics of a "medical" staff and requires that each patient's general medical condition be the responsibility of a qualified physician member of the medical staff. However, the current definition of "medical staff" has not been reinstated. Instead, medical staff is defined to include "other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital." This implies that once granted medical staff membership, an individual must be permitted to practice independently within the institution. The AAMC objected to this potential interpretation of the standard and argued that whether or not a given member of the medical staff may practice (i.e., admit, treat on either an inpatient or outpatient basis, and discharge patients) independently should depend solely upon the credentialing decision of the hospital and cannot be mandated, even implicitly, by the JCAH. The Association recommended that the definition be rewritten to read: "It includes fully licensed physicians and may include licensed dentists, and, depending upon the credentialing decision of the hospital, other individuals who qualify for clinical privileges and are licensed for independent provision of patient care services." Several other recommendations were made as well.

Peer Review Organizations

The Peer Review Improvement Act of 1983 was enacted under Title XI of the Social Security Act as part of TEFRA (P. L. 97-248) in 1982. It repealed the existing Professional Standards Review Organization (PSRO) program and required the Secretary of HHS to enter into performance-based contracts with Utilization and Quality Control Peer Review Organizations (PRO's). To force HHS to implement the PRO program, Congress included peer review provisions under the Medicare prospective payment program in the Social Security Amendments of 1983 (P. L. 98-21). HHS had delayed publishing implementing regulations because of the Administration's opposition to and proposed funding cuts for the peer review program. Congress utilized health care facilities to apply pressure on HHS by amending Medicare provisions dealing with agreements that providers of services must have in order to be paid by Medicare.

In August, 1983, proposed regulations were issued to define PRO area designations and eligible organizations, and a draft Scope of Work for PRO Contracts was made available for comment. The AAMC responded to both. In commenting on the proposed rule, the Association cited provisions that needed greater specificity and clarity:

- Eligibility of Physician-sponsored Organizations--This provision requires that a PRO be composed of at least 10 percent of the licensed doctors of medicine or osteopathy practicing in the review area. This criteria has been reduced from the 25 percent requirement under the PSRO program. If the 10% of physicians participating were concentrated in a single section of a broad PRO area to be covered, an undesirable imbalance of physician representation would occur. The Association recommended that the minimum percentage criteria be expanded to require that the 10% be "broadly representative of the licensed physician population across the entire PRO area."

- Requirements for Demonstrating Ability to Perform Review--This provision states that HCFA will determine that an organization is capable of conducting utilization and quality review if "the organization's proposed review system is adequate and it's quantifiable objectives are acceptable." It is not clear from the proposed regulations what criteria will be used to determine adequate and acceptable. The Association recommended that it be noted that an "adequate" review system must contain provision for an appeals and reconsideration mechanism which could accommodate the due process rights of affected parties. Furthermore, the Association was extremely concerned about the implications of a condition that would determine the performance effectiveness of a PRO on its ability to meet "acceptable quantifiable" objectives. There is no language in the proposed regulation which explains what HCFA desires the PRO to quantify. Judging from the Scope of Work draft, it appears HCFA's intention is to require that PRO's establish a target rate for achieving Medicare program savings above and beyond PRO contracted costs. The AAMC strenuously objected to this inappropriate focus on dollar savings at the expense of assuring proper and fair review of the quality of care provided to Medicare beneficiaries.

- Prohibition Against Contracting with Health Care Facilities-- This section precludes a hospital governing body member, officer or managing employee from serving in a similar capacity in a PRO. To deny such health facility input in PRO decision-making would be flagrantly unfair and an obstacle to comprehensive review and analysis, the AAMC wrote. The Association, therefore, strongly urged that hospital officers and personnel be permitted to sit on the board of a PRO or function on a PRO review team, provided that appropriate disqualification from decision-making is made where conflict-of-interest may be in question.

- Responsibility for Review--Part (c) of this section states that it "does not preclude PRO subcontracting of review to a health care facility for review of services furnished in that facility, provided that ultimate responsibility for review remains with the PRO." The underlined clause needs further clarification in order that the role of the health facility and its limitations may be understood.

- PRO Area Designations--The AAMC supports the HCFA proposal that each state be considered as unique and separate for purposes of PRO designation. However, if efficiency and effectiveness would be enhanced in certain instances by regional PRO areas involving adjacent states, the Association recommends that an equal representation of participating physicians (at least 10 percent) from each state be required as a condition of eligibility for the PRO.

In addition to reiterating many of the above points in its comments on the proposed Scope of Work for PRO Contracts, the AAMC noted the following:

- Limited Delegated Review--The proposed rules governing PRO Area Designation and Definitions of Eligible Organizations acknowledged that capable health care facilities could be delegated or subcontracted the PRO review function. However, the Scope of Work appears to be biased against this institutional utilization review and quality assurance alternative. Instead, it encourages centralized review of individual cases without provision for direct input from affected hospitals or their medical staffs. The AAMC believes that in most instances delegated review would provide a more administratively efficient and effective use of limited PRO funds for the review function and should be encouraged highly by HCFA in the Scope of Work.

- Limitations on Physician Participation and Representation in PRO's--Both the proposed regulations and the Scope of Work fail to ensure that a PRO has available a substantial number of active area physicians who are representative of the complete range of medical specialties to be reviewed. A PRO should be required to document that its physician members are actively involved in review activities and medical practice and are representative of the entire geographic area. Moreover, all major medical specialties should be represented to ensure that not only reconsiderations, but also initial peer review, utilization review, outlier review, and DRG validation are performed by physicians in the relevant specialty and with the appropriate

knowledge base needed. The AAMC strongly recommended that the Scope of Work reflect these legitimate concerns.

- Misuse of Scope of Work RFP to Impose Regulatory Requirements--Fundamental aspects of PRO activities and functions, objectives and review procedures appear in the draft Scope of Work Request for Proposal, but have never been addressed in regulation. The rules that have been proposed merely establish the area designation and organization eligibility criteria. Critical operational features of PRO's, such as those specified in the Scope of Work, should be subject to the formal regulatory process. This would assure appropriate opportunity for comment by the public and affected parties. Such basic PRO operational criteria should not simply be relegated to the status of an administrative procurement process which provides no defined role for hospital involvement in contractor selection. The AAMC objected to HCFA's attempt to do so.

MAJOR MEMBERSHIP MEETINGS

Two general membership meetings and a series of workshops on the new Medicare Prospective Payment System highlighted Departmental meeting activities during 1982-83. "Health Care Coalitions: Trustees in a New Role or Business As Usual?" was the theme of the COTH General Session held at the AAMC Annual Meeting in November, 1982. The featured speakers were Willis Goldbeck, Director of the Washington Business Group on Health, an organization that represents on health matters more than 200 of the nation's major business corporations, and Irwin W. Rabb, Vice Chairman of the Board and Director of the Stop and Shop Companies, Inc., a chain of retail food/drug stores headquartered in Boston.

COTH GENERAL SESSION

Business Will Exert More Influence in Health Care Costs and Delivery

Mr. Goldbeck emphasized that business, a major purchaser of health care, is increasingly aware of the need to exert some of its influence over the costs and manner in which health care is delivered. Its vehicle, he noted, is the "coalition," of which there are now between 80 and 100 in the United States involving more than 1,000 employers. He cited South Florida (Miami-Dade County area), Iowa (the Health Policy Corporation of Iowa), California (where 10 coalitions meet monthly), the Midwest Business Group on Health (a Chicago-based regional coalition that extends over several states), and Utah (the Utah Health Care Foundation) as examples of areas where business coalitions have already begun to take significant strides forward in the monitoring of utilization and introduction of increased competition in health care.

These coalitions are intent on striking a balance between need and cost, competition and regulation, and treatment and prevention, according to Mr. Goldbeck. He stated that they do not fear jeopardizing the "freedom-of-choice" of consumers because they believe such freedom is already largely non-existent. He warned that these coalitions will attempt to exercise their power as aggregate purchasers of health care, while concurrently becoming increasingly political. An example of the political activity is their vocal insistence that reform of the

hospital reimbursement systems under a prospective payment program be based on diagnosis related grouping (DRG).

Critical to the success of the coalitions will be the collection of data on such measures as the comparative costs, utilization, and quality of health care in their local areas, Mr. Goldbeck stated. He noted that this data collection process is well underway and will provide employers with the "shopping lists" they need to make informed decisions regarding their employee health benefits programs. He reminded the audience that data which do not list a specific patient's name are not subjected to confidentiality protections and will find their way into the data bases of business coalitions. He also predicted that the quality of these data would improve with its increased use for reimbursement purposes. He closed by expressing the belief that the coalitions would not use the data unreasonably or indiscriminately and invited a coalition from the academic medical community to meet with business coalition representatives in a joint effort to address the future financing of medical education.

Teaching Hospitals Should Cultivate Skills and Talents of Business

Mr. Rabb began by explaining that he found himself on both sides of the health care cost issue. On the one hand, he is a trustee of a teaching hospital and director of an HMO. On the other hand, he is director and senior executive of a corporation with 26,000 employees and a total medical bill of $11.8 million. He compared these costs to the firm's pre-tax profits of approximately $30 million, calling them "an enormous proportion (to be spending) for only one of many benefits." However, he argued that escalating health care costs were more an outgrowth of factors external to health care, such as the economy in general, rather than any dramatic change in the health care system itself. He suggested that measures taken thus far to temper these rising costs have been "fragmented and ineffective."

The ultimate answer to the problem of rising health care costs will come from "a systems approach toward which we have but begun to struggle," Mr. Rabb contended. He further explained that "the determinants of change from now on will no longer be either physicians or patients but rather those who pay the bill. Since the vast bulk of the bills are paid for by American business as well as government, it is these two cohorts that to a much greater extent will determine the shape of American medicine in the long run." He told the audience, "recognition of business as the new boy on the block and cultivation of its great skills and talents, are absolutely essential" for the survival of teaching hospitals.

Mr. Rabb believes the impetus for increased business influence over health care costs was the recent economic downturn in the United States. Corporate profits are being squeezed tighter, he explained, and under stress "those fellows in the corporate board room--the ones who have been so proud of the hosptial they serve as trustees--are listening to their corporate treasurer's calls for major cost cutting in the business," particularly in the area of employee health benefits. "The sobering fact," he asserted, "is not the rise in health care costs so much as the fall in the (corporate) profit margin...And you can bet, when it comes to an issue of who survives--the business or the hospital--you know who is going to win."

COTH SPRING MEETING

State and local schemes for controlling hospital expenditures, methods for managing physician use of hospital resources, the study of the costs of graduate medical education, and need for increased attention to be given to geriatric medicine were the main topics discussed at the annual COTH Spring Meeting. The meeting welcomed approximately 200 attendees and was held May 12 and 13 in New Orleans, Louisiana.

The featured speaker on the first morning was William Guy, who has come to be known as the "Medi-Cal Czar". In describing the experimental California Medicaid cost containment initiative that he was appointed to administer during its first year of operation, Guy characterized it as "the cure for the California disease," meaning that it fit the peculiar political and financing situations extant in his state. He cautioned that other states might not find it the correct solution for their problems.

The factors leading to California's decision to adopt his bidding process, according to Guy were: (1) the hospitals successfully opposed the concept of a public utility model for controlling expenditures; (2) a rapid growth in Health Maintenance Organizations (HMOs) in the state, some of which were able to negotiate contracts with hospitals that allowed them to pay less per episode of hospital care than Medi-Cal paid; (3) the ability of business coalitions to obtain significant discount rates for employees of their member organizations; (4) the rapid growth of for-profit hospitals in the state; and (5) the inability of state legislators to balance the budget without reducing the largest category of expenditures -- Medi-Cal hospital care. Guy said the resulting system of bidding was a "natural" because it made Medi-Cal a part of "the free-market place driven system."

States Need to Do Soul Searching

The Medi-Cal system is ostensibly a bidding process. The state is sectioned into areas of a manageable size. Hospitals within each area are invited to submit bids to provide care for Medi-Cal patients, and these bids are accepted, rejected, or used as a basis for negotiating a contract. At the time of the Spring meeting, bidding had taken place in only a limited number of areas of California; however, in those areas, some hospitals that traditionally served a substantial number of Medi-Cal patients or which served particularly difficult Medi-Cal patients, such as infants requiring intensive care, were not awarded contracts. Every state needs to "do some soul searching before changing its social system," as this Medi-Cal bidding and contracting will, Guy warned.

He emphasized that the real issue of concern to the state and federal government and businessmen is the financial accountability of hospitals and suggested that the hospital's ability to unilaterally determine the costs and charges for inpatient care will become extinct. He believes that the state legislature chose to create the "Czar" position for only one year because the system had to be implemented quickly in order to produce the requisite savings, but legislators recognized this was "not the best way to run government."

Redefinition of "Medically Necessary Services" is Major Problem

Paul Ward, president of the California Hospital Association, and William Gurtner, executive vice president of Mt. Zion Hospital and Medical Center, San

Francisco, responded to Guy's remarks and, more broadly, provided their own perspectives on the Medi-Cal system. Ward called contracting "simply a period through which we are going," predicting that attention will soon be diverted from the issue of cost to the denial of care. He said California redefined a "medically necessary service" as one involving the saving of life or limb. This change in definition, which occurred simultaneously with the change to contracting, is the major problem with Medi-Cal in his estimation.

He said that this change in definition was part of the "hidden agenda" to limit the number of Medi-Cal patients who have access to care. Another limit on Medi-Cal beneficiaries' access to care was the confusion resulting from the contracting process. He identified four drawbacks to the contracting process: (1) the apprehension of beneficiaries with selecting a health provider based on price; (2) the economic restrictions on the availability of high technology services; (3) the "dumping of high cost Medi-Cal patients on hospitals willing to provide services for which there is no assurance of payments; and (4) the reduction of services offered by hospitals under an "all inclusive" per diem.

Realities of the Process, Reactions to Denial of Contract

Hospitals that traditionally served large Medi-Cal populations had very different concerns with the contracting than those serving small numbers of Medi-Cal patients, William Gurtner told his colleagues at the Spring Meeting. Those hospitals for which Medi-Cal recipients constituted less than six percent of their patients had to consider the implications of pursuing or not pursuing a Medi-Cal contract. They had to weigh the loss of patients and potential problems with meeting Hill-Burton obligations or obtaining Certificates of Need if they appeared unwilling to serve the poor against the potential for winning a contract and attracting a larger proportion of Medi-Cal patients. "Medicaid business is not a 'winner' economically," he reminded the audience.

He called the simplicity of the bidding process "both the beauty and the beast of what Guy produced." He pointed out that it clearly defined the business of the state in health care as paying for beds. This meant no recognition was given to the differences in hospitals or the services they rendered.

Gurtner felt fortunate that at Mt. Zion, which has been one of the largest providers of care for Medi-Cal recipients, the strategic planning process had begun before the onset of contracting. Its Board of Trustees had agreed there was a point beyond which "Mt. Zion would refuse to bleed to death for the state of California." Thus, he went into the bidding with a bottom line to his negotiating.

The denial of a contract to Mt. Zion resulted in distinct reactions from three important groups. Gurtner described these as:

- Medical Staff -- Only a small number of the staff physicians were significantly involved in the treatment of Medi-Cal patients, so the majority of the staff was largely unaffected. Several saw it as an opportunity to raise the issue of the mission of the institution. Those who were directly affected found it confusing. Physicians had to be told they couln't admit Medi-Cal patients to Mt. Zion anymore, and patients were told they had to go elsewhere to receive care.

- The Press -- The media were primarily concerned with whether these changes might cause people to lose their jobs and with what "horror stories" would emerge from patients not receiving care. However, he was unable to supply examples of either, as yet.

- The Board -- He described his Board as well prepared to live with the consequences of their decision.

Gurtner warned others, that in attempting to transplant the Medi-Cal bidding process to other states, they should be cognizant of three areas of concern:

- market segmentation, that is, the skimming of the healthier patients by some hospitals and the abandonment of the more costly patients;

- teaching costs, which each payor and government body perceives to be someone else's responsibility; and

- a simplistic approach to competition, wherein the contracting fails to recognize differences among hospitals and the types of services they provide.

"Managed Care" Chosen By Massachusetts Plan

The executive director of the Commonwealth Health Care Corporation, Rina K. Spence, then described a more tedious, but it is hoped longer range, solution to restraining rising Medicaid costs that was adopted in Massachusetts. The goals of this program are to assure access to needed facilities, provide better care, and constrain costs. The solution, according to Spence, was to change the site of services rendered to the lowest cost alternative available.

The system chosen in Massachusetts is one of "managed care" delivered at the discretion of the primary care physician. The state contracts with various groups of primary care physicians to assure the provision of care to Medicaid recipients. They, in turn, decide what care is necessary and how to efficiently obtain the services of needed specialists.

While the Massachusetts' system had yet to be implemented at the time of the Spring Meeting, Spence predicted that a crucial factor in making this, or any other system to restrain costs, work is the involvement of a "critical mass" of patients. This "critical mass" would ensure that physicians and institutions could not ignore the program and would have to modify their behavior to respond to its incentives.

Teaching Hospitals Involvement in PPO

One potential response of the teaching hospital to the price sensitive and competitive environment of the current health care market is to establish a preferred provider organization (PPO), according to Gary Brukardt, vice president of Affiliated Corporations, the PPO, at Presbyterian-St. Luke's Health Care Corporation in Denver. Presbyterian-St. Luke's has established one. Brukardt emphasized the need to recognize the trend toward spending less in the hospital and more in other less costly settings. He also noted changes in life styles, particularly the increase of women in the work force, which are changing the patterns of what Americans want from the health care system into an "episodic care market." Teaching hospitals can take advantage of these trends by branching out to offer non-hospital-based services, according to the speaker.

He outlined the basics of competing as a Preferred Provider Organization, including:

- replacing the concepts of cost-based reimbursement with those of pricing theory, recognizing that routine care services need to be priced competively but "exotic care" services will not be;
- deterimining the cost of delivering each service in order to establish appropriate prices; and
- increasing awareness of the public's impression of the service and the public's perception of the institution in order to obtain and preserve a share of the market.

To dispell the notion that the public would be reluctant to join PPOs because they preferred to stay with their own physicians, Brukardt said surveys have shown that the public can be persuaded to change, and that being $18 less expensive per visit can be the difference between loyalty to one's physician and choosing a physician based on price. He concluded that the preferred provider organization is an environment in which all forces--physician, institution, payer, and patient--try to manage the costs.

Cooperative Systems Described

The approaches taken to contain hospital expenditures in the Rochester, New York area and Medicaid expenditures in North Carolina were formulated with extensive cooperation and input from the hosptial sector, according to presentations made by Gennaro J. Vasile, Ph.D., the executive director of Strong Memorial Hospital, and Eric B. Munson, executive director of The North Carolina Memorial Hospital. Vasile described the Rochester area's costs containment approach as having its genesis in the concern of the trustees of certain area hospitals that the burden of indigent care was unevenly distributed and thus threatened some hospitals' economic future. Not wishing to abandon the hospitals traditional commitment to care for the poor, they sought to establish a system that would offer all of the hospitals an opportunity to prosper. The system they developed caps revenues at the level of 1978 costs increased for inflation, volume, certificate of need approved items, and other allowances.

In contrast, the impetus for the North Carolina Medicaid system came from the reduction of federal funding for the state Medicaid program, Munson told the audience. The hospitals, state officials, and others worked to create a system which would shift Medicaid beneficiaries away from high cost providers of care and toward lower cost hospitals. They established limits on the number of high cost Medicaid patient days. This prompted teaching hospitals to be sure that their Medicaid patients genuinely needed the high cost services offered. Munson said no sophisticated analysis of the behavioral changes brought about by this system was available at the time of the Spring Meeting because the system was so new and a change to a more automated data system had resulted in an extensive backlog of claims. He speculated that little or nothing had changed in the behavior patterns in hospitals that had fewer than 10% Medicaid patients, reinforcing Spence's assertion that a critical mass of patients was necessary. Other hospitals, he felt may have found ways to shift the costs of Medicaid patients to other payers rather than alter their admissions procedures.

After several years experience with the Rochester system, Vasile commented that its strengths lie in (1) its local control, (2) its incentives for efficient

operation, (3) the way in which it can be integrated with community planning, and (4) the bolstering of the trustee-administration-physician relationship. Its faults, as he saw them included the fact that revenues have not been as predictable as originally anticipated, no acceptable case-mix adjustment method has been developed, and there is need to systematically examine the costs structure of area hospitals.

Arizona Adapts to Medicaid

After electing not to participate in the Medicaid program for 15 years, Arizona decided in 1981 to enter the program using a "delivery system for the poor driven by competition." The new system is called the Arizona Health Care Cost Containment System (AHCCCS) and reflects the conservative nature of the state's politics, David A. Reed told his fellow hospital executives. Reed, who is president of Samaritan Health Services and a new member of the COTH Administrative Board, characterized the Arizona system as a bidding process in which providers submit bids to assure care would be given to a specified segment of the poor in Arizona. These bids could be accepted or rejected by the contract administrator, but negotiation was precluded.

The program started on October 1, 1982, but experienced some initial difficulties. In some instances, providers were not informed of the enrollees for whom they were responsible. Data was not yet available for Reed to be able to report on the success or failure of the program since it was only in its eighth month of operation. However, he was able to report that initial enrollment was slow, those who did enroll were largely high risk patients or those contemplating major medical care, there was conflict between some of the rules of the program and the quality assurance guidelines of the hospitals, and generally, logistical and administrative start up problems had compromised the concepts of competition and capitation. Reed said AHCCCS was currently turning its attention toward attempting to enroll members of the private sector.

Financing Affects Consumer Behavior, Rand Study Shows

Does cost sharing effect demand? We will see that it does, Joseph Newhouse, Ph.D. told the spring meeting audience. Newhouse, who is head of the economics department at The Rand Corporation, reported on his research into how great an effect financing had on consumer behavior when purchasing health care. The Rand experiment involved more than 8000 people in six states who were covered for a wide variety of health services, but to varying degrees shared in the cost of those services. Some paid none of the cost of the service, while others paid twenty-five, fifty, or ninety-five percent of the cost. The insuror paid the remaining portion of the cost. There was a limit on the amount the insured would have to pay, and that limit was $1000 or a percentage of the family's income, whichever was smaller.

Newhouse concluded that the data collected during this experiment proved that "cost sharing did indeed make a difference." His data showed variation in the use of services of as much as 50 to 60 percent between plans in which the patient paid none of the costs and plans in which the patient paid a substantial deductible. A significant difference in the admission rates of patients were found, even when the patient is only paying the deductible on the ambulatory portion of the service. For example, the data show that 10 percent of the patients who paid none of the cost of care were hospitalized, while only 7 to 8 percent of the participants in the other insurance arrangements were hospitalized. This shift in hospitalization rate was all in the adult

population; there was no discernible difference in the pediatric admission rate, according to the Rand data.

Newhouse concluded that changes in the financing arrangements for health care would affect consumer behavior, and thus, would affect the operation of hospitals, but that teaching hospitals are not likely to be differentially affected.

Interest in Geriatric Medicine Stimulated

The AAMC has decided to take an active role in promoting geriatric medicine, John Sherman, Ph.D., explained, but it did not want to "promote a model curriculum." Sherman, who is vice president of the AAMC, stated that the AAMC prepare guidelines for education about geriatrics in order to provide a stimulus for discussion at four regional institutes to be held by the AAMC. At the conferences, the integration of material concerning care for the aged within the normal course work, and encompassing all four years of medical school, will be emphasized.

He hoped physicians would be educated to distinguish between the natural aging process and disease processes. Additionally, he believed physicians and other health practitioners should learn to preserve the independence of which the elderly are capable.

Expanding on Sherman's remarks, Carl Eisdorfer, M.D. listed existing problems hampering the provision of appropriate care to the elderly:

- Our cultural faith in high cost technology as a panacea without evaluation of the improvement in health that results from this increase in cost;
- Lack of attention to improvements in the physical environment of the elderly that might reduce reliance on institutional care; and
- Medical education's emphasis on scientific "hands on" care rather than creation of an environment for health.

Eisdorfer suggested that teaching hospitals were the appropriate institutions to take the lead in making some of the necessary changes. He lauded a Robert Wood Johnson Foundation initiative to fund ten hospitals that were attempting to involve themselves in extended care. The overwhelming positive response to project has induced the Foundation to consider doubling the number of recipients of awards. He emphasized that the elderly are the fastest growing segment of the population and the largest consumers of hospital and nursing services, a trend which is expected to increase through the turn of the century as longevity increases and as the "baby boom" generation reaches 65. He advocated the reorganization of the health care system to respond to this trend.

Options for Managing Delivery of Care

"When we are talking about cutting health care costs, we have to decide what we are going to eliminate," John M. Eisenberg, M.D. reminded the Spring Meeting audience. He, Richard Gaintner, M.D. and Warren Nestler, M.D. discussed how hospitals can manage the medical enterprise to respond to the incentives and disincentives in the new payment systems.

Eisenberg, who is chief of the section of General Medicine at the Hospital of the University of Pennsylvania (HUP), discussed the attempts to curtail residents' use of ancillary services. Drawing upon the work done in behavioral modification techniques, he asserted that there are four principles to altering behavior: (1) understand why a person behaves as he/she does; (2) offer incentives to change and/or punish old behavior patterns; (3) have scheduled reinforcement of learned behavior; and, (4) use individualized instruction for greater effectiveness.

In a survey of physicians and residents at HUP, Eisenberg found that the most common perceptions of why there is excessive use of ancillary services are the inexperience of the physician, habit, and pressure from other physicians. Successful accomplishment of change is largely dependent on having a change agent, that is, an individual who is respected by peers, to act as a catalyst, he asserted.

Six methods of behavior modification have been tested on residents, Eisenberg reported. These are: (1) education; (2) feedback; (3) administrative changes; (4) financial reward; (5) financial penalties; and (6) participation. He reported that education may work to reduce test usage during the duration of the education program; however, when the education stops, utilization tends to creep back up to its former level. Feedback alone did not work, and residents were offended by attempts to "bribe" them with financial rewards, he said. Administrative changes that increased the "nuisance factors" were the easiest changes to make, but did not drastically alter behavior. Financial penalties for over-utilization appeared to work, he said, but they are onerous. Charismatic leadership was the most effective technique for controlling resident behavior, according to Eisenberg's data. He concluded that a combination of these techniques, such as charismatic leadership in providing education and follow up by feedback to the physicians, or link to a system for rewarding such behavior, would be best.

Hopkins Uses Decentralized Approach to Management

To respond to a perceived need to improve its operating efficiency, The Johns Hopkins Hospital decentralized its operation, delegating much of the authority and responsibility for creating and living within the budget to each of its 12 department chairmen. Richard Gaintner, former vice president and deputy director at Hopkins and the current President and Chief Executive Officer of Albany Medical Center, described the Hopkins organizational configuration. The department chairman are responsible for assuring that the resources necessary for proper treatment of patients admitted to their areas are available and that the physicians in the department efficaciously use those resources. The structural change was made prior to the institution of the Maryland Hospital Rate Review Commission, but Gaintner averred that it allowed the hospital to be well-suited to respond to the state's cost containment program. He listed several factors he felt were essential in creating this decentralized structure, including:

- acceptance of and support from the nursing staff;
- development of a management information system that would allow the departments to assess their performance; and
- establishment of effective communication between the central office and the departments.

Gaintner concluded that this structure was ideal for responding to prospective payment incentives because it is "aimed at bringing physicians into the financial management as well as the medical management" of the hospital.

New Jersey Hospital Aims to Be A "Not-for-Loss" Institution

To prosper under a DRG-based prospective payment scheme, hospitals need to create an environment in which physicians can behave efficiently, and then change physician behavior so that it is efficient, according to Warren Nestler, M.D., vice president of Overlook Hospital in Summit, New Jersey. Nestler described Overlook as "a 550 bed not-for-profit, but not-for-loss" hospital which has been under New Jersey's DRG-based payment scheme since its inception in 1980. He told the Spring Meeting participants that DRGs allowed hospitals to compare their performance in terms of a "product line" and pressured hospital administrators to influence physician behavior.

Success under this system is dependent on having the commitment and involvement of the leaders of the medical staff as well as the hospital administration, Nestler stated. He also saw the need for "product line pricing reports" that compare the hospitals average performance in caring for a particular type of patient to its peers' performances. Nestler said he left the financial manipulations to the hospital's administrative staff and that the medical staff was responsible for ensuring that the correct data are recorded on the patient's chart so valid assignment to a DRG can be made.

Progress Report on National Study of Graduate Medical Education Costs

The meeting participants heard a description of the methodology being used by Arthur Young & Company to examine the cost of medical education in the teaching hospital under a four year study it is conducting for the Department of Health and Human Services. Richard F. Thompkins, Ed.D., who is manager of the study for the firm, explained the logic employed in attempting to identify the costs of medical education as well as some of the offsets to these costs. He discussed the analytic approach being used in hopes of collecting all possible data including additional personnel time spent in helping students and residents to learn, additional diagnostic test use, additional space and other needs. The study is in its second year but there was no specific data that Thompkins could report as yet.

The Medicare Prospective Payment System: Implications for Medical Schools and Faculties

During the summer of 1983 the AAMC conducted a series of four two-day regional seminars to accquaint deans, chairmen of clinical departments and teaching hospital executives with the new Medicare Prospective Payment System and the revisions to the provisions for paying physicians. In order to provide the opportunity for useful discussions between the workshop faculty and the attendees, attendance was limited. The sessions began with a keynote speech delivered by a well respected teaching hospital executive from the region in which the session was held or the president of the AAMC. John W. Colloton, director of the University of Iowa Hospitals and Clinics, delivered the keynote address at the first session. He was succeeded by Robert G. Petersdorf, M.D., Vice Chancellor for Health Sciences and dean at the University of California at San Diego at the second session; John A. D. Cooper, M.D., president of the AAMC at the third session; and Robert Heyssel, M.D., president of the Johns Hopkins Hospital at the last workshop. Each of these speakers emphasized the need for

hospitals to seriously consider the new challenge confronting teaching hospitals as a result of the adoption of the Medicare Prospective Payment System and the increasingly competitive and price sensitive environment and to respond to the new incentives so that they might continue to provide quality care, education, and research.

The workshops continued with presentations by the Department of Teaching Hospitals staff describing the relevant provisions of the Social Security Act of 1983, which established the Prospective Payment System; examining the construction of and problems with the Diagnosis Related Groups (DRGs), which are the analytic building blocks of the payment system; and enumerating the key implications for medical schools and teaching hospitals. The discussion of key implications emphasized the changes hospital executives must make in relating to the medical staff, including a reexamination of the services to be provided and the research projects to be undertaken. Then, a presentation was made by Peter Butler, Assistant Vice President for Finance at Rush-Presbyterian-St. Luke's Medical Center, displaying his institution's approach to generating the data necessary to manage under a prospective, price per case system.

At each session, presentations offering a different insight into an institution's approach to generating the necessary management data was made by Shara Pavkow, director of clinical affairs at the University of Miami School of Medicine; Donald Simborg, director of hospital information at University of California at San Francisco Hospitals and Clinics; or Francis J. Sweeney, Jr., M.D., vice president for health sciences and hospital director at Thomas Jefferson University.

These presentations on data generation were followed by discussions of various approaches to modifying physician behavior in order to respond to the new incentives. The results of studies attempting to alter physician practices were described by John Eisenberg, M.D., chief of the section of General Medicine at the Hospital of the University of Pennsylvania and Elliot Sussman, M.D., director of the health evaluation center at the same institution. Spencer (Spike) Foreman, M.D., president of Sinai Hospital of Baltimore and J. Richard Gaintner, M.D., president of Albany Medical Center offered their insites into how a hospital actually responded to prospective payment, particularly addressing how to encourage physicians to respond appropriately.

The second half of each workshop was devoted to the changes in Medicare's method of paying for physician services in a teaching hospital setting. Staff of the Department provide a clear and concise explanation of those changes. This discussion was followed by a presentation by Donald Tower, executive director of the faculty practice plan at Stanford University School of Medicine; Robert Heins, director of the Medical Service Plan at the University of Texas Southwestern Medical School; David Bachrach, director of administrative and financial affairs at the University of Michigan Medical School; or Cheryl Gillen Rice, assistant vice president for health sciences administration at Columbia University. These speakers discussed the changes that had to be made in reimbursement policies and procedures to accommodate the new rules.

Several representatives from AAMC member institutions indicated a desire to inform a broader constituency within their institution of the implications of these regulatory changes. Therefore, the AAMC has condensed these presentations into two sets of tapes. Further details are available from the Management Education Program of the AAMc at (202) 828-0519.

APPENDICES

APPENDIX A

COTH OFFICERS AND ADMINISTRATIVE BOARD
1982-1983

Officers:

Chairman: Earl J. Frederick *	The Children's Memorial Hospital, Chicago
Chairman-Elect: Haynes Rice *	Howard University Hospital, Washington, D.C.
Immediate Past Chairman: Mitchell T. Rabkin, MD*	Beth Israel Hospital, Boston, Massachusetts
Secretary: James W. Bartlett, MD	Strong Memorial Hospital of the University of Rochester

COTH Administrative Board Members:

Terms Expiring 1983:

Spencer Foreman, MD	Sinai Hospital of Baltimore, Maryland
John V. Sheehan	Veterans Administration Medical Center, Houston

Terms Expiring 1984:

Jeptha W. Dalston, PhD	University Hospitals, Ann Arbor, Michigan
Irwin Goldberg	Montefiore Hospital, Pittsburgh, Pennsylvania
Sheldon S. King	Stanford University Hospital, Stanford, California

Terms Expiring 1985:

Glenn R. Mitchell	Alliance Health Systems, Norfolk, Virginia
David A. Reed	Samaritan Health Service, Phoenix, Arizona
C. Thomas Smith	Yale-New Haven Hospital, New Haven, Connecticut

Ex-Officio Member

Robert E. Frank *	Barnes Hospital St. Louis, Missouri

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* COTH Representatives to the AAMC Executive Council

APPENDIX B

COTH REPRESENTATIVES TO AAMC ASSEMBLY
1982 - 1983

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 Forman, 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, Dallas, Tx.
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, 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.
Eric J. Frederick	The Children's Memorial Hospital, Chicago, Ill.
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	Alliance Health Systems, Norfolk, Va.
John A. Reinertsen	University of Utah Hospital, Salt Lake City, Ut.
Vito F. Rallo	University of Cincinnati Hospital, Cincinnati, Oh.

Term Expiring 1985:

Glenn Alred, Jr.	Veterans Administration Medical Center, Decatur, Ga.
Ron Anderson, M.D.	Parkland Memorial Hospital, Dallas, Tx.
Donald Cramp	Ohio State University Hospital, Columbus, Oh.
Robert Dickler	University Hospital, Denver, Co.
Phillip Dutcher	Hurley Medical Center, Flint, Mich.
William Gonzalez	University of California, Irvine Medical Center, Orange, Cal.
James Heimarck	Monmouth Medical Center, Long Branch, N.J.
Jane Hurd	Children's Hospital of Los Angeles, Cal.
Daniel Kane	Mount Sinai Medical Center, Milwaukee, Wi.
Marvin Klein	Temple University Hospital, Philadelphia, Pa.
Frank Lloyd, M.D.	Methodist Hospital, Indianapolis, Ind.
James Malloy	University of Illinois Hospital, Chicago, Ill.
Plato Marinakos	Mercy Catholic Medical Center, Darby, Pa.
James Mongan, M.D.	Truman Medical Center, Kansas City, Mo.
Robert Morris	Veterans Administration Medical Center, Hampton, Va.

Robert Muilenburg	University of Washington Hospital, Seattle, Wa.
Eric Munson	North Carolina Memorial Hospital, Chapel Hill, N.C.
H. Richard Nesson, M.D.	Brigham and Women's Hospital, Boston, Ma.
Robert Newman, M.D.	Beth Israel, Medical Center, New York, N.Y.
Linn Perkins	St. Louis Children's Hospital, St. Louis, Mo.
Barbara Small	Veterans Administration Medical Center, Boston, Ma.

APPENDIX C

COTH COMMITTEE APPOINTMENTS 1982-1983

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

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

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

AUDIT COMMITTEE

Earl Frederick, Chairman, Children's Memorial Hospital, Chicago

COTH NOMINATING

Mitchell T. Rabkin, M.D., Chairman, Beth Israel Hospital, Boston
Fred J. Cowell, Jackson Memorial Hospital, Miami
Earl J. Frederick, Chidren's Memorial Hospital, Chicago

COTH SPRING MEETING PLANNING

Glenn R. Mitchell, Chairman, Alliance Health Systems, Norfolk
Ron J. Anderson, M.D., Parkland Memorial Hospital, Dallas
James W. Holsinger, Jr., M.D., McGuire V.A. Medical Center, Richmond
Robert H. Muilenburg, University of Washington Hospitals, Seattle
Charles M. O'Brien, Georgetown University Medical Center, Washington, D.C.
Daniel L. Stickler, Presbyterian-University Hospital, Pittsburgh

COUNCIL FOR MEDICAL AFFAIRS

Robert M. Heyssel, M.D., The Johns Hopkins Hospital, Baltimore

FINANCE

Robert E. Frank, Barnes Hospital, St. Louis
Mitchell T. Rabkin, M.D., Beth Israel Hospital, Boston

GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN AND COLLEGE PREPARATION FOR MEDICINE

John W. Colloton, University of Iowa Hospitals and Clinics

GOVERNANCE AND STRUCTURE

John W. Colloton, University of Iowa Hospitals and Clinics

JOURNAL OF MEDICAL EDUCATION EDITORIAL BOARD

Sheldon S. King, Stanford University Hospital, Stanford, California
Robert K. Match, M.D., Long Island Jewish-Hillside Medical Center, New York

APPENDIX C

COTH COMMITTEE APPOINTMENTS 1982-1983

Continued

LIAISON COMMITTEE ON MEDICAL EDUCATION

J. Robert Buchanan, M.D., Massachusetts General Hospital

MANAGEMENT EDUCATION PROGRAMS

David L. Everhart, Northwestern Memorial Hospital, Chicago

AAMC NOMINATING

John W. Colloton, Chairman, University of Iowa Hospitals and Clinics
Mitchell T. Rabkin, M.D., Beth Israel Hospital, Boston

PAYMENT FOR PHYSICIAN SERVICES IN TEACHING HOSPITALS

Hiram C. Polk, Jr., M.D., University of Louisville School of Medicine
Irwin Birnbaum, Montefiore Hospital and Medical Center, Bronx, New York
David M. Brown, M.D., University of Minnesota Medical School
Thomas A. Bruce, M.D., University of Arkansas School of Medicine
Jack M. Colwill, M.D., University of Missouri-Columbia School of Medicine
Martin G. Dillard, M.D., Howard University Hospital, Washington, D.C.
Fairfield Goodale, M.D., Medical College of Georgia
Robert W. Heins, The University of Texas Southwestern Medical School, Dallas
Sheldon S. King, Stanford University Hospital, Stanford, California
Jerome H. Modell, M.D., University of Florida Miller Health Center, Gainesville
Marvin H. Siegel, J.D., University of Miami School of Medicine
Alton I. Sutnick, M.D., The Medical College of Pennsylvania, Philadelphia
Sheldon M. Wolff, M.D., Tufts University School of Medicine

PROSPECTIVE PAYMENT FOR HOSPITALS

C. Thomas Smith, Chairman, Yale-New Haven Hospital, New Haven, Connecticut
David Bacharach, The University of Michigan Medical School, Ann Arbor
Robert J. Baker, University of Nebraska Hospital and Clinics, Omaha
William B. Deal, M.D., University of Florida College of Medicine, Gainesville
Robert J. Erra, University of California Medical Center, San Diego
Harold J. Fallon, M.D., Medical College of Virgina, Richmond
Ronald P. Kaufman, M.D., George Wasington University Medical Center
Frank G. Moody, M.D., University of Texas Medical School at Houston
Ray G. Newman, Parkland Memorial Hospital, Dallas
Douglas Peters, Henry Ford Hospital, Detroit
Arthur Piper, Hospital of the University of Pennsylvania, Philadelphia

APPENDIX D

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

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202/828-0490

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202/828-0493

Joseph C. Isaacs, M.S.P.H.
Senior Staff Associate
202/828-0496

Nancy E. Seline
Staff Associate
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Melissa H. Wubbold
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Andrea L. McCusker
Secretary
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Janie Bigelow
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APPENDIX E

LISTING OF COTH PUBLICATIONS AVAILABLE FROM THE AAMC

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

TITLE	PRICE PER COPY
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
Selected Data from A Small Sample of Teaching Hospitals	$10.00
A Description of Teaching Hospital Characteristics	$ 3.00
Medicare Prospective Payment: Probable Effects on Academic Health Center Hospitals	FREE
COTH Directory of Educational Programs and Services - 1983	$ 7.00
COTH Survey of Housestaff Stipends, Benefits and Funding - 1983 (available late Fall, 1983)	$ 7.00
COTH Report (monthly newsletter)	$30.00 per annum

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