



**ASSOCIATION OF  
AMERICAN  
MEDICAL COLLEGES**

**AGENDA**

**COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD MEETING**

**June 15, 1989**

**7:30a-12:30p**

**Washington Hilton Hotel**

**Map Room**

## 1989 COTH ADMINISTRATIVE BOARD

Chair: Gary Gambuti  
St. Luke's-Roosevelt Hospital Center

Chair-Elect: Raymond G. Schultze, MD  
UCLA Medical Center

Immediate Past Chair: J. Robert Buchanan, MD  
Massachusetts General Hospital

Secretary: John E. Ives  
St. Luke's Episcopal Hospital

Calvin Bland  
St. Christopher's Hospital for Children  
Jerome H. Grossman, MD  
New England Medical Center, Inc.  
Leo M. Henikoff, MD  
Rush-Presbyterian-St. Luke's Medical Center  
William H. Johnson, Jr.  
University of New Mexico Hospital  
Sister Sheila Lyne  
Mercy Hospital & Medical Center  
James J. Mongan, MD  
Truman Medical Center  
Robert H. Muilenburg  
University of Washington Hospitals  
Max Poll  
Barnes Hospital  
C. Edward Schwartz  
Hospital of the University of Pennsylvania  
Barbara A. Small  
Veterans Administration, Durham  
Alexander H. Williams  
AHA Representative

## COTH MEETING DATES

### COTH 1989 ADMINISTRATIVE BOARD MEETINGS

June 14-15- The Washington Hilton Hotel, Washington, DC

September 27-28- Same

### COTH SPRING MEETINGS

May 9-11, 1990

The Lafayette Hotel, Boston, MA

### AAMC ANNUAL MEETINGS

October 28-November 2, 1989

The Washington Hilton Hotel, Washington, DC

October 20-25, 1990

The San Francisco Hilton Hotel, San Francisco, CA

November 8-14, 1991

The Washington Hilton Hotel, Washington, DC

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

June 14-15, 1989  
Washington Hilton Hotel  
Washington, DC

WEDNESDAY, June 14, 1989

- 6:00p JOINT ADMINISTRATIVE BOARDS SESSION  
Guest Speaker: Harvey Barkun, MD  
Executive Director, Association of  
Canadian Medical Colleges of  
Jefferson West Room
- 7:00p COTH ADMINISTRATIVE BOARD RECEPTION/DINNER  
Jefferson East Room

THURSDAY, June 15, 1989

- 7:30a COTH ADMINISTRATIVE BOARD BREAKFAST MEETING  
Guest Speaker: John A. Gronvall, MD  
Chief Medical Director, Veterans  
Administration Central Office  
Map Room
- 12:30p JOINT ADMINISTRATIVE BOARDS LUNCHEON  
Cabinet Room
- 1:30p EXECUTIVE COUNCIL BUSINESS MEETING  
Military Room

**COTH ADMINISTRATIVE BOARD MEETING**

**June 15, 1989**

**7:30a-12:30p**

**Map Room**

**Washington Hilton Hotel**

**Washington, DC**

- I. CALL TO ORDER** **John A. Gronvall, MD**  
**Chief Medical**  
**Director, VACO**
- II. OFFICERS AND STAFF REPORTS**
- A. AAMC President's Report** **Dr. Petersdorf**  
**B. COTH Chairman's Report** **Mr. Gambuti**  
**C. Division of Clinical Services' Report** **Dr. Bentley**
- III. CONSIDERATION OF MINUTES** **Page 1**
- IV. ACTION ITEMS**
- A. COTH Spring Meeting**
- o **Evaluation of Format Changes for COTH Spring Meeting** **Page 8**
- o **Preferences for 1991/1992 COTH Spring Meeting Sites** **Page 9**
- o **Followup to Breakout Sessions 1989 COTH Spring Meeting** **Page 12**
- B. September Board Meeting Speaker** **Page 15**
- C. AAU Report on Indirect Costs** **Dr. Sherman**  
**Executive Council**  
**Agenda - Page 23**
- V. DISCUSSION ITEMS**
- A. AAMC Positions on Public Policy Issues** **Executive Council**  
**Agenda - Page 24**

**Continued...**

- |    |   |  |
|----|---|--|
| B. | Conflict of Interest                          | Executive Council<br>Agenda - Page 68                  |
| C. | A Single Examination for<br>Medical Licensure | Dr. Kassebaum<br>Executive Council<br>Agenda - Page 26 |
| D. | APHIS Proposed Animal<br>Welfare Regulations  | Executive Council<br>Agenda - Page 70                  |

**VI. INFORMATION ITEMS**

- |    |   |         |
|----|---|---------|
| A. | 1989 Annual Meeting<br>COTH Session Program   | Page 16 |
| B. | PINK MEMO: "Final Comments on<br>Medicare Proposed Rules on Payment<br>for Physician Services Furnished<br>in Teaching Settings" (#89-27) | Page 17 |
| C. | BLUE MEMO: "Proposed Medicare<br>PPS Regulations" (#89-38)  | Page 20 |
| D. | Letter to AHME Representative   | Page 24 |

**VII. ADJOURNMENT**

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COTH ADMINISTRATIVE BOARD MEETING  
February 23, 1989

PRESENT

Calvin Bland  
Gary Gambuti  
Leo M. Henikoff, MD  
John E. Ives  
Sister Sheila Lyne  
James J. Mongan, MD  
Robert H. Muilenburg  
Max Poll  
Raymond G. Schultze, MD  
C. Edward Schwartz  
Alexander H. Williams

ABSENT

J. Robert Buchanan, MD  
Jerome H. Grossman, MD  
William H. Johnson, Jr.  
Barbara A. Small

GUEST

Bruce Steinwald

STAFF

James D. Bentley, PhD  
Janet Bickel  
Joanna Chusid  
Linda E. Fishman  
P. Ridgway Gilmer, MD  
Robert F. Jones, PhD  
Joyce V. Kelly, PhD  
Richard M. Knapp, PhD  
Herbert W. Nickens, MD  
Robert G. Petersdorf, MD  
Kathleen S. Turner  
Melissa H. Wubbold  
Stephen C. Zimmermann

COTH ADMINISTRATIVE BOARD  
MEETING MINUTES

Washington Hilton Hotel  
February 23, 1989

I. CALL TO ORDER

Gary Gambuti called the meeting to order at 7:30a in the State Room of the Washington Hilton Hotel. He welcomed the Administrative Board and introduced the morning's guest speaker, Bruce Steinwald, Deputy Director of the Prospective Payment Assessment Commission (PropAC).

Mr. Steinwald gave a brief history of the Commission, how it is staffed, and of whom its membership is comprised. Additionally, he also reviewed the Commission's charge and gave a brief overview of the prospective payment system (PPS) payment formula as shown in the handout included in these minutes as Attachment A.

Much of Mr. Steinwald's presentation dealt with the Administration's proposed reduction in the indirect medical education adjustment from the current 7.7% (at a .10 resident to bed ratio) level to 4.4%. PropAC analysis of PPS3 cost data shows with such a reduction, the incremental Medicare costs of serving a large fraction of low-income patients would be covered by the disproportionate share adjustment. Implementation of the reduction would redistribute PPS payments, however, with substantial revenue losses for major teaching hospitals. These institutions tend to have relatively high PPS margins but tend to demonstrate low overall margins at 50% under other averages.

After careful consideration and review of appropriate data from the AAMC and American Hospital Association, PropAC recommends that a reduction to 4.4% is too abrupt a change and is supporting a budget neutral reduction to 6.6%, the savings from which should be returned to the base for all hospitals. Additionally, the Commission recommends that changes in future years should be based on further analysis of improved data. Mr. Steinwald noted that realistic assessment of the current demands cannot be optimally met using 1984 data, and that attention needs to be given to the teaching commitment, suggesting that perhaps the resident/intern to bed ratio is not the optimal formula.

He concluded his presentation by stating that it was unlikely the Administration would accept PropAC's recommendations as they stood

and that the 6.6% budget neutral figure was not a likely outcome of the reconciliation process. However, he doubted that the opposite extreme of 4.05% would be passed, and that informed lobbying and an updated and improved information base would effect a compromise in this figure.

Mr. Gambuti thanked Mr. Steinwald for his efforts. Dr. Mongan, a member of the Commission, also thanked Mr. Steinwald, complimenting the high quality and performance of the ProPAC staff, and summed up the primary obstacles he believes the industry is facing with this issue: 1/ the national deficit; 2/ previous large teaching hospital profit margins still looming large in the Administration's mind; 3/ current high relative margins for teaching hospitals; and 4/ the "black box" regression formula. Dr. Mongan felt that the regression formula is currently surrounded by a mysticism that needs to be defused, and that teaching hospitals are becoming too vulnerable in their concentration on the IME and should seek other elements such as the outlier pool and updating the urban wage index on which to focus.

## II. PRESIDENT'S REPORT

Dr. Petersdorf thanked Mr. Steinwald for his participation and indicated that he believed AAMC/COTH should take a stand on the IME issue, and continue to support the position of no further budgetary cuts to the Medicare system.

He then welcomed new COTH Administrative Board members, Calvin Bland of St. Christopher's Hospital for Children, Philadelphia; Sister Sheila Lyne of Mercy Hospital and Medical Center, Chicago; and Rob Muilenburg, University of Washington Hospitals, Seattle. He followed with a brief summary of the Governance and Structure Committee meeting the previous day, and identified members of that committee as John Colloton, University of Iowa Hospitals and Clinics, Chair; Richard Janeway, MD, Bowman Gray School of Medicine; Robert Heyssel, MD, The Johns Hopkins Health System; Edward Stemmler, MD, University of Pennsylvania Medical Center; and Virginia Weldon, MD, Washington University School of Medicine. The Committee is charged with reviewing the current governance structure of the Association with particular attention to such issues as Council membership, changing the Association's name, and the role of housestaff in the AAMC. In his review of the Executive Committee meeting, also on the 23rd, he referenced the strategic planning document that set forth the AAMC mission statement, strategic goals, legislative objectives, and proposed activities for the Association. This document was mailed with the council agendas prior to the meetings. Dr. Petersdorf noted that the AAMC



anticipates closing on a new building site at 24th and N Streets, NW, Washington, in the near future with a moving date targeted for early 1991. Lastly, he briefly recounted the AAMC/AAHC Forum proceedings from the previous afternoon. He noted that the Group on Faculty Practice was a topic raised, but discussion was diluted by the results of an AAHC survey showing that the majority of university practice plans were responsible to the dean of the medical school. He described the meeting as good, candid, and nonadversarial.

Dr. Petersdorf concluded his remarks by encouraging the Council of Teaching Hospitals to be comfortable within the AAMC, advocating interaction between segments of the Association through meetings and other activities toward the good of academic medicine.

### III. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes from the November 14, 1988 COTH Administrative Board Meeting in full.

### IV. CHAIRMAN'S REPORT

Mr. Gambuti also welcomed the new board members and gave a brief overview of the AAMC structure, describing the three Councils and the Organization of Student Representatives. He described the Council of Teaching Hospitals as an advisory body to the AAMC Executive Council, the Association's Advisory Board, and noted that the COTH Administrative Board had four representatives to that Council in the chair, chair-elect, immediate past chair, and a member-at-large.

He then asked each board member to introduce themselves and describe their institution. This roundtable exchange gave rise to discussion of the Medicaid crisis including unreasonable rates of reimbursement and unrealistic eligibility criteria. The program was described as a "systemic problem" that is finally being brought to the attention of the federal government as being, in fact, a long-term care program for the chronically ill.

The financial problem was perceived as being bigger than Medicaid, however, with the ever growing number of the uninsured poor. The majority of these individuals are working; the large number of new jobs being touted by the Administration over the last 8 years has greatly increased the number of working uninsured.

V. DISCUSSION OF PROPOSED MEDICARE URBAN-RURAL DIFFERENTIAL

Dr. Bentley gave a synopsis of the AAMC/AHA tiered rate discussion on the proposed Medicare urban-rural differential. This discussion is referenced in his correspondence with Carol McCarthy, President, American Hospital Association, and appears in the February 23 COTH Administrative Board Agenda. The AAMC at this time continues to support the tiered rate (large/urban, urban/rural) approach until adequate adjustments for non-labor costs and severity are available.

He noted the three legislative issues currently of most concern to the Association are: 1/the tiered rate approach to the urban-rural differential; 2/ any reduction in the 7.7% IME adjustment; and 3/ continued inclusion of the disproportionate share adjustment in PPS. These and other lesser priorities are included in the February 23 agenda.

Mr. Williams added his support of AHA/AAMC relations on these issues and praises the efforts these issues have generated on both fronts.

Discussion of these legislative issues prompted Dr. Knapp to encourage Board and Council members to make a point of visiting an appropriate contact on the Hill every time they are in Washington. It is crucial to keep the Congress and their staff updated on the issues and though this type of push has not traditionally been in keeping with AAMC activities, the time has come to make this effort.

Enthusiastic discussion on the possibilities ensued and Mr. Bland noted that this type of activity is historically part of the National Association of Children's Hospitals and Related Institutions' (NACHRI) annual meeting; Mr. Muilenburg suggested these visits become a block of scheduled and committed time on future Administrative Board agendas, and Mr. Gambuti proposed that these visits be instituted at either the June or September meetings. Mr. Williams suggested inviting respective members of Congress to homeplate institutions.

The legislative topic was concluded with deliberation on the fundamental issues at the root of problems being faced by the healthcare industry today. Mr. Muilenburg raised the issue of facing the responsibility for the immense expenses incurred in massive technology acquisition and where these expenses lead; Dr. Schultze concurred, raising the conflict between NIH research and development versus the implementation cost of and payment for a

clinical procedure. He suggested that COTH/AAMC provide some leadership in addressing these paradoxes in an effort to avoid facing the same problems in perpetuity. Dr. Knapp submitted that these solutions should come from Congress, and the AAMC is most probably not the organization to address these incongruities. Mr. Schwartz cautioned against taking on nonsequiturs and trying to link unrelated issues.

Mr. Gambuti suggested that perhaps this was something to be addressed in the Association's strategic plan and summed up the major points of the discussion, those being 1/ support of AAMC position on prevailing legislative issues; 2/ congressional visits; 3/ need to focus and put strengths behind immediate issues.

#### VI. AIDS COMMITTEE REPORT

The Board complimented AAMC staff on the content and sensitivity of this report.

**ACTION:** It was moved, seconded, and carried to approve Committee recommendations and implementation plan as outlined in the Executive Council agenda.

#### VII. AAMC FRAMEWORK DOCUMENT FOR INSTITUTIONAL POLICIES AND PROCEDURES TO DEAL WITH MISCONDUCT IN SCIENCE

This was described as a multi-organizational document created in order to develop guidelines for the industry before mandatory regulations are put in place. This document notes that the focus is changing from outright fraud in research to conflict of interest issues. It is directed primarily at those institutions which have no current guidelines in place, guidelines being difficult to implement after the fact.

**ACTION:** It was moved, seconded, and carried to approve the recommendation provided in the Executive Council agenda for review and revision of the document for distribution to AAMC constituency.

#### VIII. ETHICS IN PATIENT REFERRAL ACT

Mr. Gambuti raised the question of whether the Association should take an out front position on the issue, or be one of "part of the chorus." Dr. Schultze felt that this act was primarily aimed at health care institutions and centers rather than private groups,

and that the AAMC should be at the front of the chorus. Mr. Williams noted that the American Medical Association (AMA) is heavily involved with this issue, and advised paying close attention to testimony and development of bills to avoid the passing of legislation unfavorable to teaching hospitals.

It was agreed to follow the course of this legislation closely, and to be involved in the process as is appropriate.

**IX. RECOMMENDATIONS FOR THE FORMAT AND CONTENT OF THE 1991 MCAT**

After a brief review of the MCAT Committee charges and revision recommendations, the Board took the following action.

**ACTION:** It was moved, seconded, and carried to support the proposed action as presented in the February 23 Executive Council agenda, approving the recommendations of the MCAT Evaluation Panel and Advisory Committee.

**X. GROUP ON FACULTY PRACTICE RULES AND REGULATIONS**

In keeping with GFP recommendation for approval of these rules and regulations, the Board took the following action.

**ACTION:** It was moved, seconded, and carried to recommend Executive Council approval for said rules and regulations.

**XI. DISCUSSION OF AAMC AD HOC COMMITTEE ON NURSING AND THE TEACHING HOSPITAL**

Dr. Bentley described the makeup of the committee and distributed a list of members, included in these minutes as Attachment B. He noted that the Committee is chaired by Dr. Grossman and includes COTH CEOs James Block, Ed Howell, and Administrative Board member, Max Poll. The Committee examined the nursing situation at their respective institutions in an attempt to identify the specific characteristics of teaching hospitals which contribute to problems in nurse staffing. These include the 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. He believed the meeting had been productive, and though the nursing issue is being well investigated by a number of other organizations, the committee felt that specific attention needs to

be paid to nursing issues in the academic setting. An issue paper exploring the reasonableness of the nursing workload, alternative structures for nursing roles, and relationships between hospital nursing services and nursing education programs is being developed by the Division.

#### XI. STAFF REPORT

Jim Bentley opened his quarterly staff report by distributing copies of the final program for the 1989 COTH Spring Meeting in San Diego. He noted that staff had been able to obtain space for a Saturday morning session and had reprogrammed the meeting as the Board had recommended in November. With the program organized to include two breakout sessions, Board members were asked to volunteer to serve as discussion leaders.

In reporting on staff activities, Jim Bentley noted the AAMC Directory had been revised, as requested by the Administrative Board, to include COTH members and the five senior executive for each institution. Unfortunately, the current format for the Directory is difficult to read, but the next edition, scheduled for publication in the fall, will feature a revised format for easier use. He also noted the COTH Report is being revised as a result of a readership survey, the report of the annual Executive Salary Survey is presently being mailed, and that over 100 hospitals have agreed to participate in the Survey of Academic Medical Center Hospitals Financial and Operating Data. The presentation concluded with a brief review of the November 30 meeting of the Commonwealth Fund Project's advisory committee. Three staff papers are in progress: teaching hospital profits, variations in per resident costs, and the characteristics of high cost cases. Additional papers are planned on technology and reimbursement and the indirect medical education adjustment. Three fundamental observations made by staff on the project are: 1/ much of the public data on key AAMC issues is a mess, 2/ the AAMC must collect original data on key issues, and 3/ it is not economical to acquire and analyze data for a single use.

#### XII. ADJOURNMENT

There being no further business to come before the Board, Mr. Gambuti adjourned the meeting at 12:15p.

## EVALUATION OF FORMAT CHANGES FOR COTH SPRING MEETING

The 1989 COTH Spring Meeting incorporated a number of major changes from prior meetings:

- o a resort hotel was used instead of a downtown business hotel;
- o the program sessions on Thursday and Friday morning were organized to use plenary speakers followed by discussion groups rather than simply speakers followed by Q and A;
- o the afternoons on Thursday and Friday were left open to allow free time;
- o the member-sponsored reception was moved from Thursday evening to Friday evening,;
- o a Saturday morning session was added (as a replacement for the open Thursday afternoon);
- o an optional orientation session was included on Wednesday afternoon; and
- o an unstructured spouses/guest continental breakfast was available on Thursday and Friday.

While the 1990 Spring Meeting is already booked at a downtown hotel in Boston, the Boston area offers many sightseeing opportunities that may substitute for the recreational options available at a resort. Therefore, the Administrative Board is asked to evaluate the format changes incorporated into the 1989 meeting and advise staff on the desirability of continuing:

- o discussion groups following speakers
- o open afternoons on Thursday and Friday
- o a Saturday morning session
- o the best evening (Thursday/Friday) for the member sponsored reception
- o the optional AAMC orientation session.

**SELECTION OF 1991 AND 1992 COTH SPRING  
MEETING SITES**

The past COTH Spring Meeting sites are listed below.

1978	St. Louis, MO
1979	Kansas City, MO
1980	Denver, CO
1981	Atlanta, GA
1982	Boston, MA
1983	New Orleans, LA
1984	Baltimore, MD
1985	San Francisco, CA
1986	Philadelphia, PA
1987	Dallas, TX
1988	New York, NY
1989	San Diego, CA

The 1990 meeting is scheduled for Boston, May 9-11. Though attendance was relatively low at the recent 1989 meeting in San Diego, the meeting evoked quite a bit of enthusiasm among the registrants. The consensus is that it was a successful meeting and a good turnout for 1990 is anticipated. This is the crucial time, however, to ensure the success of future meetings, and staff asks the Board to consider the various options:

**TONE OF MEETING**

The first attempt at a resort meeting for this group went very well but on a less than optimal scale. The following questions need to be considered before future sites can be selected.

- 1/ Does the enthusiasm for location of the 1989 meeting site justify placing the COTH SPRING MEETING in resort settings in the future, and if so, to what degree would the following be accepted?
  - o More difficult travel
  - o Higher rates
  - o Less concentrated meeting schedule

2/ Would combining the original downtown site format with some leisure activities offset the difficulties listed on the previous page and be preferable to an actual resort setting?

I.e., organized free time with the option of

- o Tailored tour with meal (such as private museum tour and lunch)
- o More organized spouse activities
- o Appropriate sports/leisure activities (though certain water activities may not be feasible in Charleston, golf and tennis times could be arranged)

3/ Would alternating the setting be more desirable (1990 would be in a downtown setting [Boston], 1991 could be in a more resort oriented locale, and 1992 would be downtown again)?

#### SITE SUGGESTIONS

##### Resorts

ARIZONA BILTMORE, Phoenix, AZ - 15 minutes from Phoenix Airport, onsite swimming, golf, and tennis. Frank Lloyd Wright school of architecture, oasis setting in desert community. Good meeting facilities, high rates. (May warm)

BILTMORE HOTEL, Coral Gables, FL - 15 minutes from Miami International Airport, close to shopping area and beaches, onsite swimming, golf, and tennis. Good meeting facilities and reasonable rates. (May warm+)

THE BREAKERS, Palm Beach, FL - 15 minutes from Palm Beach Airport with connections from Miami and Orlando. Old world luxury hotel (this hotel has an evening dress code) with excellent social programs as well as onsite golf, tennis, swimming, and other water activities. In proximity of famous Worth Avenue shopping area. Good meeting facilities, high rates. (May warm)

BROADMOOR HOTEL, Colorado Springs, CO - 15 minutes from airport with connections from Denver, minutes from local sites, onsite swimming, golf, tennis, and shopping. Good meeting facilities, higher rates. (May cool)



THE DON CESAR, St. Petersburg, FL - 20-25 minutes from Tampa International Airport, onsite tennis, swimming, sailing, and other water activities, golf arranged; similar setting to the Hotel del Coronado. Driving distance to Busch Gardens, Cypress Gardens, and 1-1/2 hour from Disney World. Good meeting facilities, comparable rates. (May warm)

THE GROVE PARK INN, Asheville, NC - Good connections through Charlotte and Raleigh. Grand hotel in scenic Blue Ridge area with onsite golf, tennis, and swimming. In vicinity of historic Biltmore Estate with chateau and wineries. Good meeting facilities, good rates. (May cool)

#### Cities

CHARLESTON. Good hotels in historic setting (Omni Charleston and Mill House) within minutes of airport. Interesting city with opportunities for sightseeing, tours, shopping, and limited sports activities. Travel would most always require changing planes in Atlanta, Charlotte, or Raleigh-Durham. Good meeting facilities, good rates. (May warm)

CHICAGO. Good-excellent hotels in cosmopolitan but much frequented city. Major airport. Convention city with opportunities for sightseeing, shopping, museum tours, baseball games; little sports activities. Excellent travel accessibility, moderate to high rates. (May cool)

DENVER. Good hotels (Brown Palace, Marriott) within 15 minutes of airport. Business city with historic atmosphere of the old frontier and gold rush days; opportunities for sightseeing, tours, and limited sports. Good travel, good rates. (May cool)

NEW ORLEANS. Good-excellent hotels (Hilton, Meridien, Doubletree, Fairmont) approximately 20 minutes of airport. Unique city with many sightseeing and tourist attractions, tours, riverboat rides, shopping, and limited sports. Travel would most always require changing planes in Atlanta. Good meeting facilities, good rates. (May warm)

Staff would appreciate the Board considering these options and offering suggestions for the selection of 1991 and 1992 COTH SPRING MEETING sites.

FOLLOW UP TO BREAKOUT SESSIONS  
1989 COTH SPRING MEETING

Background

At the 1989 Spring Meeting, the Thursday and Friday sessions opened with staff reports (Drs. Petersdorf and Knapp, respectively) followed by two theme speakers and breakout sessions for members to discuss and react to the presentations. The Thursday morning program on "Patient Assessment" was stimulating and exciting for most members. The Friday morning program on "The Non-College Labor Market" was less stimulating and not as well received. In the breakout sessions, members were asked to share ideas about the topics at both the hospital and AAMC levels. This report summarizes the suggestions made for AAMC responses to the topics presented. Board members are asked to review and evaluate options for consideration as the AAMC Strategic Plan is revised.

Patient Assessment

Each of the breakout groups had a stimulating discussion of the Wennberg/Greenfield presentations. Based on feedback from discussion leaders and staff, the following common ideas were suggested for further AAMC consideration:

- o The AAMC should support a policy position which advocates organizing patient assessment/outcome research as a significant mission of academic medical institutions:
  - patient assessment research should be a collaborative effort of the medical school and hospital undertaken to change the culture of clinical medicine. Integrated hospital/school programs may overcome constraints of school tenure policies which often reward projects with multiple, early publications rather than long-term projects
  - current payment incentives for hospital services emphasize high occupancy and operating profits. These may be inconsistent in the short run with hospital sponsorship/support of research to reduce inappropriate admissions and ancillary services
  - unless academic institutions provide leadership in the public domain, developments will be provided by private entrepreneurs unwilling to share and test clinical logic

- o The AAMC should develop a series of conferences to address major issues in the area of patient assessment/outcome measurement:
  - a joint COD, CAS, COTH, OSR conference could be developed to help ensure that all components of the membership are aware of and supportive of developments
  - a conference of researchers and institutional leaders could explore and evaluate appropriate organizational arrangements for funding and managing major patient assessment projects
  - a conference of COTH hospitals actively involved in one or more aspects of patient care assessment could foster multi-institutional efforts and mutual education
  - a conference of COTH hospitals could be held to discuss options for the administrative organization of patient assessment activities in light of the fact that most approaches involve multiple administrative databases plus an ongoing relationship with the clinical leadership
  - a conference could be cosponsored with other organizations to explore how assessment activities should advance from detailed evaluations of single procedures to more global assessments of physicians' cognitive styles
- o The AAMC should prepare a primer or annotated bibliography on patient assessment/outcome measures/clinical parameters which provides all members with an awareness of the conceptual and methodological characteristics of the developing field.
- o AAMC and its members should recognize that it is unreasonable to expect patient assessment and financing decisions to be kept independent.
- o AAMC should foster efforts to bring awareness of patient assessment and quality evaluation to the undergraduate curriculum as a critical step in life-long learning skills.

#### Non-College Labor Market

This topic is more global than the prior day's session and the speakers were less stimulating. Nevertheless, a number of common themes emerged from the discussion groups:

- o Labor markets for non-college youth are primarily local and the options for the AAMC are limited:
  - AAMC should work with the educational and career associations and unions to promote careers in the health services sector
  - AAMC could catalog individual member efforts to develop new sources of and approaches to the non-college labor market to distribute the report to all members
  - AAMC could develop a statement for school counselors on teaching hospital needs for non-college youth emphasizing required competencies and attitudes
  
- o AAMC should help member hospitals understand the hospital is becoming a major educational institution for entry level careers and promotions.

SEPTEMBER BOARD BREAKFAST SPEAKER

The DRG classification system which is the backbone of Medicare's prospective payment system is presently being revised and expanded to about 1,250 categories. If the new classification system is considered for adoption, several other components of the system will also be opened for discussion: outliers, indirect medical education payments, and disproportionate share payments. To provide the COTH Administrative Board with a briefing on the proposed DRGs and their impact on the structure of the Medicare payment system, staff proposed that the Administrative Board meet with Richard Averill, President of HSI of New Haven, Connecticut at its September breakfast. The Board is requested to approve/disapprove this suggestion.

PROJECTED 1989 COTH PROGRAM  
AAMC ANNUAL MEETING

Monday, October 30, 1989

- I. Luncheon of Membership
- II. Business Meeting
  - A. AAMC President's Report  
Robert G. Petersdorf, M.D.
  - B. Chairman's Report  
Gary Gambuti
  - C. Staff Report  
James Bentley
  - D. Nominating Committee Report  
J. Robert Buchanan, M.D., Chair
- III. COTH Program Session
  - The Canadian Healthcare System: Implications for COTH Hospitals  
Presiding: Raymond G. Schultze, M.D.
  - A Canadian Hospital's Experience: A CEO's Perspective  
W. Vickery Stoughton
  - A Former Canadian Chairman's Perspective  
Gerard N. Burrow, M.D.

MEMORANDUM #89-38

May 25, 1989

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

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

SUBJECT: Proposed Medicare PPS Regulations

On May 8, the Health Care Financing Administration published proposed regulations for the Medicare prospective payment system (Federal Register, pp. 19636-19796). The proposed changes, which would take effect on October 1, 1989 focus on seven major areas:

Per Case Payment Amounts (pp. 19660-19665, 19740-19749)

Despite budget proposals to the contrary, current law specifies that DRG payment rates for the next Federal fiscal year will be increased by the full change in the hospital market basket. Therefore, HCFA proposes to increase the national, adjusted standardized amounts by the full 5.8% market basket increase. When this increase is combined with other proposed changes described below, HCFA estimates the total change in PPS per case payments (including basic per case payments, outliers, disproportionate share payments, and indirect medical education payments) will be as follows:

<u>Type of Hospital</u>	<u>Expected Per Case Payment</u>		<u>Percent Change</u>
	<u>FY 1989</u>	<u>FY 1990</u>	
All hospitals	\$4,578	\$4,762	4.0%
Rural Hospitals	2,957	3,072	3.9
Small Urban (1,000,000 or fewer)	4,571	4,763	4.2
Large Urban (above 1,000,0000)	5,498	5,714	3.9
Teaching (less than 0.25 residents per bed)	5,068	5,274	4.0
Major Teaching (above 0.25 residents per bed)	7,552	7,872	4.2

The substantial differences in per case amounts for different types of hospitals reflect the impacts of differences in case mix, area wage indices, outlier payments, disproportionate share payments and indirect medical education payments.

Revision of the Hospital Wage Indices (pp. 19646-19648)

The current wage indices used to adjust PPS payments are based on an averaging of 1982 and 1984 wage data. HCFA proposes to use only 1984 data. This introduces a major change in index values for many communities, and COTH members should compare their current and proposed index values to appreciate the impact of the proposal.

Outlier Payments (pp. 19661-19662)

HCFA proposes to retain outlier payments at 5.1% of total PPS payments. To meet this goal outlier thresholds are increased as follows:

<u>Type of Outlier</u>	<u>Current Threshold</u>	<u>Proposed Threshold</u>
Day Outlier	geometric mean plus the lesser of 24 days or 3.0 standard deviations	geometric mean plus the lesser of 27 days or 3.0 standard deviations
Cost Outlier	the greater of twice the PPS rate for the DRG or \$28,000	the greater of twice the PPS rate for the DRG or \$32,000

By raising the thresholds for defining outliers, fewer cases will be defined and paid as outliers.

Recalibration of DRG Weights (pp. 19644-19646)

HCFA proposed to reweight all DRGs using data on 9.5 million patients discharged during FY 1988 and using the same methodology HCFA used last year.

Burn Outliers (pp. 19648-19649)

HCFA proposes to reduce the percentage used to compute day outlier payments from 90% to 60% while retaining the 90% adjustment for cost outliers.

Indirect Medical Education and Disproportionate Share Adjustments (pp 19654-19655)

In last year's reconciliation act, (P.L. 100-647), Congress extended the disproportionate share adjustment until October 1, 1995. HCFA proposes to make the necessary technical provisions required to ensure that the disproportionate share and indirect adjustments are extended in their current form until 1995.



Changes in DRG Classification (pp. 19637-19644)

HCFA proposed significant changes in the current DRG system including revising the surgical hierarchies and their list of complications and comorbidities used to classify patients. A number of changes in the ICD-9CM coding system are also proposed.

Discussion

Having proposed these changes, HCFA concludes by reporting (p. 19749), "the net effect of all changes would be to increase payment to rural hospitals by 3.9 percent, to large urban (area) hospitals by 3.9 percent and to other urban (area) hospitals by 4.2%. The net effect of all changes in the proposed rule, including the current law update, is a differential impact that is the opposite of the impact that would be appropriate based on the analysis of Medicare operating margins. Implementation of a higher update rate for rural hospitals and for large urban (area) hospitals would reverse this effect." (Emphasis added). Thus, HCFA appears to be urging Congress to revise present PPS law.

Comments on the proposed regulation should be provided to HCFA by July 7 to:

Health Care Financing Administration  
Department of Health and Human Services  
Attention: BERC-630-P  
P.O. Box 26676  
Baltimore, Maryland 21207

An extended comment period, until September 30, is provided for comments on future wage surveys and on volume adjustments for sole community hospitals.

For additional information, please contact James D. Bentley, Ph.D., Division of Clinical Services, (202) 828-0490.

MEMORANDUM #89-27

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

\*\*\*\*\*  
 \* 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 physicians defined as "teaching physicians".

B. Offset of Practice Plan Income

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

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

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

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



ASSOCIATION OF  
AMERICAN  
MEDICAL COLLEGES

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

April 19, 1989

Mr. Thomas Gentile, Jr.  
Assistant Administrator  
Medical Affairs  
Providence Hospital  
16001 Nine Mile Road  
Southfield, Michigan 48075

Dear Tom:

I am sorry that one component of the Associations's recent Medicare testimony -- the data on the impact of reducing the indirect medical education adjustment -- was perceived by some AHME members as an AAMC preoccupation with academic medical centers. The perception that may have been created was not our intention. Therefore, I appreciate your telephone call and welcome this opportunity to respond.

The testimony you heard, attachment A, has twenty-five pages of text. The first sixteen pages plus the final four pages discuss Medicare policies on the indirect adjustment and the direct payments as they apply to all hospitals. You will note on page 11 our illustration discussed hospitals with resident-to-bed ratios of 0.05, 0.25 and 0.50. Only the data section focuses on academic medical center hospitals.

The emphasis on academic medical center hospitals in the data analysis resulted from the availability of accurate data, not from an intention to be exclusive. As we discussed, from 1965-1985 the AAMC conducted a special data collection and analysis activity for university-owned hospitals. In August 1986, The Commonwealth Fund gave the AAMC a grant to develop a database and data analysis capability on teaching hospitals. We originally tried to build the project around public use tapes from Medicare cost reports. Our effort was unsuccessful because HCFA's data is so poor. For example, the HCFA tapes show five hospitals with more than 75,000 residents each. The tapes also show that 22% of the hospitals reporting residents in training claimed no direct medical education payments from Medicare. Faced with this problem of terrible data, we decided that a special COTH database was needed.

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Mr. Thomas Gentile, Jr.  
Page 2  
April 19, 1989

To start the database, we needed to select a manageable subset of COTH members. I decided to take the set of university-owned hospitals, with whom we had previous experience, and add freestanding academic medical center hospitals. Our original plan envisioned the following data schedule:

- 1988 -- collect and report academic medical center hospitals,
- 1989 -- add all non-Federal COTH members with 100 or more residents,
- 1990 -- add all remaining COTH members.

We have not been able to maintain our original plan because the submitted data have taken too much time to edit and correct. Therefore, our database plan has been revised in two ways:

- 1) We have moved the questions on number of housestaff and source of stipend support to the 1989 housestaff stipend survey. This allows us to collect some essential data on all COTH members.
- 2) We have slowed down the survey schedule to add additional hospitals only when we can promptly publish results on the current groups. If the processing of medical center data continues to go well, we hope to add COTH members with more than 100 residents to the survey this fall.

As you meet with your committee, I hope you will share six additional facts with them:

- 1) The current COTH Chairman is Gary Gambuti, president of St. Luke's/Roosevelt Hospital. This is an affiliated community hospital.
- 2) When the COTH Nominating Committee reported last year, they included Sister Sheila Lyne from Mercy Catholic Hospital and Medical Center in Chicago as a Board nominee. The Nominating Committee also balanced AAMC Assembly nominees between medical centers, affiliated community hospitals and the VA.
- 3) Our committee on paying physicians in the teaching hospital included Bruce Steinhauer from Henry Ford and Stephen Wang from Morristown Memorial. Our comment letter, copy enclosed, specifically addressed concerns of affiliated community hospitals.

Mr. Thomas Gentile, Jr.

Page 3

April 19, 1989

- 4) Donna and I have worked together personally to schedule AHME programs at the AAMC Annual Meeting at times that will allow all COTH members to attend.
- 5) The meeting topics selected for the 1989 COTH Spring Meeting, program enclosed, were designed to appeal to all COTH members, be they medical centers, affiliated hospitals, or VA hospitals.
- 6) The charge to the AAMC Committee on Governance and Structure includes reviewing "the means through which the Association might involve individuals with specific institutional educational responsibilities such as hospital directors of medical education . . ." (emphasis added).

The AAMC, as a whole, and the Division of Clinical Services, in particular, are committed to serving and supporting all COTH members. Thus, I would welcome a formal liaison between an AHME representative and myself and the opportunity to attend appropriate AHME meetings. On the latter point, I'm sorry I couldn't accept your invitation to attend the April 28 - May 3 meeting due to prior commitments.

I welcome the openness your telephone call represents. If we are doing something that offends any part of our hospital membership, I would like to know it. I welcome calls from you and your colleagues.

Sincerely,

James D. Bentley, Ph.D.  
Vice President for  
Clinical Services

JDB/mrl

Enclosures

cc: Robert G. Petersdorf, M.D.  
John F. Sherman, Ph.D.  
Richard M. Knapp, Ph.D.