



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 862-6000

Council of Teaching Hospitals SELECTED ACTIVITIES REPORT

May 1989
Semiannual Report

Division of Clinical Services

Document from the collections of the AAMC. Not to be reproduced without permission.



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (909) 898-0400

Council of Teaching Hospitals SELECTED ACTIVITIES REPORT

May 1989
Semiannual Report

Division of Clinical Services

Document from the collections of the AAMC Not to be reproduced without permission

FORWARD

The AAMC Annual Report presents a comprehensive description of the AAMC activities supporting the multiple components of academic medicine: medical schools, teaching hospitals, faculty, and students. The full range of member services is provided to all AAMC members. This report for COTH members has been prepared to highlight services of special interest to the executives of the nation's teaching hospitals.

AAMC
COUNCIL OF TEACHING HOSPITALS
SELECTED ACTIVITIES REPORT

MAY 1989

TABLE OF CONTENTS

SELECTED ACTIVITIES

AAMC Mission Statements.....	1
The Council of Teaching Hospitals.....	1
COTH Membership Criteria.....	1
COTH Governance.....	2
COTH Staffing.....	2
COTH Member Services.....	3
Membership Meetings.....	3
Legislative and Policy Issues.....	3
AAMC/COTH Publications.....	7
Teaching Hospital Data.....	10
AAMC Special Projects.....	11
Task Force on Physician Supply.....	12
AIDS in the Teaching Hospital.....	12
Nursing Issues.....	13

APPENDICES

Appendix A	
AAMC Governing Structure.....	15
Appendix B	
COTH Administrative Board.....	20
Appendix C	
COTH Representatives to AAMC Assembly.....	22

Appendix D	
AAMC Executive Staff.....	25
Appendix E	
AAMC Organizational Chart.....	26
Appendix F	
AAMC Division of Clinical Services.....	27
Appendix G	
Legislative and Policy Issues	
G-1 - AAMC Policy Positions on Medicare Prospective Payment System, September 1988.....	28
G-2 - AAMC Comment Letter on "Changes in Payment Policy for Direct Medical Education Costs"....	30
G-3 - AAMC Comment Letter on "Payment for Physician Services Furnished in Teaching Settings".....	35
G-4 - AAMC Letter to Prospective Payment Assessment Commission on the "Indirect Medical Education Adjustment".....	44
Appendix H	
AAMC/COTH Committee Appointments.....	54

AAMC MISSION STATEMENT

The Association of American Medical Colleges (AAMC) has as its purpose the improvement of the nation's health through the advancement of academic medicine. As an association of medical schools, teaching hospitals, and academic societies, the AAMC works with its members to set a national agenda for medical education, biomedical research and health care, and assists its members by providing services at the national level that facilitates the accomplishment of their missions. In pursuing its purpose, the Association works to strengthen the quality of medical education and training, to enhance the search for biomedical knowledge, to advance health services research, and to integrate education and research into the provision of effective health care.

THE COUNCIL OF TEACHING HOSPITALS

Teaching hospitals are the primary training sites for the clinical education of the full spectrum of health professionals. Although approximately 1,300 hospitals are involved in graduate medical education in this country, the 440 Council of Teaching Hospitals (COTH) member institutions train over 80% of the residents in the United States.

The Council of Teaching Hospitals 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, governed by a fourteen-member administrative board, is the principal source of hospital input into overall Association policy and direction.

COTH MEMBERSHIP CRITERIA

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 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 medicine, surgery, obstetrics/gynecology, pediatrics, family practice, or psychiatry. In the case of specialty hospitals, such as children's, rehabilitation, and psychiatric institutions, the COTH Administrative Board is authorized to make exceptions to the requirement of four residency programs provided that the specialty hospital meets the membership criteria within the framework of the specialized objectives of the hospital.

Those institutions with teaching missions in their communities that do not meet the above criteria may seek corresponding membership in the Council of Teaching Hospitals. Corresponding members are eligible to attend all open AAMC meetings and enjoy many of the privileges of full members, are not eligible for membership in AAMC committees, the COTH Administrative Board, the AAMC Executive Council, or AAMC Assembly. Hospitals that are eligible for full COTH membership are not eligible for corresponding membership. Effective July 1, 1989, COTH dues for teaching hospital members will be \$10,000 for non-Federal hospitals, and \$4,800 for Federal and Canadian members. Dues for corresponding members have been set at \$2,400.

COTH GOVERNANCE

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. Appendix A presents the organization of the AAMC's current governance structure and the composition and charge of the AAMC Committee on Governance and Structure. This Board also provides representation to the Association's Executive Council. The nine at-large members of the Administrative Board serve three year terms. Board membership also includes the chair, chair-elect, immediate past chair, secretary and COTH "at large" representative to the AAMC Executive Council. Gary Gambuti, President, St. Luke's-Roosevelt Hospital Center in New York City, currently serves as Chairman of the Council of Teaching Hospitals in 1988-89, succeeding, J. Robert Buchanan, MD, General Director of the Massachusetts General Hospital in Boston. Mr. Gambuti will, in turn, be succeeded as Chair by Raymond G. Schultze, MD, Director, UCLA Medical Center, for 1989-90.

The Administrative Board is elected at the COTH Business Session held during the AAMC Annual Meeting; members and officers of the 1988-89 Administrative Board are listed in Appendix B. The COTH Administrative Board meets four times during the year to conduct business, discuss issues of interest and importance, and recommend policy to the Executive Council. Appendix C contains a listing of the 63 COTH representatives to the AAMC Assembly; they are also elected at the COTH Business Session at the Annual Meeting. The Assembly convenes once a year at the Annual Meeting.

STAFFING FOR THE COUNCIL OF TEACHING HOSPITALS

The AAMC Division of Clinical Services is the component within the Association with primary responsibility for staffing the Council of Teaching Hospitals. The Division develops specialized policy analyses, membership meetings, and membership services for teaching

Document from the collections of the AAMC Not to be reproduced without permission

hospitals and other patient care organizations significantly involved in the clinical education of physicians. The primary goal of the Division is the development of programs and services which enable hospital and other clinical entities to provide high quality, personalized services to patients while supporting the clinical education and biomedical and behavioral research missions of academic medicine. The Division works cooperatively with all AAMC staff units to ensure a full range of services for COTH members. The AAMC Executive Staff, AAMC staff organizational chart, and the staff of the Division of Clinical Services are provided as Appendices D, E, and F.

COTH MEMBER SERVICES

COTH members receive a full range of AAMC and Council-specific services and publications. AAMC services include: legislative and regulatory monitoring of Federal health initiatives in the areas of hospital and physician reimbursement, biomedical research, technology, medical education, and manpower; representation and testimony at key congressional hearings; access to the Association's numerous databases; and staff support in the interpretation and analysis of national policy issues.

As needed, information memoranda which summarize or analyze a current topic of interest are distributed. A Legislative and Regulatory Update, coordinated by the AAMC Office of Government Relations, is also distributed several times a year. It updates and summarizes many of the health issues being debated during current congressional sessions.

MEMBERSHIP MEETINGS

The Council sponsors occasional educational seminars and at least two meetings annually where CEOs can share the latest information on planned government policy changes, relevant research, and problems facing teaching hospitals. The meetings generally spotlight nationally recognized experts in the health care field and provide CEOs with the opportunity to gain useful information and exchange ideas with peers. The 1989 COTH Spring Meeting will be held May 10-13 in San Diego, California; the COTH Session will be held on Monday at the 1989 AAMC Annual Meeting, October 28-November 2 in Washington, DC.

LEGISLATIVE AND POLICY ISSUES

Hospital Payment Policies

Since the implementation of the Medicare Prospective Payment System

(PPS), the AAMC has adopted both general and specific positions on a variety of PPS payment policy issues. In September 1988, the COTH Administrative Board recommended and the AAMC Executive Council adopted several policy positions on Medicare payment issues (Appendix G-1). Among the policy positions taken by the Executive Council was the firm opposition to any further reduction in the indirect medical education (IME) adjustment in the Medicare PPS. The Administration has proposed a reduction in the IME adjustment from the current 7.7 percent for each 0.1 increase in the number of residents per bed to 4.05 percent for FY1990. In September 1988, the Federal government issued proposed regulations to implement payment policy changes for the direct costs of graduate medical education.

The AAMC maintains the indirect medical education adjustment is a critically important equity factor in the Medicare PPS, compensating teaching hospitals for the higher costs they incur in providing patient care for the most severely ill patients, introducing new diagnostic and treatment services, caring for patients in the high cost core of urban areas, and providing clinical education programs in the health professions. Congress has recognized the increased costs associated with teaching hospitals by supplementing Medicare inpatient payments with the IME adjustment. However, Congress, with Administration support, reduced the level of the IME adjustment in recent years, maintaining that the adjustment factor was set too high.

In recent months, the AAMC has assessed the financial impact of the Administration's proposed reduction in the IME adjustment on teaching hospitals and has shared the results of the impact analysis with the Prospective Payment Assessment Commission (ProPAC). In a January 1989 letter to Stuart H. Altman, ProPAC Chairman, the AAMC showed that lowering the IME adjustment to 4.05 percent would substantially lower the average PPS margin of thirty-four academic medical center hospitals. AAMC analysts also showed that total hospital margins declined between 1986 and 1988. At its February meeting ProPAC Commissioners agreed to recommend a reduction in the IME adjustment from 7.7 percent to 6.6 percent for FY 1990. Previous ProPAC analysis suggested an IME adjustment of 4.4 percent.

The AAMC has also shared the results of its analysis with members of Congress. A letter with an expanded analysis of forty-five academic medical center hospitals was sent to members of the Senate and House Budget Committees, Senate Finance Committee, and House Ways and Means Committee. AAMC staff continue to make personal visits to members of Congress to ensure that the IME adjustment and its impact on teaching hospitals are understood.

In April 1989, J. Robert Buchanan, M.D., General Director of the Massachusetts General Hospital and Immediate Past Chairman of COTH, and Richard M. Knapp, PhD, AAMC Senior Vice President, testified before the Subcommittee on Health of the House Committee on Ways and Means on the AAMC's positions on the Administration's FY 1990 budget proposals to reduce the IME adjustment, emphasizing the AAMC's firm opposition to any further reduction in the IME adjustment below its current level of 7.7 percent.

Dr. Buchanan also stated the AAMC's opposition to the Administration's proposal to reduce Medicare payments for the direct costs of graduate medical education. The Administration has proposed to eliminate payment for classroom costs, the costs of supervisory faculty salaries, and allocated overhead in FY 1990.

The AAMC opposes any further legislative changes in the payment system for direct medical education costs because the impact of a previous legislative change in the method of payment for physicians in graduate training is still unknown. The passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in 1986 requires the calculation of a hospital-specific per resident amount, based on 1984 costs and updated to adjust for inflation. While these per resident payments are to become effective retroactively to July 1, 1985, the draft regulations to implement these changes were not published until September 1988. The AAMC commented on the proposed regulation to the Health Care Financing Administration (HCFA) in November 1988, as also seen in Appendix G-2. The comments discussed problems in the proposed method of counting residents, the administrative burden imposed by retroactive application of the regulation, and the identification of geriatric residency programs. The AAMC also requested that additional information on the definitions of allowable and nonallowable costs and on the inflation factor used to adjust the per resident amount be supplied. The AAMC also asked that a portion of the regulation concerning the method of counting interns and residents be republished with an additional comment period. In the absence of final regulations (as of April 1989) and the unknown impact of these changes in the payment system on teaching hospitals, the AAMC firmly opposes the Administration's proposal to reduce further payments for the direct costs of graduate medical education.

Physician Payment Issues

The AAMC Advisory Committee on Medicare Regulations for Payment of Physicians in Teaching Hospitals met in March 1989 to consider proposed HCFA regulations on paying physicians in a

teachinghospital. This 15-member Advisory Committee was charged as follows:

- o To review and consider the proposed Medicare rules issued February 7 in terms of their potential impact on teaching hospitals, medical schools, and faculty practice plans;
- o To identify those provisions of the rules which are not acceptable in their present form to the AAMC membership or which require clarification; and
- o To recommend and assist the AAMC in formulating appropriate comments to HCFA which express the concerns identified by this Committee and the membership at-large.

The AAMC has been actively involved with the issues raised in the proposed rules for twenty years. The Association has testified before Congress, met with representatives of the then Bureau of Health Insurance, and worked with HCFA staff. In 1978, Hiram Polk, MD, Chairman of Surgery at the University of Louisville School of Medicine, chaired a committee similar to the current Advisory Committee, which evaluated draft regulations developed under Section 227 of the 1972 Medicare amendments. Dr. Polk chairs the current Committee as well; committee membership is listed in Appendix H.

The March meeting of the 1989 Advisory Committee resulted in comments and recommendations which the Association has incorporated into an official comment letter to HCFA in response to the proposed rules, "Payment for Physician Services Furnished in Teaching Settings." The letter addressed the definition of a teaching physician, the offset of practice plan income, and payments to physicians not using interns and residents in the teaching setting. A copy of the comment letter is attached as Appendix G-4.

Appropriations for the Department of Veterans Administration

The AAMC continues to collaborate in a coalition called the "Friends of the VA Medical Care and Health Research" to increase support for these programs at the Veterans Administration. Last year, the AAMC Office of Governmental Relations, in conjunction with the American Federation for Clinical Research, prepared a document setting forth a proposal for FY1989 funding for the medical care and health research budgets at the VA. This document, which was sent to all members of Congress and formed the basis for Congressional testimony on behalf of the coalition, was distributed to COTH CEOs at the 1988 COTH Spring Meeting. A similar document

detailing the group's FY1990 recommendations has been prepared and will be distributed at the 1989 Spring Meeting. The coalition also has presented testimony to both the House and Senate Veterans Affairs committees and will testify before the House and Senate Appropriations subcommittees on VA/HUD/Independent Agencies on the FY1990 proposal.

AAMC/COTH PUBLICATIONS

Five AAMC publications are regularly provided to COTH members. They are Academic Medicine (formerly the Journal of Medical Education), the President's Weekly Report, the Annual Report on Medical School Faculty Salaries, the AAMC Directory of American Medical Education, and the Association's Annual Report.

Collection and analysis of data on COTH member institutions are distributed in annual publications such as: the COTH Survey of Housestaff Stipends, Benefits, and Funding; the COTH Executive Salary Survey; and the COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data. The Division also publishes various bibliographies and a newsletter, the COTH Report, which highlights current topics of interest to teaching hospitals' chief executive officers.

COTH Survey of Housestaff Stipends, Benefits, and Funding

This annual survey has an 80-85 percent response rate and provides constituents with the following data on COTH member institutions:

- (1) Housestaff stipend amounts to be paid in the coming academic year and stipend amounts paid in the current academic year;
- (2) Health and non-health benefits provided to housestaff and their dependents;
- (3) Teaching hospital expenditures and sources of funding for housestaff stipends and benefits; and
- (4) Responses to policy questions such as housestaff hours and supervision.

Nationwide mean and median stipend data are reported and are aggregated by region, type of affiliation relationship with the medical school, hospital ownership, and specific bed size. Information is also included on resident-to-bed ratios and distribution of minority residents and fellows.

Council of Teaching Hospitals Executive Salary Survey

This is an annual survey of salaries and fringe benefits for chief executive officers, senior administrative staff, and departmental executives. It includes a limited section on CEO characteristics, including age and educational data. This is a confidential report sent only to CEOs of member institutions.

Council of Teaching Hospitals Executive Salary Survey: Special Analysis of the Academic Medical Center Hospitals

This report is a special analysis of academic medical centers' chief executive officer, senior administrative staff, and departmental executive salaries and fringe benefits. It is a confidential report sent only to CEOs of academic medical center hospitals. Data are classified by two means: by public or private ownership as well as university-owned or freestanding status.

COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data

This annual survey reports on operational, financial, educational, and staffing characteristics of academic medical center hospitals for purposes of institutional comparison. It is a confidential report sent only to CEOs of participating institutions and serves as one of several sources for the AAMC Commonwealth Fund supported study to build a teaching hospital database. This survey reports operating statements from most recently available fiscal year, data on government appropriations, calculations of operating and total hospital margins, and ranked hospital expenses per discharge standardized by the Medicare wage and case mix indices. In addition, data are reported on the impact of Medicare prospective payment, case mix and DRGs, graduate medical education (costs and resident counts), Medicare outlier cases, hospital-based research, service and clinical unit availability, and utilization and personnel statistics. In the coming year, staff expect to expand this Survey to include major affiliated hospitals belonging to COTH.

AAMC Directory of American Medical Education

This directory lists the 127 member (institutional) medical schools in the United States and Puerto Rico as well as affiliate Canadian and graduate affiliate schools. Each school entry includes enrollment, type of support, clinical facilities, as well as university officials, medical school administrative

staff, and departmental chairmen in the clinical and basic sciences. The 1989 edition of this directory represents the new format and includes a separate section for the Council of Teaching Hospitals, resulting from consolidating the former COTH Directory within the AAMC Directory. This section provides an alphabetical listing by city and state of COTH member institutions, including hospital name, address, CEO and their title and telephone number. Additionally, the same information is provided for each institution's chief operating officer, chief financial officer, medical director, and nursing director.

COTH Report

The Council's newsletter, the COTH Report, has undergone a number of changes in 1989 based on the results of a 1988 readership survey. The COTH Report now contains more information on federal legislative and regulatory activities, teaching hospital data, and graduate medical education. A new feature, "COTHLine," contains graphs, tables and charts developed by the Division of Clinical Services for the purpose of informing members about teaching hospital characteristics. It has included a two-part analysis of HCFA's hospital mortality data, and tables on teaching hospitals from the American Hospital Association's Annual Survey. The COTH Report's design and format are being revised to make it more attractive and comprehensive. Publication is now six times a year.

Issue Updates (Blue/Pink/Grey memoranda)

In-depth analysis and reporting on current policy issues and agency actions such as

- o Medicare Prospective Payment regulations
- o Legislative Activities
- o Prospective Payment Assessment Commission (ProPAC)
- o Council on Graduate Medical Education (CoGME)
- o HHS Commission on Nursing

are provided to members in a series of issue-specific membership memoranda. These have included coverage of such activities as the recent publication of HCFA's Medicare mortality data; proposed regulations to revise Medicare PPS for federal FY1989, increasing DRG prices and modifying the calculation of the wage index and outlier payments; the effect of the Senate's 1988 NIH reauthorization bill on fetal research; as well as proposed HHS regulations on misconduct or fraud in science; House and Senate proposed tax code amendments; and proposed regulations on Medicare's payment for direct graduate medical education costs.

Under a new format introduced this year, "pink" memoranda will denote ACTION items, "blue" memoranda ADVISORY items, and "grey" memoranda INFORMATION items.

TEACHING HOSPITAL DATA

AAMC/Commonwealth Fund Project

Teaching hospitals carry a very special burden and responsibility for the nation's health care. They provide primary sites for clinical education for undergraduate medical students and residents, fellowship training programs, and a significant share of the nursing and allied health programs. Additionally, they are important partners in the conduct of clinical research, the testing and development of drugs, medical devices and new technologies and advanced treatment methods of patients.

Teaching hospitals are major providers of medical care, offering regionalized tertiary care services and specialized support for community hospitals in addition to essential backup and routine patient care. Although accounting for only six percent of the nation's hospitals in 1987, members of the Council of Teaching Hospitals had 23% of admissions, 28% of all outpatient visits, and 21% of all surgical operations.

These institutions also provide care to a disproportionately large share of the nation's poor and medically indigent. In 1986, short-term general, non-federal COTH members incurred 54% of the charity care charges and 33% of the bad debts of all US hospitals. The average COTH member deducted 11.8% of revenues for charity care compared to the community hospital average deduction of 7.1% of revenues.

Today's teaching hospitals face major challenges as a more diverse and competitive health care system evolves. The growing number of patients with inadequate or no health insurance strains the ability of teaching hospitals to cope in a competitive environment. Governments, confronted with fiscal deficits and necessary program cutbacks, have instituted fixed and prospective payment systems which may affect the financing of medical education. Health care cost inflation continues and cost containment pressures from public and private sectors may threaten quality of patient care in the nation's hospitals.

To analyze and address how these emerging forces will affect teaching hospitals, the AAMC's Division of Clinical Services, with support from The Commonwealth Fund, has developed a database on teaching hospital costs and operating characteristics, composed of

data from the American Hospital Association, Health Care Financing Administration, other secondary data sources, and AAMC primary data on academic medical centers. Information from the database forms the foundation for the AAMC's advocacy efforts on behalf of teaching hospitals, including the Division's impact analysis of the Administration's proposed reduction in the Medicare indirection medical education adjustment (IME). The database has also been used in three ongoing research projects: trends in teaching hospital profitability, variation in the costs of graduate medical education, and the identification and distribution of high cost patients among types of hospitals. These research topics are areas of national policy concern and must be examined so that teaching hospitals can continue to fulfill their unique missions of medical education and patient care in the face of a rapidly changing health care environment.

U.S. Hospitals AIDS Survey

For the past three years, COTH has jointly sponsored with the National Association of Public Hospitals and several other organizations, a survey of patients treated for AIDS and other HIV-related conditions in member hospitals. These surveys collect data on patients, hospitals, costs and financing associated with treating AIDS patients. Survey results have been published in JAMA and Health Affairs.

Hospital Emergency and Trauma Care Survey

COTH is also co-sponsoring, with the National Association of Public Hospitals, the 1988 Hospital Emergency and Trauma Care Survey, a survey of hospital emergency and trauma care. Results of this survey will be used to provide members and policy makers with a more accurate description of the resources used, and types of patients served, in hospital emergency departments.

AAMC SPECIAL PROJECTS

The Association, in representing teaching hospitals, medical schools, faculty, and medical students, is currently exploring a variety of issues that affect the many different aspects of academic medicine. The nursing shortage in the academic setting, manpower distribution/mix on physician supply, and AIDS in the teaching hospitals are examined below.

TASK FORCE ON PHYSICIAN SUPPLY
Committee on Physician Supply Issues
for Resident and Fellow Education

The AAMC Executive Council established the Task Force on Physician Supply with the charge of reviewing physician supply and production, considering the necessary manpower mix for provision of services in teaching hospitals, facilitating access to health care services, and assuring a sufficient number of appropriately trained researchers in biomedical and behavioral sciences.

Toward that end, the Committee on Physician Supply Issues for Resident and Fellow Education, one of four Task Force committees, was convened in July 1987. The committee's charge included the evolving societal demand for training in various disciplines and for geographic distribution of physicians; the examination of different sets of forces which influence the nature of graduate medical education opportunities and the production of trained physicians; the consideration of the economics of graduate medical education from the viewpoint of both the hospital and the resident; and the consideration of the implications of future changes in (1) the number and type of residents in training, and (2) the requirements and sites of training programs for the delivery of patient care services provided by teaching hospitals.

The Committee met several times in 1987 and 1988 and submitted its draft report to the Task Force in May 1988, recommending that the AAMC enlarge its capacity to monitor developments and trends in graduate medical education; assist in the development of manpower by issuing periodic reports on the number of graduates and their characteristics; develop, evaluate and report on specialty-specific estimates of future physician requirements; improve its capability to advise governmental and private bodies having an interest in or responsibility for graduate medical education policies; report on and monitor appropriate funding; and develop annual reports to medical schools and students on career opportunities and the likelihood of achieving institutional and personal choices. These recommendations have been reviewed by the Task Force with the intent of incorporating them into the final Task Force report planned for release at the end of 1989. This Committee has been chaired by Mitchell Rabkin, MD, President of Beth Israel Hospital in Boston; Dr. Rabkin will give a presentation on the status of the Committee and the Task Force at the 1989 COTH Spring Meeting. Committee membership is listed in Appendix H.

AIDS IN THE TEACHING HOSPITAL

The impact of AIDS on the teaching hospital varies greatly across

the nation; however, those institutions in the areas of greatest concentration are encountering a new class of problems that range from the current controversy over infectious/toxic waste disposal and community image to "Ethical Responsibilities in the Face of an Epidemic." This facet of the epidemic was addressed specifically by Abigail Zuger, MD, of New York University Medical Center, at the 1988 COTH Spring Meeting. Dr. Zuger, a self-described member of the "first generation" of AIDS physicians, presented the paradoxes encountered in treating the AIDS patient and the ethical questions that arise when a physician refuses to treat these patients. She stressed that the responsibilities of a teaching institution include education, counseling, and appreciation for all employees at all levels.

Dr. Zuger's remarks coincided with the statement on professional responsibility in treating AIDS patients drafted by the AAMC Committee on AIDS. This statement re-enforces the imperative of up-to-date information on the modes and risk of transmission of the virus, and training in protective measures to be employed in the clinical setting. These points have been incorporated in the Committee's final report, "Policy Guidelines for Addressing HIV Infection in the Academic Medical Community," and its companion piece, "The HIV Epidemic and Medical Education," which are currently available through the Association's Publications Department. COTH representatives to the Committee are James Farsetta of the Veterans Administration Medical Center, Brooklyn; William H. Johnson, Jr. of the University of New Mexico Hospital, who also serves as Chairman of the American Hospital Association's special committee on aids infection policy; and Robert G. Newman, MD, Beth Israel Medical Center, New York.

NURSING ISSUES

The nursing shortage is a major problem continuing to affect a large number of teaching hospitals in this country today, and many COTH members are unable to support a preferred number of inpatient beds as a result of this shortage. This is a significant teaching hospital issue because while COTH member institutions comprise 6% of the total hospitals nationwide, they employ approximately 29% of hospital-based registered nurses. In seeking solutions various proposals have arisen, including the creation of nurse alternative positions, scouting of high school students for nursing school, the formation of specialized high schools with a strong emphasis on healthcare, and the creation of scholarships for students pursuing careers in this field.

To educate the staff and the membership on new developments in nursing, a number of individuals prominent in the nursing

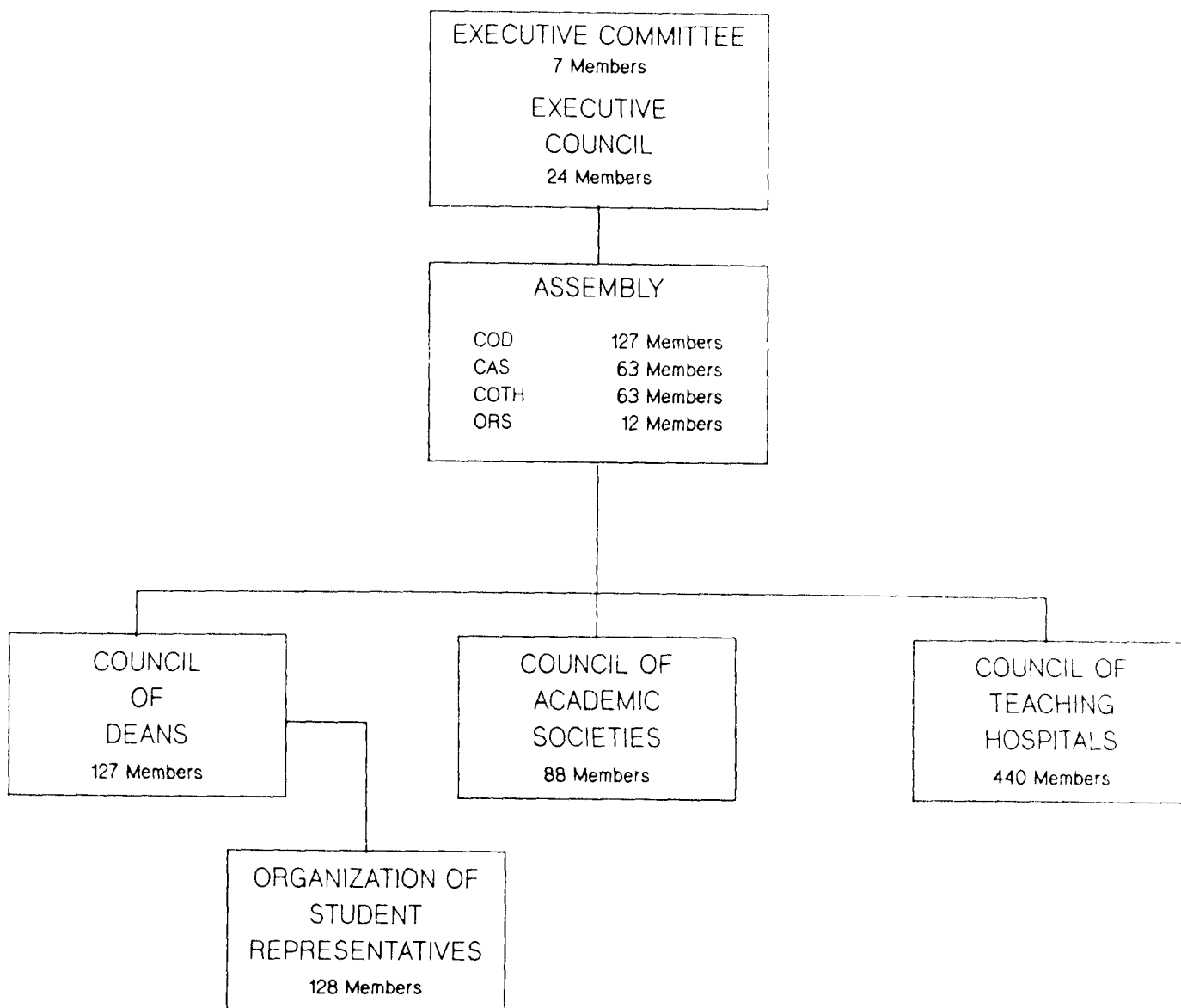
leadership were featured speakers at the 1988 COTH Spring Meeting. Since that time the nursing issue has been an agenda item at the Administrative Board meetings, and in September 1988, several representatives of the leadership of the Nursing Tri-Council (comprised of the American Association of Colleges of Nursing, the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing) joined the Board for dinner in an informal forum to establish a dialogue with Board members about the problems contributing to the nursing difficulties being faced today.

Following this encouraging exchange, the Association formed the ad hoc Committee on Nursing and the Teaching Hospital in an effort to help the Association and member institutions address nursing issues in the academic setting. This committee is staffed by the Division of Clinical Services. Chaired by Jerome H. Grossman, MD, Chairman, New England Medical Center, Inc., it is comprised of CEOs and nursing directors from various COTH member institutions, a faculty chairman, a dean, and a university vice president for health affairs. This Committee met in February 1989 and addressed the specific characteristics of teaching hospitals which contribute to problems in nurse staffing, including annual turnover of housestaff, the larger number of attending and consulting physicians, the specialized and intense nature of patient care units, and the ethical issues raised by critically ill patients. The impact of these characteristics on the reasonableness of the nursing workload, the "culture" of the nursing service, alternative structures for nursing roles, and relationships between hospital nursing services and nursing education programs are being explored in an issue paper currently under development by the Division. Staff will report back to the Committee on their findings and recommendations at the next committee meeting. Members of this Committee are listed in Appendix H.

- - -

This report is updated twice yearly in time for the COTH Spring Meeting and again for the AAMC Annual Meeting in the fall. Copies of the publications, surveys, and recommendations covered in this report may be obtained through the AAMC Division of Clinical Services by calling 202/828-0490.

*Association of American Medical Colleges
Governing Structure*



Executive Committee:

Chairman: *D. Kay Clawson, M.D., University of Kansas School of Medicine*
 Chairman-Elect: *David H. Cohen, Ph.D., Northwestern University Graduate School*
 Immediate Past Chairman: *John W. Colloton, University of Iowa Hospitals & Clinics*
 Chairman, COD: *William J. Butler, M.D., Baylor College of Medicine*
 Chairman, CAS: *Ernst R. Jaffe, M.D., Albert Einstein College of Medicine*
 Chairman, COTH: *Gary Dambuti, St. Luke's-Roosevelt Hospital Center*
 President: *Robert D. Petersdorf, M.D.*



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE: (202) 898-0400

January 26, 1989

Dear Colleague:

As you are well aware, external and internal influences affecting the nation's academic medical centers have changed substantially in recent years. As a consequence, the elected officers of our Association have initiated two significant efforts to assure the most effective service possible from the AAMC for its members. The first, the establishment of a strategic planning process, is now well under way by the Executive Staff. The second is the subject of this communication.

The Association's Executive Committee has appointed us, recent former Chairs of the Association, as a Committee on Governance and Structure to review in comprehensive fashion the appropriateness of the current organizational characteristics of the AAMC. A copy of the charge to our committee is attached, highlighting the several considerations to which particular attention must be directed.

We write now to solicit your observations or suggestions or those of your associates on these issues to facilitate our efforts. The Committee must proceed promptly with its task in order to formulate its recommendations this spring for consideration by the Administrative Boards and the Executive Council prior to this year's AAMC annual meeting. We would be grateful if you would convey your thoughts to any committee member not later than February 15. If questions arise about the committee's work, please feel free to communicate with any of us or with John F. Sherman, Ph.D., Executive Vice President of the Association, who is acting as staff to our committee.

Thank you for your help with this important matter.

Sincerely yours,

John W. Colloton - Chairman,
AAMC Governance & Structure Committee
Director, University of Iowa Hospitals
and Clinics
Ass't. to the University President
for Statewide Health Services
Iowa City, IA 52242
Tel: (319) 356-2265

Robert M. Heyssel, M.D.
President
The Johns Hopkins Health System
601 North Wolfe
Baltimore, MD 21205
Tel: (301) 955-1488

Richard Janeway, M.D.
Executive Dean
Bowman Gray School of Medicine of
Wake Forest University
300 South Hawthorne Road
Winston-Salem, NC 27103
Tel: (919) 748-4424

Edward Stemmler, M.D.
Executive Vice President
University of Pennsylvania Medical Center
21 Penn Tower
Philadelphia, PA 19104
Tel: (215) 898-2332

Virginia V. Weldon, M.D.
Deputy Vice Chancellor for Medical Affairs
Washington University School of Medicine
Box 8106
660 S. Euclid Avenue
St. Louis, MO 63110 Tel: (314) 362-6940

Ex-Officio:

D. Kay Clawson, M.D., AAMC Chair
Executive Vice Chancellor
University of Kansas
School of Medicine
39th & Rainbow
Kansas City, KS 66103
Tel: (913) 588-1433

David H. Cohen, Ph.D., AAMC Chair-Elect
Vice President for Research and
Dean of the Graduate School
Northwestern University
633 Clark Street, Crown 2-221
Evanston, IL 60201
Tel: (312) 491-3485

Addressees: Council of Academic Societies
Council of Deans
Council of Teaching Hospitals
Organization of Student Representatives
Steering Committees - AAMC Groups
Past Chairs of AAMC Assembly
Officers and Board of Directors, Association of Academic Health Centers

Attachment

cc: John F. Sherman, Ph.D.



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0400

CHARGE TO THE COMMITTEE ON GOVERNANCE AND STRUCTURE

In 1965, the Association of American Medical Colleges received the report "Planning for Medical Progress Through Education." The report, known as the Coggeshall Report after its chairman Lowell Coggeshall, a past president of the AAMC, spoke broadly on issues of medical education and trends in health care. As a result of the committee's perception of the evolving health care environment, major changes in the Association's governance were proposed. The debate within the Association on the recommendations of the report led to a tripartite organization of the Council of Deans, the Council of Teaching Hospitals, and the Council of Academic Societies. The Executive Council was expanded to include faculty and teaching hospital executives as well as medical school deans. In 1971, medical students were added to the Association's governance through the Organization of Student Representatives.

It has now been two decades since the last comprehensive review of the Association's governance. The Association's Executive Council recently adopted a new mission statement for the organization and new strategic goals are also being developed. Thus, the Association's elected leadership believes it is prudent to consider whether the current structure best meets the Association's needs and objectives or whether changes in the constituency and the organization suggest modifications.

The Committee on Governance and Structure has been established by action of the Executive Committee and is charged with reviewing the current governance structure of the Association with particular attention to the following issues:

- o the membership on each of the Association's three Councils
- o the participation in the Association by individuals at academic medical centers who are not currently represented on any of the Association's Councils, including, but not limited to vice-presidents for health affairs
- o the role of multi-hospital systems and their executives in the Association
- o the role and composition of the Assembly
- o the composition of the Executive Council

- o the nominating process by which new officers are elected to the Executive Council and Administrative Boards
- o the name of the Association and whether it accurately reflects the organization's membership and purposes
- o the role in the Association beyond election to distinguished service or emeritus membership for individuals who no longer serve on one of the three Councils
- o the fostering of a greater sense of identification with and participation in the Association by members of the Councils and by faculty and administrators of academic medical centers
- o the role of housestaff in the Association
- o the means through which the Association might involve individuals with specific institutional educational responsibilities such as hospital directors of medical education or directors of continuing medical education
- o the Association's existing and possible new Groups and their contributions to the Association's goals

1988-1989
COTH ADMINISTRATIVE BOARD

APPENDIX B

COTH OFFICERS

GARY GAMBUTI, Chair*

President

St. Luke's Roosevelt Hospital Center

Amsterdam Avenue at 114th Street

New York, NY 10025

212/523-4295

J. ROBERT BUCHANAN, MD, Immediate Past Chair*

General Director

Massachusetts General Hospital

Fruit Street

Boston, MA 02114

617/726-2100

RAYMOND G. SCHULTZE, MD, Chair-Elect*

Director

UCLA Medical Center

10833 Le Conte Avenue

Los Angeles, CA 90024

213/825-5041

JOHN E. IVES, Secretary

Executive Vice President/COO

St. Luke's Episcopal Hospital

6720 Bertner Avenue

Houston, TX 77030

713/791-3006

TERM EXPIRING 1989

JEROME H. GROSSMAN, MD

Chairman/CEO

New England Medical Center, Inc.

750 Washington Street

Boston, MA 02111

617/956-7655

WILLIAM H. JOHNSON, JR.

Administrator

University of New Mexico Hospital

2211 Lomas Boulevard, NE

Albuquerque, NM 87106

505/843-2121

BARBARA A. SMALL

Medical Center Director

Veterans Administration Medical Center

508 Fulton Street

Durham, NC 27705

919/286-0411 X-6903

TERM EXPIRING 1990

LEO M. HENIKOFF, MD

President

Rush-Presbyterian-St. Luke's Medical Center

1753 W. Congress Parkway

Chicago, IL 60612

312/942-5000

MAX POLL

President

Barnes Hospital

Barnes Hospital Plaza

St. Louis, MO 63110

314/362-5190

C. EDWARD SCHWARTZ

Executive Director

Hospital of the University of Pennsylvania

3400 Spruce Street

Philadelphia, PA 19104

215/662-2992

TERM EXPIRING 1991

CALVIN BLAND

Executive Director

St. Christopher's Hospital for Children

Fifth and Lehigh Avenue

Philadelphia, PA 19133

215/427-5000

SISTER SHEILA LYNE

President

Mercy Hospital and Medical Center

Stevenson Expressway at King Drive

Chicago, IL 60616

312/567-2000

ROBERT H. MUILENBURG

Executive Director of Hospitals

University of Washington Hospitals

Mail Stop RC-35

Seattle, WA 98195

206/548-6364

Executive Council Member "At-Large"*

JAMES J. MONGAN, MD

Executive Director

Truman Medical Center

2301 Holmes Street

Kansas City, MO 64108

816/556-3149

* Representative to AAMC

Executive Council

1988-1989
COTH REPRESENTATIVES TO AAMC ASSEMBLY

1991:
 Calvin Bland
 St. Christopher's Hospital for Children
 Philadelphia, PA
 Frank Butler
 University Hospital, Lexington, KY
 James Christian
 Veterans Administration Medical Center, Baltimore, MD
 Everett Devaney
 Fairfax Hospital, Falls Church, VA
 Dunlop Ecker
 Washington Hospital Center, Washington, DC
 James Farsetta
 Veterans Administration Medical Center, Brooklyn, NY
 John Gregg
 University Hospital of Jacksonville, Jacksonville, FL
 David Handel
 Indiana University Hospitals, Indianapolis, IN
 R. Edward Howell
 Medical College of Georgia Hospital and Clinics
 Augusta, GA
 Peter Hughes
 New York University Medical Center, New York, NY
 Sister Sheila Lyne
 Mercy Hospital and Medical Center, Chicago, IL
 Robert Muilenburg
 University of Washington Hospitals, Seattle, WA
 Thomas Mullon
 Veterans Administration Medical Center, Minneapolis, MN
 Thomas Newell, Jr.
 University Hospital, Stony Brook, NY
 Harry Nurkin, PhD
 Charlotte Memorial Hospital and Medical Center
 Charlotte, NC
 Richard Pierson
 University Hospital of Arkansas, Little Rock, AR
 Bruce Satzger
 Valley Medical Center of Fresno, Fresno, CA
 Robert Smith
 University of Missouri Hospital and Clinics, Columbia, MO
 Michael Sniffen
 Overlook Hospital, Summit, NJ
 John Springer
 Hartford Hospital, Hartford, CT
 James Stephens
 Veterans Administration Medical Center, Allen Park, MI

1990:

Peter Baglio
Veterans Administration Medical Center, East Orange, NJ

W. Daniel Barker
Emory University Hospital, Atlanta, GA

Jerry Boyd
Veterans Administration Medical Center, Tucson, AZ

Paul Broughton
Children's Hospital of Michigan, Detroit, MI

J.L. Buckingham
LA County-USC Medical Center, Los Angeles, CA

Robert Condry
Foster G. McGaw Hospital, Maywood, IL

Phillip Dutcher
Hurley Medical Center, Flint, MI

Gary Gambuti
St. Luke's-Roosevelt Hospital Center, New York, NY

Jerome Grossman, MD
New England Medical Center, Inc., Boston, MA

C. Wayne Hawkins
Veterans Administration Medical Center, Dallas, TX

Leo Henikoff, MD
Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL

James Holsinger, Jr., MD
Veterans Administration Medical Center, Richmond, VA

William Johnson, Jr.
University of New Mexico Hospital, Albuquerque, NM

Marlene Marschall
St. Paul-Ramsey Medical Center, St. Paul, MN

Larry Mathis
The Methodist Hospital, Houston, TX

Robert Newman, MD
Beth Israel Hospital, New York, NY

Max Poll
Barnes Hospital, St. Louis, MO

Raymond Schultze, MD
UCLA Medical Center, Los Angeles, CA

Robert Shakno
Mt. Sinai Medical Center, Cleveland, OH

J.P. Travers
Veterans Administration Medical Center, Washington, DC

Hugh Vickerstaff
Veterans Administration Medical Center, Birmingham, AL

1989

J. Robert Buchanan, MD
Massachusetts General Hospital, Boston, MA

John Colloton
University of Iowa Hospitals and Clinics, Iowa City, IA

Larry Deters
Veterans Administration Medical Center, Nashville, TN

Spencer Foreman, MD
Montefiore Medical Center, Bronx, NY

Martin Diamond
Mt. Zion Hospital and Medical Center, San Francisco, CA

Michael Fritz
Harper-Grace Hospitals, Detroit, MI

DeLanson Hopkins
Rhode Island Hospital, Providence, RI

David Kolasky
Medical College of Ohio Hospital, Toledo, OH

Andre Lee
George W. Hubbard Hospital, Nashville, TN

Andrew Montano
Veterans Administration Medical Center, Albuquerque, NM

Thomas Morris, MD
Presbyterian Hospital in the City of New York, New York, NY

Ralph Muller
University of Chicago Hospitals and Clinics, Chicago, IL

Bryan Rogers
The Toledo Hospital, Toledo, OH

C. Edward Schwartz
Hospital of the University of Pennsylvania, Philadelphia, PA

Paul Stajduhar, MD
Veterans Administration Medical Center, Cleveland, OH

Russell Struble
Veterans Administration Medical Center, Milwaukee, WI

James Taylor
Medical Center Hospital of Vermont, Burlington, VT

Richard Uhrich, MD
Good Samaritan Medical Center, Phoenix, AZ

Andrew Wallace, MD
Duke University Hospital, Durham, NC

David Weiner
The Children's Hospital, Boston, MA

Daniel Winship, MD
Veterans Administration Medical Center, Kansas City, MO

EXECUTIVE STAFF
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Robert G. Petersdorf, MD
President

Kathleen S. Turner
Assistant Vice President
Office of the President

John F. Sherman, PhD
Executive Vice President

Richard M. Knapp, PhD
Senior Vice President
Office of Governmental Relations

James D. Bentley, PhD
Vice President for Clinical Services

Edwin L. Crocker
Vice President for Administrative Services

Louis J. Kettel, MD
Associate Vice President for
Academic Affairs

Joseph A. Keyes
Vice President for Institutional
Planning and Development and
General Counsel

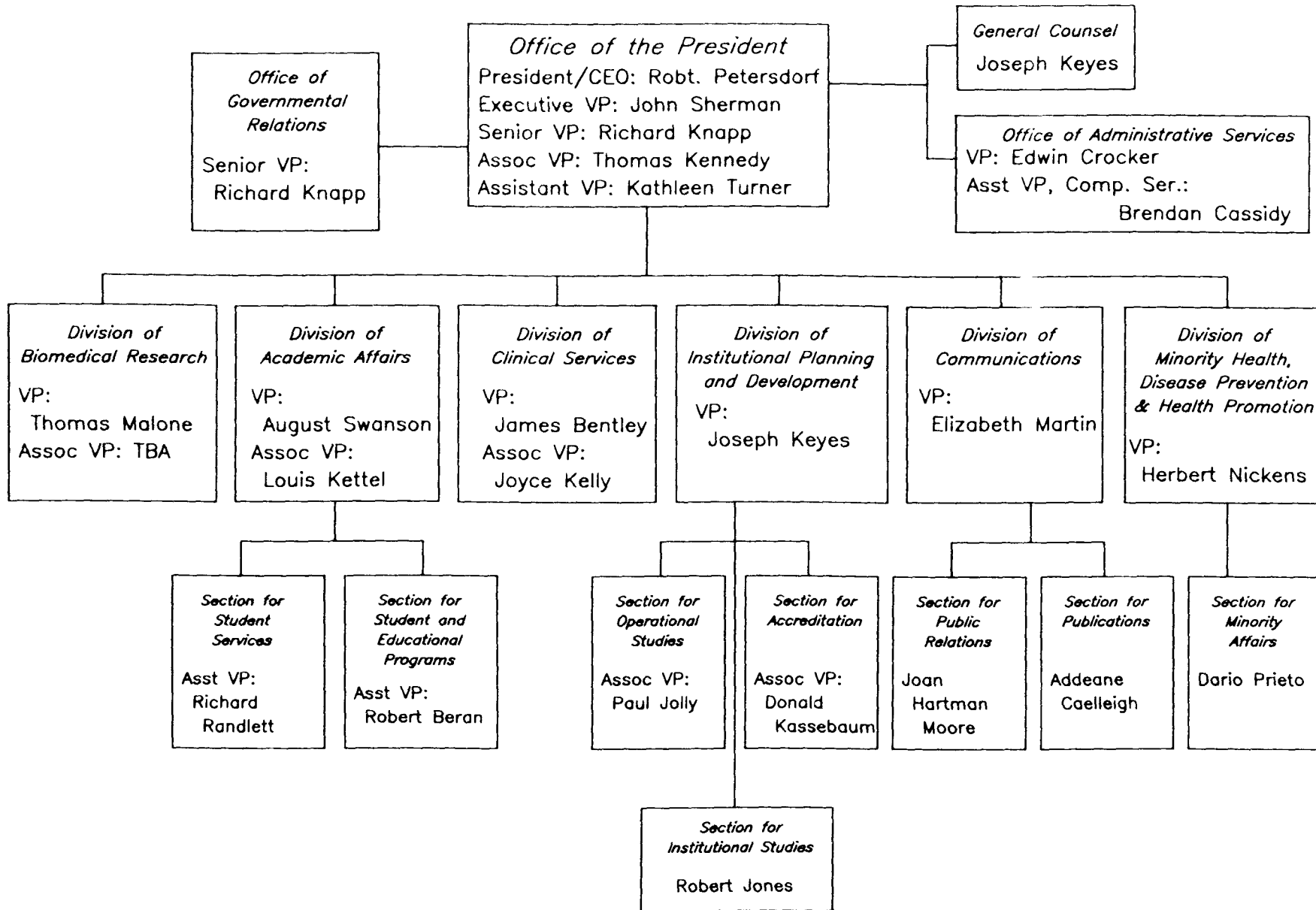
Thomas E. Malone, PhD
Vice President for Biomedical Research

Elizabeth M. Martin
Vice President for Communications

Herbert W. Nickens, MD
Vice President for Minority Health,
Disease Prevention, and Health Promotion

August G. Swanson, MD
Vice President for Academic Affairs

AAMC Organization Chart



1989

AAMC
DIVISION OF CLINICAL SERVICES

STAFF

JAMES D. BENTLEY, PhD
Vice President for Clinical Services

JOYCE V. KELLY, PhD
Associate Vice President for Clinical Services

IVY BAER
Staff Associate

JANIE S. BIGELOW
Survey Assistant

JOANNA CHUSID
Staff Assistant

G. ROBERT D'ANTUONO
Staff Associate

LINDA E. FISHMAN
Research Associate

MARJORIE R. LAWAL
Administrative Assistant

NATALIE ROBERTSON
Administrative Assistant

MELISSA H. WUBBOLD
Special Assistant

STEPHEN C. ZIMMERMANN
Research Assistant

202/828-0490

AAMC Policy Positions on the
Medicare Prospective Payment System

Adopted September 1988

In September 1988, the COTH Administrative Board recommended and the AAMC Executive Council adopted the following positions on Medicare payment issues.

- o The AAMC supports a tiered rate structure for Medicare PPS payments which recognizes cost differences between urban and rural hospitals until adequate and tested indices for both wage and non-labor components of hospital cost are available.
- o The AAMC supports, as a floor, the October 1988 formula (yielding 7.7% per 0.1 resident per bed) for the indirect medical education adjustment. This is in recognition of the multiple roles and accompanying costs teaching hospitals have in the nation's health care system, including caring for the most severely ill patients, introducing new diagnostic and treatment services, caring for patients in the high cost core cities of urban areas, and providing clinical education programs in the health professions.
- o The AAMC supports increasing the percentage of Medicare PPS payments used to compensate hospitals for high cost and long stay outliers as a means of more fully recognizing differences in patient severity of illness.
- o The AAMC supports the inclusion of a disproportionate share adjustment in the Medicare PPS and supports efforts to develop better measures of the impact of treating the poor, including the aged poor, on a hospital's overall costs and financial status.
- o The AAMC supports rebasing PPS prices, but only when rebasing includes full, public documentation and release of methodology and data; contemporary hospital cost data; and a rulemaking process with comment and appeal. If these conditions are not met, the AAMC Executive Council supports an annual increase in PPS prices at least equal to the annual increase in the price of goods and services purchased by hospitals.

- o All health care payers, including Medicare, should continue to provide their appropriate share of support for graduate medical education. Medicare may be a keystone in assuring this support since Medicare policies are determined by Congress and the Department of Health and Human Services (DHHS), bodies which are intended to guard the public interest. Accordingly, the AAMC supports the following policies:
 - 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;
 - 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;
 - an individual should be supported from patient care payers' payments to teaching hospitals for a maximum of six years of graduate medical education;
 - while public and private organizations may adopt positive financial incentives to encourage physicians to train in particular disciplines, they should not adopt financial disincentives for a particular discipline during the period of its initial board eligibility.



association of american medical colleges

ROBERT G. PETERSDORF, M.D.
PRESIDENT

(202) 828-0460

November 21, 1988

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Room 309-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC

Attention: BERC-375-P

Dear Dr. Roper:

On behalf of the Association of American Medical Colleges, I welcome the opportunity to comment on the proposed regulation "Changes in Payment Policy for Direct Graduate Medical Education Costs" (53 Federal Register 36589). The Association represents the nation's 127 medical schools, over 435 major teaching hospitals and 83 academic medical societies. The Association's member hospitals include more than 70% of all residents in training.

The Association's comments discuss problems in the proposed method of counting residents, the administrative burden imposed by the retroactive application of the regulation, the identification of geriatric residency programs, and request that additional information be supplied and that a portion of the regulation be republished with an additional comment period.

I. The Counting of Residents

The formula for determining the per resident amount involves two calculations: the determination of the allowable costs (the numerator) and the determination of an accurate resident count (the denominator) during the base period (fiscal year 1984).

In the proposed regulation, HCFA seems to have considered only the simplest case for counting residents - a hospital that provides salaries/stipends for all of its residents and that has no PPS exempt units. Never mentioned is, how to deal with the types of arrangements that are perhaps more common, such as a hospital that has interns and residents, some of whom it funds and some of whom receive funding from a totally separate source, or a hospital that has PPS exempt units. **HCFA is requested to modify the proposed rule to consider more complicated and more frequent situations, such as those described below and to clarify its intent about how such situations should be handled.**

1. Illustration of the Problem

The following two examples illustrate the complications not addressed by the proposed regulation.

Example 1

<u>Number of Interns/Residents</u>	<u>Salary/Stipend Paid by:</u>	<u>Where Assigned</u>
150	hospital	PPS unit
75	hospital	PPS exempt units

The first issue is whether residents who are paid by the hospital but assigned to PPS exempt units are to be included in the resident count; i.e., should the hospital shown above count 150 or 225 residents?

The preamble to the proposed regulation states that "for purposes of this rule we are proposing to use the number of residents reported on the Federal FY1984 cost report under indirect GME payment rules as the denominator in calculating base-period average per resident amounts" (p. 36593). This language suggests that HCFA would exclude residents in PPS exempt units, since that is what the indirect medical education payment rules require. However, counted in the allowable costs of the numerator are the costs for all residents, even those in PPS exempt units. AAMC believes that the appropriate way to derive a more accurate per resident amount is to maintain consistency between the costs in the numerator and the residents in the denominator. The only way to achieve this end is to count residents in exempt units when computing direct medical education payments. The AAMC requests that HCFA modify its rule to clearly indicate that residents in both PPS and exempt units/facilities are to be counted.

Example 2

<u>Number of Interns/Residents</u>	<u>Salary/Stipend Paid by:</u>	<u>Where Assigned</u>
200	hospital	PPS unit
75	other entity	PPS unit

The second major question raised by the proposed regulations is whether residents for whom the hospital does not provide a salary check but does incur other costs for supervision, teaching

and overhead should be included in the resident count? This raises two questions: (1) whether a hospital must actually prepare a salary check for a resident in order for the resident to be counted and (2) whether a resident compensated by another entity, irrespective of which entity writes the check (e.g., medical school, practice plan, VA hospital), should be included in the count.

As to the former point, HCFA states that "we believe it appropriate not to include in a hospital's resident FTE count those residents for whom no provider participating in Medicare incurs salary/stipend and fringe benefit costs (hereinafter referred to as salary costs)" [p. 36596]. Because the language refers to "incurring a cost" the AAMC understands that HCFA's intent is to include in the count all residents for whom any Medicare participating hospital pays, whether paid through a paycheck or by reimbursing another organization. Thus residents paid through a GME consortia using hospital funds would be counted. HCFA is requested to state clearly the policy that the hospital counts residents for whom it prepares a paycheck and residents the hospital compensates through a third party.

The questions of counting residents whose stipends are paid by a non-hospital entity is more difficult to resolve. In the preamble, HCFA is clear that it means to exclude from the resident count those residents whose stipends are fully paid by the Federal Government (p. 36596), but never addresses the issue of counting residents whose stipends may be paid by a non-related medical school, faculty practice plan or another non-hospital entity. The AAMC supports HCFA's proposal to include only residents compensated by a Part A entity.

2. Republication

Due to the numerous questions raised by HCFA's proposal regarding the method of counting interns and residents, the AAMC requests that this section of the regulation be republished as a Notice of Proposed Rulemaking and that an additional 60 day comment period be provided. The Association believes that this is the only equitable way to ensure that a clearly understood method of counting interns and residents is adopted.

II. Retroactive Application of the Regulation

As required by the legislation the application of the proposed regulation is made retroactive to each hospital's 1984-5 cost reporting period. In addition, the possibility of auditing

even earlier cost reports is opened when it is necessary to make adjustments to an institution's hospital specific rate.

In its proposed regulation HCFA never considers the administrative burden of applying the regulation retroactively. It will not be easy, and in some cases may be virtually impossible for a hospital to construct records for assigned residents from 1984 or earlier to comply with recordkeeping requirements that are not being implemented until 1989. While the AAMC supports accuracy and consistency in the implementation of the regulation, the Association also supports fairness and the avoidance of excessive administrative burdens whenever possible.

When the legislation was passed in April 1986, the retroactivity was to cost reporting periods only a year or two in the past. At that time it may have been possible to construct records, such as monthly schedules of intern and resident assignments, which hospitals are not yet required to keep. However, due to the delay in the implementation of the regulation, hospitals are now facing the prospect of reconstructing information from 1984 or earlier although it may be difficult to do so with any accuracy. The legislation does not require a monthly count of residents and, to this point, hospitals do not routinely collect such information. The AAMC believes that the September 1 resident count should be used as an alternative for the retroactive application of the regulation. If the monthly count is implemented it should be done on a prospective basis only.

III. Geriatric Residency and Fellowship Programs

As required by law, "an individual...in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish shall be treated as part of the initial residency period" for a period of not more than two years. While the proposed regulation incorporates the two-year extension for geriatric residents, it does not specify the criteria that will be used to determine which residencies and fellowship programs qualify. This is not a problem for geriatric fellowships in internal medicine and family practice where the Accreditation Council For Graduate Medical Education (ACGME) has developed mechanisms for program approval.

For disciplines in which fellowships are not yet ACGME approved, the regulations provide no mechanism for the HHS Secretary to determine which programs to designate as approved. The Association requests that HCFA make clear that disciplines

seeking approval of geriatric fellowships should follow the established ACGME mechanism for approval.

IV. Request for Additional Information

1. Misclassified and Nonallowable Costs

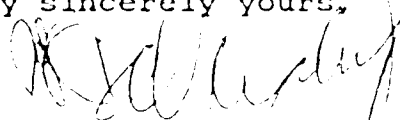
The AAMC agrees that hospitals should not be paid for misclassified and nonallowable costs. Because reaudits of cost reports to determine if such costs were claimed on a hospital's cost reports may have a significant financial impact on some institutions, the AAMC requests HCFA to set out clear, detailed definitions of which costs will be considered misclassified and nonallowable. This will help avoid confusion and will ensure that fiscal intermediaries and hospitals are working from the same set of well-defined rules.

2. CPI-U Update Factors

In the proposed regulation HCFA lists update factor for cost reporting periods from October 1, 1985 through May 31, 1985 (p. 36594). To avoid confusion about the CPI-U update to be used for later cost reporting periods, the AAMC requests that all update factors through the most currently available, be published in the final rule and that HCFA continue to publish factors on a periodic basis in the Federal Register.

Thank you for your consideration of these comments.

Very sincerely yours,



Robert G. Petersdorf, M.D.

association of american medical colleges

ROBERT G. PETERSDORF, M.D.
PRESIDENT

(202) 828-0460

January 25, 1989

Stuart H. Altman, Ph.D., Chairman
Dean, Florence Heller School
Brandeis University
Waltham, Massachusetts 02154

Dear Dr. Altman:

The "indirect medical education (IME) adjustment" is an integral, yet misunderstood, part of the Medicare Prospective Payment System (PPS). While its title has led many to believe that this adjustment to the Diagnosis Related Group (DRG) prices is to compensate for education and related program costs, its purpose is clear:

This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, March 11, 1983).

The Association of American Medical Colleges (AAMC), which represents the nation's 127 medical schools, over 435 major teaching hospitals and 83 academic medical societies, is greatly concerned that recent analyses have led some to conclude that the indirect medical education adjustment could be cut substantially without undermining the financial viability of teaching hospitals. AAMC data suggest a cut in the IME adjustment will harm substantially teaching hospitals.

At the January 10 ProPAC meeting, Commissioners were asked to consider and make recommendations on three decision elements concerning the indirect medical education adjustment:

- (1) the level of the adjustment itself;
- (2) whether a change in the IME should be phased in over time; and
- (3) whether a change in the IME should be budget neutral.

One Dupont Circle, N.W., Washington, D.C. 20036

Stuart H. Altman, Ph.D.

Page 2

January 25, 1989

During a discussion of the decision options, several Commissioners expressed the need to examine total hospital margins in addition to Medicare PPS margins, and called upon the hospital industry to share its financial data. In response to the Commission's request, the AAMC submits the attached analysis of PPS and total margins for a group of academic medical center hospitals belonging to the Council of Teaching Hospitals (COTH).

Data and Findings

The attached four tables use the financial data of thirty-four hospitals that responded by January 20 to the FY 1988 COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data. The survey is mailed annually to 121 academic medical center hospitals and has a return date of February 10. These data are collected from the hospital's most recently completed fiscal year, which for most of the thirty-four institutions ended in June or September 1988. In general, PPS data reported in these tables are from the hospitals' "as submitted" Medicare cost reports. Operating and total margin data are reported from audited financial statements.

Because AAMC policy prohibits the release of hospital-specific data without permission of the hospital chief executive, we have masked the identity of individual institutions in all tables. However, an alphabetical list of the responding hospitals is included as part of the analysis.

Table 1 shows that average PPS margins for this group of hospitals dropped dramatically in FY 1988 to 4.8 percent. The PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, indirect medical education and outlier payments) less Medicare inpatient operating costs, divided by PPS revenue. Of 31 hospitals reporting PPS margin data in both 1987 and 1988, 24 (77 percent) had lower margins in 1988. While only one hospital had a negative PPS margin in 1986, by 1988 ten hospitals reported PPS margins less than zero.

Table 2 uses 1988 data to demonstrate the impact of the various types of PPS payments on hospital margins and the effect of cutting the IME adjustment in half. This period represents the first year these hospitals received a per case DRG price based 100 percent on the national average. A striking finding in Table 2 is the significant contribution of the payment adjustments (IME and disproportionate share) to reducing the large losses that would result if payment were limited to the DRG rate plus outliers. The fully phased-in national rate does not

recognize important differences in hospital costs, including the range of services offered by these hospitals and the socioeconomic mix of their patients.

During the reporting period shown in Table 2, hospitals received an IME payment at the 8.1 percent level; therefore, a reduction of the payment by one-half pays hospitals at the 4.05 percent level, assuming no change in the FY 1988 intern and resident to bed ratio. On average, PPS margins calculated without disproportionate share but with all other components fall from about 1 percent to -10 percent when the IME payment is cut in half. The addition of the disproportionate share payment allows some hospitals to achieve positive PPS margins, but the average PPS margin is still negative at -5.5 percent.

Table 3 shows that for this group of hospitals the IME and disproportionate share payments constitute a significant portion of their total PPS payments. Between one-fifth and one-fourth of these hospitals' total PPS payments can be attributed to these adjustments. However, a high percentage of these payments relative to the total payment does not necessarily guarantee a large positive margin.

Table 4 shows both operating and total hospital margins for all payers for three years. As with PPS margins, there is a definite downward trend in both margins. The average operating margin was negative in 1988. It is important to recognize, however, that some of these hospitals receive state or county/municipal appropriations to finance operations; the funds may be treated as non-operating revenue on the financial statement. When a government appropriation is recognized in the hospital's operating statement as non-operating revenue, it may result in a positive total margin. Total margins, which include government appropriations, were cut in half, falling from 6.6 percent in 1986 to 3.3 percent in 1988.

Discussion

In the initial years of PPS, major teaching hospitals' PPS margins were high relative to some other types of hospitals. The determination of the hospital-specific DRG price was a major contributor to these profits. In the early years of PPS, when DRG prices were based 75 percent on the hospital-specific price component, major teaching hospitals earned their largest margins. Since the IME adjustment was applied only to the 25 percent federal portion of the rate, it made a relatively small contribution to teaching hospitals' PPS margins. Today, with DRG prices based 100 percent on the national rate, teaching hospital


Stuart H. Altman, Ph.D.
Page 4
January 25, 1989

margins are generally low and the adjustments, including the IME adjustment, are increasingly important to teaching hospitals.

Teaching hospitals will be unable to withstand further reductions in the IME payment, particularly since margins on both Medicare and non-Medicare patients are dropping dramatically. The indirect medical education payment is an important equity factor in the Medicare prospective payment system, compensating teaching hospitals for the severity of their patients' illnesses, the scope of services provided and the impact of teaching hospital programs on hospital operating costs. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must fulfill their unique educational and service missions.

A major and/or sudden reduction in the IME adjustment would constitute a severe economic hardship for teaching hospitals and hinder their future capability to support adverse patient selection within DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. The AAMC urges the Commissioners to consider carefully the impact of a reduction in the indirect medical education adjustment on teaching hospitals.

Very sincerely yours,


Robert G. Petersdorf, M.D.

cc: ProPAC Commissioners
Donald Young, M.D., Executive Director

TABLE 1: PPS MARGINS IN SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986-FY 1988 RANKED BY FY 1988 PPS MARGIN

HOSPITAL	PPS MARGINS		
	FY 86	FY 87	FY 88
A	25.20%	20.27%	30.03%
B	19.26%	12.42%	28.66%
C	28.15%	26.91%	27.84%
D	26.22%	21.31%	21.25%
E	7.09%	12.37%	18.58%
F	22.27%	15.39%	16.48%
G	34.98%	20.17%	16.46%
H	20.74%	19.50%	15.22%
I	23.68%	18.66%	12.53%
J	N.A.	N.A.	11.61%
K	14.27%	16.07%	10.78%
L	20.72%	16.78%	10.66%
M	39.17%	31.25%	9.89%
N	24.06%	15.93%	9.69%
O	8.52%	-22.79%	6.75%
P	23.40%	21.39%	5.05%
Q	19.35%	12.07%	3.88%
R	20.33%	12.86%	2.76%
S	13.82%	18.05%	2.48%
T	23.06%	15.55%	2.42%
U	25.64%	14.02%	1.80%
V	24.74%	14.81%	1.62%
W	8.60%	-1.33%	1.24%
X	15.92%	8.03%	0.09%
Y	16.74%	10.13%	-0.59%
Z	10.07%	7.17%	-1.39%
AA	24.68%	10.02%	-3.37%
BE	15.48%	N.A.	-3.93%
CC	18.80%	15.21%	-4.94%
DD	N.A.	N.A.	-8.76%
EE	-0.16%	1.73%	-9.10%
FF	14.94%	9.50%	-14.08%
GG	14.65%	0.68%	-14.57%
HH	7.06%	-4.76%	-20.66%
MEDIAN	19.84%	14.81%	3.32%
AVERAGE (WEIGHTED)	19.81%	14.76%	4.79%

PPS MARGIN= PPS REVENUE (WHERE PPS REVENUE= DRG PAYMENT, DISP. SHARE, INDIRECT MED. ED. AND OUTLIER PAYMENTS) LESS MEDICARE INPATIENT OPERATING COSTS, DIVIDED BY PPS REVENUE.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 BOTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 2: PPS MARGINS FOR SELECTED ACADEMIC MEDICAL CENTER HOSPITALS RANKED BY PAYMENT WITH OUTLIERS, DSH, AND 1/2 IME: FY 1988

HOSPITAL	DRG PAYMT LESS OPER COSTS	PAYMENT WITH OUTLIERS ONLY	PAYMENT WITH OUTLIERS & FULL IME	PAYMENT WITH OUTLIERS & 1/2 IME	PAYMENT WITH OUTLIERS & DSH & 1/2 IME
B	0.00%	3.87%	20.74%	13.12%	22.54%
C	-4.67%	-0.22%	21.53%	11.98%	19.84%
A	-6.67%	-3.10%	25.48%	13.49%	19.55%
D	-7.40%	0.59%	17.78%	10.00%	14.14%
E	-17.70%	-11.86%	10.64%	0.65%	10.37%
H	-20.46%	-16.05%	6.81%	-3.37%	6.87%
G	-35.41%	-23.11%	8.64%	-4.89%	5.29%
F	-19.32%	-16.59%	12.42%	-0.02%	5.24%
J	-18.48%	-10.84%	6.80%	-1.26%	4.39%
N	-30.71%	-16.13%	3.56%	-5.37%	1.90%
K	-19.88%	-14.79%	7.73%	-2.31%	1.43%
I	-25.46%	-20.38%	8.89%	-3.72%	0.97%
M	-15.77%	-11.59%	9.89%	0.30%	0.30%
L	-32.41%	-22.68%	5.96%	-6.47%	-0.48%
O	-45.00%	-30.40%	1.50%	-12.23%	-5.46%
S	-31.96%	-17.30%	2.48%	-6.50%	-6.50%
P	-31.89%	-27.01%	1.74%	-10.80%	-6.60%
W	-29.29%	-22.00%	-2.57%	-11.44%	-6.96%
U	-34.23%	-24.34%	-1.89%	-12.00%	-7.56%
R	-44.24%	-30.47%	-1.75%	-14.34%	-8.66%
T	-38.11%	-29.41%	-0.67%	-13.25%	-9.35%
BB	-36.35%	-20.47%	-7.27%	-13.48%	-9.75%
V	-41.33%	-32.30%	-2.38%	-15.43%	-10.38%
AA	-27.13%	-19.94%	-3.37%	-11.04%	-11.04%
Q	-44.22%	-32.64%	3.26%	-11.88%	-11.05%
Z	-49.83%	-38.24%	-9.69%	-22.33%	-12.08%
X	-55.00%	-40.72%	-7.72%	-22.03%	-12.10%
Y	-49.70%	-38.03%	-7.10%	-20.61%	-12.43%
DD	-28.59%	-23.44%	-8.76%	-15.64%	-15.64%
GG	-34.11%	-26.78%	-20.86%	-23.75%	-17.16%
CC	-53.33%	-36.47%	-4.94%	-19.39%	-19.39%
EE	-51.41%	-42.54%	-15.03%	-27.31%	-20.09%
FF	-42.18%	-34.23%	-14.08%	-23.34%	-23.34%
HH	-61.95%	-50.60%	-25.04%	-36.63%	-31.42%
MEDIAN	-32.19%	-22.90%	1.62%	-11.24%	-6.78%
AVERAGE (WEIGHTED)	-33.60%	-24.28%	0.99%	-10.22%	-5.52%

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND
FY 1986 COH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 3: DISPROPORTIONATE SHARE AND INDIRECT MEDICAL EDUCATION
ADJUSTMENTS AS PERCENTAGES OF TOTAL PPS PAYMENTS
RANKED BY FY 1988 PPS MARGIN

HOSPITAL	DSH AS OF TOTAL PPS PAYMT	IME AS % OF TOTAL PPS PAYMT	DSH & IME AS % OF TOTAL PPS PAYMT	FY 88 PPS MARGIN	FY 88 IRB RATIO
A	6.10%	26.04%	32.13%	30.03%	0.6506
B	9.99%	15.80%	25.79%	28.66%	0.5000
C	8.03%	19.96%	27.99%	27.84%	0.5775
D	4.22%	16.56%	20.78%	21.25%	0.5468
E	8.89%	18.33%	27.21%	18.58%	0.4449
F	4.63%	23.73%	28.36%	16.48%	0.7018
G	8.56%	23.58%	32.14%	16.46%	0.5978
H	9.02%	17.92%	26.94%	15.22%	0.5195
I	4.00%	23.34%	27.34%	12.53%	0.8091
J	5.16%	15.09%	20.25%	11.61%	0.5000
K	3.31%	18.97%	22.27%	10.78%	0.4853
L	5.00%	22.18%	27.18%	10.66%	0.6978
M	N.A.	19.25%	19.25%	9.89%	0.4800
N	6.36%	15.87%	22.23%	9.69%	0.3878
O	5.34%	23.16%	28.49%	6.75%	0.5490
P	3.37%	21.87%	25.24%	5.05%	0.5735
Q	0.65%	26.89%	27.53%	3.88%	0.5631
R	4.44%	21.03%	25.47%	2.76%	0.4308
S	N.A.	16.86%	16.86%	2.48%	0.4278
T	3.07%	21.53%	24.60%	2.42%	0.5612
U	3.62%	17.40%	21.02%	1.80%	0.4502
V	3.90%	21.73%	25.64%	1.62%	0.6501
W	3.72%	15.34%	19.05%	1.24%	0.4073
X	7.25%	21.75%	29.00%	0.09%	0.7506
Y	6.07%	21.05%	27.12%	-0.59%	0.5851
Z	7.57%	19.09%	26.66%	-1.39%	0.6172
AA	0.00%	13.81%	13.81%	-3.37%	0.3078
BB	3.11%	10.62%	13.73%	-3.93%	0.3462
CC	0.00%	24.22%	24.22%	-4.94%	0.4308
DD	N.A.	11.90%	11.90%	-8.76%	0.3810
EE	5.15%	18.31%	23.46%	-9.10%	0.5397
FF	N.A.	15.01%	15.01%	-14.08%	0.3251
GG	5.21%	4.42%	9.63%	-14.57%	0.1014
HH	3.50%	16.38%	19.88%	-20.66%	0.4685
MEDIAN	4.82%	19.03%	24.92%	3.32%	0.5098
AVERAGE (WEIGHTED)	3.85%	19.55%	23.40%	4.79%	N.A.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND
FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 4: OPERATING AND TOTAL MARGINS FOR SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986-FY 1988

HOSPITAL	OPERATING MARGINS			*	TOTAL MARGINS		
	FY 86	FY 87	FY 88		FY 86	FY 87	FY 88
A	7.47%	-4.05%	-4.16%	*	11.77%	0.46%	0.77%
B	11.58%	6.10%	-10.99%	*	13.41%	7.86%	9.87%
C	19.85%	18.96%	14.45%	*	19.85%	19.51%	14.83%
D	2.90%	10.05%	5.49%	*	3.08%	8.42%	5.92%
E	9.29%	8.37%	9.37%	*	8.37%	9.29%	9.37%
F	6.90%	5.17%	3.99%	*	6.99%	5.34%	3.79%
G	-40.36%	-34.84%	-43.40%	*	-1.19%	-0.81%	-0.77%
H	-7.86%	-11.98%	-13.05%	*	-7.86%	-11.98%	-13.05%
I	5.00%	5.34%	7.42%	*	5.01%	5.32%	7.89%
J	N.A.	N.A.	0.27%	*	N.A.	N.A.	1.52%
K	6.36%	5.87%	2.03%	*	6.16%	5.64%	3.31%
L	8.02%	1.91%	-0.66%	*	8.43%	6.39%	3.52%
M	10.92%	10.69%	10.00%	*	15.48%	13.99%	12.56%
N	10.73%	4.56%	3.64%	*	10.73%	4.58%	7.03%
O	14.00%	8.41%	7.72%	*	16.55%	11.38%	10.21%
P	2.47%	0.15%	-1.47%	*	6.63%	4.37%	2.30%
Q	2.26%	0.84%	0.89%	*	5.33%	3.95%	3.65%
R	2.59%	-0.85%	-4.76%	*	4.84%	1.85%	-2.13%
S	-2.31%	-1.71%	-3.35%	*	0.36%	0.01%	-0.46%
T	7.66%	2.64%	0.65%	*	12.72%	4.62%	2.89%
U	3.72%	1.55%	1.22%	*	5.31%	3.60%	3.47%
V	8.67%	5.61%	5.43%	*	9.18%	10.09%	6.06%
W	7.77%	2.24%	2.71%	*	10.55%	2.55%	3.04%
X	3.61%	0.47%	1.81%	*	5.35%	1.87%	2.38%
Y	-13.23%	-17.58%	-16.95%	*	1.47%	2.00%	1.16%
Z	5.06%	3.14%	3.36%	*	5.06%	3.14%	3.36%
AA	10.40%	6.26%	1.96%	*	10.63%	6.96%	2.59%
BB	0.89%	3.53%	2.24%	*	1.82%	4.47%	3.05%
CC	0.81%	0.24%	-1.10%	*	0.98%	0.75%	-0.42%
DD	N.A.	N.A.	-24.17%	*	N.A.	N.A.	1.57%
EE	3.18%	0.31%	3.82%	*	3.18%	0.31%	3.82%
FF	7.03%	8.32%	1.64%	*	8.33%	9.37%	2.44%
GG	11.67%	10.47%	4.34%	*	13.54%	19.62%	6.12%
HH	6.83%	4.70%	2.15%	*	7.53%	5.68%	4.24%
MEDIAN	6.59%	3.34%	1.89%	*	6.81%	4.60%	3.34%
AVERAGE (WEIGHTED)	2.73%	0.79%	-1.42%	*	6.57%	4.87%	3.32%

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COOH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

ACADEMIC MEDICAL CENTER HOSPITALS PROVIDING DATA
FY 1986-FY 1988

CRAWFORD LONG
DUKE UNIVERSITY
EMORY UNIVERSITY HOSPITAL
GEORGETOWN
HAHNEMANN
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
INDIANA
KENTUCKY
LA COUNTY-USC MEDICAL CENTER
LOUISIANA STATE UNIVERSITY
MASSACHUSETTS GENERAL
MEDICAL COLLEGE OF GEORGIA
MEDICAL COLLEGE OF OHIO
MEDICAL COLLEGE OF VIRGINIA
NORTH CAROLINA BAPTIST
NORTH CAROLINA MEMORIAL
REGIONAL MEDICAL CENTER AT MEMPHIS
ST LOUIS UNIVERSITY
TEMPLE
UNIVERSITY OF CALIFORNIA, DAVIS
UCLA
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
UNIVERSITY HOSPITAL (COLORADO)
UNIVERSITY OF MARYLAND
UNIVERSITY OF MICHIGAN
UNIVERSITY OF MISSISSIPPI
UNIVERSITY OF NEBRASKA
UNIVERSITY OF NEW MEXICO
UNIVERSITY OF UTAH
UNIVERSITY OF VIRGINIA
UNIVERSITY OF WASHINGTON
VANDERBILT
VERMONT
YALE-NEW HAVEN

NOTE: HOSPITALS ARE LISTED ABOVE IN ALPHABETICAL ORDER. HOSPITAL ORDER
HAS BEEN CHANGED IN THE ACCOMPANYING TABLES.



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

ONE DUPONT CIRCLE, NW
WASHINGTON, DC 20036
TELEPHONE (202) 828-0460

April 6, 1989

Administrator
Health Care Financing Administration
Department of Health and Human Services
P. O. Box 26676
Baltimore, Maryland 21207

REF: BERC-142-P

"Payment for Physician Services Furnished in Teaching Settings; Payment to Providers for Compensation Paid to Physicians Who Furnish Services to Providers"

Dear HCFA Administrator:

The Association of American Medical Colleges (AAMC) is pleased to submit these comments with respect to the above referenced proposed rules, issued February 7 (54 Federal Register 5946-5971) affecting the payment for physician services furnished in a teaching setting. The AAMC represents 365 major teaching hospitals which participate in Medicare, 127 accredited medical schools; 110 faculty practice plans and 88 academic and professional societies. Our members have a strong interest in these proposed rules and are concerned about their potential impact on the practice of medicine in teaching hospitals.

The AAMC has been actively involved with the issues raised in these proposed rules for twenty years. The Association has testified before Congress, met with representatives of the then Bureau of Health Insurance, and worked with HCFA staff. As a result, the AAMC has a unique and comprehensive perspective for evaluating the proposed rules. The AAMC comments emphasize three major issues:

- o the inadequacy of the definition of "teaching physician,"
- o the newly proposed offset of practice plan income; and
- o the proposed use of compensation related charges for physicians who do not involve residents in the care of patients.

The AAMC also raises a number of other issues for clarification and comment.

I. MAJOR ISSUES

A. Definition of a Teaching Physician.

The definition of a teaching physician, as delineated in Section 415.200 (a) on page 5963, is too broadly stated and vague:

"Teaching physician means a physician who is compensated by a hospital, medical school, other affiliated entity, or professional practice plan for physician services furnished to patients, and who generally involves interns or residents in patient care."

The terms "other affiliated entities" and "professional practice plan" are not defined. Therefore, it is not clear which physician practice groups are included and which are excluded by the definition. For example, it is not clear how a community-based group of five physicians organized into a professional corporation (P.C.) and admitting inpatients to a teaching setting will be defined. Are the five physicians defined as "teaching physicians" because the group admits its patients to a teaching hospital or as non-teaching physicians because the P.C. receives and retains all practice fees?

For physicians admitting patients to a teaching hospital, the advantage of being defined as a teaching physician is the existence of the special customary charge rules which set a minimum fee of 85% of the Medicare prevailing. For physicians with profiles in excess of the Medicare prevailing, the disadvantage is the documentation requirements necessary to replace the 85% presumption with the full Medicare prevailing. Part of this disadvantage can be minimized by constructing a simple method, based on payer mix, for overturning the 85% presumption. The disadvantage can also be reduced by narrowing the definition of "teaching physician" to one which clearly separates physicians included in the definition of teaching physicians from those not included. Therefore, the AAMC recommends that HCFA develop a "bright-line" definition distinguishing clearly the physicians defined as "teaching physicians".

B. Offset of Practice Plan Income

As explained in the preamble and in the regulations themselves, HCFA is proposing, under some circumstances, to reduce allowable hospital costs for physician services furnished to providers "if any part of the payment a physician receives for physician services furnished to individual patients is directly or indirectly returned to or retained by the provider or a related organization under a formal or informal agreement." The AAMC strongly opposes this proposed change in HCFA policy because it:

- o is inconsistent with Congressional action replacing cost-based payments for teaching physicians with charge-based payments;

- o in effect, imposes compensation related charges on hospitals and physicians who did not elect this option when provided the choice;
- o violates the separation between trust funds by using Part B trust funds to support Part A activities;
- o expands the concept of the costs of related organizations into the area of revenues of related organizations;
- o is inconsistent with Medicare's current policy of not offsetting gifts and income from endowments;
- o treats various medical center arrangements differently based solely on their legal structure, and
- o sets in place a policy which will diminish the incentive for physicians to assist their medical school or teaching hospital.

The AAMC strongly recommends that the disposition of a properly earned Part B fee should not affect either the amount of the fee or the costs incurred by a teaching hospital.

First, Section 948 of P.L. 96-499, the Omnibus Reconciliation Act of 1980, repealed provisions of Section 227 of P.L. 92-603, the Social Security Amendments of 1972. Section 227 provided that physicians in teaching hospitals must be paid on a reasonable cost basis for professional medical services unless the services were provided to a private patient (as defined by the Secretary) OR the hospital met the billing and collection provisions of the law's "grandfather" clause. Section 948 repealed Section 227 by providing provisions which enable a physician in a teaching hospital to bill charges for the services performed or personally supervised for Medicare beneficiaries. With this legislative action, Congress expressly replaced a provision which prescribed cost payments (Section 227) with a provision recognizing customary charge payments (Section 948). Thus, Congress intended for teaching hospitals, related medical schools and practice plans to benefit from the customary charge payments. It was and still is the intent of Congress to permit teaching physicians to charge a customary fee for services performed and to realize net income from those fees. The option to elect cost-based reimbursement remains if all physicians within an institution agree to be compensated in this way. Therefore, in reviewing Sections 227 and 948, the Association finds no legislative precedence for requiring the proposed offset of faculty practice income.

Second, Section 948 emphasized a charge-based approach for paying for teaching physicians. It allows, however, for all physicians in a teaching hospital to elect payment on a compensation-related basis. By definition, compensation-related payments do not include net income. The proposed offset of practice plan net income when reasonable charges are paid, in effect, converts a reasonable charge-based approach to a compensation-related approach. By imposing the offset, HCFA essentially overturns the financial effect of the physician's decision not to elect compensation-related charges. This is

contrary to the statute and undermines the physician's right to be paid on a reasonable charge basis. The Association believes the proposed offset is inconsistent with the philosophy and intent of Section 948 because it negates the benefit of customary charges by reducing hospital costs by the difference between customary and compensation-related charges.

Third, HCFA must further consider the proposed policy in terms of the separation of Medicare's Part A and Part B trust funds. Congress intended that each trust should finance only the services covered by its respective provisions, mandating a complete separation of funds. By imposing the requirement that Part B fees not used for personal compensation be offset against institutional costs, HCFA is proposing to use Part B funds to support Part A benefits. The AAMC believes strongly that any attempt to administer the trusts in the manner suggested by the proposed offset is contrary to the requirement that each trust fund support only its own benefits.

Fourth, the AAMC also disagrees with the way HCFA has chosen to expand the term "related organization" in the proposed rules. The related organization principle, which is properly titled the "cost to related organizations" in HCFA regulations and manuals has been developed and applied solely to define allowable cost. It has never applied to Part A revenues. Nor has the term been applied to discussion of Part B program issues because these issues have typically focused on revenue and payment concerns. Therefore, the Association believes it is an inappropriate to apply the concept of the cost of related organizations to the revenues of related parties.

Fifth, several years ago, Medicare modified its policy on gifts and endowment income to provide that both restricted and unrestricted gifts/endowment income would not be offset in determining hospital costs. The proposed practice income offset is inconsistent with the established policy for gifts and endowment income. A private attending in a non-teaching hospital can make a cash gift with monies earned from medical practice and the hospital does not have to take an offset against its costs. Under the proposal, a like amount which a teaching physician allows the institution to retain must be offset. This is clearly discriminatory against the teaching physician and the teaching hospital, and the AAMC strongly opposes this discriminatory treatment.

Sixth, medical centers and community teaching hospitals are organized in many ways reflecting both historical developments, local customs, and legal requirements. While the organizational and legal structures may vary, the operational functions and relationships are often quite similar. As a result, HCFA's proposal to determine the offset on the basis of common ownership or a misapplication of the related organization principle treats functionally similar situations in very different ways. In fact, the proposal penalizes some hospitals and schools for arrangements which predate the Medicare program itself. The AAMC believes it is inappropriate to impose the offset in a limited number of settings because of their long-standing legal relationship.

Lastly, if adopted, the offset is poor social policy. If a physician retains all fees, there will be no offset. If however, the physician allows the school to retain some fee income, Medicare payments to the hospital decrease in some cases. Thus, the benefit to the institution is expropriated by the government. The outcome of this rule will be to discourage teaching physicians from contributing a percentage of their income toward the support of their medical school or teaching hospital. This would serve only to decrease school and hospital operating revenues by encouraging physicians to retain all fee income. Having retained all fees, there would be no income to offset. In effect, Medicare expenditures would not change, institutional revenues would decline, and physicians' incomes would increase. The AAMC believes the effects of imposing the offset are contrary to the public policy of encouraging schools and teaching hospitals to develop new sources of private revenues and, therefore, opposes the practice plans offset.

The Association recognizes that the proposed offset rule is a substantial change in HCFA policy. The only prior HCFA reference we can find for a practice income offset is stated in a HCFA deposition responding to interrogatories submitted by McDermott, Will and Emery as part of the discovery process in the case of Foster G. McGaw Hospital of Loyola University of Chicago vs. Blue Cross and Blue Shield Association/Health Care Services Corporation Intermediary, May, 1985. In its response, HCFA stated that Medicare policy considered faculty practice income, transferred from the faculty practice plan to university education and research accounts, as donor restricted gifts. HCFA stated these funds were subject to offset against the hospital's otherwise allowable clinical teaching salary costs under the provisions of 42 CFR 405.423, "Grants, Gifts and Income From Endowments" and section 607, Transfer of Funds to a Provider by Another Component of the Same Entity. The AAMC believes this HCFA deposition demonstrates that the offset currently being proposed has a new policy basis, the revenue of related organizations. While the Association strongly opposes such a policy for reasons discussed above, the new policy, if implemented, would clearly require prospective implementation only. It should not be applied to prior years to determine prospective payment rates for inpatient services or the per resident payment amount under the proposed regulations on direct medical education payments. Moreover, because the policy would be new and would not have existed at the time of the PPS and direct medical education base periods, adoption of the policy should not be used to reduce future payments by recalculating base period costs.

C. Payments to Physicians Not Using Interns and Residents

Under Section 948, Congress limited reasonable charge-based fees to physicians practicing in hospitals where at least 25% of the non-Medicare patients paid at least 50% of their charges. The underlying policy is that Medicare will pay reasonable charges where other patients are paying on the same or similar basis. If the patients are not paying above this threshold, compensation-related charges are imposed.

The draft regulations also propose to impose compensation-related charges where other patients are paying similar charges but where the physician does not use residents in the care of patients. This proposal is inappropriate for all teaching hospitals, but it would be especially burdensome to community teaching hospitals where all physicians may not involve residents in care of their patients. Under the regulations, a physician compensated by the institution for patient services who admits and cares for a patient without involving residents, would be paid on compensation-related charges while a physician involving residents would be paid using the special customary charge rules. The physician not using residents is disadvantaged economically when compared to either the physician in a non-teaching hospital who is paid on general reasonable charge rules or to the physician involving residents in the care of patients. There is no basis for disadvantaging the physician not using residents in this way. Therefore, the AAMC strongly recommends that where a physician in a teaching hospital does not involve residents in the care of patient, the physician should be paid using the general reasonable charge rules.

II. Other Issues

A. Personally Provided Physician Services (Section 415.170)

Intermediary Letter No. 70-7, published in January, 1970 states (in the response to question four) that "a physician qualifies for Part B payment only if he performs either: (1) activities set forth in IL372 as necessary to qualify as an "attending physician," or (2) "personal, identifiable medical services" (emphasis added). The February 7 regulations discuss extensively condition one: providing services under the attending physician provisions. There is no clear discussion of the eligibility for Part B fees for personally performed medical services, condition two. If the absence of this discussion of paying for personally performed services implies a change in HCFA policy, the AAMC opposes the change and requests that it be formally proposed in a separate Notice of Proposed Rulemaking. Otherwise, the Association requests HCFA to confirm that it still intends to pay on a reasonable charge basis for services personally provided by the physician.

B. Distinct Segment of Care (Section 415.174).

The February 7 proposed rule states a physician may qualify as a patient's attending physician if the services provided constitute a distinct segment of the patient's course of treatment and are long enough to require the physician to assume a substantial responsibility for the continuity of the patient's care. In Intermediary Letter 70-7, published in June, 1970, the example given for this policy involves a medical patient who is transferred to surgery. This is an appropriate example of a change in attending physicians when a change in clinical service occurs. A second basis for the change should also be recognized. In many teaching hospitals, attending physician responsibilities for a service rotate on either a weekly or monthly basis. For example, Dr. Smith is the attending physician in orthopedics in January. At the end of the month, Dr. Smith turns all of his patients and

his attending physician responsibilities over to Dr. Jones. This example illustrates how continuity of care in a teaching hospital is assured through assigning physicians on a rotating basis to a particular service for a distinct period of time. Patient care has been provided by two attending physicians, each provided a distinct segment of care. Continuity of care was preserved vis a vis the transfer of patient responsibility to the second physician. The Association recommends that HCFA permit a physician to attain "attending physician" status when the physician's responsibility for patients changes as a result of a formal, scheduled transfer of attending physician responsibilities.

C. Supervision Costs

Section 415.50 (a) (5) states, with respect to allowable cost a provider incurs for services of physicians, that "the costs do not include supervision of interns and residents unless the provider elects reasonable cost reimbursement as specified in Section 415.160." The AAMC notes that this rule is stated in the regulatory context of cost reimbursement elected for all physician services. Some reviewers, however, are interpreting this to mean that HCFA will disallow all supervision costs in all hospitals. The AAMC's interpretation is that this rule will not affect supervision costs under the per resident payments specified by the COBRA provisions for direct medical education costs. The Association requests verification of our interpretation of this section.

D. Presumptive Tests

The proposed regulation involves two statistical tests for physician fees. The first seeks to determine whether non-Medicare patients generally pay physician fees for personal medical services in the hospital. Under the law, Medicare fees are paid on a reasonable charge basis when 25% of the non-Medicare patients pay at least 50% of their billed physician fees. For the test, the law specifies Medicaid shall be considered full payment. In the interest of minimizing administrative costs for both HCFA and AAMC members, the AAMC recommends constructing the following series of presumptive tests:

Step 1: Payer Mix Test -- Medicaid Only.
If either the hospital or the faculty practice plan for teaching physicians can show that at least 25% of the non-Medicare patients were entitled to Medicaid, certify the hospital as meeting the 25/50 test.

Step 2: Payer Mix Test -- Third Party Payers
If either the hospital or the faculty practice plan for teaching physicians can show that the primary payer for at least 25% of the non-Medicare patients was Medicaid, Blue Shield and/or commercial insurance, certify the hospital as meeting the 25/50 test.

Step 3: Aggregate Payment Test
If the hospital or the faculty practice plan for teaching

physicians can show that fees collected for non-Medicare/non-Medicaid equal at least 50% of fees billed, certify the hospital as meeting the 25/50 test.

Step 4: 25% Payment Test

If the hospital or faculty practice plan for teaching physicians can show that the percentage of Medicaid patients plus the percentage of patients paying at least half of the fees billed exceeds 25%, certify the hospital as meeting the test.

These four steps have been sequentially designed so that a hospital meeting an earlier test would not have to furnish the more extensive data required for the later test. The AAMC encourages HCFA to adopt this approach for the 25/50 test.

The second statistical test is required by the special customary charge rules. Under the proposed rules teaching physicians are paid at the greatest of: 1) the charges most frequently collected in all or substantial part, 2) the mean of charges that are collected in full or substantial part, or 3) 85% of the prevailing charge. The billing entity has the opportunity to provide evidence supporting a customary charge greater than the 85% of the prevailing. The AAMC recommend that a simple, low cost method based on payer mix be devised for demonstrating eligibility for payments above the 85% presumption as follows:

- Step 1: If the largest group of non-Medicare patients is covered by a Blue Shield plan paying charges on the basis of usual, customary and reasonable fees, declare the physician eligible for 100% of the Medicare prevailing.
- Step 2: If the largest group of non-Medicare patients is covered by a Medicaid program paying charges on the basis of usual, customary and reasonable fees, declare the physician eligible for 100% of the Medicare prevailing.
- Step 3: If the largest group of non-Medicare patients is covered by commercial insurance with major medical coverage, declare the physician eligible for 100% of the Medicare prevailing.
- Step 4: If a majority of non-Medicare patients are covered by Blue Shield, commercial insurance with a major medical, and a Medicaid program paying at the Medicare prevailing, declare the physician eligible for 100% of the Medicare prevailing.
- Step 5: If the physician can show that fees collected for non-Medicare patients equal a defined percentage of the charges billed (perhaps 60%), declare the physician eligible for 100% of the Medicare prevailing.

In all cases, because physicians are reluctant to furnish income and patient data to government auditors or agents, the AAMC recommends allowing the physician or billing group to submit a report from a licensed CPA demonstrating compliance. The tests

proposed above are designed to be applied sequentially with those meeting an earlier test not having to meet a later one.

E. The 90% Cap on Customary Charges

When the law establishing the special customary charge rules for teaching physicians was amended in 1984, the minimum payment of 85% of the Medicare prevailing was raised to 90% if all physicians accepted assignment. While this was enacted to provide an inducement to accept assignment, it may have the opposite effect. In hospitals where at least one physician does not accept assignment, the physicians can submit data to be paid up to the level of the Medicare prevailing. If all physicians accept assignment, the law appears to limit payment to 90% of prevailing. To restore the incentive to accept assignment, the AAMC wishes to work with HCFA to submit a legislative proposal providing that where all physicians in a teaching hospital accept assignments, fees would be paid at no less than 90% of prevailing charge.

F. Reasonable Compensation Equivalent Limits.

HCFA is proposing to discontinue annual review and updating of the reasonable compensation equivalent limits (RCE) on the basis that the total amount of physician compensation costs subject to the RCE limits has been greatly reduced since the advent of the hospital prospective payment system. Because publications of the information requires little effort above that necessary for HCFA to make its own annual review, the Association recommends that HCFA continue to review, calculate and publish the reasonable compensation equivalent (RCE) limits on an annual basis.

G. Anesthesiology Attending Physician Requirements

Section 415.182 proposes to revise the regulations to provide that an attending physician relationship cannot be established if an anesthesiologist concurrently directs more than two interns or residents. The AAMC supports the proposal to limit charge payment to the medical direction of no more than two concurrent cases when residents or interns are involved.

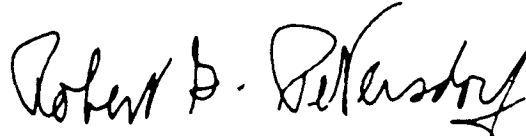
H. Outpatient Services

The proposed rules recommend modifying the attending physician criteria for services provided in all outpatient settings, including family practice and emergency department settings. The AAMC acknowledges HCFA's efforts to respond to the concerns physicians have had with the current attending physician criteria under IL-372 in the outpatient service areas. The Association welcomes these changes and regards the new criteria as essential in promoting the development of ambulatory care services in teaching hospitals.

The AAMC appreciates the opportunity to provide comments prior to issuance of a final rule on this subject. The Association would like to encourage maintaining an open dialogue with HCFA on the issues of concern discussed in this letter of comment. If HCFA

staff members would like clarification on any aspect of the AAMC's comments, please do not hesitate to contact James Bentley, Ph.D., Vice President or Robert D'Antuono, Staff Associate, Division of Clinical Services at (202) 828-0490. Thank you.

Very sincerely yours,

A handwritten signature in black ink, appearing to read "Robert G. Petersdorf". The signature is written in a cursive style with some loops and flourishes.

Robert G. Petersdorf, M.D.

1988-1989
AAMC COMMITTEE APPOINTMENTS

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

"Academic Medicine" Editorial Board

Paul F. Griner, MD
Strong Memorial Hospital
Rochester, NY

John E. Ives
St. Luke's Episcopal Hospital
Houston, TX

AIDS and the Academic Medical Center Committee

James J. Farsetta
Veterans Administration Medical Center
Brooklyn, NY

William H. Johnson, Jr.
University of New Mexico Hospital
Albuquerque, NM

Robert G. Newman, MD
Beth Israel Hospital
New York, NY

Audit Committee

J. Robert Buchanan, MD, Chair
Massachusetts General Hospital
Boston, MA

Executive Committee

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

Gary Gambuti
St. Luke's Roosevelt Hospital Center
New York, NY

Flexner Award Selection Committee

Andrew G. Wallace, MD
Duke University Hospital
Durham, NC

Governance and Structure Committee

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

Robert M. Heyssel, MD
Johns Hopkins Health System
Baltimore, MD

Investment Committee

Spencer Foreman, MD
Montefiore Medical Center
Bronx, NY

Robert M. Heyssel, MD
Johns Hopkins Health System
Baltimore, MD

Liaison Committee on Medical Education

Spencer Foreman, MD
Montefiore Medical Center
Bronx, NY

Management Education Programs Planning Committee

Jerome H. Grossman, MD
New England Medical Center, Inc.
Boston, MA

William B. Kerr
University of California, San Francisco,
Medical Center, CA

(AAMC) Nominating Committee

J. Robert Buchanan, MD
Massachusetts General Hospital
Boston, MA

(COTH) Nominating Committee

J. Robert Buchanan, MD, Chair
Massachusetts General Hospital
Boston, MA

Jeptha W. Dalston, PhD
Hermann Hospital
Houston, TX

Gary Gambuti
St. Luke's-Roosevelt Hospital Center
New York, NY

Resolutions Committee

John A. Reinertsen
University of Utah Hospital
Salt Lake City, UT

Task Force on Physician Supply

Committee on Implications of Physician
Supply Issues for Medical Student Education

Spencer Foreman, MD
Montefiore Medical Center
Bronx, NY

Committee on Implications of Physician
Supply Issues on Programs for the Education
of Biomedical Scientists

Paul F. Griner, MD
Strong Memorial Hospital
Rochester, NY

The following AAMC Committees are staffed by the Division
of Clinical Services

ad hoc Committee on Nursing Services
and the Teaching Hospital

Jerome H. Grossman, MD, Chair
New England Medical Center, Inc.
Boston, MA

James A. Block, MD
University Hospitals of Cleveland
Cleveland, OH

C. McCollister Evarts, MD
Pennsylvania State University
College of Medicine
Hershey, PA

Patricia Gibbons
Yale-New Haven Hospital
New Haven, CT

Martin Goldberg, MD
Temple University
School of Medicine
Philadelphia, PA

R. Edward Howell
Medical College of Georgia
Hospitals and Clinics
Augusta, GA

Anthony L. Imbembo, MD
University of Maryland
School of Medicine
Baltimore, MD

Max Poll
Barnes Hospital
St. Louis, MO

Helen Ripple
The Medical Center at the
University of California
San Francisco, CA

Barbara A. Small
Veterans Administration
Medical Center
Durham, NC

Carolyn Smeltzer
University of Chicago Hospitals
Chicago, IL

Advisory Committee on Medicare Regulations
for Payment of Physicians in Teaching Hospitals

Hiram Polk, Jr., MD, Chair
University of Louisville School of Medicine
Louisville, KY

L. Thompson Bowles, MD
George Washington University
School of Medicine
Washington, DC

Edward N. Brandt, MD
University of Maryland
Baltimore, MD

Ira C. Clark
Jackson Memorial Hospital
Miami, FL

Jack M. Colwill, MD
University of Missouri, Columbia,
School of Medicine
Columbia, MO

Martin G. Dillard, MD
Howard University School of Medicine
Washington, DC

Richard J. Gaitner, MD
Albany Medical College
Albany, NY

Richard A. Grossi, MD
Johns Hopkins University
School of Medicine
Baltimore, MD

Benjamin F. Kready
University of Texas Medical School
San Antonio, TX

Herbert Pardes, MD
Columbia University College of
Physicians and Surgeons
New York, New York

C. Edward Schwartz
Hospital of the University of Pennsylvania
Philadelphia, PA

Bruce Steinhauer, MD
Henry Ford Hospital
Detroit, MI

Donald B. Tower
Stanford University
School of Medicine
Stanford, CA

Stephen Wang, MD
Morristown Memorial Hospital
Morristown, NJ

I. Dodd Wilson, MD
University of Arkansas
College of Medicine
Little Rock, AR

Task Force on Physician Supply:
Committee on Implications of Physician
Supply Issues for Resident and
Fellow Education

Mitchell T. Rabkin, MD, Chair
Beth Israel Hospital
Boston, MA

William G. Anlyan, MD
Duke University School of Medicine
Durham, NC

Calvin Bland
St. Christopher's Hospital for Children
Philadelphia, PA

Ruth M. Covell, MD
University of California, San Diego,
School of Medicine, CA

Walter J. Daly, MD
Indiana University School of Medicine
Indianapolis, IN

Dunlop Ecker
Washington Hospital Center
Washington, DC

Donald G. Kassebaum, MD
University of Oklahoma College of Medicine
Oklahoma City, OK

Thomas C. King, MD
Columbia-Presbyterian Medical Center
New York, NY

Gerald S. Levey, MD
University of Pittsburgh School of Medicine
Pittsburgh, PA

Thomas P. Mullan
Veterans Administration Medical Center
Minneapolis, MN

Frank A. Riddick, Jr., MD
Alton Ochsner Medical Foundation
New Orleans, LA

Stefan Stein, MD
The Payne Whitney Clinic
Cornell Medical Center
New York, NY

Javier Vizoso, MD
University of California, San Diego,
Medical Center, CA

W. Donald Weston, MD
Michigan State University
College of Human Medicine
East Lansing, MI

Frank C. Wilson, Jr., MD
University of North Carolina
School of Medicine
Chapel Hill, NC

Commonwealth Fund Project Advisory Committee
Better Policy Analysis Capability for
Teaching Hospitals

John T. Dunlop, PhD, Chair
Harvard University
Cambridge, MA

Stuart H. Altman, PhD
The Heller School, Brandeis University
Waltham, MA

Richard A. Berman
McKinsey & Co.
New York, NY

Robert J. Blendon, ScD
Harvard University School of Public Health
Boston, MA

Don E. Detmer, MD
University of Virginia
Charlottesville, VA

William B. Kerr
University of California, San Francisco,
Medical Center, CA

Robert M. Heyssel, MD
President
The Johns Hopkins Health System
Baltimore, MD

Gerald S. Levey, MD
University of Pittsburgh School of Medicine
Pittsburgh, PA

William H. Luginbuhl, MD
University of Vermont College of Medicine
Burlington, VT

Joseph P. Newhouse, PhD
Harvard University
Boston, MA

Samuel O. Thier, MD
Institute of Medicine
Washington, DC

(Organizational Representatives)

Carol M. McCarthy, PhD, JD
American Hospital Association
Chicago, IL

James H. Sammons, MD
American Medical Association
Chicago, IL

Carl J. Schramm, PhD
Health Insurance Association of America
Washington, DC

Bernard R. Tresnowski
Blue Cross/Blue Shield
Chicago, IL