AAMC

ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

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Council of Teaching Hospitals
SELECTED ACTIVITIES REPORT

October 1989
Semiannual Report

Division of Clinical Services

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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

October 1989

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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

The Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges was formally established in 1965 to provide representation and services related to the special needs, concerns, and opportunities facing major teaching hospitals in the United States. The Council, governed by a fourteen-member administrative board, is the principal source of hospital input into overall Association policy and direction. Although approximately 1,300 hospitals are involved in graduate medical education in this country, the 420 COTH member institutions train over 80% of the residents in the United States.

COTH MEMBERSHIP CRITERIA

There are two categories of COTH membership: teaching hospital membership and corresponding membership. Both membership categories require the 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, but are not eligible to participate 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 are $10,000 for non-Federal hospitals, and $4,800 for Federal members. Dues for corresponding and Canadian members are $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. In 1988-89 Gary Gambuti, President, St. Luke's-Roosevelt Hospital Center in New York City, serves as Chairman of the Council of Teaching Hospitals. Mr. Gambuti will be succeeded as Chair for 1989-90 by Raymond G. Schultze, MD, Director, UCLA Medical Center.

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 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 hospitals 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 the 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 1990 COTH Spring Meeting will be held May 9-12 in Boston, Massachusetts; the COTH Session at the 1990 AAMC Annual Meeting will be held on Monday, October 22, in San Francisco.

LEGISLATIVE AND POLICY ISSUES

Hospital Payment Policies: Indirect Medical Education Adjustment

The AAMC continues to express to Congress and other federal policy makers its 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. 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.

Throughout 1989, 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 in testimony before the Subcommittee on Health of the House Committee on Ways and Means, with the Prospective Payment Assessment Commission (ProPAC) and with members of Congress. The analyses, which showed a significant adverse effect on the financial position of teaching hospitals, have been well received and have stimulated an open discussion on the impact of such a reduction on teaching

hospitals. AAMC staff expect to conduct on-going analyses of the importance of the IME adjustment to teaching hospitals for the federal fiscal year 1991 legislative cycle using data from the COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data, and from a similar survey that will be sent to affiliated hospitals with more than 100 residents belonging to COTH.

Medicare Payments for Direct Medical Education

On September 29, the Health Care Financing Administration (HCFA) issued the long awaited regulation that changed reimbursement for direct medical education costs from a passthrough amount to a per resident amount. As was stated in the proposed regulation published last year, the final regulation will be applied retroactively to cost reporting periods beginning during federal FY1985. The AAMC membership memorandum on these changes is included as Appendix G-6. The AAMC has retained legal counsel to analyze whether HCFA has the authority to apply the regulation retroactively and, if not, what types of challenges against it are likely to succeed.

On June 26, the Subcommittee on Health and the Environment of the House Energy and Commerce Committee, chaired by Congressman Henry Waxman (D-CA), reported out a budget reconciliation package for FY1990 that contains an amendment (the "Waxman amendment") to current law that, if passed, will result in a modification of the method for determining Medicare's payments for graduate medical education. To encourage hospitals to offer more primary care residencies, the Waxman amendment will change COBRA by weighting family medicine and primary care residents in internal medicine and pediatrics as 1.25 FTEs and non-primary care residents in internal medicine and pediatrics as 1.10 FTEs (Appendix G-4). Funding would be accomplished by placing a national cap on the per resident amount set at a level which would yield enough revenue to pay for the "bonus" payments so that Medicare would not incur additional costs.

The AAMC Administrative Boards and Executive Council discussed the proposed amendment at their September 1989 meetings. There was unanimous agreement that Mr. Waxman should be applauded for his efforts to find a way to encourage the practice of primary care medicine. However, it was felt that his amendment does not provide incentives for individuals to alter their specialty choice, but instead seeks to induce hospitals to offer additional primary care residency positions although currently primary care residency positions are going unfilled. The Executive Council voted that AAMC staff should work with Mr. Waxman's staff to find ways to attain the goal of increasing the number of primary care practitioners. Among the possibilities mentioned as physician incentives were loan forgiveness and higher reimbursement for primary care practitioners.

Medicare Reimbursement Controversies

The AAMC has begun collecting information on problems members are having with their

intermediaries regarding disallowance of costs for direct medical education and the counting of residents for purposes of the indirect medical education adjustment. To inform members of what is happening at other institutions, this information was compiled and sent to all COTH members; it is hoped that members will continue to notify the AAMC Division of Clinical Services of their reimbursement problems that relate to direct and indirect medical education so that the document can be updated periodically. The Division will act as a clearinghouse for members seeking other hospitals involved with similar issues for the purpose of providing assistance, disseminating information, or considering a group appeal.

Among the recurring issues that members face with their intermediaries are disallowances of costs for nursing and allied health programs if the hospitals is found not to be the "legal operator" of the program, and uncertainty as to the proper count to use for purposes of the indirect medical education adjustment. The AAMC has retained legal counsel to provide an opinion as to the legality of requiring that a hospital be the "legal operator" for purposes of allowing costs.

In an effort to keep members informed in the area of Medicare reimbursement, a one day conference is being planned for the end of November 1989 that will be aimed at Chief Financial Officers and Reimbursement Managers. The program will include a discussion of the new direct medical education regulation and the results of the legal analyses of the "legal operator" and retroactivity questions. Time will also be provided so that members will be able to discuss the situations at their institutions. An announcement of this conference will be forthcoming in late October.

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 teaching hospital. This 15-member Advisory Committee was charged with reviewing and considering the proposed Medicare rules issued February 7 in terms of their potential impact on teaching hospitals, medical schools, and faculty practice plans; identifying those provisions of the rules which are not acceptable in their present form to the AAMC membership or which require clarification; and recommending and assisting the AAMC in formulating appropriate comments to HCFA which express the concerns identified by this Committee and the membership at-large. The March meeting of the 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 included as Appendix G-1. Committee membership is listed in Appendix I.

A joint AAMC and Medical Group Management Association (MGMA) Advisory

Committee met July 21 in Washington, DC, to develop a national response to new Medicare claims-filing requirements developed by the Health Care Financing Administration (HCFA). HCFA has instructed regional carriers to require the name and provider number of the "referring, ordering, or rendering" physician on all claims submitted. The new requirements are intended to allow HCFA to expand data on Part B expenditures, and to monitor practice patterns of individual physicians, service volume, and the quality of care rendered to Medicare beneficiaries. Chaired by Ben Kready, faculty practice plan director, University of Texas, San Antonio, the committee debated the implications of the requirements and discussed the numerous problems that teaching hospitals and physician groups will encounter in their implementation. Originally, HCFA was to implement the new requirements as of October 1. However, subsequent meetings of AAMC staff with HCFA have resulted in a delay in implementation until April 1990.

Veterans Affairs Medical Centers

The AAMC continues to collaborate in the coalition, "Friends of the VA Medical Care and Health Research," to increase support for these programs at the Department of Veterans Affairs. The AAMC Office of Governmental Relations, in conjunction with the American Federation for Clinical Research, prepared a document setting forth a proposal for FY1990 funding for the medical care and health research budgets at the VA. This document, was sent to all members of Congress and formed the basis for Congressional testimony on behalf of the coalition. The AAMC testified on behalf of VA medical centers before several committees as shown in Appendix H.

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.

The 1989 COTH housestaff survey has been significantly revised. Stipend and benefit data are presented for those hospital characteristics most significant in determining variation in housestaff stipends and allows COTH members to compare themselves across multiple peer groups. Data are also presented for resident-to-bed ratios and distribution of minority housestaff.

Council of Teaching Hospitals Executive Salary Survey

This is an annual survey of compensation and benefits for chief executive officers, senior administrative staff, and departmental managers. The report is confidential and sent only to CEOs of member institutions. The forthcoming 1989 survey data book is in the process of being revised to present data in a more useful format.

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

This report is a special analysis of compensation and benefits for chief executive officers, senior administrative staff, and departmental managers within academic medical center hospitals. Hospitals are analyzed under public and private ownership and university-owned or freestanding status. The report is confidential and sent only to CEOs of COTH academic medical center hospitals.

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

This annual survey collects data on operational, financial, educational, and staffing characteristics of academic medical center hospitals for purposes of institutional comparison. The results of the survey are published in a confidential report sent only to CEOs of participating institutions. The survey also serves as one of several sources for The Commonwealth Fund supported AAMC project to build a teaching hospital database. Information from the COTH Survey also forms the foundation for the AAMC's advocacy efforts on behalf of teaching hospitals and provides data for several on-going research projects of national policy concern.

This survey reports operating statements from the most recently available fiscal year,

data on government appropriations, calculations of operating and total hospital margins, and ranked patient care expenses per discharge standardized by the Medicare wage and case mix indices. In addition, data are reported on Medicare prospective payment, case mix, 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 non-federal affiliated hospitals belonging to COTH with at least 100 residents.

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 directory 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 readership survey. In addition to a more readable and flexible format, the contents of the newsletter are undergoing a change as more data and topical pieces are included. More information on graduate medical education will be added in the near future, and plans are underway to develop expanded articles on topics of interest. The COTH Report is published six times yearly.

Issue Updates (Blue/Pink/Grey memoranda)

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

- Medicare Prospective Payment Regulations
- Medicare GME Payment Regulations
- Medicare Physician Payment Regulations
- Legislative Activities
- Prospective Payment Assessment Commission (ProPAC)
- Council on Graduate Medical Education (CoGME)

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; regulations to revise Medicare PPS for federal FY1989, increasing DRG prices and modifying the calculation of the wage index and outlier payments; HHS regulations on misconduct or fraud in science; House and Senate proposed tax code amendments; and regulations on Medicare's payment for direct graduate medical education costs. Under a new format introduced this year, memoranda are classified as ACTION items, ADVISORY items, and INFORMATION items to facilitate their use by members.

Special Publications

Teaching Hospitals: Multiple Roles, Diverse Characteristics

In July the first in a series entitled "Contemporary Issues of Teaching Hospitals" was published as the report, Teaching Hospitals: Multiple Roles, Diverse Characteristics. The report was written to help community and national leaders better understand the missions and features of teaching hospitals. It presents the missions and general organizational and financial characteristics of teaching hospitals. Support for the report was provided by The Commonwealth Fund of New York City. There is no charge for this report and over 5000 copies have been requested and distributed.

Medical Practice Patterns, Patient Outcomes and Quality of Care Assessment: A Selected Annotated Bibliography, September 1989

In response to plenary session presentations and member discussions at the 1989 COTH Spring Meeting, an annotated bibliography has been compiled of 77 recently published journal articles summarizing research on medical practice patterns, patient outcomes, and quality of care assessment. Uncertainty among physicians and lack of information among patients regarding the risks and benefits of particular medical services have been identified as major contributors to variations in medical care use and provision of inappropriate or unnecessary services. Many providers are examining these issues and developing methods for assessing and improving quality of care. Concurrently, third-party payers, patients, and others are seeking tangible measures of quality differences among providers. This bibliography provides an overview of these issues by summarizing the results of recent research on relationships among medical practice, patient assessment, and quality of care. It is designed to facilitate COTH hospital activities in this area of research.

TEACHING HOSPITAL DATA

AAMC/Commonwealth Fund Project

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, the 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 indirect medical education adjustment (IME). The database has also been used in three on-going 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 on the following pages.

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, chaired by Mitchell R. Rabkin, MD, President, Beth Israel Hospital, Boston, 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. Committee membership is listed in Appendix I.

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.

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 problems that range from the controversy over infectious/toxic waste disposal and community image to ethical responsibilities in the face of an epidemic. Several COTH member CEO's served on the AAMC Committee on AIDS which produced the report, "Policy Guidelines for Addressing HIV Infection in the Academic Medical Community," and its companion piece, "The HIV Epidemic and Medical Education. These reports re-enforce 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, and are currently available through the Association's Publications Department.

NURSING ISSUES

The nursing shortage is a major problem continuing to affect a large number of teaching hospitals in this country, 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.

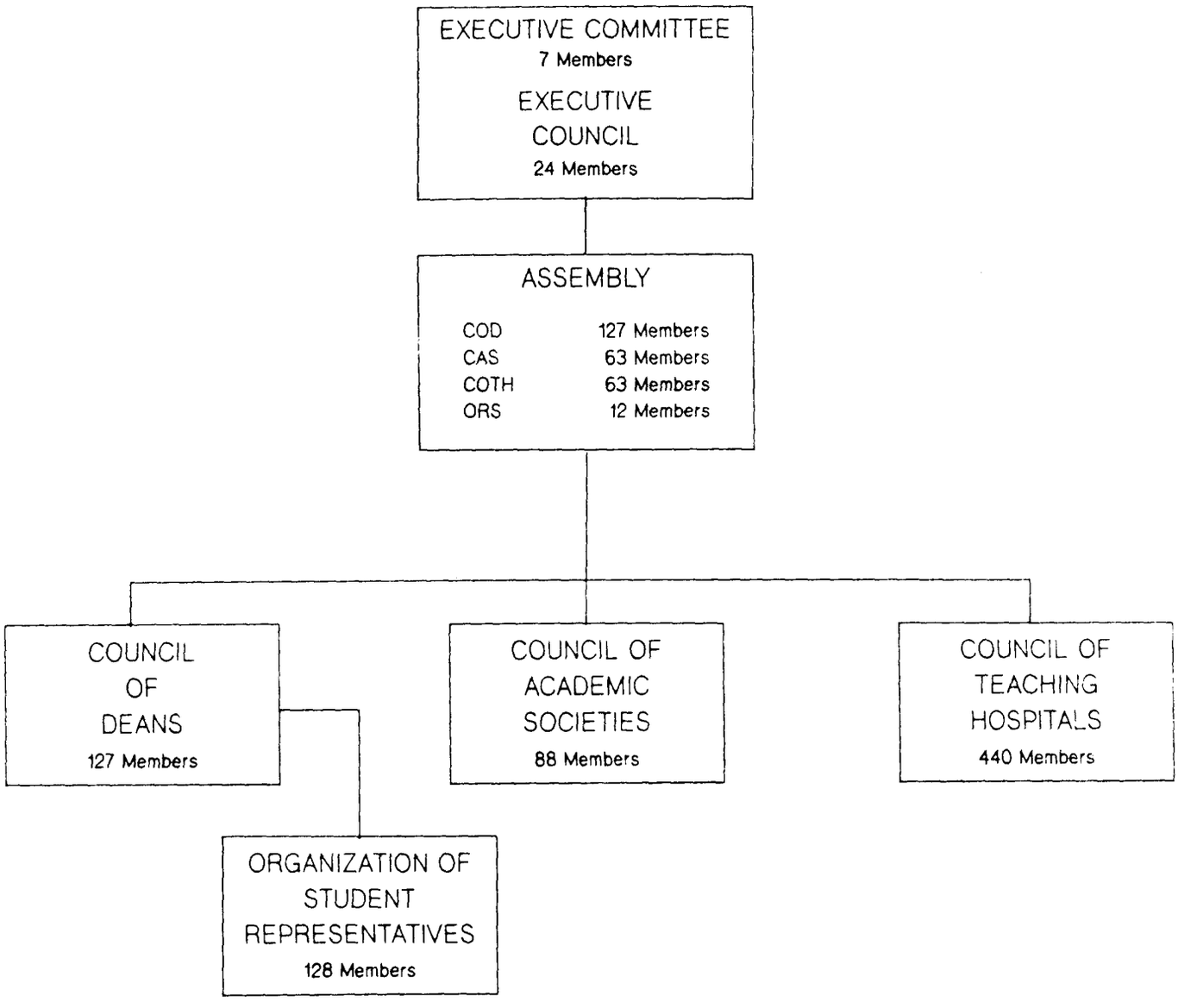
To educate the staff and the membership on new developments in nursing unique to the teaching hospital, the Association formed the ad hoc Committee on Nursing and the Teaching Hospital. Chaired by Jerome H. Grossman, MD, Chairman, New England Medical Center, Inc., it is comprised of CEOs and nursing directors from various COTH member institutions, a faculty chairman, and a deans, and a vice president for health affairs. This Committee met in February and again October 4, 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. It was agreed that the Committee should issue a report addressing the particular problems of nursing in the teaching hospital setting and should look at retention and recruitment of nurses, and the opportunities that teaching hospitals have to be leaders in the programs that are put into place. This report is expected to be finalized in 1990; members of this Committee are listed in Appendix I.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH GRANT AWARD

The National Center for Health Services Research (NCHSR) has awarded the AAMC a one-year grant of $63,600 for the research project, "AIDS and Medical Residency Selection in New York, San Francisco, and Los Angeles." This project, a cooperative effort of the AAMC's Divisions of Clinical Services and Operational Studies, uses data for 1983-1988 collected from several sources including the annual COTH Housestaff Survey and the AAMC's Student and Applicant Information Management System (SAIMS). The effects of the number of AIDS patients in teaching hospitals on the selection of graduate medical education training programs by location and specialty by graduating medical students will be analyzed, and preliminary data will be presented at the annual meeting of the American Public Health Association (APHA) in October.

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:

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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 T. Butler, M.D., Baylor College of Medicine
Chairman, CAS: Ernst R. Jaffe, M.D., Albert Einstein College of Medicine
Chairman, COTH: Gary Gambuti, St. Luke's-Roosevelt Hospital Center
President: Robert G. Petersdorf, M.D.

12/88

1988-1989
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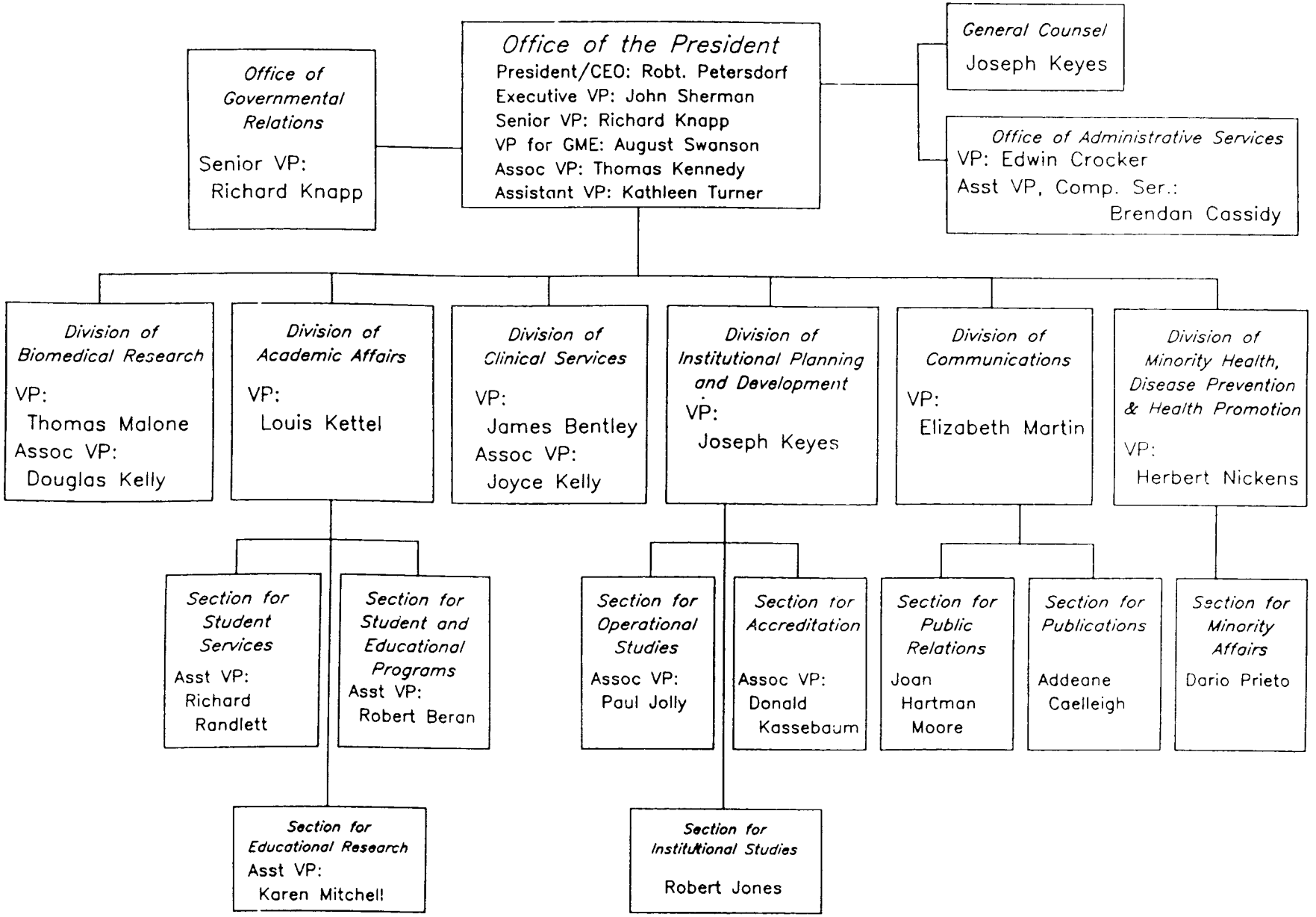
07/01/89

AAMC Organization Chart



1989

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202/828-0490

MEMORANDUM #89-27

ACTION

April 4, 1989

TO: Council of Deans
Council of Teaching Hospitals
Council of Academic Societies

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: Final Comments on Medicare Proposed Rules on Payment for Physician Services Furnished in Teaching Settings

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* ABSTRACT *
*
* This memorandum is a summary of the Association's official comments to *
* HCFA on the proposed rules on payment for physician services furnished *
* in teaching settings, issued February 7 (54 Federal Register 5946-5971). *
* All members are urged to submit comment letters to HCFA before the *
* 5:00 p.m. deadline on Monday, April 10. Since time is short, we advise *
* you to express mail all letters to assure timely delivery to HCFA, *
* Department of Health and Human Services, P.O. Box 26676, Baltimore, *
* Maryland 21207. A copy of your comments to HCFA should also be forwarded *
* to: G. Robert D'Antuono, Staff Associate, Division of Clinical Services, *
* AAMC, 1 Dupont Circle, NW, Suite 200, Washington, D.C. 20036. *
****

The AAMC comments to HCFA on the proposed rules, "Payment for Physician Services Furnished in Teaching Settings," emphasize three major issues and several other issues:

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. The AAMC recommends that

HCFA develop a "bright-line" definition distinguishing clearly the physicans 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.

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 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. 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. 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 effect 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. 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. For both statistical tests, the AAMC recommended that a simple, low cost method

based on payer mix be devised for compliance.

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. 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.

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

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 Association welcomes these changes and regards the new criteria as essential in promoting the development of ambulatory care services in teaching hospitals.

A copy of the Association's complete letter is available from the AAMC Division of Clinical Services. Also, should you require clarification of comments made by the Association, please contact Jim Bentley, Ph.D. or Robert D'Antuono, Division of Clinical Services at 202-828-0490.

Thank you.

cc: AAHC Members
Group on Faculty Practice
Group on Business Affairs (Principal Financial Officers)
Government Relations Representatives

Louis B. Hays
Acting Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-630-P
P.O. Box 26676
Baltimore, MD 21207

Dear Mr. Hays:

The Association of American Medical Colleges welcomes the opportunity to comment on the proposed rule, "Changes in Inpatient Hospital Prospective Payment System and Fiscal Year 1990 Rates." (54 Federal Register 19636). The AAMC represents the nation's major teaching hospitals, medical schools, faculty societies and faculty practice plans. The comments address three proposals: the reduction in DRG weights, the use of 1984 data to establish the labor wage index and outlier payment policies.

Reduction in DRG Weights

HCFA has proposed an across-the-board reduction of 1.35% in DRG weights. The proposal is based on a comparison of the case-mix values for 1988 discharges using both the FY1988 Grouper and the FY1986 Grouper. The value was found to be higher when the FY1988 Grouper was used. HCFA claims that "this demonstrates that changes we made to the Grouper program between FY1986 and FY1988, coupled with changes in hospital diagnostic and reporting practices made in response to those Grouper changes, inflated the case-mix and, therefore, program expenditures." (54 Federal Register 19645). HCFA concluded that "of the total increase in the case-mix value from FY1986 to FY1988 (that is, 6.4 percent), 1.35 percent is the result of recalibration and changes made to the Grouper program." (54 Federal Register 19646).

The AAMC objects to the proposed 1.35 percent cut for two reasons. First, HCFA offers no factual evidence to support its conclusion about the cause of the increase. There is no reason for HCFA to assume that the case-mix values under the new Grouper system should duplicate those of the old Grouper system. With better classification in the new system, one would expect some changes in distribution. The AAMC believes that the appropriate test for neutrality should be the database on which the new system is developed rather than a comparison based on two different systems.

Secondly, the AAMC sees the proposed reduction as an effort on the part of HCFA to reduce the update factor that Congress set by law. The effect of reducing the DRG weights is to reduce the payment updates, despite the fact that HCFA no longer has the discretion to set a PPS update.

Wage Index

As it did in the FY1989 proposed rule on changes to PPS (53 Federal Register 19498), HCFA is proposing that the wage index be computed using only 1984 data rather than the current blend of 1982 and 1984 data. The previous proposal was withdrawn when HCFA published the final rule so that the agency could "evaluate the relationship between changes in the wage index and aggregate prospective payments." (53 Federal Register 19498). However, HCFA has supplied no more information this year than last, so it is impossible to assess any evaluation HCFA may have done.

In the current proposed rule HCFA states that "our current analysis indicates that moving from a blended wage index to one based solely on 1984 data does not significantly impact aggregate prospective payments" (54 Federal Register 19646). The distributional effects are as important as the aggregate payment effect; thus, the AAMC believes that this is an inadequate basis on which to evaluate the impact.

A further problem is that since the method used for the analysis has not been published, it is impossible to assess the impact of the proposed change. AAMC recommends, as it did last year when this same proposal was made, that HCFA make its data and methodology publicly available and allow hospitals a 30 day comment period commencing with the publication of the wage indexes. More information is also needed to make a determination of whether this proposal is done in a budget neutral manner.

Also of concern is that the 1984 data used for the wage index are currently five years old. Much has happened within the health care industry during that time, including shortages in nursing and allied health professions, which have caused a huge escalation in salaries. The 1984 data do not reflect such significant changes. The AAMC is encouraged that HCFA is developing a survey to collect more current data and urges HCFA to wait until the survey methodology can be reviewed and the data are available before making changes in the wage index.

Outliers

There are two areas of concern regarding HCFA's proposals for changes in outlier payments. The first is that HCFA is keeping the total outlier pool at 5.1% and thus increasing outlier thresholds; the second is the reduction in the marginal cost factor from 90% to 60% for burn cases that are day outliers.

Research at Boston University, the University of Michigan and Johns Hopkins University has shown that at present the most practical method of recognizing severely ill patients and compensating hospitals for their care is an increase in the outlier pool. This would be accompanied by a reduction in outlier thresholds. The AAMC supports increasing the outlier pool, although recognizing that since changes in outlier payments must be accomplished in a budget neutral manner, it would be necessary to offset the increase by reductions in other PPS payments.

The AAMC is also concerned about the precipitous drop in payments for burn cases that are day outliers. If the proposed reduction is implemented it should be done over a period of several years to give those hospitals that will be most affected time to adjust to payment changes.

If you have any questions or need further information, please call James Bentley, Ph.D., Vice President for Clinical Services or Ivy Baer, J.D., M.P.H., Staff Associate, on my staff at 202-828-0490.

Very sincerely yours,

Robert G. Petersdorf, M.D.

MEMORANDUM # 89-49

ACTION

August 2, 1989

TO: Council of Teaching Hospitals
Council of Deans
Council of Academic Societies

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: Proposed Regulation on "Occupational Exposure to Bloodborne Pathogens"

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* ABSTRACT *
*
* This memorandum summarizes a proposed regulation of nearly 100 pages. *
* It covers all potential occupational exposures to bloodborne pathogens, *
* so its provisions apply to medical schools, research laboratories and *
* hospitals. The proposed regulation has extensive requirements con- *
* cerning the documentation of potential exposures, personal protective *
* equipment to be supplied to employees, medical treatment to be provided *
* free of charge, employee training and recordkeeping, some of which *
* may be particularly burdensome to educational institutions. *
*
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I. Background

On May 30 the U.S. Department of Labor's (DOL) Occupational Safety and Health Administration (OSHA) issued a proposed rule, "Occupational Exposure to Bloodborne Pathogens," (54 Federal Register pps. 23092-23139) that sets out standards for employers to follow to protect workers who have the potential of being exposed to AIDS, hepatitis B and other bloodborne diseases in the workplace. Among the requirements are that the Centers for Disease Controls universal precautions be followed, protective clothing and equipment be available, employees receive training about ways to minimize exposure and the hepatitis B vaccine be made available to employees free of charge. These, and other provisions, are described below.

The regulation which is currently in its proposed form will be effective 30 days after it is published as final. Although many hospitals may be currently complying with some of its requirements, such as following universal precautions, all hospitals must be aware that they will be required to comply

with all provisions of the regulation within 150 days of its final publication in the Federal Register. The OSHA estimates that the annual cost for each hospital to comply with the regulation will be about $33,000 and for research laboratories the cost will be about $6,300. No estimate is given for medical school compliance.

Comments must be received by August 14. They should be sent to Docket Officer, Docket No. H-370, Room N-2625, U.S. Department of Labor, 200 Constitution Ave, NW, Washington, DC 20210. The following hearings will be held on the regulation:

Washington, DC	September 12
Chicago	October 17
San Francisco	October 24

If you wish to testify, you must file a Notice of Intention to Appear by August 14 with Tom Hall at the address given above.

II. Major Provisions

The proposed regulation applies to all employees who have occupational exposures to blood and other potentially infectious materials. Its major provisions are described below:

1. Scope

It applies to all occupational exposure to blood and other potentially infectious waste (defined as semen, vaginal secretions, cerebrospinal fluid, synovial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures and any bodily fluid visibly contaminated with blood; unfixed tissue or organ; anything containing HIV or HBV cells or tissue)

2. Infection Control Plan

The employer must establish an infection control plan designed to minimize or eliminate employee exposure. The plan will:

- require an exposure determination that documents each task and procedure where there is the potential for occupational exposure to bloodborne pathogens
- contain a schedule and method of implementation
- be reviewed and updated as necessary to reflect significant changes in tasks or procedures
- be made available to the DOL and NIOSH

3. Methods of Compliance

The employer must adhere to a variety of methods of compliance:

- universal precautions must be observed, i.e., all human blood and certain human body fluids are to be treated as if they were infected with HIV, HBV or other bloodborne pathogens.

to use universal precautions if, in a particular circumstance, to do so would interfere with the proper delivery of health care or public safety services or would create a significant risk to a worker's personal safety. The employer still has the duty to assure that proper personal protective equipment is readily accessible to all employees at all times.

- engineering and work practice controls are to be examined or replaced on a regular schedule to ensure effectiveness. Engineering controls reduce employee exposure by either removing the hazard or isolating the worker from exposure. Work practice controls reduce the likelihood of exposure through changes in the manner in which a task is performed.

  For example, needles and other sharps are not to be sheared, bent, broken, recapped or resheathed by hand; needles are not to be removed from disposable syringes.

- The employer must provide personal protective equipment to employees who have the potential for exposure and for the cleaning, laundering or disposal of the equipment.

- The employer must assure that the worksite is maintained in a clean and sanitary condition. A written schedule must be established and implemented for cleaning and disinfection based on location within the facility, type of surface to be cleaned, type of soil present and tasks or procedures being performed.

4. HIV and HBV Research Laboratories and Production Facilities

There are more stringent requirements for HIV and HBV research and production facilities. For example, in HBV production facilities, work areas must be separated from other areas by two sets of doors to reduce the likelihood of accidental entry.

5. Hepatitis B Vaccination and Post Exposure Follow-up

Hepatitis B vaccine must be made available free of charge to employees who are occupationally exposed one or more times per month. There must also be appropriate medical follow-up after an exposure. HBV antibody testing is to be made available to an employee prior to deciding whether to receive the HBV vaccine. Following a report of an occupational exposure, medical evaluation and monitoring are to be made available to the employee. All medical records are to be kept confidential.

6. Information to be Provided to Employees

Employees must be given information about the hazards of bloodborne pathogens through the use of signs, labels, information and training. The training is to be provided at the time of initial employment or within 90 days after the effective date of this standard and at least annual thereafter. NOTE: Although this section of the proposed standard calls for training within 90 days of the effective date, the

implementation section calls for training within 150 days of the effective date. The final regulation will have to clarify this contradiction.

Work areas where there is the potential for exposure are to be labeled. Labels must also be put on containers of infectious waste, refrigerators and freezers containing blood and other potentially infectious materials and on containers used to store or transport such materials.

7. Recordkeeping

Employers must maintain records related to the hepatitis B vaccination and post exposure follow-up and training. Medical records are to be kept for the duration of employment plus 30 years.

Employers must also keep records on the dates of training sessions, contents or summary of the training session, names of persons conducting and attending the sessions. This record is to be retained for 5 years.

8. Schedule of Implementation of the Regulation

The regulation will be effective 30 days after the final rule is published in the Federal Register.

Within 90 days of the effective date of the regulation, employers will have to make a determination of exposure.

Within 120 days of the effective date, the infection control plan must be complete.

Within 150 days of the effective date, the following must be done: engineering and work practice controls put in place; personal protective equipment made available; standards are met for HIV and HBV laboratories and production facilities; HBV vaccine and post-exposure follow-up are available; hazards are communicated to employees via labels and training; recordkeeping put in place.

III. Issues for Members

There are several issues that members should consider raising in comment letters or testimony.

1. The standard is overly prescriptive. For instance, gowns, hoods and fluid resistant clothing are required "when the employee has a potential for occupational exposure." The word "potential" is undefined, leaving the possibility that a receptionist who accepts delivery of blood specimens may have to wear protective clothing or the employer may be cited for noncompliance.

2. The estimated per hospital cost of compliance, $33,000 annually, may greatly underestimate the actual cost. For example, no costs are attached for the development of training programs and related materials. These costs may be substantial and because knowledge about bloodborne pathogens is constantly changing, the programs

and materials may have to be revised often.

The cost estimate for hospitals does not distinguish between teaching and non-teaching hospitals. On average, teaching hospitals have about 2,500 employees and many more opportunities for workplace exposure than non-teaching hospitals, so the cost of compliance could be expected to be much higher.

3. The standard does not address whether it covers medical, dental, nursing or other allied health profession students or interns and residents. In view of the fact that students and interns and residents generally rotate in and out of many institutions during the course of their training, compliance may be very difficult for teaching hospitals if the proposed regulation applies to every person who spends any time working in an institution. For example, no one would argue against protecting students and interns and residents from potential exposure, yet if the institutions must keep medical records for 30 years for each student, the record-keeping requirements will become quite onerous. Also, must students and interns and residents receive training each time they rotate to a new institution?

   It should be noted that while the educational community considers interns and residents to be students, OSHA generally considers them to be employees. In terms of labor standards, the more difficult question is whether students will be covered under the provision of the regulation. OSHA should be asked to clarify who is to be covered.

OSHA has requested comments on the following:

- Whether the proposed definition of "other potentially infectious material" should be amended to make it consistent with CDC guidelines.

- Some employees feel that personal protective equipment interferes with their ability to perform their routine duties. How can these concerns be addressed without compromising the safety provided by barrier protection?

- Should there be additional requirements or should the proposed requirements be modified for "research laboratories" and "production facilities"? Could alternative provisions provide equivalent protection?

- Should OSHA leave the decision to use labels and signs designating a patient's infection status to the employer? Should OSHA prohibit the use of signs and labels stating a patient's HIV or HBV infection status? Should OSHA require the use of these signs and labels?

For more information please contact Ivy Baer, Staff Associate, Division of Clinical Services at 202-828-0490.

ADVISORY

MEMORANDUM # 89-54

August 29, 1989

TO: Council of Teaching Hospitals
Council of Deans
Council of Academic Societies

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: Proposed Amendment to Change Medicare Payments for Direct Medical Education

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Abstract: A House of Representatives Subcommittee has reported out an amendment that calls for weighting primary care residents as 1.25 FTEs and non-primary care residents in internal medicine and pediatrics as 1.10 FTEs for purposes of determining a hospital's Medicare reimbursement for direct medical education. It would also place a national cap on the per resident payment.

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On June 26 the House of Representatives' Health and the Environment Subcommittee of the Energy and Commerce Committee, chaired by Congressman Henry Waxman, reported out a budget reconciliation package for FY1990 that contains an amendment (the "Waxman amendment") to current law that, if passed, will result in a modification of the method for determining Medicare's payments for graduate medical education. The 1986 law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), which the Waxman amendment seeks to change has yet to be implemented.

COBRA was enacted to alter the basis for Medicare's payments for direct medical education from a pass-through amount to a per resident amount. In brief, it calls for each provider's per resident amount to be determined using the 1984-85 fiscal year and then to be updated annually by the Consumer Price Index. The per resident amount will then be multiplied by the provider's number of interns and residents(weighted as 1.0 FTE during a period of the initial residency plus one year, with a maximum of 5 years, and .5 FTE thereafter, regardless of specialty) to yield the aggregate approved amount. That amount will be multiplied by the ratio of the provider's Medicare inpatient days to total inpatient days and the result apportioned between Parts A and B to determine Medicare's payment. The regulations which will implement these changes were published in proposed form in September 1988, but final regulations have yet to appear.

To encourage hospitals to offer more primary care residencies, the Waxman amendment will change COBRA by requiring higher payments to hospitals for primary care and primary care specialty residents; the former would be weighted as 1.25 FTEs and the latter as 1.10 to determine a provider's aggregate approved amount. Funding would be accomplished by placing a national cap on the per resident amount so that Medicare would not incur additional costs.

Details of the proposed amendment and an analysis of its potential impact may be found in the attached question and answer paper.

The AAMC has not yet taken a position on the Waxman amendment, which we may support in whole, in part or not at all. The AAMC will be asked to adopt a position at the September 28 meeting of the Executive Council. Please contact Ivy Baer, Staff Associate, or James Bentley, Vice President, Division of Clinical Services, 202-828-0490 or Catherine Cahill, Legislative Analyst, or Richard Knapp, Senior Vice President, Office of Government Relations, 202-828-0410 with your comments and questions.

cc: Government Relations Representatives

QUESTIONS AND ANSWERS CONCERNING THE
PROPOSAL TO CHANGE
PAYMENTS FOR DIRECT MEDICAL EDUCATION*

Background

1. When did Medicare change the method for direct medical education payments from a cost-based system to a system based on a per resident amount?

Answer

The COBRA legislation (Section 9202) which was enacted in April 1986, and applies to hospital cost reporting periods beginning on or after July 1, 1985, changed the method of payments for direct medical education.

2. How does COBRA require residents to be weighted?

Answer

Under COBRA, a resident is weighted as 1.0 FTE for the resident's initial residency period plus one year, not to exceed a total of five years. Thereafter, the resident is weighted as .5 FTE.

COBRA Regulations

3. Have the regulations implementing this provision of COBRA been issued?

Answer

The regulations were proposed and published in the Federal Register on September 21, 1988. Final regulations have not yet been published.

4. Were any problems identified in the proposed regulations?

Answer

Yes. As proposed, the regulations are unclear as to the method to be used for counting interns and residents. Can interns and residents be counted if they are funded by a source that is totally separate from the hospital or if they serve in PPS exempt units? These questions were raised in a comment letter, but until final regulations are published they will not be answered.

* This proposal is found in the FY1990 House Energy and Commerce Committee Budget Reconciliation Package

Proposed Legislative Amendment

5. What are the provisions of the proposed amendment?

Answer

The amendment will make the following changes in COBRA provisions relating to payments to hospitals for direct medical education:

- o residents in general internal medicine, general pediatrics and family medicine will be weighted as 1.25 FTEs
- o all residents in internal medicine and pediatrics that are not in general programs will be weighted as 1.10 FTE
- o a national per resident payment limit will be set annually at a level to reduce the overall expenditure for direct medical education to hospitals in an amount equal to the total additional expenditures that will result from counting some residents as 1.25 FTE and some as 1.10.

6. When will the proposed legislative amendment be effective?

Answer

It will apply to residency years beginning on or after July 1, 1990.

7. What is the basic policy issue being addressed by the proposed amendments?

Answer

The imbalance between primary care and specialty care. There is a view that too many medical school graduates are choosing specialty and subspecialty residency programs at the expense of providing sufficient numbers of primary care physicians.

8. Has primary care been demonstrated to be undersupplied?

Answer

Using data supplied by the American Medical Association, the Council on Graduate Medical Education (COGME) in its July 1, 1988 report concluded that:

- o there is an undersupply of physicians in family practice
- o if current trends continue, "increasing shortages will result each year for general internists, while most other subspecialists in internal medicine will be in surplus"
- o currently there is an adequate supply of pediatricians but "if health care coverage is extended to substantial numbers of children who now lack it, the future supply of pediatricians could rapidly become only adequate or even inadequate."

- o "continued support and expansion of geriatric medical training are clearly warranted"

9. Why does the amendment not address other medical specialties that may be undersupplied?

Answer

The amendment is addressing the imbalance between primary care and specialty care. No effort is being made to make specialty-by-specialty changes.

10. Which residents will be assigned a weight of 1.25?

Answer

Primary care residents, i.e., those residents in family medicine, general internal medicine or general pediatrics will be counted as 1.25.

11. How will residents in general internal medicine and general pediatrics be defined?

Answer

The proposed amendment does not define a general internal medicine or a general pediatrics residency. Preliminary information indicates that residency positions which have been approved (regardless of whether they have been funded) under Title VII of the Public Health Service Act will be included. The Act awards primary care training grants for residents in general internal medicine and general pediatrics. It can be presumed that residents who are recipients of these grants would be included as general internal medicine or general pediatrics residents.

12. Which residents will be assigned a weight of 1.10?

Answer

Those residents (other than primary care residents, defined in question 10 above) in internal medicine or pediatrics. It is not clear, for example, whether a resident who is doing one year in internal medicine before going on to an anesthesiology internship would be assigned a weight of 1.10.

13. If a primary care specialty resident completes the required time in internal medicine or pediatrics, and goes into specialty training how will the resident be counted?

Answer

The proposed amendment does not affect current policy in this area. The resident will be counted as 1.10 FTE while in the internal medicine or pediatrics residency and then as 1.0 FTE while in the specialty residency until the COBRA limit of the initial residency plus one year is reached. At that point, the resident will be a .5 FTE.

14. Which medical specialties are used most frequently by Medicare beneficiaries?

Answer

According to an October 1988 Congressional Research Service report, "five physician specialties -- internal medicine, general surgery, radiology, opthamology and general practice -- account for over half of medicare physician spending."

15. Are there other disciplines who have historically taken the position that they should be included within the defi ition of "primary care"?

Answer

Yes. Representatives of the American College of Obstetrics and Gynecology and of Emergency Medicine have taken this position. There may be other disciplines that take this position as well.

16. Will the special treatment of geriatrics be affected?

No. Under COBRA, the time a resident spends in a geriatrics residency is not counted against the 5 year limitation for counting a resident as 1.0 FTE. During a geriatrics residency, the resident will be counted as 1.0 FTE; the five year limit will still be waived.

17. Will this proposal increase Medicare expenditures? Why or why not?

Answer

No, because the proposed amendment is budget neutral. As was described in Q.5, the amendment would establish a national per resident payment limit which will be set at a level to reduce the overall expenditure for direct medical education to hospitals in an amount equal to the total additional expenditures that will result from counting some residents as 1.25 FTE and some as 1.10.

18. Will non-primary care residencies get less money?

Answer

Not necessarily. For hospitals where the cost per-resident is at or below the national limit, there will be no reduction in payments for non-primary care residencies. Payments to hospitals where the cost per resident is above the national limit will be reduced.

19. Can the impact of the proposed amendment be estimated?

Answer

Yes. It is possible to take the residency positions offered in 1988 for family practice, internal medicine and pediatrics and derive a rough estimate of the impact in terms of the change in FTE positions that will be paid for by Medicare.

All family practice interns will be counted as 1.25 FTE. In the discussion that follows, it is assumed that 20% of internal medicine residents will be 1.25 FTE and 80% 1.10. It is also assumed that 50% of pediatrics interns will be counted as 1.25 FTE and 50% as 1.10 FTE. For purposes of this analysis it is assumed that all positions offered in 1988 were filled.

	Positions Offered 1988	Proposed Amendment 1.25 FTE	1.10 FTE
family practice	7,619	7,619	-
internal medicine	18,753	3,750	15,003
pediatrics	6,447	3,224	3,224
all others	51,474	0	0
TOTAL	84,293	14,793	18,227

14793 ÷ 4 = 3698 (number of "new FTEs positions" that must be funded to pay for the 25% increase weighting for primary care specialties)

18227 ÷ 10 = 1823 (number of "new FTE positions" that must be funded to pay for 10% increase in weighting for primary care specialty residents)

In 1988, for all specialties, 84,293 resident positions were offered. If the current proposal were enacted, an equivalent of 5,521 "new positions" would have to be funded to account for the 1.25 and 1.10 weightings, for a total of 89,814 funded positions. This is a 6.5% increase in positions. The money required for the "new positions" would be generated by setting a payment ceiling that would result in a 6.5% savings.

If only primary care residents (the 1.25 group) receive an increased weighting, 3,698 "new positions" will be created for a total of 88,591. This is a 4.4% increase in members of "positions." The money required for the "new positions" would be generated by setting a payment ceiling that would result in a 4.4% savings.

Two points must be noted: (1) the increases in "positions funded" must be done in a budget neutral way and (2) to expand the additional weighting factor to count some residents at 1.10, instead of limiting

the additional weighting to 1.25 for primary care residents only, leads to a 50% increase in "additional positions" to be funded.

20. What if the 10% or 25% "bonus" pushes a hospital's per resident payment over the national ceiling? (How is paragraph (F)(ii) to be interpreted?)

Answer

A hospital with a per resident amount at or above the national ceiling

can be paid more than the ceiling if it has residents who qualify for the extra 10% or 25%. However, if a hospital's cost per resident exceeds the national ceiling plus the "bonus", the hospital will not be paid the difference between its costs and the national ceiling plus the "bonus." For example, assume the national ceiling is set at $50,000 per resident. A hospital has a per resident cost of $75,000. It has residents in general internal medicine and general pediatrics each of whom is weighted as a 1.25 FTE. Medicare will pay the hospital $62,500 for each of these residents. However, that is $12,500 below cost for each resident.

Implications

21. What are the possible consequences of enacting this amendment?

Answer

- It could be viewed as the first step toward specialty by specialty funding
- If the 1.10 provision is enacted, it may encourage the expansion of subspecialty opportunities in internal medicine and pediatrics although no need has been demonstrated for additional subspecialty practitioners
- Teaching hospitals with a high volume of charity care should examine this proposal closely. These hospitals may have higher expenditures for faculty salaries because there may be more supervising physicians. This could cause the per resident amount to be high, probably exceeding the national ceiling that will be set. If these hospitals are not able to fund higher faculty expenditures, they will encounter great difficulty in attracting faculty and access to care may be limited.

ADVISORY

MEMORANDUM #89-56

September 14, 1989

TO: Council of Teaching Hospitals
Council of Deans
Council of Academic Societies

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: FY1990 PPS Regulations

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ABSTRACT: HCFA has just issued the final Prospective Payment System Regulations for FY1990. As of October 1, 1989 DRG weights will be reduced by 1.22 percent, the thresholds for day outliers and cost outliers will be increased, payments for burn outliers will be reduced and the wage index will be based solely on 1984 data. The indirect medical education adjustment remains at 7.7 percent.

****

On September 1, 1989 the Health Care Financing Administration (HCFA) published final regulations entitled "Changes to the Inpatient Hospital Prospective Payment System for Fiscal Year 1990 Rates" (54 Federal Register 36452). The final regulation is very similar to what was proposed in May. It will be effective on October 1, 1989.

The following are the major provisions of the regulation:

- All DRG weights were recalibrated using the charge data in the FY1988 MEDPAR file. Because HCFA believes the recalibration has inflated all DRG weights, **all weights have been reduced by 1.22 percent.**

- **No DRG rate update factors were published.** As the law currently stands, the update will be the marketbasket, but, as HCFA points out, Congress can legislate a different update factor. According to HCFA, "the legislatively mandated factors would automatically be applied to the rates regardless of whether a notice was published timely." In all likelihood the FY1990 Budget Reconciliation, which will be passed this fall, will contain an update of less than marketbasket for urban and large urban hospitals.

- **The wage index will be based solely on 1984 data** rather than on the current blend of 1982 and 1984 data.

- As required by law, **the indirect medical education adjustment will be at 7.7 percent unless Congress legislates a different adjustment in the FY1990 Budget Reconciliation bill.**

- The outlier pool is set at 5.1 percent of total prospective payments. To meet this lowered outlier pool the threshold for day outliers is raised to the geometric mean length of stay for each DRG plus the lesser of 28 days or 3.0 standard deviations. The cost outlier threshold is raised to the greater of 2 times the prospective payment rate for the DRG or $34,000.

- As proposed, **payments for burn outliers will be reduced from 90 to 60 percent of the marginal cost factor for day outliers only.** Cases that qualify as both day and cost outliers will be paid the greater of 60 percent of the per diem Federal rate for each day beyond the length of stay threshold or 90 percent of the difference between adjusted charges and the cost thresholds.

With the publication of this rule, HCFA took the opportunity to comment on Georgetown I, the court case that denied the Secretary of HHS authority to issue retroactive rules regarding malpractice insurance. As HCFA interprets the court case, the Secretary's authority to apply the 1986 rule prospectively is unaffected by the decision. "Therefore, the current hospital cost reporting forms properly incorporate the methodology to calculate reimbursement for malpractice premiums based on a risk portion and an administrative portion."

For more information contact Ivy Baer, staff associate, Division of Clinical Services, at 202-828-0490.

MEMORANDUM #89-66

ACTION

October 12, 1989

TO: Council of Teaching Hospials
Council of Deans
Council of Academic Societies

FROM: Robert G. Petersdorf, M.D., President

SUBJECT: Medicare Payment for Direct Medical Eduction Final Regulation

ABSTRACT

In 1986 Congress passed the Consolidated Budget Reconciliation Act that changed Medicare's reimbursement for direct medical education costs from a pass through amount to a per resident amount. HCFA has just issued the final regulation implementing the statutory provisions. The regulation will be applied retroactively to cost reporting periods beginning on or after July 1, 1985. Payments will be limited to the per resident amount determined for each hospital's base year, that is, cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984; it will be updated annually to account for inflation. Residents will be weighted as 1.0 FTE during the period of initial residency plus one year, not to exceed a total of 5 years; after that time, residents will be weighted as .5 FTE. Immediate attention must be given to this regulation which significantly affects the way that hospitals are reimbursed for their direct medical education costs.

On September 29, 1989 the Health Care Financing Administration issued a final regulation entitled "Changes in the Payment Policy for Direct Graduate Medical Education Costs" (54 Federal Register 40286) that implements provisions of the Consolidated Budget Reconciliation Act (COBRA) and the Omnibus Budget Reconciliation Act (OBRA). It will be codified in the Code of Federal Regulations at 42 CFR 413.86. This memorandum presents a synopsis of the major provisions of the final rule.

The rule which will be applied retroactively to cost reporting periods beginning on or after July 1, 1985, applies only to costs associated with approved medical, osteopathic, dental and podiatric residency programs. Although the rule changes the payment rules for direct medical education costs, it does not affect payments under the indirect medical education adjustment or payments to approved nursing and allied health training programs.

Major Provisions

1. Calculations for Determining Direct GME

Effective with cost reporting periods beginning on or after July 1, 1985, the determination of Medicare's payment for direct GME costs involves three calculations:

a. (an inflation adjusted per resident amount) x (weighted number of full time equivalent residents) = aggregate approved amount

b. (aggregate approved amount) x (Medicare inpatient days - total inpatient days) = Medicare's share of direct GME

c. Medicare's share is apportioned between Part A (hospital insurance) and Part B (supplementary medical insurance).Medicare will pay 100% of the Part A amount and 80% of the Part B amount.

Each of these computations is described below.

2. Determination of Aggregate Approved Amount

(a) Inflation Adjusted Per Resident Amount

COBRA requires the calculation of a hospital-specific per resident amount to be determined for each provider. The numerator for the calculation is based on the provider's allowable costs for its cost reporting period beginning during Federal fiscal year 1984 (October 1, 1983 through September 30, 1984).

In the preamble to the final rule HCFA discusses the determination of allowable costs. To be allowable GME costs the costs must be related to patient care furnished in the hospital and must be necessary for the clinical training function at the hospital. Among the activities of the faculty of a related medical school that are allowable are the supervision of interns and residents in activities for which no Part B charge is made and the conducting of rounds and patient care conferences related to hospital patients.

All overhead associated with GME programs will be payable only through the per resident amount, regardless of actual costs incurred, based on the overhead costs during the base period. Overhead costs incurred in connection with approved nursing and allied health programs will be reimbursed on a reasonable cost basis.

The denominator for the calculation of the base period per resident amount is the average number of FTE residents working in the health care complex during the GME base period. If documentation for interns and residents' schedules is not included in the intermediary's work papers (on Worksheet B-1), the hospital will be required to present additional documentation to determine the base year count. Hospitals will be required to count all residents working in their facility even if the residents' salaries are fully paid by other entities, whether Federal or non-Federal. This methodology will apply to both the GME base

period and cost reporting periods subject to the new payment methodology. Residents assigned to excluded units, hospital-based skilled nursing facilities and other providers and subproviders of the health care complex are to be counted.

For cost reporting periods beginning October 1, 1983, through May 31, 1984, the average per resident cost will be updated by the Consumer Price Index (CPI-U) to account for inflation in the year between the base period and the first fiscal year subject to the regulation. For cost reporting periods beginning June 1, 1984 through September 30, 1984, no update is necessary because the base period is followed immediately by the first cost reporting period subject to the regulation. For all cost reporting periods beginning on or after July 1, 1985, but before July 1, 1986, the per resident amount determined for the base period is to be updated by one percent. For cost reporting periods after July 1, 1986, the amount will be updated based on changes in the CPI-U. HCFA will publish actual and projected update factors for the CPI-U in the Federal Register before July 1 of every year. Attached to this memorandum in Table 1 are the actual update factors for cost reporting periods beginning on or after July 1, 1985 and before July 1, 1988. Table 2 contains the projected update factors for cost reporting periods beginning on or after July 1, 1988. AAMC staff is concerned that the actual updates published by HCFA for cost reporting periods beginning July 1, August 1 and September 1, 1986 are too low. We are looking into this matter and will notify members if there is further information to report.

For hospitals that were not participating in Medicare during the base period or that had no approved GME program during the base period, the per resident amount will be determined differently. The intermediary will establish an average per resident amount based on the lower of the actual graduate medical education costs of the hospital during the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period or the mean value of per resident amounts of hospitals located in the same wage area.

(b) Counting Full-Time Equivalent Residents

(i) Approved Medical Residency Program

The Act defines an approved medical residency program as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty..." The regulation defines an approved program as one "that is approved by one of the national accrediting bodies set forth in section 1861(b)(6) of the Act or that may be counted toward certification in a specialty or subspecialty cited in the 1985-1986 Directory of Residency Training Programs published by ACGME." HCFA believes that this provision does not affect its ability to recognize additional types of residency programs and has included residencies in subspecialty programs in internal medicine that were not listed in the 1985-86 ACGME Directory. Also, effective, July 1, 1989, HCFA is adding three types of programs to its approved list: Surgical Critical Care Medicine, Anesthesiology Critical Care Medicine and Critical Care Medicine (internal medicine). Furthermore, any fellowship program that meets the requirements of an approved program in geriatric medicine as defined by the Secretary will also be included in this definition. Hospitals

will be paid for fellows in approved programs on the same basis as residents in approved programs.

For residents or fellows who are in programs that are not listed in the '85-'86 "Green Book," and that are not now approved by the ACGME, hospitals are paid 80% of the reasonable costs of training services (salaries and salary-related fringe benefits) after payment of the Part B deductible by the Medicare beneficiary. No program overhead costs in connection with such residents are payable.

(ii) Counting Residents: Where the Resident's Time is Spent

The rule defines FTEs based on the total time necessary to fill a residency position rather than on a specific number of hours worked. If a resident spends time in more than one hospital, the resident's time is to be prorated between or among the hospitals where he/she works based on the number of days, or portions of days, worked at each facility. Part-time residents will be counted based on the proportion of time worked compared to the average time spent by others in the same year training in the same specialty program.

In determining the FTE count, HCFA will require hospitals to include in the FTE count residents for whom the hospital incurs no salary/stipend costs, such as residents in Veterans Administration or Department of Defense programs at civilian hospitals or residents whose stipend is paid solely with university or practice plan funds.

For residency periods beginning on or after July 1, 1987, the time spent by a resident in a non-hospital setting will be counted if two conditions are met: (1) there is a written agreement between the hospital and the non-hospital provider to the effect that the hospital pays for the resident's compensation in the outside setting and (2) the resident's time is spent in patient care activities. If a hospital has such an agreement with a non-hospital entity, the indirect medical education count will be reviewed to ensure that non-hospital residents have not been included.

(c) Weighting Factors

Weighting will involve two factors: an overall limit on the number of years that a resident may be counted as 1.0 FTE and whether a resident is a graduate of a foreign medical school.

(i) "Initial Residency Period"

The weighting factor for the "initial residency" period will be 1.0 FTE. The initial residency period is the minimum period needed for board eligibility plus one year, not to exceed a total of five years. As required by the Act, the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education will be used to determine the period of board eligibility. The Act permits changes in the initial residency period beginning July 1, 1989 if the ACGME increases or decreases the minimum number of years for board eligibility in its revised directory. Each year HCFA will publish a notice in the Federal Register before July 1 listing limits on initial

residency periods for the academic year beginning on July 1. Once the period of board eligibility plus one year is met, the resident will be counted as .75 FTE from July 1, 1986 through June 30, 1987 and as .5 FTE thereafter. Attached to this memorandum (Tables 3 and 4) is a list of the recognized residency programs and the period of initial residency that is recognized for each.

If a residency requires five years, such as surgery, the weight of 1.0 will be attached to the full five years but not to an additional year, so that the total number of years does not exceed the maximum five year period. During the additional year the surgical resident will be weighted as .5 FTE.

As required by the Act, geriatric fellowship programs will be an exception to the initial residency period. Time spent in a geriatric fellowship program will not be counted against a resident's initial residency period. In other words, an individual will be fully counted during the basic specialty program needed to gain entrance to a geriatric fellowship, the geriatric fellowship itself, and one additional year.

If a transitional year is required for a residency, such as the clinical base year needed before training can begin in anesthesiology, the transitional year is added to the years needed for the specialty training itself to determine the necessary years for the training programs, as long as the total does not exceed five years. If a resident does a transitional year simply to gain a broader base of clinical experience and the transitional year is not required by the resident's specialty, then the transitional year counts as the additional year beyond the minimum number of years of training that is required for board certification.

If a resident switches residency programs, the "initial residency period" will be counted using the period of time allotted to the first residency, plus one year.

If a resident takes time off to pursue research and laboratory work, the resident is not in an approved residency program, so the time is not counted for direct graduate medical education costs.

(ii) Counting FMGs

Under the Act, a resident who is an FMG and who otherwise qualifies by being in an initial residency period will be considered to have a weighting factor of 1.0 only if the individual has passed parts I and II of the Foreign Medical Graduate Examination in Medical Sciences or has received a certification from, or passed an examination of, the Educational Commission for Foreign Medical Graduates before July 1, 1986. In lieu of passing FMGEMS, an FMG may pass Parts I and II of the National Board of Medical Examiners. Any FMG whose residency begins on or after July 1, 1986 and who by the date the residency begins has not met the criteria for FMGs will not be counted at all. Once the criteria are met, the FMG will be counted on the same basis as any other resident for the remainder of his or her program.

3. Medicare's Share of Direct GME Costs

(a) Patient Load

To determine Medicare's share of GME costs, the rule requires a calculation that is made by dividing total Part A inpatient hospital days for all components of a health care complex that are classified as part of the hospital by total inpatient hospital days (i.e., both Medicare and non-Medicare inpatient days). Nursery days are excluded for the purpose of determining total inpatient hospital days and, consistent with this, no GME costs that are allocated to the nursery room cost center in the GME base period will be included in the GME base-period per resident amount. The inpatient days would include inpatient days of the hospital that are payable under Part A and would exclude inpatient days applicable to hospital based skilled nursing facilities and intermediate care facilities. Hospital inpatient days of Medicare beneficiaries whose hospital stays are paid by risk-basis health maintenance organizations are recorded as non-Medicare days.

(b) Misclassified and Nonallowable Costs

Due to a concern that in the past "there have been some questionable costs erroneously reimbursed through the direct medical education pass through", HCFA has added provisions about misclassified and nonallowable costs. Misclassified costs are defined as those costs that were treated in the base period as allowable GME costs, but should have been paid as allowable operating costs. For example, if the salary for a physician who managed the intensive care unit and did no resident supervision was reported as a GME cost, the physician's salary would be reclassified as an allowable operating cost. A nonallowable cost is defined as a cost which may not be reported as either a GME cost or an allowable operating cost. Examples of nonallowable costs are physician compensation costs that should be paid on a Part B reasonable charge basis.

HCFA has instructed intermediaries to reexamine Federal FY1984 GME costs and to request supporting documentation in questionable cases. Hospitals will be able to appeal HCFA's determination of the propriety of their base period amounts. Appeals of average per resident amounts are limited to appeals of the FY1984 GME costs or resident counts. Appeals of the per resident amount must be made within 180 days of the intermediary's notification that the per resident amount is HCFA's final determination. HCFA considers the per resident amount determination a separate process from the settlement of GME payments made on or after July 1, 1985. The provider will still be able to appeal the count of residents for the cost reporting year in question or the application of the update factor in the settlement of GME payments.

When costs are determined to be nonallowable, overpayments will be recouped for costs reporting periods beginning in Federal FY1984 and any prior or subsequent cost reporting period in which similar circumstances exists.

In the case of misclassified costs, the reopening of settled cost reports will be for the sole purpose of correcting a misclassification of operating costs as GME costs. The reopening will be done only at the request of the hospital so that the hospital specific rate can be adjusted upward whenever the retroactive disallowance of misclassified GME costs would result in no payments for what are otherwise allowable operating costs of the hospital. Overpayments

will not be recouped nor underpayment paid for PPS years no longer subject to reopening; however, payments may be recouped or paid for cost reports still subject to reopening.

4. States Formerly under the Medicare Waiver

Special provision is made for New York State so that it can change the state-mandated but atypical order in which it allocates administrative and general costs to the order specified in the Medicare costs report. As a result, there will also be an adjustment of direct graduate medical education costs.

5. Hospitals Electing Cost Payment for Physicians' Direct Medical and Surgical Services to Medicare Beneficiaries

The Act permits hospitals to elect payment on a reasonable cost basis for physicians' inpatient medical and surgical services to Medicare beneficiaries if they agree not to bill for charges for those services. For hospitals that made the election for cost reporting periods beginning prior to October 1, 1983, both physician's services and any resident and intern supervision incident to furnishing those services were treated separately and paid through a special payment arrangement during the base year. Since there is no documentation of the amount of time spent delivering patient services and in supervision, supervision is not reflected in the per resident amounts paid under the direct GME costs but is reimbursed separately on a reasonable cost basis.

If a hospital elected reimbursement on a reasonable costs basis after Federal FY1984, costs of supervision would be included in the intern and resident cost center and therefore would be part of the calculation of the per resident amount. For these hospitals, HCFA will adjust the per resident amounts for GME to reflect proportionately lower costs.

6. End Stage Renal Disease (ESRD) Exception Criteria

While Medicare has allowed an exception to ESRD rates based on medical education costs, the exception will now be eliminated because the per resident payment approach is to be used for all GME payments and exception payments made after July 1, 1985 will be reclaimed.

7. Removal of Limit on Costs

As called for in the legislation, the regulation will remove a paragraph from a previous regulation so that the Secretary of Health and Human Services will be prohibited from imposing limits on allowable costs of medical education other than as specifically prescribed by law.

8. 180 Day Appeals Period

It is critical that hospitals realize that if costs reported on the cost report have been misclassified, they have 180 days after notification of the base-period average per resident amount to present sufficient evidence to the intermediary to justify a charge. If an intermediary is satisfied that a

modification to a hospital-specific rate is appropriate, the rate will be modified retroactively to the provider's first cost reporting period under PPS.

If a hospital is notified that some items on its cost reports are nonallowable, the provider has 180 days to appeal the decision.

9. Lesser of Costs-or-Charges

For outpatient services paid on a cost reimbursement basis, HCFA's policy is to pay the lesser of costs or charges. The rule is suspended if charges are determined to be nominal. For purposes of determining whether or not charges are nominal, reasonable costs will include GME payments. However, if the hospital can demonstrate to the intermediary that its actual reasonable GME costs are greater than its GME payments, the actual costs may be used in applying the nominality test.

10. Retroactive Application of the Regulation

Included as part of the preamble is HCFA'S analysis of why the regulation must be applied retroactively. First, HCFA relies on the "straightforward statutory language" that requires the new payment methodology to be applied "to hospital cost reporting periods beginning on or after July 1, 1985." HCFA believes that the legislative history supports this interpretation.

HCFA finds the retroactive application of the regulation to be consistent with last year's Supreme Court decision in Bowen v. Georgetown University Hospital that held that an agency may not apply a regulation retroactively without the authorization of Congress. According to HCFA, the language of COBRA provides sufficient authority.

Finally, HCFA argues that the retroactive application of the regulation is also required by "equitable considerations." Since COBRA was enacted the agency claims that "all of HCFA's actions respecting direct medical education costs have been consistent with its stated intention to apply the new payment method beginning on the effective date of the new statute."

The AAMC has retained legal counsel to do an analysis of the legality of the retroactive application of the regulation. Members will be sent more information as soon as it is available.

11. Record-Keeping Requirements

Hospitals must furnish the following information for each resident included in the FTE count:

-- name and social security number;

-- type of residency program and number of years the resident has completed in all types of residency programs;

-- dates the resident is assigned to the hospital and any hospital-based providers;

-- dates the resident is assigned to other hospitals, other freestanding providers and any nonprovider setting;

-- name of the medical, osteopathic, dental or podiatric school from which the resident graduated and the date of graduation;

-- if the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of this regulation; and

-- the name of the employer paying the resident's salary.

For more information, contact Ivy Baer, Division of Clinical Services, 202-828-0490.

Table 1

UPDATE FACTORS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 1985 AND BEFORE JULY 1, 1988

Cost reporting period	Update factor [1]
7/1/85 to 6/30/86	1.0100
8/1/85 to 7/31/86	1.0100
9/1/85 to 8/31/86	1.0100
10/1/85 to 9/30/86	1.0100
11/1/85 to 10/31/86	1.0100
12/1/85 to 11/30/86	1.0100
1/1/86 to 12/31/86	1.0100
2/1/86 to 1/31/87	1.0100
3/1/86 to 2/28/87	1.0100
4/1/86 to 3/31/87	1.0100
5/1/86 to 4/30/87	1.0100
6/1/86 to 5/31/87	1.0100
7/1/86 to 6/30/87	1.0146
8/1/86 to 7/31/87	1.0210
9/1/86 to 8/31/87	1.0303
10/1/86 to 9/30/87	1.0378
11/1/86 to 10/31/87	1.0386
12/1/86 to 11/30/87	1.0365
1/1/87 to 12/31/87	1.0393
2/1/87 to 1/31/88	1.0426
3/1/87 to 2/29/88	1.0436
4/1/87 to 3/31/88	1.0453
5/1/87 to 4/30/88	1.0453
6/1/87 to 5/31/88	1.0443
7/1/87 to 6/30/88	1.0405
8/1/87 to 7/31/88	1.0394
9/1/87 to 8/31/88	1.0393
10/1/87 to 9/30/88	1.0390
11/1/87 to 10/31/88	1.0389
12/1/87 to 11/30/88	1.0397
1/1/88 to 12/31/88	1.0413
2/1/88 to 1/31/89	1.0402
3/1/88 to 2/28/89	1.0417
4/1/88 to 3/31/89	1.0425
5/1/88 to 4/30/89	1.0425
6/1/88 to 5/30/89	1.0442

[1] The update factor for a specified cost reporting period is applied to the prior period's per resident amount and, for cost reporting periods beginning on or after July 1, 1986, accounts for the 12-month average change in the CPI-U ending at the midpoint of the specified cost reporting period.

Table 2

PROJECTED UPDATE FACTORS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 1988, TO BE USED FOR INTERIM PAYMENT PURPOSES ONLY

Cost reporting period	Updated factor [1]
7/1/88 to 6/30/89	1.0416
8/1/88 to 7/31/89	1.0416
9/1/88 to 8/31/89	1.0416
10/1/88 to 9/30/89	1.0436
11/1/88 to 10/31/89	1.0436
12/1/88 to 11/30/89	1.0436
1/1/89 to 12/31/89	1.0453
2/1/89 to 1/31/90	1.0453
3/1/89 to 2/28/90	1.0453
4/1/89 to 3/31/90	1.0465
5/1/89 to 4/30/90	1.0465
6/1/89 to 5/31/90	1.0465
7/1/89 to 6/30/90	
8/1/89 to 7/31/90	
9/1/89 to 8/31/90	
10/1/89 to 9/30/90	
11/1/89 to 10/31/90	
12/1/89 to 11/30/90	
1/1/90 to 12/31/90	
2/1/90 to 1/31/91	
3/1/90 to 2/28/91	
4/1/90 to 3/31/91	
5/1/90 to 4/30/91	
6/1/90 to 5/31/91	

[1] The projected update factor for a specified cost reporting period is to be used for interim payment purposes only and is applied to the prior period's per resident amount. The actual update factor will be published in a future notice and is to be used for final settlement purposes. The projected update factors are based on estimates prepared for HCFA by Data Resources, Inc. on a quarterly basis. The forecasted percent changes in the CPI-U over the previous 12-month period serve as the proxy behind the All Other NonLabor Intensive portion of the hospital input price index used in the Medicare prospective payment system.

Table 3

INITIAL RESIDENCY PERIOD
LIMITATIONS EFFECTIVE JULY 1, 1985
THROUGH JUNE 30, 1989

Specialties	Initial residency period
Medicine	
Allergy & Immunology	4
Diagnostic Laboratory Immunology	4
Anesthesiology	5
Colon and Rectal Surgery	5
Dermatology	5
Dermatopathology	5
Emergency Medicine	4
Family Practice	4
Internal Medicine	4
Cardiology	4
Endocrinology and Metabolism	4
Gastroenterology	4
Hematology	4
Infectious Disease	4
Medical Oncology	4
Nephrology	4
Pulmonary Disease	4
Rheumatology	4
Neurological Surgery	6
Nuclear Medicine	5
Obstetrics and Gynecology	6
Ophthamology	6
Orthopaedic Surgery	5
Otolaryngology	5
Pathology	5
Blood Banking	5
Chemical Pathology	5
Dermatopathology	5
Forensic Pathology	6
Hematology	5
Immunopathology	5
Medical Microbiology	5
Neuropathology	6
Radioisotopic Pathology	5
Pediatrics	4
Pediatric Cardiology	4
Pediatric Endocrinology	4
Pediatric Hematology-Oncology	4
Pediatric Nephrology	4
Neonatal-Perinatal Medicine	4
Physical Medicine/Rehabilitation	5
Plastic Surgery	5
Preventive Medicine	4
Psychiatry and Neurology	5
Child Psychiatry	5
Radiology	5
Nuclear Radiology	5
Surgery	5
General Vascular Surgery	5
Pediatric Surgery	5
Thoracic Surgery	5
Urology	5

Table 4

INITIAL RESIDENCY PERIOD
LIMITATIONS EFFECTIVE JULY 1, 1989 [1]

Specialties	Initial residency period
Medicine	
Allergy & Immunology	4
Diagnostic Laboratory Immunology	4
Anesthesiology	5
Critical Care Medicine	5
Colon and Rectal Surgery	5
Dermatology	5
Dermatopathology	5
Emergency Medicine	4
Family Practice	4
Internal Medicine	4
Cardiology	4
Critical Care Medicine	4
Endocrinology and Metabolism	4
Gastroenterology	4
Hematology	4
Infectious Disease	4
Medicine Oncology	4
Nephrology	4
Pulmonary Disease	4
Rheumatology	4
Neurological Surgery	5
Nuclear Medicine	5
Obstetrics and Gynecology	5
Ophthalmology	5
Orthopaedic Surgery	5
Otolaryngology	5
Pathology	5
Blood Banking	5
Chemical Pathology	5
Dermatopathology	5
Forensic Pathology	5
Hematology	5
Immunopathology	5
Medicine Microbiology	5
Neuropathology	5
Radioisotopic Pathology	5
Pediatrics	4
Pediatric Cardiology	4
Pediatric Endocrinology	4
Pediatric Hematology-Oncology	4
Pediatric Nephrology	4
Neonatal-Perinatal Medicine	4
Physical Medicine/Rehabilitation	5
Plastic Surgery	5
Preventive Medicine	4
Psychiatry and Neurology	5
Child Psychiatry	6
Radiology	5
Nuclear Radiology	5
Surgery	5
Critical Care Medicine	6
General Vascular Surgery	5
Pediatric Surgery	5
Thoracic Surgery	5
Urology	5

AAMC TESTIMONY - 1989

1. **ADMINISTRATION'S PROPOSED FY 1990 BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION.** Presented by Kenneth I. Shine, M.D. Dean, University of California, Los Angeles, School of Medicine, before the House Committee on Veterans' Affairs, February 9, 1989.

2. **ADMINISTRATION'S PROPOSED FY 1990 BUDGET FOR THE DEPARTMENT OF VETERANS AFFAIRS VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION.** Presented by Arthur K. Asbury, M.D., Acting Dean, University of Pennsylvania School of Medicine, Milton Corn, M.D., Dean, Georgetown University School of Medicine, Washington, D.C., John M. Dennis, M.D., Dean, University of Maryland School of Medicine and Kenneth I. Shine, M.D., Dean, UCLA School of Medicine, before the Senate Committee on Veterans' Affairs, March 6, 1989.

3. **ADMINISTRATION'S FY 1990 BUDGET PROPOSAL TO REDUCE THE INDIRECT MEDICAL EDUCATION ADJUSTMENT.** Submitted to the Senate Committee on Budget, March 8, 1989.

4. **POSITIONS ON THE ADMINISTRATION'S FY 1990 BUDGET PROPOSALS TO REDUCE THE INDIRECT THE MEDICAL EDUCATION (IME) ADJUSTMENT AND DIRECT MEDICAL EDUCATION PAYMENTS.** Presented by J. Robert Buchanan, M.D., General Director, Massachusetts General Hospital, before the House Ways and Means Subcommitte on Health, April 11, 1989.

5. **FY 1990 VA FUNDING.** Presented by Richard Behrman, M.D., Vice President for Medical Affairs and Dean, Case Western Reserve University School of Medicine, before the House Appropriations Subcommittee on Veterans Affairs, Housing and Urban Development, and Independent Agencies, May 2, 1989.

6. **FY 1990 BUDGET FOR THE MEDICAL CARE AND RESEARCH PROGRAMS OF THE DEPARTMENT OF VETERANS AFFAIRS.** Presented by Dr. Irving H. Fox, Director, Kughn Clinical Research Center, University of Michigan Medical School on behalf of the Friends of the VA, before the Subcommittee on Veterans Affairs, Housing and Urban Development, and Independent Agencies, Committee on Appropriations, United States House of Representatives, May 2, 1989.

7. **FY 1990 APPROPRIATIONS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.** Presented by Aram V. Chobanian, M.D., Dean, Boston University School of Medicine, before the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, May 3, 1989.

8. **FY 1990 APPROPRIATIONS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.** Presented by D. Kay Clawson, M.D., Executive Vice Chancellor and Executive Dean, University of Kansas Medical Center, before the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, May 4, 1989.

9. **RURAL HEALTH AND MEDICAL EDUCATION.** Presented by Tom M. Johnson, M.D., Associate Dean, College of Human Medicine, Michigan State University, before the Health Personnel Work Group of the National Advisory Committee on Rural Health, May 15, 1989.

10. **FY 1990 FUNDING FOR DEPARTMENT OF VETERANS AFFAIRS.** Presented by John Dennis, M.D., Vice President for Academic Affairs and Dean, University of Maryland School of Medicine, before the Senate Appropriations Subcommittee on Veterans Affairs, Housing and Urban Development, and Independent Agencies, May 19, 1989.

11. **NATURE AND SCOPE OF PROGRAMS TO ATTRACT AND SUPPORT MINORITIES IN BIOMEDICAL RESEARCH.** Presented by Thomas E. Malone, Ph.D., Vice President for Biomedical Research, Association of American Medical Colleges, before the National Institutes of Health, April 20, 1989.

12. **HEALTH RESEARCH FACILITIES CONSTRUCTION.** Presented by David R. Challoner, M.D., Vice President for Health Affairs, University of Florida College of Medicine, and Glenn A. Langer, M.D., Associate Dean for Research, UCLA School of Medicine, before the Senate Labor and Human Resources Committee, July 24, 1989.

13. **NEED ANALYSIS SIMPLIFICATION AND RELATED ISSUES.** Presented by Michael S. Katz, University Director of Student Financial Aid, University of Medicine and Dentistry of New Jersey, before the Advisory Committee on Student Financial Assistance, August 14, 1989.

14. **THE DEPARTMENT OF VETERANS' AFFAIRS RESEARCH PROGRAM.** Presented by Joseph H. Bates, M.D., Chief Medical Service, McClellan VA Medical Center, before the U.S. House of Representatives, Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, October 11, 1989.

1988-1989
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