



association of american
medical colleges

SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

NOVEMBER, 1983-OCTOBER, 1984

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 (COH) Annual Membership meeting held each fall. This document summarizes Departmental activities from November, 1983 through October, 1984. 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 Council of Teaching Hospitals' Administrative Board represents the interests of the Council as a whole in the deliberations and policy making of the AAMC. This Board also provides representation to the Association's Executive Council. The nine members of the Administrative Board serve three year terms. Board membership also includes the Chairman, Chairman-Elect, Immediate Past Chairman, and Secretary. Sheldon S. King, Executive Vice President of Stanford University Hospital will serve as Chairman of the Council of Teaching Hospitals in 1984-85, succeeding outgoing Chairman Haynes Rice, Director of Howard University Hospital in Washington, D.C. The members and officers of the COTH Administrative Board are listed in Appendix A. The Administrative Board is elected at the AAMC annual meeting. Appendix B contains a listing of the COTH Representatives to the AAMC Assembly who are also elected at the annual meeting, and Appendix C includes Committee Appointments that occurred during 1983-84.

The Administrative Board of the Council of Teaching Hospitals has met four times during the past year to conduct business and discuss issues of interest and importance. As might be expected, substantial attention was devoted to the Medicare prospective payment system and its effect on teaching hospitals. The Administrative Board also considered a paper entitled "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals" that explored both past and possible future AAMC activities in response to the special needs, concerns and opportunities that face teaching hospitals in the rapidly changing health care environment. Other topics at the COTH Board meeting included increasing the length of graduate medical education programs, new JCAH requirements, resident supervision in teaching hospitals, formal relationships with other organizations, and participation of investor-owned hospitals in COTH. With regard to this final item, the Board requested that COTH membership be asked to express its views at the COTH Spring Meeting in Baltimore and at the annual business meeting that's held during the annual meeting in Chicago. The COTH Board also reviewed and considered items on the Executive Council Agenda which were of interest to the AAMC membership as a whole.

Two Committees with COTH representation were formed during the year to discuss specific issues. An Ad-Hoc Committee on Capital Payment for Hospitals under Medicare was established to review options and methodologies for incorporating capital costs into the prospective payment system. Results of this Committee's work will be widely distributed in November of 1984, and the Committee will continue to monitor this issue as future events unfold. The Committee on Financing Graduate Medical Education was formed to evaluate proposed alternative financing mechanisms and to safeguard the future of graduate medical education. The Committee had its organizational meeting on September 12th.

COTH Membership

Membership in the Council of Teaching Hospitals includes two categories. Teaching hospital, or full voting membership, requires that a teaching hospital be a non-profit (IRS 501)(c)(3) or a governmental hospital with a written affiliation agreement with a medical school that is accredited by the Liaison Committee on Medical Education. A letter recommending membership from the dean of the affiliated medical school must be received by the Department of Teaching Hospitals. Criteria for membership in the Council of Teaching Hospitals include: 1) hospital sponsorship or significant participation in at least four approved residency programs; and 2) that at least two of these residency programs are in the fields of internal medicine, general medicine, surgery, obstetrics-gynecology, pediatrics, family practice, or psychiatry. In the case of specialty hospitals, such as children's hospitals, exceptions may be made to the residency program requirement as long as the hospital meets the membership criteria within the framework of the specialized objectives of the hospital.

Corresponding membership is available to all 501(c)(3) and governmental institutions that cannot meet the above mentioned requirements for full membership. Corresponding members are eligible to attend all open Association meetings and receive all publications sent to the full teaching hospital membership, but do not have a vote within AAMC Assembly. Presently, the Council of Teaching Hospitals includes 430 full teaching hospitals members and 33 corresponding members. Included in the membership are private not-for-profit institutions, municipal or state owned and operated institutions, and veterans administration hospitals.

SURVEYS AND PUBLICATIONS

To provide educational and information services to its constituents, the Department of Teaching Hospitals has five regular publications which it distributes to the membership at no charge. Additionally, special reports are published that focus on applicable current events and issues of importance to the constituents. The publications are described below and those available for purchase are listed separately in Appendix E.

COTH Report

The Association's Council of Teaching Hospitals prepares a newsletter entitled the COTH Report. This newsletter is published approximately ten times annually and is distributed to more than 2,600 subscribers including COTH members, the Council of Deans, the Council of Academic Societies, the Organization of Student Representatives, and all members of the United States Congress. The objective of the newsletter is to provide readers with comprehensive coverage of Association and Council activities, legislative and regulatory actions, analyses of studies, surveys and reports that are applicable to providers of health care, and other topics of interest. Non-AAMC members wishing to subscribe to this publication are charged a \$30 fee annually.

COTH Directory of Educational Programs and Services

A directory of the COTH membership is prepared and distributed annually to all COTH members. Included in the Directory is a profile of each COTH member hospital with specific operational and educational program data. In order to complete the Directory, questionnaires are mailed in December of each year. The 1985 Directory will be published in the spring. Copies are sent to each member

of COTH and the Deans of the medical schools. The Directory is \$7 a copy and may be obtained from the AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

COTH Executive Salary Survey

Two personal and confidential surveys are completed by the Department of Teaching Hospitals each year. Information on salaries and fringe benefits of the chief executive officers of the major teaching hospitals that comprise the membership of COTH is included in the COTH Executive Salary Survey. This information, as well as additional hospital compensation policies, is presented comparatively by ownership, region, affiliation, and bed size. Similar information is provided for department heads and other administrative persons within these institutions. 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 this survey upon request. However, the chief executive officer will be informed when a copy has been provided to a board member.

COTH Survey of University-Owned Teaching Hospitals' Financial and General Operating Data

The second personal and confidential survey completed by the Department of Teaching Hospitals includes detailed information on university owned hospital revenue sources, expenses, capital expenditures, utilization of services, staffing, and other general operating data. The distribution of this report is restricted to institutions participating in the survey.

COTH Survey of Housestaff Stipends, Benefits, and Funding

The housestaff stipends, benefits, and funding survey has been completed by COTH for the past fourteen years. Preliminary information is published in June and a final report is prepared for distribution later in the year. Data include housestaff stipends by hospital region, ownership, bed size, and affiliation. This report is distributed to all COTH member hospitals. Additional copies are available for \$7 each from: AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

Toward an Understanding of Capital Costs in COTH Hospitals

Data from the American Hospital Association's annual hospital survey was used to determine historical capital outlays for teaching hospitals and to assist in describing the role capital costs play in the operating budget of major teaching hospitals compared to all hospitals. Initial findings of the survey were in conflict with the "conventional wisdom" that major teaching hospitals have atypically high costs because of their role in developing new technologies and initiating new diagnostic treatment services. The substance of this paper is described on page 18 of this report. This paper is available at no cost from the Department of Teaching Hospitals.

New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals

Developed to stimulate and focus future discussions, activities and initiatives of the AAMC's Department of Teaching Hospitals, the paper discusses how the changing environment, the challenges of competition and the need for

strategic decision making might affect future priorities of AAMC staff. Future COTH/AAMC activities proposed in the paper included strengthening the role of advocacy. The report stated:

"By its very nature and structure, the AAMC is focused on advocacy. In the past two decades, this advocacy has focused on supporting the expansion and development of member capabilities. In the near future, the advocacy emphasis will shift to protecting the diversity of the membership and preserving special benefits, subsidies, and advantages available to teaching hospitals. With third party payers increasingly setting fixed levels of expenditures for hospital services, the AAMC must work to protect the teaching hospital share. Advocacy, however, is not limited to the political process of legislation, regulation and oversight. It includes building public awareness as well as appreciation for, and support of teaching hospitals. The predominately local nature of hospital service markets and the increasing emphasis on local payment arrangements stimulates the need for public advocacy of the generic benefits provided by teaching hospitals. The role, responsibility and contributions of teaching hospitals to the health care system need to be articulated forcefully and constantly. In view of the rapidly changing hospital and medical service environment, the increasing importance of the role of the COTH and its members in the development of policies and programs of the AAMC should be clearly recognized and understood."

The paper is available at no cost from the Department of Teaching Hospitals.

The Medicare Indirect Medical Education Adjustment

The AAMC commissioned HCFA's former Research Director, Judith R. Lave, Ph.D., professor of Health Economics at the University of Pittsburgh to prepare an independent, objective review and critique of the history and role of the resident-to-bed adjustment, which is labeled the "indirect medical education adjustment" in the Medicare Prospective Payment System. This paper entitled The Medicare Indirect Medical Education Adjustment will be available from the Department of Teaching Hospitals in the winter of 1984.

Medical Education Costs in Teaching Hospitals

An annotated bibliography providing brief descriptive summaries of the research undertaken to date on the costs of medical education in teaching hospitals was revised by the Department of Teaching Hospitals in April, 1984. The bibliography provides a comprehensive summary of research available for reference use. For copies, please write to the AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036. Copies are \$4.00 each.

Background Information and Selected Readings Prepared for Committee on Financing Graduate Medical Education

To provide background information and describe the issues surrounding the financing of graduate medical education in the future, a publication was prepared for Committee members. Due to the positive response to this document, and because it contains important and informative data, quotations, and articles, this publication will be distributed to all AAMC constituents in late fall, 1984.

ACTIVITIES OF THE DEPARTMENT OF TEACHING HOSPITALS

Prospective Payment Implementation

The Prospective Payment System has substantially altered the method by which payments are made to hospitals for the care of Medicare inpatients. 1983 to 1984 became, for the Health Care Financing Administration (HCFA), a year dedicated to the formulation of implementing regulations and the AAMC was involved, for a significant portion of the year, in comment and response. Four regulations on prospective payment were published, bringing proposed rules to their final phase for both the first and second prospective payment years. The Tax Reform Act, also passed in the summer of 1984, included budgetary measures in its deficit reduction section that would affect payments for Medicare and Medicaid patients. The Tax Reform Act and all matters relating to prospective payment were followed closely by the AAMC.

Several issues included in prospective payment regulations were significant because of their direct impact on teaching hospitals. They include: the

- o indirect medical education adjustment;
- o annual update factor;
- o definition and treatment of outliers;
- o physician attestation statements;
- o definition of urban referral centers;
- o special funding for hospitals with low income patients; and
- o treatment and payment of transfer patients.

These issues will be discussed in detail below. Prospective payment rules also addressed the calculation of wage indices and their application to the payment rate; the blend of payments based on each hospital's cost base and the national and regional rates during the transition period through 1986; and a redefinition of physician participation in the Medicare program. Information on AAMC actions in response to these later issues can be obtained from staff. Also, in order to assess the impact of the prospective payment system on COTH members, a survey was developed and distributed. Analysis of the data provided by respondents is currently underway.

Medical Education Costs

The AAMC gave special attention to the support of graduate medical education throughout the year. When the new Medicare prospective payment system was proposed, various analyses were done to determine its effects across all types of hospitals. The Congressional Budget Office (CBO) determined that teaching hospitals would suffer disproportionate revenue losses under this proposed payment system and that the amount of this loss would be greater for hospitals with at least .25 residents per bed than for hospitals with a lower resident-to-bed ratio. An adjustment in the DRG payment rate for teaching hospitals, based on the ratio of residents-to-beds, was established. Called "indirect costs for graduate medical education," this adjustment would be paid by a lump sum payment separate and distinct from the base DRG rate.

There has been considerable confusion about the purposes of both direct medical education costs and the resident-to-bed adjustment for calculating indirect costs of medical education. An AAMC paper mailed to constituents on December 21, 1983 described these two costs in detail, addressed the purposes of each payment, and explained the methods used for payment calculations. Hospitals involved in the training of health care professionals incur direct costs of providing medical education experiences. Teaching hospitals provide medical care to their individual patients as well as maintain resources for the clinical education of physicians, nurses, and allied health workers. In order to support these activities, the costs of teaching must be defined and isolated from those necessary to support general patient care. These costs would include trainee stipends and benefits, supervising physician salaries and benefits, classroom space, clerical support, and allocated overhead costs. The prospective payment system intentionally does not include direct medical education costs in its methodology for calculating prospective rates paid to all hospitals in order to avoid influencing the rate by factors whose "existence is really based on objectives quite apart from the care of particular patients in a particular hospital", (Hospitals Prospective Payment for Medicare: A Report to Congress, December 1982, page 47-48).

Initial regulations addressed the calculation of the indirect, resident-to-bed adjustment through a method requiring hospitals to count house officers employed 35 hours of more per week by the hospital as one full time equivalent, and a resident or intern working less than 35 hours per week equating to one-half FTE. The AAMC commented on this proposed methodology in a letter to the Administrator of HCFA in October, 1983, calling into question the appropriateness of this method because it required the hospital to have an employment relationship with the resident and because it presumed a full-time work week of 35 hours - substantially shorter than the hours generally spent by house officers in the hospital. The AAMC requested an adjustment that focused on the number of residents on duty in a hospital, with a full-time equivalent equal to 12 months of training. The use of assigned time also would have relieved the AAMC's concern that HCFA's proposal to count residents working 35 hours or more per week in a hospital as one full-time equivalent (FTE) and those working fewer than 35 hours as one-half FTE could lead to an overstatement of the number of residents.

Final prospective payment regulations published January 3, 1984 included several significant changes in response to comments received from the hospital industry. AAMC concerns were met, in part, by a moderate change permitting hospitals to count residents and interns employed by another organizations with which they have a "longstanding historical relationship." In the preamble to the final rule, HCFA acknowledged that there were ways other than employed time which would accurately count residents, but felt the need to review the data to select the best option.

Two statements in the final regulation were not written with the desired clarity and precision that the AAMC would have liked. First, the regulations stated that the organization providing the residents be "the sole employer of substantially all the interns and residents furnishing services at the hospital." Discussions between AAMC and HCFA staff confirmed that a hospital can count both its own "employed" residents and residents from one other organization. Secondly, the other organizations must provide documentation "...to verify that no intern or resident is counted at more than one hospital." To implement this provision, HCFA stated that it intended to use a "snapshot" approach; that is, it would choose one day, such as the last day of the hospital fiscal year and count all residents in the hospital on that day.

The 1984 Tax Reform Act also addressed the resident-to-bed adjustment. For cost reporting periods beginning on or after October 1, 1984, the act revised the law to allow a hospital to count all residents in training within the institution regardless of the entity or entities issuing stipend checks. The act also recommended that hospitals establish auditable procedures for verifying their resident count.

To that end the second year prospective payment regulations published on August 31 mandated specific audit procedures to be used to verify resident counts. Final rules permit a hospital to count all residents in training (except those in exempt units) in completing the resident-to-bed adjustment to DRG prices. But to avoid double counting, HCFA imposed a detailed quarterly reporting system to include a monthly list of residents on duty, their social security numbers, and their number of hours "worked". The preamble to the final rules stated that "where the hospital is unable to supply documentation of the times worked by residents, their services will not be counted as part of the overall calculation of the payment amount" (emphasis added). The AAMC cautioned hospitals and medical schools to immediately develop tracking and reporting systems necessary to document their number of residents.

Annual Update

Regulations implementing the prospective payment system must ensure that total national expenditures under prospective payment are equal to projected expenditures under the Tax Equity and Fiscal Responsibility Act, TEFRA or "budget neutrality". The statute allows HCFA to reduce the prices for the second year of prospective payment to ensure that the payout will match the TEFRA projections. AAMC staffers Dick Knapp and Jim Bentley, along with other hospital association representatives, met with HHS Secretary Margaret Heckler on June 13 and 18, 1984 to discuss the calculation of this update factor. Issues surrounding the rate of increase of Medicare DRG prices for the second year of prospective payment were debated at the first meeting. By using the formulae mandated by adherence to the budget neutrality provision, Heckler proposed that the 1985 DRG published rates increase 5.6 percent over the 1984 published rates. However, adjustments in the DRG weights would have reduced this increase by 2.4 percent. The resulting increase would have been below the anticipated raise in the consumer price index, and about half the 6.4 percent rise in the medical care costs. A number of issues were not addressed in the briefing. For example, the AAMC questioned what if any consideration was given to projections of the Medicare patient admission volume and what assumptions about budget neutrality definitions and other technical matters might impact Medicare expenditures.

In a hearing before the Subcommittee on Health of the Senate Committee on Finance on August 8, 1984, Carolyn Davis, the Administrator of HCFA further discussed the second year prospective payment adjustment which resulted in this 2.4 percent reduction in the DRG weights. Dr. Davis explained that the prospective payment system assigned each specific DRG weight in accordance with recognition of the complexity of the treatment of the individual diagnosis as compared to other diagnoses. The established weight relied heavily on diagnostic information as coded from the medical record abstract in order to assign patients to DRGs. The weights are multiplied by the established DRG rates to arrive at the amount of payment for each diagnosis. Because hospitals had not anticipated that the information coded in 1981 (the base year for prospective payment) would be used for this purpose, there was concern that the data were not complete - that some secondary diagnoses and/or procedures could have been missed. HCFA agreed that the calculated case mix indices might have underestimated the real

case mix indices. In evaluating the first year, however, HCFA believed that improved coding procedures would make it appear that the case mix of hospitals would increase in complexity by a rate of approximately 3.38 percent for FY 1984. Reviewing first-year data, HCFA indicated that it appeared hospitals were treating a much larger number of higher cost cases than they had initially predicted, and that they had underestimated the change in coding. The results of the data analysis could have been due to a better coding of each diagnosis as a result of the hospital participation in the DRG system. HCFA's regulatory response to this analysis was to decrease the weights by 2.4 percent. In criticizing this reduction, some hospital representatives had suggested it was an inappropriate recalibration of the DRG weights. It was noted in the hearing that HCFA is not mandated by law to recalibrate the DRG rates until fiscal year 1986 and periodically after that date. Dr. Davis explained that recalibration is the process of revising the rates of each individual DRG in order to reflect a change in the resource consumption of each particular diagnosis relative to other diagnoses. The proposed across the board adjustment in the weights would not change the relationship among the individual rates and would therefore not be a recalibration.

The AAMC objected strongly to this 2.4 percent reduction, as did many health care organizations, believing it to be unreasonable. The reduction of 2.4 percent, the AAMC stated, would fail to provide an adequate payment for the increasing intensity of care received by Medicare inpatients. At the Secretary's instruction, HCFA responded to these concerns, in part, in the final regulations on the second year of prospective payment. Instead of the 2.4 percent reduction, the final rules reduced each DRG weight by 1.05 percent, with the change effective for patients discharged on or after October 1, 1984.

An inflation adjustment of 5.2 percent was used for the Federal component of DRG payments in this regulation and hospital-specific inflation adjustments range from 5.9 percent to 6.4 percent depending upon the hospital's fiscal year. However, because the actual price paid will be the product of the DRG weights and the average per case price, the 1.05 percent reduction in DRG weights results in a Federal component increase of 4.15 percent (5.2 percent - 1.05 percent) and hospital-specific increases ranging from 4.85 percent (5.9 percent - 1.05 percent) to 5.35 percent (6.4 percent - 1.05 percent).

Outliers: Atypically Expensive or Long Stay Patients

Outlier patients are those individual patients within a specific DRG whose care is atypically expensive or requires an unusually long length of stay. Under the law, outliers are required to be no less than 5 percent nor more than 6 percent of total prospective payments, and outlier payments are to be based on the "marginal cost" of caring for these patients. It was not clear in the preamble or the proposed regulation whether a hospital would receive outlier payments for an atypically expensive patient who reaches the cost outlier status before reaching the length of stay outlier day threshold. For example, if a patient was classified into a DRG for which the length of stay threshold was 30 days and the cost threshold was \$12,000, a particularly critical or complex patient might exceed the cost threshold on the 20th day of his stay. If that patient was discharged on the 29th day, the hospital would receive an amount equal to HCFA's approximation of the marginal costs incurred between the 20th and the 29th day. If the patient is discharged on the 31st day, the hospital would be eligible for a day outlier payment but no cost outlier payments for days 20-29. The Association believed a more equitable approach would be to pay for an outlier on the basis of whichever outlier threshold the patient first meets. If

a patient first qualified as a cost outlier, he should be paid for as a cost outlier as long as his continued hospital stay is medically justified. Conversely, the patient who first qualifies as an outlier by surpassing the length of stay threshold would continue to be paid for as a length of stay outlier regardless of whether he later exceeds the cost outlier threshold. The AAMC recommended that this section be modified to provide more equitable payments for outliers.

Initial prospective payment regulations set the payment for length-of-stay outliers at 60 percent of the average per diem Federal rate by DRG. The AAMC commented that this would recognize only regional and national averages and not specific hospital's base year costs. AAMC objections stated that such a computation is contrary to the spirit of the three-year transition period as defined in the regulations which intended a gradual shift to average payments. The AAMC proposed that HCFA modify the calculation to base it on the hospitals' blend payment rate and allow biweekly or monthly payments.

The AAMC recommendation that HCFA modify its basic outlier policy to recognize that high cost outlier patients who subsequently became long-stay outlier patients should continue to be paid as cost outliers, was rejected. HCFA stated that: (1) outlier definitions would have to be modified in order to maintain budget neutrality; (2) it was opposed to the concept of paying out more money on the basis of cost; and (3) such a change could provide perverse incentives to escalate the use of ancillary services or manipulate charges to maximize payment. In proposed second year prospective payment regulations, HCFA stated its intention to reduce the total expenditures for outlier payment to 5 percent. Although the AAMC requested retaining total expenditures at 6 percent, HCFA did not respond positively. However, HCFA did respond positively to the AAMC request that the cost outlier payment for transferred patients permit the transferring hospital to claim cost outlier payments even if the patient has stayed beyond the normal day outlier threshold.

Physician Attestation Statement

Medicare regulations, prior to the implementation of the second year prospective payment regulations, required the attending physician to attest in writing to the principal diagnosis, secondary diagnosis, and names of procedures performed shortly before, at, or after discharge. This attestation includes an acknowledgement that criminal or civil penalties could be imposed for intentional misrepresentation, concealment or falsification.

The second year proposed rules for prospective payment allowed the certification statement to be separate from the penalty statement but required the certification statement to appear on the discharge summary sheet. These rules would also require annual physician signatures on the penalty statement maintained by participating institutions.

The AAMC objected to the requirement that this statement appear on the discharge summary and suggested hospitals should be allowed to choose the location of this statement as long as the location was consistent for the hospital's Medicare discharges. The final rules responded positively to AAMC concerns by allowing the signed physician certification to be placed in the medical record at a location of the hospital's choice. In implementing this "local option" provision for the signed physician certification, the AAMC recommended that each hospital select the most appropriate form (e.g., discharge summary, face sheet, other) and use the same form for all Medicare patients.

Urban Referral Centers

HCFA, in initial regulations, would have required hospitals to have 60 percent of all Medicare patients residing 100 miles from the hospital or come from out-of-state, whichever is a greater distance, to qualify as an urban referral center. This provision would have virtually precluded any urban hospital from qualifying as a referral center and would have been inconsistent with Congressional intent. The AAMC objected to this impossible definition which did not recognize the legitimate characteristics of referral centers or the reasons for referring patients.

A "referral center" needs special consideration because patients are sent or attracted to a hospital service to be treated for medical problems that need specialized diagnostic or therapeutic services, available only at certain hospitals. The AAMC believes these referral patterns are generally related to a specific specialty, with some particular clinical services within a hospital more likely to treat more critically ill patients within a DRG or a major diagnostic category (MDC). Therefore, clinical services on which these critically ill patients are being served will have a disproportionate number of patients for whom the cost of care is far more expensive than the average for the DRG or MDC. In an equitable system the AAMC pointed out, services in these DRGs or MDCs would receive higher payments. The criteria for being defined as a "referral center" should reflect this variation within hospitals.

The AAMC stressed the need to recognize the problem that may be present for clinical referral services. The proposed alternative definitions for national and regional referral centers recommended by the AAMC included requiring the identification of MDCs or other groups of DRGs within an institution that qualify for special attention, rather than attempting to identify entire hospitals that qualify. Under these definitions, a hospital qualifying as a referral center in given MDCs would receive an adjustment to its rates for the one or more MDCs in which it qualified. The AAMC suggested the use of case mix comparisons to indicate qualification as a referral center for specific clinical areas of care.

In addressing the calculation of an adjustment to the rate for referral centers, the AAMC provided the following options in a comment letter to HCFA:

- o For referral centers, begin outlier payments in the appropriate MDC at the mean length of stay, plus one standard deviation, under the assumption that, in a referral center, what appears to be an average "patient" in terms of length of stay may really be atypical because it has been referred due to the complexity of the case;
- o Establish a group of hospitals that have been declared to be national referral centers and a separate group for those that have been declared to be regional referral centers for each of the MDCs and separately recalculate the DRG weights using just the data from each of the hospitals within the two groups. These new weights for the DRG prices could be used instead of weights calculated in the usual manner. This assumes that patients falling into the qualifying DRGs in the referral center hospitals will have higher average weights than those in other hospitals and these hospitals will be paid more equitably for the special role they play in the provision of care to patients with complex illnesses.

- o Recalculate the weights for the DRGs in each of three separate groups: (1) those hospitals falling into the national referral center group for a particular MDC, (2) those falling into the regional referral center for an MDC, and (3) those remaining hospitals. Then divide the weight for the national referral center by the weight for the third group. Similarly divide the weight for the regional referral center by the weight for the third group. The result will be a factor that would reflect the greater intensity of the patients within the referral centers. This factor could be used to increase the hospital's payment for those DRGs within that MDC for which it has been declared either a national or regional referral center;
- o Provide that hospitals designated as referral centers for certain DRGs or MDCs have the opportunity to appeal to the Health Care Financing Administration or some other designated body to justify payments in excess of the average DRG payments in recognition of the special care provided to a more complex patient population.

In the final regulations, HCFA rejected the AAMC proposal but modified the definition of urban referral centers to reduce the mileage criterion to 25 miles and to add a requirement that at least 50 percent of the Medicare patients are referred from other hospitals or non-staff physicians. The AAMC maintained, however, that HCFA's regulatory change would permit few, if any, urban hospital to qualify as referral centers. Moreover, HCFA's argument that the hospital as a whole must qualify as a referral center fails to recognize the specialty specific nature of referral relationships. Lastly, HCFA concluded that "...it is not possible at this time to determine which payment adjustments are appropriate" for urban referral centers. Thus, despite serious efforts to obtain recognition and additional payments for referral centers, HCFA was unresponsive to Congressional intent.

Hospitals With a High Proportion of Low Income Patients

The initial prospective payment regulation provided no definition for or payment adjustment to hospitals with a disproportionate number of low income and/or Medicare patients. In the September 1 regulation, HCFA reported not to have found a relationship between a hospital's Medicaid utilization and its average cost per Medicare case. In making this assertion, HCFA provided no information which could be used by an independent observer to verify this conclusion that there is no relationship between the income status of a hospital's patients and the hospital's cost per case. Moreover, the statute provides authority to adjust payments for a hospital's special needs, not simply its cost per Medicare case. The AAMC commented to HCFA that in order to fulfill the Congressional expectation, the adjustment for low income patients should not be limited to the proportion of patients supported by Medicaid, a program whose eligibility criteria vary by state. The Medicare program should determine low income status using a consistent definition (possibly adjusted for variations in the cost of living in specific areas) or criteria reflecting a hospital's bad debts and charity care. After identifying these hospitals, the adjustment made would recognize that the financial viability of these hospitals is in serious jeopardy unless payment for the care to the indigent is addressed in some way. The AAMC comment concluded that in an increasingly price sensitive environment these hospitals would be at a serious competitive disadvantage because of their need to set charges at a level high enough to generate revenues to offset their losses on unpaid care and not related to their ability to efficiently and effectively care for patients.

Despite the mandate to do so, HCFA still has not implemented any special payment provisions for hospitals providing care to a disproportionate number of "no pay" or "public pay" patients, although objections to this omission were raised by the AAMC.

Patient Transfers

The AAMC commented favorably on HCFA's treatment of per diem payments to hospitals transferring patients that appeared in the initial regulations. The comment stated that because teaching hospitals admit significant numbers of referred patients the AAMC will be continually interested in ensuring that the payment system does not artificially inhibit long-standing referral practices. Although HCFA sought a single payment methodology for each episode of illness in the regulation, a provision for a per diem payment for the transferring hospital therefore was included, as well as a full per case payment for the receiving hospital.

In the July 30, 1984 letter to HCFA concerning the proposed second year regulations, the AAMC supported the proposal to allow transferring hospitals to qualify for cost outlier payments. Final second year rules retained this provision.

Other Issues

There are many other substantive issues raised by the prospective payment system and the tax act that were critiqued and commented upon by the AAMC staff. Interested members are encouraged to contact staff regarding the outcome of any issue not addressed above. Such issues include: the blending of the payment rate from hospital-specific to a national average; hospitals excluded from the prospective payment system; physician payments and the freeze on Medicare payments; patients involved in research or experimentation; the impact of renal dialysis payments on hospital costs; and the services of non-physician anesthetists.

Prospective Payment Assessment Commission

A Prospective Payment Assessment Commission was established under the Office of Technology Assessment (OTA) to advise Congress and HHS regarding the prospective payment system. The Commission was charged with three basic tasks: 1) to determine how to incorporate new technology and new treatment modalities into the pricing system; 2) to help determine the annual increase factor; and 3) to define what constitutes appropriate medical practice patterns for specific diagnoses.

The AAMC nominated John W. Colloton, Director of the University of Iowa Hospitals and Clinics and Assistant to the University President for Statewide Health Services for the Pro-PAC. Mr. Colloton was selected in December as one of fifteen Commissioners from more than 450 nominations received by the OTA.

The AAMC supported the objectives of the committee through comments and attendance at all meetings of the Commission. The first report from the Pro-PAC is scheduled for publication in the April 1, 1985 Federal Register. This report is to include a recommended percentage update factor and an acceptable wage index criteria.

To assure appropriate funding for this Commission, the AAMC supported the Pro-PAC request in a letter to Appropriations Subcommittee members in the Senate and House of Representatives. The letter pointed out that it is imperative that a body such as the Commission monitor changes in the health delivery system brought about by the switch to prospective payment, to ensure that the quality of care rendered to Medicare beneficiaries is not adversely affected and that the fiscal stability of needed hospitals is not unintentionally jeopardized. The Subcommittee members were reminded that, "absent this Commission, the Department of Health and Human Services would be payor, regulator and evaluator" simultaneously. The AAMC requested support for the objective viewpoint that this Commission would provide. The Congress approved the Pro-PAC budget request in full.

PROs Taking Shape

Peer Review Organizations (PROs) were enacted under Title XI of the Social Security Act in 1982. The Peer Review Improvement Act of 1983 repealed the existing Professional Standards Review Organization (PSRO) Program and required performance-based contracts between the Secretary of HHS and PROs. Congress included peer review provisions under the Medicare prospective payment program in the Social Security Amendments of 1983 (P.L. 98-21). Four regulations were published in the spring and summer of 1984, describing the rights and responsibilities of PROs and outlining their contractual obligations. The AAMC commented on all four regulations, primarily objecting to the use of targets/goals for achieving Medicare program savings; inadequate safeguards to protect confidentiality; and the cost to hospitals of compliance within PRO requests.

Acquisition, Protection, and Disclosure of Utilization and Quality Control Peer Review Organization (PRO) Information

The regulation, published in April lacked any reassurance that institutional (hospital) confidentiality would be protected. Three major weaknesses were highlighted in AAMC comments: 1) disclosure responsibilities relating to patient information were too broad; 2) the definition of "confidential" was too narrow; and 3) other substantive definitions of key terms were lacking. PROs were also granted access to non-Medicare patient records, without patient consent, in order to perform quality review studies. The AAMC pointed out that this fact, together with the inordinate amount of data that could be requested from provider records on individual patients presented a costly, time-consuming burden on hospital staff and unauthorized disclosure of this data is highly likely.

Sanctions on Health Care Providers and Practitioners

The regulation established the obligation of providers to ensure that only medically necessary medical care is delivered, that it is appropriate, and that the quality of care is acceptable. Sanctions could be imposed, according to this regulation, if violations occurred in a "substantial number of cases" or where "gross and flagrant" violations occurred. In comments on these regulations, also published in April, the AAMC pointed out that neither "substantial number" nor "gross and flagrant" were adequately defined. There was little that restrained PRO activities because the regulations lacked precise definitions and did not provide for the protection of institution-specific information. The AAMC contended that these regulations would place hospitals in an untenable position.

Assumption of Responsibilities and Review Functions

Proposed rules published in July intended to define the working relationships of PROs with other health care entities, set out contractual expectations and outlined review functions. In the regulations, PROs are directed to establish and include in submitted contracts, "norms of care" criteria. In doing so, the PRO "must use national, or where appropriate, regional norms in conducting review, to achieve PRO contract objectives." The AAMC commented to HCFA that this directive was contrary to the language in the statute emphasizing that local and regional norms should prevail, with national norms used as modifiers. The letter pointed out that the use of national norms disregards local variations that are part of appropriate care, such as differences in demographics, access, and the types of services available. The regulations would establish a national system under the guise of an individual contractual relationship. The AAMC objected to the emphasis on the use of national norms and suggested that regional information would help provide the flexibility Congress intended in the program.

As demonstrated in the directions for the content of contracts, such "norms of care" are inevitably described in financial or mathematical terms. This is, in essence, the establishment of quotas. To predetermine what PROs will find is a policy which the AAMC would not support. The AAMC believes PRO performance should be based on a judgment of the effectiveness and appropriateness of the process the PRO has developed and applied.

The proposed regulations would require hospitals to accept financial liability if a PRO preadmission review determines the admission to be inappropriate. The AAMC strongly suggested that, following appropriate and timely notification to the beneficiary that the admission will not be covered, the beneficiary can agree to accept financial responsibility. In cases where, on either prospective or retrospective review, the coverage for the admission is denied, the AAMC cautioned HCFA to recognize the sensitive nature of this communication to the beneficiary, and take pains to eliminate possible misinterpretation to the notification information.

Reconsideration and Appeals

The AAMC objected to the proposed rules published in July because they did not provide appropriate recourse for hospitals disputing PRO determinations. In fact, the rules would prohibit providers from obtaining a hearing on their behalf. Providers are directed by the regulation to discuss the issue with the "PRO that made the initial determination". Therefore, the AAMC pointed out, the PRO would be reviewing and evaluating its own past decision. The AAMC suggested that reconsiderations and appeals of PRO decisions be made by an independent body having no previous involvement in the decision under question.

Meetings Held With Administration Officials

The AAMC outlined growing concerns about the content of contracts and implementation of the PRO program in an August 16th letter to HCFA Administrator, Carolyn Davis, and the AAMC along with other healthcare organizations, met with HCFA representatives on August 21st to discuss them. Davis reiterated her strong view that the "norms of care" are not quotas, but rather targets, and that ample opportunity will be given to the hospitals and the physician community to set forth legitimate reasons for their inability to achieve the targets. Davis stated that there is not a dollar target for the PROs, and said she wishes to

move ahead with the program. The AAMC will continue to monitor further actions and regulations that affect this important program.

Future Financing of Graduate Medical Education

The significant changes required by the implementation of the prospective payment system have called into question many long-standing relationships and methodologies. Because of the emphasis on cost-consciousness, the viewpoint of individual payers is changing dramatically. Reassessments of what is included in the costs of medical care are ongoing with all payers attempting to define these costs and to design alternatives for support of such functions as graduate medical education, new technology and uncompensated care. The Advisory Council on Social Security and the Office of the Inspector General of the Department of Health and Human Services reviewed graduate medical education financing. The AAMC monitored and commented on their actions throughout 1983-84.

The Bowen Commission

The Advisory Council on Social Security, called the "Bowen Commission", was convened in early September 1983. The Commission's particular task was to recommend policy alternatives to improve the financial status of the Medicare trust fund. One recommendation, in particular, that caused great concern to members of the AAMC called for "provid[ing] the orderly withdrawal of Medicare funds for training support". At issue was the appropriateness of Medicare payments covering anything other than patient care costs. AAMC Chairman Robert Heyssel and AAMC President John A. D. Cooper testified against this recommendation stating that the Council should reconsider its decision that Medicare stop paying these costs. Cautioning that even an "orderly withdrawal" would be premature until the Council determines what Medicare is paying under the label of direct medical education, they called for a clearly described, administratively feasible, and politically acceptable funding alternative for graduate medical education be identified before any changes are made in current funding arrangements. The testimony emphasized that it is appropriate for Medicare to cover legitimate medical education costs as patient care expenses. After hearing testimony from the AAMC and other sources, the Advisory Council altered its original recommendation to state:

"The Council recommends that costs for the training of medical personnel should be provided by a variety of federal, state, and local sources rather than the Medicare program. The Council believes that it is inappropriate for the Medicare program, which is designed to pay for medical services provided to the elderly, to underwrite the cost of training medical personnel. The Council believes that medical education is an appropriate area for governmental support and recommends that the Department of Health and Human Services undertake a study to identify and develop other federal, state, and local funding sources."

The Council also made several other recommendations for improving the viability of the Medicare Part A trust fund. In essence, their recommendations: 1) advised against using general revenues to finance the Medicare hospital insurance trust fund; 2) called for allocating an "appropriate portion" of revenues generated by taxation of employer contributions to health care plans, with this portion earmarked for the trust fund; 3) increasing taxes on alcohol and tobacco, with excess revenues earmarked for the trust fund; 4) increasing the age of eligibility for Medicare benefits from 65 to 67 based on a phase-in

schedule beginning January 1, 1985; 5) assessing various preventive care services before expanding Medicare coverage to include them; and 6) limiting the annual percentage increases in the DRG payment rates under the new Prospective Payment System to the amount of change in the market basket of goods and services purchased by hospitals.

Report from the Office of the Inspector General

Also addressing the topic of financing medical education, a report drafted by the Office of the Inspector General (OIG) of the Department of Health and Human Services recommended changes in Medicare's payments to hospitals for resident services, based on the assumption that Medicare pays too much when it pays for patient care in a teaching hospital. These costs, the report stated, included both the supervising physician costs and the bill for the resident services. The draft report proposed that HHS: 1) permit teaching hospitals to claim the cost of a resident's patient care services for only the first year of residency; and 2) permit reimbursement on a reasonable charge basis for physician services whether provided by the teaching physician or the resident (who has completed the first post-graduate year of training and met the state licensure requirements). The total charge for the combined services of the resident and teaching physician could not exceed the reasonable charge allowable for the same service in a non-teaching situation.

The AAMC voiced serious concerns about this report and met with the Department officials on two occasions to discuss it. AAMC Chairman, Robert Heyssel, M.D., President, The Johns Hopkins Hospital; J. Robert Buchanan, M.D., General Director, Massachusetts General Hospital; John A. D. Cooper, M.D., President, AAMC; and Richard Knapp, Ph.D., Director, Department of Teaching Hospitals of the AAMC met with HCFA AdministratorCarolyn Davis, Ph.D., and Assistant HHS Secretary Edward Brandt, M.D. on July 27th, and with HHS Secretary Heckler on August 8th to register objections to these recommendations. As of October, the report was still in draft with no notice of official revision or publication.

Committee on Financing Graduate Medical Education

To evaluate suggested financing alternatives for the role of graduate medical education in the future, the AAMC established a Committee on Financing Graduate Medical Education under the leadership of J. Robert Buchanan, M.D., General Director, Massachusetts General Hospital. This thirteen member committee met on September 12, 1984 to discuss the possibility that increased price conscious behavior of the purchasers of health care may force teaching hospitals to identify the costs of and seek separate funding for some services, particularly medical education, that previously have been financed through patient revenue. A series of articles and background papers were prepared for Committee members and this information document will be distributed to all AAMC constituents in the late fall of 1984. The Committee is scheduled to meet again on November 27th to discuss testimony presented before the Health Subcommittee of the Senate Finance Committee and to review further the status of future financing of graduate medical education.

Hearing on the Current Financing of Medical Education

The Senate Finance Subcommittee hearing on the financing of graduate medical education, chaired by Senator David Durenberger (R-MN), was held on October 1, 1984. C. Thomas Smith, President, Yale-New Haven Hospital and member of the Administrative Board of the Council of Teaching Hospitals, and Edward Stemmler, M.D., Dean of the University of Pennsylvania and Chairman of the Administrative Board of the Council of Deans testified on behalf of the AAMC. They pointed out that, "if future generations of Americans are to have appropriate access to well-trained physicians, we must continue to maintain and strengthen our medical education system, including its residency training component. Moreover, we must maintain the capabilities and strengths of our system in the face of dramatic changes in the environment faced by teaching hospitals, medical schools and clinical faculty." Also, they concluded,

"to remain fiscally viable, medical schools have had to adjust to substantial changes in revenue sources over which they have relatively little control. As additional constraints are placed on the sources of their funds, these institutions are finding it increasingly difficult to accommodate, without serious distortion, their multiple services of education, research and patient care.

The American system for graduate medical education is grounded in the teaching hospital. Graduate medical education cannot function effectively unless teaching hospitals are compensated for the added costs associated with their responsibility to address these complex costs.

...Contemporary American teaching hospitals are among our nation's most complex enterprises. In addition to the basic hospital services of primary and secondary inpatient care, teaching hospitals provide the bulk of the nation's tertiary care for the most seriously ill; regionalized special care and stand-by services; clinical training of physicians and other health care personnel; access to medical services for disproportional numbers of the poor and medically indigent; and the development and testing of new diagnostic and treatment services. Significantly, these multiple products are not independently provided in separate corporate divisions. Rather, the teaching hospital's added responsibilities are generally fulfilled in a single organization with multiple, interrelated objectives. As this hearing considers one of the special responsibilities of teaching hospitals, graduate medical education, the AAMC must note that the future of teaching/tertiary care hospitals rests on adequate societal support of all these specialized functions."

Other witnesses at the hearing included representatives from the Administration and other health care organizations.

Capital Payments for Hospitals

The prospective payment system and its background legislation requires HHS to report a method by which capital payments for hospitals can be incorporated into the payment system. The report was due in October of 1984. Several alternatives have been suggested by various health care organizations as they attempt to design a solution that would be equitable and acceptable.

Ad-Hoc Committee on Capital Payments for Hospitals Under Medicare

An AAMC Ad-Hoc Committee on Capital Payments for Hospitals Under Medicare was appointed in early 1984. The Committee, chaired by Robert E. Frank, President of Barnes Hospital, St. Louis, and a member of the AAMC Executive Council, considered capital payment proposals made by the American Hospital Association, Health Care Financial Management Association, the Health Care Financing Study Group and the National Committee for Quality Health Care. In addition, the Committee reviewed currently available data on Medicare capital payments, projected capital requirements for hospitals, and published papers on capital formation in the 1980s. The Committee also reviewed a paper entitled, "Toward an Understanding of Capital Costs in COTH Hospitals" analyzing capital costs and operating expenses in both COTH and non-COTH hospitals. The analysis resulted in three major findings:

- o while capital costs of COTH members are a smaller percentage of total expenses than they are of non-member hospitals, COTH members do have greater absolute capital costs per unit of workload (i.e., per day or per admission);
- o the physical facilities of COTH hospitals are 12% older than those of non-COTH hospitals; and
- o recently increased capital spending by COTH hospitals may alter statistical relationships that existed in data collected in the 1970's and early 1980's.

The report concludes by stating, "given these conclusions and the 'lumpy' capital cycle of major facility projects, COTH hospitals must give particular attention to the impacts of proposed capital payment policies on hospitals which have recently constructed or are planning in the next few years to begin construction of major plant replacements. Special care must be taken to ensure that incorrectly interpreted or past trends are not used to endanger the financial viability and competitive attractiveness of major teaching hospitals which are presently involved in major plant projects."

Policy Positions

Using this information and the recommendations of the AAMC's Ad Hoc Committee on Capital Payments for Hospitals, the AAMC Executive Council adopted the following six principles at its September 13, 1984 meeting, as a recommended policy on Medicare payment of capital costs.

1. The AAMC supports replacing institutionally specific, cost based retrospective payments for capital with prospectively specified capital payments.
2. The AAMC supports separating capital costs into two components -- (1) movable equipment and (2) fixed equipment and plant.
3. The AAMC supports incorporating capital payments for movable equipment into prospective payment using a percentage "add on" to per case payments.
4. The AAMC supports a percentage add-on to per case prices for capital costs of fixed equipment and capital that is no less

than Medicare's current percentage of hospital payments for facilities and fixed equipment provided that the add-on is based upon a per case price which appropriately compensates tertiary care/teaching hospitals for their distinct costs.

5. The AAMC supports a long-term, hospital-specific transition from the capital passthrough to prospective payments for plant and fixed equipment.
6. The AAMC supports a transition period which allows each hospital its choice of (1) cost reimbursement for depreciation and interest on adjusted base period capital or (2) a prospective percentage add-on that is no less than Medicare's current percentage of hospital payments for facilities and fixed equipment.

The AAMC believes capital payments made to teaching hospitals should be computed as a percentage add-on to the combined DRG and resident-to-bed payments. A single percentage add-on for all hospitals has been selected because no analysis to date has identified a more equitable approach.

Hearing on Medicare Payments for Capital Costs

The National Council on Health Planning and Development (NCHPD) held a two-day hearing on how Medicare should pay for capital costs under the prospective payment system, April 5-6, 1984. AAMC staffer Nancy Seline told the NCHPD that the Association had not yet adopted a position on the issue. She raised the concerns voiced during the first meeting of the AAMC Ad-Hoc Committee on Capital Costs in Hospitals, which included the need for equitable distribution of capital funds, access to capital markets regardless of the hospital payor mix, and concern over the data used to generate the proposed percentage add-ons. Ms. Seline referred to a recent paper by James Bentley, Ph.D., Associate Director, of the Department of Teaching Hospitals, which showed that in teaching hospitals on average, capital costs are a lower percentage of total expenditures than in other hospitals, because: 1) teaching hospitals expenditures for items other than capital, which form the denominator, are significantly larger per admission and per patient day; and 2) teaching hospitals physical plants are approximately 12 percent older than non-teaching hospitals.

Tax Reform Act of 1984 P.L. 98-369

Many changes to the Medicare and Medicaid payments for physician and hospital services were proposed by the House and Senate during deliberations on the 1984 Tax Reform Act. Three particular interests to AAMC members were:

- (1) Elimination of Technology Factor -- Under the previously existing law, the Medicare DRG prices were to be increased annually by the increase in prices of the market basket of goods and services purchased by hospitals plus one percent for technology. The House bill did not alter this provision. However, the Senate proposed to eliminate the one percent for technology.
- (2) Federal Medicaid Payments Reduced -- The House bill contained no reductions in federal Medicaid matching monies. The Senate bill proposed reductions of 3 percent in each successive fiscal year from 1985 through 1987.

- (3) Physician Fees Freeze -- The Senate bill would freeze all customary and prevailing fees for one year beginning July 1, 1984. The freeze would be in effect for a second year for those physicians who do not accept assignment. After a heated debate over a proposal that would have linked the fee freeze to mandatory assignment, the House adopted a bill without either freezes or mandatory assignment.

The AAMC vigorously supported the House provisions on all three issues. Final provisions were adopted and signed into law July 17, 1984 and did not include the original Senate proposal to extend the reductions in federal matching payments to states for Medicaid expenditures. The price increase factor was approved at the market basket plus .25 percent for technology, and the physician fee freeze was not technically linked to a mandatory assignment clause, per se, but included language strongly encouraging participation through future financial incentives.

An additional and highly important provision, amending the requirement of the 1980 Omnibus Reconciliation Act, was the payment for professional services of a teaching physician. To help ensure a reasonable minimum for Medicare fees the AAMC accepted a provision that would set two floors for Medicare fees in a teaching setting: (1) Medicare calculated fees cannot be paid at less than 85 percent of the Medicare prevailing fee in the area for that service and (2) if all "teaching physicians" (to be defined regulation) in a hospital agree to accept assignment for Medicare patients, calculated fees cannot be paid at less than 90 percent of the Medicare prevailing fee. This provision became part of the Act.

Other changes mandated by the Deficit Reduction Act that directly affected physicians and hospitals resulted in: 1) limitations on payments for laboratory services provided to outpatients, set at 60 percent of prevailing charges for independent laboratories or when a hospital provides services to a non-hospital patient and 62 percent for hospital outpatients; 2) a mandated study of area wage indices; 3) clarification of the method of counting residents in training within the institution in order to determine the hospital's resident-to-bed adjustment; 4) payment for nurse anesthetist services as a cost-based passthrough; 5) an expanded definition of rural referral centers; 6) a change in the classification criteria for urban hospitals; and 7) an exemption from the cost-to-charge test for outpatient services was provided for hospitals that serve a substantial number of indigent patients.

Provision of Charity Care

Testimony on the Provision of Uncompensated Care

Both AAMC Chairman, Dr. Robert Heyssel, M.D., President, The Johns Hopkins Hospital and Haynes Rice, Hospital Director of Howard University Hospital and Chairman of the Council of Teaching Hospitals, presented testimony on the issue of uncompensated care in the teaching hospital. Mr. Rice testified before the National Council on Health Planning and Development of the Department of Health and Human Services on September 13, and Dr. Heyssel testified on September 28th before the Subcommittee on Health of the Senate Finance Committee, that "charity care is a major problem in competitive environments because such care is unevenly distributed across hospitals. This uneven distribution in a competitive market handicaps hospitals serving the indigent and medically indigent and benefits hospitals with primarily paying patients." Dr. Heyssel and Mr. Rice stated that

a long history of providing charity care by some major teaching hospitals has exacerbated the belief that the issues of housestaff training and providing charity care are inextricable. It is important, both speakers emphasized that the issues of medical educational and charity care be considered separately and that separate solutions to their funding be developed. Teaching hospitals may well sustain a larger burden of the provision of care to the indigent or medically indigent because they often establish large clinics and primary care services in order to meet neighborhood needs. Programs that provide care for burn victims, trauma victims, high risk maternity cases, and those suffering from alcohol and drug abuse and in need of psychiatric care, also attract patients that are unable to pay for such a sophisticated level of care.

AAMC Actions Relating to Uncompensated Care

During the past year, the Administrative Board of the Council of Teaching Hospitals and the AAMC Executive Council have been engaged in a strategic planning effort for the Association's hospital activities. After a thorough review, it has been determined that one of the most important issues presently facing COTH is the future financing of uncompensated care. Association efforts are now emphasizing this priority. The first step in developing efforts in the area of uncompensated care has been an attempt to review the research about uncompensated care patients. To date, the staff review has identified seven primary concentrations of uncompensated care:

- o obstetrical and pediatric patients,
- o chronically ill patients repeatedly admitted,
- o patients awaiting placement in a less than acute care setting,
- o patients admitted for catastrophic medical services such as burn or trauma care,
- o uninsured patients including the unemployed and illegal aliens,
- o patients who have abused drugs and alcohol, and
- o insured patients unable to pay copayments and deductibles.

In individual teaching hospitals, the mix of these seven types of patients varies substantially. Nevertheless, the finding that uncompensated care patients can be categorized suggests that focused responses can be developed to assist these patients.

To maintain present levels of assistance for these types of patients, the AAMC has continually lobbied Congress to retain adequate funding for the Medicaid program. The AAMC opposed the three year reduction in Medicaid funding enacted in 1981 and opposed the unsuccessful efforts to extend those reductions this year. The Association also actively supported this year's successful effort to expand Medicaid coverage for first time pregnant women, pregnant women in households where the primary wage earner is unemployed, and children under five.

The second step in developing efforts in the area of uncompensated care has been to review and follow the growing body of research seeking to identify the characteristics of hospitals with atypical burdens of uncompensated care. Initial findings indicate that the most heavily burdened hospitals are publicly

sponsored hospitals in metropolitan areas and not-for-profit hospitals in decaying inner city neighborhoods. Once again this suggests the possibility of developing categorical or focused solutions.

A number of alternative solutions are presently being tried and the Association is reviewing carefully their impact on COTH members. The all payer approved charge systems in New Jersey and Maryland have assisted COTH members with atypical uncompensated care burdens. The enthusiasm for this approach is not uniform throughout the Association membership. The recent experience in which Blue Cross of Maryland developed a preferred provider program, giving patients financial incentives to use suburban hospitals with little uncompensated care rather than downtown hospitals with substantial uncompensated care costs included in approved rates, may weaken the enthusiasm of those who support this approach.

Because of the recent Maryland experience, members and staff are giving increased attention to the "revenue pools" established in New York and Florida to help finance uncompensated care. These "revenue pools" are a much more recent development and their intended and unintended consequences are too recent to fully assess. In an equally preliminary way, members and staff are watching the developments in California and Arizona to see what lessons may be learned from those approaches.

Baby Doe

The AAMC was involved in extensive discussions with HHS officials and other health care organizations concerning final rules entitled, "Nondiscrimination on the Basis of Handicap Relating to Health Care for Handicapped Infants". Proposed federal regulations were published in the spring of 1982 in the wake of the case of the Indiana infant, "Baby Doe", who was born with severe disabilities and was allowed to die. These proposed regulations were struck down by a federal court because HHS had failed to follow the proper procedure in issuing them. A second set of regulations, nearly identical to the first, was published in September of 1983. The regulations called for publicly posted notices and toll-free hotlines to be used by persons suspecting that nutrition or treatment was wrongfully being withheld from an infant. The AAMC believed the proposed regulations would: 1) usurp the role of parents in deciding what is best for their child; 2) provide a great potential for mischievous or ill-informed callers to initiate investigations and possibly disrupt care to all infants in the nursery; and 3) inappropriately involve the state child protection agencies in the matter. The AAMC and other health care organizations strongly criticized the regulations. In response to comments some changes were made in the final rules published in January, but the medical community was still not satisfied, believing the changes to be superficial.

Acting under these regulations, the federal government requested access to the medical records of "Baby Jane Doe", an infant hospitalized at the University Hospital at Stony Brook, New York. Access was denied by the hospital. The federal government sued to obtain the records, presumably so they could force surgical treatment of Baby Jane. After a series of court battles, the Federal Court of Appeals denied the government's request and in so doing called into question the legislative authority under which the regulations had been issued. The Court held that Section 504 of the Rehabilitation Act, does not apply to treatment decisions involving impaired newborn infants. The AAMC, AMA, AHA, and others filed suit in Federal District Court to have HHS permanently enjoined from

enforcing the rule. The suit was successful, and HHS was prohibited from investigating these cases under the Rehabilitation Act.

Throughout the year, Congress has been considering legislation that could be used to set policy concerning a public role in these "Baby Doe cases." Amendments attached to the Child Abuse Prevention and Treatment Act, introduced by Senator Jeremiah Denton (R-AL) and Congressman John Erlenborn (R-IL), would have defined the decisions not to treat severely ill infants as child abuse. A coalition of associations representing health care providers worked to oppose the amendments. A substitute amendment that would have continued to rely on the parents and physicians to make these difficult decisions was offered in the House by Representatives Rodney Chandler (R-WA), Henry Waxman (D-CA), James Quillen (R-TN), and J. Roy Rowland (D-GA). Although this amendment lost by a narrow margin, the entire child abuse bill was passed by a wide margin. The bill was stalled in the Senate until several of the health care groups involved in the activities of the coalition agreed to compromise language. This compromise required hospitals to report instances of "withholding medically indicated treatment", which was defined as a failure to provide care to an infant unless he/she is irreversibly comatose or about to die despite any treatment that might be provided. Although the language called for reports to be made to the Child Protection Services, the "compromise" did not define the decision to withhold treatment as "child abuse". The AAMC, AMA, and the Association of Medical School Pediatrics Department Chairmen, Society for Pediatrics Research and the American Pediatrics Society refused to support this compromise, believing it would force physicians to treat infants who might then have chronic pain, recurrent debilitating diseases, or not be able to minimally relate to their environment. Despite these objections, the Senate passed the bill with the compromise amendment. In conference, the House receded to the Senate's version of the Baby Doe language with some minor changes. The conferenced bill was then passed by both Houses and signed into law on October 9.

Organ Transplantation

The House considered a bill creating a national center for acquiring and dispersing organs for transplantation including a 24-hour hot-line through which organs could be matched with potential recipients. The bill also called for a task force to study medical, ethical, legal, economic, and social issues raised by the procurement and transplantation of human organs. In the most controversial provision, the Secretary was to have been given authority to determine patient, physician and/or hospital access to any type of new or existing technologies and procedures, not just those for organ transplantation. This last provision was widely opposed by the medical community. The AAMC, in a letter to Representative Dan Rostenkowski (D-IL) interpreted the intent of the legislation as empowering the Secretary to permit Medicare to pay for new emerging technologies in hospitals that meet certain criteria designed to assure the safe and appropriate use of such treatments. Currently, Medicare law has been interpreted to mean that Medicare can cover a service only if it may safely be performed in any setting. Adoption of the provision in the Organ Transplantation bill would expedite appropriate use of these new treatments. The AAMC letter suggested that the Secretary's authority to designate appropriate physicians and hospitals be limited to new organ transplantation procedures and technologies.

The letter concluded by suggesting the bill contain a provision allowing the Secretary of HHS to use her authority under the Prospective Payment System to classify hospitals as national or regional referral centers and provide special

payment rate adjustments to centers meeting the criteria to perform transplants. The adjustment would be provided for certain DRGs because of the significant costs associated with personnel and equipment that would be needed to meet the criteria for safe and effective use of new treatments established by the Secretary. In final action, a new House bill was drafted and passed which excluded this adjustment provision. The Senate adopted a similar bill, also devoid of the controversial provision. Action was still pending in Congress at the time this report was written.

Low-Level Nuclear Waste Disposal

As of January 1, 1986, any group of states which have formed a compact in order to establish a site for the disposal of low-level nuclear waste would have the right to restrict access to that disposal site by "out of region" low-level waste generators, according to the Low-Level Radioactive Waste Policy Act of 1980 (P.L. 96-573). The progress in developing the state compacts to locate these disposal sites has been slow. Inevitably, some regional compacts and states not involved in compacts will not have their sites in operation by that deadline. This could mean that hospitals would not have the ability to dispose of their low-level nuclear wastes as of that date. The AAMC urged the Judiciary Committee to reassess its position and extend the deadline for states involved in good faith efforts to establish disposal sites. Concerns were expressed to the Committee of the Judiciary that "unreasonable delays or restrictions on the availability of, and access to low-level disposal sites could retard educational, medical, and research activities" and warned that if the deadline is applied inflexibly, the "the consequences of denying major sections of the country access to existing disposal sites could be devastating." It would be possible for hospitals, universities, and biomedical research facilities in regions without a disposal site to be forced to cease or curtail severely all diagnostic, therapeutic, and research activities which use radioactive material and generate low-level waste. A compromise, suggested by Dr. Cooper, would allow outside access to disposal sites after the deadline if states can demonstrate that: 1) they have reasonably utilized their on-site storage capacities; 2) they are progressing toward establishment of regional facilities; and 3) they can demonstrate that the volume of waste proposed to be shipped has been reduced through economically feasible and environmentally safe low-level waste volume reduction techniques.

Additional Representation and Testimony

The cost-cutting activities of the federal government, together with the more stringent requirements of future prospective payments, created unease and concern for AAMC constituents. In formal testimony and through representation, staff, members, and officials of the AAMC addressed several issues of future concern or that required definition and analysis.

Implications of For-Profit Enterprises in Health Care

A discussion of the "Implications of For-Profit Enterprise In Health Care" was held by the Institute of Medicine on March 15, 1984. AAMC Chairman Robert M. Heyssel, M.D., President, The Johns Hopkins Hospital, represented the AAMC. He pointed out that "with the exception of research grants and contracts, and state and local government support for a relatively small number of hospitals, patient service revenues in teaching hospitals are the dollarstream that support very necessary societal functions, ...the provision of tertiary care services;

educational endeavors; research initiatives; and care of indigent patients." Heyssel stated, "the investor-owned corporations have a legal obligation to their shareholders, that each decision a corporation makes with regard to service mix, program selection, and population served will have an impact on earnings per share." The issue, he said, is whether certain necessary societal functions can be continued. More than twenty representatives of labor, consumer groups, for-profit and non-profit hospitals appeared at this one-day hearing.

Nurse Training, Health Professionals Education and the Prospective Payment System

Dr. Richard Knapp, Director of the Department of Teaching Hospitals, spoke before the Ad-Hoc Task Force of the National Advisory Councils on Nurse Training and Health Professionals Education on August 8, 1984. Dr. Knapp outlined the prospective payment system's effects on the teaching hospital. In particular, he described the calculation and purpose of both direct medical education costs and the indirect medical education adjustment.

Cost Containment Strategies and State Legislation

Cost containment strategies for hospitals were considered by the Special Committee on Health Care Cost Containment of the National Conference of State Legislators on September 20, 1984. The legislators wished to examine specific recommendations from participating organizations that should be kept in mind when establishing cost containment strategies and options. The constraints on choices and descriptions of successful alternatives were presented throughout this hearing. Morton I. Rapoport, M.D., President and Chief Executive Officer of the University of Maryland Hospital spoke on behalf of the AAMC. He particularly addressed the complexities of the teaching hospital. He discussed how uncompensated care, graduate medical education, diagnostic case mix, regional stand-by services, and the presence of clinical research constrain the strategic options of the teaching hospital. He stated, "Under both regulation and marketplace models, price competition is the present emphasis, and teaching hospitals are disadvantaged by the pricing implications of their societal contributions". Rapoport closed his testimony by stating, "be careful. To the extent price is the driving force behind the effort to keep costs down, you may hurt institutions you may wish to support."

Educational Programs

The AAMC both presented and participated in several educational programs throughout the year. A Management Education Program (MEP) was presented to 29 participating medical center directors from Veterans Hospitals across the country. This seminar was held from February 6th through 9th, 1984. Richard Knapp, Ph.D., Director of the Department of Teaching Hospitals described the diverse membership of the Council of Teaching Hospitals for the participants. Changes in the health care environment have created new challenges for AAMC constituents. Dr. Knapp addressed how the COTH and the department are responding to these challenges to assist the membership in conforming to and directing change.

James Bentley, Ph.D., Associate Director of the Department of Teaching Hospitals, provided participants with an update on the Prospective Payment System. Dr. Bentley described this new Medicare payment system's effect on member institutions.

In June, the Healthcare Financial Management Association (HFMA) sponsored a special two-day seminar on major financial issues facing the chief executive officers of teaching hospitals. The seminars were held as part of the HFMA Annual Institute. The session was developed by Dr. Bentley and John Eresian, Chief Financial Officer of Northwestern Memorial Hospital in Chicago. Fifty COTH chief financial officers attended the seminar.

During the summer of 1983, the AAMC conducted a series of four two-day regional seminars to introduce and explain the Medicare Prospective Payment System. At each session, presentations offered insights into institutional data management, physician behavior modification and changes directly effecting the teaching hospital setting. In order to inform a broader constituency on the implications of these regulatory changes the AAMC condensed the presentations into two sets of videotapes entitled "The Medicare Prospective Payment System: Implications for the Medical Schools and Faculties". Further details may be obtained by calling the Management Education Program offices of the AAMC at (202) 828-0519.

MAJOR MEMBERSHIP MEETINGS

Two general membership meetings highlighted the activities of the Council of Teaching Hospitals in 1983-84. On November 7th the COTH General Session, held annually as part of the AAMC Annual Meeting, addressed "ethical dilemmas and economic realities." Lawrence B. McCullough, Ph.D., Associate Professor of Community and Family Medicine and senior research scholar at the Kennedy Institute of Ethics of Georgetown University, discussed the role of a hospital administrator, particularly a teaching hospital administrator, and the increasing ethical problems facing the medical community.

COTH GENERAL SESSION

"Moral principles and obligations are limited by the demands of other moral principles and obligations," Lawrence B. McCullough, Ph.D., told the COTH General Session. Dr. McCullough stressed the need for clarity of reasoning, rigor and consistency in reaching the resolution to a problem, and developing the appreciation of and tolerance for the ongoing tests of balancing the demands of conflicting moral principles and the obligations they generate.

Dr. McCullough quoted Dr. James Gregory who in the 1800s', said, "whatever it is the duty of physicians and surgeons to do to their patients, it is the duty of the managers of a hospital to procure for the sick poor who are admitted in it. Whatever it is the duty of the physicians and surgeons not to do to their patients, it is the duty of the managers not to permit in their hospitals." Dr. McCullough felt this philosophy no longer held true in the contemporary hospital. He suggested that Gregory's principle was impractical in a day of constrained resources. "In an era of advanced and terribly expensive medical technology," he said, "this duty will surely clash with others (e.g., maintaining the economic viability of a particular unit or department or even of the hospital itself) not to mention controlling the cost of the hospital care." McCullough suggested that it was this tension between the principle advocated by Gregory and the current principle advocating efficient use of resources in caring for a patient that created the conflict for the hospital administrator.

CEOs Must Choose Between Life and Death for Patient and Hospital

Dr. McCullough illustrated his points with several case studies, including the case of an uninsured foreign national in renal failure. This patient required thousands of dollars worth of dialysis treatment, but had no ability to pay for such treatment. The conflict, he said, "involves balancing the best interests of this particular patient here and now against the best interests of future patients."

Dr. McCullough also discussed the conflict between the educational and research roles of the teaching hospital and its patient care role. He described the conflict between trying to decide what is in the best interests of a single patient now versus what benefit might be derived by future patients as a result of the research or teaching that takes place.

Finally, he addressed the issue of internal conflicts within a teaching hospital such as when a particular department wishes to purchase very expensive pieces of high technology. He cited the obligation of the hospital administration to protect the community from unnecessary increases in hospital costs that could result from the purchase of major pieces of equipment that might not be needed for the mix of patients served by the hospital.

Dr. James Bartlett of Strong Memorial Hospital in Rochester and Charles O'Brien of Georgetown Hospital responded to Dr. McCullough's remarks, raising their own questions regarding ethical behavior and moral dilemmas facing the teaching hospital executive officers.

COTH ANNUAL SPRING MEETING

The annual Spring Meeting of the Council of Teaching Hospitals was held May 16-18 in Baltimore, Maryland. Addressing approximately 225 attendees, speakers focused on two main themes: the changes that have occurred to both teaching hospital organizations and to the health care environment; and the relationship of investor-owned corporations to the teaching hospital.

Senator Durenberger Keynote Speaker

Senator David Durenberger (R-MN) began the Annual COTH Spring Meeting by discussing the environmental and regulatory changes in the health care field. The Senator reiterated his position that competition and consumer choice should be the driving force behind the health care marketplace. Federal funds are stretched to the limit and hospitals should not anticipate that more dollars will be added to the Medicare system, he said. Stabilizing Medicare expenditures is the goal of the federal government, and the Senator described the prospective payment system and its use of a DRG payment mechanism as "price regulation." The changes to the Medicare payment system will require a difference in the behavior of hospitals and will reward efficiency, he said.

Durenberger reviewed some of the problems of the prospective payment system that are also of concern to HHS and HCFA and will be addressed in the near future. They included: the likelihood of inappropriate admissions and readmission on the part of hospitals to recoup income lost due to costs exceeding DRG payment levels; the need to establish a "policing" mechanism to monitor quality of care such as a Peer Review Organization; and the need to examine current practice patterns. The Senator predicted future changes in Medicare would include greater participation in Health Maintenance Organizations; the

possible development of a Medicare voucher; and a form of physician mandatory assignment or fee freezes.

Remarking on the status of Medicare's portion of the payment for the cost of medical education, Durenberger strongly suggested that these costs, along with those of high technology and care provided to indigent patients, be separately identified. Such costs should not be paid for from the patient revenue stream but rather through legislative block grants to the states, he suggested. The Senator recognized the difficult position of the academic medical center at this time and said he believes the "future of quality medicine" goes hand in hand with excellence of medical education and "we can't let it die." He concluded by requesting attendees to discuss alternative ideas on how to address issues such as payment for medical education and care for the poor, and bring suggestions to the attention of his staff.

A Call for "Dynamic Entrepreneurs"

Robert W. Crandall, Ph.D., Senior Fellow of the Brookings Institution, discussed the need for restructuring of the marketplace as a result of deregulation. He observed that in other industries, such as banking and the airlines, the key to success after deregulation has been the willingness of the organizations to restructure themselves and pursue a profit, realizing that in so doing, the organization would assume new risks. He called this reorganizing "entrepreneurial activity", and suggested hospitals must develop more entrepreneurial activities in their new marketplace. On a cautionary note, he predicted that significant changes in the marketplace, such as those seen in health care, may lead to some undesirable results.

The regulation of the past years created a natural monopoly with restrictions on new entry into the health care delivery system, Crandall said, but these restrictions are no longer in force. The assumption that regulation would benefit or protect the poor or under-served was incorrect because the cross subsidy payments assumed by such regulations were not always made. In other industries deregulation and the entry of competition demonstrated that costs could be lowered. New market forms such as Health Maintenance Organizations (HMOs) and Independent Practice Associations (IPAs) illustrate a growing tolerance in the industry for new economic forms. In closing, Crandall warned there will be continued pressure to find alternative delivery systems and a growing need for "dynamic entrepreneurs."

A Reregulated Environment

Karl D. Bays, Chairman of the Board of the American Hospital Supply Corporation described the conflicting signals regarding price, quality and quantity of health care services resulting from the reregulated marketplace. These differing signals suggest a need to reevaluate the importance of the following: competition, use of Medicare waivers; state rate setting, access to care, business coalitions, and attitudes of the general public. However, Bays found a consistent theme to these messages: the need for a more efficient system. The alternative to efficiency, Bays said, is more federal control and perhaps second rate medical care.

Bays considers the "management of change" as something progressive and beneficial. He cited the evidence of structural changes in hospital management, mergers, acquisitions, strategic planning, and marketing initiatives as clear indications that the hospital industry is responding to the challenge. He called

upon teaching hospital executives to intensify their efforts to foster change in the academic medical center in order to become competitive.

Consumer Choice Leads to Changes in the Health Insurance Industry

"Consumer Behavior Under Multiple Insurance Choices" was the topic of the presentation by James Isbister, senior vice president for federal programs, Blue Cross and Blue Shield. He described the current health care environment as one containing revolutionary changes and multiple choices. Consumer choice of insurance coverage, Isbister said, is now primarily based on an acceptable level of premiums rather than a quest for high option coverage. He sees changes in the health care environment as creating multiple opportunities, with high risks and a high potential for gain. He concluded that companies will use new incentives to attempt to manage the selection of subscribers and encourage reduced utilization of services.

The Problem of Providing Medical Care for the Uninsured

Lawrence S. Lewin, president of Lewin and Associates in his presentation entitled "Coverage for Uninsured Patients: Some Proposals to Consider" demonstrated that appropriate policy responses to address the problem of paying for charity care can be designed only if one identifies characteristics of both those individuals who are unable to pay for their services and the specific hospitals providing the care. Lewin noted that the problem of paying for medical care of the poor is most acute in public teaching hospitals that provide 12 percent of the total volume of care, but 42 percent of the total uncompensated care. He stated that solutions may be found at the state level, but that they will vary. As one example of how a state chose to address its indigency problem, he described a recent initiative in Florida which would create a "medically indigent pool" from a net revenue tax on all hospitals and from state funds.

Should Health Care Providers Share Financial Risk

The Superintendent of the University of Wisconsin Hospital and Clinic, Gordon H. Derzon, emphasized that organizational restructuring for pre-paid health care, with its assumption of provider risk, should be both an immediate and long term objective of the teaching hospital. If teaching hospitals are out of the mainstream of the health maintenance organization (HMO) development, the number of referrals could be drastically reduced. Derzon stated that alternate treatment systems, such as HMOs, together with an increase in physician supply and cost containment requirements, are putting pressure on the hospital industry.

Hospitals must keep in mind the importance of the primary care physician as the "gatekeeper", Derzon said, and encourage linkages that will recognize the key role of these physicians. Derzon described organizational changes at the University of Wisconsin Hospital and Clinic that were necessary to establish a health maintenance organization. He described the cooperative arrangements that had to be developed between the primary care departments and specialty departments. The organizational objectives of the HMO include: maintaining the quality of the educational experience; obtaining cost reductions; maintenance of tertiary care clinical activity and efficient management.

Where Are The New Payment Systems Leading Us?

Robert A. Zelten, Ph.D., associate professor of The Wharton School described the options available for hospitals in the new environment that range from being

a supplier of services to being the organizer and underwriter of health programs. Zelten encouraged hospitals to assess where they are in the health care distribution system and to identify their vulnerabilities.

It was his view that many teaching hospitals are at the very end of the patient distribution system. He encouraged these hospitals to examine their future, and consider whether this position is one which will allow them to prosper. In addition, he said the prospective payment system encourages new incentives for efficiency and business, as a primary insurer, is going to add more and more restrictions to health benefit packages and will probably require provider financial-risk sharing agreements. Zelten encourages hospitals to consider becoming an "insurance broker," and go directly to the employers with health care coverage packages. He also emphasized the important role of the primary care physician should not be underestimated.

Indirect Medical Education Adjustment: Historical Development and Current Status

Judith R. Lave, professor of health economics at the University of Pittsburgh reviewed the historical development and future prospects of the "indirect medical education adjustment" under the Medicare prospective payment system. Her presentation focused on the initiation and evolution of this adjustment for the higher costs of teaching. She described how the "adjustment" was incorporated into the new payment system, the factors that in her view, contribute to the estimated effect of the number of residents on Medicare operating costs. Dr. Lave stated that there is variability within DRGs and it is likely that teaching hospitals treat a more costly mix of patients. She cited other factors such as problems caused by accounting conventions, the pricing algorithm, and incomplete adjustments for variations in wages paid by hospitals in the central cities. These problems should be corrected on their merits, in her view, particularly since this adjustment is mislabeled and very vulnerable to budgets cuts.

Initial Prospective Payment Impacts

A presentation on the impact of Medicare's prospective payment system on teaching hospitals was made by James Bentley, Ph.D., Associate Director, AAMC Department of Teaching Hospitals. The presentation was based on responses to a questionnaire sent to COTH members in the Spring. It could not be definitive because most hospitals in states with a Medicare waiver had not returned questionnaires, only 40 percent of the members in non-waiver states had returned questionnaires, and more than 50 percent of responding members do not go on the system until July 1, 1984. Dr. Bentley's tentative observations showed that four factors contributed to the success a hospital expected in the first prospective payment year: regional location; area wage index; increase in actual over published case mix; and resident-to-bed adjustment. Dr. Bentley stressed the point that in order to understand the beneficial or adverse impact of the system on a particular hospital, each of those four factors must be examined. While some prospective payment critics had argued that teaching hospitals would increase direct medical costs to "game the system," Dr. Bentley observed that most hospitals were reporting only minor increases in medical education costs under prospective payment. In conclusion, it was noted that a follow-up questionnaire will be sent to non-responding hospitals so that a more complete report to the membership will be available in the fall.

Meeting Concludes With Consideration of the Investor-Owned Corporations

A panel of three presented case studies exploring the relationship of investor-owned corporations to the teaching hospital. The speakers were Ronald P. Kaufman, M.D., Vice President for Medical Affairs, The George Washington University Medical Center; Donald R. Kmetz, M.D., Vice President for Hospital Affairs and Dean, University of Louisville School of Medicine; and J. Robert Buchanan, M.D., General Director of the Massachusetts General Hospital. All three speakers set forth the circumstances and environment which caused their respective institutions to review possible relationships with investor owned corporations. The University of Louisville has moved ahead, action at McLean Hospital in Boston has thus far been rejected, and George Washington University continues to have the matter under study.

New Challenges for COTH

AAMC staff member, Richard Knapp, Director, AAMC Department of Teaching Hospitals presented the discussion paper entitled, "New Challenges for the Council of Teaching Hospitals and the AAMC Department of Teaching Hospitals." This paper was distributed at the meeting and had been mailed to all AAMC constituents in early May. His presentation addressed the questions of what characteristics COTH members should have, and what issues should be given top staff priority. The pros and cons of an "exclusive" COTH membership were presented, and he raised the question of investor-owned hospital participation in COTH. Knapp concluded his presentation stating his view that financing graduate medical education and providing services to those patients unable to pay are the issues which should receive major attention from the staff. The meeting concluded with a spirited discussion by participants concerning the involvement of investor-owned hospitals in COTH.

APPENDIX A

COTH OFFICERS AND ADMINISTRATIVE BOARD
1983-1984

Officers:

Chairman: Haynes Rice *	.....	Howard University Hospital, Washington, DC
Chairman-Elect: Sheldon S. King *	.....	Stanford University Hospital, Stanford, California
Immediate Past Chairman: Earl J. Frederick *	.....	Children's Memorial Hospital, Chicago, Illinois
Secretary: Spencer Foreman, M.D.	.....	Sinai Hospital of Baltimore, Baltimore, Maryland

COTH Administrative Board Members

Terms Expiring 1984:

Jeptha W. Dalston, Ph.D.	.....	University Hospitals, Ann Arbor, Michigan
Irwin Goldberg	.....	Montefiore Hospital, Pittsburgh, Pennsylvania
William B. Kerr	.....	University of California Hospitals and Clinics, San Francisco, California

Terms Expiring 1985:

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

Terms Expiring 1986:

J. Robert Buchanan, M.D.	.....	Massachusetts General Hospital, Boston, Massachusetts
Eric B. Munson	.....	North Carolina Memorial Hospital, Chapel Hill, North Carolina
Thomas J. Stranova	Veterans Administration Medical Center, West Roxbury, Boston, Massachusetts

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 THE AAMC ASSEMBLY
1983-1984

Terms Expiring 1984:

James W. Bartlett, M.D.Strong Memorial Hospital, Rochester, New York
Donald A. BradleyMorristown Memorial Hospital, Morristown,
New Jersey
A. Sue BrownUniversity of Medicine and Dentistry
Hospital of New Jersey, Newark, New Jersey
Robert B. BrunerThe Mount Sinai Hospital, Hartford,
Connecticut
Thomas J. CampbellState University, Upstate
Syracuse, New York
Jack M. CookMemorial Medical Center, Springfield,
Illinois
Jose R. CoronadoAudie L. Murphy Memorial Veterans
Administration Hospital, San Antonio,
Texas
Fred J. CowellJackson Memorial Hospital, Miami, Florida
Jeptha W. Dalston, Ph.D.University of Michigan Hospital, Ann Arbor,
Michigan
James C. DeNiroVeterans Administration Medical Center,
Palo Alto, California
William J. Downer, Jr.Blodgett Memorial Hospital Center, Grand
Rapids, Michigan
John R. FearsVeterans Administration Medical Center,
Hines, Illinois
Sidney M. FordVeterans Administration Medical Center,
St. Louis, Missouri
Earl J. FrederickThe Childrens's Memorial Hospital, Chicago,
Illinois
Irwin GoldbergMontefiore Hospital, Pittsburgh,
Pennsylvania
William I. JenkinsWishard Memorial Hospital,
Indianapolis, Indiana

Sheldon S. KingStanford University Hospital, Stanford,
California

James T. KrajeckVeterans Administration Medical Center,
Albany, New York

Mark S. LevitanHospital of the University of Pennsylvania,
Philadelphia, Pennsylvania

Glenn R. MitchellAlliance Health Systems, Norfolk, Virginia

John A. ReinertsenUniversity of Utah Hospital, Salt Lake
City, Utah

Vito F. RalloRoger Williams General Hospital,
Providence, Rhode Island

Term Expiring 1985:

Glenn Alred, Jr.Veterans Administration Medical Center,
Decatur, Georgia

Ron Anderson, M.D.Parkland Memorial Hospital, Dallas, Texas

Donald CrampOhio State University Hospital,
Columbus, Ohio

Robert DicklerUniversity Hospital, Denver, Colorado

Phillip DutcherHurley Medical Center, Flint, Michigan

William GonzalezUniversity of California, Irvine
Medical Center, Orange, California

James HeimarckMonmouth Medical Center, Long Branch,
New Jersey

Jane HurdChildren's Hospital of Los Angeles,
California

Daniel KaneMount Sinai Medical Center, Milwaukee,
Wisconsin

Marvin KleinMichael Reese Hospital and Medical Center,
Chicago, Illinois

Frank Lloyd, M.D.Methodist Hospital, Indianapolis, Indiana

James MalloyUniversity of Illinois Hospital, Chicago,
Illinois

Plato MarinakosMercy Catholic Medical Center, Darby,
Pennsylvania

James Mongan, M.D.Truman Medical Center, Kansas City, Missouri

Robert MorrisVeterans Administration Medical Center,
Hampton, Virginia

Robert MuilenburgUniversity of Washington Hospital,
Seattle, Washington

Eric MunsonNorth Carolina Memorial Hospital, Chapel Hill,
North Carolina

H. Richard Nesson, M.D.Brigham and Women's Hospital, Boston,
Massachusetts

Robert Newman, M.D.Beth Israel Medical Center, New York,
New York

Linn PerkinsSt. Louis Children's Hospital, St. Louis,
Missouri

Barbara SmallVeterans Administration Medical Center,
Boston, Massachusetts

Term Expiring 1986:

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

John T. CarsonVeterans Administration Medical Center,
Ann Arbor, Michigan

William E. CorleyAkron General Medical Center,
Akron, Ohio

B. H. CorumBexar County Hospital District,
San Antonio, Texas

James H. CuerVeterans Administration Medical Center,
Kansas City, Missouri

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

Robert C. HallLouisiana State University Hospital,
Shreveport, Louisiana

James W. Holsinger, Jr., M.D. .Veterans Administration Medical Center,
Richmond, Virginia

- L. Russell JordanMiami Valley Hospital, Dayton, Ohio
- William B. KerrUniversity of California Hospitals and
Clinics, San Francisco, California
- John E. LynchNorth Carolina Baptist Hospitals,
Winston-Salem, North Carolina
- David A. ReedSamaritan Health Service, Phoenix, Arizona
- Haynes RiceHoward University Hospital, Washington, D. C.
- C. Edward SchwartzUniversity of Minnesota Hospitals and
Clinics, Minneapolis, Minnesota
- Robert SmithUniversity of Missouri Hospitals and
Clinics, Columbia, Missouri
- C. Thomas SmithYale-New Haven Hospital, New Haven,
Connecticut
- William F. SmithHermann Hospital, Houston, Texas
- Thomas J. StranovaVeterans Administration Medical Center,
West Roxbury, Boston, Massachusetts
- Norman B. UrmyVanderbilt University Hospital,
Nashville, Tennessee
- Gennaro J. Vasile, Ph.D.United Health Services, Johnson City,
New York
- Thomas C. WinstonUniversity of California, Davis Medical
Center, Sacramento, California

APPENDIX C

COTH COMMITTEE APPOINTMENTS 1983-1984

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

AUDIT COMMITTEE

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

COTH NOMINATING

Earl J. Frederick, Chairman, Children's Memorial Hospital, Chicago
John A. Reinertsen, University of Utah Medical Center, Salt Lake City
Haynes Rice, Howard University Hospital, Washington, D.C.

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 Hospital, Seattle
Charles M. O'Brien, Jr., 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, Iowa City

GOVERNANCE AND STRUCTURE

John W. Colloton, University of Iowa Hospitals and Clinics, Iowa City

JOURNAL OF MEDICAL EDUCATION EDITORIAL BOARD

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

LIAISON COMMITTEE ON MEDICAL EDUCATION

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

MANAGEMENT EDUCATION PROGRAMS

David L. Everhart, Northwestern Memorial Hospital, Chicago

AAMC NOMINATING

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

* * * * *

AAMC COMMITTEE APPOINTMENTS OF SPECIAL INTEREST TO
TEACHING HOSPITALS 1983-1984

PAYMENT FOR PHYSICIAN SERVICES
IN TEACHING HOSPITALS

Hiram C. Polk, Jr. M.D., Chairman, University of Louisville School of Medicine,
Kentucky

Irwin Birnbaum, Montefiore Hospital and Medical Center, Bronx, New York

David M. Brown, M.D., University of Minnesota Medical School Minneapolis

Thomas A. Bruce, M.D., University of Arkansas College of Medicine, Little Rock

Jack M. Colwill, M.D., University of Missouri-Columbia School of Medicine,
Columbia

Martin G. Dillard, M.D., Howard University Hospital, Washington, D.C.

Fairfield Goodale, M.D., Bowman Gray School of Medicine, Winston-Salem

Robert W. Heins, The University of Texas Southwestern Medical School, Dallas

Sheldon S. King, Stanford University Hospitals, Stanford

Jerome H. Modell, M.D., University of Florida, Gainesville

Marvin H. Siegel, J.D., University of Miami School of Medicine, Miami

Alton I. Sutnick, M.D., The Medical College of Pennsylvania, Philadelphia

Sheldon M. Wolff, M.D., Tufts University School of Medicine, Boston

PROSPECTIVE PAYMENT FOR HOSPITALS

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

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 Virginia, Richmond

Ronald P. Kaufman, M.D., George Washington University Medical Center Washington,
D.C.

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

AD-HOC COMMITTEE ON CAPITAL PAYMENTS FOR HOSPITALS

Robert E. Frank, Chairman, Barnes Hospital, St. Louis
William G. Anlyan, M.D., Duke University, Durham
Bruce C. Campbell, Dr.PH, University of Chicago Hospitals and Clinics, Chicago
David Ginzberg, Presbyterian Hospital in the City of New York, New York
Leo M. Henikoff, M.D., Temple University School of Medicine, Philadelphia
Larry L. Mathis, The Methodist Hospital, Houston
Richard Meister, Goldman, Sachs & Co., New York
William Ryan, Deloitte, Haskins & Sells, Philadelphia
C. Edward Schwartz, University of Minnesota Hospitals and Clinics, Minneapolis
Clyde M. Williams, M.D., Ph.D., University of Florida College of Medicine,
Gainesville
Leon Zucker, Jackson Memorial Hospital, Miami

COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

J. Robert Buchanan, M.D., Chairman, Massachusetts General Hospital, Boston
Richard A. Berman, New York University Medical Center, New York
David W. Gitch, St. Paul-Ramsey Medical Center, St. Paul
Louis J. Kettle, M.D., University of Arizona, Tucson
Frank G. Moody, M.D., University of Texas Medical School, Houston
Gerald T. Perkoff, M.D., University of Missouri, Columbia
Robert G. Petersdorf, M.D., University of California, San Diego
Louis Sherwood, M.D., Albert Einstein College of Medicine of Yeshiva University,
Bronx
Charles C. Sprague, M.D., University of Texas, Dallas
William Stoneman, III, M.D., St. Louis University, St. Louis
Richard Vance, M.D., Wake Forest University Medical Center, Winston-Salem
W. Donald Weston, M.D., Michigan State University, East Lansing
Frank C. Wilson, Jr., M.D., University of North Carolina, Chapel Hill

APPENDIX D

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