



association of american medical colleges

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD BREAKFAST

November 5, 1979
Washington Hilton Hotel
Chevy Chase Room
7:30 a.m. - 9:00 a.m.

A G E N D A

- I. Call to Order
- II. Consideration of Minutes ATTACHMENT A
- III. Nominating Committee Report David L. Everhart
- IV. Membership Applications
(Affiliation Agreements to Be
Distributed at the Meeting)
 - Allentown and Sacred Heart Hospital Center ATTACHMENT B
Allentown, Pennsylvania
 - Moses H. Cone Memorial Hospital ATTACHMENT C
Greensboro, North Carolina
- V. Describing the Teaching Hospital:
Alternatives for COTH Activities ATTACHMENT D
- VI. Other Business
- VII. Adjournment

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
September 13, 1979

M I N U T E S

PRESENT:

Robert M. Heyssel, M.D., Chairman
John W. Colloton, Chairman Elect
David L. Everhart, Immediate Past Chairman
John Reinertsen, Secretary
James Bartlett, M.D.
Stuart Marylander
Robert K. Match, M.D.
Mitchell T. Rabkin, M.D.
William T. Robinson, AHA Representative

ABSENT:

Dennis R. Barry
Jerome R. Dolezal
James M. Ensign
Mark S. Levitan
Malcom Randall
Elliott C. Roberts

GUESTS:

Spencer Foreman, M.D.
William D. Mayer, M.D.

STAFF:

Martha Anderson, Ph.D.
James D. Bentley, Ph.D.
Judy Braslow
Peter Butler
John A.D. Cooper, M.D.
Gail Gross
James I. Hudson, M.D.
Joseph Isaacs
Chip Kahn
Richard M. Knapp, Ph.D.
John F. Sherman, Ph.D.
Emanuel Suter, Ph.D.
August G. Swanson, M.D.

I. Call to Order

Dr. Heyssel called the meeting to order at 8:00 a.m. in the Kalorama Room of the Washington Hilton Hotel.

II. Consideration of Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the June 14 COTH Administrative Board Meeting

Dr. Knapp introduced Chip Kahn, who recently joined the Department of Teaching Hospitals' staff as an Administrative Resident. Mr. Kahn is a graduate of Johns Hopkins University and is currently pursuing a masters degree in Health Systems Management at Tulane University.

III. Membership

A. Terminations

Dr. Knapp wanted the Board to be aware that St. Elizabeth Hospital Medical Center, Youngstown, Ohio and St. Johns Episcopal Hospital, Brooklyn, New York had voluntarily withdrawn their membership in the Council of Teaching Hospitals. He also pointed out that the membership of New York Medical College - Flower and Fifth Avenue Hospital should be terminated since it has not responded to several AAMC requests for payment of overdue membership fees. Dr. Knapp also asked for Board action on termination of the membership of Mayaguez Medical Center in Puerto Rico. Its dues have not been paid for three years and Dr. Knapp has notified them that their membership would end if their account was not settled by September 30. The Board agreed with these recommendations.

B. Membership Applications

Dr. Bentley reviewed eight applications for COTH membership. Based on staff recommendation, the Board took the following actions:

ACTION: It was moved, seconded and carried to approve Cabell Huntington Hospital, Huntington, West Virginia for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Cabrini Medical Center, New York, New York for COTH full membership.

ACTION: It was moved, seconded and carried to approve The Children's Hospital, Columbus, Ohio for COTH full membership.

ACTION: It was moved, seconded and carried to approve The Community Hospital of Springfield & Clark County, Springfield, Ohio, for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Greene Memorial Hospital, Inc., Xenia, Ohio for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Saint Francis Hospital, Tulsa, Oklahoma for COTH full membership.

ACTION: It was moved, seconded and carried to approve Scott and White Memorial Hospital, Temple, Texas for COTH full membership.

ACTION: It was moved, seconded and carried to approve Veterans Administration Medical Center, Huntington, West Virginia for COTH corresponding membership.

AICPA "Exposure Draft"

Dr. Heyssel called attention to an "Exposure Draft on Clarification of Reporting Practices Concerning Hospital-Related Organizations," which was prepared by the AICPA Subcommittee on Health Care Matters. Dr. Bentley informed the Board that COTH submitted a statement on this a year and one-half ago and would be commenting again by October 31 of this year. Board comments and suggestions were welcomed.

Medicare Section 223 Schedule of Limits

Dr. Heyssel reviewed the contents of a September 10 letter from the AAMC to HCFA Administrator Len Schaeffer on the Section 223 limits. Dr. Knapp briefed the Board on activities relating to this issue which directly resulted from Board action at its June meeting. He reported that a COTH membership meeting was held on July 10 with HCFA officials at Georgetown University. It was attended by approximately 100 individuals from about 50 COTH-member hospitals affected by the Section-223 regulations. Presentations were made by three HCFA representatives: Leonard Schaeffer, Clif Gaus, and Bob O'Conner. Dr. Knapp felt that these officials were made aware by hospital representatives of their intense negative feelings about the regulations, particularly by California and Chicago hospitals which also visited their Congressmen. Dr. Knapp thought the fact that some hospitals' (those with large bed sizes) limits were reduced by \$12 between the proposed and final regulations was the major reason for the withdrawal of the final regulations and subsequent reissue of the regulations for a three month period with a new opportunity to submit comments. This fact had the most impact in discussions with Congressmen.

Mr. Schaeffer and Congressman Rostenkowski met on July 13th and as a result action was taken to return to the 80th percentile, at least for those institutions with a July 1 through September 30 fiscal year. However, it is uncertain whether HCFA will revert back to 115% of the mean after public comments have been received.

In his presentation at the July 10 meeting, Clif Gaus indicated that a decision would be made by December on whether HCFA will implement a per admission method of reimbursement based on the DRG model. Dr. Heyssel expressed concern about this potentiality and urged Board members to carefully review the staff report on case mix measures.

IV. JCAH Professional and Technical Advisory Committee (PTAC) Report

Mr. Everhart, AAMC representative to the JCAH Professional and Technical Advisory Committee, summarized the proceedings of the first meeting of that Committee and described its composition. George Way, AMA President-Elect, was elected Chairman of the PTAC and Mr. Everhart was appointed the PTAC's representative to the JCAH Hospital Accreditation Committee, which makes the final decision on the accreditation of all hospitals and meets monthly in Chicago. Mr. Everhart was impressed with the caliber of the individuals at the meeting and thought it would be interesting to see what impact the advisory committee would have on the process of accreditation. He promised to keep the Board informed of future PTAC activities.

V. Confidentiality of COTH Executive Salary Survey

Dr. Heyssel discussed a request made to him by John H. Gerstenmaier, Chairman of the Board of Trustee's Compensation Committee at Akron City Hospital. Mr. Gerstenmaier desired data from the COTH Executive Salary Survey which Dr. Heyssel agreed to release, thereby making an exception to current COTH policy which allows release of such data only to COTH-member CEOs. Dr. Heyssel asked the Board for guidance with regard to future requests of this nature. Dr. Knapp informed the Board that in a survey taken last year, 74% of the COTH membership reiterated the feeling that the Executive Salary Survey should be sent to Chief Executive Officers only. Mr. Colloton felt Dr. Heyssel's decision to release the information to a Trustee was appropriate, but that the chief executive officer should be notified when such information has been requested and subsequently sent to a Trustee of his institution. The Board generally agreed.

VI. COTH Spring Meeting Planning Committee Report

Dr. Knapp summarized the proceedings of the meeting of the COTH Spring Meeting Planning Committee which was held on July 26 in Chicago. The Spring Meeting will be held May 14-16, 1980 at the Brown Palace Hotel in Denver. Wednesday evening would begin with a speaker prior to cocktails and dinner; Thursday morning would be devoted to a session with a group of deans; Thursday afternoon would be a half-day to explore "case mix and hospital reimbursement;" and Friday

morning would begin with four one and one-half hour concurrent sessions and conclude with a final session of all the membership, the topic for which would be decided later.

Dr. Knapp welcomed Board comments and suggestions with regard to the style and format for the specific sessions and overall meeting. Dr. Heyssel particularly asked for suggestions for the initial speaker; Dr. Knapp suggested that a speaker well-versed in "deregulation and competition" could make a timely presentation about implications of such a policy on teaching hospitals. Several suggestions were made, with John Dunlop (former Director of the Cost of Living Council) from Harvard or someone he might suggest topping the list. It was generally decided that Mr. Colloton and Dr. Knapp would make the final decision with regard to the speaker for the opening session. Dr. Knapp stated that he would seek someone with a hospital background who could bridge the gap between theory and implementation.

VIII. Flexner and Borden Awards

ACTION: It was moved, seconded and carried that the Executive Council approve the recommendations of the Flexner and Borden Award Committees as set forth on page 24 of the Executive Council Agenda.

IX. CCME "Policy on Policy"

ACTION: It was moved, seconded and carried that the Executive Council approve the CCME "Policy on Policy" as set forth on page 25 of the Executive Council Agenda.

X. Bylaws Change for LCGME

Responding to a question from Dr. Bartlett regarding whether or not these bylaws changes had been reviewed by legal counsel, Dr. Knapp indicated that he did not know but would raise the question at the Executive Council meeting.

ACTION: It was moved, seconded and carried to approve the bylaws change for the Liaison Committee on Graduate Medical Education as set forth on page 27 of the Executive Council Agenda.

XVIII. Medical Sciences Knowledge Profile (MSKP) Program

ACTION: It was moved, seconded and carried that the Executive Council approve the substitution of the MSKP program for COTRANS and authorize moving forward with its implementation in 1980.

VII. Case Mix Measures and Their Reimbursement Applications

Dr. Bentley reviewed "Case Mix Measures and Their Reimbursement Applications: A Preliminary Staff Report" which was a separate attachment to the COTH Agenda. He reported that, based on an initial literature review and a series of site visits which he and Peter Butler made to various individuals active in case mix research, the paper had been organized in three sections: (1) description of initial literature review and site visits, methods for measuring case mix and of ongoing and planned applications; (2) outline of proposed final report; and (3) recommendations for future AAMC policy. Dr. Bentley welcomed Board comments on the paper specifically on (1) whether any case mix applications were missed, (2) the general contents of the paper, (3) what should be done with recommendations presented in the paper, and (4) whether COTH is fulfilling the objectives set forth by the membership at the Spring Meeting. Dr. Heysel felt that this was an outstanding initial effort on the part of the staff and noted that he had written to Clif Gaus regarding the inherent weaknesses of the DRG model.

Mr. Colloton maintained that HCFA clearly intends to implement the DRG model by the end of 1980. He suggested that a collaborative effort should be considered wherein COTH and HCFA conduct pilot studies of case mix. Mr. Reinertsen agreed that there was urgency in dealing with this issue, but did not favor sharing any information with HCFA until the data can be better verified. Mr. Marylander also felt that it would not be feasible to work with HCFA productively in the formative stages of the study, but resources should continue to be devoted to learning more about the whole issue in order to prepare for future implementation of the DRG model. In addition, he recommended that the staff paper be widely distributed among the membership.

Dr. Bentley noted that everyone he and Peter talked to -- large and small hospitals, state regulators and hospital associations -- believed they would win with case mix and this give him some concern. Mr. Everhart asked if there were alternatives to the DRG model that had been explored by anyone. Aside from some conference and workshop level involvement of some "Big Eight" accounting/consulting firms, staff could not offer evidence of any investigations of other alternatives. Mr. Colloton suggested employing a consulting firm to grapple with the problem and evaluate other methods. Dr. Cooper suggested that RAND Corporation might be a good choice for such consulting services.

Following further discussion the board generally agreed that (1) the "Preliminary Staff Report on Case Mix" should be sent to the COTH membership with a cover letter discussing the future plans for the case mix study and (2) prior to the COTH annual meeting in November staff should:

- identify data which can be used to evaluate the DRG's as an intensity measure for reimbursement;
- identify researchers/consultants with expertise and an interest in conducting such an evaluation; and

- prepare a list of projects which could be conducted or sponsored by COTH/AAMC (1) to evaluate present DRG payment applications and the planned HCFA application and (2) to develop alternative reimbursement approaches for tertiary care teaching hospitals.

XVIII. Liaison Committee on Continuing Medical Education

Dr. Cooper reviewed this item for the Board. Mr. Colloton asked Mr. Robinson where the AHA stood on this issue. Mr. Robinson reported that the AHA supported continuation of the LCCME. Following discussion the Board decided on the following action:

ACTION: It was moved, seconded and carried that the Executive Council adopt the policy regarding LCCME as set forth in numbers 1-3 on page 134 of the Executive Council Agenda.

XIII. A Position Paper: The Expansion and Improvement of Health Insurance in the United States

Mr. Colloton, a member of the AAMC ad hoc Committee on National Health Insurance, described the position paper which resulted from that Committee's review of the AAMC's 1975 policy statement on national health insurance. The Committee decided to move away from a comprehensive national health insurance program toward a policy statement that promotes the expansion of health insurance in the United States. The statement addresses three major deficiencies: (1) the coverage gap which exists relative to basic health insurance for low income Americans; (2) the inadequacy of health insurance protection for catastrophic illness; and (3) the need for an accepted minimum standard for basic health insurance plans. Addressing these deficiencies, the statement calls for expansion and improvement of Medicaid on a national scale to bring about broader eligibility of low income people and minimum standardization of the benefit package. With regard to catastrophic illness, it is recommended that employers be mandated to provide full-time employees with catastrophic health insurance meeting certain minimum HEW standards for adequacy of coverage and eligibility. Commercial insurance firms would form pools to underwrite catastrophic coverage for self-employed part-time workers and the non-employed. Finally, it is recommended that an independent certifying body or commission composed of representatives of insurance carriers, providers and consumers be established for purposes of placing its "seal of approval" on minimally acceptable basic health insurance packages. It is hoped that this would promote the upgrading of inadequate basic plans and provide a valuable source of additional information.

Mr. Colloton concluded that the statement also addressed the matter of reasonable reimbursement of physicians and institutional providers, graduate medical education reimbursement, and lastly the appropriate use of cost sharing mechanisms in the financing of the nation's health insurance program. Mr. Colloton believed the paper's one shortcoming is in this area where he believed there is a lack of emphasis on controlling the unnecessary demand for medical services through use of deductibles and co-insurance. He then presented evidence from the research literature indicating the influence of co-insurance and deductibles on demand.

Dr. HeysseI indicated concern about mandating that employers provide catastrophic coverage for full-time employees. Mr. Everhart disagreed and felt the employer requirement was necessary. Dr. Bartlett believed that employers should not be subject to such a mandate and felt that the language on page 72 of the Executive Council Agenda, discussing the nation's health insurance system as an appropriate mechanism for "replenishing the health manpower pool," did not represent conventional wisdom on this issue. Following further discussion, the Board generally agreed that the position paper represented a good start but that some parts need more attention and modification.

Dr. Cooper indicated that approval of the new position statement was necessary to replace a former AAMC position on national health insurance in the event that the Association must testify on national health insurance before January (1980). He suggested Board approval of the statement with recommendations for improvement and/or changes. The Board discussed and generally agreed with the three major disparities identified as persistent in the nation's health insurance system, as set forth on page 62 of the Executive Council Agenda. Mr. Marylander emphasized that any expansion of the health insurance system must be contingent on the existence of a sound financial structure for it and reimbursement under it. Mr. Reinertsen recommended that the Board agree to abandon the former AAMC position, agree in principle with the new policy statement, and further pursue the draft and alter it as necessary for use as official AAMC policy. There was a division of opinion among the Board members with regard to the proposed solutions set forth in the paper to deal with the three identified disparities. Further discussion resulted in the following action:

ACTION: It was moved, seconded and carried to accept the following measures with regard to the Position Paper on the Expansion and Improvement of Health Insurance in the United States:

- Abandon the 1975 AAMC policy statement on national health insurance;
- Express agreement with the three major disparities that persist in the nation's health insurance system as set forth in the Position Paper on page 62 of the Executive Council Agenda;
- Express concern with the "mandating" concept, the section on co-insurance and deductibles, and other issues discussed which were noted by the staff and suggest redrafting of these positions of the position which would be more acceptable to the Board; and
- Use this Position Paper as preferable to the 1975 position should it become necessary to have a formulated AAMC policy prior to the recommended redrafting.

XIV. Final Report - Specialty Distribution Working Group

Spencer Foreman, M.D., a member of the Working Group on Specialty Distribution of the Task Force on Graduate Medical Education, reviewed the final report of the working group which is set forth on pages 76-104 of the Executive Council Agenda. Dr. Foreman indicated that there was considerable compromise involved in developing the report recommendations. He felt that the paper had more deficiencies than strengths since there are conclusions presented without supporting data. He continued that the paper is an attempt to address specialty distribution through reimbursement mechanisms which seem most rational. Dr. Cooper warned that HEW's alternative could be control by the Secretary of the number of residencies or some other undesirable arrangement. He said that the Board's approval of the report in principle was being sought and that a group of residents will be reviewing this prior to the annual meeting, at which time the report will be presented to the full AAMC Assembly for approval. Following discussion, the Board generally agreed to approve the report in principle but raised a number of concerns.

ACTION: It was moved, seconded and carried to approve, in principle only, the Final Report of the Specialty Distribution Working Group, with the understanding that there would be further discussion and modification of the report prior to the AAMC Assembly meeting in November. In addition, it is requested that the recommendation on page 95 of the Executive Council Agenda be reworded to more clearly suggest the provision of incentives to academic medical centers by third-party payors and governmental agencies for adjustment of the mix and size of their graduate programs.

XVI. Final Report - Working Group on Financing

Dr. Swanson reviewed this report for the Board, noting that the posture taken was that graduate medical education should be financed by third-party payors of all categories in order to ensure necessary physician manpower in the future.

Mr. Colloton felt that item #2 on page 18 of the document failed to address the longitudinal involvement of the physician in the care of a patient throughout his or her stay. He suggested language to read under Special Issues, (1) Compensating Teaching Physicians, No. 2 on page 18 (Lines 14-17) as follows:

2. "Payment of professional fees for service rendered by graduate medical education faculty should be provided by third-party payers when the faculty member has intimately participated with the resident team in the provision of care to a beneficiary throughout the course of the beneficiary's hospitalization or clinic stay."

Dr. Swanson suggested I.L. 372 language here. Mr. Colloton was amenable.

Mr. Colloton contended that the section under Special Issues, (3) Financing Ambulatory Care Educational Settings, Allocation of Costs on Page 25 (Lines 9 on) failed to adequately address the allocation of graduate medical education costs. He called for the addition of such discussion, without specifying particular language (i.e., he spoke generally of GME as a general burden, based on inpatient revenue to the clinics, etc.). Dr. Swanson agreed with the need for such discussion.

Dr. Heyssel was generally concerned that the paper was argued on the basis of educational concerns rather than those relating to the service component. He suggested that the service performed by residents could be discussed as part of the educational experience. He was also concerned with statement No. 2 under Capital Costs on Page 8 (Lines 11-13) because he did not believe that decisions on technological needs should be based on graduate medical education needs.

Under Sources for Financing Graduate Medical Education, Page 11 (Lines 4-7) Dr. Swanson recommended the following language with which most Board members concurred: "This view neglects two facts: patients benefit from the services they receive from residents who care for them during their educational experiences in teaching hospitals, and 94% of all hospital revenues are now derived from third-party insurers."

On Page 3 (Lines 5-8) Dr. Knapp called for the deletion of the last two sentences of the paragraph which ends on lines 5-8 and discusses the size of resident stipends as noncontroversial.

After further discussion, the Board took the following action:

ACTION: It was moved, seconded and carried to approve, with modification suggested by the Board, the final report of the Working Group on Financing, subject to further action by the Assembly at the annual meeting in November.

XI. General Requirements Section of the Essentials of Accredited Residencies

Dr. Swanson reviewed the "Essentials," noting that the LCGME has not as yet had a chance to approve or disapprove the document. He anticipated that comments would be forthcoming from the LCGME following its meeting in November.

Mr. Colloton pointed out that at the March 29 COTH Board meeting, action had been taken to delete the word "detailed" from line 15 of section 1.1.2 on page 36, as well as the first two sentences of that section. However, the current document showed no evidence of such changes. Dr. Swanson indicated that he would try to have the changes incorporated into the document this time.

ACTION: It was moved, seconded and carried to approve "The Essentials of Accredited Residencies in Graduate Medical Education" as set forth on pages 29-49 of the Executive Council Agenda, modifying section 1.1.2 on page 36 by deleting the word "detailed" from line 15 and the first two sentences of that section.

XV. Final Report - Working Group on Quality

Dr. Anderson reviewed this report and the following action resulted from Board discussion:

ACTION: It was moved, seconded and carried to approve the Final Report of the Working Group on Quality subject to the following changes:

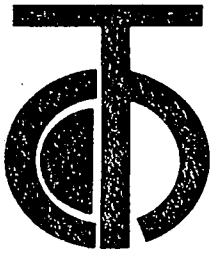
- Principle 2 on page 122 of the Executive Council Agenda should read: "The institution(s) should have an appropriate mechanism for an effective allocation of educational resources and the evaluation of the quality of each program."
- Line 9 on page 122 should read: "institution(s) should be of concern to the entire institution. How institutions. . ."
- The first word on line 10 on page 122 -- "faculties" -- should be deleted.

XII. Final Report - Ad Hoc Committee on Continuing Medical Education

William Mayer, M.D., Committee Chairman, reviewed the report explaining that changes recommended by the COTH Board at its previous meeting had been incorporated into the report.

ACTION: It was moved, seconded and carried to approve the Final Report of the Ad Hoc Committee on Continuing Medical Education as set forth on pages 49-60 of the Executive Council Agenda.

The meeting was adjourned at 1:00 p.m.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges
 Council of Teaching Hospitals
 Suite 200
 One Dupont Circle, N.W.
 Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Allentown and Sacred Heart Hospital Center
 Hospital Address: (Street) 1200 South Cedar Crest Blvd.
 (City) Allentown (State) Pennsylvania (Zip) 18105
 (Area Code)/Telephone Number: (215) 821-2100
 Name of Hospital's Chief Executive Officer: Ellwyn D. Spiker
 Title of Hospital's Chief Executive Officer: Administrator

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>396</u>	Admissions:	<u>13,114</u>
Average Daily Census:	<u>328.7</u>	Visits: Emergency Room:	<u>31,698</u>
Total Live Births:	<u>None</u>	Visits: Outpatient or Clinic:	<u>38,146</u>

B. Financial Data

Total Operating Expenses: \$ 30,181,741

Total Payroll Expenses: \$ 16,259,127

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 477,727

Supervising Faculty: \$ 97,500

C. Staffing Data

Number of Personnel: Full-Time: 1104
Part-Time: 308

Number of Physicians: 313

Appointed to the Hospital's Active Medical Staff: 199
With Medical School Faculty Appointments: about 40 - no specific documentation

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Emergency Room Medicine (shared with Allentown Hospital)

Pathology Surgery (shared with Allentown Hospital)

Does the hospital have a full-time salaried Director of Medical Education?: No

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>12/month</u>	<u>42</u>	<u>Elective</u>
Surgery	<u>10</u>	<u>6</u>	<u>Elective</u>
Ob-Gyn	<u> </u>	<u> </u>	<u> </u>
Pediatrics	<u> </u>	<u> </u>	<u> </u>
Family Practice	<u> </u>	<u> </u>	<u> </u>
Psychiatry	<u> </u>	<u> </u>	<u> </u>
Other: <u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible *	2 at ASHHC 4: 2 at AH 20 at ASHHC	2 at ASHHC 4: 2 at AH 20 at ASHHC		
Medicine *	27: 7 at AH	27: 7 at AH		1968-applies to AH
Surgery	16 at ASHHC	9 at ASHHC	4	1940-applies to AH
Ob-Gyn				
Pediatrics				
Family Practice				
Psychiatry				
Other: Pathology	4	1		1978
Plastic Surgery	2 at ASHHC	2		1948-applies to AH
Colo-Rectal Surgery	1 at ASHHC 2: 1 at SHH	1 at ASHHC 2: 1 at SHH	0	1946-applies to SHH
Vascular Surgery Fellowship	1 at ASHHC	1	0	
Cardio-Vascular Disease Fellowship	1 at ASHHC			

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

*Shared program between Allentown Hospital and Allentown and Sacred Heart Hospital Center.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: University of Pennsylvania

Dean of Affiliated Medical School: Edward J. Stemmler, M.D.

Information Submitted by: (Name) Gary Steinberg

(Title) Associate Administrator

Signature of Hospital's Chief Executive Officer:

 (Date) 9-13-79

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ALLENTOWN AND SACRED HEART HOSPITAL CENTER

A Joint Venture of the Allentown Hospital and the Sacred Heart Hospital

P.O. Box 689 • 1200 South Cedar Crest Boulevard, Allentown, Pennsylvania 18105

IV. SUPPLEMENTARY INFORMATION

Allentown and Sacred Heart Hospital Center is one of three allopathic hospitals located in Allentown, Pennsylvania. It is a 396 bed community and tertiary care center which provides residency training, elective rotations, and fellowship training programs in cooperation with Allentown Hospital and Sacred Heart Hospital. These training programs were planned and established as affiliated programs because all A&SHHC physicians are staff members at either one or both of the other allopathic hospitals in Allentown. All three hospitals jointly sponsor graduate medical training in the Allentown area. All three hospitals have a major affiliation with the University of Pennsylvania School of Medicine. This letter summarizes A&SHHC's specific commitment within this joint effort of graduate training.

The residencies programs in general surgery, plastic surgery, and pathology are based at A&SHHC. Allentown Hospital is the base institution for the flexible PGY-1, medicine, and obstetrics/gynecology residency programs. The residencies in family practice, diagnostic radiology, and colo-rectal surgery are based at Sacred Heart Hospital.

Elective rotations in anesthesiology are offered at all three hospitals. Elective rotations in psychiatry and pediatrics are offered at Allentown Hospital, while Sacred Heart Hospital offers a rotation in ophthalmology and otolaryngology.

Fellowships in general internal medicine, vascular surgery, and cardio vascular diseases are offered by A&SHHC, while Allentown Hospital offers fellowships and programs in hematology, medical oncology, gastroenterology, and infectious diseases.

Since there is no full-time salaried director of medical education, the individual program directors are responsible for graduate medical training.

All responses to questions in the application pertain to A&SHHC unless otherwise indicated. A letter of recommendation from Dr. Edward Stemmler, Dean of the School of Medicine at the University of Pennsylvania accompanies this application.

Attachments:

September 13, 1979

UNIVERSITY of PENNSYLVANIA MEDICAL CENTER

PHILADELPHIA 19104

The School of Medicine G3

Office of the Dean

In Response Refer to:

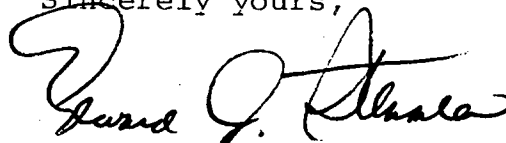
September 17, 1979

Gary Steinberg
Associate Administrator
Allentown and Sacred Heart
Hospital Center
P.O. Box 689
1200 South Cedar Crest Boulevard
Allentown, Pennsylvania 18105

Dear Mr. Steinberg:

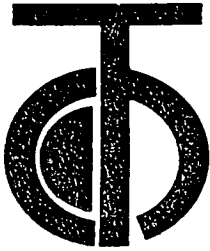
I am delighted to write a letter of support for your application for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges. Your Institution has demonstrated through its program development and clear commitment to education that it not only deserves membership but it will enhance the membership of that distinguished organization. The Allentown and Sacred Heart Hospital Center maintains a strong affiliation with the University of Pennsylvania School of Medicine. Your center has helped to increase the educational and research capability of the School of Medicine through its strong leadership and effective undergraduate and graduate educational programs conducted in association with us.

Sincerely yours,



Edward J. Stemmler, M.D.
Dean

EJS/lp



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges
 Council of Teaching Hospitals
 Suite 200
 One Dupont Circle, N.W.
 Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Moses H. Cone Memorial Hospital
 Hospital Address: (Street) 1200 N. Elm Street
 (City) Greensboro (State) N. C. (Zip) 27420
 (Area Code)/Telephone Number: (919) 379-3900
 Name of Hospital's Chief Executive Officer: Harold L. Bettis
 Title of Hospital's Chief Executive Officer: Director

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>483</u>	Admissions:	<u>15,504</u>
Average Daily Census:	<u>345</u>	Visits: Emergency Room:	<u>50,307</u>
Total Live Births:	<u>2,345</u>	Visits: Outpatient or Clinic:	<u>21,742</u>

B. Financial Data

Total Operating Expenses: \$ 23,344,706

Total Payroll Expenses: \$ 13,067,114

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 167,180

Supervising Faculty: \$ 153,699

C. Staffing Data

Number of Personnel: Full-Time: 1,344

Part-Time: 150

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 209

With Medical School Faculty Appointments: 103

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Anesthesia _____

Does the hospital have a full-time salaried Director of Medical Education?: Yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>60</u>	<u>60</u>	<u>Required</u>
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	<u>24</u>	<u>12</u>	<u>Required</u>
Family Practice	<u>9</u>	<u>6</u>	<u>Required</u>
Psychiatry	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	13	8	_____	1973
Surgery	_____	_____	_____	_____
Ob-Gyn	_____	_____	_____	_____
Pediatrics	9	4	_____	1973
Family Practice	21	20	_____	1970
Psychiatry	_____	_____	_____	_____
Other:	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: University of North Carolina

Dean of Affiliated Medical School: Stuart Bondurant, M.D.

Information Submitted by: (Name) Leonard J. Rabold, M. D.

(Title) Director of Education

Signature of Hospital's Chief Executive Officer: *Harold L. Bellis* (Date) September 5, 1979

THE MOSES H. CONE MEMORIAL HOSPITAL

GREENSBORO, NORTH CAROLINA 27420

September 27, 1979

James D. Bentley, Ph.D.
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear Dr. Bentley:

Recently Moses H. Cone Memorial Hospital submitted an application for membership in the Council of Teaching Hospitals. In preparing the application I inadvertently omitted the Dermatopathology Residency and therefore would like to add the following addendum to Part III, Section B of Graduate Medical Education:

Type of Residency	Dermatopathology
Positions Offered	2
Positions Filled by U.S. and Canadian Graduates	1
Positions Filled by Foreign Medical Graduates	0
Date of Initial Accreditation	July 1, 1977

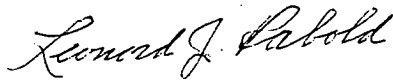
I would also like to submit additional information that may be pertinent. Since 1973 this hospital has continuously maintained an affiliation with the Bowman Gray School of Medicine. The purpose of this affiliation is to provide training for third and fourth year residents from the Orthopedic Residency Training Program of that institution. Two orthopedic residents are assigned to Moses H. Cone Memorial Hospital and their entire salary is paid by this hospital.

Under Part II, Section C there should be an addendum to indicate that there is a full-time salaried Chief of Respiratory Service. This Pulmonary Medicine physician has a very active teaching role in the residency training program.

For at least eight years Cone Hospital had a full-time salaried Chief who operated the Heart Catheterization Laboratory. In addition he was a specialist in Pediatric Cardiology and made a valuable contribution to graduate medical education. Due to his untimely death this position is now open. There is an active search committee interviewing potential candidates for the vacancy.

I hope this additional information will help in the evaluation of Moses H. Cone Memorial Hospital's application to the Council of Teaching Hospitals. Please accept my apologies for the incomplete information on the original application.

Yours sincerely,



Leonard J. Rabold, M.D.
Director of Education

LJR:lmm

cc: Mr. Dennis Barry



THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

Office of the Dean
The School of Medicine

The University of North Carolina at Chapel Hill
MacNider Building 202 H
Chapel Hill, N.C. 27514

September 7, 1979

Mr. Richard Knapp, Executive Director
Council of Teaching Hospitals
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, DC 20036

Dear Dick:

I am pleased to support the application of the Moses H. Cone Memorial Hospital in Greensboro, North Carolina for membership in the Council of Teaching Hospitals. Our College of Medicine has had its longest standing affiliation with this fine institution dating back to 1967. It is also the community hospital in which we had our first off-campus tenured full-time medical faculty member.

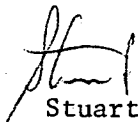
The Moses Cone Hospital continues an active affiliation with our College through the Area Health Education Centers Program. We rely heavily on the Hospital in our medical education program. Several of our second year medical students receive a portion of their physical diagnosis course there. The Hospital also hosts third year medical students serving a portion of the important internal medicine clinical clerkship off-campus. In addition, there are at least two fourth year medical students in pediatrics and two in internal medicine doing acting internships in the Hospital at all times. There are a variety of clinical electives as well for our students.

In support of these medical student rotations, we have ten full-time tenure track medical faculty based in the Hospital. These men and women are tangible evidence of the strong affiliation we have with the Moses H. Cone Memorial Hospital.

As strong as these ties are, I expect they will be further strengthened by the recent recruitment of Mr. Dennis Barry to become the new executive director of the Hospital. Certainly the long-standing support of the Hospital's Board of Trustees and its medical staff also indicates that we anticipate a long and continuing relationship.

I look forward to the Hospital's admission to the Council on Teaching Hospitals.

Sincerely,



Stuart Bondurant, M.D.

SB/pw

DESCRIBING THE TEACHING HOSPITAL:
ALTERNATIVES FOR COH ACTIVITIES

October, 1979

James D. Bentley, Ph.D.
Peter W. Butler, M.H.S.A.

Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

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BACKGROUND

At the COTH Spring Meeting, participating members recommended that the AAMC/COTH sponsor or conduct a study (or studies) to quantify the intensity of patient care and the costs of education programs provided in teaching hospitals. This recommendation was supported by the COTH Administrative Board and the AAMC Executive Council. As a first step, staff were directed to develop a state-of-the-art paper on approaches to quantifying patient intensity and an annotated bibliography on educational costs. The first version of the intensity paper, "Case Mix Measures and Their Reimbursement Applications: A Preliminary Staff Analysis," was provided to the COTH Administrative Board at its September meeting and the Board recommended that staff:

- identify data which can be used to evaluate the DRG's as an intensity measure for reimbursement;
- identify researchers/consultants with expertise and an interest in conducting such an evaluation; and
- prepare a list of projects which could be conducted or sponsored by COTH/AAMC (1) to evaluate present DRG payment applications and the planned HCFA application and (2) to develop alternative reimbursement approaches for tertiary care teaching hospitals.

This paper responds to the Board's recommendations (1) by summarizing the research activities of others and (2) by suggesting several possibilities for COTH-sponsored activities.

ON-GOING CASE MIX RESEARCH

Case Mix Measures

Since the preliminary staff report was presented at the September COTH Administrative Board meeting, four developments in case-mix measurement have occurred. First, Yale University researchers -- Robert Fetter, John Thompson, and Richard Averill -- have received a grant from the Health Care Financing Administration to reformulate the diagnosis related groups using: the new ICD-9-CM coding convention; a nationwide data base maintained by the Commission on Professional and Hospital Activities, Virgil Slee, President; and the clinical advisory panels developed and organized by the Commission on Professional and Hospital Activities. This project is designed to ensure that DRG's are available for hospitals and programs using ICD-9-CM and to increase the professional acceptability of DRGs.

The National Center for Health Services Research is launching an intramural Hospital Cost and Utilization Project under the direction of Mark Hornbrook, Ph.D.. The objective of the study is to develop an economic model by quantifying the sources of cost differences between hospitals. For the 410 hospitals included in the study, the data base includes a year of discharge abstracts, a year of patient charge data, Medicare cost reports, and information describing the hospital itself. As a case mix measure in his model, Dr. Hornbrook would prefer to use the disease staging techniques developed by Systemetrics. He appears willing to use Center funds to complete disease staging as a case mix measure.

The diagnosis related groups developed at Yale and the disease staging system developed by Systemetrics are essentially clustering schemes for grouping diagnoses. While the procedures used to establish the clusters are quite

different, with DRG's using length of stay homogeneity and disease staging using the natural history of disease states, it is possible that the final clusters created by both approaches are relatively similar. To examine and evaluate this possibility, the Health Care Financing Administration has contracted with the Commission on Professional and Hospital Activities (Ann Arbor, Michigan) to study the similarity of the distribution of a set of PAS discharge abstracts using three categorizing schemes: DRG's, disease staging, and the PAS (A) list.* When completed next spring, the study will establish empirical estimates of the differences between the systems.

Since July, Susan Horn, Ph.D., of Johns Hopkins, and perhaps others, have developed a technique for weighting cases within a DRG using the patient's age, stage of disease, and response to therapy. The system establishes four subgroups for each DRG and is reported to significantly reduce the variation in costs within each category. Staff plan to meet Dr. Horn on October 26th to discuss this development.

Case Mix Applications

The New Jersey reimbursement experiment uses DRG-specific rates to reimburse selected hospitals. While participation is currently voluntary, the state plans to mandate its use in 26 hospitals in 1980. The Health Research and Educational Trust of New Jersey, an affiliated organization of the New Jersey Hospital Association, is presently conducting an evaluation of the state program. The evaluation, directed by J. Joel May, has an advisory council

* The PAS (A) list groups diagnoses by ICDA code, age, sex, and the presence or absence of surgery.

to promote objectivity which includes the New Jersey Commissioner of Health, the Hospital Association President, the State Representative and State Senator who Chaired committees that legislated cost containment, the President of the State Medical Society, and Herman Somers of Princeton University. In the two and one-half year project, the following issues will be examined:

- the statistical stability of the DRGs,
- the symmetry of the length of stays in a DRG,
- the allocation of costs to the DRGs,
- the quality and accuracy of discharge abstract data,
- the alternatives for computing DRG rates,
- the procedure for regrouping DRG's to account for changes in practice patterns,
- the impact of the DRG rates on individual hospitals,
- the cost of operating the state system, and
- the cost/benefit implications of the system.

As designed, the project staff will include state employees, hospital association employees, contract professionals, and employees of the audit and consulting staffs of one of the nation's "big eight" public accountants.

Cost Accounting on a DRG Basis

Concerned that present cost accounting systems are so aggregated and charge oriented that they do not permit an accurate determination of the costs per DRG, researchers at the University of Pennsylvania -- Steven Finkler, Ph.D., Sankey Williams, M.D.; and John Eisenberg, M.D. -- are developing a detailed cost accounting of three DRG's (one medical, one surgical, and one psychiatric) at a single hospital. The method they are using combines sampling, management engineering, and accounting. The objective of the study is to test the

feasibility of the method and to compare its cost estimates for the DRGs with estimates developed using present accounting practices.

In a project similar to that proposed by the Pennsylvania researchers, the Illinois Hospital Association and Ernst and Whinney have used management engineering techniques to develop a method establishing DRG specific costs at three hospitals: Evanston Hospital, Christ Hospital, and Katherine Shaw Bethea Hospital. The project accepts the Yale definition of the 383 DRGs and computes standard costs and standard times for activities used to care for patients in each DRG. The basic unit for the research project is the patient care unit (PCU), defined as a discrete service provided to patients. Examples of PCUs include individual X-ray procedures, individual lab procedures, individual therapy procedures, and individual days on a patient unit. With a completed list of over 2,000 PCUs, the project has attempted to identify the labor, material, department overhead, and hospital overhead costs associated with production of each PCU at each of the test hospitals.

Once the PCU time standards are computed for each hospital, standard costs for the individual labor services, materials, and overhead elements are determined using a hospital's actual costs. Average costs for a DRG are determined by aggregating the standard costs of the PCUs provided to a patient in that DRG. When completed, the approach could be used by hospitals in New York or New Jersey to test the cost allocation methods proposed for the DRG systems in those states.

Teaching Hospital Comparisons

The issue of the cost of services provided in teaching hospitals is beginning to draw attention from university researchers. In a proposal limited to inpatient costs, researchers at New York Hospital - Cornell Medical Center -- Hirsch Ruchlin; George Reader, M.D.; Livingston Farrand; Mary Goss, Ph.D., and David Thompson, M.D. -- are submitting a grant application to the National Center for Health Services Research to compare teaching and non-teaching hospitals. The study, which would use diagnostic and cost data from New Jersey and Maryland, would explore the following questions:

- do teaching hospitals treat a more severely ill population?
- when adjusted for case mix, is the length of stay longer in teaching hospitals?
- when adjusted for case mix, is ancillary service utilization greater in a teaching hospital?
- when adjusted for product mix, are departmental costs greater in a teaching hospital?
- is the quality of care higher in a teaching hospital? and
- does a hospital's participation in medical education programs increase or decrease its financial viability?

The grant application, in the amount of \$420,000 (direct cost), is being submitted to the National Center about November first. The AAMC has provided the researchers with a promise to help obtain COTH member participation in the study, see Attachment A.

In a grant application for \$500,955 submitted to the Robert Wood Johnson in July, Brandeis University researchers -- led by Stuart Altman, Ph.D. and Joanna Lion, Ph.D. -- propose a study comparing the cost of hospital-based and office-based ambulatory care. As proposed, the study will compare the mix of cases treated in hospital and office practices, the impact of mandatory

and elective cost allocation procedures for ambulatory hospital services, and the impact of situation costs (e.g., medical education, social services, facility and operating costs, bad debts) upon hospital-based ambulatory care. Thus, while the study's primary objective is not a comparison of teaching and non-teaching hospitals, the dominance of teaching hospitals in the provision of hospital-based ambulatory care will permit analyses and conclusions concerning the role and cost of teaching hospitals.

Recommendation

Several research efforts are presently underway or proposed for funding which will expand available case mix measures, evaluate a major case mix reimbursement application, establish procedures for cost accounting on a case mix basis, and compare teaching hospitals with their non-teaching counterparts or office based practices. Each of these efforts is being conducted by experienced investigators, and most involve advisory or steering committees of affected parties. Therefore, it is recommended:

- that AAMC staff establish and maintain liaison with each of the projects described in this section,
- that the AAMC consider supporting one or more of these projects only if
 - relatively small amounts of money are needed for project start-up or continuation between other sources of funds,
 - special analyses of importance to teaching hospitals are identified but unfunded by other sources, or
 - funds are needed to communicate research findings to affected hospitals or public policy makers.

POSSIBLE COTH PROJECTS

Based on the workshop discussions at the 1979 Spring Meeting, staff believe most members would like the AAMC to sponsor a study with two objectives: first, to once and forever identify the cost differences between teaching and non-teaching hospitals and, second, to divide any such difference into costs resulting from differences in the product produced, including medical education, the intensity of patient care, and the scope of services. Staff do not believe such a study is feasible at this time because broadly accepted procedures for quantifying the educational and case mix impacts do not exist. Moreover, several third party payors and hospital chief financial officers believe the benefit of such a study is illusory. Because the identification of differences would be based on present day operating practices, they believe the study findings would simply shift the debate from a challenge to demonstrate differences to a challenge to justify them. Therefore, in lieu of an all encompassing study, staff are suggesting several more modest research alternatives for the Board's consideration and evaluation. Following favorable Board action on one or more of these proposals, staff would work to develop or solicit a completed proposal, with budget, by the Executive Council's January meeting.

A Reference Book for Describing Teaching Hospitals

In its annual survey, the American Hospital Association gathers service, facility, utilization, financial, and personnel data on U.S. hospitals. To date, information provided by this survey has not been used in the AHA's statistical supplement to describe teaching hospitals and to compare them with their non-teaching counterparts. Therefore, it is suggested that COTH, using the AHA data, could prepare and publish a statistical compendium comparing

teaching and non-teaching hospitals. The compendium, limited to short-term general and specialty hospitals, could have the format shown in Figure 1 and could include variables from the AHA survey as shown in Figure 2. The completed tables would be distributed to all COTH members.

A Tabulation of Medicare Cost Report Data

The exceptions procedure for Medicare routine service limitations has been difficult for hospitals to use because they lack comparative data on the hospitals with which they are grouped. As a result, hospitals seeking exceptions cannot demonstrate either the norm for their group or their difference from such a norm. The AAMC probably could not obtain cost report data on all teaching and non-teaching hospitals in a HCFA category. It would be possible to obtain copies of cost reports only from COTH members and to use that data to prepare statistical description for COTH members in the largest three bed size categories as shown in Figure 3. The initial publication of such data could include either the components of routine costs or the components of all costs. In addition to its potential usefulness for Medicare exceptions, the report would be partially responsive to the frequent member requests for typical cost data on teaching hospitals.

A Data Base on Case Mix and Per Case Costs

The case mix reimbursement experiments underway in New York and New Jersey and HCFA's plan to use case mix in setting hospital payment limitations have stimulated an interest among some COTH members in comparing their case mix and case-specific costs with those of other teaching hospitals. This has been difficult because no case mix data base for teaching hospitals exists. There-

Figure 1

Basic Format for Summarizing Teaching and Non-Teaching Hospitals

Descriptive Value (Examples from Fig. 2)	Non-Teaching Hospitals		Teaching Hospitals			
	<u>Proprietary</u>	<u>NonProfit and Governmental</u>	<u>Limited</u>	<u>Major</u>	<u>Medical Center</u>	<u>Childrens</u>
ICU Beds per Hospital	_____	_____	_____	_____	_____	_____
Payroll Expenses per Adjusted Patient day	_____	_____	_____	_____	_____	_____
FTE Residents per admission	_____	_____	_____	_____	_____	_____

Figure 2

Possible Variables for Hospital Comparisons

Please return to the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611
AMERICAN HOSPITAL ASSOCIATION
ANNUAL SURVEY OF HOSPITALS 1978

Report data for a full 12-month period, preferably October 1, 1977 through September 30, 1978 (365 days).

1. Indicate period used: Beginning date: Month Day Year Ending date: Month Day Year Number of days: _____

2. Were you in operation 12 full months in the end of your reporting period? Yes No

B. CLASSIFICATION

1. CONTROL: Based on the categories below, AHA files indicate that the type of organization responsible for establishing policy concerning overall operation of your hospital last year was: _____

2. SERVICE: AHA files indicate that the type of service provided by your hospital provided to the majority of admissions last year was: _____

3. FACILITIES AND SERVICES: Check the box identifying a facility or service which is located WITHIN THE HOSPITAL. If your hospital shares facilities or services located in another institution, do NOT check the boxes for those facilities and services. Also, in the right-hand column, record utilization data as requested for the reporting period (SEE THE ACCOMPANYING INSTRUCTIONS AND DEFINITIONS SHEET).

D. BEDS AND UTILIZATION BY INPATIENT SERVICE

Account for all adult and pediatric inpatient beds set up and staffed for use at the end of the reporting period. List beds for a particular service area only if a unit is specifically designated for that service area. Do not count beds more than once. (SEE ACCOMPANYING INSTRUCTIONS AND DEFINITIONS SHEET.)

1. General medical and surgical (adult) (include eye/ear/nose) _____

2. General medical and surgical (pediatric) _____

3. Pediatric intensive care _____

4. Neonatal intensive care _____

5. Cardiac intensive care _____

6. Mixed or other intensive care _____

7. Burn care _____

8. Obstetrics _____

9. Neonatal intermediate care _____

10. Self care _____

11. Long term skilled nursing _____

12. Other long term (include ICFS) _____

13. Psychiatric _____

14. Mental retardation _____

15. Alcoholism/chemical dependency _____

16. TB and other respiratory diseases _____

17. Eye, ear, nose, and throat _____

18. Rehabilitation _____

19. Oncology _____

20. Chronic disease _____

21. Other (specify treatment area) _____

22. Other (specify treatment area) _____

E. TOTAL HOSPITAL BEDS AND UTILIZATION

1. LICENSED BED CAPACITY: The maximum number of beds authorized by state licensing (certifying) agency. If state does not regulate number, give report "NONE".

2. HEAVY NURSERY: _____

3. TOTAL STATISTICAL OPERATIONS: Whether major or minor, performed in the operating room(s).

4. OUTPATIENT UTILIZATION: Please record BOTH the number of outpatient visits and the number of outpatient occasions of service, if available, for each of the categories below.

5. Emergencies _____

6. Limited _____

7. Total _____

PLEASE REVERSE ATTACHED CARBON PAPER BEFORE COMPLETING THIS PAGE
 BE SURE TO MAKE AN ENTRY FOR EVERY BLANK, ENTER "0" WHENEVER ZERO IS APPROPRIATE

All statistics reported in E, F, and G must be on a COMPARABLE basis. For example, all units included in E4 must be included in F and G and vice versa.

E. TOTAL HOSPITAL BEDS AND UTILIZATION, continued

5. ADULT AND PEDIATRIC INPATIENTS (exclude newborn nursery):

a. Was there a permanent change or a significant temporary change in the total number of adult and pediatric beds during the reporting period? Yes No

b. Does your hospital maintain separate units specifically designated for short-term and long-term care (exclude newborn nursery)? Yes No

(1) Bed change (+ or -): _____ Date: _____ (2) Bed change (+ or -): _____ Date: _____

F. FINANCIAL DATA (if actual figures are not available, use estimates; round to the nearest dollar)

1. REVENUE (for the reporting period only):

a. Gross revenue from service to PATIENTS (based on established rates) \$ _____

b. Gross revenue from service to OUTPATIENTS (include established rates) \$ _____

c. TOTAL GROSS REVENUE from service to PATIENTS (a + b) \$ _____

d. (1) Deductions for contractual adjustments \$ _____

(2) Deductions for bad debts \$ _____

(3) Deductions for charity \$ _____

(4) Other deductions \$ _____

(5) Total deductions \$ _____

f. TOTAL NET REVENUE from service to PATIENTS (c - d - e) \$ _____

g. OTHER OPERATING REVENUE (appropriations, contributions, grants) \$ _____

h. NONOPERATING REVENUE (appropriations, contributions, grants) \$ _____

i. TOTAL REVENUE (e + f + g) \$ _____

2. EXPENSES (for the reporting period only):

a. PAYROLL EXPENSES for all categories of personnel specified below:

(1) Physicians and dentists (include only salaries) \$ _____

(2) Medical residents (include medical interns) \$ _____

(3) Dental residents (include dental interns) \$ _____

(4) Other trainees (medical technology, x-ray therapy, admin., and so forth) \$ _____

(5) Registered and licensed practical nurses \$ _____

(6) All other personnel \$ _____

(7) TOTAL PAYROLL EXPENSES (add (1) through (6)) \$ _____

b. NONPAYROLL EXPENSES:

(1) Employee benefits (social security, group insurance, retirement benefits) \$ _____

(2) Professional fees (medical, dental, legal, auditing, consultants, and so forth) \$ _____

(3) Depreciation expense (FOR REPORTING PERIOD ONLY) \$ _____

(4) Interest expense \$ _____

(5) All other expenses (supplies, purchased services, and so forth) \$ _____

(6) TOTAL NONPAYROLL EXPENSES (add (1) through (5)) \$ _____

c. TOTAL EXPENSES [(7) + (6)] \$ _____

3. UNRESTRICTED FUNDS

a. ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased):

(1) Current cash and short-term investments \$ _____

(2) (a) Current receivables \$ _____

(b) Uncollectibles \$ _____

(c) Net receivables [(2) - (b)] \$ _____

(3) Other current assets \$ _____

(4) (a) Gross plant & equip. assets (include land, build., equip.) \$ _____

(b) LESS: Depreciation for accumulated depreciation \$ _____

(c) NET plant & equipment assets [(4) - (b); if zero, please explain] \$ _____

(5) Long-term investments (at lower of cost or market) \$ _____

(6) Other unrestricted assets \$ _____

(7) Total unrestricted assets [(1) + (2c) + (3) + (4c) + (5) + (6)] \$ _____

b. LIABILITIES AND FUND BALANCE

(1) Current liabilities \$ _____

(2) Long-term debt \$ _____

(3) Other liabilities \$ _____

(4) Unrestricted fund balance \$ _____

(5) Total unrestricted liabilities & fund balance [(1) through (4)] \$ _____

4. RESTRICTED FUNDS - Report fund balances only

a. Specific purpose (other) \$ _____

b. Plant replacement & expansion \$ _____

c. Endowment funds \$ _____

G. PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1978

Report full-time and part-time personnel who were on the payroll AS OF SEPTEMBER 30, 1978, and whose payroll expenses are reported in F2a above. Include members of religious orders for whom dollar equivalents were reported, if figures here are discrepant with F2a please explain.

FULL-TIME PART-TIME TOTAL PAID MAN-HOURS (For reporting period)

1. Physicians and dentists (exclude nonmedical personnel) _____ (35 hrs/wk or more) (Less than 35 hrs/wk)

2. Medical residents (include medical interns) _____

3. Dental residents (include dental interns) _____

4. Other trainees _____

5. Registered nurses _____

6. Licensed practical nurses or licensed vocational nurses _____

7. All other personnel _____

8. TOTAL PERSONNEL (add 1 through 7) _____

Date of completion: _____ Signature of Administrator: _____

If there are questions about your responses to this survey, who should be contacted: _____ Name (print or print) Title Area Code Telephone Number

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Figure 3

Costs Allocated to the Inpatient Routine Cost Center

<u>Medicare Category</u>	<u>Percentile for COTH Member Hospitals</u>					
	<u>Depreciation: Bill & Fixtures</u>		<u>Depreciation: Movable Equipment</u>		<u>Employee Health & Benefit</u>	
	<u>50%ile</u>	<u>70%ile</u>	<u>50%ile</u>	<u>70%ile</u>	<u>50%ile</u>	<u>70%ile</u>
100-404 beds						
405-684 beds						
685 or more beds						

fore, one project which COTH could undertake would be to construct a case mix data base from a sample of members (1) able to supply discharge abstracts on all patients for a given year, (2) able to supply detailed patient bills for patients included in the discharge sample, and (3) willing to submit financial and cost data using a standardized cost reporting procedure. Once constructed, the data base could be used (1) by sampled and other participating hospitals to compare similarities in case mix and costs per case and (2) by AAMC staff to approximate the financial impact of various case-specific reimbursement experiments. The project would undoubtedly be costly, would require sampled hospitals to contribute substantial amounts of in-kind services, and would probably require subscription or user fees for hospitals seeking to use the data base.

Examining the HCFA Methodology

The methodology which has been developed by the Health Care Financing Administration to include case mix in Medicare payment limitations makes a number of assumptions which do not appear to have been examined:

- HCFA is using a 20% sample of Medicare discharges to compile its case intensity index. While previous studies have shown that this sample is adequate for national data comparisons, no one has assessed whether a 20% sample of Medicare discharges provides an unbiased estimate of a hospital's case mix.
- The HCFA approach will weigh each DRG by an index representing the average cost of treating that DRG across all hospitals. Essentially, the index becomes a relative value scale for the DRG and its validity depends upon the consistency of the rank ordering, by cost, of the DRGs across hospitals. To date, no one has examined the consistency of these rank orderings.
- The HCFA methodology assumes insignificant year-to-year changes in the case mix of a hospital's Medicare patients. If this is untrue, HCFA needs either to adopt a high threshold for the ceiling or to set the final ceiling for a hospital retrospectively. Without empirical evidence on year-to-year changes, HCFA will adopt neither a high threshold nor year-end adjustments.

To provide answers for these issues, COTH could solicit and fund requests for proposals from established researchers who have been active in case mix research and its reimbursement applications (e.g., Jack Cook, formerly of the Maryland Cost. Commission; Susan Horn of Johns Hopkins; Don Simborg of the University of California, San Francisco).

Workshops to Educate the Membership

Across the country, it appears that hospitals know relatively little about the characteristics and limitations of existing case mix measures or their use in reimbursement applications. To increase the case mix awareness of teaching hospitals, COTH could sponsor a two day workshop with selected outside speakers. Workshop topics would include descriptions of the case mix measures, reviews of the reimbursement experiments, discussions of the major alternatives which must be faced in designing a case mix reimbursement program, and presentations on steps hospitals can take to prepare for case mix reimbursement. Depending upon the detail desired, the workshops could be held for CEOs and administrative associates, chief financial officers, medical records personnel, and/or clinical service administrators.

A "Think Tank" Conference on Reimbursement

Case mix reimbursement systems using prospective rates seem to be the newest direction being emphasized for hospital payment. To date, most of the applications involve public payors who have previously reimbursed hospitals on a cost basis. COTH could contribute to the development of case mix thinking by sponsoring a "think tank" conference on reimbursement. Conference attendees

could include a limited number of attendees representing teaching hospitals, HCFA, Medicaid programs, private payors, rate setting authorities, and researchers. The conference agenda could focus on a series of prepared papers and discussion sessions addressing the identification of high priority research items, the assessment of alternative reimbursement experiments, and the selection of payment incentives (and risks) which are acceptable to hospitals and payors.

SUMMARY

At September's meeting of the COTH Administrative Board, staff presented a report on case mix measures and their reimbursement applications. This paper extends that report by briefly describing ongoing case mix research and by identifying several activities which COTH could undertake to make available data comparing teaching and non-teaching hospitals, to develop a data base on teaching hospital case mix, to investigate major assumptions in HCFA's case mix methodology, to establish a workshop on developments in case mix, and to conduct a conference on future directions in hospital payments. It is requested that the Board evaluate these alternatives for COTH action and suggest additional ideas at its November 5th breakfast.

October 11, 1979

Hirsch S. Ruchlin, Ph.D.
Professor of Economics in
Public Health
The New York Hospital-
Cornell Medical Center
525 East 68th Street
New York, New York 10021

Dear Dr. Ruchlin:

As you know, teaching hospitals -- because of their activities in medical education, supervised research, and tertiary care patient services -- fulfill a critically important and indispensible role in the nation's health care system. In spite of the importance of this role, there has been no empirical study which comprehensively describes and quantifies the patient care and cost differences among teaching hospitals and between teaching and non-teaching hospitals. As planning agencies struggle with resource allocation decisions and as third-party payors establish programs to limit hospital revenues, a comprehensive comparison of teaching and non-teaching hospitals is needed to help promote informed and realistic public policies. The study you propose, if conducted in Maryland or in Maryland and New Jersey, would provide a significant contribution to our understanding of the patient role and cost differences between hospitals. Therefore, if the National Center for Health Services Research funds your proposal, the AAMC would work through the members of its Council of Teaching Hospitals to obtain full member participation and cooperation in this study.

Sincerely,

Original signed by
J. A. D. COOPER, M.D.

John A.D. Cooper, M.D.

Prepared by: D. P. King

Date: 10/11/79

Reviewed by:

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

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COUNCIL OF TEACHING HOSPITALS
ANNUAL MEETING, NOVEMBER, 1979

TAB

COTH Institutional Membership Meeting and General Session,
Monday, November 5, 1979, 1:00 p.m. - 4:00 p.m.

AGENDA

A

TRANSCRIPT OF PROCEEDINGS

B

GENERAL SESSION - 2:00 - 4:00 p.m.

CONFLICT: CONTINUING ADVANCEMENT IN MEDICAL
TECHNOLOGY AND THE QUEST FOR COST CONTAINMENT

"What's Ahead In The Medical Technology
Explosion"

C

Barry Weinberg
Channing, Weinberg & Co., Inc.
950 Third Avenue
New York, New York

"The Government's Planned Approach to Technology:
Efficacy Evaluation, Utilization Standards, And
Reimbursement of Resulting Services"

D

John R. Ball, M.D., J.D.
Senior Policy Analyst
Office of Science and Technology Policy
Executive Office of the President
Washington, D.C.

COTH NOMINATING COMMITTEE REPORT, David L. Everhart

E

COTH CHAIRMAN'S REPORT, 1978-1979, Robert M. Heysel, M.D.,
(To COTH & Assembly)

F

STAFF REPORT, To COTH Membership, Richard M. Knapp, Ph.D.

G

SELECTED ACTIVITIES - Department of Teaching Hospitals,
October, 1978 - November, 1979

H

COTH INSTITUTIONAL MEMBERSHIP MEETING
Monday, November 5, 1979
Ballroom W
Washington Hilton Hotel
Washington, D.C.
1:00 p.m. - 2:00 p.m.

A G E N D A

- I. Call to Order - Introductions
Robert M. Heysse
COTH Chairman
Executive Vice President & Director
The Johns Hopkins Hospital
- II. Report of COTH Staff
James I. Hudson, M.D.
Director
Department of Health Services

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
- III. Report of the COTH Chairman
- IV. Report of the COTH Nominating
Committee and Election of Officers
David L. Everhart, Chairman
COTH Nominating Committee
- V. Presentation of Awards
- VI. Installation of Incoming Chairman
- VII. New Business
- VIII. Adjournment

COTH GENERAL SESSION
2:00 p.m. - 4:30 p.m.

CONFLICT: CONTINUING ADVANCEMENT IN MEDICAL
TECHNOLOGY AND THE QUEST FOR COST CONTAINMENT

"What's Ahead In The Medical Technology Explosion?"

Barry Weinberg
Channing, Weinberg & Co., Inc.
950 Third Avenue
New York, New York

"The Government's Planned Approach to Technology:
Efficacy Evaluation, Utilization Standards, And
Reimbursement of Resulting Services"

John R. Ball, M.D., J.D.
Senior Policy Analyst
Office of Science and Technology Policy
Executive Office of the President
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COTH Institutional Membership Meeting

Reel 1

Washington Hilton

Washington, D. C.

November 5, 1979

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P R O C E E D I N G S

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MR. : -- head of our Division of Health Services. John Cooper, I think, would like to say a few words, I think John has to leave.

MR. COOPER: Thank you very much. I'm not going to give a long speech of gloom and doom to follow up what we heard this morning. I did want to take this chance to thank the COTH, its membership and its very impressive chairman and board for all the contributions that they have made to the Association during this past year. They have, I must say, represented you very ably in the development of policy and the consideration of issues within the Association.

They've been very busy working with the other parts of the Association in trying to get some resolution to the serious which have been imposed on the teaching hospitals by Section 223, and the hospital case mix. And the results of the spring meeting of the COTH has put us on a -- has caused us to establish a program of very careful consideration of all the approaches that are being used around the country in attempting to measure case mix so that possibly we can find a way to get more adequate reimbursement for the kind of care that we give in the teaching setting.

The COTH members have also been actively involved in Association committees and taskforces. In addition, many of you have actively supported the Association with Congressional

contacts and letters and comments on the various regulations that have been proposed during the year. This kind of participation keeps the COTH vibrant and helps ensure that government officials take due cognizance of the teaching hospital in setting policies.

Lastly, I would like you to know that I believe an essential ingredient of a strong medical center is a sound, well run, financially viable hospital, meeting the needs of its patients, as Dave Rogers pointed out this morning. The COTH is essential to the viability and the vitality of these academic medical centers. More importantly, to us, it is also important to the vitality and viability of the Association.

We certainly look forward to continuing to work with you over the next year, and we particularly are happy that Chuck Woemer (PHONETIC) will assume the chairmanship of the Association on Tuesday. He will be the third member from the COTH group to have this highest office within the Association. Thank you very much.

(Applause.)

Thank you, John. And now if you'll proceed with your lunch, we'll follow that with our annual business meeting and general session. Those are open sessions and everyone here is invited to attend, if you wish. Thank you.

(Recording interruption.)

MR. HEYSSEL(?): -- meeting of the Council of Teaching

Hospitals to order, please.

First, I think we ought to hear from the staff, Dr. James Hudson first, and then from Dr. Richard Knapp. Jim.

DR. HUDSON: Mr. Chairman, once again this year, as was the case last year and seemingly as far back as eternity itself, Dick Knapp's staff in the Department of Teaching Hospitals has spent considerable effort on such issues as reimbursement, reasonable cost, case mix, cost containment, house staff inter-relationships, et cetera, et cetera.

During this time, on the other hand, the Department of Health Services has enjoyed the luxury of being able to contemplate certain issues rather than react to specific regulations or legislation. As a case in point, this Department has engaged the issue of health care cost containment from the perspective of educational programs for medical students and house offices. We've gone about this mainly through an effort to produce a text for faculty and students on cost containment and quality assurance in collaboration with John Williamson at Hopkins and eight other contributing authors.

The trick has been to orchestrate these works into a manuscript that is both cohesive and clear and comprehensive, as well as being accurate and, in fact, interesting. Now, I initiated this task about a year ago, fully confident that it would prove to be provocative and enjoyable and relatively simple, in that order. I was dead right about the first two

assumptions, and as you can possibly imagine, I was grievously over-optimistic about the third.

This has turned out to be a marvelously complex undertaking, and without the acquisition of some excellent staff support, I fear we could not have progressed nearly so far as we have even today.

The task is to develop a text which will provide the future practitioners with the methodology to analyze their own practice in terms of quality and cost control, which draws upon a broad, theoretical and practical constructive base. The effort must be sufficiently comprehensive and complex to provide this competency, while at the same time it cannot be so overly complex as to constitute a turn-off.

I must tell you that I've reviewed a few of the programs. There are some 41 official programs among our 126 medical schools and teaching hospitals, which feature formal cost containment efforts and education, and there must be at least 50 others beginning. And they run the gamut from very simple programs through more complex ones. The most popular ones seem to be among your house staff to develop sort of investigative case reporting, comparing the cost of a bag of IV fluid to their weekly stipend. And that really turns them on, as well as the medical students who see themselves there in a few years. But I think we can all appreciate it's a lot more complex than that.

The results of our field-testing of the manuscript this summer and this fall in some of your own institutions, incidentally, tell us that we have several large tasks ahead with this primer. First, once we've eliminated the extraneous jargon and become convinced that the language is clear and appropriate, we then must really decide on the degree to which we'll have to simplify the entire text with the aim to produce a product with the highest degree of practical use.

Secondly, we're facing, really, a pedagogical question here. We're persuaded that a systematic approach to cost containment and quality assurance implies a review of practice performance in the aggregate, through analysis of data gained by appropriate sampling techniques. How to reconcile this methodology with the usual medical education pedagogy which emphasizes clinical principles through the application to individual patients poses a challenge that this text still must ultimately address.

Incidentally, as a corollary to this activity, we're now preposing to develop, in concert with Mary Lee Ingbar (PHONETIC) at University of Massachusetts and Carl Hittleman (PHONETIC) at University of California, San Francisco, yet another text on cost containment theory based on the case study approach.

Now, if we are successful in obtaining the necessary financial support for this, then the Department will devote the

biggest part of next year to that project.

Armed with these two texts, then, and with the appropriate stable of knowledgeable consultants which have been derived through the course of these activities, one should be able to generate a series of useful regional workshops for our faculty on these methodologies for teaching, sometime in the future.

So much for textbooks and primers. The other half of our activity has concerned itself with the development of criteria and standards for the evaluation of continuing education programs for health professionals. That particular project involves a collaboration with Manny Suta's (PHONETIC) Division of Educational Resources and Programs and with a number of staff from the Veterans Administration.

The first year effort has now culminated in the announcement of about 12 essentials for CME, with a group of detailed criteria and standards to be applied to each. This afternoon the medical college CME director will be reviewing these criteria and tomorrow a mini-workshop on CME will feature a review of the project. These principles, criteria and standards will be further reviewed by a joint workshop of the LCCME and the Council of Medical Specialty Societies during the CMSS annual meeting in January.

And once all these criteria and standards have been critiqued by these bodies and similar organizations, they will,

in turn, be utilized for the production of some instructional manuals for learners, CE providers and program evaluators. And eventually, we would hope to do some pilot testing of this CE evaluation system in some 21 VA Hospitals featuring continuing education.

As a last assumption, it's expected that the results of that field test, which we expect to be completed about a year hence or a year and a half hence, will be useful in the final design of an accreditation system for CMME applicable to the larger world outside the Veterans Administration.

A brief review of that continuing education project is provided to you in this single sheet handout that you have.

Beyond these tasks, the Department has continued to respond to requests for information concerning issues on ambulatory care reorganization, prepaid practice arrangements and so forth. And we may be developing a new round of more formal activities in these areas next spring, depending upon funding and interest.

I would now like to introduce to you members of this Department who have worked in concert with the aforementioned projects this past year. First, Dr. Madeline Nebbins, (PHONETIC) Madeline, are you here today? Oh, there she is.

Many of the good results of our effort to produce a primer can be traced to Dr. Nebbins' excellent work. It is she who has done a major portion of the editing and a lot of

the writing. It is she who has organized and conducted the field tests, and it is she whom we hope may be able to work on the new text and eventual conferences.

Next, Mrs. Kathy Hupshire (PHONETIC). Kathy, would you stand? Mrs. Hupshire has worked both as staff secretary for the primer project and for the continuing education project. As you can imagine, this has required some organizational ability and stamina and a lot of good humor for at least two people. And she has accomplished all of this and more with real class. I'm particularly impressed with the quantity and caliber of work of these two individuals.

Mr. Chairman, in the past it's been customary for me to conclude this report with a thank you very much, and then you and the group, in turn, have responded with some light applause. This year I'd like to alter that procedure slightly and instead ask you to join me in a round of applause for these two individuals who have made the Department look as well as it has this past year.

(Applause.)

That does conclude my spiel. This has been a fun year. We've been working on some projects which I believe are important ones. As always, I've gained pleasure from working with the COTH staff and the administrative board. And furthermore, I have even enjoyed giving this report. Thank you very much.

DR. KNAPP(?): Anyone who spends a good deal of time involved in public speaking, as most of you do, faces times when there seems to be so very little to say. There are other times when the potential for discussion seems rather limitless. There are a wide variety of regulatory and legislative issues I could review and there are other organizational, financial and delivery matters about which many of you, I know have concerns.

Rather than trying to do justice to these issues in the short time available, we have prepared a very comprehensive and detailed review of our activities, which was made available to you as you came into the room today. I urge you to read that document and I'd like to hear from you if we've overlooked something or missed the mark on a particular issue or two.

In preparing my remarks for this afternoon I tried to ask myself what made this past year different. There is one issue that in the past has lurked beneath the surface but this year, I've noted, has more frequently made its way into the public and the professional press. That is the debate over whether a patient should be in a teaching hospital or non-teaching hospital. I know stating it in that simple fashion doesn't do justice to the complexity of the issue. There seems always to be more emotion than factual substance, but all participants to the debate seem to agree that the seriously ill belong in teaching institutions.

However, let me quote for a moment from a book en-

titled "The Life You Save: A Guide to Getting the Best Possible Care from Doctors, Hospitals, and Nursing Homes." The author states, "Some physicians would argue that any patient is better off in a teaching hospital because the latest equipment and best-trained physicians are there. On the other hand, even some top men on medical school faculties will tell you that the teaching hospital is no place to be sick. Unless you are seriously sick. There is often a cold, impersonal atmosphere." And the quote goes on in a very negative vein from there.

Now, since books and reviews of them, which I tend to see more frequently of late, with these blatant generalities do little to enhance the confidence of the public in our institutions. However, it does serve as a healthy reminder that it isn't always just a good medical outcome that is the basis upon which patients measure performance. The process of caring while that outcome was achieved is remembered as well. And as teaching hospitals are faced with more and tougher competition, this matter of caring will require more and more attention.

There are times when I wonder if our organization either could or should be doing something in this area. However, on a related matter, I know we should be doing more and we plan to do so in the coming year. Collectively, you gave the staff a mandate at the spring meeting in Kansas City and we've been at work attempting to chart a course or a proper

response to a better articulation and description of the teaching hospital and its products, better known as case mix research and development activities.

We think we've identified all of the major actors who are working in this field, and Jim Bentley and Peter Butler have visited most of them. We sent you an interim report in September and at this morning's COTH board meeting a number of possible specific projects were presented to the board for review.

Now, enough money to get started has been set aside in our current budget, and that's not been a major problem. What has been a major problem is everybody's in search of the answer. Our difficulty has been what the right question is. What is it that we're really trying to do here. It is clear to me that everyone wants a solution that will settle the case mix issue and its complexities once and for all. But I'd ask you to remember Eric Sevareid's proposition that every solution creates its own problems.

Now, in this regard I have two observations which worry me a bit. The first is that every hospital representative I talked to think that a good case-mix measure tied to reimbursement will increase his or her revenue. Teaching hospitals believe such a measure will justify a higher average cost, while non-teaching hospitals believe such a measure will demonstrate that more routine admissions ought to be hospitalized in their

less-costly hospitals.

While these viewpoints are not necessarily contradictory, I don't believe that both groups of hospitals can expect to receive an increase in revenue. Now, secondly, I think it needs to be remembered that any case-mix reimbursement mechanism, any reimbursement mechanism, including one based on case-mix, is subject to limitations not dissimilar to those which we are constantly and presently opposing. In other words, ceilings based on percentile ranks, means or medians can and probably will be calculated, no matter what the unit of analysis.

I ask that you bear these two points in mind as we move ahead in this area. We need all the help we can get on this subject and if you have some thoughts for doing something at your hospital that we ought to know about, please give us a call. This has been a busy year, we have a relatively small staff that will stay that way. Thus, there are some issues to which we don't give much attention and I believe this is appropriate. In determining what issues should receive priority we ask how a subject relates to the distinctive features and objectives of the teaching hospital, and ask what we can add that won't duplicate some other organization's effort.

I think this view keeps our eye on the ball. But again, we're always interested in your opinions and I would like to hear from you. All of what we do would not be possible

without your cooperation and your support. You complete the questionnaires, write the letters and give the advice, and more and more of you are giving your time and effort on a variety of committees, taskforces, and editorial boards. Please know we recognize and appreciate it all.

I'd like to thank the COTH board members, say it's been a pleasure to work with your chairman, Dr. Heysel. Jim Hudson is a pleasure to work with. And before closing I do wish to thank the people who work directly with me and I'd like to ask each of them to stand as I mention their name. Jim Bentley, Joe Isaacs, Peter Butler, Chip Cohn, who is an administrative resident at Tulane who joined us in July, Gail Gross, Melody Bishop, Tina Williams, (ALL PHONETIC), I think they're terrific. And thank you very much.

(Applause.)

MR. HEYSSEL: I'd like to comment that of all the staffs of all the associations I've seen, I think we're blessed with really the best. They do more than do what we ask them to. Very commonly, they tell us what we ought to be doing, and that's what a staff should do and we really are very fortunate in having this group of people.

I want to particularly thank both Dick and Jim and their staffs for the support they've given me this year, and how much fun it's made it to be your chairman.

That leads me to my task today, which is to try to

summarize some things that I think are important that have happened in the past year. But I won't do that by going through all of the activities, both Jim and Dick have done that. And again, I'd call your attention to the summary document which I think is available over at the door yet, if you haven't picked that up I hope you will, and give it some attention.

I want to talk about a couple of matters, the COTH spring meeting, the second one was held, as many of you know who were there, in Kansas City this last spring. Those meetings were intended to give the membership broadly a better opportunity to participate in the affairs of this Association and to provide the administrative board some guidance in exactly what Dick Knapp was talking about, what we should focus on and what we should do, from the special perspective of teaching hospitals.

The staff this year prepared a paper entitled "Toward a More Contemporary Public Understanding of the Teaching Hospital," an all together excellent document. Out of that discussion came a mandate for the administrative board and the staff to really focus on the issue of case-mix reimbursement, BRG's, and all of that other business that Dick was talking about.

Subsequent to that meeting a preliminary staff report called "Case Mix Measures and their Reimbursement Applications," was developed and sent to you in September. Based on this

particular participation and follow-up activities, it's clear to me that the spring meeting really does provide an opportunity to get together and serves as a focus and impetus for the staff to prepare reports such as I just cited.

I'd like you to make your calendars, then, for May 14th and 16th of next year, when we will be having the third COTH spring meeting, this time in the Brown Palace Hotel in Denver. You'll note we have moved West; St. Louis, Kansas City, now Denver. I'm not sure I can draw any conclusions from that, but it is further from Washington which probably has some merit in this country today.

The planning committee for the upcoming meeting is chaired by Earl Frederick (PHONETIC) of Children's Memorial Hospital in Chicago. Other members of the Committee are Fred Baun of the VA Hospital in Durham, North Carolina, Irv Goldberg from Montefiore Hospital in Pittsburgh, Bill Kerr of the University of California Hospitals and Dick Sedgenals from Harper Grace Hospitals in Detroit. (ALL PHONETICS). They're putting together a good program and they do want your input, they're paying attention to your comments from the last two meetings and I hope this will be an even better program.

A second matter I'd like to call your attention, very briefly, is a meeting of the AAMC assembly tomorrow afternoon at 1:00 p.m. The entire section is to be devoted to a discussion of the report of the taskforce of the AAMC on graduate

medical education. I hope you'll all do your best to try to be there. Spike Foreman of Sinai Hospital in Baltimore and Merlin Oleson of the University of Colorado (PHONETIC) are COTH representatives on that taskforce. They've produced a series of important documents, important to us as teaching hospitals, important to graduate medical education in this country. It really does require the full participation of everyone in the AAMC. It's open to all interested individuals and I urge your participation and attendance.

The way in which the report, which is lengthy, is to be reviewed appears on page 15 of your annual meeting program. Take a look at that before you come.

Now, having reported on these business matters, I'd like for a moment to share some personal observations with you on the topics of state rate review, patient case mix, and the role of physicians in hospital management. In one of the trade publications recently, some hospital spokesmen indicated that they believed state rate review programs to control hospital costs are dead. And I'm sure you're all well-aware that Colorado, which had created a state rate review commission, un-created it only this last year. A surprising example of government dismantling a regulatory agency totally.

Perhaps my own views on this matter are colored by the fact that I'm from a state where such a program is alive and well and functioning, and maybe I'd like to put you all in the

same boat, since misery has company. But in fact, that is still very much an alive issue. The Carter cost containment bill for the first time spreads the option there for all the states to participate at the state level in state rate review, and it continues to -- or it should continue to occupy our concerns as to what our stance should be. While we may want a state where we're regulation free, that's not likely to happen. I can't see that utopia occurring in the near future and we still have to be concerned as to whether we want that at the state or the Federal level.

In Baltimore we are close enough to Washington so that I can hear what's being said, but we're not so close that I hear it often enough to believe it. There does seem to be a free enterprise dialog on hospital issues that is growing. The discussion and rhetoric for the moment seem to be more at the conceptual than the operational level. In other words, I don't think anyone's quite sure how things would work, that is in a deregulated, competitive industry, but people are politically and personally attracted to the idea of deregulation and competition today.

This is a subject to which I think we in teaching hospitals really need to give some thought. How competitive would we be? If it's true price competition, can we compete even for those non-tertiary care services? What do we do with the costs that are related to our teaching programs? And they

are real. What, really, would be our strategy for surviving and prospering in an environment of full-blown deregulation as teaching hospitals?

I don't have a short answer to that, or even a long one, perhaps. But it does need more careful thought and brings me to the other issue I wish to mention, that is patient diagnostic case mix, and the physician's role in hospital management.

I believe each of us would be well-served to be sure efforts are well underway in our own hospitals, to have a thorough understanding of the diagnostic case mix of the patients we are serving, and the relationship of that case mix to the expenditures in the hospital. There are a variety of ways of doing this, but I can assure you, since we're sort of living with that now in Maryland, that it requires more players at the table than the administrator and the chief financial officer. It requires the physicians on the staff to be involved in that, along with a lot of supporting personnel in the computer area, in medical records, the whole quality assurance group, and so forth.

In an age of competition as well as regulation, substantiating case mix expenditures is essential if we are to be able to continue to market our services and justify our prices. The prospect of Medicare incorporating a case mix measure in setting its limits next year, really should be

incentive enough to all of us to look hard at that issue and to be sure that we work at it.

At the COTH general session two years ago, I spoke on the topic of physician responsibility and accountability for controlling the demand for hospital services. Some more of that was said this morning by Dr. Relman and Dr. Rodgers. My views on the subject hasn't changed much in two years; if anything, they are stronger. I believe we must find ways to bring the medical faculty and staff into positions where they can exercise leadership and take an institutional view of issues such as case mix, of issues such as cost containment. I think we can do that and I think people do respond to economic and other incentives.

We must find a way to make a change in behavior of our staffs, again following Dr. Relman's lead this morning, worth while. That's especially true when you consider the collective appetite for new technology, which is the subject of our session this afternoon.

It's been a pleasure for me to serve as your chairman during the past year. I want to thank the members of the COTH board for the support they've given me and for their contribution to our effort. Thank you very much.

(Applause.)

I'd like to now move ahead with the agenda and ask Dave Everhart to give the report of the nominating committee.

MR. EVERHART: We now come to that electric moment in this proceeding, when you can exercise your option of free will to elect the representatives and officers of the Council of Teaching Hospitals for the coming year.

The nominating committee consists of three people, the immediate past chairman, which is why I'm here, the present chairman and one member at large, who this year was Jean Staples from the University of West Virginia Hospitals. Therefore, the nominations which I will present come from the fertile minds of those three individuals.

I think all of you know that the governance of the AAMC is vested in an assembly and a division into councils. In the case of the Council of Teaching Hospitals we have 57 representatives on the AAMC assembly, therefore this year we have 19 nominations to put in place for a three year term, and we do have one unexpired term that I'd also like to suggest.

Therefore, Mr. Chairman, for nomination for a three year term expiring in 1982 the following people for the AAMC Assembly. First, Jess Burrough, VA Hospital, Sepulveda, California. Lawrence Foye, VA Hospital, San Francisco. Louis Frazier, VA Hospital, Shreveport, Louisiana. William Kurtner, Mt. Zion Hospital, San Francisco. Warren G. Harding, Bayer County Hospital in San Antonio. Roger Hunt, Indiana University Hospitals in Indianapolis. John Ives, The Shanz Teaching Hospital in Gainesville, Florida. Don Kasbaum, University of Oregon

Hospitals in Portland. James Malloy, the John Dempster Hospital in Farmington, Connecticut. Bruce McFadden, University of Maryland Hospitals, Baltimore. Joseph Moore, VA Hospital, Lakeside, Chicago. Charles O'Brien, the Georgetown University Hospital here in D. C. David Pitts, Oxner Foundation in New Orleans. Ruth Rothstein, Mt. Sinai Hospital in Chicago. Jerome Cepaulski, Miriam Hospital, Providence, Rhode Island. Dick Sedgenost, Harper Hospital, Detroit. Robert Taylor, Hanaban County Hospital, Minneapolis. Dave Weiner, Children's Hospital, Boston. And Bernie Weinstein, Westchester County Medical Center in Valhalla, New York. And for a one-year term, expiring in 1980, John Reinardson, University of Utah Hospital in Salt Lake. (All PHONETICS).

I think I will go ahead with the rest of these and then you can take care of the elections all at once.

We have three openings on the COTH Administrative Board and one opening for the COTH Secretaryship. Therefore, we're nominating for a one-year term, expiring 1980, Mitch Rapkin, Beth Israel Hospital in Boston. And Mitch, I wonder if you'd stand so people can identify you.

For three-year terms on the COTH Administrative Board, Fred Cowl, Jackson Memorial Hospital, Miami, Florida. Fred, are you here? I hope. I guess not. Bob Frank, Barnes Hospital, St. Louis. Bob is here, would you stand? Earl Frederick, Children's Memorial Hospital in Chicago. Earl, would

you stand.

For representative to the AAMC Executive Council, three-year term, John Reinardson, University of Utah Hospitals. John is here.

Mercifully, you don't have to vote on this, but Heyssel becomes past chairman, that's automatic.

The chairmanship is also automatic, John Colleton is nominated for your chairman for this year. And for Chairman-Elect, Mr. Stuart Merilander, Cedar Sinai Medical Center, Los Angeles.

Mr. Chairman, I move these nominations.

MR. HEYSSEL: Thank you, Dave. Are there further nominations from the floor?

If not, could I have a second, please.

Since there are no further nominations, the slate is elected. I was sitting here wondering what in God's name I'd do if there were further nominations, having been here several years for this.

Thank you. Now, there is a moment of pleasure in the sense of recognising past contributions to the Association. Members of the Administrative Board whose terms of office expire this year, and I'd like to have Mr. James Ensign, Mr. Jerry Dallzall, and Dave Everhart step forward, please.

David, thank you on behalf of all of us.

(Applause.)

(Background conversations and applause.)

It's now my pleasure to turn the meeting over to your new chairman, John Carleton (PHONETIC). John?

(Applause.)

MR. CARLETON: Thank you very much, Bob. One year ago at this juncture in our meeting, Rober Heyssel stood before you and chokingly said, "It's a pleasure and honor for you to have me as your chairman."

(Laughter.)

End of quote. Today I would like to say that Bob Heyssel told it like it was, for he truly has been an outstanding chairman. So Bob, on behalf of the entire Council, it's my pleasure to present you with this gavel, inscribed with the dates of your term of office, with deep appreciation from all of us.

(Applause.)

We are now at that point when we will adjourn if there is no new business. Hearing none, I would remind you that we are scheduled to reconvene for our general session at 2:00 p.m. Thank you, and we are adjourned.

(Recording interruption.)

MR. CARLETON: In 1978, Congress passed the Health Services Reasearch, Health Statistics and Health Care Technology Act, which some authorities say potentially establishes, for the first time in this country, a central authority charged by law

with determining the future of medical practice.

This, obviously, is an awesome responsibility, and has many profound implications, one of which we will address today. The theme of our session addresses the conflict between continuing advancement in medical technology and the quest for cost containment. We'll first hear from each of two speakers and then take questions thereafter.

Our first speaker is Mr. Barry Weinberg, president of Channing, Weinberg and Company of New York City. Channing, Weinberg is a consulting and market research firm which has served more than 200 of the world's leading medical manufacturing companies, as well as hospitals, governmental agencies and financial organizations. In addition, the firm has worked extensively with and assisted in the financing of many smaller, emerging companies, whose products have had a significant influence on advances in medical technology.

Prior to founding the firm in 1968, Mr. Weinberg served in various management roles, including a major international consulting group, a computer equipment manufacturer, and with ETT. He earned a Master's degree in electrical engineering from Northeastern University and an MBA from New York University. It's my pleasure to present to you, Mr. Barry Weinberg, who will speak on what's ahead in the medical technology explosion. Barry.

MR. WEINBERG: Thank you, John. I wish my children

had such nice things to say about me.

The technologies I'm going to tell you about today are technologies that, in our opinion, will gain widespread acceptance, not withstanding cost containment and other control efforts. That's not to say that cost containment is not going to have an effect; we think it will and it will deter what would otherwise have been a more dramatic growth. However, we feel that in many of these cases the medical benefits offered by these new technologies will be of such a magnitude that practitioners and the public will simply not do without them.

And here, I think we have to count very heavily on the role of the public. This is a new phenomenon that we haven't had in the past. The "National Enquirer," for example, now has more articles on medicine than on sex.

(Laughter.)

Four months ago the "National Enquirer" ran an article on a new kind of laser device that supposedly cured laryngeal cancer with no surgery, and my ear, nose, and throat specialist friends told me they were deluged with phone calls from the public asking if they had the new laser yet.

I think it's pretty clear that the American public wants better quality health care and we're going to see a continuing conflict here, as John pointed out, between the new technologies, demands of the public, and the emphasis on cost containment. I think my wife is a perfect example. My

wife is a real firebrand when it comes to controlling costs, she's very anti-medicine, she's against the high costs that are incurred for both hospitals and doctors' office visits. However, as soon as one of our kids gets sick, she wants every test that's done. And I think this is a good example of what's going to happen in the United States, the public is becoming more educated, it's more aware of its health, and we're simply not going to see the end of technology.

While I think the medical benefits will be the prime motivation for advanced technology, there will certainly be other cases, and we've seen it with the CAT scanner, which is probably the most fascinating example, where competition among institutions to offer the best health care possible will also add to the quest for new technology.

Whatever the reason, however, it seems clear to us that technology will continue to have a major impact on medicine for the foreseeable future. Now, I have some slides here which are going to talk about some very specific technologies that we see becoming important in the future. And also, the first two slides are of a background nature which will set the scene in which we think technology will gain acceptance.

(Inaudible) -- typical technology problems. Is it possible to dim the lights? There we go.

The emphasis on technology arises out of what we consider to be the new medicine, and here are just a few of

the areas that we think are going to receive emphasis in medicine. One is increasingly early emphasis on diagnosis. Not only is it good medicine but many of the cost containment people feel that ultimately, by diagnosing a condition before it becomes irreversible, it will be possible to keep a patient out of a long-term, costly hospital stay.

Another area of emphasis will be on ambulatory care, keeping a patient out of the high-priced surgical and acute care bed. Cost containment, I'm sure you've heard about this in the last few days, everybody agrees that it's one of the major aspects of health care and we certainly feel that it's going to deter the acceptance of technology, although not destroy it.

One way of overcoming some of these limitations is the involvement in longer term treatment, very often outside of the hospital environment, as a replacement for, again, acute care facilities. One of the things we've seen in Europe, which are countries involving much more direct government-intervention, the government has arbitrarily set health care limits. In Sweden, for example, if you're 65 years old and you need a pacemaker, but you also have some complicating disease such as cancer, you probably won't get it because the government has made an arbitrary decision that you're a high-risk patient who's probably going to die anyway within a few years.

More technology, clearly. In our opinion, technology is the only device that is capable of meeting the two distinct

needs of the emerging health care environment. That is, better quality health care and more const control.

And finally, with the increased use of new technology, we see greater dominance of the medical field by specialists, individuals who are capable of taking advantage of the capabilities of these highly specialized devices.

What about the role of specialists? Specialists in the New Technology is the title here, in case you can't see it. One of the things we see happening with these new technologies is that departmental demarcations are blurring. Traditionally, for example, the radiology department was responsible for buying imaging equipment. Well, now we see cardiology, obstetrics, gynecology, neurology, all buying new technology devices like ultra-sound equipment. In the future we think it's going to be more difficult to say that a particular specialist in the hospital is going to be responsible for all areas of a certain kind of technology.

We've also seen new fiefdoms arise. Fifteen or twenty years ago the cardiologist, for example, was primarily a purchaser of pills and stethoscopes, and perhaps \$1,500.00 EKG machines. Well, last year we estimate that cardiologists purchased, in the United States, about \$500 million worth of equipment, not including another \$250 million worth of pacemakers. So here, out of no where, has come a high powered purchasing center in the hospital.

Clearly, one of the factors contributing to the growth of technology has been increasing concern about malpractice on the part of practitioners. The more tests that can be done on an individual, the ability to show that you're using the latest technology, is a defense against malpractice, and also has support in the sense of being good medicine.

We also see conflict within the hospital environment in who's going to control these patients? Many of these specialized devices, the results can only be interpreted by a highly specialized, specially trained individual. And I know in my own family, for example our family doctor is now a cardiologist as opposed to a general practitioner. And more and more we're going to see, in our opinion, the patient going to a specialist at an earlier stage of his disease development.

Finally, we see a dollar-oriented pecking order arising in the hospital, very often based on the developments and new technology. I had the occasion last week to walk through a hospital in Japan and I saw a situation that was very similar to that existing in the United States. The cardiology department has all fancy, new equipment, highly streamlined, a lot of electronic gear making funny beeps and sounds. When you go down to the respiratory care department it tends to be a weak sister. The technicians there are making do with equipment that's 20 years old. So clearly, within the hospital we've seen a hierarchy develop among those doctors who are able to get purchases of highly advanced equipment.

Let's look at some of the major technological trends now taking place in the field. One of the things that we see proliferating in a wide variety of institutions all across the country are non-invasive diagnostics. And I'll discuss each one of these areas in more detail later on.

Also, we see an increasing emphasis on something called least-invasive surgery. This involves getting away from cutting the patient open, from involving surgically created wounds that may be difficult to heal, that may cause further complications to the patient, doing surgery in a way that is more ambulatory.

Care of the acute patient, I think, in spite of the high cost of treating acute patients, our country is not going to diverge from the traditional concept of using whatever power is available to keep the patient alive.

The availability of intelligence in a wide variety of electronic equipment, through the use of micro-processors, is something we see proliferating throughout all specialties. Here we're talking about adding small, micro-miniaturized chips that have computing capability to various kinds of diagnostic and therapeutic devices, to provide intelligence, to provide analytical capability, to enhance the ability of the practitioner to both diagnose and serve the patient.

And finally, widely improved implants. Now, let's look at each of these in a little more depth. What are some

of the specific areas in non-invasive diagnostics we see growing? Well, probably at the top of the list here is ultra-sound. Ultra-sound is a safe, relatively inexpensive, easy to use approach that's applicable to a wide variety of specialties. We estimate, for example, that in 1978, about \$120 million was spent by hospitals and private practitioners in the United States on ultra-sound equipment. By 1984 we're predicting that this level will increase to about \$425 million. And we expect to see this technology being accepted by a variety of specialties that are not currently using it. Right now cardiology and radiology are the big users. In the future we see obstetrics, gynecology, neurology, perhaps urology also using this.

The measurement of physiological parameters. Right now ultra-sound is used primarily to measure anatomical characteristics but we see the improved technology being utilized to measure such things as blood pressure non-invasively in cardiac output.

Ambulatory monitoring is another area of important growth in our opinion. Right now ambulatory monitoring is primarily involved with portable 24 hour ekg recorders, where the patient wears an ekg recorder for 24 hours, his ekg signal is recorded for the full period of time, and then it's analyzed by a technician and a playback device. But we see other parameters such as blood pressure, perhaps respiration, being added to these devices that provide a dramatic increase in information over

resting ekg's or short-term measurement of these parameters.

Other areas we see are increased emphasis on imaging. Imaging is an important part of diagnostic medicine and will not disappear in importance, even though we have CAT scanners all over the place. And already, after the CAT scanner, we're looking at two other kinds of technologies here that are certainly by no means proven but which offer the potential for important medical advances.

These may be terms that you're not familiar with. One is nuclear magnetic resonance. This involves measuring the parameters of the molecules of various kinds of tissues, and potentially differentiating between pathology and cystic tissues. Electron spin resonance is another technique that involves measuring the characteristic of tissue electrons. As you can imagine, these are techniques that are not in use right now. They're going to require a lot of development and research before they become proven. We think that by the mid to late 1980's, you're going to see devices installed in hospitals using these techniques.

Least-invasive surgery, as I mentioned before, is an attempt at minimizing the cutting of patients. And here we see three devices that will increase in use. One is lasers; right now lasers are used primarily on experimental basis but I had the opportunity a few weeks ago to go to see laryngeal cancer removed by a laser and the patient being awakened

about half an hour after the procedure was completed. The whole procedure took about 30 minutes, there was no wound made in the patient's throat, the pathology was removed to a very minute degree without injuring the larynx. The medical advantages of the laser in this kind of surgery are tremendous. And the patient could go home a day later instead of having to stay in the hospital for a week.

The use of endoscopes to diagnose the patients and also deliver therapy is an area that we think is going to receive increasing acceptance in the future. Some of the advancements in fiberoptics now allow flexible endoscopes to be inserted in normal body openings and essentially threaded through complex anatomies such as the sigmoid for direct visualization and removal of pathology on an ambulatory basis.

Finally, we see the increased use of microsurgery. The magnification and light advantages of the use of microscopes are truly immense and the fact that many surgeons have grown up without the microscope has contributed to a rather slow acceptance of this technique to date. However, most of the younger doctors are being trained in these techniques and we think will accept them as a more natural approach and consequently, we think that most surgery in the mid to late 1980's will be done through microscopes.

Let's look at care of the acute patient, what some of the things we see here. Well, clinical nutritional support

is a new area. For many years nutrition in the hospitals was looked at as akin to motherhood. But some studies were done recently which showed that upward of 30 percent of all surgical patients are malnourished. Not in the sense that their bones were showing, but they can't really fight off the disorders and conditions of their post-operative surgery. So we're looking at an emerging new specialty here involving the clinical support of patients, both pre and post operationally, and the use of a wide variety of nutritional solutions and new kinds of pumping systems and delivery systems here are, we think, going to gain acceptance in the 1980's.

Improved patient monitoring, adding intelligence to patient monitoring systems, to allow such things as automated arrhythmia detection is just one example of the kind of thing we see happening here that will probably lead to an upgrading of acute care facilities through the 1980's.

Finally, mechanical assist devices. I'm sure all of you have heard of things such as the inter-aortic balloon pump, which is primarily looked upon as a device of last resort right now. But we see many advances being made on an experimental basis on some of these devices and it may be possible in the 80's, for example, to implant devices like pacemakers but that provide assistance to the pumping mechanism of the heart, not simply the electrical conduction system.

We have a little technology problem here. One of

the slides won't go down so we have to use a knife to push it down. It reminds me of a time I borrowed somebody's Cadillac to take a trip and was horrified to discover at each tollbooth I had to open the door to pay the toll because the electrical motor that operates the window broke down.

The addition of intelligence through micro-computers is an area that we think is going to achieve a great deal of emphasis in the 1980's. For example, the use of these micro-miniaturized chips to perform automated ekg analysis. Just this past year one of the major computer companies introduced a small, three-channel ekg cart that not only produces an ekg trace when the button is depressed, but also produces a computerized evaluation of that patient's wave form which suggests therapeutic measures.

So more automated analysis is something that we think is going to affect the field. Likewise in imaging, the application of computer techniques to ultrasound, for example, can substantially improve ultrasound, perhaps bring it up to a condition comparable to that of x-ray. And the use of computer techniques with ultrasound would be akin to the application of computer techniques to x-ray for the development of computerized tomography.

Patient monitoring, as I mentioned earlier, is another area where intelligence will be used to monitor a patient's condition, perhaps ultimately automatically bring about thera-

peutic measures based upon the condition of the patient, without having to wait for manual intervention. Respiratory care, automated delivery of anesthesia are just two more areas where we think the use of micro-processors will have an important impact on the field.

This last slide here covers the area of implants. Here we see materials, new kinds of material processing techniques, leading to substantially improved orthopedic joints. We recently completed a survey of orthopedic surgeons which indicated that if there were available better artificial hips and better cements for implanting those artificial hips, the number of procedures would be substantially greater than that which exists at present. And we see developments taking place, not only in America but overseas as well, that will lead to substantially improved orthopedic joints.

Artificial vessels, right now probably the most widely used application in artificial vessels is in dialysis patients where arteriovenous fistulas are produced using bovine grafts. Well, it's our opinion that in the future you're going to see plastic and other manmade materials being used to produce highly effective artificial vessels that can be used to bypass damaged vessels.

Intraocular lenses is another example of an area that we've already seen dramatic growth. We estimate that in 1978 almost \$30 million was spent in the United States on

intraocular lenses by hospitals, compared with only about \$3 million just two years earlier. A clear indication of what can happen when new technology gains acceptance among a group of practitioners.

Finally, we see artificial organs, implantable artificial organs being developed in the late 1980's and early 1990's, that will negate the need for some of the palliative measures now taken. For example, we anticipate an implantable artificial kidney that will do away with the need for dialysis externally by 1990. Likewise, an artificial pancreas to overcome many of the problems associated with diabetes is a real possibility in the late 1980's.

So what I've attempted to do here is simply summarize some of the important developments that we see taking place in the field. And we think that in spite of the increasing emphasis on cost containment, that we're not going to see a demise of technology, that in fact technology is going to continue to thrive because it offers a hope for performing those two distinct requirements of the health care field, namely better quality medicine and also lower cost. And it's really the only thing on the horizon that seems to have the potential for doing this.

I don't think we disagree that cost containment is going to have an effect on technology, but it's going to cut back on its growth somewhat, but clearly, the increasing

interest of the American public in improved quality of health is not going to allow a deterioration in technology.

Thank you very much.

(Applause.)

MR. COLLETON : Thank you very much, Barry, for that analytical view of what's ahead. I'm sure the audience will have a good many questions for you momentarily.

Our next speaker is Dr. John Ball, senior policy analyst in the President's Office of Science and Technology. Dr. Ball was a Robert Wood Johnson Clinical Scholar at George Washington University and received both his M.D. and J.D. degrees from Duke. He has served in various capacities at HEW including chief of the medical audit branch of the Division of Peer Review during 1976 and 1977, and was assistant to the Director of the Office of Quality Standards from 1974 through 1976.

It is with great pleasure that I present Dr. John Ball, who will speak to you on the government's planned approach to technology, efficacy evaluation, utilization standards and reimbursement of resulting services. Dr. Ball.

(Applause.)

DR. BALL: Thank you, Mr. Colleton. I should like at the start of this session to note that the title of the general session, that is Conflict: Continuing Advancement in Medical Technology and the Quest for Cost Containment, reflects

a presupposition that may limit our vision of the future and our understanding of the future. I, for one, don't accept the assumption that continuing advancement in technology is necessarily in conflict with the quest for cost containment, and in that I echo Mr. Weinberg. I believe it's possible to have both more rational expenditure of health care dollars and innovation in health care technology.

This isn't to say that those goals aren't in potential conflict, nor is it to say that the balancing of divergent or seemingly divergent values is not inherently difficult. It is to say that the choice need not be either/or, either cost containment or innovation.

One should also hesitate to read too much into the titles of speeches, but in this case mention should be made of the title assigned by your program committee to Mr. Weinberg, "What's Ahead in the Medical Technology Explosion." That title contains a loaded word, explosion. Inadvertently or not, your program committee put its collective finger on a most important problem, explosions in the traditional sense have the capacity for good or for ill. But it's part of the nature of explosions that their effects are not highly predictable but are often random and destructive.

I want to suggest that a part of our common problem is the way in which health care technology finds its way into

and is used in medical practice. I'd be unfair at this point if I didn't comment on the title assigned to me, "The Government's Planned Approach to Technology: Efficacy Evaluation, Utilization Standards, and Reimbursement of Resulting Services." The titles of the general session and of the other presentation each contain loaded words, "conflict" in the former, "explosion" in the latter. The loaded word in the title assigned to my presentation is "planned."

It would be at best inaccurate to say that the Federal Government has had or presently has a planned approach to health care technology. In fact, another part of our common problem is that the government has no rational approach to health care technology. In essence, what I've been asked to do is predict the future. I shall attempt to do so by the usual method, presenting my own data, making certain assumptions, analyzing trends and drawing conclusions. The reason that you, the audience, have an interest in all of this is that the better you and your institutions can predict the future, the better you can cope with the changes that the future will bring. The better you cope with change, the more likely you are to survive to prosper.

What I shall do therefore is to relate present activity and to predict future policy in health care technology from the Federal Governmental perspective. Specifically, what is likely to occur in the areas of efficacy evaluation, utili-

zation standards and resulting reimbursement of services. In order that these remarks be placed in their proper perspective, you should be assured that they reflect no hidden agenda. That is, there does not exist, either within HEW or the Department of Health and Human Services, or within the Executive Office, a secret health care technology policy, lurking, ready to spring upon you.

First, then, efficacy evaluation. Louis Thomas, in his delightful and perceptive book "The Lives of a Cell" wrote, "Technology assessment has become a routine exercise for the scientific enterprises on which the country is obliged to spend vast sums for its needs. Brainy committees are continually evaluating the effectiveness and cost of doing various things in space, defense, energy, transportation and the like, to give advice about prudent investments about the future. Somehow medicine, for all the money that it is said to cost the nation, has not yet come in for much of this analytical treatment. When, as is bound to happen sooner or later, analysts get around to the technology of medicine itself, they will have to face the problem of measuring the relative cost and effectiveness of all the things that are done in the management of disease. They make their living at this kind of thing, and I wish them well. But I imagine they will have a bewildering time."

Thomas was right on at least two accounts. The analysts have gotten around to technology of medicine itself,

and yes, they are having a bewildering time. He was, however, at least partially wrong on one count. Technology assessment, at least in some form, isn't new. Technology assessment, that is the evaluation of health care technology, has been occurring in some rudimentary fashion for years. What is new are new methodologies, new structures, new laws and new public concern.

Public concern has come about because of heightened public awareness of and fascination with technology in general and health technology in particular. The electronics industry represents a stunning example of the vast range of products of technology and the rapidity of technological change. The breakthrough of the miracle chip has made possible gigantic steps in computer applications as well as in a plethora of consumer products. In the short space of one decade, students have replaced the slide rule with personal desk-top computers which have capacities far exceeding the giant instruments of the 1960's. And in the electronics industry, as in most other industries, technological change has brought decreases in costs and in prices.

The development of such fascinating products of science and technology has led to an increased public awareness of the potential for technology and to increased public expectations of the benefits of technology. That awareness and those expectations are beginning to be focused on health care technologies.

The public, partly mystified by modern medicine and partly dissatisfied with the inability of many medical practices to improve patient outcomes, quite naturally expect that the increasing application of technology to medical care will bring significant benefits. Anyone who's been inside the modern hospital may surely expect that the current explosion in laboratory tests, machinery and people, should bring him and her increased well being.

In addition to public expectations of increased benefits, there are also public expectations that technology will bring decreased costs. In almost every other industry, technological improvements lead to decreased manpower and production costs. In contrast, it has been said, in the health field new technologies usually increase both labor and capital cost. The public is frustrated over the rising cost of health care and technology has become the lightning rod to capture that frustration. Impersonal, tangible and very visible, technology is an easy target for public dissatisfaction.

The current climate in which the discussion of health technology proceeds, therefore, is one of public expectation and public frustration. Keeping that climate in mind, let me weave a picture of the current technology assessment, returning to a theme introduced a few moments ago; that is that some evaluation in health technologies has

been proceeding for years. The seeds of comprehensive technology assessment are quite old.

Estimating efficacy and safety takes place at several different levels: pre-clinical, informal, epidemiological, randomized clinical trials and formal consensus development. The first, pre-clinical testing, is designed to evaluate a technology in biochemical or animal systems prior to human testing. Examples of pre-clinical testing are very familiar, chemical analyses for purity, animal testing for the determination of therapeutic and toxic levels, and physical testing to determine material strength.

Second, informal estimating of efficacy and safety is the most common method of evaluation. It's estimated that 80 to 90 percent of all procedures have been evaluated only by informal techniques. Personal experience is the oldest and most common informal method of judging the efficacy and safety of a medical technology and is the primary method that determines whether the technology is adapted into widespread practice. Such informal evaluation has led in many if not most cases to appropriate decisions on the application of technology. In other cases, the informal method has not fared so well.

The third way of estimating efficacy and safety is the epidemiological approach. Again, the methods used are quite familiar. Retrospective studies to compare groups of people with a certain disease to those without the disease, and

prospective studies to follow the histories of persons both exposed and unexposed to the factor under study.

The fourth method, randomized control clinical trials, are in a sense a sophisticated extension of the epidemiological approach. Subjects, as you know, are assigned randomly to experimental and control groups and the results of the trial are analyzed to evaluate the relative risks and benefits of the technology.

The fifth and last, presently existing, method of efficacy and safety evaluation is formal consensus development, a method that's the philosophical child of the informal approach, perhaps less familiar than the other approaches, it's present stage of evolution is epitomized by the consensus development conferences now ongoing at the NIH. Recent subjects of evaluation in these exercises include antenatal diagnosis, management of primary breast cancer, interocular lens implantation and the use of micro-processor based machines in patient care. It's good to know that we had two of the four on your list.

What characterizes these five general mechanisms of technology evaluation is that they are all by and large controlled by the private sector. The health technology industry and the health professionals. to be sure, external forces, that is governmental regulation and products liability law to name but two, have played an important role in the institution and continuation of such evaluations. But the evaluations

themselves are designed and carried out internally. Governmental regulation has generally focused on requiring the health industry to develop evidence of safety and efficacy. Generally, also, governmental regulation has been responsive to public health tragedies, the elixir sulfonamide (?) disaster of the late 1930's led to Federal Food and Drug and Cosmetic Act, and its requirement that drugs be shown to be safe before being marketed, the thalidomide tragedy in the early 1960's led to the further development that drugs be shown to be efficacious.

Technology assessment in the future is likely to be quite different. While the same methods described a moment ago will continue, three events will likely change the course of assessments. These three are, new methodologies, new laws, and new structures. All three will emphasize two basic differences with the existing process. First, although present evaluations are internal, that is industrial and professional, additional evaluations may well be external. That is, governmental and third-party payers. And second, governmental regulation previously responsive primarily to safety and efficacy considerations will increasingly be responsive to cost containment considerations.

These two factors, external evaluation and cost responsiveness, in turn suggest that technology assessment will become significantly broader than it presently is. Consider, for example, the description given by the Congressional

Office of Technology Assessment. Technology assessment is said to be a comprehensive form of policy research that examines the short and long-term social consequences of the application or use of technology. It is an analysis of social rather than technical issues and it is especially concerned with unintended, indirect or delayed social impacts.

Thus, although evaluation of safety and efficacy will doubtless continue, a new dimension will likely be added to the evaluation of technology. That is, the assessment of broader social, ethical, legal and political effects of technology. Obviously, there are great problems with this broader evaluation. First, there is no standard, usable method yet available. Second, medical technologies are quite diverse, a standard format for assessment may not be possible. Third, the interdisciplinary approach necessary is difficult, practically, to develop. And fourth, the dollar cost and time costs are extremely high.

Nevertheless, the basic weakness, lack of an adequate methodology, is being approached methodically and is beginning to grow stronger. The work of OTA, of the Center for the Analysis of Health Practices at Harvard, the Technology Center at the University of Missouri and of the Health Policy Center at Georgetown and in many other settings shows promise of providing the basic tools of assessment.

New laws provide a second event that's likely to

change the emphasis of technology evaluation. This nation has had, I believe, a progression of laws having to do with technology and its evaluation, or as some would have it, its control. Safety was our first concern, and the earliest food and drug laws focused solely on the assurance of safety. Efficacy was our next concern, although it was less than two decades ago that this factor was added to the drug laws. But the character of the Federal statutes regulating health technologies has begun to change much more rapidly. Although in 1976, the Medical Devices Amendments to the Food, Drug, and Cosmetic Act, gave FDA the responsibility of evaluating the safety and efficacy of medical devices, the amendments also added a little noticed but highly potentially powerful provision, the restrictive devices provision, which states, "The Secretary may, by regulation, require that a device be restricted for sale, distribution or use upon such other conditions as the Secretary may prescribe if, because of the potentiality for harmful effect or the collateral measures necessary for its use -- or the collateral measures necessary for its use -- the Secretary determines that there cannot otherwise be reasonable assurance of its safety and effectiveness." Thus, with regard to medical devices there exists the statutory authority to restrict not only the sale but also the use of a device, even if the device itself is safe and efficacious.

The most recent Federal law, that passed almost exactly one year ago, and referred to by Mr. Colleton, which established the National Center for Health Care Technology. That statute provides the Center to undertake comprehensive assessments of health care technology, taking into account these factors; the safety, effectiveness, cost effectiveness, and the social, ethical and economic impact of health care technologies. The rapidity by which the law has expanded its focus is thus breathtaking.

Consider: 1938, safety; 1962, efficacy; 1976, collateral measures; 1978, social, ethical and economic impact. It should be stated, to be completely accurate, that only the first three enactments are regulatory in nature. That is, only safety, efficacy and collateral measures may be taken into account in determining approval or disapproval for sale and use of certain technologies. Nevertheless, two very specific and quasi-regulatory activities given by law, make the effects of the actions of the National Center for Health Care Technology potentially as important as any regulatory action.

These two functions of the Center and its Advisory Council are first, to develop exemplary standards, norms and criteria concerning the use of a particular health care technology, and two, to make recommendations with respect to reimbursement policy.

The third event that will have an impact on technology

evaluation is the development of new structures. Several of these new structures have already been mentioned. The Office of Technology Assessment, the National Center for Health Care Technology, the consensus development conferences at the NIH, which consider not only technical issues but also economic ones.

At least equally important is the development of new structures within the medical profession, in which there is a growing interest in the broader issues posed by the utilization of technology. The profession is openly discussing whether new technologies and changes in old technologies are worth their cost. Whether on balance they significantly improve patient care. Now being debated are such questions as whether diagnostic -- as whether a particular procedure merely adds to the completeness of a diagnostic work-up or whether it actually replaces an outmoded procedure; whether a beta radiologic picture of an inoperable brain tumor really helps the patient; and whether electronic fetal monitoring in fact leads to increased mortality and morbidity by increasing the frequency of Cesarean sections.

This broader discussion has recently found its way onto the agendas of hundreds of professional meetings. There is then, I believe, a developing critical mass of the medical profession, enough individuals and organizations, to begin a shift in emphasis in technology evaluation from informal evaluation of safety and simple efficacy, to more systematic

assessments of the broader implications.

Thus, given this environment, public expectations of benefit from technology and public frustration over health care costs, and given these developments, that is new methodologies, new laws and new structures, it is most likely that the near future will see much broader assessments of health care technologies both required by and in some cases carried out by the government.

The bulk of this presentation has been devoted to technology assessment, the first of the three sub-topics in the title. The remaining two sections will be much briefer, primarily because the issues of appropriate utilization of reimbursement are, to a large extent, subsumed by technology assessment and I've already touched upon those.

Utilization standards, the phrase in the title of this presentation, raises the old fears of government control of medical practice and of cookbook medicine. I would submit, however, that we in the medical profession have had utilization standards for quite some time, and that far from rebelling against them, we have embraced them. Not only has the profession developed certain standards and guidelines, but also government agencies have done likewise and we have followed them. A few examples might be instructive.

First, three decades ago, premature infants given high percentages of inspired oxygen were developing blindness

secondary to retrolental fibroplasia. The American Academy of Pediatrics developed guidelines for the use of oxygen in the newborn, and the profession followed them to the great benefit of infants.

A second example, treatment of sexually transmitted diseases have long been a source of controversy in medicine until the Center for Disease Control issued guidelines for the treatment of syphilis, gonorrhea, and other diseases. The profession was quick to adopt these guidelines and it is a very rare public clinic that does not have them posted for easy reference.

The third example, the ability rapidly to diagnose pulmonary embolism is a vital medical necessity, but not until studies appeared in the literature given frequencies of positive test results correlating with the diagnosis, did we have much rational basis for doing anything but ordering every test available.

Thus it is that when genuine controversy over the appropriate utilization of technology exists, individual physicians have been willing to grasp any straw in the wind that offers support for a particular approach. When that aid comes in the form of good studies, good technology assessment, or the carefully considered opinion of experts, be they within the profession or within government, the physician relies on and acts on it. Guidelines that are credible and are developed

with at least the assistance of the profession are accepted, welcomed and embraced. In all the areas in the Federal Government in which the utilization of health technologies are considered, there is considerable input from the medical profession. The examples are numerous.

Historically there is much precedent for the development and acceptance of guidelines in medical practice. Governmental activity to date has been consistently constructive, I believe, and there's no evidence that this is likely to change. There is, however, a change in the tenor of government involvement. Because of the frustration over costs of a specific technology, that is the computer tomography scanner, (PHONETIC) dramatized the inability of government to oversee rational allocation and utilization in new technologies, it is likely that much more attention in technology assessment will be paid to the issue of appropriate utilization. It is also likely that new government activity will emphasize what Schartz and Goscow (PHONETIC) have called utilization efficiency, in contrast to production efficiency. That is, the emphasis will be on whether the net medical benefit exceeds or equals the cost of achieving it. These two somewhat separate issues, guidelines for appropriate utilization and utilization efficiency, share one commonality; the growing recognition that safety and simple efficacy are insufficient bases alone, but that the way in which a technology is used is equally important.

Thus, I believe we will see increasing emphasis in government activity in the area of utilization of technology. The NIH consensus development conferences will likely achieve much greater impact than they now do, with broader input, discussion, and dissemination. Although in the first two meetings of the National Council on Health Care Technology, the phrase, "standards of utilization" was hardly mentioned, the area is one in which the National Center cannot long ignore and its potential impact is great. The task for each of these activities is to proceed only at the rate of the state of the art and always to be aware of its limitations, but nevertheless, to proceed.

Finally, this presentation wouldn't be complete without some analysis of the direction the reimbursement system might take, given the environment I've described. It is, in the first place, all too obvious that the present reimbursement system is at the root of the problem of health care costs. There is no other system that has such perverse economic incentives. In a free market economy prices are set by arm's-length transactions between buyers and sellers. In health care, the seller can determine what the buyer needs, where he needs it, when he needs it, and how much it will cost. And the buyer will acquiesce because he has no incentive, economic or otherwise, not to agree. With regard to technologies, there is no direct economic incentive for producers not to produce

a technology, a physician not to utilize it, and a patient not to have it applied to him. In fact, in health economics, there are no truly informed buyers, only passive payers.

In practice, this economics is as perverse as it is inferior. The Federal Government, through its Medicare program, has been the epitome of the passive payer. In essence, whatever services are billed for, are paid for. Statutory mandate of the Medicare program is to reimburse providers only for those health services that are reasonable and necessary. That mandate has never been taken seriously. In fact, there are neither regulations nor written guidelines under which the Medicare program determines reimbursement policy. The responsibility for reimbursement decisions has been abdicated largely to carriers and intermediaries. Greater than 99 percent of the determinations of covered services under Medicare have been and are being made by carriers and intermediaries. If a service has been previously billed for, a bill received for the same type of service will be paid. If a bill for a new service is received, it may face the following scenario. First, the carrier may pay without question, or, the carrier might consider the issue, then pay; or the carrier might request an opinion of the regional HEW office and then pay; or the regional office may go to the Medicare Central Office and then pay. Or, finally, the Medicare Central Office may request a medical opinion of the Public Health Service. In such a parametal system, few so-called

coverage issues are ever decided at a central point.

If the system for coverage decisions were not bizarre enough, the present mechanism for deciding coverage issues at the national level is even more odd. For the first 12 years of the Medicare program, that is until 1977, there were no formal criteria about which coverage decisions were made. Today there's a document outlining that process, but even now that document is no more than an informal guideline. Thus, the present Federal policy for reimbursement of new technologies, plainly stated, appears to be this: Any bill that is received is paid, carriers and intermediaries decide coverage policy, and there are no criteria by which coverage decisions are made.

This is an absurd situation. Its absurdity is, however, belatedly being recognized by those responsible for the administration of the reimbursement programs. And it's likely that the near future will bring significant changes in this system. One of the basic problems in reforming the system, however, is the absence of data of two sorts; first, data on the number, types and distribution of procedures that are done. As you know, a hospital bill for reimbursement doesn't contain a listing of all the procedures done. And two, data on the long-term benefits and risks of technology.

The first sort of data lack is being addressed by the development of the common procedural technology and of

other uniform data systems. Clearly, such systems have a long way to go but the pieces seem to be falling into place.

More importantly, the second type of data lack, that is data on the effectiveness of medical services, is now finally being addressed. The common instigation of parts of the medical profession, of our Office of Science and Technology Policy, and of parts within the Department of Health and Human Services, a model is being developed whereby imaginative use of the reimbursement system can help develop data on effectiveness, on which rational reimbursement policy can be made. The model should make it possible to identify new technologies of potentially significant impact, and would trade reimbursement dollars in the investigational phase of the technology for data on effectiveness supplied under an agreed upon experimental protocol. The model would make it possible for the producer to recover some of the developmental costs early and for the reimbursing to make rational decisions on coverage policy.

This development is quite new, but it is exciting and it's likely to be a significant part of the reimbursement policy in the future.

The structures within which change in reimbursement policy will occur are several. Already mentioned is the National Center for Health Care Technology and the function it has in coverage issue analysis. Equally important, however,

is the quiet but persistent activity taking place outside government, by the medical profession, private insurers and private industry. The concern that health care costs are high and that we are not reaping all the benefits of health care technology we might, is not solely a concern of government but is shared by many sectors.

In 1977 Blue Shield published a list of obsolete procedures, which would no longer automatically be paid for. More recently, Blue Cross has made similar changes in its policy toward pre-surgical work-ups and routine admission laboratory testing. The medical profession has been acting with reimbursers in policy changes such as these. The American College of Physicians, through its medical necessity project, and the Council of Medical Specialty Societies, have both been quietly pursuing means by which to make reimbursement decisions rational.

Private industry in several different kinds of businesses have begun to form consortia, negotiating with health insurers on ways to lower costs. The development of a rational approach to deciding what services are covered is a large part of their concern.

There is, I believe, a developing broad consensus that the solution to the problem of high health costs begins with changing of perspective. Passive payers must become informed buyers. Until that occurs, all incentives will

continue to favor utilization -- over utilization of health technologies with consequent unnecessary costs.

In summary, the picture I paint is one of the extension of trends of which you already should be cognizant. Efficacy evaluation, utilization standards and reimbursement of services are not new concepts. What is new is the coalescence of the concerns of the public, patients, physicians, payers and politicians. Together with new methodologies, new laws and new structures.

To return at last to the title of this session, there need be no conflict between innovation and the quest for cost containment. The necessity for assessment of the effects of technology should be clear. What technology assessment will do, if carried out with caution and perspective, is to change the present focus on incremental improvements in existing technologies to a focus on truly innovative breakthroughs in the development of curative technologies.

The challenge to you, the teaching hospitals, is to join in these compatible quests: Innovation and cost containment. Thank you.

(Applause.)

MR. COLLETON: Thank you, Dr. Ball, for the Government's view on the question before us. We are now ready to take questions from the audience. Your speakers have a microphone and all of you have a loud voice, or microphones on either

end of the room. So if we might commence. And I might ask in the interest of personalizing the meeting a bit, that you identify yourself and the institution from which you come.

Jimmy?

MR. METSIDE: Jim Metside (PHONETIC), from Oklahoma Nebraska (inaudible). Mr. Weinberg, you made several references to your travels abroad. Do you see these new technologies arising markedly (inaudible) companies or smaller or foreign (inaudible) companies?

MR. WEINBERG: I think it varies from country to country. In the United States the innovation seems to lie primarily with the manufacturers. In Europe there is relatively little innovation except in the drug area, compared to that of the United States.

On the other hand, in Japan, there's probably much more rapid development of innovation than there is even in the United States. And this seems to be due primarily to the interests of the Japanese medical societies, which are heavily device and new technology oriented. So I think it varies from country to country.

MR. : (Inaudible), University of Pennsylvania. (Inaudible) you described to us a rather radical change in (inaudible).

MR. WEINBERG: Well, fortunately, that's not my business, I don't have to make that decision. I'm not sure

I'm really qualified to offer that kind of advice.

One thing I can say is that in many of these technology areas that I've mentioned, the pace of technological change is increasing and the ultimate form of the technology is rather uncertain. A few years ago, obviously, computerized tomography looked like the ultimate solution to detection of certain kinds of pathology. Well, today it doesn't scratch the surface compared to the potential that nuclear magnetic resonance, for example, offers.

So it's very, very difficult to predict with any degree of certainty what the ultimate form would be. Obviously, it varies from technology to technology. In the area of interocular lenses, for example, technology is changing much less rapidly than in imaging. So I think you have to look through each area individually and make your assessment based on that.

MR. COLLETON: I wonder if I might insert a question, Barry, to kind of bring it into a little sharper focus. If one were to ask you, on a scale of one to 100 percent, what we might look forward to in the next decade, that is the 80's versus the 70's, in terms of technological enhancement, how would you respond to that question?

MR. WEINBERG: Well again, I think you have to look from area to area. I think that in the area of non-invasive diagnostics, for example, which are a very controversial area, Dr. Ball mentioned specifically, I think that the technology

there is going to change very rapidly and that it's going to be possible to undertake a variety of new kinds of tests at a very low cost that were not possible in the past.

On the other hand, in the area of interocular lenses, which I mentioned before, there's not a heck of a lot of change going to take place. I think the real question here is whether these non-invasive tests that are clearly going to offer advantages over the way things are currently done, are simply going to be layered on top of traditional tests or whether they're going to displace these traditional tests. And maybe Dr. Ball could mention how the Government would examine something of that nature.

DR. BALL: If one could predict trends, which is what I tried to do, one could expect what Government will look at as to whether a new technology, particularly a new diagnostic technology, does more than and replaces a technology that perhaps is not so good or not so specific. And we'll say, we will reimburse -- the Government might well say, we will reimburse only for the new technology if the older technology is not also done.

Now, that decision would have to depend upon a very good, well-done, assessment of whether or not the new technology actually can replace the old.

MR. COLLETON: Just to follow up on that a minute, you know, there've been studies done by the AHA and others

that indicate that new technology has been growing at the rate of four to seven percent per year. The current cost containment legislation, as you know, has got a one percent allocation for new technology. Is it fair to conclude that from the governmental point of view that that is the magnitude of curtailment that we might be shooting for in the future, in this area?

DR. BALL: It will probably mean that harder decisions as to what technologies will be purchased will be the case. Certainly, technology growing at the rate of three to five percent a year under a cost cap of one percent is going to mean that you can't buy all the kinds of technologies that you've bought in the past, and harder choices will have to be made.

The reimbursement system now says you'll be reimbursed for whatever, in fact, your costs are. Under cost containment, you'll be reimbursed for whatever your costs are up to a certain amount. And that will mean, then, hard choices to be made. You can still increase the amount of technologies that you purchase, three, four, five percent, if you cut down in other areas. So it's not one percent cap on technology, itself, that's the amount that was factored into the whole of the cost cap.

MR. WEINBERG: I wonder if I could just add to that a stirring example of what Dr. Ball just mentioned, occurred in Germany recently when we visited there. And what has

happened there is that the Federal reimbursers have gotten around to allocating a certain amount of money to a hospital and the hospital has to decide how they're going to allocate that money among departments. And we saw a perfect example of this in the cardiology department where the cardiology department in a German hospital is now given x thousands of Deutch marks a year to spend whatever way it wants. And we found a very interesting thing happening, where the department itself is beginning to make decisions on how to allocate its resources.

For example, traditionally German doctors purchased American-made pacemakers. But in our last visit we found an increasing percentage of the pacemakers being used by German doctors are of Italian origin. Now, five years ago you never would have found a German doctor being willing to use an Italian-made product. But the cost considerations have forced them to examine other alternatives and now the Italian pacemakers sell at about half the price of American-made products and their role in the market is increasing dramatically.

So I think this is a real example of how these allocation systems work, and that they very often can be -- they can be very effective if left to the professional community, with a certain amount of pressure from above, as opposed to having some centralized body, as in Sweden, as I mentioned before, for example, making that decision.

MR. COLLETON: Mitch?

MR. : (Inaudible) talking about (inaudible) reimbursement in relation (inaudible). But that says nothing about the market, the economy of the manufacturers. The manufacturers may very well tell you that we innovate because we like to sell products and innovation (inaudible) products with the likelihood of getting some return on our investment. What you're saying, Dr. Ball, says the manufacturer, is going to make the likelihood of return on our investment much less or at least delay that return. Therefore, we will no longer orient our innovation toward the health care _____ when the path appears to be delay or diminished. We're going to concern ourselves with aerospace (inaudible).

Have you considered this? What, then, will be the impact on the innovation not in health care, perse, but among the manufacturers? My own _____ prediction of that is that ultimately the Center for Health Care Technology will wind up becoming the _____ which will take the dollars that have been saved by all these restrictions and grant them to the manufacturers so that they will now be willing to spend some time innovating in health care. I'd like to hear your comments on that.

(End of Reel 1 as recorded.)

rfm

P R O C E E D I N G S

MR. : That particular question is always the toughest one. Balancing two kinds of social good is a very difficult public policy process. On the one hand, we're spending a lot of money for health care. On the other hand, the good and the value that we get out of innovation, particularly in health care technology innovation, are two tough things to balance.

At the present time we've got a system for evaluating health technology. It's an informal system. A technology gets out there, it gets informally evaluated, it's diffused into use, and it either may prosper, survive and prosper, or it may die out. It's an informal system and it shows that different health technologies have different sorts of life spans and different curves in their life span. What we get from that is that with relatively little control over the development, diffusion of health technology process, is that there is encouragement to innovate in health care technology. And so that the slippage that we have in the system, that is some technologies that aren't ultimately of benefit get out into use and cost some money, may harm some people, that amount of slippage is the price that we pay for innovation.

The question becomes is that slippage too much and can we shift it a little bit so we have a little bit less slippage. To put that in practice is going to be an extremely

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difficult sort of thing, so that we don't decrease the amount of innovation that takes place. So that the modest steps that this National Center for Health Care Technology has taken, the modest steps that the Health Care Financing Administration are taking, are to me appropriate. We don't have the methodologies now to determine long term sorts of benefits, so the very best we can do is to be very cautious in doing that, and constantly, before both those groups, is the detriment that may be possible against innovation.

Now, a second side of that is the sort of issue that Lewis Thomas raises in talking about health care technologies. He talks about non-technologies, halfway technologies and curative technologies. And one point that he makes is that truly curative technologies are much less costly than halfway technologies. He compares polio vaccine or penicillin, which he says is curative, with renal dialysis, which is halfway. Now, that's a simple, or almost too simple, example; but it does suggest that with a little bit more feeling of tech -- a little bit more technology assessment, we might be able to innovate in the direction of curative technologies, rather than, as most manufacturers are doing now, innovate by increments.

MR. : Dave?

MR. ABBARD : Dave Abbard (PHONETIC), Northwestern Memorial in Chicago. Most of us in this room are involved with the day to day problems with the organization and management

of teaching hospitals. And as part of that daily process we have developed rather traditional mechanisms for making decisions within that institution, and particularly for -- and we're constantly struggling with how to decide about the allocation of resources within the institution, and who makes decisions and who doesn't make decisions.

Mr. Weinberg, I'd like to go back a couple of questions to the illustrations you were talking about in your recent European trip. To what extent does this explosion of technology, is it going to impact on the traditional mechanisms that we have for decision making in organization and management in hospitals? What kind of suggestions, recommendations can you give us about how we might have to alter that system?

MR. WEINBERG: Well, I think I alluded to some of these in my slides, where I pointed out that this new technology tends to be much more specialized in nature than many traditional health care products, and this has led to the development and strengthening of the specialist's position in the hierarchy in the hospital, and I think that the kinds of developments we see taking place are even more specialized in nature, which means that it's going to be very difficult for somebody from the outside to assess the value of these, and frankly this is a double edged sword, because what you find, for example, is that in the area of computerized EKG, it's been now proven in a variety of clinical evaluations that computerized analysis of electro-

-cardiograms is as effective as manual interpretation for a great bulk of the cases.

However, because many cardiologists derive a good part of their living from reading EKG's, they refuse to accept these, even though an EKG automated device may in the long run be a lot cheaper and more effective for the hospital.

So I think you have a two edged sword here. You have the -- right now, I would say the key element in the equation is the specialist, who determines the need for this product and is the only individual right now able to assess the validity and value of it.

Now, if some of the things Dr. Ball talks about come true, then this may not be the case, but for the foreseeable future, from our point of view, the specialist is going to be the key element in the equation. And then among the specialists in the hospital you're seeing this hierarchy develop of for example, we're great believers in the cardiovascular area, and the American Heart Association says there are some 30-odd million Americans with some form of cardiovascular disorder, yet only about 4 million have been diagnosed. So you've got a tremendous potential pool out there. Everybody's worried about their hearts. The American Heart Association has been very effective at getting the message out. So we see a lot of emphasis on cardiovascular devices and equipment in the foreseeable future.

Cancer is the same way. If somebody were able to come up with either a diagnostic or therapeutic device, I think you'd see widespread acceptance, because the public demands that.

So I'd say the real emphasis is going to be on the specialist and his role in the structure.

I want to get back to a question that this gentleman over here raised before. I'm sorry, I've forgotten your name. But I think what has happened is that the opposite of the case you put forth has occurred today. If you look at the stock market, you'll find that health care stocks generally sell at higher multiples than do most other kinds of stocks, and you find a great number of companies that sell, you know, industrial gasses and chemicals, striving to diversify into the health care field. And you go to the executives of these companies, and you say, "Well, why are you interested in this? It's a horrible business. Everybody's predicting doom. There's all kinds of government involvement." And the executive will just look at you with a very simple face and say, "Look, my stock sells at six times earnings and health care stocks sell at 15 times earnings." So unless there's a dramatic change taking place, I don't think you're going to see a lack of interest on the part of companies in the health care field. Many businessmen look upon health care as relatively recession-proof, for example. That doesn't happen to be the case, as I'm sure you

all know. But compared to aerospace and other commodity kinds of businesses, automobiles, it is.

I think the real problem that you touched on is that the current structure of the health care field that's emerging is one that's not conducive to innovation. It's conducive to something which I call engineering. That is taking products that are already around and trying to find other uses for them. And this is the result of the fact that it's becoming increasingly difficult for small companies to continue to exist in the health care field. Governmental regulation and the increasing role of the need to support the specialists, which requires a tremendous amount of marketing cost, is making it very difficult for these small companies that traditionally have been the innovators in the field, to survive. And what you're seeing developing is an oligopolistic situation wherein in each market segment of the health care field you're finding five or six large companies beginning to dominate those markets, and once large companies get into an oligopolistic situation they don't become very innovative. They're more interested in protecting their market share and growing with the market as a whole. So I think the real danger here, from the point of view of good quality health care, is that you're going to see the small companies fall by the wayside because of an inability to remain competitive.

MR. : Stewart?

MR. MERRYLANDER: I'm Stewart Merrylander (PHONETIC),

from the Cedar-Sinai Medical Center. Dr. Ball, I'd like to follow up on what Mitch Rabkin said. We've seen a switch from one of the focuses of RMP, when we were concerned that new technologies were not getting to the practicing physician fast enough to have as optimal an impact on the patient as quickly as we like, to the situation we're in today where we're being accused of all kinds of wrongdoing, specifically, as an example, with respect to the CAT scanner. And if imaging is going to continue to grow, as Mr. Weinberg has indicated, the chances are very great that we'll have other such new innovations come along. I wish you'd spend a moment to explain, perhaps a bit more, what you will be using in evaluating the new technology, because I for one am concerned that we sometimes have the feeling that the control is based more in an effort to either control the failure of the planning effort, or the decision being based on the cost, rather than what's in the patient's best interest.

DR. BALL: I think one caveat is due, and that is that I'm not going to be doing the assessment. Somewhere else in the bowels of HEW perhaps are going to do some of the assessments. What I tried to do is to say these are the trends and the direction of which government may take.

First of all, depending on what the technology is designed to do, the criteria to what that technology, or how that technology will be assessed, you need to develop. That is, if

one has a diagnostic technology, clearly the criteria for assessment for efficacy and effectiveness are going to be much different than if one has a curative technology.

Thus far, neither the Office of Technology Assessment in the Congress, nor the National Center for Health Care Technology has developed those kinds of criteria yet. And that's the first sort of task of this group.

The history of governmental involvement in and development of either evaluation or of guidelines has been such that it's fair -- it's been -- first of all, depends to a large degree on the input of the profession itself, and second, it's been a very cautious approach. The Center for Disease Control, for example, in determining what influenza policy should be -- and influenza vaccine is a technology -- depends to a large extent upon both practitioners and upon experts in immunology and in vaccination, so that the guidelines that are developed are based on what the profession at that time thinks is the best state of the art.

So I don't think that you should be scared yet on the direction that government would take, or in the vastness or degree of that direction. Certainly with no criteria existing yet, and with a history of government involvement, being cautious and depending on the profession itself, I wouldn't expect that in the near future there are going to be substantial detriments to the development of technology.

MR. : John?

MR. : (Inaudible)

MR. : For those of you who may not have been able to hear, the question was what process will the government use to select sites for evaluation of new technology.

MR. : Right now the only structure within the government that has the potential for letting grants and contracts for the assessment of technology is the National Center for Health Care Technology. There's no specific mechanism that's set up by statute or that they have in guidelines on exactly how they will go about that.

The Center itself is run, very much though, on the mode of the NIH, and that will be that there will be competitive grants program and probably also a contracts program, with a high degree of input from its national advisory council. The statute makes the advisory council have to approve or to review and approve grants or contracts that are over \$35,000.00 each. So it's very likely that there'll be high input from its advisory council and in the usual mode that the NIH uses for competitive grants and for contracts as well.

Beyond that, I can't have any prediction. They've not done any, they've not let any contracts yet.

MR. : Yes, sir?

MR. : (Inaudible)

MR. : I don't think I followed that.

(Laughter)

MR. : No. What I tried to do is to say there are certain facts that we see now, certain history, certain facts, and we can take those facts with certain assumptions and analyze the trends and make predictions. I don't think that anything in the existing -- either in the past history or the existing policy would make us predict that we're going to do things like that in this country.

There are a couple of things that we've done in the past in the medical profession though, without government coming in, that has had some of those same sort of effects. Back in the 1960's, when the availability of renal dialysis was not sufficient to meet all the needs of the patients, physician groups, individual physicians, hospitals themselves, had to allocate existing technologies to patients. Some patients got the technology and thereby had presumably a longer life span and some patients didn't get it and had a longer life span. I don't think that that's a decision that government should make. I think that's a decision that individual physicians, patients and institutions should make. And I see no trend that government is going to get into that.

MR. : Our distinguished outgoing Chairman, Dr. Robert Heyssel, from Johns Hopkins Institution will ask the next question.

DR. HEYSSEL: (Inaudible)

MR. : The question essentially was that sometimes the viewpoint of a single person is better than that of the entirety of the rest, and that only by that way do we better quality patient care and increase perhaps innovation.

Certainly that's the case. I don't see, within the trend of what's now happening within government, that the decisions are going to be, quote, "made on high," and then laid down upon an unsuspecting public that had no opportunity for input into those. All of the types of guidelines that have come out of governmental activity thus far have been made with substantial and very significant input from the profession. I mentioned the CDC and its immunization practices. The FDA has, as well, many councils within advisory groups within its Bureau of Medical Devices, on decisions on safety and efficacy of medical technology. The NIH Consensus Development Conferences are just that, the getting together of groups of physicians and experts in the field, to try to come to some consensus with regard to the technology.

This is not to say that those groups can't be wrong, and there's the likelihood that in certain events they can be wrong. But I don't see that the laying down of those things on high will necessarily mean that each and every physician will have to follow them, lock step. There's no indication that that'll be the case. There's certainly no statutory mandate for that to be the case, and historically I don't think it's

been the case.

MR. : Jim?

MR. : (Inaudible)

MR. : The policy seems to be that there will be a split in the functions between the National Center for Health Care Technology on the one hand, and health systems agencies on the other hand. The National Center for Health Care Technology will have three major functions, the assessment of technology, recommendations with regard to reimbursement, and recommendations where it's appropriate with regard to the use of technology.

Health systems agencies, on the other hand, have the primary function of allocating technology among perhaps competing but among institutions, and the general policy will be that sort of split.

Now, whether continued technology assessment will force major pieces of technology, that is major devices and machines into the private sector, is unknown. There are several bills before the Congress now, as you know, that would allow the health planning process to have more effect in private offices than they presently do. I certainly think that it's a little unreasonable to have a certain fairly high dollar limit for those things in the way that they go into private institutions. But I don't think that the new wave of technology assessment is going to have any significant effect on forcing pieces of

equipment out of hospitals and into physicians' offices.

MR. : Bill?

MR. : (Inaudible)

MR. : The questions are getting tougher.

With regard to the latter part of the question, there is no sense that I see in that the government will hold up a technology until an assessment has taken place. There's a clear recognition, and I think Arnold Rellman (PHONETIC), as reported to me mentioned it this morning, that the resources given to the federal government by the Congress, or given to the National Center for Health Care Technology by the Congress, are not sufficient to analyze every single technology. But that does not mean that the technology won't get out until it gets analyzed. For example, the National Center for Health Care Technology has set criteria for which they will look at particular technologies. They'll start with technologies that have a high degree of risk to patients, high volume, and high spinoff effects, high economic cost, as the first ones they'll look at. They won't look at all of them. It's impossible to look at all of them.

On the other hand, the Bureau of Medical Devices is required by Congress, and has been since 1976, to at least look at some specific things with regard to safety and efficacy. It doesn't have the mandate to look at all these broader social, legal, political and ethical effects, and it won't, but it will

look at the safety and efficacy.

I think Congress, as regards the first part of your question, I think what Congress has done in its passage of the laws as I pointed out, saw a public concern about safety back in the 1930's, and so the first law was passed on safety. It didn't see a concern in the public on these other issues. 30 years later, 25 years later, Congress envisioned a public concern about efficacy and effectiveness, and so then passed the law on the FDA to look at efficacy and effectiveness. Rapidly, though, in the past, apparently Congress has seen the public concern that the government ought to look into these broader sorts of issues, and has passed these sorts of laws.

I think that what the laws are are a reflection of public concern. If it turns out that these strictures as you see them, on innovation and technology, become so severe, I think Congress will respond appropriately to that as well.

MR. : I'd just like to add something here. I don't know if any of the other speakers mentioned it, but about four months ago the state of New York put a hold on purchases of ultrasound equipment. There was such a dramatic increase in purchases of ultrasound equipment that the government simply said no shipments are going to be allowed, even for equipment that was in budget that had been ordered, pending a study. Now the study is late. It's probably not going to be

completed for about two more months, and no new equipment has been shipped into New York hospitals in the last four months.

Now, we've gone out and talked to some people who are consultants to various state reimbursers, and they felt that was a precursor of things to come, that more and more governments on the state level were going to make these kind of studies, to determine the extent to which these new kinds of devices or equipment should be utilized, and then how they should be distributed.

MR. : Are there other questions? Yes, sir.

MR. : (Inaudible)

MR. : As I said in an answer to an earlier question, it's precisely true. We've got that system now, an informal system that, as you characterize it, is sloppy. The question is, is it too sloppy or is it just right, and that's one thing we're trying to find out. We need a certain amount of sloppiness if we're going to have continued innovation. How much sloppiness is the question. Congress has responded by saying we've got too much sloppiness, and now HEW is trying to do something about that. I'm not sure whether in fact we have too much sloppiness. We might not have enough sloppiness in the system. But it's clear that in certain instances we've gone too far, and people, Congress, have responded to those. The CAT scanner, again, dramatized that technology could explode on the scene with no assessment, high dollar cost, and still high

dollar cost, while we're still learning to do it. There have been many others, as you know. The example that Harvey Feinberg characterized, of gastric freezing. Gastric freezing came around, 20,000 instruments for gastric freezing were sold in the early and mid-1960's, before finally people began to realize that this procedure was of no efficacy at all, and the procedure itself died out. It had a natural life span. It was developed, it diffused, it was used, it was found not to be worthwhile and it died out. There was some cost to that system. Patients unnecessarily treated, instruments unnecessarily evolved. The question is whether we allow a system -- perhaps we should -- allow a system that allows that to happen, in order to have the benefits that flow from innovation in the other areas.

Congress is now saying no, we shouldn't allow that. The way HEW is responding to the Congressional mandate is to go very cautiously. Hopefully they will go just as cautiously as necessary, and at that point I'd like to define what caution means.

The story is that a patient who was having his eyes examined went to an ophthalmologist, and the patient was viewed as a cautious man. The ophthalmologist asked the patient to look out the window and tell him the color of a car which was just then passing by. The cautious man replied, "Green, on this side." I think that's what we need to do in our approach to technology assessment, be that cautious.

MR. : Are there other questions? I hope the good news portion of this meeting comes tomorrow, because it's all been downhill today.

(Laughter)

MR. : By way of summary, I think one might say that there continues to be a bundle of new technology out there that's going to be coming down the pike in the next ten years. Government is busy establishing the machinery by which to assess its introduction, not only in terms of efficacy and safety, but also on economic, ethical and social considerations. When we get to the question of reimbursement, it appears that to the extent that we are authorized to implement such technology, we would be expected to reduce other costs in order to absorb this cost beyond some minimal level which, at least in the current cost containment legislation is one percent.

So, with those cheery words I would thank both of our speakers for their presentations today, in which I think has been a very informative and interesting session, and may we give them a round of applause.

(Applause)

MR. : Thank you all for coming, and we are adjourned.

(End of proceedings as recorded.)

WHAT'S AHEAD IN THE MEDICAL TECHNOLOGY EXPLOSION?

(Unedited transcript of presentation)

Barry Weinberg
Channing, Weinberg & Co., Inc.
New York, New York

Presented at AAMC Annual Meeting/COTH General Session,
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wife is a real firebrand when it comes to controlling costs, she's very anti-medicine, she's against the high costs that are incurred for both hospitals and doctors' office visits. However, as soon as one of our kids gets sick, she wants every test that's done. And I think this is a good example of what's going to happen in the United States, the public is becoming more educated, it's more aware of its health, and we're simply not going to see the end of technology.

While I think the medical benefits will be the prime motivation for advanced technology, there will certainly be other cases, and we've seen it with the CAT scanner, which is probably the most fascinating example, where competition among institutions to offer the best health care possible will also add to the quest for new technology.

Whatever the reason, however, it seems clear to us that technology will continue to have a major impact on medicine for the foreseeable future. Now, I have some slides here which are going to talk about some very specific technologies that we see becoming important in the future. And also, the first two slides are of a background nature which will set the scene in which we think technology will gain acceptance.

(Inaudible) -- typical technology problems. Is it possible to dim the lights? There we go.

The emphasis on technology arises out of what we consider to be the new medicine, and here are just a few of

the areas that we think are going to receive emphasis in medicine. One is increasingly early emphasis on diagnosis. Not only is it good medicine but many of the cost containment people feel that ultimately, by diagnosing a condition before it becomes irreversible, it will be possible to keep a patient out of a long-term, costly hospital stay.

Another area of emphasis will be on ambulatory care, keeping a patient out of the high-priced surgical and acute care bed. Cost containment, I'm sure you've heard about this in the last few days, everybody agrees that it's one of the major aspects of health care and we certainly feel that it's going to deter the acceptance of technology, although not destroy it.

One way of overcoming some of these limitations is the involvement in longer term treatment, very often outside of the hospital environment, as a replacement for, again, acute care facilities. One of the things we've seen in Europe, which are countries involving much more direct government-intervention, the government has arbitrarily set health care limits. In Sweden, for example, if you're 65 years old and you need a pacemaker, but you also have some complicating disease such as cancer, you probably won't get it because the government has made an arbitrary decision that you're a high-risk patient who's probably going to die anyway within a few years.

More technology, clearly. In our opinion, technology is the only device that is capable of meeting the two distinct

needs of the emerging health care environment. That is, better quality health care and more control.

And finally, with the increased use of new technology, we see greater dominance of the medical field by specialists, individuals who are capable of taking advantage of the capabilities of these highly specialized devices.

What about the role of specialists? Specialists in the New Technology is the title here, in case you can't see it. One of the things we see happening with these new technologies is that departmental demarcations are blurring. Traditionally, for example, the radiology department was responsible for buying imaging equipment. Well, now we see cardiology, obstetrics, gynecology, neurology, all buying new technology devices like ultra-sound equipment. In the future we think it's going to be more difficult to say that a particular specialist in the hospital is going to be responsible for all areas of a certain kind of technology.

We've also seen new fiefdoms arise. Fifteen or twenty years ago the cardiologist, for example, was primarily a purchaser of pills and stethoscopes, and perhaps \$1,500.00 EKG machines. Well, last year we estimate that cardiologists purchased, in the United States, about \$500 million worth of equipment, not including another \$250 million worth of pacemakers. So here, out of no where, has come a high powered purchasing center in the hospital.

Clearly, one of the factors contributing to the growth of technology has been increasing concern about malpractice on the part of practitioners. The more tests that can be done on an individual, the ability to show that you're using the latest technology, is a defense against malpractice, and also has support in the sense of being good medicine.

We also see conflict within the hospital environment in who's going to control these patients? Many of these specialized devices, the results can only be interpreted by a highly specialized, specially trained individual. And I know in my own family, for example our family doctor is now a cardiologist as opposed to a general practitioner. And more and more we're going to see, in our opinion, the patient going to a specialist at an earlier stage of his disease development.

Finally, we see a dollar-oriented pecking order arising in the hospital, very often based on the developments and new technology. I had the occasion last week to walk through a hospital in Japan and I saw a situation that was very similar to that existing in the United States. The cardiology department has all fancy, new equipment, highly streamlined, a lot of electronic gear making funny beeps and sounds. When you go down to the respiratory care department it tends to be a weak sister. The technicians there are making do with equipment that's 20 years old. So clearly, within the hospital we've seen a hierarchy develop among those doctors who are able to get purchases of highly advanced equipment.

Let's look at some of the major technological trends now taking place in the field. One of the things that we see proliferating in a wide variety of institutions all across the country are non-invasive diagnostics. And I'll discuss each one of these areas in more detail later on.

Also, we see an increasing emphasis on something called least-invasive surgery. This involves getting away from cutting the patient open, from involving surgically created wounds that may be difficult to heal, that may cause further complications to the patient, doing surgery in a way that is more ambulatory.

Care of the acute patient, I think, in spite of the high cost of treating acute patients, our country is not going to diverge from the traditional concept of using whatever power is available to keep the patient alive.

The availability of intelligence in a wide variety of electronic equipment, through the use of micro-processors, is something we see proliferating throughout all specialties. Here we're talking about adding small, micro-miniaturized chips that have computing capability to various kinds of diagnostic and therapeutic devices, to provide intelligence, to provide analytical capability, to enhance the ability of the practitioner to both diagnose and serve the patient.

And finally, widely improved implants. Now, let's look at each of these in a little more depth. What are some

of the specific areas in non-invasive diagnostics we see growing? Well, probably at the top of the list here is ultra-sound. Ultra-sound is a safe, relatively inexpensive, easy to use approach that's applicable to a wide variety of specialties. We estimate, for example, that in 1978, about \$120 million was spent by hospitals and private practitioners in the United States on ultra-sound equipment. By 1984 we're predicting that this level will increase to about \$425 million. And we expect to see this technology being accepted by a variety of specialties that are not currently using it. Right now cardiology and radiology are the big users. In the future we see obstetrics, gynecology, neurology, perhaps urology also using this.

The measurement of physiological parameters. Right now ultra-sound is used primarily to measure anatomical characteristics but we see the improved technology being utilized to measure such things as blood pressure non-invasively in cardiac output.

Ambulatory monitoring is another area of important growth in our opinion. Right now ambulatory monitoring is primarily involved with portable 24 hour ekg recorders, where the patient wears an ekg recorder for 24 hours, his ekg signal is recorded for the full period of time, and then it's analyzed by a technician and a playback device. But we see other parameters such as blood pressure, perhaps respiration, being added to these devices that provide a dramatic increase in information over

resting ekg's or short-term measurement of these parameters.

Other areas we see are increased emphasis on imaging. Imaging is an important part of diagnostic medicine and will not disappear in importance, even though we have CAT scanners all over the place. And already, after the CAT scanner, we're looking at two other kinds of technologies here that are certainly by no means proven but which offer the potential for important medical advances.

These may be terms that you're not familiar with. One is nuclear magnetic resonance. This involves measuring the parameters of the molecules of various kinds of tissues, and potentially differentiating between pathology and cystic tissues. Electron spin resonance is another technique that involves measuring the characteristic of tissue electrons. As you can imagine, these are techniques that are not in use right now. They're going to require a lot of development and research before they become proven. We think that by the mid to late 1980's, you're going to see devices installed in hospitals using these techniques.

Least-invasive surgery, as I mentioned before, is an attempt at minimizing the cutting of patients. And here we see three devices that will increase in use. One is lasers; right now lasers are used primarily on experimental basis but I had the opportunity a few weeks ago to go to see laryngeal cancer removed by a laser and the patient being awakened

about half an hour after the procedure was completed. The whole procedure took about 30 minutes, there was no wound made in the patient's throat, the pathology was removed to a very minute degree without injuring the larynx. The medical advantages of the laser in this kind of surgery are tremendous. And the patient could go home a day later instead of having to stay in the hospital for a week.

The use of endoscopes to diagnose the patients and also deliver therapy is an area that we think is going to receive increasing acceptance in the future. Some of the advancements in fiberoptics now allow flexible endoscopes to be inserted in normal body openings and essentially threaded through complex anatomies such as the sigmoid for direct visualization and removal of pathology on an ambulatory basis.

Finally, we see the increased use of microsurgery. The magnification and light advantages of the use of microscopes are truly immense and the fact that many surgeons have grown up without the microscope has contributed to a rather slow acceptance of this technique to date. However, most of the younger doctors are being trained in these techniques and we think will accept them as a more natural approach and consequently, we think that most surgery in the mid to late 1980's will be done through microscopes.

Let's look at care of the acute patient, what some of the things we see here. Well, clinical nutritional support

is a new area. For many years nutrition in the hospitals was looked at as akin to motherhood. But some studies were done recently which showed that upward of 30 percent of all surgical patients are malnourished. Not in the sense that their bones were showing, but they can't really fight off the disorders and conditions of their post-operative surgery. So we're looking at an emerging new specialty here involving the clinical support of patients, both pre and post operationally, and the use of a wide variety of nutritional solutions and new kinds of pumping systems and delivery systems here are, we think, going to gain acceptance in the 1980's.

Improved patient monitoring, adding intelligence to patient monitoring systems, to allow such things as automated arrhythmia detection is just one example of the kind of thing we see happening here that will probably lead to an upgrading of acute care facilities through the 1980's.

Finally, mechanical assist devices. I'm sure all of you have heard of things such as the inter-aortic balloon pump, which is primarily looked upon as a device of last resort right now. But we see many advances being made on an experimental basis on some of these devices and it may be possible in the 80's, for example, to implant devices like pacemakers but that provide assistance to the pumping mechanism of the heart, not simply the electrical conduction system.

We have a little technology problem here. One of

the slides won't go down so we have to use a knife to push it down. It reminds me of a time I borrowed somebody's Cadillac to take a trip and was horrified to discover at each tollbooth I had to open the door to pay the toll because the electrical motor that operates the window broke down.

The addition of intelligence through micro-computers is an area that we think is going to achieve a great deal of emphasis in the 1980's. For example, the use of these micro-miniaturized chips to perform automated ekg analysis. Just this past year one of the major computer companies introduced a small, three-channel ekg cart that not only produces an ekg trace when the button is depressed, but also produces a computerized evaluation of that patient's wave form which suggests therapeutic measures.

So more automated analysis is something that we think is going to affect the field. Likewise in imaging, the application of computer techniques to ultrasound, for example, can substantially improve ultrasound, perhaps bring it up to a condition comparable to that of x-ray. And the use of computer techniques with ultrasound would be akin to the application of computer techniques to x-ray for the development of computerized tomography.

Patient monitoring, as I mentioned earlier, is another area where intelligence will be used to monitor a patient's condition, perhaps ultimately automatically bring about thera-

peutic measures based upon the condition of the patient, without having to wait for manual intervention. Respiratory care, automated delivery of anesthesia are just two more areas where we think the use of micro-processors will have an important impact on the field.

This last slide here covers the area of implants. Here we see materials, new kinds of material processing techniques, leading to substantially improved orthopedic joints. We recently completed a survey of orthopedic surgeons which indicated that if there were available better artificial hips and better cements for implanting those artificial hips, the number of procedures would be substantially greater than that which exists at present. And we see developments taking place, not only in America but overseas as well, that will lead to substantially improved orthopedic joints.

Artificial vessels, right now probably the most widely used application in artificial vessels is in dialysis patients where arteriovenous fistulas are produced using bovine grafts. Well, it's our opinion that in the future you're going to see plastic and other manmade materials being used to produce highly effective artificial vessels that can be used to bypass damaged vessels.

Intraocular lenses is another example of an area that we've already seen dramatic growth. We estimate that in 1973 almost \$30 million was spent in the United States on

intraocular lenses by hospitals, compared with only about \$3 million just two years earlier. A clear indication of what can happen when new technology gains acceptance among a group of practitioners.

Finally, we see artificial organs, implantable artificial organs being developed in the late 1980's and early 1990's, that will negate the need for some of the palliative measures now taken. For example, we anticipate an implantable artificial kidney that will do away with the need for dialysis externally by 1990. Likewise, an artificial pancreas to overcome many of the problems associated with diabetes is a real possibility in the late 1980's.

So what I've attempted to do here is simply summarize some of the important developments that we see taking place in the field. And we think that in spite of the increasing emphasis on cost containment, that we're not going to see a demise of technology, that in fact technology is going to continue to thrive because it offers a hope for performing those two distinct requirements of the health care field, namely better quality medicine and also lower cost. And it's really the only thing on the horizon that seems to have the potential for doing this.

I don't think we disagree that cost containment is going to have an effect on technology, but it's going to cut back on its growth somewhat, but clearly, the increasing

THE GOVERNMENT'S PLANNED APPROACH TO TECHNOLOGY:
EFFICACY EVALUATION, UTILIZATION STANDARDS, AND
REIMBURSEMENT OF RESULTING SERVICES

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I should like to note at the start that the title of this general session --"Conflict: Continuing Advancement in Medical Technology and the Quest for Cost Containment" -- reflects a presupposition that may limit our vision of the future and our understanding of the future. I, for one, do not accept the assumption that continuing advancement in medical technology is necessarily in conflict with the quest for cost containment. I believe it is possible to have both more rational expenditure of dollars for health care and innovation in health care technology. This is not to say that these goals are not in potential conflict. Nor is it to say that the balancing of divergent (or seemingly divergent) values is not inherently difficult. It is to say that the choice need not be either-or: either innovation or cost containment.

One should hesitate to read too much into the titles of speeches, but in this case, mention should be made of the title assigned by the program committee to Mr. Weinberg: "What's Ahead in the Medical Technology Explosion?" The title contains a loaded word: "explosion." Inadvertently or intentionally, the program committee put its finger on a most important problem. Explosions, in the traditional sense, have the capacity for good or for ill. But it is part of the nature of explosions that their effects are not highly predictable, but are often random and destructive. I would suggest that a part of our common problem is the way in which health care technology finds its way into, and is used in, medical practice.

Now, I would be unfair at this point if I did not comment on the title assigned to me: "The Government's Planned Approach to Technology: Efficacy Evaluation, Utilization Standards, and Reimbursement of Resulting Services." The titles of the general session and the other presentation each contain loaded words: "conflict" in the former, "explosion" in the latter. The loaded word in the title assigned to my presentation is "planned." It would be at best inaccurate to say that the Federal government has had, or presently has, a "planned approach" to health care technology. In fact, another part of our common problem is that the government has had no rational approach to health care technology.

In essence, what I have been asked to do is to predict the future. I shall attempt to do so by the usual method: presenting known data, making certain assumptions, analyzing trends, and drawing conclusions. The reason that you, the audience, have an interest in all this is that the better you and your institutions can predict the future, the better you can cope with the changes the future will bring. The better you cope with change, the more likely you are to survive and to prosper.

What I shall do, therefore, is to relate present activity and to predict future policy in health care technology from the Federal governmental perspective. Specifically: What is likely to occur in the areas of efficacy evaluation, utilization standards, and resulting services reimbursement? In order that these remarks be placed in proper perspective,

you should be assured that they reflect no hidden agenda. That is, there does not exist, either within HEW (or the Department of Health and Human Services) or within the Executive Office, a secret health care technology policy lurking ready to spring upon you.

Efficacy Evaluation

Lewis Thomas, in his delightful and perceptive book, The Lives of a Cell, wrote:

Technology assessment has become a routine exercise for the scientific enterprises on which the country is obliged to spend vast sums for its needs. Brainy committees are continually evaluating the effectiveness and cost of doing various things in space, defense, energy, transportation and the like, to give advice about prudent investments for the future.

Somehow medicine, for all the money that it is said to cost the nation, has not yet come in for much of this analytical treatment. . . .

When, as is bound to happen sooner or later, the analysts get around to the technology of medicine itself, they will have to face the problem of measuring the relative cost and effectiveness of all the things that are done in the management of disease. They make their living at this kind of thing, and I wish them well, but I imagine they will have a bewildering time.

Thomas was right on at least two counts: the analysts have gotten around to the technology of medicine itself, and, yes, they are having a bewildering time. He was, however, at least partially wrong on one count: technology assessment, at least in some form, is not new.

Technology assessment -- the evaluation of health care technologies -- has been occurring in some rudimentary fashion for years. What is new are new methodologies, new structures, new laws, and new public concern.

Public concern has come about because of heightened public awareness of and fascination with technology in general and health technology in particular. The electronics industry represents a stunning example of the vast range of products of technology and of the rapidity of technological change. The breakthrough of the "miracle chip" has made possible gigantic steps in computer applications as well as a plethora of consumer products. In the electronics industry as in most other industries technological change has brought decreases in costs and in prices.

The development of such fascinating products of science and technology has led to increased public awareness of the potential of technology and to increased public expectations of the benefits of technology. That awareness and those expectations are beginning to be focused on health technologies. The public, partly mystified by modern medicine and partly dissatisfied with the inability of many medical practices to improve patient outcomes, quite naturally expect that the increasing application of technology to medical care will bring significant benefits. Anyone who has been inside the modern hospital must surely expect that the current explosion in laboratory tests, machinery, and people should bring him or her increased well-being.

In addition to public expectations of increased benefits, there are also public expectations that technology bring decreased costs. In almost every other industry, technological improvements lead to decreased manpower and production costs. In contrast, in the health field new technologies usually increase both labor and capital costs. The public is frustrated over the rising costs of health care, and technology has become the lightning rod to capture that frustration. Impersonal, tangible, and very visible, technology is an easy target for public dissatisfaction.

The current climate in which the discussion of health technology proceeds, therefore, is one of public expectation and public frustration. Keeping that climate in mind, let me weave a picture of the current state of technology assessment, returning to a theme introduced a few moments ago: that is, that some evaluation of health technologies has been proceeding for years; the seeds of comprehensive technology assessment are quite old.

The estimation of efficacy and safety takes place at several different levels: preclinical, informal, epidemiological or statistical, randomized controlled clinical trials, and formal consensus development. The first, preclinical testing, is designed to evaluate a technology in biochemical or animal systems prior to human testing. It is generally

carried out for one of two purposes: (1) to develop preliminary evidence to gain the right to test with humans; and (2) to develop performance standard compliance to establish marketability. Examples of preclinical testing are very familiar: chemical analyses for purity, animal testing for determination of therapeutic and toxic levels, physical testing to determine material strength.

Second, informal estimating of efficacy and safety is the most common method of evaluation. It is estimated that 80 to 90 percent of all procedures have been evaluated only by informal techniques. Personal experience is the oldest and most common informal method of judging the efficacy and safety of a medical technology and is the primary method that determines whether the technology is adopted into widespread practice. Such informal evaluation has led in many, if not most, cases to appropriate decisions on the application of technology. In other cases the informal method has not fared so well.

A third way of estimating efficacy and safety is the epidemiological/statistical approach. Again, the methods used are quite familiar: retrospective studies to compare groups of people with a certain disease to those without the disease; and prospective studies to follow the histories of persons both exposed and unexposed to the factor under study. The drawbacks and problems of those methods are also well-known: incomplete data in the former and high cost in the latter.

Randomized controlled clinical trials are in a sense a sophisticated extension of the epidemiological/statistical approach. Subjects are assigned randomly to experimental and control groups and the results of the trial are analyzed to evaluate the relative risks and benefits of the technology. The advantages of randomization are several: (1) the elimination of bias in the assignment of treatment; (2) the prevention of bias with respect to variables inherent in the experiment; and (3) the validity of the statistical tests of significance used. The problems of controlled trials are also several, the most important of which relate to the ethics of randomization and to their very high costs. Controlled trials are most appropriate when the benefits of a new technology are uncertain and when the relative benefits of existing therapies are disputed. Controlled trials are not necessary in every case; other mechanisms may be more appropriate in specific cases.

The fifth and last presently existing method of efficacy and safety evaluation is formal consensus development, a method that is the philosophical child of the informal approach. Perhaps less familiar than the other approaches, its present stage of evolution is epitomized by the "consensus development" exercises now ongoing at the NIH. Recent subjects of evaluation in these exercises include antenatal diagnosis, management of primary breast cancer, intraocular lens implantation, and the use of microprocessor-based machines in patient care.

What characterizes these five general mechanisms of technology evaluation is that they are all, by and large, controlled by the private sector: the health technology industry and the health professions. To be sure, external forces (governmental requirements and products liability law, to name but two) have played an important part in the institution and continuation of such evaluations. But the evaluations themselves are designed and carried out internally. Governmental regulation has generally focused on requiring the health industry to develop evidence of safety and efficacy. Generally, also, governmental regulation has been responsive to public health tragedies: the elixir sulfanilimide disaster of the late 1930s led to the Federal Food Drug and Cosmetic Act and its requirement that drugs be shown to be safe before being marketed; the thalidomide tragedy the early 1960s led to the further requirement that drugs be shown to be efficacious.

Technology assessment in the future is likely to be different. While the same methods described a moment ago will continue, three events will likely change the course of assessments. These three are: new methodologies, new laws, and new structures. All three will emphasize two basic differences with the existing process. First, although present evaluations are internal (that is industrial and professional), additional evaluations will be external (that is, governmental and third party payor). And second, governmental regulation, previously responsive primarily to safety and efficacy considerations, will increasingly be responsive to

cost containment considerations. These two factors -- external evaluation and cost responsiveness -- in turn suggest that technology assessment will become significantly broader than it presently is. Consider, for example, the description given by the Office of Technology Assessment:

Technology Assessment is a comprehensive form of policy research that examines the short- and long-term social consequences (e.g., societal, economic, ethical, legal) of the application or use of technology. It is an analysis of social rather than technical issues, and it is especially concerned with unintended, indirect, or delayed social impacts.

Thus, although evaluation of safety and efficacy will doubtless continue, a new dimension will likely be added to the evaluation of technology: the assessment of the broader social, ethical, legal, and political effects of technology. Obviously, there are problems with this broader evaluation: (1) there is no standard, usable method yet available; (2) medical technologies are quite diverse -- a standard format for assessment may not be possible; (3) the interdisciplinary approach necessary is difficult practically to develop; and (4) the dollar cost and time costs are extremely high. Nevertheless, the basic weakness -- lack of an adequate methodology -- is being approached methodically and is beginning to grow stronger. The work of OTA, of the Center for the Analysis of Health Practices at Harvard, of the Technology Center at the University of Missouri, of the Health Policy Center at Georgetown, and of many other settings shows promise of providing the basic tools of assessment.

New laws provide a second event that is likely to change the emphasis of technology evaluation. This nation has had, I believe, a progression of laws having to do with technology and its evaluation (or, as some would have it, its control). Safety was our first concern, and the earliest food and drug laws focused solely on the assurance of safety. Efficacy was our next concern, although it was less than two decades ago that this factor was added to the drug laws. But the character of the Federal statutes regulating health technologies has begun to change more rapidly. At the same time that the 1976 medical devices amendments to the Food, Drug, and Cosmetic Act gave FDA the responsibility of evaluating the safety and efficacy of medical devices, they added a little-noticed but potentially powerful provision, the "restricted devices" provision:

The Secretary may by regulation require that a device be restricted to sale, distribution, or use ... upon such other conditions as the Secretary may prescribe ... if, because of its potentiality for harmful effect or the collateral measures necessary to its use, the Secretary determines that there cannot otherwise be reasonable assurance of its safety and effectiveness.

Thus, with regard to medical devices, there exists the statutory authority to restrict not only the sale but also the use of a device, even if the device itself is safe and efficacious.

The most recent Federal law is that passed almost exactly one year ago which established the National Center for Health Care Technology. That statute provides that the Center undertake comprehensive assessments of health care technology, taking into account "the safety, effectiveness, and cost-effectiveness of, and the social, ethical, and economic impact of health care technologies." The rapidity with which the law has expanded its focus is breathtaking. Consider: 1938 -- safety, 1962 -- efficacy, 1976 -- collateral measures, 1978 -- social, ethical, and economic impact.

Only the first three enactments are strictly regulatory in nature. That is, only safety, efficacy, and collateral measures may be taken into account in determining approval or disapproval for sale, distribution, and use of certain technologies. Nevertheless, two very specific and quasi-regulatory authorities given by law make the effects of actions of the National Center for Health Care Technology potentially as important as any regulatory action. These two functions of the Center and its Advisory Council are: (1) to develop exemplary standards, norms, and criteria concerning the use of particular health care technologies; and (2) to make recommendations with respect to reimbursement policy.

The third event that will have an impact on technology evaluation is the development of new structures. Several of these new structures have

already been mentioned: the Office of Technology Assessment, the National Center for Health Care Technology, and the consensus development conferences of the NIH (which consider not only technical issues, but also economic issues). At least equally important is the development of new structures within the medical profession, in which there is a growing interest in the broader issues posed by the utilization of technology. The profession is openly discussing whether new technologies and changes in old technologies are worth their cost -- whether on balance they significantly improve patient care. Now being debated are such questions as whether a particular procedure merely adds to the "completeness" of a diagnostic workup, or whether it actually replaces an an outmoded procedure; whether a better radiologic picture of an inoperable brain tumor really helps the patient; and whether electronic fetal monitoring in fact leads to increased mortality and morbidity by increasing the frequency of Caesarean sections. This broader discussion has recently found its way onto the agendas of hundreds of professional meetings. There is, then, I believe, a developing critical mass of the medical profession -- enough individuals and organizations -- to begin a shift in emphasis in technology evaluation: from informal evaluations of safety and simple efficacy to more systematic assessments of the broader implications of technologies.

Thus, given this environment -- public expectations of benefits from technology and public frustration over health care costs -- and given these developments -- new methodologies, new laws, and new structures -- it is most likely that the near future will see much broader assessments of health care technologies both required by, and in some cases carried out by, government.

Utilization Standards

"Utilization standards," the phrase in the title of this presentation, raises the old fears of government control of medical practice and of "cookbook medicine." I would submit, however, that we in the medical profession have had utilization standards for quite some time, and that, far from rebelling against them, we have embraced them. Not only has the profession developed certain standards and guidelines, but also government agencies have done likewise, and we have followed them. A few examples may be instructive: (1) Three decades ago, premature infants given high percentages of inspired oxygen were developing blindness secondary to retrolental fibroplasia. The American Academy of Pediatrics developed guidelines for the use of oxygen in the newborn, and the profession followed them, to the great benefit of infants. (2) The treatment of sexually transmitted diseases had long been a source of controversy in medicine, until the Center for Disease Control (then the Communicable Diseases Center) issued guidelines for treatment of syphilis, gonorrhea, and other diseases. The profession was quick to adopt these guidelines, and it is a very rare public clinic that does not have them posted for easy reference. (3) The ability rapidly to diagnose pulmonary embolus is a vital medical necessity, but not until studies appeared in the literature giving frequencies of positive test results correlating with the diagnosis did we have much rational basis for doing anything but ordering every test available. Thus it is that when genuine controversy over the appropriate utilization of technology exists, individual physicians are willing to grasp any straw in the wind that offers support for a

particular approach. When that aid comes in the form of good studies, good technology assessment, or the carefully considered opinion of experts, be they in the profession or in government, the physician relies on and acts on it. Guidelines that are credible and that are developed with the assistance of the profession are accepted, welcomed, and embraced.

In all areas in the Federal government in which the utilization of health technologies is considered, there is considerable input from the medical profession. Examples are numerous: (1) The CDC, in reviewing its policy on influenza immunization, annually confers in public meeting with many medical practitioners and experts in immunization. (2) The NIH, in its consensus development conferences, brings together several dozen physicians and researchers in what Donald Fredrickson has termed "a novel exercise to hasten the search for consensus in the old-fashioned way." (3) The FDA, with the help of internists, neurosurgeons, and radiologists, has developed guidelines for the appropriate utilization of skull x-rays in the emergency room, guidelines that when applied in practice have decreased such procedures by more than half with no detriment to patients. (4) Professional Standards Review Organizations (PSROs) are physician groups which review hospital services to determine their medical necessity and appropriateness; the criteria for their reviews were developed by the AMA and 36 specialty societies. The list is long, and nowhere is there reasonable evidence of anything but the careful development of criteria and the thoughtful application of those criteria.

Historically, there is much precedent for the development and acceptance of guidelines of medical practice. Governmental activity to date has been consistently constructive, and there is no evidence that it is likely to change.

There is, however, a change in the tenor of government involvement. Because of the frustration over costs and because a specific technology -- the computed tomography scanner -- dramatized the inability of government to oversee rational allocation and utilization of new technologies, it is likely that much more attention in technology assessment will be paid to the issue of appropriate utilization. It is also likely that new government activity will emphasize what Schwartz and Joskow have called "utilization efficiency" in contrast to "production efficiency." That is, the emphasis will be on whether the net medical benefit exceeds or equals the cost of achieving it. These two somewhat separate issues -- guidelines for appropriate utilization and "utilization efficiency" -- share one commonality: the growing recognition that safety and simple efficacy alone are insufficient, but that the way in which a technology is used is equally important.

Thus, I believe we will see increasing emphasis in government activity in the area of utilization of technologies. The NIH consensus development conferences will likely achieve much greater impact than they now do, with broader input, discussion, and dissemination. Although in the first two meetings of the National Council on Health Care Technology,

the phrase "standards of utilization" was hardly mentioned, the area is one which the National Center cannot long ignore, and its potential impact is great. The task for each of these activities is to proceed only at the rate of the state of the art and always to be aware of its limitations; but nevertheless to proceed.

Reimbursement of Services

Finally, this presentation would not be complete without some analysis of the direction the reimbursement system may take, given the environment I have described. It is, in the first place, all too obvious that the present reimbursement system is at the root of the problem of health care costs. There is no other system that has such perverse economic incentives. In a free-market economy, prices are set by arms-length transactions between buyers and sellers. In health care, the seller (physician) can determine what the buyer (patient) needs, where he needs it, when he needs it, and how much it will cost... and the buyer will acquiesce because he has no incentive, economic or otherwise, not to agree. With regard to technologies, there is no direct economic incentive for a producer not to produce a technology, a physician not to utilize it, or a patient not to have it applied to him. In fact, in health economics there are no truly informed buyers, only passive payors.

This economics is as perverse in practice as it is in theory. The Federal government, through its Medicare program, has been the epitome of the passive payor. In essence, whatever services are billed for, are

paid for. The statutory mandate of the Medicare program is to reimburse providers only for those health services that are "reasonable and necessary." That mandate has never been taken seriously. In fact, there are neither regulations nor written guidelines under which the Medicare program determines reimbursement policy. The responsibility for reimbursement decisions has been abdicated, largely to carriers and intermediaries. Greater than 99% of the determinations of covered services under Medicare have been and are being made by carriers and intermediaries. If a service has previously been reimbursed for, a bill received for the same type of service will be paid.

If the system for coverage decisions were not bizarre enough, the present mechanism for deciding coverage issues at the national level is even more odd. For the first 12 years of the Medicare program, until 1977, there were no formal criteria by which coverage decisions were made. Today, there is a document outlining the process, but even now, that document is no more than an informal guideline.

Thus, the present Federal policy for reimbursement of new technologies, plainly stated, is this: (1) any bill that is received, is paid; (2) carriers and intermediaries decide coverage policy; and (3) there are no criteria by which coverage decisions are made.

This is an absurd situation. Its absurdity is, however, belatedly being recognized by those responsible for the administration of the reimbursement

programs, and it is likely that the near future will bring significant changes in the system. One of the basic problems in reforming the system, however, is the absence of data of two sorts: (1) data on the number, types, and distribution of procedures that are done (a hospital bill for reimbursement does not contain a listing of all procedures done, for example); and (2) data on the long-term benefits and risks of technology.

The first category is being addressed by the development of a common procedural terminology and of other uniform data systems. Clearly, such systems have a long way to go, but the pieces are falling into place.

More importantly, the second category -- data on the effectiveness of medical services -- is now being addressed. At the common instigation of parts of the medical profession, of our Office of Science and Technology Policy, and of parts of the Department of Health and Human Services, a model is being developed whereby imaginative use of the reimbursement system can help develop data on effectiveness on which rational reimbursement policy can be made. That model will make it possible to identify new technologies of potentially significant impact, and would trade reimbursement dollars in the investigational phase of the technology for data on effectiveness, supplied under an agreed-upon experimental protocol. The model would make it possible for the producer to recover some of the development costs early, and for the reimbursor to make rational decisions

on coverage policy. This development is quite new, but is exciting, and is likely to be a significant part of reimbursement policy in the future.

The structures within which change in reimbursement policy will occur are several. Already mentioned is the National Center for Health Care Technology and its function in coverage issue analysis. Equally important, however, is the quiet but persistent activity taking place outside government, by the medical profession, private insurers, and private industry. The concern that health care costs are high and that we are not reaping all the benefits of health technology that we might is not solely a concern of government, but is shared by many sectors.

In 1977, Blue Shield published a list of obsolete procedures which would no longer automatically be paid for. More recently, Blue Cross has made similar changes in its policy toward presurgical workups and routine admission laboratory testing. The medical profession has been active with reimbursers in policy changes such as these. The American College of Physicians, through its medical necessity project, and the Council of Medical Specialty Societies have both been quietly pursuing means by which to make reimbursement decisions rational. Private industry, in several different kinds of businesses, have begun to form consortia, negotiating with health insurers on ways to lower costs; the development of a rational approach to deciding what services are covered is a large part of their concern. There is, I believe, a developing broad consensus

that the solution to the problem of high health costs begins with changing a perspective: passive payors must become informed buyers. Until that occurs, all incentives will continue to favor overutilization of health technologies, with consequent unnecessary costs.

In summary, the picture I paint is one of the extension of trends of which you should already be cognizant. Efficacy evaluation, utilization standards and reimbursement for services are not new concepts. What is new is the coalescence of the concerns of the public -- patients, physicians, payors, and politicians -- together with new methodologies, new laws, and new structures.

To return at last to the title of this session, there need be no conflict between innovation and the quest for cost containment. The necessity for the assessment of the effects of technology should be clear. What technology assessment will do, if carried out with caution and perspective, is to change the present focus on incremental improvements in existing technologies to a focus on truly innovative breakthroughs in the development of curative technologies. Technology assessment may tend to make merely incremental improvements less profitable, but will make the development of truly curative technologies vastly more worthwhile. The challenge to you, the teaching hospitals, is to join in these compatible quests: innovation and cost containment.

COTH NOMINATING COMMITTEE REPORT

DAVID L. EVERHART, CHAIRMAN

NOVEMBER 5, 1979

BY TRADITION, THE NOMINATING COMMITTEE IS COMPOSED OF THE IMMEDIATE PAST CHAIRMAN OF THE COTH ADMINISTRATIVE BOARD WHO SERVES AS THE CHAIRMAN, THE CURRENT CHAIRMAN OF COTH, AND ONE MEMBER-AT-LARGE. THUS, YOUR COMMITTEE INCLUDES: MYSELF AS CHAIRMAN, ROBERT HEYSSEL AND EUGENE STAPLES, DIRECTOR, WEST VIRGINIA UNIVERSITY HOSPITAL.

I HAVE SEVERAL GROUPS OF NOMINATIONS, AND I WILL PRESENT THE ENTIRE SLATE AND LET THE CHAIRMAN TAKE IT FROM THERE.

IN ACCORDANCE WITH THE AAMC BYLAWS, COTH IS ENTITLED TO 57 REPRESENTATIVES ON THE AAMC ASSEMBLY. THEREFORE, WE HAVE:

19 NOMINATIONS FOR THE AAMC ASSEMBLY FOR A THREE-YEAR TERM EXPIRING 1982:

JESS E. BURROW

VETERANS ADMINISTRATION HOSPITAL
SEPULVEDA, CALIFORNIA

LAURANCE V. FOYE, JR., M.D.

VETERANS ADMINISTRATION HOSPITAL
SAN FRANCISCO, CALIFORNIA

LOUIS M. FRAZIER, JR.

VETERANS ADMINISTRATION HOSPITAL
SHREVEPORT, LOUISIANA

WILLIAM H. GURTNER

MT. ZION HOSPITAL & MEDICAL CENTER
SAN FRANCISCO, CALIFORNIA

WARREN G. HARDING

BEXAR COUNTY HOSPITAL DISTRICT
SAN ANTONIO, TEXAS

ROGER S. HUNT	INDIANA UNIVERSITY HOSPITALS INDIANAPOLIS, INDIANA
JOHN E. IVES	SHANDS TEACHING HOSPITAL GAINESVILLE, FLORIDA
DONALD G. KASSEBAUM, M.D.	UNIVERSITY OF OREGON HOSPITAL PORTLAND, OREGON
JAMES MALLOY	JOHN DEMPSEY HOSPITAL FARMINGTON, CONNECTICUT
G. BRUCE MCFADDEN	UNIVERSITY OF MARYLAND HOSPITALS BALTIMORE, MARYLAND
JOSEPH MOORE	VETERANS ADMINISTRATION, LAKESIDE HOSPITAL CHICAGO, ILLINOIS
CHARLES O'BRIEN	GEORGETOWN UNIVERSITY HOSPITAL WASHINGTON, D.C.
DAVID R. PITTS	OCHSNER FOUNDATION HOSPITAL NEW ORLEANS, LOUISIANA
RUTH M. ROTHSTEIN	MT. SINAI HOSPITAL MEDICAL CENTER CHICAGO, ILLINOIS
JEROME R. SAPOLSKY	THE MIRIAM HOSPITAL PROVIDENCE, RHODE ISLAND
RICHARD L. SEJNOST	THE HARPER HOSPITAL DETROIT, MICHIGAN
ROBERT J. TAYLOR	HENNEPIN COUNTY MEDICAL CENTER MINNEAPOLIS, MINNESOTA
DAVID S. WEINER	CHILDRENS HOSPITAL MEDICAL CENTER BOSTON, MASSACHUSETTS
BERNARD B. WEINSTEIN	WESTCHESTER COUNTY MEDICAL CENTER VALHALLA, NEW YORK

TO REPLACE A REPRESENTATIVE ON THE ASSEMBLY WHO IS NO LONGER
ASSOCIATED WITH COTH MEMBER INSTITUTIONS, WE HAVE:

ONE NOMINATION FOR A ONE-YEAR TERM EXPIRING 1980:

JOHN REINERTSEN	UNIVERSITY OF UTAH HOSPITAL SALT LAKE CITY, UTAH
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NOMINATION FOR COTH SECRETARY FOR A ONE-YEAR TERM EXPIRING 1980:

MITCHELL T. RABKIN, M.D. BETH ISRAEL HOSPITAL
BOSTON, MASSACHUSETTS

NOMINATIONS FOR THREE-YEAR TERMS ON THE COTH ADMINISTRATIVE BOARD:

FRED J. COWELL JACKSON MEMORIAL HOSPITAL
MIAMI, FLORIDA

ROBERT E. FRANK BARNES HOSPITAL
ST. LOUIS, MISSOURI

EARL J. FREDERICK CHILDRENS MEMORIAL HOSPITAL
CHICAGO, ILLINOIS

REPRESENTATIVE TO THE AAMC EXECUTIVE COUNCIL FOR A THREE-YEAR TERM:

JOHN REINERTSEN UNIVERSITY OF UTAH MEDICAL CENTER
SALT LAKE CITY, UTAH

IN ADDITION TO THESE APPOINTMENTS, WE HAVE THE IMMEDIATE PAST CHAIRMAN WHICH IS AUTOMATIC - DR. ROBERT HEYSSEL.

THE CHAIRMANSHIP, WHICH LIKEWISE IS AUTOMATIC SINCE YOU EXERCISED YOUR FRANCHISE LAST YEAR - MR. JOHN COLLOTON.

CHAIRMAN-ELECT - MR. STUART MARYLANDER, CEDARS-SINAI MEDICAL CENTER, LOS ANGELES.

MR. CHAIRMAN, I MOVE THE NOMINATIONS.

CHAIRMAN'S REPORT

1978-79

ROBERT M. HEYSSEL, M.D.

AS IS THE CASE EACH YEAR, JIM AND DICK HAVE SET FORTH VERY WELL THE PAST YEAR'S ACTIVITIES OF INTEREST TO YOU, SO I'LL NOT DWELL ON THEM ANY FURTHER. INSTEAD I'D LIKE TO CALL YOUR ATTENTION TO A COUPLE OF ITEMS OF INTEREST AND SHARE SOME PERSONAL THOUGHTS WITH YOU.

FIRST, I'LL MENTION THE COTH SPRING MEETING. OUR EFFORT LAST SPRING IN KANSAS CITY WAS DESIGNED TO ENHANCE THE DIRECT PARTICIPATION OF THE MEMBERSHIP, AND I THINK WE SUCCEEDED. THE STAFF PREPARED AN EXCELLENT DOCUMENT FOR THAT MEETING ENTITLED, "TOWARD A MORE CONTEMPORARY PUBLIC UNDERSTANDING OF THE TEACHING HOSPITAL." IN RESPONSE A STRONG MANDATE WAS CLEARLY HEARD TO BETTER DEFINE THE PRODUCTS OF THE TEACHING HOSPITAL, TO ARTICULATE MORE CLEARLY OUR SPECIAL PROBLEMS AND CHARACTERISTICS, AND TO RELATE THESE DIMENSIONS TO OUR COSTS OR EXPENDITURES. SUBSEQUENT TO THE MEETING A PRELIMINARY STAFF REPORT CALLED, "CASE MIX MEASURES AND THEIR REIMBURSEMENT APPLICATIONS" WAS DEVELOPED AND SENT TO YOU IN SEPTEMBER. BASED ON THIS PARTICIPATION AND FOLLOW-UP ACTIVITIES, IT'S CLEAR TO ME THAT THE SPRING MEETING PROVIDES US WITH AN OPPORTUNITY TO GET TOGETHER, BUT ALSO SERVES AS AN IMPETUS AND A FOCUS FOR THE STAFF TO PREPARE REPORTS SUCH AS THOSE

I'VE JUST MENTIONED WHICH I THINK ARE PARTICULARLY IMPORTANT AND HELPFUL TO US. WITH THIS IN MIND, I'D ASK THAT YOU MARK YOUR CALENDARS FOR MAY 14-16 OF NEXT YEAR WHEN OUR NEXT SPRING MEETING WILL BE HELD AT THE BROWN PALACE HOTEL IN DENVER. THE PLANNING COMMITTEE FOR THE UPCOMING MEETING IS CHAIRED BY EARL FREDERICK OF CHILDREN'S MEMORIAL HOSPITAL IN CHICAGO. OTHER MEMBERS OF THE COMMITTEE ARE FRED BROWN OF THE VA HOSPITAL IN DURHAM, NORTH CAROLINA, IRV GOLDBERG FROM MONTEFIORE HOSPITAL IN PITTSBURGH, BILL KERR OF THE UNIVERSITY OF CALIFORNIA HOSPITALS AND DICK SEJNOST FROM HARPER-GRACE HOSPITALS IN DETROIT. I CAN ASSURE YOU THAT THEY'VE BEEN PUTTING TOGETHER AN EXCELLENT PROGRAM, AND HAVE TAKEN INTO ACCOUNT YOUR COMMENTS AND SUGGESTIONS FROM THE LAST MEETING.

A SECOND MATTER I'D LIKE TO CALL TO YOUR ATTENTION IS THE MEETING OF THE AAMC ASSEMBLY TOMORROW AFTERNOON AT 1:00 P.M. THE ENTIRE SESSION WILL BE DEVOTED TO A DISCUSSION OF THE REPORT OF THE AAMC TASK FORCE ON GRADUATE MEDICAL EDUCATION. SPIKE FOREMAN OF THE SINAI HOSPITAL IN BALTIMORE AND MERLIN OLSON WITH THE UNIVERSITY OF COLORADO ARE COTH REPRESENTATIVES ON THAT TASK FORCE. A COPY OF THAT REPORT WAS SENT TO EACH COTH MEMBER ABOUT TWO WEEKS AGO. THE MEETING IS OPEN TO ALL INTERESTED INDIVIDUALS, AND I'D URGE YOUR ATTENDANCE AND PARTICIPATION. THE WAY IN WHICH THE REPORT IS TO BE REVIEWED APPEARS ON PAGE _____ OF YOUR ANNUAL MEETING PROGRAM. TAKE A LOOK AT IT, AND I'D LIKE TO SEE YOU THERE.

HAVING REPORTED ON THESE BUSINESS EVENTS, I'D LIKE FOR A MOMENT TO SHARE SOME PERSONAL OBSERVATIONS WITH YOU ON THE TOPICS OF STATE RATE REVIEW, PATIENT CASE MIX AND THE ROLE OF PHYSICIANS IN HOSPITAL MANAGEMENT. I READ RECENTLY IN ONE OF OUR TRADE PUBLICATIONS THAT SOME HOSPITAL SPOKESMEN BELIEVE STATE RATE REVIEW PROGRAMS TO CONTROL HOSPITAL COSTS ARE DEAD. AT THE SAME TIME OTHERS CONTEND THAT RATE REVIEW IS ALIVE AND WELL, EVEN THOUGH INTEREST IN THE PROGRAMS HAS WANED. MY OWN VIEWS ON THE SUBJECT ARE OBVIOUSLY COLORED BY THE FACT THAT I'M FROM A STATE WHERE SUCH A PROGRAM IS ALIVE, SUPPORTED BY THE HOSPITALS AND THEIR ASSOCIATION, AND WORKING REASONABLY WELL. WHILE A STATE OF AFFAIRS FOR OUR INSTITUTIONS WHICH IS "REGULATION FREE," IS MOST DESIRABLE, I CANNOT SEE SUCH A UTOPIA OCCURRING ANYTIME IN THE NEAR FUTURE.

ON THE OTHER HAND, IN BALTIMORE, WE'RE CLOSE ENOUGH TO WASHINGTON SO I CAN HEAR WHAT'S BEING SAID, BUT NOT SO CLOSE SO THAT I HEAR IT OFTEN ENOUGH TO BELIEVE IT. HOWEVER, THERE DOES SEEM TO BE A FREE ENTERPRISE DIALOGUE ON HOSPITAL ISSUES THAT IS GROWING. THE DISCUSSION AND RHETORIC FOR THE MOMENT SEEM TO BE MORE AT THE CONCEPTUAL THAN THE OPERATIONAL LEVEL. IN OTHER WORDS, NOBODY'S QUITE SURE HOW THINGS WOULD WORK BUT THEY ARE POLITICALLY OR PERSONALLY ATTRACTED TO THE IDEA OF DEREGULATION AND COMPETITION. THIS IS A SUBJECT TO WHICH MOST OF US IN TEACHING HOSPITALS HAVE NOT GIVEN ENOUGH THOUGHT. WHAT WOULD BE OUR STRATEGY FOR SURVIVING AND PROSPERING IN AN ENVIRONMENT OF "FULL-BLOWN" DEREGULATION AND

OPEN COMPETITION? HOW WOULD WE SUPPORT OUR EDUCATIONAL PROGRAMS UNDER THESE CONDITIONS? I DON'T HAVE THE SHORT ANSWER -- OR EVEN THE LONG ONE -- TO THAT QUESTION, BUT IT DOES NEED MORE CAREFUL THOUGHT AND BRINGS ME TO THE OTHER ISSUES I WISH TO MENTION -- PATIENT DIAGNOSTIC CASE MIX AND THE PHYSICIAN'S ROLE IN HOSPITAL MANAGEMENT.

FIRST, I BELIEVE EACH OF US WOULD BE WELL SERVED TO BE SURE EFFORTS ARE WELL UNDER WAY IN OUR OWN HOSPITALS TO HAVE A THOROUGH UNDERSTANDING OF THE DIAGNOSTIC CASE MIX OF THE PATIENTS WE ARE SERVING, AND ITS RELATIONSHIP TO OUR EXPENDITURES. THERE ARE A VARIETY OF WAYS OF DOING THIS, BUT EACH OF US SHOULD HAVE A MANAGEMENT GROUP, WHICH INCLUDES PHYSICIANS, WORKING ON THIS SUBJECT. IN AN AGE OF COMPETITION, AS WELL AS REGULATION, SUBSTANTIATING THE CASE-MIX EXPENDITURE RELATIONSHIP IS ESSENTIAL IF WE ARE TO BE ABLE TO CONTINUE TO MARKET OUR SERVICES AND JUSTIFY OUR PRICES. THE PROSPECT OF MEDICARE INCORPORATING A CASE MIX MEASURE IN SETTING ITS LIMITS NEXT YEAR SHOULD BE INCENTIVE ENOUGH TO GET INTO THIS AREA.

AT THE COTH GENERAL SESSION TWO YEARS AGO I SPOKE ON THE TOPIC OF "PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR CONTROLLING THE DEMAND FOR HOSPITAL SERVICES." MY VIEWS ON THAT SUBJECT HAVEN'T CHANGED MUCH IN TWO YEARS -- IF ANYTHING, THEY ARE STRONGER. WE MUST FIND WAYS TO BRING THE MEDICAL FACULTY AND STAFF INTO POSITIONS WHERE THEY CAN EXERCISE LEADERSHIP AND TAKE AN INSTITUTIONAL VIEW OF THE

ISSUES. PEOPLE DO RESPOND TO ECONOMIC AND OTHER INCENTIVES AND WE MUST FIND WAYS TO MAKE A CHANGE IN BEHAVIOR WORTHWHILE. THIS IS ESPECIALLY TRUE WHEN YOU CONSIDER THE COLLECTIVE APPETITE FOR NEW TECHNOLOGY WHICH IS THE SUBJECT OF OUR SESSION THIS AFTERNOON.

IT'S BEEN A PLEASURE TO SERVE AS YOUR CHAIRMAN DURING THE PAST YEAR, AND I'D LIKE TO TAKE THIS OPPORTUNITY TO THANK THE MEMBERS OF THE COTH BOARD FOR THEIR SUPPORT AND CONTRIBUTIONS TO OUR EFFORT.

THANK YOU VERY MUCH.

CHAIRMAN'S REPORT TO THE ASSEMBLY

1978-79

ROBERT M. HEYSSEL, M.D.

I HAVE ONLY A FEW THOUGHTS TO SHARE WITH YOU THIS MORNING.

FIRST, I'LL MENTION THE COTH SPRING MEETING. OUR EFFORT LAST SPRING IN KANSAS CITY WAS DESIGNED TO ENHANCE THE DIRECT PARTICIPATION OF THE MEMBERSHIP, AND I THINK WE SUCCEEDED. THE STAFF PREPARED AN EXCELLENT DOCUMENT FOR THAT MEETING ENTITLED, "TOWARD A MORE CONTEMPORARY PUBLIC UNDERSTANDING OF THE TEACHING HOSPITAL." IN RESPONSE A STRONG MANDATE WAS CLEARLY HEARD TO BETTER DEFINE THE PRODUCTS OF THE TEACHING HOSPITAL, TO ARTICULATE MORE CLEARLY OUR SPECIAL PROBLEMS AND CHARACTERISTICS, AND TO RELATE THESE DIMENSIONS TO OUR COSTS OR EXPENDITURES. SUBSEQUENT TO THE MEETING A PRELIMINARY STAFF REPORT CALLED, "CASE MIX MEASURES AND THEIR REIMBURSEMENT APPLICATIONS" WAS DEVELOPED AND SENT TO COTH MEMBERS IN SEPTEMBER. BASED ON THIS PARTICIPATION AND FOLLOW-UP ACTIVITIES, IT'S CLEAR TO ME THAT THE SPRING MEETING PROVIDES COTH WITH AN OPPORTUNITY TO GET TOGETHER, BUT ALSO SERVES AS AN IMPETUS AND A FOCUS FOR THE STAFF TO PREPARE REPORTS SUCH AS THOSE I'VE JUST MENTIONED WHICH I THINK ARE PARTICULARLY IMPORTANT AND HELPFUL TO US.

HAVING REPORTED ON THIS COTH EVENT, I'D LIKE FOR A MOMENT TO MAKE SOME PERSONAL OBSERVATIONS ON THE TOPICS OF STATE RATE REVIEW, PATIENT CASE MIX AND THE ROLE OF PHYSICIANS IN HOSPITAL MANAGEMENT. I MADE THESE POINTS YESTERDAY AFTERNOON TO THE COTH MEMBERSHIP, AND I'M GOING TO REPEAT THEM AGAIN THIS MORNING. I READ RECENTLY IN ONE OF OUR TRADE PUBLICATIONS THAT SOME HOSPITAL SPOKESMEN BELIEVE STATE RATE REVIEW PROGRAMS TO CONTROL HOSPITAL COSTS ARE DEAD. AT THE SAME TIME, OTHERS CONTEND THAT RATE REVIEW IS ALIVE AND WELL, EVEN THOUGH INTEREST IN THE PROGRAMS HAS WANED. MY OWN VIEWS ON THE SUBJECT ARE OBVIOUSLY COLORED BY THE FACT THAT I'M FROM A STATE WHERE SUCH A PROGRAM IS ALIVE, SUPPORTED BY THE HOSPITALS AND THEIR ASSOCIATION, AND WORKING REASONABLY WELL. WHILE WE ALL MIGHT VIEW AN ENVIRONMENT FOR OUR INSTITUTIONS WHICH IS "REGULATION FREE" AS MOST DESIRABLE, I CANNOT SEE SUCH A UTOPIA OCCURRING ANYTIME IN THE NEAR FUTURE.

ON THE OTHER HAND, IN BALTIMORE, WE'RE CLOSE ENOUGH TO WASHINGTON SO I CAN HEAR WHAT'S BEING SAID, BUT NOT SO CLOSE SO THAT I HEAR IT OFTEN ENOUGH TO BELIEVE IT. HOWEVER, THERE DOES SEEM TO BE A "FREE ENTERPRISE" DIALOGUE ON HOSPITAL ISSUES THAT IS GROWING. THE DISCUSSION AND RHETORIC FOR THE MOMENT SEEM TO BE MORE AT THE CONCEPTUAL THAN THE OPERATIONAL LEVEL. IN OTHER WORDS, NOBODY'S QUITE SURE HOW THINGS WOULD WORK, BUT THEY ARE POLITICALLY OR PERSONALLY

ATTRACTED TO THE IDEA OF DEREGULATION AND COMPETITION. THIS IS A SUBJECT TO WHICH MOST OF US IN MEDICAL SCHOOLS AND TEACHING HOSPITALS HAVE NOT GIVEN ENOUGH THOUGHT. WHAT WOULD BE OUR STRATEGY FOR SURVIVING AND PROSPERING IN AN ENVIRONMENT OF "FULL-BLOWN" DEREGULATION AND OPEN COMPETITION? HOW WOULD WE SUPPORT OUR EDUCATIONAL PROGRAMS UNDER THESE CONDITIONS? I DON'T HAVE THE SHORT ANSWER -- OR EVEN THE LONG ONE -- TO THAT QUESTION, BUT IT DOES NEED MORE CAREFUL THOUGHT AND BRINGS ME TO THE OTHER ISSUES I WISH TO MENTION -- PATIENT DIAGNOSTIC CASE MIX AND THE PHYSICIAN'S ROLE IN HOSPITAL MANAGEMENT.

FIRST, I BELIEVE EACH OF US WOULD BE WELL SERVED TO BE SURE EFFORTS ARE WELL UNDER WAY IN OUR OWN MEDICAL CENTERS TO HAVE A THOROUGH UNDERSTANDING OF THE DIAGNOSTIC CASE MIX OF THE PATIENTS WE ARE SERVING, AND ITS RELATIONSHIP TO OUR EXPENDITURES. I BELIEVE IT'S IN THE INTEREST OF THE DEANS AND FACULTY TO SUPPORT AND ENCOURAGE THIS KIND OF AN EFFORT. IN AN AGE OF COMPETITION, AS WELL AS REGULATION, SUBSTANTIATING THE "CASE-MIX/EXPENDITURE" RELATIONSHIP IS ESSENTIAL IF WE ARE TO BE ABLE TO CONTINUE TO MARKET OUR SERVICES AND JUSTIFY OUR PRICES. THE PROSPECT OF MEDICARE INCORPORATING A CASE MIX MEASURE IN SETTING ITS LIMITS NEXT YEAR SHOULD BE INCENTIVE ENOUGH TO GET INTO THIS AREA.

AT THE COTH GENERAL SESSION TWO YEARS AGO I SPOKE ON THE TOPIC OF "PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR CONTROLLING THE DEMAND FOR HOSPITAL SERVICES." MY VIEWS

ON THAT SUBJECT HAVEN'T CHANGED MUCH IN TWO YEARS -- IF ANYTHING, THEY ARE STRONGER. WE MUST FIND WAYS TO BRING THE MEDICAL FACULTY AND STAFF INTO POSITIONS WHERE THEY CAN EXERCISE LEADERSHIP AND TAKE AN INSTITUTIONAL VIEW OF THE ISSUES. PEOPLE DO RESPOND TO ECONOMIC AND OTHER INCENTIVES AND WE MUST FIND WAYS TO MAKE A CHANGE IN BEHAVIOR WORTHWHILE. THIS IS ESPECIALLY TRUE WHEN YOU CONSIDER THE COLLECTIVE APPETITE FOR NEW TECHNOLOGY WHICH WAS THE SUBJECT OF OUR COTH GENERAL SESSION YESTERDAY AFTERNOON.

IT'S BEEN A PLEASURE TO SERVE AS THE COTH CHAIRMAN DURING THE PAST YEAR, AND I'D LIKE TO TAKE THIS OPPORTUNITY TO THANK THE ENTIRE AAMC STAFF FOR THEIR SUPPORT AND CONTRIBUTIONS TO OUR EFFORT.

THANK YOU VERY MUCH.

REPORT TO COTH MEMBERSHIP

DR. RICHARD KNAPP

1978-79

ANYONE WHO SPENDS A GOOD DEAL OF TIME INVOLVED IN PUBLIC SPEAKING, AS MOST OF YOU DO, FACES TIMES WHEN THERE SEEMS TO BE SO LITTLE TO SAY; THERE ARE OTHER TIMES WHEN THE POTENTIAL FOR DISCUSSION SEEMS LIMITLESS. THERE ARE A WIDE VARIETY OF REGULATORY AND LEGISLATIVE ISSUES I COULD REVIEW, AND THERE ARE OTHER ORGANIZATIONAL, FINANCIAL AND DELIVERY MATTERS ABOUT WHICH MANY OF YOU I KNOW HAVE CONCERNS.

RATHER THAN TRYING TO DO JUSTICE TO THESE ISSUES IN THE SHORT TIME AVAILABLE, WE'VE PREPARED A VERY COMPREHENSIVE AND DETAILED REVIEW WHICH WAS MADE AVAILABLE TO YOU AS YOU CAME INTO THE ROOM. I URGE YOU TO READ THAT DOCUMENT, AND I'D LIKE TO HEAR FROM YOU IF WE'VE OVERLOOKED SOMETHING OR MISSED THE MARK ON A PARTICULAR ISSUE.

IN PREPARING MY REMARKS FOR THIS AFTERNOON I TRIED TO ASK MYSELF WHAT MADE THIS PAST YEAR DIFFERENT. THERE IS ONE ISSUE THAT IN THE PAST HAS LURKED BENEATH THE SURFACE, BUT THIS YEAR I'VE NOTED HAS MORE FREQUENTLY MADE ITS WAY INTO THE PUBLIC AND PROFESSIONAL PRESS -- THAT IS, THE CONTINUING DEBATE OVER WHETHER A PATIENT SHOULD BE IN A TEACHING OR NON-TEACHING HOSPITAL. ALL PARTICIPANTS IN THE DEBATE SEEM TO AGREE THAT THE SERIOUSLY ILL BELONG IN TEACHING INSTITUTIONS.

HOWEVER, LET ME QUOTE FOR A MOMENT FROM A BOOK ENTITLED, THE LIFE YOU SAVE: A GUIDE TO GETTING THE BEST POSSIBLE CARE FROM DOCTORS, HOSPITALS AND NURSING HOMES. THE AUTHOR STATES, "SOME PHYSICIANS WOULD ARGUE THAT ANY PATIENT IS BETTER OFF IN A TEACHING HOSPITAL BECAUSE THE LATEST EQUIPMENT AND BEST TRAINED PHYSICIANS ARE THERE. ON THE OTHER HAND, EVEN SOME TOP MEN ON MEDICAL SCHOOL FACULTIES WILL TELL YOU THAT THE TEACHING HOSPITAL IS NO PLACE TO BE SICK - UNLESS YOU ARE SERIOUSLY SICK. THERE IS OFTEN A COLD, IMPERSONAL ATMOSPHERE..." AND THE QUOTE GOES ON FROM THERE IN A NEGATIVE VEIN. SUCH BOOKS AND REVIEWS OF THEM WITH THESE BLATANT GENERALITIES DO LITTLE TO ENHANCE THE CONFIDENCE OF THE PUBLIC IN OUR INSTITUTIONS. HOWEVER, IT DOES SERVE AS A HEALTHY REMINDER THAT IT ISN'T ALWAYS JUST A GOOD MEDICAL OUTCOME THAT IS THE BASIS UPON WHICH PATIENTS MEASURE OUR PERFORMANCE. THE PROCESS OF CARING WHILE THAT OUTCOME WAS ACHIEVED IS REMEMBERED AS WELL. AS TEACHING HOSPITALS ARE FACED WITH MORE AND TOUGHER COMPETITION, THIS MATTER REQUIRES MORE AND MORE ATTENTION.

THERE ARE TIMES WHEN I WONDER IF OUR ORGANIZATION OUGHT TO BE DOING SOMETHING IN THIS AREA. HOWEVER, ON A RELATED MATTER, I KNOW WE SHOULD BE DOING MORE, AND PLAN TO DO SO IN THE COMING YEAR. THIS CONCERNS A BETTER ARTICULATION AND DESCRIPTION OF THE TEACHING HOSPITAL PRODUCT -- BETTER KNOWN AS PATIENT CASE MIX RESEARCH AND DEVELOPMENT. COLLECTIVELY, YOU GAVE THE STAFF A MANDATE AT THE SPRING MEETING IN KANSAS

CITY, AND WE'VE BEEN AT WORK ATTEMPTING TO CHART A COURSE FOR THE PROPER RESPONSE. WE THINK WE'VE IDENTIFIED ALL THE MAJOR ACTORS WHO ARE WORKING IN THIS FIELD, AND JIM BENTLEY AND PETER BUTLER HAVE VISITED MOST OF THEM. WE SENT YOU AN INTERIM REPORT IN SEPTEMBER, AND AT THIS MORNING'S COTH BOARD MEETING A NUMBER OF POSSIBLE SPECIFIC PROJECTS WERE PRESENTED TO THE BOARD FOR REVIEW.

ENOUGH MONEY TO GET STARTED HAS BEEN SET ASIDE IN OUR CURRENT BUDGET, AND THAT'S NOT BEEN A MAJOR PROBLEM. ASKING THE PROPER QUESTIONS HAS BEEN THE MOST DIFFICULT TASK. WHAT IS IT THAT WE ARE TRYING TO DO? IT'S CLEAR TO ME THAT EVERYONE WANTS A SOLUTION THAT WILL SETTLE THE CASE MIX ISSUE AND ITS COMPLEXITIES ONCE AND FOR ALL, BUT I'D ASK YOU TO REMEMBER ERIC SEVEROID'S PROPOSITION THAT, "EVERY SOLUTION CREATES ITS OWN PROBLEMS." IN THIS REGARD I HAVE TWO OBSERVATIONS WHICH WORRY ME. THE FIRST IS THAT EVERY HOSPITAL REPRESENTATIVE THINKS THAT A GOOD CASE MIX MEASURE TIED TO REIMBURSEMENT WILL INCREASE HIS OR HER REVENUE. TEACHING HOSPITALS BELIEVE SUCH A MEASURE WILL JUSTIFY A HIGHER AVERAGE COST WHILE NON-TEACHING HOSPITALS BELIEVE SUCH A MEASURE WILL DEMONSTRATE THAT MORE ROUTINE ADMISSIONS OUGHT TO BE HOSPITALIZED IN THEIR LESS COSTLY HOSPITALS. WHILE THESE VIEWPOINTS ARE NOT NECESSARILY CONTRADICTORY, I DON'T BELIEVE BOTH GROUPS OF HOSPITALS CAN EXPECT TO RECEIVE MORE REVENUE.

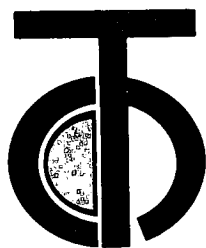
SECONDLY, IT NEEDS TO BE REMEMBERED THAT ANY REIMBURSEMENT MECHANISM, INCLUDING ONE BASED ON CASE MIX, IS SUBJECT TO LIMITATIONS NOT DISSIMILAR TO THOSE WE ARE PRESENTLY OPPOSING. IN OTHER WORDS, PERCENTILE RANKS, MEANS OR MEDIANS CAN AND PROBABLY WILL BE CALCULATED NO MATTER WHAT THE UNIT OF ANALYSIS.

I ASK THAT YOU BEAR THESE TWO POINTS IN MIND AS WE MOVE AHEAD IN THIS AREA. WE NEED ALL THE HELP WE CAN GET ON THIS SUBJECT; IF YOU HAVE SOME THOUGHTS, OR ARE DOING SOMETHING AT YOUR HOSPITAL THAT WE OUGHT TO KNOW ABOUT, GIVE US A CALL.

THIS HAS BEEN A VERY BUSY YEAR. WE HAVE A RELATIVELY SMALL STAFF WHICH WILL STAY THAT WAY. THUS, THERE ARE SOME ISSUES TO WHICH WE DON'T GIVE MUCH ATTENTION. I BELIEVE THIS IS APPROPRIATE. IN DETERMINING WHAT ISSUES SHOULD RECEIVE PRIORITY, WE ASK HOW THAT SUBJECT RELATES TO DISTINCTIVE FEATURES AND OBJECTIVES OF THE TEACHING HOSPITAL, AND WHAT CAN WE ADD THAT WON'T DUPLICATE SOME OTHER ORGANIZATION'S EFFORT. I THINK THIS VIEW KEEPS OUR EYE ON THE BALL, BUT AGAIN WE'RE ALWAYS INTERESTED IN YOUR OPINIONS.

ALL OF WHAT WE DO WOULDN'T BE POSSIBLE WITHOUT YOUR COOPERATION AND SUPPORT. YOU COMPLETE THE QUESTIONNAIRES, WRITE THE LETTERS AND GIVE THE ADVICE. AND, MORE AND MORE OF YOU ARE GIVING YOUR TIME AND EFFORT ON A VARIETY OF COMMITTEES, TASK FORCES AND EDITORIAL BOARDS. PLEASE KNOW THAT WE RECOGNIZE AND APPRECIATE IT ALL. I'D ALSO LIKE TO THANK THE COTH BOARD MEMBERS, AND SAY IT'S BEEN A PLEASURE TO WORK WITH YOUR CHAIRMAN DR. HEYSSEL.

JIM HUDSON IS A PLEASURE TO WORK WITH, AND BEFORE CLOSING, I DO WISH TO THANK THE PEOPLE WHO WORK DIRECTLY WITH ME AND MAKE ME LOOK GOOD -- JIM BENTLEY - JOE ISAACS - PETER BUTLER - CHIP KAHN, AN ADMINISTRATIVE RESIDENT FROM TULANE WHO JOINED US IN JULY - GAIL GROSS - MELODY BISHOP - TINA WILLIAMS. THANK YOU.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
NOVEMBER, 1978 - OCTOBER, 1979

OUTLINE OF SELECTED ACTIVITIES

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THE COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges was formally established in 1965. Its purpose is to provide representation and services related to the special problems, concerns, and opportunities of medical school-affiliated and university-owned hospitals. As one of the three governing councils of the Association, COTH also serves an important role in determining overall Association policy and direction.

COTH Membership

There are two categories of COTH membership: teaching hospital membership and corresponding membership. Both membership categories require the applicant institution to have a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education and a letter recommending membership from the dean of the affiliated medical school. Teaching hospital membership is limited to not-for-profit IRS 501(c)(3) and publicly-owned hospitals which sponsor or significantly participate in at least four approved residency programs. At least two of the approved residency programs must be in the following speciality areas: internal 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. Hospitals qualifying for teaching hospital membership receive the full range of AAMC and COTH services and publications and are eligible to participate in the AAMC's governance, organization, and committee structure.

Non-profit and governmental hospitals and medical education organizations (e.g., consortia, foundations, federations) not eligible for teaching hospital membership may apply for corresponding membership. Corresponding members are eligible to attend all open AAMC meetings and to receive all publications forwarded to institutions in the teaching hospital membership category. The present membership of the Council of Teaching Hospitals includes 409 teaching hospital members and 20 corresponding members. Three hundred and thirty-one of the members are not-for-profit, municipal, and state hospitals. The remaining 78 members are Veterans Administration hospitals. Sixty-four members are university-owned hospitals.

COTH Administrative Board

There are nine members on the COTH Administrative Board, each serving a three year term. Three new members are elected annually. In addition, the Immediate Past Chairman, the Chairman, the Chairman-elect, the Secretary, and the COTH Representatives to the AAMC Executive Council are members of the

Administrative Board. COTH Officers and Administrative Board members are listed in Appendix A of this report. The Administrative Board meets four times a year and is authorized to conduct business of the Council of Teaching Hospitals between the annual meetings of the membership.

The Council of Teaching Hospitals reports to the AAMC Executive Council and is represented by four Administrative Board Members. Creation of standing committees and any major actions by the COTH Administrative Board are taken only after recommendation to and approval by the AAMC Executive Council. COTH Officers, new Administrative Board members and new representatives to the AAMC Assembly -- the highest legislative body of the AAMC -- are elected annually by all COTH members at the AAMC Annual Meeting. For the coming 1979-1980 year, John W. Colloton, Director of the University of Iowa Hospitals and Assistant to the University President for Health Services, will take over as Chairman of the COTH Administrative Board. It is also of special note that for the coming year the Chairman of the Executive Council will be Charles B. Womer, President of the University Hospitals of Cleveland. Mr. Womer is the third COTH representative to serve as the AAMC Executive Council Chairman.

Department of Teaching Hospitals

The Department of Teaching Hospitals is the staff component of the Association responsible for representing interests of the teaching hospital community in AAMC activities and with other organizations and agencies. The following report summarizes the major activities undertaken by the staff since our last annual meeting in October, 1978. Individuals seeking more detailed and supplementary information on any of the activities described are encouraged to contact the Department of Teaching Hospitals. A list of staff and their phone numbers is provided in Appendix B of this report.

MEDICARE REIMBURSEMENT ISSUES AND REGULATIONS

Section 227 - Payments to Physicians and Teaching Hospitals

Background

Section 227 of the 1972 Medicare Amendments to the Social Security Act established special provisions for payment of physicians' professional medical and surgical services in teaching hospitals. On July 19th, 1973, the Department of Health, Education, and Welfare (DHEW) published proposed regulations for the implementation of Section 227. The proposed regulations were widely criticized by the medical education community as unworkable, inequitable, harmful to existing patterns in medical education, and punitive to physicians practicing in teaching hospitals. Those proposed regulations were withdrawn before implementation and Congress chartered the Institute of Medicine to conduct a study of the payment of physicians in teaching hospitals. The IOM

published its findings in March, 1976, but new regulations were not available for the scheduled implementation date on October 1, 1977. Therefore, the Administrator of the Health Care Financing Administration, Robert Derzon, recommended -- to the respective chairmen of the Senate Finance Committee and the House Ways and Means Committee -- a further deferral of Section 227 implementation until October 1, 1978. Senator Robert Dole (R-Kansas) sponsored legislation which accomplished the one-year delay.

Draft Regulations

Last year, the draft regulations for Section 227, which were informally circulated in July, 1978, were highly criticized by the teaching hospital community. The October 1 implementation date passed by without publication of regulations. At the AAMC Annual Meeting in October, 1978, then HEW Secretary Joseph A. Califano publicly stated his agreement to further delay implementation and to provide the medical education community with an opportunity to comment on any regulations that would be forthcoming.

Subsequent to last year's Annual Meeting, the Association's Ad Hoc Committee on Section 227 was expanded and reconstituted with Hiram C. Polk, Jr., Chairman of the Department of Surgery at the University of Louisville School of Medicine, as its Chairman. The purpose of this committee was to review the Association's position on Section 227 and to evaluate any future proposed regulations. The initial meeting of this group was held on January 4th, 1979. The Committee conducted an intensive review of last year's AAMC position on the draft 227 regulations. In developing Association strategy for Section 227, the Committee discussed HEW Undersecretary Hale Champion's letter to Senator Dale Bumpers (D-Arkansas) agreeing to a one year delay in the implementation of 227 regulations. The Committee also discussed meetings scheduled with Champion and Health Care Financing Administration Administrator Leonard Schaeffer for January, 1979. While the Committee decided to initially emphasize the development of acceptable regulations under the present law, it appointed a subcommittee, chaired by Edward M. Brandt, Jr., Vice Chancellor for Health Affairs of the University of Texas to develop legislative recommendations for use if HEW failed to develop appropriate changes in the draft regulations.

Following the January 4th Ad Hoc Committee meeting, Association staff met with Leonard Schaeffer, Clifton Gaus and Al Diamond of the Health Care Financing Administration on January 15th to discuss Section 227. The purpose of the meeting was to describe concerns with the draft regulations and to discuss the process by which differences of opinion hopefully could be resolved. Mentioned as primary concerns were the private patient test, the fiscal test for fee level, supervision of residents, and determination of the cost for physicians' services. On January 17th, members of the Association's Executive Committee, together with Stuart Bondurant, Chairman of the Association Task Force on Support for Medical Education and Hiram Polk, Chairman of the Ad Hoc Committee on Section 227, met with then HEW Undersecretary Hale Champion. This meeting included a discussion of health manpower legislation and concerns with Section 227. Also present at this meeting were Assistant Secretary for HEW, Julius Richmond; Deputy Assistant Secretary for Planning and

Evaluation, Karen Davis; Health Resources Administration Administrator, Henry Foley; and Leonard Schaeffer. Both of these meetings included candid and open discussions of the critical issues that need to be resolved.

In an effort to get widespread comments from the Association members, the Association held four one-day, regional workshops on Section 227 during January. The primary objectives of the workshop were to: have attendees clarify whether or not the July 19th, 1978 draft regulations would have an adverse impact on their school, hospital or physicians; clarify the critical issues of the draft regulations by examining their impacts on individual hospitals and schools; and develop consensus positions, if possible, on critical issues. The workshops were organized in two sessions. During the morning, descriptions of differing adverse impacts of the draft regulations were presented to provide workshop participants with examples with which they could assess their own situation. During the afternoon, critical issues identified in the morning and the previous Association analysis of the regulations were discussed and debated to develop recommended policy positions. In total, the regional workshops provided almost 350 AAMC members, representing broad geographic, institutional, and professional organizations with an opportunity to help formulate the Association's positions on Section 227 implementation.

The January meetings were followed by three half-day sessions between HCFA officials and a five member subcommittee of the AAMC Ad Hoc Committee on Section 227, which included: Hiram Polk, Chairman of the Ad Hoc Committee, Martin Dillard of Howard, Edward Brandt of the University of Texas, Marvin Siegel of Miami, and Irwin Birnbaum of Montefiore Hospital. In the sessions, HCFA presented tentative recommendations on the major issues. Dr. Polk stated that the recommendations were partially responsive to the Association's concerns, but that a discriminatory fiscal test remained and that the cost based method of payments resulted in payments less than cost.

Since last Spring, there has been little word from HCFA as to when new regulations might be published. It remains unclear what priority is presently being given to publishing new regulations. Leonard Schaeffer, HCFA Administrator, has publicly stated on several occasions that HCFA is actively addressing this issue, but he has not stated when new guidelines can be expected.

Legislative Activity

While Secretary Califano at last year's AAMC Annual Meeting agreed to delay implementation of Section 227, no legislative action was taken to officially postpone implementation beyond the October 1, 1978 deadline. There have been several efforts this year in both the House and the Senate to pass legislation that would delay Section 227 to October 1, 1979. Senator Dale Bumpers (D-Arkansas) and Representative Tim Lee Carter (D-Kentucky) introduced legislation to delay the date of implementation until October, 1979. The delay provision was also in the Talmadge-Dole Medicare and Medicaid Reform provisions, which were passed by the Senate Finance Committee on July 12, 1979. More recently, Representative David Satterfield (D-Virginia) has introduced a bill (H.R. 1821) that would, in effect, repeal Section 227.

In order to address the Section 227 issue and other Medicare and Medicaid amendments up for consideration, the Health and the Environment Subcommittee of the House Interstate and Foreign Commerce Committee recently held hearings. On Monday, October 22, Edward N. Brandt, Jr., Vice-Chancellor for Health Affairs of the University of Texas System, and John A. D. Cooper appeared before the Subcommittee to testify on Section 227. In his summary remarks, Dr. Brandt specifically recommended: 1) that an amendment be passed delaying the implementation for Section 227 until a period of 180 days has expired subsequent to the issuance of proposed implementing regulations in The Federal Register; 2) that the committee report accompanying the amendment clearly indicate Congressional intent on the three issues raised in our testimony; and 3) that the Subcommittee and its staff monitor HEW's regulations on these issues.

The members of the Subcommittee present at the hearing had great interest in the issues surrounding Section 227 and related matters. There was extensive questioning following the oral presentation. It is not clear what action will be taken by the Subcommittee. Developments will be reported in Dr. Cooper's Weekly Activities Report.

Section 223 - Limitations on General Routine Operating Costs

Section 223 of the 1972 Social Security Admendments authorized Medicare to impose limitations on the costs paid for services provided under the program's Part A coverage. Since 1974 and until this year, Medicare had annually promulgated limitations on routine service costs based on a hospital's bed size, its geographic location, and the per capita income of its surrounding community. This year, HCFA made a series of significant changes in the methodology used to set the limits. These changes resulted in a great deal of controversy and were the focus of much of the staff's time.

In the March 1 Federal Register, the Health Care Financing Administration proposed a new schedule of limits on payments to hospitals for routine inpatient services furnished to Medicare beneficiaries. The proposed regulations differed from those in previous years in several important respects. First, the limitations on inpatient routine service costs were replaced by a limitation on general routine operating costs. In determining general routine operating costs, capital related costs and the costs of approved medical education programs were excluded. Second, the hospital classification system was reduced from 35 categories to seven categories by deleting the variable of per capita income and using only bed size and rural/urban location. Third, a wage index derived from service industry wages was used to adjust the portion of the limitations which represent wages paid. Fourth, the proposed regulations used a "market basket" price index to update historical data and set projected ceilings. The market basket index is designed to measure and adjust for price changes in the goods and services purchased by the hospitals. Fifth, group limits were set at the 80th percentile rather than the 80th percentile plus 10% of the mean.

In responding to these proposed regulations, the Association expressed concern for the following reasons: the grouping scheme used to classify hospitals failed to recognize the distinctive characteristics of specialty and tertiary care hospitals; several costs which varied between hospitals were not removed; trending factors failed to reflect the hospital labor markets and the increasing intensity of the production inputs in tertiary care hospitals; and the use of the 80th percentile rather than the previously used 80th percentile plus 10% of the mean automatically forced twenty percent of the hospitals to be inefficient by arbitrary definition.

On June 1, 1979, HCFA published the final regulations for setting routine service limitations for all cost reporting periods beginning on or after July 1, 1979. The final regulations differed from the March 1st proposed rule in two significant respects: hospitals in states that use less than the national average of bed days for Medicare patients were provided an upward adjustment in their ceilings, and the limitation threshold was set at 115% of the mean cost for each group of hospitals rather than at the 80th percentile. The final regulations also replaced the service industry wage index with a more specific hospital wage index.

Based on a mailgram survey completed by AAMC's Council of Teaching Hospitals in May and on the changes from the March 1st proposed regulations to the June 1st final regulations, it appeared that COTH members would be disproportionately penalized by the new payment limitations. Moreover, it appeared that midwestern and western COTH members and medical centers would be particularly hard hit. Because of the adverse impact on COTH members, the COTH Administrative Board recommended and the AAMC Executive Council approved holding a national meeting on Section 223: 1) to allow HCFA to describe the present limitations and exception methodology; 2) to provide HCFA with a sense of the financial devastation the regulations create for the nation's major hospitals and medical centers; and 3) to provide COTH members with an opportunity to explain to their Congressional representatives the adverse financial and operational impacts resulting from these limitations.

The meeting was held on July 10th at Georgetown University Hospital in Washington, D.C.. Three officials from HCFA addressed the approximately 100 individuals in attendance from COTH institutions. Leonard D. Schaeffer, HCFA Administrator, first provided an overview of the history of HCFA and the rationale for its current policies. Mr. Schaeffer was followed by Robert O'Connor, Director of HCFA's Bureau of Program Policy. Mr. O'Connor described Section 223 regulations issued on June 1 as the product of a slow evolution which has taken place since initial implementation of routine service costs approach in 1974. Finally, Dr. Clifton Gaus, then Director of HCFA's Office of Research, Demonstrations, and Statistics, outlined HCFA's plans for changing the methodology for setting payment limits beginning July 1, 1980. Dr. Gaus indicated that HCFA would like to move to: 1) per admission limitations; 2) limits on all inpatient costs including ancillary services; and 3) adjustments in the ceilings for individual hospitals based on case mix. The case mix adjustment would incorporate the Diagnosis Related Groups methodology developed at Yale University. Dr. Gaus indicated that a "go/no-go" decision on this new methodology would be made around December of this year.

Much of the concern expressed by members at this meeting focused on the regulations scheduled to be effective for cost reporting periods on or after July 1, 1979. There was also concern expressed about the timeliness and effectiveness of the exceptions process. After the meeting, a number of COTH hospital representatives went to Capital Hill to visit their Congressional leaders and inform them of the capricious and inequitable nature of the current Section 223 regulations and their disproportionately negative impact on the nation's teaching hospitals.

Subsequent to these meetings and additional meetings between Congressmen and HCFA officials, HCFA published on August 9th in the Federal Register a Notice of Proposed Rule Making that reset the per diem limits at the 80th percentile for cost reporting periods beginning from July 1, 1979 through September 30, 1979 and invited public comments on the statistical threshold used to set the limitation. In the Association's comments on this proposed rule, the negative and inequitable impact of using 115% of the mean to set limits was outlined. The AAMC strongly recommended that HCFA return to using the 80th percentile plus 10% of the mean for determining a limit in each grouping of hospitals as was done in previous years. The closing date for receipt of comments for the proposed rule was September 10th, 1979. It was expected that the final decision on the statistical measure to use to set the limits would be published prior to the expiration on October 1 of the 80th percentile limit. However, the final regulations have not been issued.

Limitations on Reasonable Costs

In addition to establishing specific routine operating costs ceilings, Section 223 operates under general regulatory principles used to develop payment limitations. On March 15th, 1979, the Health Care Financing Administration published in the Federal Register proposed changes to these general principles. Most of the revisions addressed methods used to determine exceptions to imposed payment limitations. These included: new exceptions for hospitals with seasonal variations in population, hospitals with atypically short lengths of patient stays, and hospitals with atypical labor costs. Also included were an explicit exception for atypical costs of paramedical and medical education programs when the hospital can demonstrate that hospitals in its limitation category generally do not incur similar costs and an exception for hospitals threatened with insolvency as a result of the imposed payment limitation. The proposed regulations required that a provider requesting an exception agree to accept review of hospital operations by the Health Care Financing Administration. Moreover, continued eligibility for future exceptions would be made contingent upon adopting the recommendations made by the operational review.

In responding to the proposed changes, the Association first outlined its concerns about the manner in which the exceptions process has been handled since its inception in 1974. Specifically, the AAMC recommended that the exception and appeal process provide (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of comparable hospitals located in each group be made available; (3) that the Secretary be required to regularly publish base line data for typical costs for each group of hospitals in the classification system; and (4) that the basis on which exceptions are granted

be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties. The letter of comment also recommended that non-patient services, atypical input costs, and case mix differences be permitted as grounds for exceptions. Finally, the Association strongly recommended that the mandatory imposition of an operational review as part of the exceptions process be deleted. The March 15th proposed regulations became final on June 1st, 1979. Unfortunately, the final regulations differed very little from the proposed rule.

Apportionment of Malpractice Costs

A fourth issue that was the subject of new regulations under Medicare was a change in the determination of allowable malpractice costs. In the March 15th Federal Register, the Health Care Financing Administration released proposed regulations that would require malpractice costs incurred by a provider to be directly apportioned to Medicare based on Medicare malpractice loss experience instead of the current apportionment basis of Medicare's overall utilization of provider services. The regulations, which became final on June 1st, require a separate accumulation and direct apportionment of malpractice insurance premiums and self-insurance fund contributions. In addition, if a provider is paying uninsured malpractice losses directly, either through deductible or coinsurance provisions or as a governmental provider, or as a result of an award in excess of reasonable cost limits, Medicare will reimburse the cost of these losses and any related direct costs only as attributable to Medicare beneficiaries. The purpose of this new rule is to reimburse Medicare providers on a basis more closely related to the actual malpractice experience of Medicare beneficiaries.

In its comments to the Health Care Financing Administration, the Association strongly protested this new rule because: the policy was based on an HEW-funded study, "Medical Malpractice Closed Claims Study - 1976," which was seriously deficient in its data and findings; the new rule sets a dangerous and inappropriate, discriminatory precedent for reimbursing on the basis of direct costs rather than on average costs which has been used in the past; malpractice claims vary dramatically from year to year which could grossly misrepresent the hospitals long-term performance in this area; the policy could have a significant inflationary impact if hospitals decide to obtain separate insurance for Medicare patients; and the regulations violate the limitations linking Medicare and Medicaid rates.

Definition of Hospital Special Care Units

At the present time, Medicare sets hospital payment limits only on general routine operating costs. Payment limitations are not presently imposed on ancillary service costs or special care unit costs.

In the past several years as special care units have proliferated, hospitals and Medicare officials have increasingly debated the definition of a special care unit. In an effort to resolve this issue, the Health Care Financing

Administration proposed a new definition for special care units in the May 16th Federal Register. Under the new proposed rule, a hospital service must meet seven criteria to be classified as a special care unit: the unit must have specific written policies concerning admissions; must be in a hospital; must be physically and identifiably separate from other hospital units; must have specific written admissions and discharge policies; must have continuous registered nursing care that is not decreased during the night or during the weekends; must provide a minimum of 12 scheduled hours of direct nursing care per patient day; and must continuously provide life saving equipment to treat the critically ill.

This definition is significantly more stringent than the one used in the past, and as a result, some patient units presently reported as special care units would now be reclassified as routine service costs subject to Section 223 payment limitations.

In response to the proposed rule, the Association noted the valuable medical and social contributions special care units have made to patient care. It was recommended that because the proposed regulations do not define special care units in terms of patient needs, HCFA should withdraw the proposed input and facility-oriented regulations and develop process-oriented regulations. Final regulations on this issue have not yet been published.

Cost to Related Organizations

Under the Medicare program, a hospital's reimbursable costs for services, facilities, or supplies furnished to it by another organization are normally the charges made by the supplying organization. However, when the hospital and the supplier are related by common ownership or control, the hospital's allowable costs are limited to the supplier's costs rather than its charges. Present Medicare policy requires the presence of significant ownership or significant control for a determination that the hospital and its supplier are related organizations. Regulations proposed would replace the present concepts of significant ownership and significant control with any ownership and any control.

If the proposed rules are adopted, Medicare may take the position that a hospital and a medical school from which the hospital obtains services are related organizations when the hospital and the school have one or more common members on their governing boards. Once the medical school is determined to be a related organization, the hospital would be reimbursed for medical school services on the basis of the school's costs, not its charges for services unless the school provides at least 80% of the supplied service in "the open market." Medicare officials did state that the existence of a hospital-medical school affiliation would not necessarily provide the basis for treating the two organizations as related.

The Association responded to the proposed rule in a March 23rd letter to Leonard Schaeffer, HCFA Administrator. The Association expressed concern with six aspects of the Notice of Proposed Rule Making: failure of the notice to adequately describe its proposed impact, the assumption that a standard of "any" control eliminates subjective evaluations, the absence of a critical de-

inition in stating the open market exception, extension of Medicare cost principles to suppliers, and the potential problems created for hospitals seeking informed trustees. As is the case with the special care unit regulations, final regulations on this subject have not yet been published.

Reimbursement Changes for Grants for Primary Care Training Programs

On Friday, August 10th, 1979, the Health Care Financing Administration announced proposed rules in the Federal Register to amend regulations governing Medicare reimbursement for primary care training programs supported, in part, by grants. Under current regulations, all grants and donations specifically designated for education must be deducted from program costs in determining allowable reimbursement costs. The proposed amendments would change this rule by allowing providers not to offset grants in four primary care areas: family practice, general practice, general internal medicine, and general pediatrics.

The new rules, which would affect all cost reporting periods beginning on or after January 1, 1980, state: (1) in determining a provider's net educational costs for reimbursement, deductions would not be required for any grants the provider receives and applies to internships and residency programs in the four areas listed above; (2) in its cost report the provider would be required to identify the total program costs and total revenues applicable to its primary care residency programs. The provider would have to identify specifically the donor of any grants designated to support primary care training costs; (3) if total revenues, including patient care revenues and grants, exceeded the total costs of the program, and if the provider had a Title VII Public Health Service grant, HCFA would notify the Public Health Service which would either recover the surplus revenues or redesignate them for the succeeding year. If the provider had no Title VII grant or if the surplus exceeded the amount of the Title VII grant, HCFA would notify other grant donors. However, HCFA would make no adjustments in Medicare reimbursement.

The proposed rule also expressed general concern about interpretation of present regulations for determining net educational costs. HCFA stated that this problem is being reviewed, and a subsequent Notice of Proposed Rule Making revising the general principles for determining net educational costs could be expected in the near future.

The AAMC responded to the proposed rules by endorsing, for the most part, the changes. However, the AAMC raised issue with two specific items. First, the Association recommended that the regulations be applicable to cost reporting periods beginning on or after January 22, 1975 rather than the proposed January 1, 1978 date. The rationale for the earlier date was that confusion over this issue was created on that date by HEW's Region IV office in Atlanta which released an intermediary letter which informed providers that grants for primary care training programs would be treated as "seed grants", and thus would not be offset in determining reimbursement. A year later, a subsequent intermediary letter was sent to providers which reversed this policy and ordered the retrospective adjustment of reimbursement already permitted under the previous intermediary letter.

The second concern of the Association was the change in language for the general principle for determining cost of educational activities. Under the explanatory language in the Notice of Proposed Rule Making, it stated that the principle for reimbursement of approved educational activities had been restated, but that "there is no change intended in how the regulations are currently being implemented." Presently, the costs of educational activities include "trainee stipends, compensation of teachers, and other costs." The proposed language would delete "and other costs". The Association expressed concern that the deletion of "and other costs" could inappropriately result in disallowance of essential educational costs, including direct costs such as fringe benefits and the indirect costs appropriately allocated to the educational cost center. For this reason, the Association strongly recommended that "and other costs" be reinstated. Final regulations on this proposed reimbursement change have not yet been published.

HILL-BURTON CHARITY CARE REGULATIONS

On May 18th, HEW published final regulations governing the requirements to provide uncompensated charity care and community service in hospitals which received Hill-Burton construction funds for assistance under Title XVI of the Public Health Service Act. In spite of objections by the AAMC and numerous other organizations to the proposed rules published in October 1978, the final regulations are similar to the proposed rule. The new regulations require hospitals that have received Hill-Burton funds to provide specific minimum dollar levels of free or reduced-charge care for indigent patients. The old regulations allowed uncompensated care to be provided in two ways. The first method, the "open door" policy was eliminated. The second option, the lesser of three percent of operating costs (less Medicare and Medicaid reimbursement) or ten percent of the assistance originally provided, is retained but modified. In future years, the ten percent option would be increased each year by an inflation factor based on the medical care component of the Consumer Price Index. Facilities assisted under the old Hill-Burton program which provide less than the required amount of care will be required to make up the difference in future years. In addition, facilities will remain obligated to provide free or reduced-charge service for 20 years from the time Hill-Burton loan or grant was made, but the regulations affect only that portion of the 20-year obligation periods which begins in 1979. The effective date of the regulations was September 1st, 1979. Health facilities with fiscal years beginning after May 18th and before September 1st were required to comply with the new regulations by September 1.

SYSTEM FOR HOSPITAL UNIFORM REPORTING

Section 19 of P.L. 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977, mandated a system for uniform reporting of data for hospitals. In the January 23rd Federal Register of this year, the Health Care

Financing Administration published proposed regulations that outlined the reporting requirements for all hospitals participating in Medicare and Medicaid programs. The new reporting system is intended to be used to allow for comparisons among hospitals. The uniform reporting requirement would be effective with hospital reporting periods beginning six months after publication of final regulations. HEW has stated that it expects the new reports to be used by local health planning agencies, state hospital rate-setting agencies, and local hospital administrators, as well as federal agencies in fraud and abuse investigations.

Since the January release of proposed regulations, SHUR has been the target of a great deal of criticism by hospital and health associations as well as individual hospitals which flooded HCFA with letters of comments and concerns. The AAMC submitted its concerns to HCFA on April 23rd. The Association noted that, in the past, it has supported a nationwide system of uniform cost reporting as an important requirement for the proper measurement, evaluation, and comparison of hospital costs. In taking this position, the Association specifically opposed uniform hospital reporting as a means of mandating uniform hospital accounting. The Association emphasized that it still endorses uniform reporting, but is strongly opposed to the proposed HCFA regulations which would impose SHUR as the nationwide reporting system. The Association contended that SHUR is seriously deficient as a uniform reporting system for both policy and technical reasons and urged HCFA to withdraw the Notice of Proposed Rule Making in order to develop a reasonable and concise reporting system which minimizes compliance costs at hospital, intermediary, and federal agency levels. The AAMC also stated that it opposed the reporting system on the grounds that it is an excessive use of the HEW Secretary's authority, requires excessive information, fails to comply with existing regulatory procedures, and fails to provide necessary additional revenue for system introduction and maintenance.

In April HCFA released a nationwide study conducted under contract to HCFA by the California public accounting firm of Morris, Davis, and Company, that attempted to evaluate the cost of implementing SHUR in 50 hospitals. The results of that study suggested that it will cost hospitals an average of \$11,500 to \$35,000 to switch to a federally mandated system for uniform reporting. The American Hospital Association, one of the national organizations which urged that this study be undertaken, harshly criticized the study results. AHA argued that the study's figures were unrealistically low and that (1) no valid conclusions can be drawn from the results of the reporting hospitals because of the wide discrepancies of the results reported within the test site hospitals, (2) the 50 hospitals used as test sites for the study do not represent a valid statistical sample, (3) the study methodology to capture SHUR costs was inadequate, and (4) the HCFA estimate does not include, nor was the study required to examine any costs associated with non-hospital SHUR activity.

Over the summer, SHUR also surfaced on the legislative front. On June 27th, by a vote of 306 to 101, the House adopted an amendment to the fiscal 1980 Labor-HEW appropriations bill (H.R. 4389) prohibiting the use of any funds to implement SHUR. In sponsoring the amendment, Representative Douglas K. Bereuter (R-Nebraska) argued that HEW's proposed implementation

of the SHUR system goes far beyond what Congress intended in the original legislation. In addition, he stated that HEW was trying to install an accounting system when Congress had directed only a uniform reporting system.

In the Senate, the Senate Appropriations Committee endorsed HCFA's plans to create a uniform hospital reporting system, but effectively agreed with the House that the proposed SHUR regulations should not be implemented in fiscal year 1980. The Committee added report language to the Labor-HEW appropriations bill prohibiting the use of fiscal year 1980 funds for data collection pursuant to SHUR. It directed HEW to modify its proposal in order to minimize the burden it would place on hospitals and to publish "substantially revised regulations," only after appropriate consultation with Congress.

Following this activity in the Senate and the House, the joint House-Senate Conference Committee on the FY 1980 Labor-HEW appropriations bill deleted the Bereuter amendment and adopted language used in the Senate Appropriations Committee report on the legislation which expressed concern with the "unnecessary and unintended burden on health care facilities which would have resulted if the regulations originally proposed for this system had gone into effect. The conferees therefore direct that the Secretary not issue final regulations for the program until the Department's proposed revisions have been formally approved by the appropriate committee of each house designated by the Speaker of the House of Representatives and the Majority Leader of the Senate."

HOSPITAL COST CONTAINMENT

Administration's Proposal

For the third successive year, President Carter has pushed for hospital cost containment legislation. Despite the fact that the hospital industry met last year's Voluntary Effort goal of 13.6% and the excellent performance of hospitals this year relative to general inflation, hospital cost containment legislation appears to be a very real possibility. The President's "Hospital Cost Containment Act of 1979," (H.R. 2626, S. 570) was introduced in the House of Representatives on March 6th and later in the Senate. As originally introduced in Congress, this year's bill would place a 9.7% national "voluntary limit" on the increase on total hospital expenses for 1979. Failure by the hospital industry to meet the limit would trigger a mandatory standby program for some hospitals for 1980 and subsequent years which would set ceilings on total hospital inpatient revenues per admission.

The Administration based its 9.7% rate on estimates of three components of hospital costs: (1) a 7.9% inflation allowance for the costs of goods and services purchased by hospitals in 1979 which could be revised at year-end if the actual inflation rate is higher; (2) an 0.8% allowance for population growth; and (3) an allowance of 1% for new services. All of the bills now

reported out of committees have revised the 9.7% rate upward, to as high as 11.6%, which is the hospital industry's Voluntary Effort goal for 1979. This figure could be raised even higher depending on actual inflation in the costs of goods and services in 1979.

If the hospital industry as a whole fails to meet the voluntary limit, a state or even an individual hospital could still be exempt from mandatory controls in 1980, if it were under the nationwide voluntary limit which would be adjusted to take into account state population trends and local non-supervisory wage levels. The various versions of the bill also have some provisions for exemption of hospitals in states that have approved rate review mechanisms, hospitals with under 4,000 admissions, hospitals less than three years old, and hospitals with 75% of their patients enrolled in a qualified health maintenance organization. One bill would exempt children's hospitals.

For hospitals which are not exempted, a mandatory program, if triggered, would be initiated in 1980 that would set allowable rates of increase in inpatient revenues per admission for each hospital. The limit would: (1) be based on a national inflation allowance to cover the increase in the costs of goods and services purchased; (2) include an allowance for the actual rate of increase in non-supervisory wage rates experienced by that hospital; and (3) establish groups of similar hospitals and provide an efficiency bonus of up to 1% if the hospital was below the group median or an inefficiency penalty of up to 2% if the hospital was above 115% of the median of routine hospital per diem costs for its group. The bill would also take into account individual hospital performance under the voluntary program in setting a hospital's ceiling under the mandatory program.

The President's bill also provides severe penalties for hospitals that place an unequal burden on charge-based payors, who currently account for approximately 40% of hospital revenues. The legislation would require excess revenue from this class of payor to be placed in an escrow account which would be drawn on in future years only if revenue from charge payors was below the mandatory limit. The hospital refusing to comply with the escrow requirement would be assessed a federal tax of 150% of the excess revenues.

The Association testified on three occasions on the Administration's cost containment bill: Dr. David D. Thompson, Director of the New York Hospital and former Chairman of the COTH Administrative Board, testified on March 14th before the Senate Finance Committee's Subcommittee on Health; Dr. Robert Heyssel, Chairman of the COTH Administrative Board and Executive Vice President of the Johns Hopkins Hospital, testified before the Health Subcommittee of the House Ways and Means Committee on March 23rd and then again before the House Interstate and Foreign Commerce Committee's Subcommittee on Health and the Environment on May 21st. In each of the Association's statements the legislation was opposed for six main reasons: (1) overly broad policy and administrative powers for the Secretary; (2) added bureaucratic demands; (3) a modified wage pass through that is inconsistent with cost containment objectives; (4) inadequate allowance for new services; (5) a meaningless "antidumping" provision; and (6) undermining of current voluntary efforts.

A version of the President's original bill has now passed in three of the four Congressional committees with jurisdiction over the cost containment legislation. In the House, the Interstate and Foreign Commerce Committee, by a 23-19 vote, adopted an amended hospital cost containment bill offered by Representative Henry Waxman (D-California), Chairman of the Committee's health subcommittee. The bill passed by this committee was similar to that passed earlier this summer by the House Ways and Means Committee. Each bill is a watered down version of the Administration's bill introduced in February. Significantly, each bill contains a provision that would permit either House of Congress 30 days to veto standby controls for the next year if the established voluntary limit for increases in hospital expenditures were exceeded.

In the Senate, both committees with jurisdiction over cost containment legislation acted prior to the August recess. The Committee on Human Resources reported out a bill similar to the Administration's which is much stricter than those approved in the House. The Finance Committee tabled the President's bill, but did vote for Senator Herman Talmadge's (D-Georgia) alternative Medicare and Medicaid reimbursement reforms. As was the case last year, Senator Gaylord Nelson (D-Wisconsin) is expected to lead the fight for passage of the cost containment bill in the Senate. The bill, if brought to the full Senate, will most likely be offered as an amendment to the Talmadge proposal. However, it is probable that the Senate will not take up the legislation until the House acts. At this time, the House bills have been sent to the House Rules Committee to set the conditions under which the legislation will be considered by the full House.

Talmadge Bill

On March 1st, Senator Herman Talmadge (D-Georgia), Chairman of Subcommittee on Health of the Senate Finance Committee, and Senator Robert Dole (R-Kansas), ranking minority member of the Committee, introduced the "Medicare-Medicaid Reimbursement Reform Act of 1979," S. 505. The bill, essentially the same as the "Talmadge Bill" introduced in the two previous sessions of Congress, would modify Medicare and Medicaid Reimbursement practices for hospitals and physicians. Although Senator Talmadge has stated publicly that he does view the bill as being in competition with the Administration's cost containment bill, it is clear that Congress has viewed the legislation as being an alternative to the President's approach.

The bill differs from the Administration's proposal in many important respects: limits would be set initially on routine operating costs only, not on total inpatient costs; the costs of education and training, residents and non-administrative physicians, energy, and malpractice insurance would be excluded from determination of the per diem limits; the bill would apply only to Medicare and Medicaid reimbursement, not to all sources of hospital revenue; and the payment limitations set under S. 505 would be determined by establishing categories of similar hospitals and setting the limitation at 115% of a category's average routine operating per diem costs. In the grouping scheme a separate category would be established for the "primary affiliates of accredited medical schools." Unlike past Talmadge proposals, the primary affiliates category would not be limited to one hospital per medical school.

In contrast to the Administration's proposal, the Talmadge-Dole bill, argued Dr. David Thompson on behalf of the Association before the Senate Finance's Health Subcommittee on March 14th, is "a thoughtful, careful, non-percipient proposal which will moderate hospital cost by redefining an institution's self interest." Dr. Thompson complimented the Health Subcommittee for developing legislation that recognizes the rudimentary state-of-the-art in hospital classification schemes, and that provides for a combination of flexibility and a health facilities cost commission which can carefully monitor implementation. The Association's testimony also expressed its appreciation for the provision permitting more than one teaching hospital per medical school to be included in the teaching hospital category. While this modification is an improvement, the Association said that it remained concerned about the creation of a category for teaching hospitals because: (1) no one knows how routine operating costs in major teaching hospitals compare with routine operating costs in non-teaching hospitals; and (2) the principle source of atypical costs in major teaching hospitals results from the scope and intensity of services provided and the diagnostic mix of patients treated, not from the presence of an educational relationship with a medical school. Thus, the Association strongly recommended that the Secretary of DHEW be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals" before establishing a separate teaching hospitals category. In its written testimony, the AAMC also commented on several other of the Medicare/Medicaid reforms that are part of the bill, such as state rate review, payment to hospital-based physicians, and a provision to delay implementation of Section 227.

The Senate Finance Committee voted on July 12th by 11 to 9 to adopt Senator Robert Dole's (R-Kansas) proposal to table Senator Gaylord Nelson's (D-Wisconsin) compromise version of the President's bill. The Committee did, however, adopt provisions of Senator Talmadge's Medicare and Medicaid Reimbursement Reform legislation. Thus far, the Senate Finance Committee has been the only Congressional Committee to consider and vote favorably on the Talmadge bill.

HOUSE STAFF UNIONIZATION

It has now been over three years since the National Labor Relations Board (NLRB) declared, in its Cedars-Sinai and similar decisions, that house staff are primarily students rather than employees for purposes of coverage under the National Labor Relations Act (NLRA). The NLRB rulings, however, have continued to be challenged. Once again this year, house staff unionization surfaced as a major issue in both the courts and in Congress.

Judicial Activities

The first court action in 1979 on house staff unionization occurred early this Spring when the United States Court of Appeals for the District of Columbia Circuit reversed, by a split decision of 2 to 1, a 1978 District Court decision that dismissed an action brought by the Physician's National House-staff Association (PNHA). In that case, the District Court found that it lacked jurisdiction to review the NLRB determination because of the limited role assigned to the District Courts by the Act.

In this case, the PNHA was appealing the 1978 decision. The PNHA identified a narrow exception to the general rule and argued that the exception created jurisdiction for purposes of this action. The Appellate Court found that the exception applied to the case and remanded it to the District Court for further proceedings.

The majority opinion of the three judge panel ruling on the appeal stated that the legislative history of the 1974 amendments to the Health Care Act demonstrates that Congress fully intended to include residents, interns, and teaching fellows under the jurisdiction of the NLRB. In a dissenting opinion, Associate Circuit Judge Roger Robb stated, "In this case, the Board (NLRB) carefully analyzed the facts and reached a conclusion that interns, residents, and clinical fellows are primarily engaged in graduate educational training and that their status is therefore that of students rather than employees."

Following that court action, on April 30th, the NLRB petitioned the U.S. Court of Appeals for the District of Columbia Circuit to rehear the case before the full Court. The NLRB's rehearing request was based on the importance of the case in two respects: (1) it is an unprecedented limitation on the Board's discretion, specifically granted by Congress, to determine whether certain individuals are employees within the meaning of the Act; and (2) it represents an unjustified expansion of the narrow exception to the prohibition of judicial review of such matters. In addition, the NLRB stated that the Court's interpretation of Congressional intent to cover house staff under the 1974 amendments to the Taft-Hartley Act was in error. While the NLRB has conceded that residents have some characteristics of employees, it is argued that "they participate in these programs not for the purpose of earning a living; instead, they are there to pursue the graduate medical education that is a requirement for the practice of medicine."

In a brief order issued on June 5th, which cited the "amici curiae" appeals of the AAMC and others, the U.S. Court of Appeals for the District of Columbia Circuit granted the NLRB's petition for a rehearing by the entire court in the case of PNHA vs. Murphy. In its decision, the Appellate Court took the unusual step of vacating the panel's judgment and opinions. This action, taken on the court's own initiative, suggests that the panel's decision should not be relied upon by lawyers engaged in similar litigation or be regarded as precedent by the courts.

The rehearing by the full, 10-member Court of Appeals was held on October 9th with oral arguments on the case. If at least five members of the court conclude that the court lacks jurisdiction to review the NLRB's decision, the District Court decision will be affirmed. It is not known at this time how long it will be before a decision is reached. However, final decision may not come until next year.

Legislative Activity

On February 15th, 1979, Representatives Frank Thompson, Jr. (D-New Jersey) and John Ashbrook (R-Ohio) introduced legislation which would amend the National Labor Relations Act to define interns and residents as employees for purposes of the Act. The bill, if passed, would overturn the March, 1976 Cedars-Sinai decision of the NLRB. Upon introduction into the House,

H.R. 2222 was referred to the Committee on Education and Labor where Representative Thompson is Chairman of the Subcommittee on Labor-Management Relations and Representative Ashbrook is the ranking Republican.

On July 17th, the Subcommittee on Labor-Management Relations held hearings on H.R. 2222. Testifying on behalf of the Association, John A. D. Cooper, President, reviewed the AAMC's substantive objections to the legislation: (1) the fundamental relationship between the interns and residents and the program director and his faculty would be changed from one of teacher and student to one of employer-employee; (2) the program director would no longer be able to shape each individual's training to suit individual educational needs, but would have to deal with "employees" on a collective basis; (3) hospital administrators would be expected to bargain about subjects over which they have no control; (4) the education emphasis of graduate medical education would be replaced by a new emphasis on "wages, hours, and terms and conditions of employment"; (5) as the programs at affected hospitals changed from an emphasis on education to an emphasis upon the material element of the employer-employee relationship, graduate medical education programs would face loss of accreditation; and (6) an administrative body could become the final arbitrator of the content of graduate medical education by virtue of defining the scope of collective bargaining and affected programs.

In addition, Dr. Cooper noted the large number of professional and scientific medical organizations that are strongly opposed to this legislation. Carl Vogt, AAMC legal counsel, concluded the Association's testimony by describing how the administrative, procedural, and legal structure of the NLRA would inevitably lead to the substantive concerns of the medical education and higher education communities. Additional testimony opposing H.R. 2222 was presented by Jack Myers, past President of the American College of Physicians, and Willard M. Boyd, President of the University of Iowa.

On September 20th, the House Education and Labor Committee approved, by 23 to 9, H.R. 2222. While the markup session was not lengthy, two amendments were considered. Representative John Erlenborn (R-Illinois) offered an amendment which stated that "provisions of this act shall not be construed to require collective bargaining regarding matters affecting educational policy or programs." The amendment was rejected by a vote of 12 to 21. The Committee did adopt, by voice vote, an amendment by Representative Thompson to clarify that medical house staff would be covered under the NLRA as "employees" as well as "professional employees".

The bill has now gone to the House Rules Committee with a request that it be scheduled for one hour of floor debate prior to action by the full House of Representatives. It is not known when the Rules Committee will act.

HEALTH PLANNING

Renewal of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), which has been operating under special extensions since its expiration date in 1977, was the focus of legislative activity in health planning this year. Passage of renewal legislation came only after months of debate, negotiations, and amendments. On October 4, President Carter signed into law the "Health Planning and Resources Development Amendments of 1979," P.L. 96-79.

Congressional activity on health planning legislation was initiated on March 5th, 1979 when Senator Edward M. Kennedy (D-Massachusetts), Chairman of the Senate Subcommittee on Health and Scientific Research, and seven of his colleagues on that Subcommittee, introduced renewal legislation (S. 544) that would extend the act until 1982. The bill introduced by Senator Kennedy was very similar to the planning bill which was considered and approved by the Senate in July of 1978, but was lost in the legislative log jam at the end of the Congressional session last year. Once again this year, the Senate was quick to act on the legislation. On May 1st, by voice vote and without debate, the Senate unanimously passed S. 544.

In contrast to the swift Senate action on the health planning amendments, the House version, H.R. 3917 (previously H.R. 3441), originally sponsored by Representative Henry Waxman (D-California), advanced through the legislative process at a considerably slower pace. The Commerce Health Subcommittee had attached 50 amendments to the bill before the full Commerce Committee began its deliberations. After rejecting some of the Subcommittee's amendments, the Commerce Committee reported out a bill on May 15th. On June 7th, H.R. 3917 proceeded through the House Rules Committee where it was ruled that only one hour would be permitted on the House floor for additional debate on the bill. The House did not pass its version of the health planning bill until July 19th. Following that action, the House-Senate Conference Committee on August 1st adopted a three year, \$1.37 billion extension of the "Health Planning and Resources Development Act." It still took until September 21st for the full House and Senate to agree on and adopt a single piece of legislation.

The AAMC submitted written testimony on two occasions this year commenting on the proposed legislation. The Association called for: (1) consideration of the clinical and access needs of biomedical research programs in review of proposed new health services; (2) the extension of certificate of need review requirements to all major medical equipment in excess of \$150,000, regardless of setting or ownership; (3) HSA's to be prohibited from conditioning approval of one health service request on an agreement to develop another health service; (4) HSA's to be permitted to approve the limited introduction of new technologies prior to development of planning guidelines for them; (5) the elimination of provisions in both bills which proposed grant support to states for development of potentially mandatory programs for decertification of institutional resources and facilities; (6) the amendment of HSA and SHCC board composition requirements to include at least one chief executive officer of a short-term, general, tertiary care/referral hospital; (7) appropriateness review to be limited to an areawide review of selected health services if it is to be maintained as a realistic component of the planning process; and (8) elimination of HSA federal grant review and approval for manpower and research grants without a significant service component.

In addition, the AAMC specifically urged health planning legislation to include provisions that would (1) require that the dean of at least one medical school be represented on an HSA board if the health service area contained one or more accredited schools of medicine, and (2) require that HSA and state agency reviews consider the effect of proposed services on the clinical needs of health professional training programs in the area and the extent to which the health professions school in the area would have access to the services for training purposes. Both of these provisions appeared in several of the early versions of the legislation this year. Only the second provision was adopted in the final bill.

Among the other provisions included in the "Health Planning and Resources Development Amendments of 1979", those of particular interest to COTH members include:

- Membership requirements for the composition of health systems agency boards are amended so that at least one half of the members on the board will be providers and at least one of them shall be engaged in the administration of a hospital.
- HSA and the State Agency are required to carefully consider factors that preserve and improve competition in the health service area.
- Appropriateness reviews are to be made on either an areawide or institution-specific basis, as deemed appropriate locally; become more detailed in the future; and provide for hearings in the cases of institution-specific reviews.
- An HSA can establish goals that are different from the National Health Planning Guidelines in order to be responsive to the unique needs and resources of its area, but must provide a detailed statement of such inconsistencies.
- The State Agency is required to establish a period within which approval or disapproval of the application for a Certificate of Need (CON) shall be made. If a State Agency fails to approve or disapprove an application within the applicable time period, the applicant may file suit in an appropriate state court to require the State Agency to approve or disapprove the application.
- In reviewing construction projects, the HSA and the State Agency shall consider the effect of the application on the cost and charges to the public of other providers' health services. In the case of existing services, the quality of care provided by such a facility in the past must be considered. In both cases, consideration must be given to the extent to which such proposed services will be accessible to all residents of the area to be served by such services.

- Certificate of Need programs must:
 - provide for periodic review of progress on approved projects and for withdrawal of certificates in case of extended delays;
 - require coverage of all major medical equipment serving inpatients;
 - limit coverage of other uses of non-institutional major medical equipment to requirements under state laws enacted prior to September 30th, 1982;
 - exclude coverage of HMOs which singly or in combination serve at least 50,000 persons.
- Each HSA shall collect annually the rates charged for each of the 25 most frequently used hospital services in the state including the average semi-private and private room rates. HSAs are to make such information publicly available.
- Research and training under the Public Health Service Act should not be reviewed unless the grants are to be made, and entered into, or used for the development, expansion or support of health resources which would make a significant change in the health services available in the health services area.
- HSAs may review and comment on plans for Federal facilities only when specifically requested to do so by federal agencies.

NATIONAL HEALTH INSURANCE

Legislative Activity

During 1979, national health insurance has received a renewed high level of interest. Numerous bills have been introduced. Despite the number of proposals being considered by Congress, it does not appear at this time that Congress will take action on any bills before the Congressional year ends.

President Carter first unveiled his national health insurance plan on June 12th, urging Congress to "act without delay" on an annual \$24.3 billion national health insurance plan to protect "all of our people" against "devastating health bills". The bill was formally introduced in the House and the Senate on September 25th as the "National Health Plan Act" (H.R. 5400, S. 1812). The proposed legislation includes three major components. The first, Employer Guaranteed Coverage, would mandate employers to provide all full-time employees and dependents with a certified package of comprehensive benefits. Employers would be required to pay a maximum of \$2,500 in out-of-pocket payments per year. No cost-sharing could be imposed on prenatal, delivery and infant services.

The second major component of the plan, "HealthCare", calls for a new Federal insurance program that would consolidate Medicare and Medicaid and broaden eligibility for the poor. Employers and individuals could also purchase coverage under HealthCare if desired. Benefits would be the same as

those outlined under the employer-mandated program although out-of-pocket payment would be limited to \$1,250 for most and could be much less for the low-income population.

The third portion of the bill, Health Systems Reforms, would incorporate the President's cost containment bill and an annual national limit on capital expenditures which would be allocated among the states.

Senator Edward Kennedy (D-Massachusetts) has also offered a national health insurance bill to be considered by Congress. His bill was first outlined on May 14th in front of a large press gathering in the Russell Senate Office Building where his brothers John and Robert announced their candidacies for President of the United States. The bill was formally introduced in Congress on September 6th as S. 1720 and H.R. 5191. The bill has seven co-sponsors in the Senate and 59 co-sponsors in the House where Representative Henry Waxman (D-California) is leading the effort. The Kennedy proposal has five major principles which were developed in cooperation with organized labor's Coalition for National Health Insurance. These principles include: (1) comprehensive benefits; (2) universal coverage; (3) system reform to encourage preventive medicine and prepaid group practice; (4) strict cost control; and (5) quality controls.

The plan would provide full coverage of inpatient hospital services, physician services in and out of the hospital, X-rays, lab tests, ambulance services, and medical equipment for all U.S. residents. Drugs (for the elderly), home health, nursing home care, and mental health care would all be partially covered. Financing the plan would be primarily through wage related employer/employee contributions with the employee providing up to 35% of the total cost of the premium. Medicare would continue to cover the elderly and Medicaid would be upgraded.

Individuals could choose among private insurers, but all insurers must provide at a minimum, the mandatory benefits. Thus, competition among insurers would be based on administrative efficiency and supplemental coverage. Kennedy expects that implementation of the program would not be before 1983. He said that national health care expenditures would be \$40 billion greater as a result of the plan during its first year of operation. However, he argued that strict cost controls in the proposal would make the plan cheaper than existing programs by the fourth year after implementation.

It now appears that if any bill is to be passed, it would be some form of catastrophic national health insurance. Senator Russell Long (D-Louisiana) has been a leading advocate of this approach for many years. As Chairman of the powerful Senate Finance Committee and as a key individual in any national health insurance deliberations, Senator Long has expressed his intentions to take up national health insurance in his committee this fall. It appears that the Senate Finance Committee may be the only one of the four Congressional committees with jurisdiction over national health insurance that may act in this session of Congress.

There are a number of other national health insurance plans that have been introduced in Congress, most of which are variations of the three mentioned above. However, there are several plans that take a different approach to national health insurance. The primary characteristics of these plans is their emphasis on increasing free choice, market incentives, and competition into the health care system. Representative Al Ullman (D-Oregon), Chairman of the House Ways and Means Committee is supporting such an approach. According to Ullman, his plan "does not broaden health coverage; nor will it increase the layer of benefits. It costs the Government nothing, and it can be achieved this year." Rather than proposing a health insurance scheme, Ullman attacked built-in incentives to spend money that fuel inflation and health care costs. He also rejected Government regulation of the entire health care system. His approach would be based on: (1) changing tax laws to encourage greater enrollment in prepaid health plans; (2) placing a cap on the Federal tax subsidy for medical insurance; (3) requiring a choice of health plans offered by an employer; (4) requiring employers to pay equally to each plan; (5) changing Medicare law to encourage elderly patients to join HMOs; and (6) mandating a statewide demonstration project similar to Oregon's project health for the low-income population.

Senator Richard Schweiker (R-Pennsylvania), ranking minority member on the Senate Human Resources Subcommittee on Health and Scientific Research, has also introduced a national health insurance plan that addresses cost controls, catastrophic health insurance, and disease prevention by restructuring tax incentives and requiring coverage by employers. While neither Senator Ullman's plan or Senator Schweiker's plan is expected to pass, there is some consensus that increased incentives for cost consciousness are likely to be a part of any national health insurance debate in the coming months.

AAMC Activity in National Health Insurance

Because of Congressional interest in national health insurance in 1979, last summer the AAMC appointed an Ad Hoc Committee on National Health Insurance. The Committee was charged to review and revise where necessary the Association's November 1975 policy statement on national health insurance. Under the leadership of John A. Gronvall, Dean of the University of Michigan Medical School and 1978-79 Chairman of the AAMC, the Ad Hoc Committee met on August 2nd, 1979. Members of that Committee include John W. Colloton, Director of the University of Iowa Hospitals and Clinics and Assistant to the President for Health Services at the University of Iowa and Chairman-elect of the COTH Administrative Board; James F. Kelly, formerly the Executive Vice-Chancellor of the State University of New York - Albany, now retired; William H. Luginbuhl, Dean of the Division of Health Sciences at the University of Vermont College of Medicine; Peter Shields, Chairman of AAMC's Organization of Student Representatives; Virginia V. Weldon, Professor of Pediatrics and Assistant to the Vice-Chancellor at the Washington University School of Medicine; and Charles B. Womer, President of the University Hospitals of Cleveland and Chairman-elect of the AAMC Executive Council.

The Committee recommended that the Association policy be directed not at national health insurance per se, but at "the need for the expansion and improvement of health insurance in the United States." The Committee noted three major disparities that exist in the Nation's health insurance system: (1) the lack or inadequacies of basic health insurance coverage for low-income Americans; (2) the inadequacy of health insurance protection against the high cost of catastrophic illness; and (3) the lack of a generally accepted minimum standard for basic health benefit plans.

Following the Ad Hoc Committee meeting, AAMC staff drafted a position paper on the expansion and improvement of health insurance in the United States. This draft was reviewed by the Ad Hoc Committee members and by the Executive Council at its September, 1979 meeting. The final position paper of the AAMC, when approved by the Executive Council, will serve as the basis for AAMC testimony on national health insurance should Congressional Committees decide to hold hearings on national health insurance.

HOSPITAL PHILANTHROPY LEGISLATION

On February 27th, 1979, Representative Tim Lee Carter (R-Kentucky) introduced "The Voluntary Hospital Philanthropic Act," H.R. 2455. The major objective of the bill is to encourage and protect philanthropy in the health care field, especially philanthropy provided to hospitals. The bill, as presently drafted, contains several specific provisions. The first provision in the bill is that in determining hospital costs and allowable reimbursement under the Medicare, Medicaid, and Crippled Childrens Programs, hospital expenses may not be reduced by any donations, gifts, grants, or endowment funds. This provision would significantly alter present practices by prohibiting federal programs from reducing hospital cost by restricted donations when determining federal payments.

The second significant provision in the bill is that it prohibits states from adopting programs for limiting hospital revenues unless such programs exclude from the revenue limitation (1) all donor restricted funds, including those restricted to operations, and (2) all other donated funds limited by the governing board to non-operating expenses. Donated funds not restricted by the donor or limited to operating purposes by the governing board are not addressed in the bill. The third major provision in the bill is that it prohibits any federal hospital cost containment program from including in the revenue limitation (1) all donor restricted funds, including those restricted to operations, and (2) all other donated funds limited by the governing board to non-operating expenses. Donated funds not restricted by the donor or limited to operating purposes by the governing board are not addressed in the bill.

The bill, which was jointly referred to the House Committee on Ways and Means and the House Committee on Interstate and Foreign Commerce, has not been the subject of any Congressional hearings or actions. AAMC staff

has expressed Association interest in the legislation to Representative Carter's staff, and is preparing comments on the bill to be submitted to the Health Subcommittee of the House Interstate and Foreign Commerce Committee.

COTH SPRING MEETING

The AAMC's Council of Teaching Hospitals held its second annual Spring Meeting in Kansas City, Missouri on May 16-18, 1979. The two day meeting, which was conducted to provide the chief executive officers (and their chief associates) of COTH member hospitals with an opportunity to meet personally and discuss common issues and concerns, attracted over 150 participants.

The meeting opened on the evening of May 16th with an address by Dr. Jack Lein, Associate Dean for Continuing Education and Development at the University of Washington School of Medicine. The topic of his discussion, was "Legislators are not Illiterate-They Just Don't Believe us Anymore." While his presentation was humorous, his message was clear with regard to the need and appropriate methods for active participation in the legislative policy decision-making processes at all levels of government.

The morning session on May 17th, featured a presentation by Richard Knapp, Director of the Department of Teaching Hospitals, on the subject "Toward a More Contemporary Public Understanding of the Teaching Hospital." Dr. Knapp reviewed the highlights of a paper on that topic prepared by the Department staff. Following his presentation, participants were assigned to discussion groups to review the paper within the context of major issues related to hospital reimbursement, health planning and national health insurance. In the afternoon, each discussion group leader presented a report on his group's morning session. The reports were followed by floor discussion.

Spring meeting activities for May 17th concluded with four concurrent sessions on special topics of interest: (1) Paul Hanson, President of Genessee Hospital in Rochester, and Dr. James Block, President of the Rochester Area Hospital Association discussed "The Maxicap Experiment: Present Status and Future Probability;" (2) Dr. Henry Zaretsky, Director of California Office of Statewide Health Planning and Development and Dr. Robert Tranquada, Associate Dean of Postgraduate and Regional Medical Education at the UCLA School of Medicine, discussed "The Manpower Component of the State Health Plan"; (3) "An Informal Session with Staff of the Voluntary Effort" was conducted by Paul Earle, Executive Director for the Voluntary Effort; and (4) a session on the "Role of Veterans Administration Medical Centers with Medical Schools" was led by Al Gavazzi, Director of the VA Hospital in Washington, D.C.; B. Fred Brown, Director of the VA Hospital in Durham, North Carolina; Turner Camp, M.D., Director of the VA Hospital in Phoenix, Arizona; and William Mayer, M.D., Assistant Chief Medical Director of the VA. The evening program included a reception hosted by the Truman Medical Center of the University of Missouri - Kansas City.

The final day of the meeting was devoted to a discussion of "State Rate Review and the Teaching Hospital". First, "The Experience in Maryland" was discussed by representatives from two COTH member institutions in metropolitan Baltimore. The sobering experiences of the University of Maryland with the state rate review were reviewed by its Director, G. Bruce McFadden, while the more favorable experiences of the Johns Hopkins Hospital were related by Irv Kues, the Hospital Vice President for Management Systems and Finance. Later in the morning, a debate was held on the question, "Should We Support Immediate Development of State Rate Review Agencies?" Both sides of the issue were argued effectively, with Dave Hitt, who recently left his post as Executive Director of the Baylor University Medical Center, taking a qualified "pro" stance, and Irwin Goldberg, Executive Director of the Montifiore Hospital in Pittsburg, Pennsylvania, arguing the "con" position.

SPECIAL PROJECTS: EDUCATIONAL COSTS AND HOSPITAL CASE MIX

In addition to routine services and activities conducted by the Department of Teaching Hospitals, the staff occasionally undertakes projects related to specific timely, important issues. This year the staff has begun two projects which are outlined below.

As was stated in the summary description of the COTH Spring Meeting, a portion of that meeting was devoted to discussion of a paper prepared by staff titled "A More Contemporary Public Understanding of the Teaching Hospital". At the workshops which addressed this paper in light of national health insurance, health planning and reimbursement issues, the consensus of the members attending the meeting was that the problems facing teaching hospitals in the future result from three factors: atypical service costs resulting from the complexity or intensity of care provided patients, atypical institutional costs resulting from educational program activities, and a wide variation in these costs among teaching hospitals. Because of the variation among teaching hospitals, members suggested that methodologies were needed to quantify intensity and educational costs so that teaching hospitals could be classified into homogeneous groups or scaled into continuous distributions. More specifically, it was recommended that the AAMC/COTH sponsor or conduct a study (or studies) to quantify the intensity of patient care and the costs of educational programs.

The COTH Administrative Board at its June meeting, with Executive Council approval, directed staff to prepare a state-of-the-art paper on methods for quantifying the intensity of care and an annotated bibliography on educational program costs. When completed, these papers would serve as resources for developing and designing the member-recommended studies.

Work has begun on the annotated bibliography on educational costs in teaching hospitals. A thorough literature search has been conducted, and abstracts are being prepared for all articles and studies that have addressed the problem of identifying and documenting the costs of medical education programs in teaching hospitals.

In regards to the state-of-the-art paper on intensity of care, staff completed a preliminary report titled "Case Mix Measures and Their Reimbursement Applications," which was presented to the COTH Administrative Board and AAMC Executive Council at their September 13th meetings. Case mix measures were selected as the initial focus of staff activity because of the active attention these measures are currently receiving from several researchers, because of several reimbursement experiments presently attempting to apply them, and because of Medicare's effort to add case mix measures to next year's payment limitations methodology. The report, which was based on numerous site visits conducted by staff last summer, gives particular attention to the Diagnosis Related Groups (DRGs) developed at Yale University because this method is the most fully developed and is being used in several reimbursement experiments. The COTH Board and AAMC Executive Council accepted the report as a source of background information, authorized completing the final case mix report, approved the policy recommendations in the report, and directed staff to begin expanding its activities on quantifying the intensity of patient care provided in teaching hospitals. The case mix report was forwarded to all COTH members in September.

As a next step in this project, staff is identifying data which can be used to evaluate the DRGs as an intensity measure for reimbursement, identifying researchers/consultants with expertise and interest in conducting such an evaluation, and preparing a study plan which can be used to develop an equitable method for reimbursing hospitals that specialize to varying degrees in tertiary care, medical education, supervised research, and the introduction of new treatment and diagnostic services.

SURVEYS/PUBLICATIONS

The Department of Teaching Hospitals has maintained its program of regular and special issue membership surveys. The staff has also prepared several special reports. All of these publications have been made available to COTH members.

COTH Report

The COTH Report, which expanded its format last year, is published approximately 10 times a year. In addition to reporting Washington developments and AAMC activities of concern to COTH members, increasing emphasis has been placed on summarizing major government and private studies focusing on current health policy issues. The newsletter has also initiated a new section entitled "Faces in the News". This section highlights individuals who have contributed to and influenced major health care policy decisions in the country.

COTH Directory of Educational Programs and Services

This Directory, which was published in April, has been prepared annually for the past eleven years. The Directory provides a profile of each COTH member hospital, including selected operational and educational program statistics. Questionnaires for the 1980 Directory were mailed in July and September, depending on the hospital's fiscal year.

COTH Executive Salary Survey

The 1978 Executive Salary survey was published and mailed to COTH chief executive officers last spring. Based on responses from 70% of all non-Federal teaching hospitals members, the report describes salaries, fringe benefits, and hospital compensation policies. The tables in the report present the data by hospital's type of ownership, regional location, type of affiliation, and bed size. In addition, means, medians, quartiles, and percentiles are presented for the salary information. Questionnaires for the 1979 survey were mailed in August, and it is anticipated that the findings from the survey will be published early in 1980. This year's survey, unlike the previous survey, will include all VA members in the survey results. COTH Administrative Board policy limits distribution of this report to chief executive officers of COTH member hospitals. COTH hospital board members may also receive the survey upon request, but the chief executive officer will be informed when a copy has been provided to a board member.

COTH Survey of the University Owned Teaching Hospitals

This survey, which is also prepared annually, publishes comparable and detailed hospital data on hospital income sources, expenses, utilization of services, and staffing for university owned hospitals. The eighth annual COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data was published in April. The data presented in the report is based on fiscal year's ending in 1977. Questionnaires for this year's survey were mailed in June. The responses have now been received from all but one of the 64 participating hospitals. Results of this survey will be published early in 1980. Distribution of this report is restricted to those institutions participating in the survey.

COTH Survey of House Staff Stipends, Benefits and Funding

The preliminary results of the 1979 annual survey of house staff were mailed to all COTH member hospitals in June, 1979. This survey publishes information on levels of stipends for house staff by hospital region, ownership, bed size, and affiliation. It also provides information on fringe benefits for house staff and on sources and amounts of funding per hospital. The 1979 final report, which will be published this winter, is based on responses from over 350 hospitals.

Toward a More Contemporary Public Understanding of the Teaching Hospital

In preparation for the COTH Spring Meeting this year, the Department staff prepared a paper which outlines the evolution of the teaching hospital during the past two decades; identifies characteristics which distinguish teaching hospitals from non-teaching hospitals; and attempts to describe differences among the teaching hospital population. The report was sent to all COTH members last June.

Case Mix Measures and Their Reimbursement Applications

This report was prepared by staff based on membership recommendations during the Spring Meeting and a charge from the Administrative Board in June to prepare a state-of-the-art paper on methods for quantifying the intensity of care provided in hospitals. The report was distributed to all COTH members in September.

Other Materials Available from Department Files

In addition to the above surveys and reports, the Department of Teaching Hospitals maintains a collection of materials on various topics which are available to COTH members. While some of these items contain rather lengthy documentation and unfortunately cannot be copied upon request, the Department welcomes members to write or visit our offices in Washington, D.C. to review them. These materials include:

- copies of Section 223 exception requests submitted by COTH member hospitals to HCFA;
- time and effort reporting forms used by some member hospitals and medical schools to allocate staff time to various activities;
- a file of COTH hospital-medical school affiliation agreements;
- a file of COTH hospital house staff manuals;
- job descriptions for medical staff leadership positions at COTH hospitals;
- a survey conducted this year of sources of construction funds in teaching hospitals, which was summarized in a datagram in the August, 1979 issue of the Journal of Medical Education; and
- a collection of articles and literature on topics of special interest to teaching hospitals.

The purpose of this report is to provide COTH members with a summary of the past year's activities and of the types of services, publications, and documents available to members. If you should have any questions, you are encouraged to contact the staff of the Department of Teaching Hospitals (see Appendix B).

Appendix A

COUNCIL OF TEACHING HOSPITALS
OFFICERS AND ADMINISTRATIVE BOARD
1978-79

Chairman

*Robert M. Heyssel, M.D.
Executive Vice President & Director
The Johns Hopkins Hospital
Baltimore, Maryland

Chairman-Elect

*John W. Colloton
Director and Assistant to the
President for Health Services
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Immediate Past Chairman

*David L. Everhart
President
Northwestern Memorial Hospital
Chicago, Illinois

Secretary

John Reinertsen
Executive Director
University of Utah Medical Center
Salt Lake City, Utah

Term Expiring 1981

Dennis R. Barry
General Director
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Mark S. Levitan
Executive Director
Hospital of the University of Pennsylvania
Philadelphia, Pennsylvania

Robert K. Match, M.D.
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Long Island Jewish -
Hillside Medical Center
New Hyde Park, New York

Term Expiring 1980

James Bartlett, M.D.
Medical Director
Strong Memorial Hospital
of the University of Rochester
Rochester, New York

Malcom Randall
Hospital Director
Veterans Administration Hospital
Gainesville, Florida

Elliott C. Roberts
Director
Charity Hospital of Louisiana
at New Orleans
New Orleans, Louisiana

Term Expiring 1979

Jerome R. Dolezal
Hospital Director
Veterans Administration Hospital
Seattle, Washington

James M. Ensign
President
Creighton Omaha Regional Health
Care Corporation
Omaha, Nebraska

Mitchell T. Rabkin, M.D.
General Director
Beth Israel Hospital
Boston, Massachusetts

Ex Officio Member

*Stuart J. Marylander
President
Cedars-Sinai Medical Center
Los Angeles, California

* Representative to AAMC Executive Council

Appendix B

STAFF
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Richard M. Knapp, Ph.D.
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Administrative Resident
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Gail Gross
Administrative Secretary
202/828-0490

Melody J. Bishop
Secretary
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Tina D. Williams
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