

COUNCIL OF DEANS

Meeting: Congressional Room
(2nd floor mezzanine)
Lunch: Senate Ballroom
(2nd floor mezzanine)

Thursday, May 21, 1970
9:00 a.m. - 5:00 p.m.
Statler Hilton Hotel
Washington, D.C.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
MINUTES
COUNCIL OF DEANS

February 6, 1970

Palmer House Hotel
Chicago, Illinois

I. Call to Order

The meeting was called to order by Dr. Sprague at 2:00 p.m.

II. Roll Call

The roll was called and a quorum established.

III. Minutes of October 31, 1969 Meeting

The minutes of the meeting of October 31, 1969 were accepted without change.

IV. Election of Member to the COD Administrative Board

The Bylaws of the Council of Deans call for an Administrative Board composed of the COD Chairman and Chairman-Elect, those deans elected as members of the AAMC Executive Council, plus one other member elected from the Council of Deans. To fill this latter position, a Nominating Committee was appointed; the Committee nominated Dean Robert S. Stone from The University of New Mexico.

ACTION: On motion, seconded and carried, the Council of Deans elected Dean Robert S. Stone to the COD Administrative Board.

V. Dr. Robert Q. Marston

Dr. Marston, Director of NIH, discussed the FY 70 budget and provided members with information concerning the outlook for NIH support of medical education and research both for 1970 and 1971.

There was an active exchange of questions and answers between members and Dr. Marston. It was commented that increases for health were substantial compared to other parts of the budget, and that this should be viewed as a serious effort by the administration to meet the real needs of the institutions.

VI. Dr. John A. D. Cooper

In discussing the FY 70 budget, Dr. Cooper commented that having Dr. Roger Egeberg in the office of Assistant Secretary for Health and Scientific Affairs was starting to have its effect in increasing the interest of the administration in health and medical education. Also, the Senate contacts by the individual Deans had certainly been effective in educating the Senate about the real needs of the medical institutions. The Senate recommended an increase in appropriations for DHEW over that recommended by the House, and approximately one-half of the increase was retained in the Conference Committee, which was most unusual. The Presidential veto was a blow, however, and makes one question the administration's priorities. There was some indication, none-the-less, that the President's concern was not with the appropriations for health but rather with the larger overall education budget. A Presidential health message is anticipated.

VII. Financing Medical Education

Dr. Russell Nelson has agreed to chair an AAMC committee which will study faculty compensation and other aspects of the financing of medical education. NIH has started to look at the same problem; if their proposal for proceeding is accepted by the Secretary, we have been promised that we will have input into their committee. Both the AAMC and the NIH agree that the definition of what all is medical education is a real problem.

Mr. Joseph Murtaugh stated that we must have a revision of the health manpower act - that a more rational relationship must be established between research and education, and an end put to artificial separations. It is necessary to work out a concept which includes all the systems involved in medical education and provides support for them.

VIII. Federal Health Programs Committee

The Federal Health Programs Committee has been dissolved in favor of using special ad hoc committees to deal with specific problems. Gratitude was expressed for the fine work Dr. Carleton Chapman has done as Chairman of the Federal Health Programs Committee. Dr. Chapman has agreed to chair an AAMC committee to look at the issue of a universal health insurance.

IX. Medicare

The Senate Finance Committee has just released a staff report titled, "Medicare and Medicaid Problems, Issues and Alternatives". Chapter Six of this document deals with "Payments to 'Supervisory' Physicians in Teaching Hospitals". The report makes a distinction between private and service patients (describing the latter as "Institutional" patients), and questions the validity of Part B fee-for-service charges by full-time supervisory physicians in a teaching setting: "Almost by definition, the supervisory physician, regardless of how much or how little direct patient care he renders, essentially functions in a

teaching or instructional capacity with respect to institutional patients. Medicare now reimburses under Part A for that portion of his salary or stipend attributable to administration and teaching responsibilities."

The report "concludes that there is no justification under the present Medicare statute for reimbursement of supervisory physician services to an institutional patient in a teaching setting and that there is no legal obligation on the part of the patient to pay him for those services".

Mr. Danielson reported that payment to 268 hospitals had been stopped as a result of Intermediary Letter 372, but that payment to all but about 90 hospitals has been resumed. In conjunction with a consultant, a position paper on this issue is being developed by the staff which will be presented to the Association for its reaction. The Council of Teaching Hospitals is concerned that there be an "Association approach" and not individual reactions.

Dr. Sherman Mellinkoff told of favorable settlements of law suits filed by UCLA, and advised that the Association seek astute and aggressive legal advice.

ACTION: On motion, seconded and carried, the Council of Deans actively endorses the efforts of the President toward developing a policy statement concerning reimbursement for professional fees which does not prohibit the use of the fees for educational purposes. The Council further recommends that the President obtain legal advice if he deems it necessary.

X. VA Fringe Benefits

Dr. Alfred Gellhorn has raised the point that the Veteran's Administration policy with regard to fringe benefits is making it difficult to retain VA personnel. The problem is being referred to the AAMC's Educational Advisory Committee to the VA.

XI. Next COD Meeting

Dr. Sprague announced that the next meeting of the Council of Deans will be May 21, 1970 in Washington, D.C. The Council will meet for a full day. A tentative agenda will be forthcoming shortly.

XII. Adjournment

The meeting was adjourned at 4:30 p.m.

AD HOC REPORT OF TASK FORCE ON PHYSICIAN'S ASSISTANTS TRAINING PROGRAMS

At the time of the November 1969 annual meeting, the Council of Academic Societies was requested to look into the program of accreditation of training programs for more highly trained physician's assistants. The Council approved this request, and a task force was appointed with Dr. Harvey Estes as chairman. Also on the task force were representatives of the Council of Deans and the Council of Teaching Hospitals. Representatives of the staff of the AMA Councils on Medical Education and on Health Manpower were guests of the task force at its meetings. On February 5, 1970 this group submitted the attached report.

On February 6, 1970 the Executive Committee of the Council of Academic Societies voted to distribute the report to the members of the Council for information only and to refer it to the Executive Committees of the Councils of Deans and of Teaching Hospitals and to the Executive Council of the Association. The Liaison Committee on Medical Education was also informed of these activities and of the content of the report.

It is important to realize that the recommendations of the report relate only to the accreditation of programs for the training of Type A (Level I) Physician's Assistants. These are the most highly trained physician support personnel who, under a physician's direction, are equipped to carry out many of the functions traditionally assigned to the doctor. Such assistants have also been called health care technologists or Level I assistants.

The report does not concern itself with the education of Type B (Level II or health care technician) assistants - more narrowly trained individuals in a tightly defined specialty area - such as an operating room technician or an orthopedic assistant, nor does it touch upon programs of Type C (Level III or health care aides) in which the great bulk of what are now called allied health physician support personnel fall.

Even with this limited scope the report brings before the Executive Council a major issue which can be divided into four parts:

1. The general question of AAMC support of the physician's assistant concept.
2. The responsibility of AAMC institutions for the education and training of such personnel.
3. AAMC's position in relation to the role of such personnel in the provision of health services in institutions.
4. The role of such personnel in the noninstitutional or private practice of medicine.

The report resolves none of these definitively, and in keeping with its charge the task force addressed itself primarily to the second.

In the meantime, a Physician's Assistants Association has been organized. The National Board of Medical Examiners has been approached about the writing of national-level examinations. The AMA Councils on Medical Education and Health Manpower are increasingly active in the fourth area, that of the potential relation of physician's assistants to practicing physicians. At its last meeting the Liaison Committee voted to invite representatives of the AMA Council on Medical Education, AMA Council on Health Manpower, and the AAMC to form another task force which would be charged with taking the recommendations of the enclosed report the next step further - sufficient clarification for their presentation to the House of Delegates of the AMA and by inference to the Assembly of the AAMC in November 1970.

At its May 7, 1970 meeting, the Executive Council of the AAMC reviewed the report of the task force and:

1. Accepted the report as information;
2. Agreed that individuals be appointed to meet with representatives of the AMA Councils.

REPORT OF AAMC TASK FORCE ON PHYSICIAN'S ASSISTANT PROGRAMS

February 5, 1970

PREAMBLE:

The Task Force was formed by action of the Council of Academic Societies at its November 2, 1969 meeting. It was formed in response to the many questions, both expressed and anticipated, raised by the rapid growth of physician's assistant programs and in recognition of the opportunity for the Council to exert leadership in this new area of medical education. Because of the possible implications for the Council of Deans and the Council of Teaching Hospitals, a representative of each was appointed to the Task Force.

The Task Force was asked to consider the role of these assistants and the need for standards for programs producing them, and to make appropriate recommendations to the council by February 5, 1970.

The Task Force met on two occasions, January 9, 1970, and January 27, 1970, and the following report is a result of these deliberations. Representatives of the American Medical Association were invited to meet with the Task Force, and Mr. Ralph Kuhli and Dr. T. F. Zimmerman were present at and participated in its meetings. Dr. Cheves Smythe of the AAMC and Dr. John Fauser of the AMA also participated in the first meeting.

The group is aware of the great variety of questions raised by this new type of health manpower, many of which were not considered a part of the charge of this particular Task Force and are therefore not addressed in this report. Among the questions are:

- (a) The legal aspects of registration and/or control of individual assistants.
- (b) The relationship between these categories of assistants and the established, previously defined, health professions (nursing, physical therapy, laboratory technology, etc.).
- (c) The relationship between these individuals and physicians and/or medical institutions, such as hospitals, including methods of financial support after the training period and the manner of billing patients for their services.
- (d) The need for additional numbers within each of the previously defined, established manpower categories and for still other, yet unspecified, assistants within the broad limits of health care.

I. THE NEED:

- A. New types of assistants to the physician are necessary components of the health care team. The current output of medical schools, plus the output of new and expanded schools, will be insufficient to meet the health care needs of those segments of society now being served, while extending equivalent services to those segments now receiving little or no care.
- B. Even if sufficient expansion of physician output could be achieved to meet the total need for services, there is doubt that this would be a wise course, since certain tasks do not require the unique talents of the physician and may be more appropriately performed by those with less total training.
- C. The existing manpower categories (such as professional nurses and physical therapists) could assume many of these functions with added training but should not be considered as the sole or the

primary entry pathway into these new health professions. There are already shortages in nearly all of the existing health manpower categories; and insistence that new functions be assumed by members of these categories would severely limit the availability of new manpower for these purposes. A new primary pathway into the new category of physician's assistant would tend to open the range of health careers and would enhance the potential for recruitment of male candidates.

II. THE RESPONSIBILITY OF AAMC:

- A. While it is possible for assistants to the physician to be trained by an educational institution, such as a junior college, and a group of practicing physicians, it is less likely that an adequate combination of facilities, medical faculty and interest will be found outside the teaching hospitals and medical teaching institutions represented by the AAMC.
- B. As a part of its overall concern for the training of the physician, the AAMC should have an interest in any technique or system which will make his work more efficient or more effective. The utilization of well trained assistants is one such technique.
- C. As a part of its concern for the provision of high quality health care to all persons, the AAMC must become concerned with the proper training, proper function, and proper utilization of such personnel.
- D. As a part of its concern for medical students, the AAMC must promote the concept of an effective health care team as a means of extending the scope of services offered to patients by providing exposure to effective use of assistants at the medical school level.

III. RECOMMENDED ACTION:

- A. The AAMC should demonstrate leadership in the definition of the role and function of these new categories of health care personnel, in setting educational standards for programs producing them, and in considering the additional problems raised in the preamble.
- B. The AAMC should seek the counsel and the cooperation of other interested organizations and agencies as it moves ahead in the above task.
- C. The AAMC should work toward an accrediting agency as a means of effective accreditation and periodic review of programs producing such personnel. A joint liaison committee with the AMA, similar to the Joint Liaison Committee for Medical Education, is one suggested mechanism.

IV. GUIDELINES FOR DEFINITION OF FUNCTIONAL LEVELS OF ASSISTANTS:

- A. In view of the great variety of functions which might be assumed by assistants, the variety of circumstances in which these functions might be carried out, and the variety of skills and knowledge necessary to perform these functions, it is necessary to define several categories of assistants. These are defined primarily by their ability for making independent judgmental decisions. This, in turn, rests on breadth of medical knowledge and experience.
 1. Type A within this definition of an assistant to the physician is capable of approaching the patient, collecting historical and physical data, organizing the data, and presenting it in such a way that the physician can visualize the medical problem and determine the next appropriate diagnostic or therapeutic step. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordi-

nating the role of other more technical assistants. It is recognized that he functions under the general supervision and responsibility of the physician, though he might, under special circumstances and under defined rules, operate away from the immediate surveillance of the physician. To properly perform at this level, the assistant must possess enough knowledge of medicine to permit a degree of interpretation of findings and a degree of independent action within these defined rules and circumstances.

2. Type B is characterized by a more limited area of knowledge and skill, and a more limited ability for integration and interpretation of findings. He is, as a result, less capable of independent action, but within his area of skill and knowledge he may be equal in ability to the Type A assistant or to the physician himself. Assistants at this level may be trained in a particular specialty without prior exposure to more general areas of medical practice, or may be trained in highly technical skills.
 3. Type C is characterized by training which enables him to perform a single defined task or series of such tasks for the physician. These tasks generally require no judgmental decisions and are under direct supervision.
- B. All such assistants should function under the general supervision and authority of a physician or a group of physicians and should not establish an independent practice. In addition, the functions performed by such assistants should be within the competence and capability of the responsible physician or physicians. For example, it would be inappropriate for a surgeon's assistant to perform a preoperative cardiac evaluation, unless the surgeon is competent to review his work critically and assume responsibility for its accuracy and completeness.

V. GUIDELINES FOR EDUCATIONAL PROGRAMS FOR TYPE A ASSISTANTS:

This document concerns itself solely with the guidelines for training of Type A assistants. This does not preclude the need for guidelines for other types as described above.

A. General Objectives:

To provide educational guidelines insuring high standards of quality for programs training Type A assistants as specified in Paragraph (IV-A-1) above, while preserving sufficient flexibility to permit innovation, both in content and method of education, all in the interest of protecting the public, the trainees, and those employing graduate assistants; to establish standards for use by various governmental agencies, professional societies, and other organizations having working relationships with such assistants.

B. General Prerequisites:

1. An approved program must be sponsored by a college or university with arrangements appropriate for the clinical training of its students. This will usually be a hospital maintaining a teaching program. There must be evidence that this program has education as its primary orientation and objective.
2. An approved program must provide to the accrediting agency, to be available in turn to other educational institutions, prospective students, physicians, hospitals, and others, information concerning the program including the following:

Name and Location of School
 College/University Affiliation
 Clinical/Hospital Affiliation

Director
 Student Capacity
 Academic Calendar
 Tuition and Fees

3. An approved program must also provide, for the use of the accrediting agency, sufficient confidential information to establish that the program is in compliance with the specific guidelines which follow.

C. Administration:

1. An approved program may be administered by a medical school, hospital, university, college or other entity, providing it can assure that the educational standards can be maintained and other requirements met.
2. The administration shall be responsible for maintaining adequate facilities and a competent faculty and staff.
3. The administration shall assure the continued operation and adequate financing of the program through regular budgets, which shall be available for review by the accrediting agency. The budget may be derived from gifts, endowments, or other sources in addition to student fees.
4. The administration shall assure that the standards and qualifications for entrance into the program are recorded and available to the accrediting agency, and that these standards are met. Records of entrance qualifications and evaluations for each student shall be recorded and maintained, including transcripts of high school and college credits.
5. The administration shall make available to the accrediting agency yearly summaries of case loads and other educational activities done by clinical affiliates, including volume of outpatient visits, number of inpatients, and the operating budget.

D. Organization of Program:

1. The Program must be under supervision of a qualified director, who has at his disposal the resources of competent personnel adequately trained in the administration and operation of educational programs.
2. It will be the responsibility of the director to maintain a qualified teaching faculty.
3. The director will maintain a satisfactory record system to document all work done by the student. Evaluation and testing techniques and standards shall be stated, and the results available for inspection.
4. The director will maintain records on each student's attendance and performance.
5. The director will maintain on file a complete and detailed curriculum outline, a synopsis of which will be submitted to the accrediting agency. This should include both classroom and clinical instruction.

E. Physical Facilities:

1. Adequate space, light, and modern equipment should be provided for all necessary teaching functions.
2. A library, containing up-to-date textbooks, scientific periodicals, and reference material pertaining to clinical medicine, its underlying scientific disciplines, and its specialties, shall be readily accessible to students and faculty.
3. A hospital or other clinical facility shall be provided and of sufficient size to insure clinical teaching opportunities adequate to meet curriculum requirements.

F. Faculty:

1. An approved program must have a faculty competent to teach the

didactic and clinical material which comprises the curriculum.

2. The faculty should include at least one instructor who is a graduate of medicine, licensed to practice in the location of the school, and whose training and experience enable him to properly supervise progress and teaching in clinical subjects. He shall be in attendance for sufficient time to insure proper exposure of the student to clinical teaching and practice.
3. The program may utilize instructors other than physicians, but sufficient exposure to clinical medicine must be provided to insure understanding of the patient, his problem, and the diagnostic and therapeutic responses to this problem. For this reason attention is specifically directed to provision of adequate exposure of students to physician instructors.

G. Prerequisites for Admission:

1. For proper performance of those functions outlined for Type A assistants as described in Paragraph (IV-A-1) above, the student must possess an ability to use written and spoken language in effective communication with patients, physicians and others. He must also possess quantitative skills to insure proper calculation and interpretation of tests. He must also possess behavioral characteristics of honesty, dependability, and must meet high ethical and moral standards in order to safeguard the interest of patients and others. An approved program will insure that candidates accepted for training are able to meet such standards by means of specified evaluative techniques, which are available for review by the accrediting agency. The above requirements may be met in several ways. The following specific examples could serve the purpose of establishing the necessary qualifications and are provided as guides.
 - a. Degree-Granting Programs: The successful completion of the preprofessional courses required by the college or university as a part of its baccalaureate degree.
 - b. Non-Degree (Certificate) Programs: A high school diploma or its equivalent, plus previous health related work, preferably including education and experience in direct patient care, plus letters of recommendation from physicians or others competent to evaluate the qualifications cited above.
2. All transcripts, test scores, opinions, or evaluations utilized in selection of trainees should be on file and available to the accrediting agency on request.

H. Curriculum:

1. The curriculum should provide adequate instruction in the basic sciences underlying medical practice to provide the trainee with an understanding of the nature of disease processes and symptoms, abnormal laboratory tests, drug actions, etc. This shall be combined with instruction, observation and participation in history taking, physical examination, therapeutic procedures, etc. This should be in sufficient depth to enable the graduate to integrate and organize historical and physical findings as described in Paragraph (IV-A-1).
2. The didactic instruction should follow a planned and progressive outline and include an appropriate mixture of classroom lectures, textbook assignments, discussions, demonstrations, and similar activities. There should be sufficient evaluative procedures to assure adequate evidence of student competence.
3. Instruction should include practical instruction and clinical experience under qualified supervision sufficient to provide

understanding of and skill in performing those clinical functions required of this type of assistant. Evaluation techniques should be described and results recorded for each student.

4. Though the student may concentrate his effort and his interest in a particular specialty of medicine, he should possess a broad general understanding of medical practice and therapeutic techniques, so as to permit him to function with the degree of judgment previously defined.
5. Though some variation is possible for the individual student, dependent on aptitude, previous education, and experience, the curriculum will usually require two or more academic years for completion.
6. It is urged that the college or university sponsoring the program establish course numbers and course descriptions for all training, and that a transcript be established for each student. Students should receive college credit when this is appropriate, and should receive a suitable degree if sufficient credit is earned. If a degree is not earned, a certificate or similar credential shall be granted to the student on completion of the course of study.

I. Health:

1. Applicants will be required to meet the health standards of the sponsoring institution.
2. As evidence of its concern for imparting the importance of proper health maintenance, the program should provide for the students the same health safeguards provided for employees of affiliated clinical institutions.

J. Accreditation Procedures:

1. Applications for approval of a program for the training of Type A assistants as described above shall be made to the accrediting agency.
2. Forms and instructions will be supplied on request and should be completed by the director of the program requesting approval.
3. Approval of a program may be withdrawn when, in the opinion of the accrediting agency, the program fails to maintain the educational standards described above. When a program has not been in operation for a period of two consecutive years, approval will automatically be withdrawn.
4. Approved programs should notify the accrediting agency in writing of any major changes in the curriculum or a change in the directorship of the program.

H. Robert Cathcart, Vice President
Pennsylvania Hospital

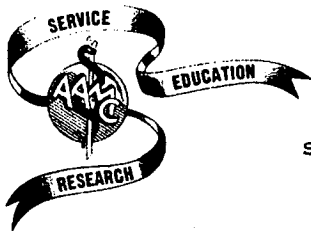
James C. Eckenhoff, Chairman, Dept. of Anesthesia,
Northwestern University Medical Center

Robert W. Ewer, Asst. Professor of Medicine,
University of Texas Medical Branch

William D. Mayer, Director, Medical Center,
University of Missouri

Lee Powers, Director, Division of Allied Health
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Community Health Sciences, Duke University
Medical Center



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

April 22, 1970

The extensions of the Health Professions Education Assistance Programs authorized in the Health Manpower Amendments Act of 1968 expire June 30, 1971. As yet nothing has emerged from the Administration that gives any indication of the nature of the further extension of these authorities which it will give to the Congress.

In order that the AAMC may agree upon the nature of further changes in these programs and be able to submit to interested Congressmen such proposals for specific legislation in this area, early conclusions will have to be reached on these matters.

Following is a series of proposed changes in the existing law which have been developed as a basis for discussion.

Department of Planning
and Policy Development

PRELIMINARY

Proposed Changes in HPEA Act
as Compared With Existing Law

Provision	Existing Law	Proposed Change
A. Construction		
1. Appropriation authorization (Sec. 720)	1970 \$170,000,000	1972 \$300,000,000
	1971 225,000,000	1973 350,000,000
		1974 400,000,000
		1975 450,000,000
		1976 500,000,000
2. Availability of funds (Sec. 720)	Two years	Three years
3. Clinical facilities (Sec. 721)	Affiliated hospitals	Affiliated hospitals and outpatient facilities
4. Enrollment requirement:		
a. Expansion	Highest 1st year enrollment in past 5 years must be exceeded over next 10 years by 5 %, or 5 students, whichever is greater	Appropriate increase in enrollment as determined by the Secretary
b. Replacement (Sec. 721)	No provision	Maintain existing enrollment capacity
5. Federal share of cost of construction (Sec. 722)	75 Percent: Public health schools	85 Percent: Schools of public health, medicine, osteopathy, and dentistry, if required
	66 2/3 Percent: New school or major expansion	75 Percent: New school or major expansion
	50 Percent: All other, but 66 2/3 percent in "unusual circumstances."	66 2/3 Percent: All other

<u>Provision</u>	<u>Existing Law</u>	<u>Proposed Change</u>
6. Definition of construction (Sec. 724)	Excludes cost of land acquisition	Includes cost of land acquisition
<u>B. Student Loans</u>		
1. Annual maximum award per student (Sec. 741)	\$2,500	\$3,500 for medicine, osteopathy and dentistry \$2,500 for others
2. Appropriation authorization (Sec. 742)	1971 \$35,000,000	1972 \$45,000,000 1973 45,000,000 1974 45,000,000 1975 45,000,000 1976 45,000,000
3. Allotment formula (Sec. 742)	Enrollment	Enrollment plus consideration of higher annual loan maximums for students in the case of schools of medicine, osteopathy and dentistry.
<u>C. Scholarships</u>		
1. Annual maximum award per student (Sec. 780)	\$2,500	\$3,500 for medicine, osteopathy and dentistry \$2,500 for others
2. Formula for appropriations and allocations (Sec. 780)	\$2,000 multiplied by ten percent of enrollment	\$3,000 multiplied by ten percent of enrollment for schools of medicine, osteopathy and dentistry. \$2,000 multiplied by ten percent of enrollment for other schools

<u>Provision</u>	<u>Existing Law</u>	<u>Proposed Change</u>
<u>D. Improvement Grants</u>		
1. Appropriation authorization for formula and project grants (Sec. 770)	1970	\$117,000,000
	1971	168,000,000
	1972	\$250,000,000
	1973	300,000,000
	1974	350,000,000
	1975	400,000,000
	1976	450,000,000
2. Division of funds between formula and project grants (Sec. 770)	Determined by Secretary unless specified in appropriation acts	No change
<u>E. Formula Grants</u>		
1. Base grant per school per year (Sec. 771)	\$25,000	\$50,000 for schools of medicine, osteopathy and dentistry \$25,000 for other schools
2. Formula for distribution of funds after the award of base grants (Sec. 771)	75 percent on the basis of relative enrollment multiplied by one and relative increase in enrollment multiplied by two 25 percent on the basis of relative number of graduates	Relative enrollment with a weight of two for enrollment in schools of medicine, osteopathy and dentistry and a weight of one for enrollment in other schools
3. First year enrollment expansion requirement (Sec. 771)	2½ percent, or 5 students, whichever is greater, over the average of the two highest first year enrollments during the period 1963-8 This requirement may be waived by the Secretary	Financial incentive for expansion in enrollment is transferred to project grants

Provision	Existing Law	Proposed Change
<u>F. Project Grants</u>		
1. Eligible institutions (Sec. 772)	Accredited schools covered by HPEA Act	Same, plus public and private nonprofit institutions and agencies
2. Purpose of grants (Sec. 772)	<p>Projects to:</p> <p>Plan, develop or establish programs of education in HPEA professions;</p> <p>Improve curriculums of HPEA schools;</p> <p>Conduct research in fields related to HPEA education;</p> <p>Develop training for new levels or types of health professions personnel;</p> <p>Assist schools in serious financial straits;</p> <p>Plan experimental teaching facilities;</p> <p>Strengthen, improve, or expand programs to train HPEA personnel; or</p> <p>Increase the supply of adequately trained HPEA personnel.</p>	<p>Projects to:</p> <p>Accomplish all of the objectives under existing law, plus:</p> <p>Assist public and private nonprofit institutions and agencies in planning, establishing and developing HPEA schools;</p> <p>Assist in increasing the supply of well-qualified faculty members in the HPEA health professions;</p> <p>Assist in making significant expansions in enrollment capacity of HPEA schools; or</p> <p>Permit the Secretary, upon the recommendation of the National Advisory Council on Health Professions Educational Assistance, to adopt such additional means as he deems necessary to provide for an adequate supply of well trained HPEA health manpower.</p>

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EXPLANATORY STATEMENT
RELATING TO
PROPOSED CHANGES IN HPEA ACT
AS COMPARED WITH EXISTING LAW

The AAMC recommends a five-year extension of the HPEA Act with increased appropriation authorizations for construction, student loans, scholarships, and improvement grants. Proposed modifications to existing law would:

Increase the Federal share of construction costs;

Increase the annual maximum award per student in the case of loans and scholarships in medicine, osteopathy, and dentistry with appropriate recognition of the increases in the allocation of funds among the HPEA schools;

Simplify and improve the formula for the allocation of institutional grants; and

Expand the purposes for which special project grants may be awarded.

Foreword

At the outset, it should be recognized that this proposal does not purport to be the ideal solution to the problem of providing adequate Federal financial assistance for schools of medicine. Instead, the proposal takes a practical approach to what can be achieved in terms of the cost of the legislation and its content. Thus, in some instances the proposal moves in the desired direction rather than reaching what can easily be justified as a reasonable goal.

As an example, the formula for institutional grants may be cited. Under existing law each eligible school receives the same amount per student, approximately \$500. This proposal

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doubles the amount for students of medicine, osteopathy and dentistry. It might be argued that the amount should be tripled or quadrupled in the case of these schools where educational costs far exceed those in schools of pharmacy, optometry or podiatry. The increase therefor is more practical than theoretical.

The departures of the proposal from existing law were formulated by keeping in mind the interests of the Federation of Associations of Schools of the Health Professions. At a recent meeting of the Federation, Ken Endicott discussed the need for adjustments in the HPEA Act due to the higher educational costs in medicine, osteopathy and dentistry. His recommendations encountered no objections from the members of the Federation.

The proposal has been prepared in consultation with the Bureau of Health Professions Education and Manpower Training. This step was taken in recognition of the fact that Congressional staff will undoubtedly seek HEW advice, on an informal basis, prior to the introduction of the legislation.

Finally, the proposal takes into consideration "the political facts of life" by recommending only moderate adjustments to legislation already approved by Congress.

A. Construction

Appropriation authorization. Authorizations are increased progressively over a five-year period from \$300 million to \$500 million for construction. Of the \$225 million authorized for 1971 only \$118 million is requested in the PHS budget for 1971.

Availability of funds. Funds appropriated now remain available for obligation for two years, or more precisely, for the year following the year in which they are appropriated. In actual practice, this means that the funds are available for approximately 18 months because of delays in Congress and in the Bureau of the Budget. The proposal of HEW to decentralize authorities to the regional offices will probably add to the time needed for processing grant applications, at least in the beginning. Consequently, a three-year availability of funds is proposed. A potential disadvantage of the extended availability is that it would facilitate HEW efforts to delay the approval of applications in the interests of geographical dispersion, etc.

Clinical facilities. Under existing law there is no authority for Federal financial assistance for the construction of an outpatient facility that is independent of a hospital.

Enrollment requirement. Although HEW reports that the expansion requirement for construction does not constitute a hardship, a more flexible approach is proposed. Its workability depends on the judgement of the PHS and the Secretary.

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A requirement for maintaining enrollment capacity in the case of replacement projects is added as an offset to criticism over the apparent "weakening" of the expansion requirement.

Federal share of construction costs. The maximum Federal share of construction costs would be increased to 85 percent and extended to schools of medicine, osteopathy, and dentistry. (Under existing law only schools of public health are eligible for the maximum of 75 percent; they would also be eligible for the 85 percent share.) Schools would not be automatically eligible for the maximum Federal share but would have to demonstrate a need. The Federal share for new schools and major expansions would be increased from 66 2/3 percent to 75 percent. The rate for all other projects would be increased from 50 percent to 66 2/3 percent.

Definition of construction. The definition of construction would be expanded to include the cost of land acquisition. Such a definition has been approved in the case of many other Federal construction programs. HEW recommended the more liberal definition only in the case of land with an existing building.

Student loans. The annual maximum award per student would be increased from \$2,500 to \$3,500 in the case of medicine, osteopathy and dentistry, in recognition of their higher educational costs. In addition, the appropriation authorization would be increased from \$35 million to \$45 million. The Secretary would be required to give considera-

tion to the higher annual loan maximums for medicine, osteopathy and dentistry as well as enrollment in the allocation of funds among schools. Under existing law the funds are allocated on the basis of enrollment.

Scholarships. The annual maximum award per student would be increased from \$2,500 to \$3,500 in the case of medicine, osteopathy and dentistry, in recognition of their higher educational costs. The increase would also be reflected in the formula for allocating funds among schools. For schools of medicine, osteopathy and dentistry, the formula for appropriations and allocations would be 10 percent of the full-time enrollment multiplied by \$3,000. For the remaining schools the formula would continue to be 10 percent of the full-time enrollment multiplied by \$2,000.

Improvement grants. The appropriation authorizations for formula and project grants would be increased over the five years, 1972-1976, reaching a maximum of \$450 million in the last year. The proposal would continue the provision under existing law that permits the Secretary to divide the total appropriation between formula and project grants, unless specified in appropriation acts. Our long range objective, however, will be to increase the proportion of funds in formula grants (as opposed to project grants) as data are developed to measure differences in educational costs among the eligible categories of schools. Such data would be used to modify the allocation formula.

Formula grants. The base grant of \$25,000 per school per year would be increased to \$50,000 in the case of schools of medicine, osteopathy and dentistry, in recognition of their higher educational costs. Financial incentives for expansion of enrollment would be deleted from the allocation formula for formula grants and transferred to project grants. The proposed formula for allocating funds among schools would be based only on enrollment, but enrollment at schools of medicine, osteopathy and dentistry would be given a weight of two as compared to a weight of one for enrollment at the remaining schools. This change would increase the proportion of improvement grants awarded through the formula mechanism, but would not reduce the formula grant funds for any category of schools. The net effect of the change in formula, exclusive of the change in base grants for schools of medicine, osteopathy and dentistry, is shown below:

<u>Category</u>	<u>Formula grants in millions of dollars</u>	
	<u>Present*</u>	<u>Proposed</u>
<u>Total</u>	<u>\$46.5</u>	<u>\$78.1</u>
Medicine	21.3	42.6
Osteopathy	1.1	2.2
Dentistry	9.2	18.4
Optometry	1.5	1.5
Pharmacy	10.2	10.2
Podiatry	0.7	0.7
Veterinary medicine	2.5	2.5

* 1970 level.

Project grants. Eligibility for project grants would be extended to public and private nonprofit institutions and agencies. All of the existing authorities with respect to the purposes for which project grants may be awarded would be retained. The proposal would add a minimum of four new authorities or purposes: (1) Assistance in the establishment of a new school, (2) Assistance in increasing the supply of well-qualified faculty through training grants (including traineeships), (3) Assistance in making significant expansions in enrollment capacity (transferred from formula grants), and (4) Broad authority to permit the Secretary "to adopt such additional means as he deems necessary to provide for an adequate supply of well-trained health manpower." One example of a project that could be financed under the latter authority would be a project to give additional training to potential HPEA students through remedial education.

Conclusion.

Additional attention and discussion is needed with respect to several aspects of the legislation:

1. Should authority be provided to permit a university to secure financial assistance through the HPEA Act to establish schools covered by the Act and also a nursing school and a training center for the allied health professions ?

2. The proposal does not authorize guaranteed loans for construction that might cover up to 90 percent of construction

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costs. A danger here is the trend in HEW to substitute guaranteed loans for grants in construction programs. The Hill-Burton Program is an example.

3. Should the geographic distribution of HPEA Act manpower be taken into consideration to a greater degree than is already provided for ?

4. Federal financial assistance for the education of interns and residents.

May 11, 1970

Russell A. Nelson, M.D.
President
The Johns Hopkins Hospital
601 N. Broadway
Baltimore, Maryland 21205

Dear Russ:

Attached is an initial draft of a proposal for a national commission to examine the structure, process, and financing of present-day medical education in the United States.

This proposal represents my variations on the concepts developed in the meeting with Roger Egeberg some weeks ago. I have broadened the focus of the study from financing per se to encompass a rather broad examination of medical education. This enlargement results from my conviction that it would be extremely difficult to speak to the matters involved in the financing of medical education without some consensus on what constitutes the essential ingredients and attributes of medical education.

As you well know, there appear to be two prevailing views about medical education. One group holds that additional numbers of physicians can only be produced through a continued replication of existing structure and content of present-day medical education if we are to have the quality of medicine in this country which was the objective of the Flexner Report. The other group holds that there can be a substantial expansion of medical education in new modes and arrangements which will not require continued investment in research and graduate activities on the order that has characterized the development thus far.

Thus the question emerges clearly, "What is the design for medical education around which financing determinations and public and private investment therein should be based?" Contemplation of this dilemma led me down the line reflected in the attached document. It would obviously be a substantial venture to undertake, but it might be of greater interest to the foundations.

Needless to say, I would appreciate your comments and suggestions and, indeed, further direction after you have had a chance to read and think about this proposal.

Sincerely yours,

Joseph S. Murtaugh
Director
Department of Planning
and Policy Development

Attachment

PROJECT GILEAD

"Is there no balm in Gilead; are there no physicians there?"
Jeremiah 8:22

SUMMARY PROPOSAL

It is proposed that a national commission be established under independent private auspices to carry out a searching examination of their structure, process, and financing of present-day medical education in the United States. The purpose of this examination would be to provide:

...a set of national goals and objectives for the further development of the nation's resources for medical education, research, and related patient care in the context of current and prospective health needs, problems, and opportunities.

...a thorough review and assessment of the current functions, content, and role of medical education and its institutions in relation to national needs in the context of emerging health, scientific, economic, and science trends

...a contemporary view of the essential elements of the process of medical education, its institutional framework, its functional components, and its relationships to the university structure and the community health framework.

...a basis for an appropriate distribution of roles, functions, and responsibilities among Federal, state, local, institutional, and individual interests in this area to provide for the most effective achievement of the goals sought

...a new framework of policies, programs, and support mechanisms which will assure a sound, rational, and mutually supportive relationship between national objectives and goals in this area and the nature, capabilities, and appropriate roles of the institutions involved

...a comprehensive body of data covering the income, expenditures, and costs of the present structure of medical education and bearing on the observations and conclusions of the Commission.

This examination would be carried out over a two-to-three year period by an independent body created and funded through joint action of interested foundations, the relevant professional organizations, and the Department of Health, Education and Welfare. Guidance for the study would be through a group of distinguished professional and lay individuals drawn from the nation as a whole working under the chairmanship of an outstanding figure in national affairs and supported by a full-time staff.

THE NATURE OF THE PROBLEM:

Medical education and the institutions involved have arrived at a critical stage of development. Substantial forces, both internal and external and often conflicting, are demanding or compelling change. These reflect wide-spread dissatisfaction with present-day medical education, its conceptual base, its institutional framework, its economics, and its relevance to current and prospective national needs. The specifics of this dissatisfaction are diverse but for the most part center around:

...the quantity and orientation of the physicians being produced

...the financial needs of medical education and the distribution of the responsibility for and burdens of its support

...the relationship among the teaching, research and science functions of medical centers

...the medical center's role in and responsibility for its surrounding community and the delivery of health services

...the nature and sources of the student body involved

...the content and structure of curricula in the context of advancing science and technology, changing disease patterns, and the conditions and needs of medical practice

...the connection between the education of physicians and other health personnel

...the respective tasks of the pre-medical, medical, graduate, and post-graduate stages of medical education

...the administrative, academic, and financial relationships between medical centers and their university settings.

This set of contemporary problems has its origins in a broad underlying set of historical determinants which have brought medical education and its institutions to where they are today.

THE PREVAILING CONCEPTS:

The dominant ideas that influenced the development of medical education through the better part of the twentieth century derive from the creation of the Johns Hopkins School of Medicine, the development of the Rockefeller Institute, the university envelopment of medical schools promulgated by the Flexner Report, and the emergence of medical specialization. Thus, the past thirty-five years or so have been characterized not by the generation of new concepts for the further evolution of medical education and its institutional forms, but by the development of mechanisms for the implementation and conservation

of concepts that emerged in the first third of the century. These mechanisms include the large university-based medical center, the medical specialty boards, the support programs of foundations, and Federal agencies. There is now wide-spread questioning of the continued relevance of these ideas, unchanged, to the needs and opportunities of the present and prospective social scene.

THE ROLE OF THE FEDERAL GOVERNMENT:

The ascendant position of the Federal government in relationship to medical education and health services has been characterized by incremental enlargement of the scope and focus of its role and objectives. For the better part of the post-war period, Federal programs were limited by the fact that only in the support of research was there a clear national consensus concerning the Federal role. Prior to 1963 no such agreement existed in respect to medical education or health services. Not until the passage of the Health Professions Education Assistance Act in 1963, and the enactment of Medicare in 1965, did a consensus on Federal activity in these areas, however limited, emerge.

Thus, in a period of increasing social needs and wants in the health area, the sole basis of Federal action relevant to the national need in the health area was the advancement of medical research; and the single instrument of relationship between the Federal government and the medical schools was the support and expansion of their research functions. The consequences of this limited but intensive relationship have been many, both good and bad. It induced in the schools a pattern of growth and a series of stresses that limited their response to educational and service needs. The financial structure of medical education was distorted and the underlying and growing economic

instability of the institutions involved, obscured. A series of support mechanisms designed solely to serve research purposes and needs were developed, which forced artificial distinctions between the teaching, research, and service function of the institutions and which also tended to diminish institutional responsibility and integrity. These instruments and the funds which flow through them exert such a dominant force upon the structure and stability of medical schools that there is great apprehension about and reluctance, if not resistance, to any change in their nature. Now with the emergence of Federal programs aimed directly at the educational and health-service roles of these institutions there is both the need and the opportunity to completely reorganize the structure of support for the full range of medical school functions. A new structure of support mechanisms, that is built around the real nature of medical education and its functions and purposes, providing for the valid needs of the institution involved and serving directly and explicitly the national purposes and objectives sought, is an urgent requirement.

CONCERN WITH HEALTH SERVICES AND MANPOWER SHORTAGES:

The entire post-war scene has been characterized by rising public expectation that social wants and needs in major areas bearing upon the well being of individuals and the population at large will be met with increasing speed and dimension. This public expectation is now focusing with growing intensity upon the delivery of health services. This development, which is generating enormous pressures upon the structure and process of academic medicine, is in a very real

sense a consequence of the successful achievements of the original set of ideas that have dominated the evolution of academic medicine in the first two-thirds of this century. Through the progress of medical research, knowledge and technology are now available that can substantially diminish the burden of disease, disability, ill health, and the attendant suffering and pre-mature death with which people at large have long contended and for which medicine heretofore had little capability to offset. The growth of the academic medical center has engendered a widening public awareness of the growing difference between the level and quality of the medical care available therein and the quality of care and the availability of services that, in general, characterize the community scene. This circumstance coupled with the effects of the economic determinants in medicine which have skewed health services and resources toward wealth and ability to pay and their geographic locations and away from health needs, poverty and their location has led to increasing public demand that these deficiencies be corrected and that the full benefits of modern medicine be available to all. The first major steps in this direction were the enactment of the Medicare - Medicaid programs aimed at diminishing financial barriers to health services for the aged and the needy. These programs have, among other effects, dramatically revealed the inadequacy of present arrangements for the delivery of health services and particularly the critical shortages of health manpower, especially physicians.

The emergence of these problems has resulted in increasing inquiry being directed toward the relationship of the present structure and process of medical education:

...to the immediate and urgent needs for additional physicians
...to the problems and conditions of and need for change in the present forms and patterns of medical practice

...to the health needs and problems of the contiguous community and to community health and medical care generally.

Thus, the service functions of medical schools is increasingly the center of public attention in much the same way as the research function was the center of public interest until recently. There is an increasing demand for a new formulation of the role and responsibility of medical education and its institutions in the community setting, in contributing to the improvement of health services, and in responding to the quantitative demands for health manpower.

COSTS AND FINANCIAL REQUIREMENTS:

Medical education has long been the highest cost area of higher education both in terms of direct educational expenditures and the high opportunity costs of the long period of training required. These costs have increased at substantial rates and amounts throughout the post-war period. The inflation price-wage trends have been an important contribution to these increases. Perhaps of greatest influence, however, has been the effect of the enormous change in the complexity, content, and scope of the functions, programs, and facilities involved in medical education which is so well demonstrated by the magnitude and diversity of the present-day university medical center. Thus, present-day medical education is enveloped in an extraordinarily complex and inter-related set of educational, research, and

service activities serving many purposes and diverse public needs. This rapid expansion has been supported through many sources in which Federal funds have been increasingly dominant. There were three critical consequences of this expansion:

...the rate of growth and development has been so rapid that the basic instability of the funding of the educational function of the institutions involved has been for the most part obscured.

...the structure of programs and activities that developed are for the most part a reflection of national needs and purposes. They have been largely subtended by Federal funds and thus have inherently enlarged the Federal responsibility for the well being of the institution as a whole. The private and non-Federal role and responsibilities in the financing of medical education has become blurred.

...although Federal funds have been made available in highly restricted and categorized programs, the whole institution is so dependent upon the totality of this diverse flow of money that any diminishment of support for one program has immediate pervasive effects upon the integrity of the entire structure.

The continued importance of the nation's medical center to the accomplishment of many national purposes requires a more responsible plan for the further investment of public and private funds in the capital and operating requirements of these institutions.

GENERAL PLAN

The public importance of these matters, their implications for long-term public policy and expenditure, and their critical import for the stability and further development of a set of institutions of profound social significance requires a broad and thorough examination and assessment and a new formulation of public policy and programs of action . This review should be conducted by a group whose bona fides and sense of broad public responsibility cannot be faulted and which can be carried out in a setting free of official obligation and any implication of vested interests.

Thus it is proposed that a Commission on National Policy for Medical Education, comprised of eighteen members and a chairman be created. Half the members of the Commission would be chosen from outstanding leaders in medical and health affairs, and the other half comprised of individuals from other fields and distinguished in public affairs.

The creation of the Commission would be through joint action of the AAMC, AMA, AHA, APHA, the major foundations active in the health area, and the Department of Health, Education and Welfare. The funding of the Commission would also be through a similar joint arrangement.

A full-time staff to serve the Commission would be set up under the direction of ^acompetent and skilled director. The work of the Commission would involve the conduct of organized inquiry, extensive

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deliberation, data collection and analysis, culminating in the publication over a three-year period of a report or series of reports speaking to the purposes set forth above.

The first step in proceeding with the creation of such a Commission would be the establishment of an ad hoc committee of the parties to the joint arrangement to formulate and initiate the necessary implementary actions.

13 May 1970

MEMORANDUM

TO: Council of Deans
SUBJECT: National Health Insurance

The attached set of principles have been agreed to by the heads of the Committee on National Health Insurance for your consideration.

The Committee has assigned to each member one of the specific areas for further development and examination. These are now in the process of being collected and the staff will review the new material and another meeting will be called to consider the establishment of a final statement of policy.

This matter was reviewed by the Council of Teaching Hospitals and they took an action to recommend that an additional principle or two be added. These principles would deal with the capital investment required to sustain the system. By capital, here, we refer to start-up capital, work capital (which currently is inadequate), and risk capital. The Council felt that some statement ought to be made concerning a construction of finances that would foster rather than change, which could only take place in an adequate financed program.

John M. Danielson

JMD:ec

The Ad Hoc Committee on National Health Insurance of the AAMC supports the principle of National Health Insurance for all citizens as a significant opportunity to improve the health care of the American people. It must be recognized that such improvement in health care will not automatically follow the institution of National Health Insurance. Therefore, to insure improvement in health care, the plan adopted must be structured so as to provide incentives and support for a health care system with the following minimal characteristics:

1. Access to needed care without regard to economic circumstances of the individual.
2. Planned community programs providing a full range of services with appropriate attention to individual and group preventive measures.
3. Efficient and effective use of health resources.
4. Public accountability combined with appropriate balance between professional and consumer participation in program development.
5. Development and implementation of priorities for achievement of specific health goals established at national, state and local levels.
6. Provision for systematic evaluation with adequate flexibility to respond to changing opportunities and needs.
7. Recognition of the dependence of the system on the education of adequate numbers of health professionals and the continuous generation of biomedical knowledge.
8. Capitalize on the strength of the current system of financing health care and encourage appropriate substitution for the areas of weak financing recognizing that a single source of financing is self-limiting and a pluralistic financing system is preferable.

CHRONOLOGICAL LISTING OF THE
ACTIVITIES OF THE AAMC ON THE ISSUE
OF PART B PAYMENTS TO ATTENDING PHYSICIANS
IN TEACHING SETTINGS

March, 1969 The attention of the Senate Finance Committee was first focused on Cook County Hospital

April Intermediary Letter 372 published by S.S.A. (reaction to Senate pressures)

June Carriers started suspending payments to attending physicians in teaching settings

June Senate Finance Committee instructs staff to continue its investigations

June Representatives of medical schools began to exercise independent and frequent action with S.S.A. and Congressional representatives

July 1-2 Initial hearing by Senate Finance Committee on Medicare and Medicaid Abuses

July Dr. Cooper appoints an Ad Hoc Committee to coordinate the activity for AAMC constituency

July 24 First meeting of the President's Ad Hoc Committee. Major recommendations were to: (1) assess the extent of the problem; (2) establish Association Liaison with SSA; (3) to make recommendation to Mr. Tierney

August Appraisal by Dr. Cooper of the gravity of the situation to Dr. Egeberg

 Liaison developed with S.S.A.

 Mr. Danielson met with Mr. Constantine of the Senate Finance Committee. Meetings held with Mr. Hess and Mr. Tierney

 268 hospitals payments suspended

September Began developing a reinterpretation of Intermediary Letter 372 with S.S.A. officials. Attempted to establish a national policy for resumption of payments (Priority #1)

 Began work on back payment negotiations

PAGE TWO

September 30

HIBAC recommended to the Secretary HEW that "the department initiate an overall study of the financing of medical education"

October 23

Ad Hoc Committee met in Baltimore with officials of S.S.A. and HEW to make recommendation concerning resolution of the problem of payment to physicians for professional services in a teaching setting (recommendation attacked)

First breakthrough in resumption of payment negotiated at the University of Texas

Resumption of Payment letter to all carriers sent by S.S.A.

Annual Meeting of the AAMC - reporting hope of resolution

November

Continued meetings with S.S.A. and HEW staff on team approach and institutional review

First indication of V.A. Hospital involvement. The issue of V.A. full-time physicians assigned on service at Cook Hospital allowing their name to be used for Medicare billing as representing team billing

December

S.S.A. publish interpretation of Intermediary Letter 372 in form of "Questions and Answers". Much softer approach.

Meeting with NIH Committee to study the financing of Medical Education

90% Hospitals back on payments

Mr. Danielson visited with Wilbur Mills (Chairman House Ways and Means Committee) in Arkansas and was requested to present to the House Ways and Means Committee a position statement.

January, 1970

NIH representatives asked to advise S.S.A. on Part A and Part B payments.

Engaged Peat, Marwick and Mitchell as staff consultants

First draft of position paper on reimbursement of physicians in a teaching setting was presented to the Ad Hoc Committee

PAGE THREE

- January, 1970 Second draft sent to the entire Assembly for comment and review.
- Third draft sent to Executive Council and Committee.
- February 9 Publication of Senate Finance Committee Reports.
- February 25-6 Second Hearing on Medicare and Medicaid - Senate Finance Committee.
- March 16 Final draft presented at Executive Session of the House Ways and Means Committee by Drs. Chase, Nelson, and Shorey and Mr. Danielson.
- Intermediary Letter 70-9 Suspension of Part B Payments for Services Rendered by VA Physicians in Teaching Hospitals was published by SSA.
- Meeting with SSA Officials concerning their proposals for amendment to PL 89-97 presented to House Ways and Means Committee.
- March 17 Meeting of Liaison Committee between AAMC/BCA (major portion of agenda dealt with Medicare and Medicaid)
- March 23 Venneman proposed Part C as an amendment to PL 89-97.
- April 15-6 Hearings by Senate Finance Committee's Subcommittee on Medicare and Medicaid.
- Since a number of physicians in the teaching setting have indicated that they were not aware of bills submitted in their name, SSA issues a directive to carriers requiring any physician in the teaching setting that has his bills for medicare collected by an organization exclusive of the hospital, the physician must personally sign the 1490 bill.
- April 20 Negotiations immediately started to reverse this ruling or change it to make it less punitive. We were assured changes would be made.
- Holding for House Ways and Means Committee final report.
- April 25 Meeting with Mr. Doetch - personal lawyer to Mr. Long in New Orleans, LSU, Dr. Stewart, et. al.

PAGE FOUR

May 7 House Ways and Means Committee report out.

May 15 Private audience with Mr. Long, LSU Deans, et. al.

May 27 2:00 p.m., Formal appearance before Senate Finance
Committee.

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ADMINISTRATIVE LEGISLATIVE PROPOSAL TO PROVIDE
A PART C "HEALTH MAINTENANCE BENEFIT"

(1) The Medicare beneficiary would have the choice of continuing under the present Part A and B arrangements or electing Part C, where a health maintenance organization exists, which would bring together all the resources the Medicare patient needs.

(2) Under Part C a guarantee would be given to each enrollee by the provider, a health maintenance organization, that all services covered under Parts A and B of Medicare, plus preventive services will be available.

(3) This care would be provided under a health maintenance contract calling for payment of a fixed annual sum negotiated in advance at a price less than the government presently pays for conventional Medicare benefits in the locality.

(4) The Part C option could be designed to encourage the growth of Health Maintenance Organizations to serve Medicaid and private consumers, according to the proposal.

(5) Payments from Medicare would be directly negotiated and based on average payments under Parts A and B in the locality, taking account of cost differentials such as age.

SOME AREAS OF AAMC CONCERN

(1) One of the most serious areas of omission, within the specifications thus far presented, relates to the lack of funding of developmental or "risk" financing in support of the establishment of such comprehensive programs. Evidence which has been generated in those medical centers that have undertaken such activities indicates that the initial "start-up costs" are very substantial and well beyond the capability of the medical center to underwrite.

PAGE TWO

(2) The administration, in developing the concept of the health maintenance benefit program has also introduced a new reimbursement proposal. The proposed reimbursement mechanism would be contractual in nature and would call for payment of a fixed annual sum negotiated in advance at a price less than the government presently pays for conventional Medicare benefits in the locality.

(3) The reimbursement proposal indicates that payments from Medicare, for services rendered to beneficiaries would not only be directly negotiated, but that they would be based on average payments made under Parts A and B in the locality. Based upon recent experience in the state of New York and the development of hospital reimbursement on a prospective basis, it is very doubtful that geographic "averaging" of costs will provide an equitable pattern of reimbursement to teaching hospitals.

91st Congress }
2d Session }

COMMITTEE PRINT

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

PRESS RELEASE

Announcing Summary of Decisions
of the
COMMITTEE ON WAYS AND MEANS
With Respect to
AMENDMENTS TO THE SOCIAL SECURITY
ACT

Including Amendments to
THE OLD-AGE, SURVIVORS',
AND DISABILITY INSURANCE SYSTEM,
THE MEDICARE PROGRAM,
AND THE MEDICAID PROGRAM



MAY 4, 1970

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1970

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COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
1102 LONGWORTH HOUSE OFFICE BUILDING,
Washington, D.C. 20515.

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(II)

CHAIRMAN WILBUR D. MILLS (DEMOCRAT, ARKANSAS), COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES DECISIONS MADE BY THE COMMITTEE ON SOCIAL SECURITY, MEDICARE AND MEDICAID

The Honorable Wilbur D. Mills, (Democrat, Arkansas) Chairman Committee on Ways and Means, U.S. House of Representatives today announced the decisions made by the Committee on Ways and Means on the subject of Social Security, Medicare, and Medicaid for drafting purposes. The staffs have been instructed to prepare a draft embodying these decisions and bring it back to the Committee.

The decisions are as follows:

I. AMENDMENTS RELATED TO THE SOCIAL SECURITY CASH PROGRAM

1. CASH BENEFIT INCREASE

Social security payments to the 26.2 million beneficiaries on the rolls would be increased by 5 percent beginning with payments for the month of January 1971 (payable on February 3, 1971). This benefit increase will mean additional payments of \$1.7 billion in the first 12 months.

2. RETIREMENT TEST

The retirement test, which provides for reducing benefits of social security beneficiaries who have earnings would be amended by increasing the annual exempt amount from the present level of \$1,680 to \$2,000. For each \$2 of earnings up to \$3,200, a recipient's benefit would be reduced by \$1. For each \$1 of earnings over \$3,200 per year a beneficiary would lose \$1 in benefit payments. An additional \$47 million would be paid out for months in 1971 under this provision.

3. 100 PERCENT WIDOW'S AND WIDOWER'S BENEFIT AT AGE 65 AND REDUCED BENEFITS FOR WIDOWERS AT AGE 60

Under present law a full widow's (or dependent widower's) benefit applied for at age 62 or later is equal to 82½ percent of the primary insurance amount of the wage earner. An actuarially reduced benefit may be received by a widow at age 60. Under the bill a widow or widower would be entitled to a benefit equal to 100 percent of the

(1)

primary insurance amount if first applied for at age 65 or later. Benefits applied for between age 62 and 65 would be proportionately increased over the present 82½ percent rate according to the age of the applicant at the time of application. There are 3.3 million widows and widowers on the rolls who will receive additional benefits. \$700 million in additional benefit payments will be made in the first 12 months. In addition, widowers under age 62 would be granted the same privilege of applying for benefits on an actuarially reduced basis as now applies to widows.

4. AGE 62—COMPUTATION POINT FOR MEN

Under present law, the method of computing benefits for men and women differs in that all years of earnings up to age 65 must be taken into account in determining average wages for men, while for women, only years up to age 62 must be included. This discrepancy, which presently favors women over men, would be eliminated by applying the same rules to men as now apply to women. In the first 12 months, an additional \$925 million would be paid out. An estimated 10 million on the rolls on the effective date will receive larger benefits under this provision and in addition 60,000 persons—workers and their dependents not eligible under present law—will be added to the rolls.

5. ELIMINATE REDUCTION IN WOMEN'S BENEFITS IN CERTAIN CASES

Under present law, when a woman applies for a retirement benefit prior to age 65, it is computed under the actuarial reduction formula; if she later applies for a spouse's benefit, it is reduced in the same proportion as her retirement benefit. The bill would eliminate the actuarial reduction in such cases when the spouse's benefit is applied for. The same rule would apply to dependent husbands entitled to spouse's or widower's benefits. Approximately 100,000 beneficiaries would be affected by this provision, which will result in additional benefit payments estimated at \$12 million during the first 12 months.

6. DISABILITY BENEFITS FOR BLIND PERSONS

Under present law one of the general requirements for disability insurance benefits is that the disabled person must have worked 5 out of the 10 years before he becomes disabled. This requirement would be dropped for blind people. As a result a blind person could qualify for benefits when he had sufficient work to qualify for retirement benefits.

7. WORKMEN'S COMPENSATION OFFSET FOR DISABILITY INSURANCE BENEFICIARIES

Under present law a disability insurance beneficiary who also qualifies for workmen's compensation has his Social Security benefit reduced so that his combined payment will not be more than 80 percent of his average earnings before he became disabled. Under the bill the combined payments allowable would be raised to 100 percent of his average earnings.

8. MILITARY SERVICE CREDIT

Present law provides for a credit of \$100 a month, in addition to pay, for military service performed after 1967. This credit would also be provided for service provided from 1957, the date military service was covered under social security.

9. CHILDHOOD DISABILITIES

The ages at which a childhood disability could begin and qualify a person for child's benefits would be extended to include disabilities that begin after age 18 and before age 22.

10. OTHER AMENDMENTS

The Committee also adopted other amendments relating to Social Security coverage for policemen and firemen in Idaho, the coverage of Home Loan Bank employees, the coverage of certain self-employed persons paying taxes on a fiscal year basis, the treatment of earnings under the retirement test of persons in the year they attain age 72, and payment of disability insurance benefits on the basis of applications filed after the death of the disabled person.

11. FINANCING

In order to pay the additional cost of the new benefits provided and to meet the existing actuarial deficit in the hospital insurance (part A of Medicare) program, the tax base would be increased from \$7,800 a year to \$9,000 a year, starting January 1, 1971, and a new schedule of tax rates would be provided as follows:

(In percent)

	OASDI	HI
January 1, 1971	8.4	2
January 1, 1975	10.0	2
January 1, 1980	11.0	2

II. AMENDMENTS RELATED TO THE MEDICARE, MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

COVERAGE AND BENEFIT CHANGES UNDER MEDICARE

1. *Relationship Between Medicare and Federal Employees Benefits.*—No payment would be made under medicare for services covered under a Federal Employees Health Benefits plan effective with January 1, 1972, unless in the meantime the Secretary of Health, Education, and Welfare determines that the Federal Employees Health Benefits Program has been modified to make available coverage supplementary to medicare benefits and to assure that Federal employees reaching age 65 will continue to have the benefit of the government contribution towards health insurance.

2. *Hospital Insurance for the Uninsured.*—People **h**ing age 65 who are ineligible for hospital insurance benefits under medicare

would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare, provided that those who enroll must pay the full cost of the protection—\$27 a month at the beginning of the program, rising as hospital costs rise. States and other organizations would be permitted to purchase such protection on a group basis for their retired employees age 65 or over.

3. *Health Maintenance Organization Option.*—Individuals eligible for both Part A and Part B medicare coverage would be able to choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). The government would pay for such coverage on a capitation basis not to exceed 95% of the cost of medicare benefits provided to beneficiaries in the area not covered under the health maintenance organization.

IMPROVEMENTS IN THE OPERATING EFFECTIVENESS OF THE MEDICARE, MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS

1. *Limitation on Federal Payment for Disapproved Expenditures.*—Reimbursement amounts to providers of health services under medicare, medicare, and maternal and child health for capital costs, such as depreciation and interest, would not be made with respect to capital expenditures (in excess of \$100,000) which are inconsistent with state or local health facility plans.

2. *Experiments and Projects in Prospective Reimbursement and Incentives for Economy.*—The Secretary of Health, Education, and Welfare would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under medicare, medicaid and maternal and child health. In addition, the Secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy, and with community-wide utilization review mechanisms.

3. *Limits on Costs Recognized as Reasonable.*—The Secretary of Health, Education, and Welfare would be given authority to establish and promulgate limits on provider costs to be recognized as reasonable under medicare based on comparisons of the cost of covered services by various classes of providers in the same geographical area. Hospitals and extended care facilities could charge beneficiaries for the care not covered (except in the case of an admission by a physician who owns an interest in the facility).

4. *Limitation on Recognition of Physician Fee Increases.*—Charges determined to be reasonable under the present criteria in the medicare, medicaid, and maternal and child health law would be limited by providing: (a) that for fiscal year 1971 medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during calendar year 1969; (b) that for fiscal year 1972 and thereafter the prevailing charge levels recognized for a locality may be increased, on the average, only to the extent justified by increases in the cost of production of medical services, levels of living and the earnings of other professional, managerial and technical personnel; and (c) that for medical supplies, equipment and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges allowed

as reasonable may not exceed the lowest levels at which such supplies, equipment and services are widely available in a locality.

5. *Changes in Federal Matching Percentages with Respect to Certain Services.*—The Federal medicaid matching for certain outpatient services would be increased and the Federal matching with respect to long-term institutional care would be decreased and certain other limitations would be imposed. Specifically, (1) the Federal matching percentage for outpatient hospital services, clinic services and home health services would be increased by 25 percent; (2) the Federal percentage after the first 60 days of care in a general or TB hospital would be reduced by one-third; (3) the Federal percentage after the first 90 days of care in a year in a skilled nursing home would be reduced by one-third; (4) the Federal matching for care in a mental hospital after 90 days of care would be reduced by one-third and no Federal matching would be available after 275 days of such care during an individual's lifetime; and (5) the Secretary would be authorized to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

6. *Payments for Services of Teaching Physicians.*—Medicare and medicaid would not pay for the services of teaching physicians unless other patients who have insurance or are able to pay are also charged for such services and the medicare deductibles and coinsurance amounts are regularly collected. Medicare ~~attached~~ payment would be authorized for services to hospital patients by staff of certain medical schools that now furnish these services without charge to the hospital.

7. *Termination of Payments to Providers Who Abuse the Medicare Program.*—The Secretary of Health, Education, and Welfare would be given authority to terminate or suspend payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. Program review teams would be established to furnish the Secretary professional advice in carrying out this authority.

8. *Repeal of Medicaid Provision Requiring Expanded Programs.*—The requirement in present law that States have comprehensive medicaid programs by 1977 would be repealed.

9. *State Determination of Reasonable Hospital Costs.*—States would be permitted to pay hospitals on the basis of their own determination of reasonable cost, provided there is assurance that the medicaid program would pay the actual cost of coverage of hospitalization of medicaid recipients.

10. *Government Payment No Higher Than Charges.*—Payments for services under the medicare, medicaid, and maternal and child health programs would not be higher than the charges regularly made for those services.

11. *Institutional Budgeting.*—Health institutions under these programs would be required to have a written plan reflecting an operating budget and a capital expenditures budget.

12. *Federal Matching for Modern Claims Processing Systems.*—Federal matching at the 90-percent rate would be available under medicaid for the states to set up mechanized claims processing and informational retrieval systems. Federal matching for the continuous operation of such systems would be at the 75-percent rate.

13. *Guarantee of Payment for Extended Care Services.*—The Secretary of Health, Education, and Welfare would establish specific periods

of time (by medical condition) after hospitalization during which a patient would be presumed to require extended care level of services in an extended care facility. Similar provision would be made for post-hospital home health services.

14. *Prohibition of Reassignments.*—Medicare and medicaid payments to anyone other than a patient or his physician would be prohibited, unless the physician is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

15. *Utilization Review in Medicaid.*—Require hospitals and skilled nursing homes participating in the medicaid and maternal and child health programs to have the same utilization review committee with the same functions as in the medicare program.

16. *Medicaid Deductibles for the Medically Indigent.*—States would be permitted to impose a flat deductible or cost sharing provision with respect to people eligible under medicaid programs but not eligible for cash public assistance payments. (Present law requires such deductible or cost sharing to vary directly with the amount of the recipient's income.)

17. *Stopping Payment Where Hospital Admission Not Necessary.*—If the utilization review committee of a hospital or extended care facility in its sample review of admissions finds a case where institutionalization is no longer necessary, then payment would be cut off after 3 days. This provision parallels the provision in present law under which long-stay cases are cut off after 3 days when the utilization review committee determines that institutionalization is no longer required.

18. *Role of State Health Agencies in Medicaid.*—State health agencies would be required to perform certain functions under the medicaid and maternal and child health programs relating to the quality of the health care furnished to recipients.

MISCELLANEOUS AND TECHNICAL AMENDMENTS

1. *Retroactive Coverage Under Medicaid.*—States would be required to cover under medicaid the cost of health care provided to an eligible individual during the 3-month period before the month in which he applied for medicaid.

2. *Certification of Hospitalization for Dental Care.*—A dentist would be authorized to certify to the necessity for hospitalization to protect the health of a medicare patient who is hospitalized for noncovered dental procedures.

3. *Christian Science Sanitoria under Medicaid.*—Christian Science sanitoria would be exempted from the Medicaid requirement that they have a licensed nursing home administrator and from other inappropriate skilled nursing home requirements.

4. *Physical Therapy Services Under Medicare.*—Under medicare's supplementary medical insurance program, beneficiaries would be covered for up to \$100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's prescription. Hospitals and extended care facilities could continue to provide covered physical therapy services

to inpatients who have exhausted their days of hospital insurance coverage. Where physical therapy is furnished under contractual arrangement with a hospital or extended care facility medicare reimbursement to the institution will in all cases be based on a reasonable salary payment for the services.

5. *Grace Period for Paying Medicare Premium.*—Where there is good cause for a medicare beneficiary's failure to pay supplementary medical insurance premiums, an extended grace period of 90 days would be provided.

6. *Extension of Time for Filing Medicare Claims.*—The time limit for filing supplementary medical insurance claims would be extended where the Medicare beneficiary's delay is due to administrative error.

7. *Enrollment Under Medicare.*—Relief would be provided where administrative error has prejudiced an individual's right to enroll in medicare's supplementary medical insurance program. Eligible individuals would be permitted to enroll under medicare's supplementary medical insurance program during any prescribed enrollment period and would no longer be required to enroll within 3 years following first eligibility or a previous withdrawal from the program.

8. *Waiver of Medicare Overpayment.*—Where incorrect medicare payments were made to a deceased beneficiary, the liability of survivors for repayment could be waived if the survivors were without fault in incurring the overpayment.

9. *Medicare Fair Hearings.*—Fair hearings, held by medicare carriers in response to disagreements over amounts paid under supplementary medical insurance, would be permitted only where the amount in controversy is \$100 or more.

10. *Collection of Medicare Premium by the Railroad Retirement Board.*—Where a person is entitled to both Railroad Retirement and Social Security monthly benefits, his premium payment for supplementary medical insurance benefits would be deducted from his Railroad Retirement benefit in all cases.

11. *Medicare Benefits for People Living Near U.S. Border.*—Medicare beneficiaries living in the United States close to the U.S. border would get covered care if the hospital they use is in Canada or Mexico and is closer to their residence than a comparable hospital in the U.S.

12. *Chiropractors' Services.*—The existing ~~Advisory Council on Social Security~~ would be required to study the feasibility of covering chiropractic services under Medicare. The Council would have a chiropractor appointed to the Council for this purpose and would devise an experiment under Medicaid to test the effects of a very limited form of such coverage.

Secretary of

**ASSOCIATION OF
AMERICAN MEDICAL COLLEGES**

**TEACHING HOSPITAL MEDICAL STAFF
ORGANIZATION**

PRINCIPLES FOR REIMBURSEMENT



Peat, Marwick, Mitchell & Co.

April 1970

PEAT, MARWICK, MITCHELL & Co.

1025 CONNECTICUT AVE., N. W.

WASHINGTON, D. C. 20036

May 6, 1970

Mr. John M. Danielson
The Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle
Washington, D.C.

Dear Mr. Danielson:

Peat, Marwick, Mitchell & Co. is submitting this final report which will complete the contractual requirements of our engagement with the Association of American Medical Colleges, relating to the payment of professional services rendered in teaching hospitals under Public Law 89-97. The final report contains a Preamble and a Statement of Principles for the AAMC. Appended to this document are teaching hospital staff organization patterns and hospital objectives and approaches to expenses and revenues.

The engagement approach was to utilize Peat, Marwick, Mitchell & Co. consultants, in conjunction with AAMC personnel, who have experience with teaching hospitals and the administration of P.L. 89-97. Preliminary documents were submitted to an advisory committee following which recommended changes were made. For determining the medical staff organization, PMM&Co. developed a matrix and visited six teaching hospital settings to test its viability.

It is our understanding that the Statement of Principles will be further reviewed by AAMC officials.

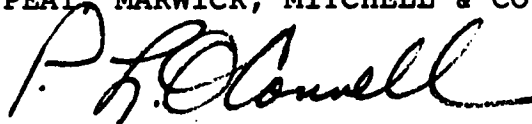
Mr. John M. Danielson
The Council of Teaching Hospitals

May 6, 1970
-2-

Because of the importance of the nation's teaching hospitals in providing the setting for services to patients, clinical education, and research, may we take this opportunity to compliment the AAMC for the leadership it has demonstrated in postulating these principles.

Sincerely,

PEAT, MARWICK, MITCHELL & CO.



Philip L. O'Connell
Principal

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I. BACKGROUND

The second half of the twentieth century has brought the controversies of progress to the American medical scene. The public is generally aware of the giant strides that American medical knowledge has made in relieving many aspects of human suffering. As a result, the demand for medical services has risen sharply which, in turn, has created some serious problems, including how to:

- . prepare more and better educated medical professional personnel;
- . improve the use of available financial, personnel, and facility resources;
- . develop a better system for the delivery of health and medical care;
- . make high quality health and medical care available to everyone;
- . provide programs and services to all at a price they can afford to pay.

The controversies that arise, relating to these problems are:

- . determining the degree of government involvement in health and medical affairs;
- . developing leadership for solution of problems in the health care field;
- . establishing closer working relationships between doctors and hospitals for dealing with health and medical care problems in the community;
- . developing a master plan to guide the implementation of innovative programs for controlling resources while providing

services to patients, education of medical personnel, research in medical sciences, management systems of health affairs, and information systems for evaluating current and future program effectiveness; and

- . determining the objectives for a health care system and the roles of practitioners and institutions in their communities.

The Senate Finance Committee recently prepared a report which confronted the teaching hospitals and the schools of medicine with these problems and controversies. The report, in part, centers upon the payment for services rendered by the medical staff of a teaching hospital under Public Law 89-97. It indicates that, in some instances, the manner in which the medical staff is organized to provide patient care does not comply with the requirements for payment. There are professional health and medical services rendered for patients in teaching hospitals which, under any rule of equity, should be eligible for payment. The question is whether the medical staff is organized, as pertains to P.L. 89-97, in a manner that makes it eligible to receive payment for those services rendered.

It should be pointed out that patients have the right of choosing a physician to personally provide their care under this law. Further, they have the right, under the law, to choose the institution and method whereby this professional service is rendered. Whether the services in a setting are or should be personally provided, is part of the controversy. It also should be noted that clinical education of students, interns, and residents is involved in this consideration. Further, the financial solvency of the hospital in obtaining revenue for its operation from these services is a major concern.

Thus the membership of the Association of American Medical Colleges (AAMC) has much at stake in the satisfactory resolution of these problems. AAMC leadership, therefore, is essential to any consideration of:

- . altering the organization of the medical staff of the teaching hospital;
- . altering the existing administrative regulations of P.L. 89-97; and
- . amending the law itself.

First, the AAMC must take a general policy position affecting the medical staff organization of teaching hospitals. Second, the AAMC staff must speak for its member hospitals in working out solutions to problems related to P.L. 89-97 with governmental officials. On the one hand, AAMC must consider the financial requirements of the hospital and its medical staff. On the other hand, its policies should not restrict the opportunities of a teaching hospital to consider alternative methods of staff organization to deliver services, nor should they interfere with the development of innovative educational relationships of the medical staff with students, interns, and residents. Accordingly, the principles set forth in this report are, in effect, standards upon which AAMC members can seek agreement and which may alleviate the problems which governmental officials face in administering P.L. 89-97 including payment for services rendered.

The member institutions of the AAMC should recognize that the parent organization must establish a policy that sets forth alternative ways in which a medical staff may be organized to provide patient services in a teaching setting while complying with the requirements of P.L. 89-97. In addition, the AAMC should assume a leadership role in improving the nation's health and medical system. An action-oriented program for comprehensive health planning in each region served by a teaching hospital appears essential in view of the national crisis in the delivery of health services.

During the engagement, Peat, Marwick, Mitchell & Co. worked closely with the AAMC staff in developing background materials for a Statement of Principles that would be used as a guide for the organization of medical staffs of teaching hospitals. To support the discussion of the advisory committee appointed by the President of the AAMC, additional

documents were developed to illustrate several of the approaches that AAMC could consider in determining principles. The first of these documents is a categorization of existing patterns of teaching hospital staff organization and hospital governing control, and appears in this report as Appendix A. In the second document, Appendix B, broad objectives for a teaching hospital are presented, and approaches to the isolation of hospital and professional expenses and revenues are developed. The purpose of this document is to initiate discussions about the flow of money in the hospital as it provides services and education and research programs.

To illustrate when payment may be made for professional services performed by the medical staff and the associated staff, we have prepared a matrix and included it as Appendix C.

Section II presents the Statement of Principles. These principles were reviewed and rewritten as a result of staff conferences and the advisory committee meeting. Incorporated in the Statement of Principles is a definition of terms and a Preamble which states the issues to which the principles are directed.

Since PMM&Co. has an active interest in and concern for the nation's health care programs, it has been a distinct pleasure to work with the AAMC on this project, and we offer our continued interest and service as it may be needed in the future.

II. STATEMENT OF PRINCIPLES

Preamble

The Association of American Medical Colleges' (AAMC) Statement of Principles is structured upon Section 1392 of P.L. 89-97, wherein it is stated:

Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

AAMC believes this guarantee of freedom of choice and acceptance should be extended to all patients in the nation.

Teaching hospitals have a special role and responsibility in the delivery of health care and the education and training of health professionals. The nation looks to them for excellence in the provision of care. Teaching hospitals are expected to provide highly skilled personnel and a broad spectrum of programs and services, education, and research. They provide the setting for the major part of the education and training of the nation's physicians and other health professionals. These obligations place an unusually heavy financial burden upon the teaching hospital.

The patient turns to the teaching hospital for a high level of health and medical services, which are unusually complex, scientifically advanced, and costly in nature, to meet his special needs. In meeting these needs, the hospital and the physician are ultimately legally and morally responsible for the quality of care which the patient receives; and to provide for this care, the hospital must maintain a qualified medical staff. In the teaching hospital, this medical staff may be organized in a variety of ways to encompass its responsibilities for services to patients, education, and research.

The availability of patients through the practice of medicine by the medical staff is essential to the education of health personnel and is important to the development of health manpower. In addition, the practice of the teaching staff is important to the community because teaching physicians are in the forefront of the knowledge of medical sciences.

Statement of Principles*

These principles are written to clarify the organizational relationships in the teaching hospital. They define certain necessary financial relationships of the hospital, its medical staff and associated staff, to assist and support them in their educational as well as patient care activities.

1. In any legislation dealing with health care, it is essential that research and development, innovation, and demonstration of new methods for the delivery of health care services be promoted. At the same time, it is important to experiment with and evaluate new methods of payment for such services.

In developing alternative methods of organizing the teaching hospital medical staff along different delivery patterns, payment for hospital and professional services should be commensurate with the effort incurred in the rendering of that service. For example, ways could be designed to render "units of service" and payment made for these "units of service" based on reasonable charges. The hospital and its medical staff should be supported in developing ways to extend the quantity, quality, and equality of health care to all socio-economic levels of society.

* It is to be emphasized that these principles relate to the teaching hospital and its medical staff and not to the medical school itself, except as the medical school faculty participates in the delivery of medical care.

2. Every patient admitted to the hospital has the right to the personal services of a responsible physician on the hospital medical staff, in charge of his diagnosis and therapy.

The Association of American Medical Colleges concurs that this is necessary to insure the highest quality of care possible for the patient. It is also necessary for establishing responsibility for the management of the care and for payment of professional fees. This patient-physician relationship should also exist because of medical-legal problems which extend from out-patient, emergency, and continuing hospital medical care. Further, it is necessary for the conduct of medical education, which increasingly will involve the private patient-medical staff relationship.

3. The teaching hospital's medical staff should be organized as a team to provide continuous, direct, and personal care to patients and should develop organizational methods which guarantee appropriate access for patients, as well as availability of on-call and emergency services.

Every patient has the freedom to choose the arrangements under which he will receive medical care. Included is the right to all of the advantages which accompany a close relationship between the responsible physician and his associated staff in education as well as practice.

4. A charge should be made for all hospital and professional services rendered to patients.

Improvements in the payment for medical services, while still not adequate, have affected the relationships among patient, doctor, hospital, and the payor. Since there are increasingly fewer individuals without some form of health insurance, this change in relationships requires development of a greater

understanding between hospital and medical staff organizations relative to hospital costs and professional charges. The payors must also recognize the implications of inadequate reimbursement for patient care in the teaching setting.

5. Any member of the hospital medical staff rendering professional services to the patient is eligible for payment for such services. The medical staff and associate staff should be organized for rendering services to patients in a manner which will allow accountability for charges submitted. The senior resident and/or chief resident may be considered eligible for appointment to the medical staff with appropriate limitations on his privileges.

Since the medical staff of the teaching hospital is departmentalized and the associated staff is assigned along these departmental lines, all physicians restrict their practices to a greater or lesser degree. It follows that the senior resident and/or chief resident can accept responsibility for the medical care of patients within limits set by the senior medical staff members who are responsible for the conduct of his education, training, and experience. Senior and chief residents may be assigned responsibilities similar to those of the attending physician personally assisting interns and other residents with the care of patients. They may render consultations.

6. As an acceptance of public accountability, the teaching hospitals and medical staff agree that a professional audit of patient records and other pertinent documents should be continued and that documentation describing professional services rendered be incorporated into the patient's medical record.

7. The teaching hospital must have adequate financial resources for current operations, new and/or expanded programs as well as capital uses.

The teaching hospital's expansion of scientific competence is in direct response to the growth of the body of medical knowledge. This growth imposes new requirements for space, equipment, and personnel to bring to patients the best in modern medical care.

The special nature of the teaching hospitals in their capacity of providing high quality, frequently innovative medical care, in providing an environment for teaching and scientific research, and in setting standards of excellence, have caused the costs of providing care in these hospitals to rise. As the hospitals attempt to meet the increase in public demand for services, and as they meet expanding modern scientific standards, requiring more highly skilled personnel, this trend is expected to continue. At the same time, however, teaching hospitals have a special obligation to improve the management of patient care, to maximize the use of available resources, and to minimize the patient's length of stay.

The teaching hospital is the environment in which medical scientific knowledge and skills are translated into innovations in methods and equipment for the delivery of high quality medical care. Growing specialization in medicine requires greater coordination of patient care management to avoid undue fractionation. However, new or expanded programs or services should be related to the demonstration of need.

Definition of Terms

1. Personally Rendered Professional Services

In the teaching hospital, the quality of care rendered to all patients should not be determined by economic status or the method of entry into the health care system. Each has a responsible physician who personally rendered care.

The responsible physician may utilize the professional services of the associated staff or other staff members, creating a team-of-physicians approach to patient care. To qualify for billing and collecting the professional fees for such services, there should be evidence that the responsible physician has personally rendered the care having reviewed and coordinated all care rendered by the team. Further, during technical procedures, such as surgical operations, the responsible physician must be present even though he may not be the operating surgeon of record. This means that the patient is informed of the team members. It is understood that, as a member of the team, the responsible physician may only observe the procedure, being immediately available to perform the surgery if needed.

"Personally rendered professional services" also includes those services provided by a member of the hospital medical staff, at the request of the patient's responsible physician, and with the patient's knowledge. It is necessary that an opportunity be provided to make a unit charge for the total service rendered in the diagnosis, treatment and follow-up of an episode of disease. In the teaching hospital, the unit of service involves the medical care team and the reimbursement should be negotiated to cover appropriate charges for the care rendered.

2. Medical Staff Patient

A patient who has chosen a member of the hospital's medical staff, or has accepted a practicing physician

assigned by the medical staff of the hospital to personally provide and be responsible for his medical care. Assignment of a physician is accomplished in accordance with established policies and procedures agreed upon by the medical staff and the hospital.

3. Attending Physician

A physician who has been appointed by the hospital to the hospital's medical staff, to personally provide and be responsible for the care of the patients.

4. Responsible Physician

A physician who has been appointed to the hospital's medical staff who assumes the responsibility for providing or observing personally the medical care of his patients. The responsible physician may be a faculty member, a chief resident, senior resident or any other member of the medical staff.

5. Eligible

Professional fees may be billed for services rendered by the medical staff. Professional fees may be billed for services rendered by the associated staff when a responsible physician is personally present.

6. Associated Staff

The interns, assistant residents, residents, senior residents and chief resident physicians who are appointed to the hospital's approved teaching programs by the medical school faculty, the hospital's medical staff and the hospital.

7. Assistant Resident

A physician who has been appointed to the hospital's graduate education staff but has not yet attained the final year or two years of specialty qualifications (as described in #8 below).

8. Resident

A physician who has been appointed to the hospital's graduate education staff and has attained:

- a. Final year of a two- or three-year program, or
- b. The final two years of a four-year or longer program.

9. Senior Resident

A resident physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He may be appointed to the hospital's active medical staff for an appropriate period according to the policy of the hospital. He has the training chronology of the chief resident on the specialty service, but does not have that designation.

10. Chief Resident

A resident physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He can be appointed to the hospital's active medical staff for an appropriate period according to the policy of the hospital. The designation of chief resident and the selection of the chief resident is a function of the medical school faculty, the hospital's medical staff, and the hospital.

11. Medical Care Team

As referred to in these principles and accompanying documents, the team consists of a responsible physician from the hospital's medical staff working with one or more members of the associated staff. The team in special care situations may also include other members of the hospital's medical staff working with the responsible physician and members of the associated staff.

APPENDICES

APPENDIX A

Principal Medical Staff Organization Patterns

Pattern I

- I. Hospital medical staff
 - A. Composition
 - . Clinical faculty of the medical school only
 - B. Payment
 - . Salaried by the medical school
- II. Hospital associated medical staff
 - A. Payment alternatives
 - . Salaried by the medical school
 - . Salaried by the hospital
- III. Hospital ownership alternatives
 - A. Owned by university
 - B. Owned by another organization
 - . Private, non-profit
 - . Government - state, county, local

Pattern II

- I. Hospital medical staff
 - A. Composition
 - . Clinical faculty of the medical school only

B. Payment

- . Partially salaried by the medical school
- . Partial fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

- . Salaried by the medical school
- . Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

- . Private, non-profit
- . Government - state, county, local

Pattern III

I. Hospital medical staff

A. Composition

- . Clinical faculty of the medical school
- . Attending staff with medical school appointment

B. Payment alternatives

- . Clinical faculty - salaried by the medical school
- . Clinical faculty - partially salaried by the medical school

- . Clinical faculty - partial fee-for-service arrangement
- . Attending staff - salaried by the medical school
- . Attending staff - partially salaried by medical school
- . Attending staff - partial fee-for-service arrangement

II. Hospital associated medical staff

A. Payment Alternatives

- . Salaried by the medical school
- . Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

- . Private, non-profit
- . Government - state, county, local

Pattern IV

I. Hospital medical staff

A. Composition

- . Clinical faculty of the medical school
- . Attending staff with medical school appointment
- . Attending staff without medical school appointment

B. Payment alternatives

- . Clinical faculty - salaried by the medical school
- . Clinical faculty - partially salaried by the medical school
- . Clinical faculty - partial fee-for-service arrangement
- . Attending staff with medical school appointment - salaried by the medical school
- . Attending staff with medical school appointment - fee-for-service arrangement
- . Attending staff without medical school appointment - fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

- . Salaried by the medical school
- . Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

- . Private, non-profit
- . Government - state, county, local

Pattern V

I. Hospital medical staff

A. Composition

- . Clinical faculty of the medical school
- . Attending staff without medical school appointment

B. Payment alternatives

- . Clinical faculty - salaried by the medical school
- . Clinical faculty - partially salaried by the medical school
- . Clinical faculty - partial fee-for-service arrangement
- . Attending staff - fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

- . Salaried by the medical school
- . Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

- . Private, non-profit
- . Government - state, county, local

Pattern VI

I. Hospital medical staff

A. Composition

- . Clinical faculty of the medical school
- . Hospital appointed full-time or part-time staff

B. Payment alternatives

- . Clinical faculty - salaried by the medical school
- . Clinical faculty - partially salaried by the medical school
- . Clinical faculty - partial fee-for-service arrangement
- . Hospital staff - salaried by the hospital
- . Hospital staff - partially salaried by the hospital
- . Hospital staff - partial fee for service arrangement
- . Hospital staff - percentage of revenue

II. Hospital associated medical staff

A. Payment alternatives

- . Salaried by the medical school
- . Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by the university

B. Owned by another organization

- . Private, non-profit
- . Government - state, county, local

Pattern VII

I. Hospital medical staff

A. Composition

- . Clinical faculty of the medical school
- . Hospital appointed full-time or part-time staff
- . Attending staff without medical school appointment

B. Payment alternatives

- . Clinical faculty - salaried by the medical school
- . Clinical faculty - partially salaried by the medical school
- . Clinical faculty - partial fee-for-service arrangement
- . Hospital staff - salaried by the hospital
- . Hospital staff - partially salaried by the hospital
- . Hospital staff - partial fee-for-service arrangement
- . Hospital staff - percentage of revenue
- . Attending staff - fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

- . Salaried by the medical school
- . Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by the university

B. Owned by another organization

- . Private, non-profit
- . Government - state, county, local

Pattern VIII

I. Hospital medical staff - non-university

A. Composition

- . Attending staff of neighboring medical school
- . Attending staff without medical school appointment

B. Payment

- . Fee-for-service arrangement

II. Hospital associated medical staff

A. Payment

- . Salaried by the hospital

III. Hospital ownership alternatives

- A. Private, non-profit
- B. Government - state, county, local

Pattern IX

- I. Hospital medical staff - non-university
 - A. Composition
 - . Full-time hospital staff
 - B. Payment
 - . Salaried by the hospital
- II. Hospital associated medical staff
 - . Salaried by the hospital
- III. Hospital ownership
 - . Private, non-profit

Pattern X

- I. Hospital medical staff - non-university
 - A. Composition
 - . Hospital full-time chiefs of staff
 - . Attending staff
 - B. Payment alternatives
 - . Hospital full-time chiefs - salaried by the hospital

- . Hospital full-time chiefs - percentage of revenue
- . Attending staff - fee-for-service arrangement
- II. Hospital associated medical staff
 - A. Payment
 - . Salaried by the hospital
- III. Hospital ownership
 - A. Private, non-profit
 - B. Government - state, county, local

Pattern XI

- I. Hospital medical staff - non-university
 - A. Composition
 - . Attending staff
 - B. Payment
 - . Fee for service
- II. Hospital associated medical staff
 - A. Payment
 - . Salaried by the hospital
- III. Hospital ownership
 - A. Private, non-profit

APPENDIX B

Teaching Hospital Organization

Assumptions Regarding Hospital Objectives

1. The primary objective of a teaching hospital is to provide the clinical setting for the delivery of health and medical care to patients and for the education of health manpower.
2. Research in the basic medical sciences and laboratory clinical sciences is a secondary objective of a teaching hospital. Research should be considered as a program for the hospital, within readily available facilities and financial resources designated for that purpose. Monies for research should not be considered as hospital revenue.
3. The hospital intends to assure itself, the university, and the public that it can maintain a stable financial position as a not-for-profit institution. Further, it seeks to demonstrate that it must operate from revenues derived from providing services to patients.
4. The hospital seeks to provide space, equipment, and health manpower for rendering care to patients.
5. The hospital, through its relationship with the medical school, seeks to collaborate in carrying out educational programs for health manpower as far as its resources will permit.
6. To carry out its objectives in patient care and education, the hospital must have an organized medical staff.

Problems Encountered in Meeting Objectives

1. With rising payroll, equipment, modernization, and replacement costs, the hospital is having increasing difficulty in meeting financial obligations in view of the level of money resources available to it.
2. The hospital would like to control costs. At the same time, it would like to expand programs and services to patients and staff.
3. The hospital is facing major problems in obtaining capital funds for modernization, replacement, and new construction.
4. As scientific medical knowledge has expanded dramatically, the hospital has increasing responsibility for providing proper medical staff coverage for all patients, at all times.
5. Operating income shortages require the hospital to explore all means of controlling expense and collecting all revenues to which it is entitled. The restrictions under P.L. 89-97 on payment for professional services provided by the associated staff, the faculty, and the attending staff require careful planning and full cooperation between the hospital, its medical staff, and the medical school.

Steps to be Considered in Solving These Problems

1. Define the elements of the hospital's financial position. In order to approach full reimbursement or direct pay for expenses incurred in the operation of the hospital, the full identification of costs and revenues must be refined. These principles are established for hospitals in the American Hospital Association's (AHA) Statement on Financial Requirements of Health Institutions and Services and are supported by the AHA Chart of Accounts.

a. Hospital Operating Costs

Hospital operating costs would include salaries and benefits of all professional and administrative personnel, space, equipment, overhead, and maintenance for:

1. All services rendered to patients.
2. Education of the public and education of health manpower.
3. Research in basic and clinical sciences and in delivery of health care.
4. The administration of patient service, education, and research programs.
5. Certain renovations of the physical plant necessary for operating these programs.
6. Debts which have been incurred in operating the hospital's programs.

b. Hospital Revenue

The identification of all funds available for the operation of the programs of the hospital is necessary to determine the final allocation of monies, from each source, to meet the expenses of the hospital.

1. All revenues personally paid by patients; reimbursement from third-party payors, Blue Cross, Blue Shield, Medicare, Medicaid, Compensation; government allowances for own-paying or partially paying patients; government or other allowances or subsidies for support of hospital patient operations; endowments or special funds used in providing services to patients.

2. All funds from tuition; endowment; foundation; government or private subsidy, gifts, or support; grants; allowances from third-party payors for expenses incurred in the hospital's educational program.
3. Endowments, gifts, subsidies, and allowances from third-party payors or governments; grants or other funds used for research.

c. Capital Funds of the Hospital

Capital funds of the hospital for replacement, renovation, modernization, or expansion of the physical plant; for operation of existing programs; or for development of new ones must be identified.

1. Endowments, gifts, and allowances for capital use.
 2. Funded depreciation.
 3. Funds from grants or foundations.
 4. Monies from governmental or other public or private sources for capital use.
 5. Funds available from borrowing.
2. Define the costs of educational programs which are hospital expenses. All the educational programs which are expenses to the hospital should be listed, including internship, residency, continuing education, nursing, medical technology, X-ray technology, etc.
- a. Classroom, laboratory and, didactic instruction.
 - b. Teaching patient rounds, case studies, and similar patient teaching exercises.

- c. Grand rounds and clinical conferences.
 - d. Records review of clinical experience.
 - e. Library, reading, writing papers, and other similar assignments.
 - f. Salaries, equipment, space, overhead, maintenance, and administration of program.
 - g. Time of associated staff and medical staff, nursing staff, etc., spent in the hospital for teaching and administration of teaching programs.
3. Define the reimbursable professional services for rendering in-patient care.
- a. Daily and special rounds for patient care.
 - b. Consultations for patients.
 - c. Special examination and technical procedures on patients.
 - d. Diagnostic tests on patients.
 - e. Treatments, operations, and procedures for therapy of patients.
4. Define the reimbursable hospital services for rendering in-patient care (including acute short-term care, emergency unit care, and intensive care).
- a. Hospital technical and professional services, nursing, dietary, and supportive therapies.
 - b. Bed care services of patients.
 - c. Ancillary services of laboratory, X-ray, etc., used for in-patients.

- d. Administrative support elements of patient care, including personnel, purchasing, shipping, receiving, stores, maintenance, house-keeping, clerical, business, and other general administrative support.
 - e. Salaries, equipment, space, and overhead.
5. Define the reimbursable services for rendering out-patient care. The ambulatory care, clinic care, or office care of patients is related more to professional service cost and revenue.
- a. Time of the medical staff and the associated staff spent in the out-patient department, in rendering services to patients, and in education in the out-patient department, including administration of services and education.
 - b. Ancillary services of laboratory, X-ray, etc., for care of out-patients.
 - 1. Allocate revenues and expenses of caring for in-patients in the out-patient department and back to the hospital in the in-patient department.
 - 2. Salaries, space, equipment, maintenance, and overhead of out-patient services.
 - 3. General administrative support of out-patient services.
6. Define the hospital's in-patient department arrangement for management of revenue derived from medical professional services of both the associated staff and the medical staff and the related expense. Relate these to the expense of professional salaries.

7. Define the hospital's out-patient department arrangement for the management of revenue derived from medical professional services and the related expense. Relate these to the expense of professional salaries.
8. Define the billing and receiving arrangement for professional services rendered in the hospital's in-patient department.
9. Define the billing and payment receiving arrangement for professional services rendered in the hospital's out-patient department.
10. The source documents used by the hospital as media for professional charging and billing should identify the following for each service rendered.
 - a. The in-patient.
 - b. The out-patient.
 - c. The responsible medical staff physician.
 - d. The service rendered.
 - e. The charges for the service.
 - f. The physician rendering service.
 1. Intern.
 2. Resident.
 3. Senior resident.
 4. Chief resident.
 5. Faculty staff member.
 6. Attending staff member.

(If rendered by associated staff, it should identify the physician who was present.)

- g. The cost center where service was rendered.
- h. The hospital or out-patient service which accompanied the professional service.
- i. The source of payment.
 - 1. Personal payment.
 - 2. Blue Cross.
 - 3. Blue Shield.
 - 4. Medicare A.
 - 5. Medicare B.
 - 6. Medicaid.
 - 7. Private insurance.
 - 8. Compensation.
 - 9. Industrial-company paid.
 - 10. Other.
- 11. For each fiscal year, determine eligible staff.
 - a. Medical staff, by in-patient professional department and division.
 - b. Associated staff.
 - 1. Intern by professional department.
 - 2. Assistant resident by professional department and division.
 - 3. Resident by professional department and division.
 - 4. Senior resident by professional department and division.

5. Chief resident by professional department and division.
- c. Medical staff by out-patient professional department and division.
 - d. Associated staff by out-patient professional department and division.
 1. Intern by professional department.
 2. Assistant resident by professional department and division.
 3. Resident by professional department and division.
 4. Senior resident by professional department and division.
 5. Chief resident by professional department and division.
 - e. Eligible staff.

Generally speaking, third parties will reimburse salaries of hospital, in-patient department staff and will pay professional fees for medical staff services in the in-patient and out-patient hospital departments.

1. Each patient should have clearly identified medical staff physician and associated staff.
2. This indicates the need for each associated staff member to have a clearly identified relationship to the medical staff.
3. Each year the medical staff should consider appointing licensed chief residents and senior residents to the medical staff if they are judged qualified to see patients

independently except for consultation on difficult medical management problems.

4. Each medical staff member must see the patients he has accepted, and the hospital must have a medical staff method for accepting each patient as a medical staff responsibility, in addition to an associated staff responsibility.

12. Define hospital and medical staff organization roles in medical care, education, and finance objectives. To provide a stable base for the hospital to offer medical care to patients and to offer a clinical setting for the education of physicians, the hospital must be able to finance these operations. It must be in a position to bill and collect for all hospital services rendered to patients. If professional staff expenses are borne by the hospital, it must be in a position to bill and collect for professional services rendered.

- a. In 1970, all patients should be considered as private in the sense that their care should be personally rendered by the medical staff. The associated staff, whose primary objective is education, may assist the medical staff in rendering care.
- b. Departmentalization of the medical staff should be fully implemented in the hospital's in-patient and out-patient services. All physicians, including the associated staff, should be identified with a department and a specialty division.
- c. A uniform fee structure should be determined by the medical staff and published within the hospital organization.
- d. For a medical staff member to render service, be eligible for payment, and satisfy legal

requirements, he must be available to see patients at all hours, except when he has assigned patient responsibility to a medical staff colleague (not a member of associated staff).

WHEN THE PHYSICIAN
WHO PERSONALLY
RENDERED OR WAS
PERSONALLY PRESENT
WHEN THE CARE
WAS RENDERED

WAS

PAYMENT MAY BE MADE WHEN SERVICES WERE PERFORMED BY						
	MEDICAL STAFF	CHIEF RESIDENT	SENIOR RESIDENT	RESIDENT	ASSISTANT RESIDENT	INTERN
HOSPITAL MEDICAL STAFF MEMBER	YES	X	X	YES	YES	YES
CHIEF RESIDENT*	X	YES	X	YES	YES	YES
SENIOR RESIDENT*	X	X	YES	YES	YES	YES
ASSOCIATED STAFF MEMBER	NO	NO	NO	NO	NO	NO

*ELECTED FOR ONE YEAR TO
HOSPITAL MEDICAL STAFF

APPENDIX C
MEDICAL STAFF ELIGIBILITY FOR PAYMENT OF SERVICES

1970 PROGRAM PREVIEW
Plenary Sessions

Friday morning, October 30, 1970

Chairman's Address

Robert B. Howard, Chairman, AAMC; and
Dean, University of Minnesota Medical School

The Academic Health Center and
Health Care Delivery -
The Changing Scene

Carleton B. Chapman
Dean, Dartmouth Medical School

Joseph T. English
Administrator, Health Services &
Mental Health Administration

SAMA President

Panel discussants

Saturday morning, October 31, 1970

The Academic Health Center and
Health Care Delivery -
Preparing Personnel to Meet
the Demand

George E. Burket, Jr.
Former President, American Academy of
General Practice

Robert J. Haggerty
Chairman, Department of Pediatrics
University of Rochester, School of
Medicine and Dentistry

Joseph F. Volker
Executive Vice President
University of Alabama

Panel discussants

Sunday morning, November 1, 1970

Alan Gregg Memorial Lecture

Lincoln Gordon
President, The Johns Hopkins University

The Academic Health Center and
Health Care Delivery -
Organizational Patterns for
New Responsibilities

John R. Evans
Dean, McMaster University

Irving London
Harvard MIT Planning Committee
Massachusetts Institute of Technology

SNMA President

George James
Dean, Mount Sinai School of Medicine

PARTIAL
CALENDAR OF MEETINGS

PLENARY SESSIONS

Friday, October 30	8:30 a.m. - 12:30 p.m.
Saturday, October 31	8:30 a.m. - 12:30 p.m.
Sunday, November 1	8:30 a.m. - 12:30 p.m.

ASSEMBLY

Friday, October 30	5:00 p.m. - 6:00 p.m.
Sunday, November 1	2:00 p.m. - 5:00 p.m.

CHAIRMAN'S ADDRESS

Friday, October 30	8:30 a.m.
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PRESIDENT'S ADDRESS

Sunday, November 1	2:30 p.m.
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ALAN GREGG MEMORIAL LECTURE

Sunday, November 1	8:30 a.m.
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PUBLIC FORUM

Friday, October 30	8:00 p.m. - 10:00 p.m.
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CHAIRMAN'S RECEPTION

Saturday, October 31	6:00 p.m. - 7:30 p.m.
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ANNUAL BANQUET

ABRAHAM FLEXNER AWARD PRESENTATION

BORDEN AWARD PRESENTATION

Saturday, October 31	7:30 p.m. - 9:00 p.m.
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COUNCIL OF ACADEMIC SOCIETIES

Thursday, October 29	(Reception)	5:30 p.m. - 7:00 p.m.
Friday, October 30	(Program)	2:00 p.m. - 5:00 p.m.
Saturday, October 31	(Program)	2:00 p.m. - 3:30 p.m.
Saturday, October 31	(Business)	3:30 p.m. - 5:00 p.m.

COUNCIL OF DEANS

Friday, October 30	(Business)	1:30 p.m. - 5:00 p.m.
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COUNCIL OF TEACHING HOSPITALS

Thursday, October 29	(Luncheon)	12:00 noon - 1:00 p.m.
Thursday, October 29	(Business)	1:00 p.m. - 5:00 p.m.
Friday, October 30	(Reception)	6:00 p.m. - 8:00 p.m.
Saturday, October 31	(Program)	1:30 p.m. - 5:00 p.m.

** SPECIAL ACTIVITIES ARE BEING PLANNED FOR THE LADIES **

BILTMORE HOTEL
LOS ANGELES, CALIFORNIA