

AGENDA
FOR
COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

Thursday, December 14, 1972

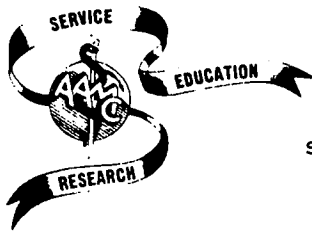
9:00 am - 3:30 pm

Room 827, 8th Floor
1 Dupont Circle, N.W.
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

AGENDA
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ADMINISTRATIVE BOARD

December 14, 1972
Room 827, 8th Floor
1 Dupont Circle, N.W.
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9:00 am - 3:30 pm

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III. <u>Discussion Items:</u>	
A. Report of Executive Committee Retreat	
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V. <u>12 Noon to 3:30 p.m.</u> Joint meeting with COD and COTH Administrative Boards with Mr. Thomas M. Tierney, Director of the Bureau of Health Insurance, Social Security Administration and other SS staff to discuss problems relative to HR1's effect upon reimbursement for patient services in the teaching environment.	29

MINUTES
ADMINISTRATIVE BOARD
COUNCIL OF ACADEMIC SOCIETIES

September 14, 1972

AAMC Headquarters
Washington, D.C.

PRESENT: Board Members

Sam L. Clark, Jr., Chairman (Presiding)
Ludwig Eichna
Ronald W. Estabrook
Robert E. Forster, II
Charles F. Gregory
Robert G. Petersdorf
*Jonathan Rhoads
*James V. Warren
William B. Weil, Jr.

Staff

Michael F. Ball
**L. Thompson Bowles
Connie Choate
**John A.D. Cooper
Mary H. Littlemeyer
**Joseph M. Murtaugh
**James R. Schofield
August G. Swanson

ABSENT: Board Members

Ernst Knobil
Louis G. Welt

I. Adoption of Minutes.

The minutes of the CAS Administrative Board meeting held May 18, 1972 were adopted as circulated.

II. Chairman's Report.

Dr. Clark reported on various actions taken since the last Board meeting. Among items of particular interest were the following:

1. The Chairman of the Council of Deans convened a committee on July 11, 1972 to consider medical school admissions problems. The Board requested that minutes of this meeting be circulated. A copy is attached hereto. (ATT. A)

* Ex Officio
** For part of meeting

2. At its meeting in June 1971, the Executive Council directed the AAMC staff to "explore moving the February meeting to a suitable location in March as soon as possible." An announcement was made at the October meeting of the Assembly that the AAMC would not continue to meet in conjunction with the AMA Congress on Medical Education after its commitment was fulfilled in February 1972.

Several factors precipitated this proposed change. The February date followed too closely after the Annual Meeting (three months), and past history proved that little or no business required Assembly action in February. In addition, members felt that the combined meeting of the AAMC and the AMA Congress required them to be away from their schools for too long a period of time.

3. The Executive Council on May 19, 1972 approved the following policy statement on the establishment of a Cabinet-level Department of Health.

The issues confronting this nation in providing a higher level of health and well being to its citizenry are among the most vital and urgent of existing domestic problems. The prospect of some form of universal health insurance coverage will press to the absolute limits our resources and ingenuity to provide health services based on need rather than on arbitrary economic determinants.

Since its establishment in 1953, the Department of Health, Education and Welfare has grown into a bureaucracy of 102,000 employees with an overall budget of nearly \$79 billion, one-third of the entire federal budget. More than 250 categorical grant programs are operated by the Department, including 40 separate health-grant programs.

The present framework within the Department of Health, Education and Welfare subordinates and submerges the health function in a manner which derogates the critical significance of these vitally important issues. There needs to be a single, authoritative point of responsibility for health policy within the federal structure. There needs to be a vigorous national leadership for the evolution of sound federal programs in the health field.

The President's current Executive reorganization proposal to create a Cabinet-level Department of Human Resources would only further obscure the process of policy formulation in health.

THEREFORE BE IT RESOLVED that the Association of American Medical Colleges wholeheartedly supports the establishment of a Cabinet-level Department of Health to serve as the single point of responsibility for defining health policy, administering federal health programs and evaluating the state of the nation's health. The Department should be administered by a Secretary of Health appointed by the President with the advice and consent of the Senate. The Secretary should be responsible for all health programs now administered by the Secretary of Health, Education and Welfare including Medicare and Medicaid and any new program of national health insurance. In connection with establishment of a new Department of Health, an independent panel of experts should conduct a study to develop a thoughtful and coordinated national health policy and a detailed national health program for meeting current and future health needs of the United States.

III. Action Items.

1. Revised Dues Schedule for submission to CAS Business Meeting, November 3, 1972.

Below are the two options for a dues structure voted on by the Administrative Board at its May 18th meeting (see Page 2 of Minutes). The dues schedule was presented to the Executive Council at its May 19th meeting. The Executive Council made the recommendation that the CAS implement a variation of Option B to avoid having the Business Affairs Office of the AAMC handle reimbursement procedures for transportation of representatives.

CAS Dues Increase

Option A

<u>Membership</u>	<u># of Soc.</u>	<u>Dues</u>	<u>Yield</u>
Less than 300	28	\$ 750	\$21,000
300; less than 1,000	10	1,000	10,000

Option A (cont.)

<u>Membership</u>	<u># of Soc.</u>	<u>Dues</u>	<u>Yield</u>
1,000; less than 5,000	8	\$2,000	\$16,000
5,000 or more	<u>5</u>	3,500	<u>17,500</u>
TOTALS	51		\$64,500

Utilizing the above schedule, one representative from each member society will be provided coach class transportation (no accommodations) to the Annual Meeting of the AAMC. Reimbursement for this transportation would be by the Business Office of the AAMC.

Option B

<u>Membership</u>	<u># of Soc.</u>	<u>Dues</u>	<u>Yield</u>
Less than 300	28	\$ 500	\$14,000
300; less than 1,000	10	1,000	10,000
1,000; less than 5,000	8	2,000	16,000
5,000 or more	<u>5</u>	3,000	<u>15,000</u>
TOTALS	51		\$55,000

Under this option no transportation services would be provided.

ACTION: On motion, duly seconded, the CAS Administrative Board voted (6 for and 2 against [Drs. Weil and Estabrook]) to recommend Option B at the Fall Business Meeting.

AMENDMENT: An amendment was offered to the effect that expulsion of a Society requires a vote. This amendment to the motion was not accepted.

AMENDMENT: The motion was subsequently amended to specify
Accepted

that ACTIVE members constitute the dues base.

A CAS Brief concerning this dated September 18
was distributed to the Membership (ATT. B).

2. Submission of Resolution on Basic Sciences in Medicine to the
Council for action.

RESOLUTION

Modern education of both undergraduate and graduate medical students requires an academic environment which provides close day-to-day interaction between basic medical scientists and clinicians. Only in such an environment can those skilled in teaching and research in the basic biomedical sciences maintain an acute awareness of the relevance of their disciplines to clinical problems. Such an environment is equally important for clinicians, for from the basic biomedical sciences comes new knowledge which can be applied to clinical problems. By providing a setting wherein clinical and basic scientists work closely together in teaching, research and health delivery, academic health centers uniquely serve to disseminate existing knowledge and to generate new knowledge of importance to the health and welfare of mankind.

Schools of medicine and their parent universities should promote the development of health science faculties composed of both basic and clinical scientists. It is recommended that organizational patterns be adopted which reduce the isolation of biomedical disciplines from each other and assure close interaction between them.

The Association of American Medical Colleges should vigorously pursue this principle in developing criteria for the accreditation of medical schools.

On May 18, 1972 the Executive Council approved this resolution in principle and agreed that it should be considered by the COD and COTH Administrative Boards and transmitted to the Liaison Committee on Medical Education.

ACTION: On motion, duly seconded, the CAS Administrative Board voted unanimously to put this resolution before the Council of Academic Societies at its fall meeting.

Dr. Swanson was asked to write to the Association of Medical School Microbiology Chairmen to convey the Board's appreciation of their resolution on this matter.

3. Membership applications.

ACTION: On motions, duly seconded, applications for membership in the Council of Academic Societies were approved for the following societies:

1. The Central Society for Clinical Research, Inc.
2. The American College of Psychiatrists
3. Biophysical Society
4. American College of Radiology

4. Policy Statement of the AAMC on the Protection of Human Subjects.

There have been a number of widely publicized incidents recently concerning major health research projects (the Tuskegee Syphilis Experiment, for example) which have raised serious questions about the ethics of certain kinds of research on human beings and the adequacy of government supervision of Federally-supported research. This is not a new issue but recent newspaper articles have created new interest in it. This interest is being reflected in an increasing number of Congressional proposals to study the ethics of biomedical research and to extend tighter Federal control over the kinds of research receiving Federal support. Bills have been introduced to establish study commissions on the ethics of research, to earmark a percentage of Federal research funds to the study of the implications of the research, and to prohibit Federal research support unless the human subjects of the research are fully informed of the implications and dangers of the project. Most recently

Mr. Javits has introduced a bill to amend the Public Health Service Act by inserting a new section concerned with the protection of human subjects.

ACTION: On motion, duly seconded, the CAS Administrative Board adopted the following policy statement:

POLICY STATEMENT OF THE AAMC ON THE PROTECTION
OF HUMAN SUBJECTS

The Association of American Medical Colleges asserts that academic medical centers have the responsibility for ensuring that all biomedical investigations conducted under their sponsorship involving human subjects are moral, ethical and legal. The centers must have rigorous and effective procedures for reviewing prospectively all investigations involving human subjects based on the DHEW Guidelines for the Protection of Human Subjects as amended December 1, 1971. Those faculty charged with this responsibility should be assisted by lay individuals with special concern for these matters. Ensuring respect for human rights and dignity are integral to the educational responsibility of the institutions and their faculties.

5. Policy of Veterans Administration Relating to Dual Payment of House Staff.

The CAS Administrative Board discussed VA Circular #10-72-184, dated August 15, 1972 on the subject "Coverage in the Admitting Area." (ATT. C)

Drs. Petersdorf and Warren provided information that indicated this had not been a unilateral action on the part of the VA, inasmuch as they both had been involved in prior discussions of the issue. Additionally, this was felt to be a local problem, rather than a national one, which varied

considerably from setting to setting.

ACTION: On motion, duly seconded, the CAS Administrative Board voted unanimously that, the intrinsic issue involved in VA Circular #10-72-184, is not of sufficient magnitude to justify confronting the VA.

Improved communications are expected to result from liaison already established with the VA by Dr. Ball, who will meet with them monthly.

IV. Information Items.

1. Mr. Murtaugh reported on the activities of the Committee on the Financing of Medical Education. Dr. Sprague will make a progress report in the fall. The first report of the Committee is expected by December.

2. Dr. Swanson expects that the National Library of Medicine will award a contract to the AAMC whereby it will, among other things, bring together faculty and CAS representatives for the purpose of identifying, developing, producing, and utilizing biomedical educational materials.

3. Dr. Schofield reviewed the history of the Liaison Committee on Medical Education which is the official accrediting body for undergraduate medical education. Approximately 30 - 35 accreditation visits are conducted annually. By 1973, the number of medical schools is expected to reach 113. By 1975, first-year enrollment is expected to total 15,000 or approximately a 100% increase in 25 years. The increasing societal expectations for M.D. production have resulted in undue enthusiasm from many groups ill-equipped but desirous of starting new medical schools. Accreditation functions include consulting with groups thinking of planning new medical schools. The

problem of increasing the production of physicians must be related to the appropriate use of the physician's time and an equitable geographic distribution of the physicians.

4. An abstract of the COD-CAS Joint Meeting to be held Sunday, November 5, in Miami Beach was reviewed. This session is entitled "Colleges and Medical Schools--Approaches to Accomplishing Their Joint Mission."

Dr. Warren suggested that this program, as presented in the Agenda, be promoted to the CAS full mailing list.

Dr. Forster was enthusiastic about the timeliness of the program planned and asked if speakers were being asked to contribute articles for a symposium issue of the Journal of Medical Education.

5. Dr. Swanson reported on the CAS Workshop on Individualized Medical Curricula originally planned for Spring, 1973. Foundation support is currently being sought. Dr. Swanson was urged to proceed with faculty recruitment, although in the absence of eventual funding, they would be required to pay their own expenses.

Dr. Weil indicated that he would like to see a topic added for discussion of the conflict between the integrated curriculum and the individualized curriculum.

6. Dr. Ball reported on taxability of fellowship stipends. AAMC legal counsel indicated that effective immediately training stipends must be treated as salary and wages and are not excludable from income tax or social security.

7. An AAMC Committee on Graduate Medical Education, chaired by Dr. William G. Anlyan, held its first meeting on July 20, 1972. The Committee will work at the national level on policy matters relating to the Coordinating

Council on Graduate Medical Education and the Liaison Committee on Graduate Medical Education and on problems relating to financing. At the meeting to be held October 4, 1972, a preliminary draft of a structure and functions document will be presented and a generic model for designating when students have achieved a sufficient level of responsibility to be considered junior associates will be presented. At the local level, the Committee will be available for advice and counsel to institutions intending to implement institutional responsibility for graduate medical education.

8. Dr. Warren informed the Board of the official action by the A.M.A. House of Delegates to prohibit students from writing on patient records. The Board agreed that this action runs counter to effective teaching in the clinical setting and asked that Dr. Warren report on and discuss this issue at the Fall CAS meeting.

V. Discussion Items.

1. Dr. Warren reiterated his interest in seeing the Committee on Primary Care activated. A report on programs in primary care or in family practice in the medical schools would be valuable. Dr. Petersdorf supported this idea.

2. Dr. Rhoads suggested the possibility of a workshop which would consider the possibility of a new format of awarding degrees in medicine that would recognize that medical education has multiple functions. To illustrate, Dr. Rhoads said at Level 1, which would be the awarding of the M.D., the generalist would be produced; Level 2, perhaps a Masters degree, a specialist; and Level 3, perhaps a Ph.D. or D.Sc. degree, would recognize the scholar/researcher who had done a thesis.

3. The need to improve the timetable and the mechanical aspects of the National Intern and Residency Matching Program were discussed.

4. The agenda for the fall CAS meeting was outlined.

VI. Other Items.

At the conclusion of the meeting Dr. Clark expressed official appreciation on behalf of the Administrative Board of the Council of Academic Societies to Drs. Rhoads and Warren for their very significant years of service in its leadership.

VII. Adjournment.

The meeting was adjourned at 3:40 p.m.

MHL:smc
9/25/72

IV. REPORT OF THE AD HOC COMMITTEE TO CONSIDER MEDICAL
SCHOOL ADMISSIONS PROBLEMS

Report of the Committee Convened by the Chairman of the Council of
Deans to Consider Medical School Admissions Problems

July 11, 1972

Martin S. Begun
Associate Dean (Administrative)
New York University School of
Medicine

Carleton Chapman, M.D.
Chairman, Council of Deans
Dean and Vice President
Dartmouth Medical School

John E. Chapman, M.D.
Associate Dean for Education
Vanderbilt University School
of Medicine

Sam L. Clark, Jr., M.D.
Chairman, Council of Academic Societies
Chairman of Anatomy
University of Massachusetts
Medical School

Clifford Grulee, Jr., M.D.
Dean, University of Cincinnati
College of Medicine

Frederick Hofmann Ph.D.
Associate Dean for Admissions
Columbia University
College of Physicians and Surgeons

Cheves McC. Smythe, M.D.
Dean, University of Texas at
Houston, Medical School

Robert L. Tuttle, M.D.
Chairman, Group on Student Affairs
Associate Dean for Academic Affairs
University of Texas at
Houston, Medical School

Harold Wiggers, Ph.D.
Dean, Albany Medical College
of Union University

James Erdmann, Ph.D.
Director, Division of Educa-
tional Research and Measurement
AAMC

Waltraut F. Dubé, Assistant
Director, for Special Programs,
Division of Student Affairs
AAMC

Roy K. Jarecky, Ed.D.
Associate Director, Division
of Student Affairs
AAMC

Joseph A. Keyes, J.D.
Assistant Director
Department of Institutional
Development
AAMC

James R. Schofield, M.D.
Deputy Director
Department of Institutional
Development
AAMC

August G. Swanson, M.D.
Director
Department of Academic Affairs
AAMC

Robert Thompson, Ed.D.
Director, Division of
Academic Information
AAMC

Marjorie P. Wilson, M.D.
Director
Department of Institutional
Development
AAMC

The meeting was convened in response to the mandate of the Council of Deans expressed in a resolution passed at the 1971 AAMC Annual Meeting and reaffirmed at the mid-year meeting in Chicago on February 5, 1972:

Resolved: That there be established an ad hoc committee, a task force or other appropriate mechanism to examine the nature and extent of admissions problems and to recommend to the COD ways to ameliorate these problems.

The resolution was stimulated by the recognition that the rapidly increasing number of applications to be processed by each medical school has reached proportions that are placing serious burdens on schools and applicants alike and that serious attention must be devoted to the concomitant problems to ensure that the admissions process is as efficient and equitable as possible.

While the number of first year places has been enlarged substantially since 1960-1961 (from 8,298 to 13,000 presently, an increase of 57%), the number of individuals seeking admission has risen at a much more rapid rate (from 14,397 to 36,302 during the same period, an increase of 153%). At the same time, as the relative difficulty of gaining admission has increased, applicants have sought to improve their chances by increasing the number of schools to which they apply. A total of 245,000 applications are expected to be filed for the entering year 1973-74. As a consequence, schools are frequently called upon to process a volume of applications that exceeds their projected enrollment by 20 to 40 times. The sheer administrative burden of processing these applications and supporting documents is substantial. New files, storage and personnel have been required. Moreover, the task of processing countless papers is merely the beginning. Remaining is the primary function of selecting perspective students with characteristics germane to the educational program of the particular school from an oversized applicant pool.

The current situation presents a series of challenges to the medical schools:

1. To process applications efficiently so that this function is not an undue drain on the institution's resources.
2. To process applications in a fair and equitable manner which ensures each applicant a full opportunity to have his credentials reviewed.
3. To select from the qualified applicants, those who are most likely to contribute to the fulfillment of the objectives of the educational program of the institution.
4. To minimize the financial, academic and emotional cost to the applicant.
5. To assist potential applicants with a realistic assessment of their potential for success in gaining admission to medical school.

The committee has developed a series of recommendations designed to

assist the schools in meeting these challenges.

Recommendations

DEFINE OBJECTIVES

Careful attention should be devoted to defining the mission and objectives of the medical school and specifying the role of the admissions process as it relates to institutional objectives.

ARTICULATE AND PUBLISH SELECTION FACTORS

Factors influencing applicant selection, including minimum cut-off scores and GPA's, should be articulated as explicitly as possible. They should be widely published, consistently expressed wherever they appear and adhered to faithfully in the selection process. Catalogues, Medical College Admission Requirements Handbook entries and AMCAS materials should portray the schools' policies consistently and accurately.

CAREFULLY SELECT AND EDUCATE THE COMMITTEE

Admissions committee members should be carefully selected according to their ability, their commitment to the institution's policies and their willingness to devote the substantial time and energy requisite to the task. This task is of such importance that the decisions require the full participation and consistent attention of each committee member.

Admissions committee members should undertake their assignment only after carefully informing themselves of institutional policies and objectives, the mechanics of the process, and the current state of the art represented by the literature on the subject. Locally organized seminars or briefing sessions might contribute significantly to this objective. The AAMC staff should assist in this by providing appropriate educational material including an annotated bibliography on the subject, and by standing ready to provide consultative assistance on problems within the areas of their expertise.

PROVIDE FULL-TIME SUPPORT

There should be a full-time admissions staff appropriately trained and under the direction of a responsible official of the administration whose sole or primary function consists of providing appropriate assistance to the dean, the admissions committee, and students who apply.

DESIGN PROCESS WITH COSTS IN MIND

Every aspect of the admissions process should be designed with full cognizance of the substantial financial, emotional and academic cost of the process to each applicant. Each step in the process should be designed to minimize these costs and to maximize the return to both the applicant and the institution.

Interviews should be recognized as the most expensive element in the process to the applicant and should be arranged in order

to minimize this expense. All reasonably competitive applicants should be afforded an opportunity to visit the school and be interviewed at their option, but no interview should be required which will not substantially contribute to the selection decision. Where interviews are deemed desirable in cases involving applicants geographically distant from the school, consideration should be given to sending the interviewer to the applicant's locale, rather than requiring each to travel to the school.

A TRAVEL LOAN SUPPLEMENT FEASIBLE?

The cost of travel to interviews is a heavy financial burden on the applicants, particularly on those with limited means. The committee considered this problem and a suggested approach to solving it. To ensure that this burden does not operate to preclude the admission of worthy but financially strained candidates, some mechanism might be developed whereby students would be able to apply for supplementary financial assistance to cover the special costs involved in such travel. A student who has already demonstrated financial need and is receiving student aid should be able to receive further assistance through the regular undergraduate college financial aid office for this purpose. A successful medical school applicant should be able to defray some of these extraordinary costs through a similar process. His medical school student aid officer could take into consideration the accumulated financial obligations which were in part derived from his quest to enter medical school.

The AAMC staff, in conjunction with the GSA, might profitably pursue this suggestion and explore its feasibility.

UNIFORM ACCEPTANCE DATES

The establishment of uniform acceptance dates is a worthy objective. It would facilitate a more consistent review of applications, provide for a more orderly process and minimize the anxiety of applicants associated with the continuing uncertainty of their status. Further efforts should be devoted to surmounting the remaining obstacles to the establishment of uniform acceptance dates.

DECISIONS SHOULD BE TIMELY MADE AND COMMUNICATED

Selection decisions should be announced in accordance with a predetermined schedule and applicants should be promptly informed of their status. Applicants who are clearly not qualified for the work of the school should be indentified early and so informed. Only those who clearly have a reasonable opportunity should be placed on "hold" and their status should be continually re-examined.

POLICIES MUST ACCORD WITH THE PUBLIC TRUST

Admissions policies should be designed with full cognizance of substantial public trust placed in the medical school. This involves recognition of the role of admissions decisions in governing access to the medical profession and the needs of society and particular socio-economic groups for medical services.

AMCAS USEFUL SUPPORT

The Committee was pleased to note the Association's efforts directed toward improving the usefulness to the schools of the American Medical College Application Service (AMCAS). The service, now under the direction of Dr. Robert Thompson, was viewed as having the potential to be of great assistance in the effort to simplify and expedite the applications process. 70 schools will be participating in the program during the academic year 1972-73, as they choose their September 1973 entering class. Those schools which are not yet participating are urged to carefully evaluate the progress of AMCAS as they assess its potential for meeting their future needs.

ADVISORS DESERVE SUPPORT

Pre-medical advisors are in a position to assist potential applicants in assessing their suitability for medical education and to assist medical schools in their assessment of the applicants. The AAMC should continue to devote substantial attention to enhancing the effectiveness of these advisors. Individual medical schools should work closely with these advisors to ensure that they have an accurate understanding of the admissions process, of the demands of medical education, and the nature of the medical profession.

HUMAN BIOLOGY AND HEALTH CAREERS

In view of the increasing interest in health careers among college students, medical educators should cooperate fully in the development of courses in the undergraduate curriculum designed to provide a fundamental understanding of human biology and the full spectrum of health careers available. Such courses would provide substantial assistance to students in making early and appropriate career choices.

GSA IMPORTANT FORUM

The Group on Student Affairs has proved to be an important forum for the exchange of views and information regarding the admissions process and for reaching agreement among the schools on matters requiring a common approach. Deans should be cognizant of this resource and should utilize it to the fullest.

A MATCHING PLAN FEASIBLE?

A matching plan similar in concept to the NIRMP is a possible next step in organized efforts to expedite the application and admissions process. The COD should recommend that the Group on Student Affairs and the AAMC staff begin immediately to explore all aspects of the feasibility of undertaking such a program.

FURTHER STUDIES NECESSARY

The AAMC should continue its studies to determine those characteristics of an applicant which influence not only his ability to successfully complete the medical curriculum, but also those which influence his effectiveness as a physician.

In addition to the matters set out above, the committee considered a number of policy related issues which it found difficult to reduce to specific recommendations. Basic to this aspect of the discussion was the underlying desire to achieve greater confidence that the procedures, policies, standards and decisions could be designed to ensure that admissions determinations produced an optimal match between students selected and the needs of society and the medical profession. No formula was discovered for assuring beyond dispute this kind of result.

The legal challenges being brought against admissions committee decisions were discussed. It was agreed that while legal considerations were important, they should not be viewed with alarm. Mr. Begun has recently surveyed a number of New York State judges regarding their views on a series of issues related to the admissions process. This survey is expected to be published shortly and is commended to your attention. (Attachment I)

The committee recognizes that it has not taken a startling new approach in its recommendations. Many may appear obvious and most are undoubtedly implemented in some fashion at schools around the country. Nevertheless, it is believed that if each school evaluates its procedures against these suggestions, much room for improvement will be found. Consequently, the committee is forwarding its report to the Council of Deans and urges the Council's endorsement. The report is also submitted to the Group on Student Affairs and the Council of Academic Societies for their information and consideration. (

8-14-72



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

SEPTEMBER 18, 1972

CAS BRIEFS

NO. 10

THE ADMINISTRATIVE BOARD OF THE CAS ON SEPTEMBER 14TH APPROVED A NEW DUES SCHEDULE FOR COUNCIL ACTION AT ITS BUSINESS MEETING ON NOVEMBER 3, 1972 IN MIAMI BEACH, RECOGNIZING THAT YOU MAY WISH TO CONSULT WITH YOUR OFFICERS AND/OR COUNCILS REGARDING ACTION ON THE CHANGE IN DUES, THIS LETTER IS SENT IN ADVANCE OF THE AGENDA.

THE PROPOSED SCHEDULE DISTRIBUTES DUES IN 4 CATAGORIES BASED UPON NUMBERS OF ACTIVE MEMBERS IN EACH SOCIETY, ON A PER-MEMBER BASIS THE RANGE WILL BE FROM APPROXIMATELY \$5.00 PER MEMBER FOR THE SMALL SOCIETIES, TO LESS THAN \$.50 PER MEMBER FOR THE LARGE ORGANIZATIONS.

<u>MEMBERSHIP</u>	<u># OF SOC.</u>	<u>DUES</u>	<u>YIELD</u>
LESS THAN 300	28	\$ 500	\$14,000
300; LESS THAN 1,000	10	1,000	10,000
1,000; LESS THAN 5,000	8	2,000	16,000
5,000 OR MORE	<u>5</u>	3,000	<u>15,000</u>
TOTALS	51		\$55,000

PRESENTLY, DUES FOR MEMBER SOCIETIES ARE \$100. THIS YIELDS \$5,100 PER YEAR, AN AMOUNT MUCH SMALLER THAN THE RESOURCES NEEDED TO SUPPORT ACTIVITIES GENERATED BY THE CAS WITHIN THE AAMC. FOR EXAMPLE, THE ESTABLISHMENT OF THE POSITION OF ASSISTANT DIRECTOR FOR BIOMEDICAL RESEARCH AND FACULTY DEVELOPMENT HAS ADDED IN EXCESS OF \$70,000 TO THE ASSOCIATION BUDGET. THIS POSITION WAS STRONGLY URGED BY THE AD HOC BIOMEDICAL RESEARCH POLICY COMMITTEE OF THE CAS AND ENDORSED BY THE COUNCIL.

THE ACTION OF THE COUNCIL ON NOVEMBER 3RD MUST BE APPROVED BY THE EXECUTIVE COUNCIL OF THE AAMC AND RATIFIED BY THE ASSEMBLY. THEREFORE, IT IS LIKELY THAT THE DUES INCREASE WILL NOT BECOME EFFECTIVE UNTIL 1974.

COUNCIL OF ACADEMIC SOCIETIES

Veterans Administration
Department of Medicine and Surgery
Washington, D. C. 20420

CIRCULAR 10-72-184

August 15, 1972

SUBJECT: COVERAGE IN THE ADMITTING AREA

TO : Directors of VA Hospitals, Domiciliary, VA Outpatient Clinics,
and Regional Offices with Outpatient Clinics

In order to meet the critical problem faced by some VA hospitals in staffing the admitting office, Central Office will consider granting authority to appoint medical residents presently on VA rolls as fee basis physicians for coverage during nights, weekends, and holidays. Approval can be granted only on an individual station basis when the following conditions are met and certified to the appropriate Regional Medical Director; (1) the Deans Committee has determined that admitting office duty is not a valid training experience in the VA and (2) no other means of providing medical coverage in the admitting office is available to station management. Medical residents appointed on this basis will be paid the fee per tour established by the Regional Medical Director in addition to their regular resident stipend.

Requests for this exception will be submitted to the appropriate Regional Medical Director (052A) and will contain the following information: (1) description of index and community hospital practices and rates for similar duty, (2) statement that Deans Committee has officially determined that admitting office duty in the VA is not a valid training experience for residents and that they concur in the proposal being submitted, (3) number and duration of tours to be established per week, and (4) explanation and justification why station management has determined that this method of coverage is necessary instead of using staff physicians and/or non-VA fee basis physicians.

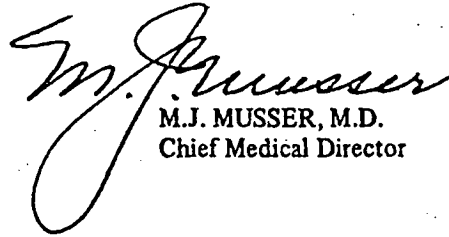
Dual appointment and pay of residents on VA rolls for any purpose other than performing an established tour of admitting office duty is prohibited. Existing RMD authorities for fee basis admitting office tours of duty are not to be construed as authorities for the dual appointment and compensation of residents on VA rolls; separate authority is required for this purpose. If the station is requesting authority for fee basis admitting office tours of duty in which private physicians and residents on VA rolls will be utilized, this should be so indicated in the submission.

If the appropriate RMD approves fee basis tours of duty for admitting office coverage and the utilization of residents on VA rolls for such tours, then stations so authorized must keep a record of the names of all such residents given dual appointments for this purpose, the number, type and duration of each tour performed, and the total amount paid each resident under his fee basis appointment. This information is required to be reported annually to Central Office. Reports will be due August 1 of each year covering the preceding fiscal year, and will be submitted to the

CIRCULAR EXPIRES AUGUST 14, 1973

appropriate Regional Medical Director (052A). A format for this report will be prescribed in a forthcoming issuance.

The appointment of a fee basis physician under 38 U.S.C. 4114(a)(1)(B) who is also appointed as a resident under 38 U.S.C. 4114(b) does not require the submission of additional data into the PAID System to reflect the fee basis appointment.



M.J. MUSSER, M.D.
Chief Medical Director

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III. Discussion Items:

STRATEGIES FOR CONSOLIDATION OF THE CAS

Since the CAS was founded, there has been gradual improvement in understanding by its membership of the purpose of the CAS-AAMC. However, further consolidation of the CAS membership is essential and the following items should be particularly considered at this meeting.

1. A spring CAS meeting has been scheduled for March 29-31, 1973. Should this meeting become an annual event? If so, how should it be structured?
2. Should the CAS Business Meeting agenda be presented in a different fashion? What should be the goals of the CAS Business Meeting?
3. Should the CAS and COD continue to hold joint meetings at the Association's Annual Meeting?
4. Should we hold an informal CAS Administrative Board meeting with someone from the Federal Government as a part of each Administrative Board meeting in the future?

MISSIONS FOR THE CAS

The morning will be principally devoted to a free-ranging discussion of the special role the CAS can assume in furthering the programs of the Association.

The member societies of the CAS represent a variety of special disciplinary interests, and in the main, conduct their programs to further their special interests with relatively little regard for the overall concerns of academic medicine. The programs of the Association listed below are relevant to the member societies, principally because they are directed toward the stability and development of the total academic mission. They are all of importance and their furtherance is of concern to all three Councils. Which of these programs can the CAS particularly promote and assist? How?

Biomedical Research

1. Maintenance of opportunities for support of investigator-initiated research.
2. Maintenance of support for essential research training programs.

3. Assistance in the development of management skills for directors of large research programs.

Education

1. Promoting the participation of faculty in accrediting medical schools.

2. Dealing with the problem of rapidly increasing applicant admission pressures.

3. Promoting increased flexibility in medical curricula.

4. Developing multimedia teaching systems and inter-institutional educational networking.

5. Promoting the acceptance of responsibility for graduate medical education by the academic medical center.

6. Developing effective continuing medical education.

7. Educating the health-care team together.

8. Improving the recruitment and retention of disadvantaged (minority) students.

9. Promoting the development and retention of medical school faculty.

Health Services

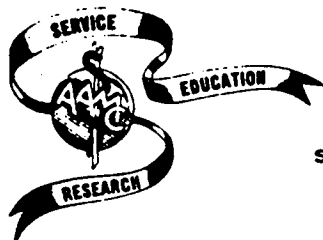
1. Promoting the development of new models for providing primary care.

2. Resolving the problems of specialty and geographic maldistribution of physicians.

3. Improving the function and educational effectiveness of ambulatory care in the academic institutions.

4. Promoting the development of mechanisms to satisfy requirements for assuring the quality of health care.

5. Ensuring that any future national health insurance programs provide for support of the education of health professionals.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

COUNCIL OF ACADEMIC SOCIETIES

WORKSHOP ON

INDIVIDUALIZED MEDICAL EDUCATION

The Mayflower Hotel, Washington, D.C.
March 29-31, 1973

Flexibility in academic programming for undergraduate medical students is becoming the rule rather than the exception. Tailoring education and training to the needs of the student is also spreading into graduate medical education. While absolute course requirements diminish, elective opportunities increase so that some schools allow students to arrange individual programs to accommodate their own pace of learning. The flexibility provided by these changes enhances individualization of medical education and training.

The Council of Academic Societies, representing a membership responsible for the education and training of American physicians, is holding a workshop to assess the current state of individualized programming for undergraduate and graduate medical students. Major goals of the workshop include the exploration of methods for evaluating student achievement, and the development of ideas and recommendations which will insure that meaningful individualization will not compromise the quality of students' preparation for a medical career.

What are the advantages and disadvantages of individualization to both students and faculties?

Does individualization potentiate selection and graduation of students from a wider range of applicant pool (e.g. minorities and women)?

Do advance-placement programs really work? If so, for what categories of students? Are they predominantly successful only with bioscience majors? Can students who have pursued non-science majors take advantage of this kind of acceleration? Can advance placement be facilitated by national achievement exams in specific subject areas?

What methods of evaluation can be employed to assure that the overall objectives of education for medicine have been fulfilled?

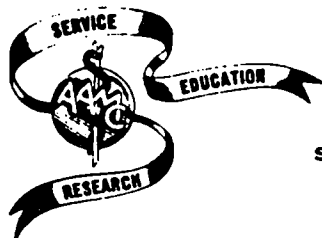
Does individualization promote greater diversity, or do students and faculty continue in conservative patterns and reproduce traditional curricula?

Can individualization be made more cost-effective if schools promote exchange-student programs, thus providing additional enrichment of student opportunities without excessive course development in each institution?

Do self-instructional and computer-assisted programs prove effective in facilitating individualization?

Can individualization be carried across the boundary between undergraduate and graduate medical education? If students' undergraduate programs are correlated with their graduate programs, does this lead to a narrowing of experience or can reasonable breadth be assured?

These questions among others will be raised and addressed at the workshop. A workshop program is attached.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

CAS WORKSHOP ON INDIVIDUALIZED MEDICAL EDUCATION

The Mayflower Hotel, Washington, D.C.

March 29-31, 1973

Thursday, March 29

6:00 p.m. Reception.

Friday, March 30

8:30 a.m. Welcome. Dr. August Swanson, AAMC Staff.

8:35 a.m. "The Range of Individualization now Provided in Medical School Curricula." Dr. Thompson Bowles, AAMC Staff.

9:00 a.m. Discussion.

9:15 a.m. "An Evaluation of Experiences at the Ohio State Pilot Medical School." Dr. Robert Folk, Ohio State U.

9:45 a.m. Discussion.

10:00 a.m. "An Evaluation of Experiences with an All-Elective Curriculum at Stanford." Dr. Oleg Jardetzky, Stanford U.

10:30 a.m. Discussion.

10:45 a.m. Coffee Break.

11:00 a.m. "An Evaluation of Experiences with Early Career Tracking at the University of Washington." Dr. Gary Striker, U. of Washington.

11:30 a.m. Discussion.

CAS WORKSHOP AGENDA
Continued

- 11:45 a.m. "Individualization for Students with Unusual Backgrounds at the University of California, San Francisco."
Dr. John Wellington, U.C., San Francisco.
- 12:15 p.m. Discussion.
- 12:30 p.m. Lunch.
- 2:00 p.m. Workshops convene.
- 5:30 p.m. Workshops adjourn.
- 6:30 p.m. Reception.
- 7:30 p.m. Free Evening.

Saturday, March 31

- 8:30 a.m. Workshops reconvene for summary discussion and approval of final report.
- 10:00 a.m. Coffee.
- 10:15 a.m. Plenary Session. Recorder's reports on workshops.
- 11:45 a.m. General Discussion.
- 12:30 p.m. Adjourn.

SIMULTANEOUS WORKSHOPS

Friday, 2:00-5:30 p.m.

Saturday, 8:30-10:00 a.m.

WORKSHOP #1

"Developing an Array of Electives which Meet Student Needs."

Chairman - Dr. D. C. Tosteson, Duke U.

Vice-Chairman - Dr. Oleg Jardetzky, Stanford U.

Recorder - Dr. Thompson Bowles, AAMC Staff.

WORKSHOP #2

"Academic and Career Counselling."

Chairman - Dr. John Wellington, U.C., San Francisco.

Vice-Chairman - Dr. Mitchell Rosenholtz, U. Missouri, Columbia.

Recorder - Dr. Roy Jarecky, AAMC Staff.

WORKSHOP #3

"The Present Need and Future Means for Assessment of Achievement."

Chairman - Dr. William Schofield, U. Minnesota.

Recorder - Dr. James Erdmann, AAMC Staff.

WORKSHOP #4

"Self-Instructional Program Development."

Chairman - Dr. Merrel Flair, U. North Carolina.

Vice-Chairman - Dr. Douglas Eastwood, Case Western Reserve.

Recorder - Dr. William Cooper, AAMC Staff.

WORKSHOP #5

"Articulation with the Undergraduate College Experience."

Chairman - Dr. Paul Elliot, U. Florida, Tallahassee.

Vice-Chairman - Dr. Joseph Gonnella, Jefferson Medical College.

Recorder - Dr. Davis Johnson, AAMC Staff.

WORKSHOP #6

"Extending Individualization Across the Boundary Between Medical School and Graduate Medical Education."

Chairman - Dr. William Enneking, U. Florida, Gainesville.

Recorder - Dr. Michael Ball, AAMC Staff.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM

NOVEMBER 30, 1972

TO: Administrative Board Members - CAS, COD, COTH

FROM: John A. D. Cooper, M.D.

SUBJECT: Meeting on December 14 with Mr. Tom Tierney, Director, Bureau of Health Insurance, Social Security Administration.

Since all three Administrative Boards will be meeting on Thursday, December 14, arrangements have been made to meet with Mr. Tom Tierney, Director of the SSA Bureau of Health Insurance. The main theme of the session with Mr. Tierney will be future regulations concerning fee payments to supervisory physicians in the teaching setting. As background for this discussion, I have attached copies of the pertinent sections of the House Ways and Means and Senate Finance Committee Reports.

The session with Mr. Tierney will begin with lunch at 12 noon in the AAMC Conference Room and adjourn in mid-afternoon.

SENATE FINANCE COMMITTEE REPORT

to a reasonable proportion of charges for the initial visit and to limit charges recognized for visits on the same day to a number of patients in the same institution to amounts that are reasonable in relation to the time usually spent and services provided under such circumstances. Of course, such limitations would not preclude individual consideration of requests for higher allowances where such followup visits or multiple visits are justifiable as being nonroutine.

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs after enactment of the bill may not be made with respect to any amount paid for items and services which exceeds these new limits. This would be consistent with policy in the present medicaid program.

The medicaid provisions of the Social Security Amendments of 1965 contained nothing which attempted to limit the charges by physicians that States could pay under their medicaid programs. States could and usually have set some type of limits of their own, typically less than usual or customary charges. The Social Security Amendments of 1967 added a new medicaid provision which required that a State plan must provide assurances that "payments (including payment for any drugs under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

On November 11, 1971, HEW issued regulations which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The regulation stipulated that in no case could payment exceed the highest of:

- (1) Beginning July 1, 1971, the 75th percentile of customary charges in the same localities established under title XVIII during the calendar year preceding the fiscal year in which the determination is made.
- (2) Prevailing charge recognized under part B, title XVIII for similar services in the same locality on December 31, 1970.
- (3) Prevailing reasonable charge recognized under part B, title XVIII.

Under the House bill, the Health Insurance Benefits Advisory Council is directed to study the methods of reimbursement for physicians' services under medicare and to report to the Congress by July 1, 1972, on how these methods affect physicians' fees, the extent to which they increase or decrease the number of cases for which physicians accept assignments, and the share of total physician charges which beneficiaries must pay. It is clear, however, that the group will be unable to complete the study requested by the House by July 1, 1972. The committee has therefore extended the deadline to January 1, 1973 so that HIBAC may comply with the House request.

The proposed amendment is substantially along the lines of the present regulation, and would be effective upon enactment.

Payment for Supervisory Physicians in Teaching Hospitals

(Sec. 227 of the bill)

When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of

how medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions, even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

In the typical community hospital and other teaching settings where patients are expected to pay fees for these services, fee-for-service payment for physicians' services would continue to be made by the medicare program. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive. Also, the payments tend to support the maintenance of two classes of patients in some cases.

To deal with these problems, H.R. 1 as passed by the House and approved by the committee, contains a provision, originally developed by this committee in 1970, which would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital or, where the number of full-time salaried physicians is minimal, at like institutions in the area. The committee expects that any determination with respect to whether the size of a particular hospital's salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervision on a regularly scheduled basis to nonprivate patients. Such services would be reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a reimbursable basis. Medicare payments for such services would be made available on an appropriate legal basis by the fund to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' services were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physicians. To facilitate efficient administration, a presumption may be made that all of the patients in an institution, or portion of an institution, are private patients but only where the institution offers satisfactory evidence that all patients are treated the same with respect to arrangements for care and accommodations, that all patients receive their principal physician services from an attending physician, and that all of the patients are billed for professional services and the great majority pay. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

It is recognized, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services.

In some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers. Also, the outpatient department of a hospital may organize the provision of and billing for physicians' services in that department differently from the inpatient setting. In such cases, the decision regarding whether cost or charge reimbursement is appropriate should be made separately for inpatients and outpatients. However, if the services are contracted for on a group basis, and medicare and medicaid directly or indirectly pay for such services, the normal basis of reimbursement by the two programs would be one of cost if the services are provided by a directly or indirectly related organization.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in

whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

The committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

Another provision in this section would permit a hospital to include among its reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. In order to receive reimbursement the hospital would be required to pay the reasonable cost of such services to medicare patients to the institution that bore the cost. The committee expects that such costs will be reimbursable only where there is a written agreement between the hospital and medical school specifying the types and extent of services to be furnished by the school and disposition of any reimbursement received by the hospital for those services.

This amendment would be effective with respect to accounting periods beginning after December 31, 1972.

Advance Approval of Extended Care and Home Health Coverage Under Medicare

(Sec. 228 of the bill)

Under present law, extended care benefits are payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The posthospital home health benefit is payable on behalf of patients

HOUSE WAYS AND MEANS COMMITTEE REPORT

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(g) *Payment under medicare for services of physicians rendered at a teaching hospital.*—When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of how medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions,

even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

Your committee does not question the appropriateness of fee-for-service payment for physicians' services in the typical community hospital and other teaching settings where patients are expected to pay fees for these services. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive. Also, the payments tend to support the maintenance of two classes of patients in some cases.

Therefore, your committee's bill would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital or, where the number of full-time salaried physicians is minimal, at like institutions in the area. Your committee expects that any determination with respect to whether the size of a particular hospital's salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervisory voluntary service on a regularly scheduled basis to nonprivate patients. Such services would be billed for by the organized medical staff of the hospital and reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time which would otherwise have to be obtained through employed staff on a reimbursable basis. Such funds would in general be made available on an appropriate legal basis to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when

expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

There are also teaching physicians whose compensation is paid by a medical school. With respect to reimbursement for their direct or supervisory services for nonprivate medicare patients, payments should be made on the basis of actual or salary-equivalent costs. The funds so received may be assigned by such physicians to an appropriate fund designated by the medical school for use in compensating teacher physicians, or for educational purposes. Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' service were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

Your committee recognizes, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services. Furthermore, in some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

Your committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

Your committee's bill also provides that the law be amended so that a hospital could include the actual reasonable costs which an affiliated medical school incurs in paying physicians to provide patient care services to medicare patients in the hospital. The bill would also permit including in a hospital's reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. The hospital would be required to pay the reasonable cost of the services in question to the institution that bore the cost.

The above provisions would become effective with respect to accounting periods beginning on or after July 1, 1971.