association of american medical colleges

SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

OCTOBER, 1985-SEPTEMBER, 1986

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

aamc association of american medical colleges

SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

OCTOBER, 1985-SEPTEMBER, 1986

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

INTRODUCTION

The Department of Teaching Hospitals is the staff component of the Association of American Medical Colleges (AAMC) which is responsible for representing the interests and concerns of teaching hospitals in the activities of the Association and in interaction with other organizations and agencies. The Department prepares an annual summary of its activities during the preceding year. This report, Selected Activities, is distributed at the Council of Teaching Hospitals' (COTH) membership meeting, which is held in conjunction with the AAMC's Annual Meeting each fall. This document summarizes Departmental activities from October, 1985 through September, 1986.

Those interested in knowing more about these activities are encouraged to contact Departmental staff for additional information. Staff members and their phone numbers are listed inside the back cover of this report.

TABLE OF CONTENTS

THE COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges was formally established in 1966. 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 and the AAMC Assembly. The Executive Council includes the three chairmen-officers of the COTH Administrative Board, plus an "at large" COTH Administrative Board representative. The AAMC Assembly includes 63 COTH representatives and is the highest legislative body of the AAMC.

COTH Administrative Board

The Administrative Board of the Council of Teaching Hospitals represents the interests of the Council as a whole in the deliberations and policymaking 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, secretary and COTH "at large" representative to the Executive Council. Spencer Foreman, MD, president of the Montefiore Medical Center, will serve as chairman of the Council of Teaching Hospitals in 1986-87, succeeding outgoing chairman C. Thomas Smith, president of Yale-New Haven Hospital. The members and officers of the 1985-86 COTH Administrative Board are listed in Appendix A. The Administrative Board is elected at the COTH business meeting held during 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 1985-86.

The COTH Administrative Board met four times during the past year to conduct business and discuss issues of interest and importance. A major item of business was the discussion and approval of the Final Report of the AAMC Committee on Financing Graduate Medical Education, chaired by J. Robert Buchanan, M.D. The Committee's report outlines eighteen recommendations regarding sources of funding, responsibilities, and limitations. Among other issues addressed by the Board were: COTH/AAMC relationships with emerging hospital consortia; Medicare payment of capital costs; Medicare payment for services provided to patients by radiologists, anesthesiologists, pathologists, and emergency room physicians; malpratice insurance legislation; tax reform; changes in graduate medical education training requirements; the recommendations of the National Task Force on Organ Transplantation; trends in medical school applicants; accreditation of foreign medical schools by the LCME; and the role of the AAMC in the promotion of academic medical centers to the public. In addition to the general AAMC matters of business, the Administrative Board engaged in the following activities:

- joined with the other AAMC councils in January in a dinner to honor former HCFA Administrator Carolyne Davis, Ph.D.;

- held an evening session in April to exchange views with Ed Mihalski, Deputy Chief of Staff for Health Policy of the Senate Finance Committee;

- met with William Roper, M.D., Administrator of the Heath Care Financing Administration, in September to discuss the implications of recent changes in Medicare reimbursement, and future directions for health care legislation and regulation;

COTH Membership

There are two categories of COTH membership: teaching hospital membership and corresponding membership. Both membership categories require the applicant institution to have a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education and a letter recommending membership from the dean of the affiliated medical school.

Teaching hospital membership is limited to those hospitals which sponsor, or significantly participate in, at least four approved, active residency programs. At least two of the approved residency programs must be in the following specialty areas: internal medicine, surgery, obstetrics-gynecology, pediatrics, family practice, or psychiatry. In the case of specialty hospitals, such as children's hospitals, the COTH Administrative Board is authorized to make exceptions to the residency program requirement provided that the hospital meets the membership criteria within the framework of the specialized objectives of the hospital.

Corresponding membership is available to institutions that cannot meet the above mentioned requirements for full membership, but which have an affiliation agreement with an accredited medical school. 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 435 full teaching hospital members and 30 corresponding members. Included in the membership are private, not-for-profit institutions, municipal or state-owned and operated institutions, and Veterans Administration hospitals. In October, 1985, the AAMC by-laws were amended to permit membership of investor-owned teaching hospitals. Four current members are either owned or leased by investor-owned corporations.

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. 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 D.

COTH Report

The Association's Department 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 selected coverage of Association and Council activities; legislative and regulatory actions; studies, surveys and reports that are of particular relevance to the educational and research mission of 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 and the deans of the medical schools accredited by the Liaison Committee on Medical Education. 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 1987 Directory will be published in the spring. Additional copies of the Directory are available for $8, and may be obtained from the AAMC, Attn: Membership and Subscriptions, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036.

COTH Survey of Housestaff Stipends, Benefits, and Funding

The housestaff stipends, benefits, and funding survey has been completed by the Department of Teaching Hospitals for the past sixteen 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. Other related issues surveyed in 1986 included unfunded or "externally-funded" residency positions, policies for maternity leave, and anticipated changes in the number of residency positions available. This report is distributed to all COTH member hospitals and medical school deans. Additional copies are available for $8 each from 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 is presented 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 Academic Medical Center Hospitals' Financial and General Operating Data

The second personal and confidential survey completed by the Department of Teaching Hospitals includes detailed information on revenue sources, expenses, capital expenditures, utilization of services, staffing, and other general operating data in hospitals where a majority of the clinical chiefs of service are also heads of the academic departments. The distribution of this report is restricted to institutions participating in the survey.

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; it was published in 1985, and is available from the Department of Teaching Hospitals at no cost.

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.

Financing Graduate Medical Education

To provide background information, informative data and articles on the subject of financing of graduate medical education in the future, a

publication entitled Background Information and Selected Readings was prepared for members of the Committee on Financing Graduate Medical Education. To encapsulate the issues debated by the committee, and to facilitate further informed discussion of appropriate alternatives for the financing of graduate medical education, the AAMC published a Statement of Issues paper in March of 1985. The Committee issued its Final Report, outlining the issues, options, and the Committee's recommendations, in April 1986. It was adopted as AAMC policy by the AAMC Executive Council later that month. All three reports are available without charge from the Department of Teaching Hospitals.

The Commonwealth Fund Grant to Analyze Teaching Hospital Data

An area of concern to the AAMC in recent months has been that developing state and national policies on health care delivery and payments usually assume that teaching hospitals are relatively homogenous. A number of pilot studies conducted by the Task Force on Academic Medical Centers of The Commonwealth Fund clearly indicated that this simplifying assumption is incorrect. In an effort to replace the assumption of homogeneity with clear analytical information on the differing characteristics of subgroups of teaching hospitals, the AAMC has received funding from The Commonwealth Fund for a three-year effort to establish a coordinated database on teaching hospitals. Data will be developed at the individual hospital level so that the impacts of a particular policy can be assessed on different types of teaching hospitals. To the degree that it is possible, the database will be assembled using existing data currently collected by the American Hospital Association, the Health Care Financing Administration, the National Institutes of Health, and the Accreditation Council for Graduate Medical Education. For COTH hospitals, the general data will be supplemented by both existing annual surveys on resident stipends and funding sources for graduate medical education, and by special purpose surveys developed to collect information on issues such as hospital debt structure and payment requirements.

Three types of project reports will be prepared. The first set will develop alternative typologies of teaching hospitals based on their organizational, patient service, educational, research, and financial characteristics. The next reports will use the developed typology to assess the comparative impacts of existing policies/ developments on subgroups of teaching hospitals. For example, changes in the number of admissions can be compared across hospital subgroups to identify relationships between hospital characteristics and operational experience. The third set of reports will use the alternative typologies and the assessments of present policies to model the impact of proposed policies.

Advising the AAMC on the project will be a committee comprised of individuals knowledgeable about teaching hospitals and policy analysis.

ACTIVITIES OF THE DEPARTMENT OF TEACHING HOSPITALS

During 1985-86, the attention of the Department of Teaching Hospitals was focused on several major issues which have signficant long-range implications for the nation's teaching hospitals. These included the continued refinement of the Prospective Payment System (PPS) for Medicare reimbursement to hospitals, and the options for future financing of graduate medical education. The staff of the the Department took an active role in:

- opposing any freeze in Medicare payments to hospitals, and recommending that Congress amend the Prospective Payment System so that payments are made on a DRG-specific, blended rate of hospital-specific and federal component prices;

- continuing to analyze and comment upon the Administration's cost-cutting budgetary proposals, pointing out their probable adverse, imbalanced effects on teaching hospitals;

- opposing the Health Care Financing Administration's (HCFA) excessive and inappropriate use of regulation rather than legislation to implement budgetary goals;

- testifying before the Health Subcommittee of the Senate Finance Committee and the Subcommittee on Health of the House Ways and Means Committee, regarding Medicare payment policies;

- outlining the role of teaching hospitals in the provision of uncompensated or "charity" care;

- opposing action by the House Ways and Means Committee to restrict tax-exempt financing for 501 (c)(3) organizations;

- staffing the AAMC Committee on Financing Graduate Medical Education, which developed recommendations for the AAMC policy positions;

- publishing membership surveys and reports such as the Executive Salary Survey, the Survey of Housestaff Stipends, Benefits and Funding, and the COTH Report.

The following is a summary of the Department's activities in major areas of interest during the past year.

Overview

As a result of Congressional activities in 1985, the Association reviewed and revised its positions on Medicare hospital payment policies. The AAMC vigorously opposed any freeze in Medicare payments to hospitals and strongly recommended that Congress amend the Prospective Payment System so that payments are made on a DRG-specific, blended rate of hospital-specific and federal component prices. If Congress does not enact DRG-specific price blending, then the Association recommended amending the DRG price formula to a blend of 50% hospital-specific costs and 50% regional average costs.

The AAMC supported recomputing the resident-to-bed adjustment using hospital resident and bed data, up-to-date corrected hospital case mix indices, corrected wage indices, and a regression equation which incorporates only variables used in determining DRG payments. The most recent analyses by the Congressional Budget Office support a curvilinear adjustment of 8.7% per 0.1 resident per bed. The AAMC strongly supported including the same types of residents in the payout of the indirect medical education adjustment as are included in the statistical formulation of the adjustment. Explicit Medicare funding should be retained for graduate medical education for the period required to attain board eligibility plus one additional clinical year (to a maximum of six years) for advanced specialty and subspecialty positions in hospitals in which the positions were supported by Medicare in FY84-85. The AAMC supported eliminating Medicare funding for residents who are not graduates of accredited medical or osteopathic schools in the United States or Canada. For any resident presently in training who would not be included in the passthrough, there should be a phase-in of Medicare payment changes.

The Association endorses an adjustment in prospective payments to recognize the generally higher costs incurred by hospitals serving a disproportionate number of indigent Medicare patients, even if implementation of such an adjustment leads to a recalculation of the indirect medical education adjustment. The AAMC supported correcting the wage index numbers used in Prospective Payments but recommended amending the law to eliminate the current requirement that the new index numbers be applied retroactively to October 1, 1983. Congress should require HCFA to update each hospital's published case mix index using data from the hospital's first year under prospective payment. The Association also advocated removing the Medicare Part A Trust Fund from the automatic reduction provisions of the Emergency Deficit Control Act of 1985.

Financing Graduate Medical Education

An overriding concern of the Department and the AAMC as a whole has been the ongoing reassessment of current and future financing mechanisms for graduate medical education (GME). Historically, these costs have been included in patient service revenues and supported primarily by Medicare and other third party payors. However, this policy is increasingly being called

into question. To address alternatives to the current financing methodologies, the Association established a Committee on Financing Graduate Medical Education in 1984.

The AAMC Committee on Financing Graduate Medical Education was charged with assessing the current methods for financing graduate medical education and determining whether those sources could continue to provide adequate support in the near future. Since graduate medical education takes place primarily in teaching hospitals and adds to the cost of operating the hospital, changes in payment methods have raised the concern that teaching hospitals may no longer be able to sustain their current support of graduate medical education. Further, more care is delivered in ambulatory settings which have no clear sources of funding for education activities.

The first major issue discussed by the Committee was the creation of a separate fund for financing graduate medical education to eliminate the current reliance on teaching hospital payments from insurers and governmental programs. However, it would mean total dependence on the funding policies established by this single source. The Committee concluded that changes in hospital payments are likely to reduce the support teaching hospitals can provide for graduate medical education. Although the full effects of the current environment on teaching hospitals' ability to support graduate medical education are unknown, the Committee believed that they do not warrant acceptance of the disadvantages of a single national fund at this time. The Committee recommended that teaching hospital revenues from patient care payers continue to be the principal means of support for graduate medical education with all payers providing their appropriate share. Sources such as state and local governments, special purpose federal programs, and private organizations may also need to provide greater support in the future. Other recommendations of the Committee concerned the obligation of the medical education community to monitor the quality of residency training programs, to train the types of physicians needed by society, and to operate in a cost-effective manner. The Committee further recommended that limits be placed on the length of training for which teaching hospitals are expected to provide a major source of support. The following recommendations were made:

> *Residents in approved training programs should be funded largely by payments to teaching hospitals by patient care payers at least through the number of years required to achieve initial board eligibility in their chosen discipline.*

In making this recommendation, the Committee recognized that the various specialties have structured their training programs differently. For example, in internal medicine, residents must generally complete a three year internal medicine residency before entering subspecialty training. In surgery, residents are allowed to enter some specialized surgical programs and complete them within the same time period required for a resident in general surgery. Similar differences are present in other specialties. As a result of the differences in the structures of training programs,

specialties would be affected differently if the proposal were limited to support residents solely through initial board eligibility.

The Committee was concerned that the fiscal stability of fellowship programs that provide the training for those who want to practice in the subspecialties or who wish to become academic physicians would be unduly jeopardized if no support were provided from teaching hospital revenues. In reaching this conclusion, the Committee was aware that the majority of those enrolled in fellowship programs have completed residency training in internal medicine and that a recent study by Schleiter and Tarlov found that only two-fifths of fellowship funding for the subspecialties of internal medicine are supported by non-federal hospital revenues. However, the extent to which hospital revenues provide support for particular programs differs greatly across hospitals. The fellows in some programs are funded almost completely out of teaching hospital revenues. In other programs, the support comes largely from a combination of research and training grants and physician fees. A third group of programs has a mixture of revenue sources. This disparity means that some programs would be greatly affected by the sudden elimination of hospital revenues as a source of funding. Therefore, the Committee recommended:

> *One additional year of funding beyond initial board eligibility should be provided from teaching hospital revenues for fellows in accredited training programs to the extent that the hospital funded such training in 1984.*

The Committee recommended restricting the extension of fellowship funding to one year as a means of balancing the needs of the hospitals to reduce the expenditures on graduate medical education with the need for adequate support for training programs that provide skilled practitioners in all of the subspecialties as well as the specialties. In recognition of the fact that hospital patient care payers are unlikely to be willing to spend more in the aggregate on graduate medical education than they do now, the Committee recommended the reliance on teaching hospital revenues as a source of fellowship support to be limited to the hospital's current level of fellowship support. By this, the Committee did not intend to suggest a freeze in the dollars of support provided. Instead, the Committee intended that the proportion of support provided from the teaching hospital should not increase.

To be responsive to the concerns of society and the teaching hospitals over the length of training to be supported, the Committee believed it was necessary to establish a limit on the maximum number of years to be supported for an individual resident. The Committee recommended:

> *An individual should be supported from patient care payers' payments to teaching hospitals for a maximum of six years of graduate medical education.*

This recommendation would mean that residents in thoracic surgery, which requires seven years of formal training, would not be funded by the

hospital in the final year of training. Also, residents that change specialties after completing some portion of their initial training may reach the six year limit. The Committee also recommended that a coordinated, nationwide private sector effort should be made to collect and disseminate information on the supply of physicians by specialty, and residents and programs in the ambulatory care settings must be supported.

Tax Exempt Bond Financing

The AAMC joined twenty-nine other organizations representing nonprofit health care and higher education institutions in opposing House Ways and Means Committee action to restrict tax-exempt financing for 501(c)(3) organizations. The Committee placed section 501(c)(3) bonds under a state volume cap and protected only about one-half of their 1984 volume with a $25 per capita set-aside. This set-aside would inevitably become a "ceiling" rather than a "floor" because the demand for other types of bonds far exceeds the amount which could be issued under the remainder of the volume cap. The AAMC and other organizations opposed the Committee's position because it did not recognize that private nonprofit health care and higher education institutions serve public purposes which the government would otherwise have to provide. It would treat private nonprofit institutions differently from public institutions performing the same functions. The Committee's position would arbitrarily allocate capital for nonprofit hospitals and universities according only to state population, despite these institutions's characteristics as national resources.

The Committee bill also denied advance refunding authority to section 501(c)(3) organizations, which is used to reduce debt service. The Committee also imposed a limit on the amount of outstanding bonds of institutions other than hospitals, eliminated the use of arbitrage, and placed numerous restrictions on bond issuance for section 501 (c) (3) organizations. The AAMC emphasized that it is essential that they not be subject to any volume restrictions, and that such organizations have the same limited advance refunding authority that the bill provides for governmental bonds.

Tax Reform and Abortion: The Humphrey Amendment

In June 1986, the Association wrote all members of Congress in opposition to the tax bill amendment being offered by Senator Gordon J. Humphrey. Senator Humphrey wished to amend the tax reform bill by denying tax-exempt status to any organization that "directly or indirectly performs, finances, or provides facilities" for abortions. This amendment would jeopardize the tax-exempt status of any not-for-profit or public hospital or university whose medical school faculty performs abortions for any reason other than to save the life of the mother. It would force hospitals to choose between retaining their tax-exempt status, which enables them to accept deductible contributions, and providing a legal medical service. It might jeopardize the tax status of any 501(c)(3) organization, including private universities without a medical school or a hospital, as well as libraries and museums, if that organization offers its employees a health

benefit plan that includes abortions among the covered services, because that would mean financing an abortion. Although this amendment was subsequently removed from the tax reform measure, its supporters planned to re-introduce it as an amendment to the Continuing Resolution or another important piece of legislation in the near future; the Association continued its strong opposition to this amendment and wrote to all members of the Council of Deans, the Council of Teaching Hospitals, and the Council of Academic Societies to encourage them to contact their senators and ask them to oppose this amendment and its far-reaching consequences.

Medicare Capital Payment

In February 1986, the AAMC submitted testimony to the Subcommittee on Health of the House Committee on Ways and Means, on the subject of Medicare payments for hospital capital. The AAMC testimony pointed out that historical data comparing capital to total expenses have been misinterpreted by some to imply that major teaching hospitals have lower absolute capital costs than other hospitals. In fact, capital costs per unit of workload performed are higher in major teaching hospitals than in other hospitals. Further, major teaching hospitals have older plants than other hospitals, and recently increased capital spending by major teaching hospitals may alter statistical relationships from the 1970s and early 1980s. The AAMC supported replacing institutionally specific, cost-based retrospective payments for capital with prospectively specified capital payments, and supported separating capital costs into movable equipment and fixed equipment and plant. The Association's testimony indicated support for incorporating capital payments for movable equipment into prospective payment using a percentage "add-on" to per case payments. The AAMC supported a percentage add-on to per case prices for capital costs of fixed equipment and plant that is no less than Medicare's current percentage of hospital payments for facilities and fixed equipment, provided it appropriately compensates teaching hospitals for their distinctive costs. The AAMC further supported a long-term, hospital-specific transition from the capital passthrough to prospective payments for plant and fixed equipment. The transition period should allow each hospital its choice of cost reimbursement for depreciation and interest on adjusted base period capital or a prospective percentage add-on that is no less than Medicare's current percentage of hospital payments for facilities and equipment.

In March 1986, George Middleton, Chairman of the Board of Alliance Health Systems, Norfolk, Virginia, testified for the AAMC before the Subcommittee on Health of the Senate Finance Committee, regarding Medicare payments for hospital capital. The Administration's proposed budget for FY87 advocated implementing a new policy for Medicare capital payments by regulation. The AAMC strongly opposed changing Medicare capital payments by regulation, preferring the legislative process because it is more open and public. To ensure that the legislative process has an opportunity to consider a new capital payment policy, the AAMC recommended that the Health Subcommittee adopt legislation prohibiting HHS from making changes in the capital passthrough until Congress enacts legislation with a specific capital payment methodology. The Association further recommended that the

federal component for computing capital payments for a phase-in be based on actual 1986 Medicare capital payments updated annually for increased construction and borrowing costs, and that the hospital-specific component for computing capital for a phase-in transition be based on each hospital's actual capital costs for that current year. With regard to the capital proposal made by Senators Durenberger and Quayle, the AAMC recommended consideration of a hospital-specific transition approach which varies the transition period with either the percentage of a hospital's fixed assets which are debt financed or the percentage of fixed assets presently depreciated. The Association recommended specifying the base year and the specific update factors in the legislation, recommended that any offset of interest earned be limited to interest earned on funded depreciation, and that any effective date for a new capital policy be based on individual hospital fiscal years.

The AAMC opposed five major elements of HCFA's capital proposal. First, the capital cost data from 1983 substantially understate current capital costs. HCFA's efforts to update 1983 data are inadequate because the HCFA adjustment is based primarily on interest rate changes and ignores the increase in capital spending since 1983. Second, the AAMC opposed using a four-year transition to national rates as too short to allow hospitals with major modernization or replacement projects to adjust their capital costs to an average national rate. A ten year transition is more appropriate. Third, the AAMC opposed limiting the hospital-specific payment during the transition to 1986 allowable costs. During each year of the transition, hospitals should be allowed to use actual allowable costs. Fourth, the AAMC opposed offsetting interest received on funded depreciation against interest paid on capital costs. For twenty years, allowable capital costs have not included the offset, and debt instruments currently in force often require segregating both depreciation and interest earned on funded depreciation. Thus, interest earned on funded depreciation is often not legally available for capital payments. Fifth, the AAMC opposed a capital exceptions policy that requires hospitals to approach insolvency before qualifying for more individualized capital payments. In good faith, communities and hospitals have sought to maintain technically up-to-date facilities and equipment. Requiring these hospitals to substantially weaken their financial position in order to have atypical costs recognized is an inappropriate public policy which threatens hospital viability and beneficiary access. Each of these five elements of the capital proposal is a major shortcoming; together they consititute an unacceptable proposal.

In developing a capital payment policy, the AAMC does not recommend using a separate component after the transition period. To accomplish this objective, it is important to adjust all payments by the case mix index, the indirect medical education adjustment, and the disproportionate share adjustment. To help ensure equity across hospitals, it is necessary to standardize any capital component by each of these payment variables.

Medicare Hospital Payment

In March, 1986, Charles O'Brien, Administrator of Georgetown University Hospital, testified on behalf of the Association before the House Ways and Means Committee's Subcommittee on Health, outlining the AAMC's positions on the Administration's FY86 Medicare budget proposals. Of specific concern to teaching hospitals and physicians were proposals to: reduce payments in direct medical education; reduce to 5.79 percent the indirect medical education adjustment in spite of an extensive CBO analysis supporting a reduction to only 8.7 percent; implement DRG payments at 100 percent national rates effective October 1, 1987; increase DRG prices by two percent, essentially a freeze at 1985 payment levels if Graham-Rudman-Hollings reductions go into effect; implement a restrictive capital payment policy; and retroactively recalculate the Medicare economic index to reduce fee payments for physicians.

The AAMC made a number of specific recommendations in its testimony. The testimony recommended that Congress amend the Prospective Payment System so that payments are based on a DRG-specific, blended rate of hospital-specific and federal component prices, that the current pause in the phase-in of national prices be continued throughout 1986, and that the FY87 price be based on at least a hospital-specific component of 25%. The AAMC further supported increasing DRG prices for 1987 by the market basket plus 0.25% , and establishing an adjustment in prospective payments to recognize the generally higher costs incurred by hospitals serving a disproportionate number of indigent patients. The AAMC opposed any extension of the Medicare freeze on payments to physicians for professional medical services, and urged Congress to mandate retaining the present methodology for calculating the medical economic index.

In July, the AAMC submitted written comments to the Health Care Financing Administration regarding the proposed rule for the fourth year of the Medicare prospective payment system. The Association is especially interested in the proposed rules because its teaching hospital members provide approximately 20% of Medicare inpatient days. The Association's comments focused on the increase in DRG prices, payment for capital costs, market basket recalculation, restandardization of prices, classification of burn patients, and periodic interim payments. In the proposed rule, HCFA argued that an appropriate price increase for FY86 DRG prices is an 0.9% decrease, but recommended a 0.5% increase in DRG prices. The AAMC is concerned with the inadequate justification HCFA offers for both the increase and the decrease. Given HCFA's apparent unwillingness to develop an adequate, politically independent estimate for DRG prices, the AAMC recommended using the price increase of 2.2% developed by the Prospective Payment Assessment Commission (ProPAC).

The AAMC supported the regular revisions in the market basket to estimate price increases in the goods and services purchased by hospitals. The AAMC is disappointed, however, that HCFA, in proposing a new wage index, has not conducted a retrospective impact anaylsis using data from 1982-1984. The AAMC believes that in proposing a new market basket, HCFA

should demonstrate the redistributional impact of using the new approach. Until such an analysis is conducted and published, the AAMC is unable to evaluate the market basket weights and proxies of the HCFA proposal.

COBRA made significant changes in area wage indices, the indirect medical education adjustment and the disproportionate share adjustment. As a result, the law required HCFA to restandardize regional and national prices. These adjustments are consistent with AAMC policy.

The AAMC is pleased that HCFA is using its discretionary authority to categorize and weight tertiary care services. While HCFA has not released the data necessary to evaluate the change in DRGs relating to burn patients, the Association believes this is an appropriate step and recommended that HCFA continue to develop additional diagnosis-related groups for patients requiring substantially different hospital resources.

The AAMC opposed HCFA's proposal to simply eliminate the periodic interim payments until detailed specifications for intermediary performance are in place and enforceable. Rather than abandoning PIP in a blanket manner, HCFA should initially establish intermediary standards for paying provider claims. Only when a provider demonstrates a sustained ability to meet the performance standard should HCFA consider eliminating PIP for that intermediary. If an intermediary is allowed to discontinue PIP, HCFA should publish semiannual data on intermediary payment performance. If an intermediary fails to meet the performance criteria, HCFA should immediately reinstate PIP until the performance standard can be met.

The AAMC believes that the proposed regulation for the fourth year of prospective payment demonstrates HCFA's continued emphasis on limiting program expenditures and its unwillingness to provide adequate public statistical information on the impacts of its proposals.

Medicare Physician Payment

Another issue of concern to the AAMC in the past year has been Medicare payment for physician services. The AAMC recognizes the present dissatisfaction and unrest with Medicare's usual, customary and prevailing system for determining payments for physician services, but stresses that the form and content of any revised payment system for professional services will provide economic incentives that influence the attractiveness of the various specialties and subspecialties. Therefore, change in the payment system must be approached carefully and with demonstration projects so that intended benefits and unintended consequences are understood. At the same time, the AAMC believes that Congress should not extend the physician fee freeze. Currently, fees for physician services are based on information submitted in 1982 with no adjustment provided for increasing practice costs such as the rapid rise in malpractice premiums. The AAMC strongly recommended halting the fee freeze on physician services.

As new approaches to physician payment are considered, the AAMC urged careful attention to the application of the approach in teaching settings.

The revised payment system should incorporate several principles for the equitable application of payments in teaching settings. If the level of professional medical services provided is equivalent to the level of services furnished a patient in a non-teaching setting, payment should be made on the same basis. Payments should be determined in the same manner regardless of setting. The determination of the level of payments for professional services should not be negatively influenced by the extent to which physicians provide services to non-paying or Medicaid patients. Payments for physicians in teaching settings should not impose requirements which result in artificial or atypical relationships on the provider organization and its medical staff. The AAMC further believes that special attention should be given to ensuring that any revised payment system does not preclude or discourage resident training in the full spectrum of long-term care and ambulatory care settings.

The Association expressed its views on the proposed regulation to augment the procedures for establishing reasonable charge limits for Part B of Medicare in a letter to the Health Care Financing Administration. The proposed regulation sought to establish a mechanism by which the usual method of establishing a "reasonable charge" for a service can be abridged when it will result in an unreasonably high charge. The AAMC expressed its understanding that there may be instances in which HCFA's formula for determining charges may result in inappropriate levels of payment; e.g., new medical technologies and techniques can dramatically affect the time and effort involved in providing services to patients. However, the Association opposed the method suggested in the proposed regulation, in which HCFA would identify areas in which it suspects that Part B compensation is excessive, would calculate new payment amounts for these services, and would publish proposed regulations to establish those payment amounts. After eliciting comments from the public, HCFA would then publish the final regulation, which may contain changes from the proposed rule. As the agency responsible for Medicare outlays, HCFA is not an objective independent party able to determine what constitutes a "reasonable" outlay for a particular service. Under this regulation, HCFA would act as both the unilateral determiner of the rules for "reasonable payment" under Part B and as the payer. The interests of the government, patients, and providers would be best served if proposed changes from the current accepted method of fee determination were discussed publicly, and enacted only on advice and consent of a knowledgeable, independent advisory body established to look at such payment issues. The Physician Payment Review Commission (PhysPRC) or a similar body would be an appropriate advisor for these payment changes. The Association proposed an alternative process in which HCFA publishes instances which it believes warrant deviation from the normal methodology for calculating payments, and that publication is followed by a hearing before an independent body to review HCFA's rationale and information. That body then advises HCFA on whether to proceed with regulations and solicit suggestions on acceptable formulae for any recalculation.

Federal Budget Concerns

In March 1986, concern about health budget cuts prompted the AAMC to join with over one hundred health-related organizations in writing to Senator Pete V. Domenici, Chairman of the Senate Budget Committee. The letter stated that despite concerns about budget deficits, a balanced solution is needed. The organizations were deeply disturbed by continued efforts to cut public health programs, including health research and education, in a disproportionate manner. The letter pointed out that during the past five years, Medicare had been cut by nearly $40 billion. This constituted 12% of total budget cuts, even though Medicare represented only 7% of federal outlays. An additional $55 billion in cuts over the next five years were proposed along with cuts of $1.3 billion from Medicaid in 1987, although that program is already unable to protect millions of indigent patients due to inadequate funding. These proposals would adversely impact the quality of services and access to needed health care by elderly and poor patients. The AAMC urged Congress to adopt a budget resolution which rejected such arbitrary and unfair cuts and established reasonable targets for health programs in the FY87 budget resolution.

MAJOR MEMBERSHIP MEETINGS

At its 96th Annual Meeting held in Washington, DC, on October 26-31, 1985, the Association of American Medical Colleges Assembly unanimously approved a change to its bylaws permitting investor-owned hospitals to become members of the AAMC's Council of Teaching Hospitals. The issue had been discussed previously at the COTH annual Spring Meeting in Baltimore in 1984, at the 1984 annual business meeting held for COTH members as part of the AAMC Annual Meeting, and at the 1985 COTH Spring Meeting in San Francisco. During his chairman's address at the COTH General Session of the 1985 AAMC Annual Meeting, Sheldon S. King, executive vice president and director of the Stanford University Hospital, stated that in addition to COTH membership review and discussion, the Administrative Board had considered the issue on two occasions. He pointed out that because "COTH and the AAMC are organized to support the patient care, education, and research missions of teaching hospitals, the ownership status of the hospital should not exclude hospitals sharing common interest in supporting these objectives."

At the COTH General Session held during the 1985 AAMC Annual Meeting, Richard M. Knapp, PhD, and James D. Bentley, PhD, director and associate director of the Department of Teaching Hospitals, shared the platform with Sheila P. Burke, deputy chief of staff, Office of the Senate Majority Leader. Drs. Knapp and Bentley focused on the future in "Looking Ahead at Academic Medical Centers", while Ms. Burke dealt with the present dilemmas of "Health Policy Directions in an Era of Budget Constraints."

COTH GENERAL SESSION

Dr. Bentley postulated that the academic medical center, when viewed as a social system faced with excess physician supply and hospital bed capacity, can manage change by emphasizing business practice and insurance functions, or by establishing disciplined and functionally interrelated clinical practices. In considering the historical development of the hospital and its relationship to physicians and insurers, present-day changes in hospital relationships, and implications for teaching hospitals in the years ahead, Dr. Bentley called for careful assessment of the strengths of the teaching hospital as the underpinning for successful adaptation.

Dr. Knapp considered the pace of change and the resulting escalation of events in the health care environment, calling on hospital CEOs to take time for reflection. Remarking on the past use of cross-subsidization to support the teaching hospital's multiple missions, he observed that the current climate appears to call for an impossible alliance between cooperation and competition, especially in graduate medical education. While allowing for flexibility and changes in the field of health care delivery, Dr. Knapp cautioned that members not lose respect for the roots of the teaching hospital-- a triumvirate of education, research, and patient care.

Ms. Burke provided a retrospective view of health policy decisions, presenting the deliberations of Congress and the administration by focusing on institutional providers of care, patients and cost-sharing, and the individual physician. She warned that the overriding concern for the federal budget deficit will heavily influence federal decisions in the health care arena. Since the budget process lacks specificity, authorization committees must provide substantive amendments to budget-related legislation to allow practical and equitable implementation. She encouraged AAMC members to help the Congress understand the complexity of the health care delivery system for knowledgeable decision-making.

COTH ANNUAL SPRING MEETING

The Ninth Annual Spring Meeting of the AAMC Council of Teaching Hospitals was held in Philadelphia on May 7-9, 1986, with over two hundred hospital executives attending. Presentations at the meeting focused on the impact of recent changes in health care reimbursement and developments in medical technology, and the implications of these changes for the future.

The program began with a dinner at which AAMC President John A.D. Cooper, M.D., Ph.D., was the guest of honor. Following a toast by Russell Nelson, M.D., the first COTH member to serve as an AAMC chairman, entertaining commentary on the national political scene was provided by Mark Russell, a popular Washington political satirist and a favorite of Dr. Cooper's.

Session One -- New Thoughts on Teaching Hospitals

Hospitals and Economic Incentives: A View from the ProPAC Chairman

Stuart Altman, Ph.D, Dean and Professor of National Health Policy at the Heller Graduate School of Brandeis University and Chairman of the Prospective Payment Assessment Commission, began Thursday morning's session with an overview of the Commission's recent activities and recommendations. Emphasizing that ProPAC's two major responsibilities are to advise the Executive Branch and Congress on the annual update factor, and to help them to take advantage of new technologies, Altman stated that ProPAC's likely impact is on structural changes within the DRG system. He discussed in detail the recommendations which the Commission makes in its April 1986 report to Congress (see "Items Worth Reading", COTH Report, April, 1986), and special projects in which ProPAC is involved, such as those concerning "disproportionate share" hospitals, and the transition to national rates.

The Relationships Between Severity, Intensity, and Quality of Care

Paul Gertman, M.D., Vice Chairman of CAREMARK, Inc., discussed recent developments in the field of health care research, problems with DRG assignment, and adjustment for differences in severity of illness. Describing the methods for case-mix adjustment as a "black box", the

equivalent of "1920's meteorology", Gertman likened health systems research to "pathophysiology" in that it tries to isolate problems. He pointed to the current method of DRG reimbursement for an episode of illness related to a single hospitalization, and questioned whether optimal cost-effective care might involve differentiating acute episodes of care (e.g., appendectomy) from continuous multi-admission care (e.g., spina bifida or diabetes). He discussed the areas of weakness in the current system because of data inaccuracies, lack of definitional standards, and the differences between physicians in approaches to treatment for the same illness and conditions. He pointed out that the current DRG system takes very limited advantage of clinical and other data which are potentially available in the system, and he advocated the development of a case severity adjustment which would involve clinically defined mathematical models, excluding complicated and atypical cases, and which would outline standard conditions on which all hospitals can be compared.

Challenging the Conventional Wisdom: Teaching Hospitals and Graduate Medical Education Studies

Myles Lash, National Director of Health Care for Arthur Young and Co., discussed predicted trends in teaching hospitals and new issues and challenges in the current milieu. He pointed to increased price competition, shortened inpatient stays, and the emphasis on ambulatory care as important factors in the emerging scene, and raised the question of whether the residents themselves, the attending physicians who benefit from their presence, or the institutions in which they practice should pay for the residents' training. He discussed the evolving emphasis on computerization in medical care, citing a study which looked at data processing as a percentage of total hospital budget, and at the satisfaction levels of hospital directors with their data processing systems. His predictions included a continued increase in acuity in institutions, a continued dropoff in the number of inpatient beds, a decrease in total FTEs (although he reported that 23% of teaching hospitals expect an increase in FTE residents and fellows), and a high probability of a move on the part of academic medical centers toward sponsoring HMOs and PPOs.

Managing Resources Using DRGs

Al Zamberlan, director of the Great Lakes Region of the Veterans' Administration, discussed the VA's experiences in resource allocation using DRGs. Pointing out that there are 72 VA hospitals which are members of COTH, and 120 VA hospitals which have some teaching programs, Mr. Zamberlan discussed the possibility of substantial reductions in personnel during the coming year. He described the VA's experience with a new method of allocating resources. Until FY85, the system which the VA had used to allocate its health care appropriation was based on historical workloads adjusted for inflation and program changes. In FY85, VA began using a system based on the number of veterans which each center treated and the severity of their illnesses. Zamberlan discussed this new method of strategic management and its relationship to measures of productivity,

staffing standards, cost containment, prospective planning, and incentives for efficiency.

The Teaching Hospital: Looking Behind the Averages

The morning session ended with a presentation by Richard Berman, former Executive Vice President of New York University Medical Center (and currently a candidate for the U.S. House of Representatives from Westchester County, New York), in which he discussed an approach to identifying the effects of key policy changes on different groups of teaching hospitals. The findings were part of a study done to identify the shared problems and vulnerabilities, the extent of risk or gain involved in various policy options, and changes in existing policy which would alleviate problems. The work was performed by Lewin and Associates, and funded by the Commonweath Fund Task Force on Academic Health Centers. A series of pilot studies attempted to identify which teaching hospitals would be "losers" and "winners" under different options, and what attributes would characterize each group. Specifically presented were data on the impact of a percentage add-on for capital payment under the Medicare program. Berman pointed out that the groupings of hospitals varied according to the issue under scrutiny. He discussed the necessity for ongoing studies of this nature, recognizing the need for core data, for appropriate technical and analytical resources, for leadership and organizational commitment, and for adequate financing.

Session Two: The Patient, the Physician, and the New Technology

Transplantation and the Emerging Technology

John S. Najarian, M.D., Regents' Professor and Chairman, Department of Surgery, University of Minnesota Medical School, described recent advances in technology related to transplantation, particularly kidney transplants. He discussed the beginnings of transplantation in 1954, pointing out that the current survival rate for kidney transplant patients is 95% for one year. He described related advances in the fields of tissue typing and matching and immunosuppression, and pointed to surprising recent developments such as adult-to-infant transplants, and pancreatic and beta cell transplants as a treatment for diabetes. He described the potential effects of heart/lung and liver transplants on other services within the hospital, pointing out the ethical and economic issues raised by these technological advances.

New Technology and the Physician

William A. Nolen, M.D., Chairman, Department of Surgery, Litchfield Clinic, discussed the impact of the new technology and of changes in the health care delivery system (e.g., HMOs) on the practice of "small-town medicine." He contrasted his experiences as a surgical resident at Bellevue Hospital in New York City in the 1950's with his experience of the past

twenty years, as a practitioner in a rural setting. He described humorously the "encroachment" of an HMO from a nearby city which is seeking out potential patients in the town where he currently practices. While acknowledging that specialization and advanced technology do enhance the abilities of physicians in academic medical centers, Nolen also stressed the continued importance of the "art" of medicine and of caring and concern on the part of the physician. He concluded his presentation with observations on how medical center specialists might improve relationships with referring physicians.

The Patient's Orientation

The afternoon's closing presentation was delivered by R. Jack Powell, Executive Director, Paralyzed Veterans of America, who raised ethical issues regarding seriously disabled patients' access to advanced technology and medical care in an era when we are beginning to understand that health resources are limited. He traced the development of his organization, pointing out that patients with disabilities are among the best informed regarding advances in treatment. He discussed underlying attitudes which may affect care for disabled veterans, from the feeling that "VA care is free" and therefore veterans have no right to complain, to the sense that physicians are concerned with treating and curing illnesses, but are less interested in long-term rehabilitation and restoration of independent functioning. Powell stressed the importance of physicians keeping abreast of technological advances which may benefit their disabled patients, and of the need to view disabled patients as "worthy" of receiving state-of-the-art medical care.

Session Three: Leading and Managing in the Future

Looking at the Uncertain Future

On Friday morning, Robert J. Blendon, ScD, Senior Vice President of the Robert Wood Johnson Foundation, discussed the implications of recent changes in the health care marketplace, and the need for increased awareness of the political climate in relation to heath care legislation. Before stating his predictions for the next few years, he reminded the audience that no one has perfect foresight. Just ten years ago, he and others at Robert Wood Johnson predicted a physician shortage, the emergence of national health insurance, and the abilty to bring the poor into the mainstream. He pointed out that because inflation came to be viewed as the most important U.S. problem, there was a focus on "health costs", a reduction of support for the poor, and a movement to treat health care like the rest of the economy. The impact of recent changes has been felt in a decrease in overall hospital admissions, a decrease in inpatient hospital admissions per physician, and an increase in the number of out-of-hospital ambulatory care facilities. He predicted that admissions, which have historically been the mainstay of the physicians' income, will be reduced dramatically, and that young physicians will have to take patients away from another physician in order to start a new practice. These developments will give rise to major tensions between generations of doctors, and to a major new role for physicians in

ambulatory care facilities. He also predicted increased entry into new fields such as sports medicine and learning disorders, and a return to old fields of interest such as hospital administration, mental hospitals, and perhaps even house calls.

Employer Use of Medical Information Systems to Manage Health Care Costs: Ford Motor Company Informed Dialogue Program

The meeting's final presentation was a panel chaired by Jack K. Shelton, Manager, Employee Insurance Department, The Ford Motor Company, who discussed the role of industry in managing health care for their employees. He described the concerns which led to Ford's efforts to contain employee health care costs, and discussed experiences in the past five years in employee costsharing and in self-insurance.

David Chinsky, Senior Health Economist, Ford Motor Company, then discussed the process by which abnormal costs were identified, and discussions were initiated with participating hospitals. He presented findings from a study of 70 hospitals serving Ford employees; the study compared hospital costs for similar procedures and identified approximately $20 million in potentially excess medical costs which Ford paid in 1984 in the Detroit metropolitan area. The 70 hospitals had participated in a symposium on hospital use and costs, in which each hospital was compared with the others regarding inpatient claims, desribing DRG assignment, cost per case, and length of stay. The costs per case compared each hospital's DRG performance against either a teaching hospital or a non-teaching hospital norm; total Ford payments "above expected" were found to be over $5 million, and length of stay for Ford patients was found to be 35% above norms for the region.

Dennis Becker, Vice President for Planning and Development at MEDSTAT Systems, Inc., concluded the panel by speculating on future actions in this area, addressing the changes in employment in the U.S. in the last five years, and the resulting emphasis this has placed on cost containment. He raised the question of whether purchasers will continue paying premium prices for academic medical centers, stating that the impact of continuing cost pressure is likely to be felt in demands for justification for higher prices, the separation of financing for education and research, and competition for basic services. He predicted a structural realignment of teaching programs, with less specialization and increased ambulatory experience.

APPENDIX A

COTH OFFICERS AND ADMINISTRATIVE BOARD

1985-86

OFFICERS

Chairman:	
C. Thomas Smith	Yale-New Haven Hospital, New Haven CT
Chairman-Elect:	
Spencer Forman, MD	Montefiore Medical Center, Bronx, NY
Immediate Past Chairman:	
Sheldon S. King	Stanford University Hospital, Stanford, CA
Secretary:	
John E. Ives	Shands Hospital, Gainesville, FL

COTH REPRESENTATIVES TO AAMC EXECUTIVE COUNCIL

1986:	
Sheldon S. King	Stanford University Hospital, Stanford, CA
1987:	
J. Robert Buchanan, MD	Massachusetts General Hospital, Boston, MA
1987:	
C. Thomas Smith	Yale-New Haven Hospital, New Haven, CT
1988:	
Spencer Forman, MD	Montefiore Medical Center, Bronx, NY

COTH ADMINISTRATIVE BOARD MEMBERS

1988:	
Larry L. Mathis	The Methodist Hospital, Houston, TX
Charles M. O'Brien, Jr.	Georgetown University Hospital, Washington, DC
Raymond G. Schultze, MD	UCLA Hospitals and Clinics, Los Angeles, CA
1987:	
Robert J. Baker	University of Nebraska Hospital, Omaha, NE
Gary Gambuti	St. Luke's-Roosevelt Hospital Center, NY, NY
James J. Mongan, MD	Truman Medical Center, Kansas City, MO
1986:	
Gordon M. Derzon	Univ. of Wisconsin Hospitals, Madison, WI
Eric B. Munson	North Carolina Mem. Hospital, Chapel Hill, NC
Barbara A. Small	VA Medical Center, San Diego, CA

APPENDIX B

COTH REPRESENTATIVES TO THE AAMC ASSEMBLY

1985-1986

Terms Expiring 1986

J. ROBERT BUCHANAN, MD	Massachusetts General Hospital, Boston, MA
JOHN T. CARSON	VA Medical Center, Ann Arbor, MI
B. H. CORUM	Bexar County Hosp. Dist., San Antonio, TX
JAMES H. CUER	VA Medical Center, Kanas City, MO
SPENCER FOREMAN, MD	Montefiore Medical Center, Bronx, NY
ROBERT C. HALL	Louisiana State Univ. Hosp., Shreveport, LA
JAMES W. HOLSINGER, MD	VA Medical Center, Richmond, VA
L. RUSSEL JORDAN	Miami Valley Hospital, Dayton, OH
WILLIAM B. KERR	U. of Calif. Hospitals, San Francisco, CA
JOHN E. LYNCH	N.C. Baptist Hospitals, Winston-Salem, NC
ERIC MUNSON	North Carolina Mem. Hosp., Chapel Hill, NC
WILLIAM NEWELL, JR.	University Hospital, Stony Brook, NY
CHARLES O'BRIEN, JR.	Georgetown Univ. Hosp., Washington, DC
DAVID A. REED	Samaritan Health Service, Phoenix, AZ
HAYNES RICE	Howard University Hopsital, Washington, DC
C. EDWARD SCHWARTZ	Univ. Minnesota Hospitals, Minneapolis, MN
ROBERT SMITH	Univ. Missouri Hospitals, Columbia, MO
C. THOMAS SMITH	Yale-New Haven Hospital, New Haven, CT
NORMAN URMY	Vanderbilt Univ. Hosp., Nashville, TN
GENNARO J. VASILE, PhD	United Health Services, Johnson City, NY
THOMAS C. WINSTON	Erlanger Medical Center, Chattanooga, TN

Terms Expiring 1987

ROBERT J. BAKER	Univ. Nebraska Hospital, Omaha, NE
BARRY L. BELL	VA Medical Center, Portland, OR
RICHARD A. BERMAN	NYU Medical Center, New York, NY
CHARLES R. BUCK, JR,ScD	Hosp. of the Univ. of PA, Philadelphia, PA,
FRANK A. BUTLER	Univ. Kentucky Hospital, Lexington, KY
ALETHEA O. CALDWELL	Univ. Arizona Hospital, Tucson, AZ
JEPTHA W. DALSTON, PhD	Univ. Michigan Hospitals, Ann Arbor, MI
GORDON M. DERZON	Univ. Wisconsin Hospital, Madison, WI
GARY GAMBUTI	St. Luke's-Roosevelt Hosp. Cntr., NY, NY
THOMAS GIGLIOTTI	VA Medical Center, Pittsburgh, PA
JEROME H. GROSSMAN, MD	New England Medical Center, Boston, MA
SCOTT R. INKLEY, MD	Univ. Hospitals, Cleveland, OH
ROBERT J. JOHNSON	DC General Hospital, Washington, DC
WILLIAM H. JOHNSON, JR.	Univ. New Mexico Hospital, Albuquerque, NM
SHELDON S. KING	Stanford University Hospital, Stanford, CA
LARRY L. MATHIS	Methodist Hospital, Houston, TX
RONALD NELSON	VA Medical Center, Sepulveda, CA
MORTON I. RAPOPORT, MD	Univ. Maryland Hospital, Baltimore, MD
RAYMOND G. SCHULTZE, MD	UCLA Hospitals and Clinics, Los Angeles, CA
JAMES STEPHENS	VA Medical Center, Allen Park, MI
ALBERT B. WASHKO	VA Medical Center, Albany, NY

Terms Expiring 1988

J. SCOTT ABERCROMBIE, JR. MD	University Hospital, Boston, MA
JOHN ASHLEY, MD	Univ. Virginia Hosps., Charlottesville, VA
JOHN BIHLDORFF	Univ. of Conn. Health Cntr., Farmington, CT
CALVIN BLAND	St. Christopher's Hosp., Philadelphia, PA
JOHN BUCKLEY, JR.	St. Joseph Hospital, Phoenix, AZ
JUDGE CALTON	Methodist Hospital of Memphis, TN
JAMES DOOLEY	VA Medical Center, New York, NY
PAUL GRINER, MD	Strong Memorial Hospital, Rochester, NY
JOHN IVES	Shands Hospital, Gainesville, FL
KEVIN HALPERN	Cooper Hospital, Camden, NJ
TERRENCE JOHNSON	VA Medical Center, Indianapolis, IN
STUART KLEIT, MD	Indiana Univ. Hospitals, Indianapolis, IN
A.L. LEBLANC, MD	Univ. Texas Medical Branch, Galveston, TX
GARY MECKLENBURG	Northwestern Memorial Hosp., Chicago, IL
JAMES MONGAN, MD	Truman Medical Center, Kansas City, MO
THOMAS MULLON	VA Medical Center, Minneapolis, MN
DOUGLAS PETERS	Henry Ford Hospital, Detroit, MI
HOWARD PETERSON	Penn. State Univ. Hosp., Hershey, PA
MARY PICCIONE	Downstate Medical Center, Brooklyn, NY
BARBARA SMALL	VA Medical Center, San Diego, CA
MICHAEL STRINGER	University Hospital, San Diego, CA

APPENDIX C

AAMC COMMITTEE APPOINTMENTS
1985-1986

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

ACCREDITATION COUNCIL FOR
GRADUATE MEDICAL EDUCATION

Spencer Foreman, M.D.	Montefiore Medical Center, Bronx
Haynes Rice	Howard University Hospital, Washington, DC

AUDIT COMMITTEE

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

FACULTY PRACTICE COMMITTEE

Robert M. Heyssel, M.D.	The Johns Hopkins Hospital, Baltimore
John E. Ives	Shands Hospital, Gainesville
Raymond G. Schultze, M.D.	UCLA Hospital and Clinics, Los Angeles

FINANCE COMMITTEE

Chairman: Mitchell T. Rabkin, M.D.	Beth Israel Hospital, Boston
Robert M. Heyssel, M.D.	The Johns Hopkins Hospital, Baltimore

FLEXNER AWARD COMMITTEE

Paul F. Griner, M.D.	Strong Memorial Hospital, Rochester

GOVERNANCE AND STRUCTURE COMMITTEE

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

JOURNAL OF MEDICAL EDUCATION EDITORIAL BOARD

John E. Ives,	Shands Hospital, Gainesville
Paul F. Griner, M.D.	Strong Memorial Hospital, Rochester

LIAISON COMMITTEE ON MEDICAL EDUCATION

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

MANAGEMENT EDUCATION PROGRAMS COMMITTEE

Jerome H. Grossman, M.D.	New England Medical Center, Boston
William B. Kerr	University of California, SF, Hospital and Clinics, San Francisco

AAMC NOMINATING COMMITTEE

Sheldon King	Stanford University Hospital, Stanford

RESOLUTIONS COMMITTEE

Earl J. Frederick	Children's Memorial Hospital, Chicago

* * * * * * * *

COTH COMMITTEE APPOINTMENTS
1985-1986

The following AAMC committees are staffed by the AAMC Department of Teaching Hospitals:

COTH NOMINATING COMMITTEE

Chairman: Sheldon S. King	Stanford University Hospital, Stanford
David A. Reed	Samaritan Health Service, Phoenix
C. Thomas Smith	Yale-New Haven Hospital, New Haven

1987 COTH SPRING MEETING PLANNING COMMITTEE

Chairman: James J. Mongan, MD	Truman Medical Center, Kansas City
Paul F. Griner, MD	Strong Memorial Hospital, Rochester, NY
David H. Hitt	Methodist Hospital, Dallas
DeLanson Y. Hopkins	Rhode Island Hospital, Providence
Barbara A. Small	VA Medical Center, San Diego
Michael R. Stinger	University Hospital, UC, San Diego

COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION

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

APPENDIX D

LISTING OF COTH PUBLICATIONS
AVAILABLE FROM THE AAMC

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

TITLE	PRICE PER COPY
Price Competition in the Health Care Marketplace: Issues for Teaching Hospitals	$3.00
Medical Education Costs in Teaching Hospitals: An Annotated Bibilography	$4.00
A Description of Teaching Hospital Characteristics, 1982	$3.00
Medicare Prospective Payment: Probable Effects on Academic Health Center Hospitals	NO CHARGE
COTH Directory of Educational Programs and Services - 1986	$8.00
COTH Survey of Housestaff Stipends, Benefits, and Funding, 1986 (available December, 1986)	$8.00
COTH Monthly Report (monthly newsletter)	$30.00 per annum
New Challenges for the Council of Teaching Hospitals and The Department of Teaching Hospitals	NO CHARGE
Final Report of the AAMC Committee on Financing Graduate Medical Education - April, 1986	NO CHARGE
AAMC Committee on Financing Graduate Medical Education: Statement of Issues, March, 1985	NO CHARGE
Background Information and Selected Readings: Prepared for the Committee on Financing Graduate Medical Education, Revised November, 1984	NO CHARGE
The Medicare Adjustment for the Indirect Costs of Medical Education: Historical Develeopment and Current Status, by Judith R. Lave, Ph.D.	NO CHARGE

All orders of $25.00 or less for publications from the AAMC Office of Membership and Subscriptions must be paid in advance. All orders above $25.00, if not prepaid, must be accompanied by an institutional purchase order. Please do not send cash.

Staff of the Department of Teaching Hospitals
Association of American Medical Colleges

One Dupont Circle, N.W.
Suite 200
Washington, DC 20036

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

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

Nancy E. Seline
Staff Associate
202/828-0496

Judith L. Teich
Staff Associate
202/828-0496

Sonia M. Kohan
Administrative Resident
202/828-0496

Melissa H. Wubbold
Administrative Secretary
202/828-0490

Janie S. Bigelow
Secretary

Marjorie R. Lawal
Secretary

Cassandra R. Veney
Secretary