

COUNCIL OF TEACHING HOSPITALS
Executive Committee Agenda
Private Dining Room 16
Palmer House
Chicago, Illinois
February 6, 1970

- I. Call to Order - 9:00 a.m.
- II. Approval of Minutes Meeting of October 30, 1969 (TAB A)
- III. Membership (TAB B)
- A. New Applications for Membership
 - 1. St. John's Hospital, Springfield, Illinois
 - 2. Memorial Hospital, Springfield, Illinois
 - 3. Hamot Hospital, Erie, Pennsylvania
 - 4. Harborview Medical Center, Seattle, Washington
 - B. Status of Membership Drive
 - C. Consideration of Personal Membership
- IV. Report of Meetings (TAB C)
- A. AAMC-AHA Liaison Committee (TAB D)
 - B. COTH-ACTH (TAB D)
 - C. Officers Retreat
 - D. Nursing
 - E. Midwest/Great Plains Regional Meeting (TAB E)
- V. Legislative Activities
- A. Current Status of Hill-Burton Legislation
 - B. Senator Hart's Hearings
 - C. 1970 DHEW FY70 Appropriations and Administration's Budget for FY 71
- VI. Recommendations for Special Programs Relating to Public Teaching Hospitals (TAB F)
- VII. Report on Continued Reorganization of AAMC and the Department of Health Services
- VIII. Report on Current Negotiations with Medicare (HANDOUT)
- IX. Relationships with Association for Hospital Medical Education (TAB G)
- X. G.C.R.C. Space Usage Proposal (TAB H)
- XI. Status of Unionization Activities of House Staff (TAB I)
- XII. Comprehensive Health Planning (TAB J)

- XIII. Blue Cross Administrative Bulletin No. 205 (TAB K)
- XIV. Research Activities
- A. COTHIC
1. Special Study - Sources of State Appropriations to Teaching Hospitals (TAB L)
 2. Policy on Distribution of Salary Survey
 3. Submission of Contract Extension
 4. Priority Preference Survey
- B. COTHMED Progress Report
- XV. Proposals from Annual Meeting Relating to COTH Activities in International Medical Education (TAB M)
- XVI. Other Business
- XVII. Adjournment: 2:00 p.m.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
One Dupont Circle, N.W.
Washington, D.C. 20036

MINUTES

EXECUTIVE COMMITTEE MEETING 69-5
October 30, 1969
Netherlands Hilton Hotel
Cincinnati, Ohio

Present:

Roy S. Rambeck, Chairman
T. Stewart Hamilton, M.D., Vice Chairman
Lad F. Grapski, Immediate Past Chairman
Ernest N. Boettcher, M.D., Member
Leonard W. Cronkhite, Jr., M.D., Member
L. H. Gunter, Member
Irvin G. Wilmot, Member
Joseph H. McNinch, M.D., AHA Representative

Excused:

Charles E. Burbridge, Ph.D., Member
Charles H. Frenzel, Member
Reid T. Holmes, Member
David Odell, Member

Staff:

John M. Danielson, Director, COTH
Fletcher H. Bingham, Ph.D., Associate Director, COTH

I. Call to Order:

The meeting was called to order at 2:00 p.m. Because of the schedule of plane arrivals of the membership of the Committee, the Chairman announced that for purposes of conducting the meeting, a quorum was present.

II. Consideration of Minutes, Meeting 69-4:

On motion, seconded and carried, the minutes of Executive Committee Meeting #69-4 held on September 11 and 12, 1969 in Washington, D.C. were approved as distributed.

III. Membership Items:

A. Proposed Membership Criteria

The proposed revision of Section 6 of the AAMC Bylaws relating to Teaching Hospital Members was presented as follows:

Teaching Hospital Members shall consist of (a) teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialities including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, Psychiatry, and are elected by the Council of Teaching Hospitals and (b) those hospitals nominated by an Institutional Member or Provisional Institutional Member, from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals.

Teaching Hospital Members shall be organizations operated exclusively for educational, scientific, or charitable purposes.

The voting rights of the Teaching Hospital Members shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of which shall have 1 vote in the Assembly.

Following a full and free discussion it was:

MOVED, SECONDED AND CARRIED THAT THE PROPOSED AAMC BYLAWS REVISION BE PRESENTED TO THE COTH INSTITUTIONAL MEMBERSHIP AND AAMC ASSEMBLY FOR ACTION.

B. New Applications for Membership

ON MOTION SECONDED AND CARRIED THE EXECUTIVE COMMITTEE APPROVED FOR MEMBERSHIP THE BERNALILLO COUNTY MEDICAL CENTER IN ALBUQUERQUE, NEW MEXICO.

THE EXECUTIVE COMMITTEE HELD IN ABEYANCE APPROVAL OF THE MARTIN LUTHER KING, JR. GENERAL HOSPITAL UNTIL SUCH TIME AS NOMINATION IS RECEIVED BY THE DEAN OF THE DREW POSTGRADUATE SCHOOL OF MEDICINE.

(In later discussions, it was determined that under existing AAMC Bylaws, institutions such as Drew Postgraduate School of Medicine was ineligible for membership in the Association. Necessary Bylaws revisions to rectify this situation are to be presented at the next meeting of the Association's Assembly. Following this action, the necessary follow-up will be accomplished to permit the membership of Martin Luther King, Jr. General Hospital.

C. Confirmation of Mail Ballots

ON MOTION, SECONDED AND CARRIED, THE EXECUTIVE COMMITTEE
CONFIRMED THE APPROVAL BY MAIL BALLOT OF THE FOLLOWING
INSTITUTIONS: NORFOLK GENERAL HOSPITAL, NORFOLK, VIRGINIA
PONTIAC GENERAL HOSPITAL, PONTIAC MICHIGAN
ALLENTOWN HOSPITAL ASSOCIATION, ALLENTOWN, PENNSYLVANIA
HURLEY HOSPITAL, FLINT, MICHIGAN

IV. Recent Developments in Issue of Part B Payments to Attending Physicians in A Teaching Setting:

A draft set of "Questions and Answers", developed by the Social Security Administration to further clarify Intermediary Letter 372 was revised and commented on by the Committee. Following this review and commentary, it was the consensus of the Committee that the "Questions and Answers" as drafted should not be distributed to the entire membership, but they should be reviewed by a Committee. Staff was instructed to report on the status of these "Questions and Answers" at the next Executive Committee Meeting. Mr. Danielson reported on a meeting called at the invitation of the Social Security Administration to discuss further the problems surrounding Part B payments to attending physicians in a teaching setting. He noted that COTH

had been represented at this October 23rd and 24th meeting by Mr. Stanley A. Ferguson and Mr. Charles B. Womer. He characterized the meeting as very productive and noted particularly the "single voice" through which the representatives of the COD, COTH, and CAS and the Business Officers Section expressed their concern to the representatives of the S.S.A. Mr. Danielson indicated that the Department of Health Services and Teaching Hospitals would continue to pursue this issue with S.S.A. and attempt to reach a favorable conclusion.

V. Report on Meeting with Association of Canadian Medical Colleges and Association of Canadian Teaching Hospitals:

The Director reported on a meeting with these groups that he had attended. He noted the problem that had developed relating to Canadian teaching hospitals and their paying dues to an Association outside of Canada. Following a full discussion of the applications of this issue:

ON MOTION, SECONDED AND CARRIED THE STAFF WAS INSTRUCTED TO BEGIN EXPLORATIONS ON AN INFORMAL BASIS WITH REPRESENTATIVES OF THE ASSOCIATION OF CANADIAN TEACHING HOSPITALS TO ATTEMPT TO DETERMINE APPROPRIATE LIAISON BETWEEN THE TWO ORGANIZATIONS.

VI. Discussion - Draft Statement on "The Teaching Hospital and Its Role in Health Planning at the Local and Regional Levels":

The discussion draft was revised carefully by the members of the Committee, and numerous suggestions of both a substance and editorial nature were made. It was agreed that further comments were invited and that they should be sent to the staff for inclusion in another draft.

Prior to adjournment, it was noted that this was Mr. Rambeck's last Executive Committee as Chairman of the Council of Teaching Hospitals.

ON MOTION, SECONDED AND CARRIED THE EXECUTIVE COMMITTEE EXPRESSED ITS APPRECIATION TO MR. ROY S. RAMBECK FOR HIS GUIDANCE AND LEADERSHIP AS CHAIRMAN OF THE COUNCIL OF TEACHING HOSPITALS.

VII. Adjournment:

There being no further business, the meeting adjourned at 5:00 p.m.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF TEACHING HOSPITALS
 ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 1340 CONNELL AVENUE, N.W.
 WASHINGTON, D.C. 20036
 202/223-5304

Application for Membership
 in the
 Council of Teaching Hospitals

(Please type)

Hospital: Harborview Medical Center (formerly King County Hospital)
Name
325 Ninth Avenue
Street
Seattle Washington 98104
City State Zip Code

Principal Administrative Officer: Robert I. Jetland
Name
Administrator
Title

Hospital Statistics:
 Date Hospital was Established: 1931
 Average Daily Census: 248 (1969)
 Annual Outpatient Clinical Visits: 43,424 (1969)

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1931</u>	<u>29</u>	<u>29</u>
Mixed	<u>-</u>	<u>-</u>	<u>-</u>
Straight	Surgery: <u>1961</u>	<u>4</u>	<u>4</u>
	Medicine: <u>1967*</u>	<u>14</u>	<u>14</u>

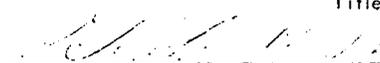
*A combined program with the University of Washington

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1931</u>	<u>56**</u>	<u>56</u>
Surgery	<u>1931</u>	<u>24**</u>	<u>24</u>
OB-Gyn	<u>1947</u>	<u>14**</u>	<u>13</u>
Pediatrics	<u>1948</u>	<u>33**</u>	<u>33</u>
Psychiatry	<u>1961</u>	<u>47**</u>	<u>43</u>

**Residency positions now offered through University of

Information submitted by: Washington Affiliated Residency Program.

Geoffrey N. Lang Assistant Administrator
Name Title
January 19, 1970 
Date Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, ~~2530 Ridge Avenue, Evanston, Illinois 60201~~, retaining the blue copy for your file.

Membership in the Council:

Hospitals as institutions will be members of the Council and each institution will be represented by a designated person, designated by the hospital, for the purpose of conducting the business of the Council.

Membership in the Council will be annually determined and consist of:

- a. Those hospitals nominated by a medical school member of the AAMC from among the major teaching hospitals affiliated with the school,

and

- b. Teaching hospitals which are either nominated by a medical school member of the AAMC on the basis of important affiliations for the purposes of medical education or which have approved internship programs and full residencies in three of the following five departments: Medicine, Surgery, OB-Gyn, Pediatrics, Psychiatry, and are elected to membership by the members of the Council of Teaching Hospitals.

All members will vote at the annual meeting for officers and members of the Executive Committee. Voting on all other matters will be limited to one representative member for each medical school, who, in order to give broad representation, shall consult with the other teaching hospital members in his geographic region before votes are taken.

If nominated by School of Medicine, complete the following:

Name of School of Medicine U. of W. School of Medicine

Name of Parent University University of Washington

Name of Dean of School of Medicine August Swanson, M.D., Acting Dean

From the Office of: Complete address of School of Medicine University of Washington

School of Medicine

Seattle, Washington

98105

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1540 RIDGE AVENUE, N.W.
WASHINGTON, D.C. 20036
202-297-5334

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

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From the Office of:

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1345 CONNORWAY AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

(Please type)

Hospital: Memorial Hospital of Springfield
Name
1st and Miller Streets
Street
Springfield Illinois 62701
City State Zip Code

Principal Administrative Officer: George K. Hendrix
Name
Administrator
Title

Hospital Statistics:
Date Hospital was Established: 1897
Average Daily Census: 446
Annual Outpatient Clinical Visits: No organized department as yet

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating		None yet	
Mixed		None yet	
Straight		None yet	

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine		None yet	
Surgery		" "	
OB-Gyn		" "	
Pediatrics		" "	
Psychiatry		" "	

Information submitted by:

George K. Hendrix
Name
December 16, 1969
Date
George K. Hendrix, Admin.
Title
Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

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If nominated by School of Medicine, complete the following:

Name of School of Medicine Southern Illinois University Medical School at Springfield

Name of Parent University Southern Illinois University at Carbondale

Name of Dean of School of Medicine Richard H. Moy, M.D.

Complete address of School of Medicine 7th and Carpenter

From the Office of:

Springfield, Illinois 62702

COUNCIL OF TEACHING HOSPITALS
 ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 1245 CONNORWAY AVENUE, N.W.
 WASHINGTON, D.C. 20026

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Remarks: _____

Invoiced _____ Remittance Received _____

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From the Office of:
MATTHEW E. McNULTY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1340 CONNORVILLE AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: St. Johns Hospital
701 East Mason Street
Springfield Illinois 62701
City State Zip Code

Principal Administrative Officer: Sister Jane Like, F.A.C.H.A.
Administrator
Name Title

Hospital Statistics:
 Date Hospital was Established: 1875
 Average Daily Census: 581
 Annual Outpatient Clinical Visits: 32861 in Emergency and Outpatient Facility

Approved Internships: None

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	_____	_____	_____
Mixed	_____	_____	_____
Straight	_____	_____	_____

Approved Residencies: None

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	_____	_____	_____
Surgery	_____	_____	_____
OB-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Psychiatry	_____	_____	_____

Information submitted by:
Richard Moy, M.D.
Name
December 15, 1969
Date

Dean of Southern Illinois University Medical School
Title
[Signature]
Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

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and

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If nominated by School of Medicine, complete the following:

Name of School of Medicine SIU Medical School located at Springfield

Name of Parent University Southern Illinois University

Name of Dean of School of Medicine Richard Moy, M.D.

Complete address of School of Medicine Carpenter and Seventh Streets

Springfield, Illinois 62702

From the Office of:

MATTHEW F. McNULTY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 1349 CONNECTICUT AVENUE, N.W.
 WASHINGTON, D.C. 20036

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____



Lamot Hospital

ORGANIZED 1881

ERIE • PENNSYLVANIA

APPROVED BY THE JOINT COMMISSION
ON ACCREDITATION OF HOSPITALS
AND THE
COUNCIL ON MEDICAL EDUCATION AND
HOSPITALS FOR INTERN AND RESIDENT
TRAINING

January 5, 1970

John M. Danielson, Director
Council of Teaching Hospitals
and Health Services
1346 Connecticut Avenue, N.W.
Washington, D. C. 20036

Dear Mr. Danielson:

In accordance with your letter of December 8, in which you indicated that membership is determined by two standards, one of which besides having an approved program, to have an approved Residency in two of the five that you mentioned. We have currently approved Residencies in Surgery, OB-GYN, Pathology, Urology, and Orthopaedics and an affiliated Residency Program in Psychiatry.

We are affiliated with the Warren State Hospital which has a fully approved Psychiatry Residency under H. J. Reinhard, M.D. Our Orthopaedic Program is now affiliated with the Duke University Medical Center Orthopaedic Residency under the direction of J. Leonard Goldner, M.D.

Enclosed is our completed application and our check in the amount of \$700.00.

Sincerely yours,


George J. D'Angelo, M.D.
Director
Medical Education and Research

GJD/blc

Enclosures: 2

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COUNCIL OF TEACHING HOSPITALS
 ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 Application for Membership
 in the
 Council of Teaching Hospitals

1340 CONNECTICUT AVENUE, N.W.
 WASHINGTON, D.C. 20036
 202/223-5364

(Please type)

Hospital: Hamot Hospital

4 East Second Street Name

Erie Pennsylvania 16512

City State Zip Code

Principal Administrative Officer: Wm. H. Ennis

Executive Director

Title

Hospital Statistics:

Date Hospital was Established: 1888

Average Daily Census: 390

Annual Outpatient Clinical Visits: 7,729

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1903</u>	<u>12</u>	<u>7</u>
Mixed	<u></u>	<u></u>	<u></u>
Straight	<u></u>	<u></u>	<u></u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u></u>	<u></u>	<u></u>
Surgery	<u>1947</u>	<u>4</u>	<u>4</u>
OB-Gyn	<u>1962</u>	<u>4</u>	<u>4</u>
Pathology	<u>1948</u>	<u>4</u>	<u>2</u>
Pediatrics	<u></u>	<u></u>	<u></u>
Orthopaedics	<u>1946</u>	<u>4</u>	<u>4</u>
Psychiatry	<u></u>	<u></u>	<u></u>
Urology	<u>1957</u>	<u>4</u>	<u>4</u>

Information submitted by:

George J. D'Angelo, M.D.

Director, Medical Education and Research

January 5, 1970 Name

Date

George J. D'Angelo Title

Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

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MINUTES OF AHA-AAMC LIAISON COMMITTEE MEETING
AAMC OFFICES
1346 Connecticut Avenue, N.W.
Washington, D.C.
Monday, January 5, 1970

Present:

Association of American
Medical Colleges

William G. Anlyan, M.D.
Jonathan E. Rhoads, M.D.
T. Stewart Hamilton, M.D.
John A.D. Cooper, M.D., Ph.D.
John M. Danielson
Cheves McC. Smythe, M.D.
Fletcher H. Bingham, Ph.D.

American Hospital Association

George Wm. Graham, M.D.
Mark Berke
John A.L. Hahn
David B. Wilson, M.D.
Edwin L. Crosby, Jr., M.D.
Robert C. Love, M.D.

- I. Dr. Cooper called the meeting to order at 10:30 a.m. indicated that by prior agreement the AAMC had prepared the agenda for the meeting. In the temporary absence of the AAMC Chairman-Elect Dr. Anlyan, Dr. Cooper asked Dr. Rhoads to chair the meeting until Dr. Anlyan's arrival.

II. Universal Health Insurance:

Dr. Cooper presented the four points contained within the resolution adopted by the AAMC Assembly at Cincinnati and noted further that it was improbable that the AAMC, through its Committee would work toward the development of separate legislative specifications from which a piece of legislation could be drafted. He commented that the emphasis of activities within the Association would be that of preserving the integrity of academic medical centers in the various proposals that are presented.

Mr. Berke noted that the AHA does not have a firm position on universal health insurance at the present time, but that the Association was in the process of reviewing the many activities relating to the delivery of health services. Following a full discussion relating to continued dialogue

between the two Associations on the issue, it was agreed:

That the AHA-AAMC Liaison Committee believes that a joint meeting between the "Chapman Committee" (AAMC) and the "Perloff Committee" (AHA) would be most useful. Additionally, the AAMC should appear before the Perloff Committee at a time that is mutually convenient. Staff was requested to work the arrangements.

III. Unionization of House Officers and Associations' Relationship with Social Security Administration (separate agenda items discussed jointly):

Mr. Danielson reported on the bargaining activities of the Committee of Interns and Residents in New York City and indicated that this could no longer be considered a localized issue, but that it was assuming national dimensions. He noted that the AAMC is following these activities quite closely and that the AAMC course of action on either the local or the national level had not been fully determined. It was noted that the AHA is to establish a committee on house staff remuneration.

Discussion then flowed naturally into current problems relating to the payments of attending physicians in a teaching setting. Mr. Danielson reviewed the four alternatives that appeared to be the most favorably received by S.S.A. and the Senate Finance Committee, at the present time:

1. Continuation of Intermediary Letter #372's interpretation of the 1967 Federal Regulations
2. Placing all charges for "physician services" in teaching settings under Part A with no Part B billing.

3. Place all charges for "physician services" under the Part B program. Hospitals would not be allowed to include in the Part A "hospital costs" interns or residents stipends and the salaries of supervisory physicians.
4. Maintenance of existing Part A hospital reimbursement, but provide for a discounted Part B fee. The discount would be negotiated and based on the involvement of house staff in patient care.

Following a discussion of these alternatives, Mr. Danielson indicated that because of the varying nature of the constituencies represented by the two Associations that it is conceivable that there may emerge differing positions by the respective Associations on this issue. He expressed further that although he hoped that this would not be necessary that it was entirely conceivable. It was noted that the AAMC, in its negotiations with the S.S.A. and the Senate Finance Committee would prefer to maintain some flexibility in the options made available to each teaching setting. It was agreed that this was an issue on which contact between the two Associations should be firmly maintained.

IV. Financing of Medical Education:

Dr. Cooper and Mr. Danielson noted this item was largely informational and that a number of study groups and advisory bodies including HIBAC and The Carnegie Commission on the Future Financing of Higher Education, have recently shown much interest in this issue and that the AAMC had begun to develop a conceptualization of the many facets surrounding this very complicated financing methodology. Dr. Crosby indicated that data gathered by the HAS program might be useful in such a study and that

the AAMC might wish to explore this as a possible source of secondary data.

V. Comprehensive Health Planning:

The positions of the AAMC and AHA relating to comprehensive health planning were thoroughly reviewed. Additionally the implications of the BOB Circular A-95 were explored in depth. After a full discussion, it was agreed that the two Associations should continue to keep one another closely informed in further developments of their positions.

VI. Possible Hearings by Senate Judiciary Monopoly Subcommittee:

Mr. Danielson indicated that this item was informational in nature and it was highly probable that hearings by this Subcommittee, chaired by Senator Hart of Michigan would be scheduled for late February. It was agreed that the two Associations should maintain close contact and ties on their strategy as it relates to their approach to the Subcommittee.

VII. Education of Allied Health Professionals:

The issue of the quantity and quality of health professionals, both those that are established and those emerging was given much discussion. Additionally, the educational relationships between the hospital and institutions of higher education, including both universities and colleges were carefully developed. Following a broad and wideranging discussion of the issue, it was agreed that health manpower was one of the critical areas for the AAMC to pursue with the AHA maintaining a close liaison in these activities.

There being no further business, it was noted that the AHA would serve as host for the next meeting. The meeting adjourned at 2:30 p.m.

MINUTES OF THE COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF CANADIAN TEACHING HOSPITALS
AD HOC COMMITTEE MEETING
Mainliner Room #2
O'Hare Airport
Chicago, Illinois
January 20, 1970

Present:

Council of Teaching Hospitals

Irvin G. Wilmot
Stanley A. Ferguson
John M. Danielson
Fletcher H. Bingham, Ph.D.

Association of Canadian Teaching Hospitals

Bernard Snell
Peter Swinehart

Mr. Danielson called the meeting to order at 10:30 a.m. explaining that the meeting was informal in nature and that it represented an opportunity to discuss items of mutual interest and concern.

Dr. Snell outlined the history of the ACTH pointing the similarities in organizational growth between ACTH and COTH. These were identified especially in terms of the relationship of ACTH to the Association of Canadian Medical Colleges and COTH to the AAMC. He noted that, at the moment, members approximate 40. The ACTH does not have a permanent staff, and they are now negotiating with ACMC to provide a part-time person who would serve as secretary.

Mr. Danielson reviewed the reorganization of the Association of American Medical Colleges and indicated some of the concerns of the Association relating to current issues in the organization of health care delivery and health education.

Following a general and full discussion, it was agreed that there was a mutuality of interest between the two organizations, regarding the following issues:

1. The organizational relationship of teaching hospitals to the health centers.
2. Problems relating to the financing of medical education, particularly with regard to faculty, house staff and other costs relating to educational and service programs.
3. The relationship of house staff to the teaching physicians and the explorations of this relationship on the management and financing of patient care in a teaching setting.

It was agreed that because of these common problems and issues that some mechanism of formal relationship between COTH and ACTH would be very desirable. It was further agreed that some form of "bloc membership" by the ACTH in COTH would be most advantageous and would most probably alleviate any budgetary problems imposed by provincial or Federal Canadian officials. Suggested areas for ACTH participation in COTH activities include:

1. Receipt of the COTH REPORT by ACTH members.
2. ACTH Participation in COTH Survey and receipt of material generated by these studies.
3. ACTH availability of the services of the COTH Information Center.
4. Member hospitals of the ACTH would be invited to attend COTH Regional Meetings and the AAMC Annual Meeting.
5. A mechanism for interassociation relationships was discussed and the alternative which appeared most desirable was mutual invitations to attend Executive Committee Meetings of the respective organizations on a participating, but non voting, basis.

Although no financing was mentioned, it was agreed that Mr. Danielson would submit in writing the substantive points of agreement and include further items, including those of financial nature, following the presentation of a proposal to the COTH Executive Committee on February 6th, for review and decision. It was noted that action was also necessary by the Executive Committee of ACTH before finalization of the proposal.

There being no further business the meeting was adjourned at 2:10 p.m.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

January 9, 1970

Statement of Situation - Midwest/Great Plains Regional Meeting:

COTH established its regional meeting series in 1968. Following this original meeting, a subsequent meeting was scheduled for May 1, 1969 and a memorandum to COTH membership indicating this meeting date was sent to the membership on February 29, 1969.

Subsequent to this, a meeting of the entire Association in the Midwest/Great Plains Region including representatives of the Council of Deans, the Council of Faculties (not Academic Societies), Council of Teaching Hospitals and the Business Officers Section was scheduled for April 21-22, 1969. Because of the long standing commitment for the independent COTH meeting, it was agreed that COTH would not participate in this original meeting of the combined Midwest/Great Plains activities.

At the May 1st COTH Regional Meeting, the issue of the joint Midwest/Great Plains Meeting was discussed and the action taken is displayed in Attachment 1.

This action was referred to the COTH Executive Committee (for COTH Executive Committee action see Attachment #2).

Following the original joint meeting of the Midwest/Great Plains Meeting, one additional meeting was held on October 6 and 7, prior to this January 12 and 13 meeting and COTH membership attendance at this meeting was very small, mainly because we believe notification was inadequate and not coordinated with COTH staff.

ATTACHMENT 1

RECOMMENDATION FROM COTH MIDWEST/GREAT
PLAINS REGIONAL MEETING - MAY 1, 1969
REGARDING JOINT REGIONAL MEETINGS WITH REPRESENTATIVES
OF THE COUNCIL OF DEANS (COD), COUNCIL OF ACADEMIC
SOCIETIES (CAS) AND BUSINESS OFFICERS SECTION (BOS)

After lengthy discussion, it was unanimously agreed that there were enough items of unique interest to teaching hospital administrators and therefore, the Council of Teaching Hospitals should continue its independent Regional Meeting Series.

Additionally, after full discussion it was recommended that no representative of COTH be selected to sit on the Midwest/Great Plains COD-CAS-BOS-COTH Executive Committee.

Adopted by COTH Midwest/Great Plains
Regional Members at Meeting of
May 1, 1969

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

MINUTES

EXECUTIVE COMMITTEE MEETING (#69-3)
Thursday and Friday, May 8 & 9, 1969
Washington Hilton Hotel
1919 Connecticut Avenue, N.W.
Washington, D.C. 20009

Present:

Roy S. Rambeck, Chairman
T. Stewart Hamilton, M.D., Chairman-Elect**
Lad F. Grapski, Immediate Past Chairman
L. H. Gunter, Member
David Odell, Member
Irvin G. Wilmot, Member
Ernest N. Boettcher, M.D., Member
Leonard W. Cronkhite, Jr., M.D., Member
Charles R. Goulet, Member
Charles E. Burbridge, Ph.D., Member
Charles H. Frenzel, Member
Reid T. Holmes, Member
Joseph H. McNinch, M.D., AHA Representative

Staff:

John A. D. Cooper, M.D., Ph.D., President, AAMC*
Matthew F. McNulty, Jr., Director, COTH
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Richard M. Knapp, Ph.D., Project Director, COTHRIC
Clara J. Williams, Project Director, COTHMED
Grace W. Beirne, Staff Associate, COTH
Armand Checker, Staff Associate, COTHRIC
Howard R. Veit, Assistant Project Director, COTHMED

Excused:

Russell A. Nelson, M.D., Ex Officio Member

VIII. Report of Regional Meetings:

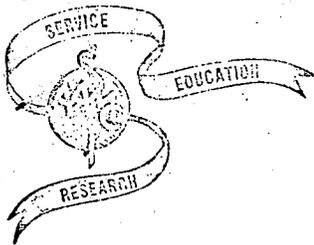
Dr. Bingham, called the attention to the agendas for the four regional meetings, noting that all the meetings went extremely well, including the joint meeting in the Southern region with AAMC Southern deans.

Dr. Boettcher commented on an action taken at the COTH Midwest/Great Plains Regional Meeting recommending that no joint regional meeting be held with COD, CAS and the BOS, and that COTH decline the opportunity to nominate a representative to the Regional Executive Committee that had been proposed. As background to this item, it was pointed out that this issue resulted from a joint regional meeting that had been planned through the Evanston office which was to include all segments of the AAMC, but which COTH offices had not been notified.

COTH members agreed that there should be developed some mechanism for communication among all segments of the AAMC within each region but COTH members in the Midwest/Great Plains region had indicated a desire not to set up a separate administrative mechanism that would add further problems to the current administrative processes.

In discussion, Executive Committee members agreed that it would be undesirable at this point to have formal joint meetings as a regular process and that regional level committees would add a burden to an already complex administrative structure within the AAMC. It was agreed that COTH should continue its meetings as they now exist as a general policy. The consensus was that this was a very sincere attempt to improve communication among the various divisions of the AAMC and an attempt should be made to clearly communicate the rationale of the Midwestern members of COTH.

In summary, the Executive Committee agreed that this matter should be brought to the attention of Dr. Cooper, along with the sentiments of both the COTH Executive Committee and the COTH Midwest/Great Plains Regional Membership. It would be hoped that Dr. Cooper could resolve the problem through informal discussion as necessary.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D. C. 20036
202/223-5364

November 24, 1969

Mr. Leslie R. Smith
Administrator
County of Los Angeles
Harbor General Hospital
1000 West Carson Street
Torrance, California 90509

Dear Les:

Thanks very much for your letter of November 12th and the suggestions you made for further action by the Council of Teaching Hospitals in this area of involvement.

Although I have not had the opportunity to discuss this item with Dave Odell, he has previously requested that any substantive recommendations that flow from your meeting be brought to the attention of the Executive Committee.

It was very good seeing you in Cincinnati and I am sorry that I did not have more time to spend with you.

Cordially,

FLETCHER H. BINGHAM, PH.D.
Associate Director
Council of Teaching Hospitals

FHB:car

cc: David Odell



COUNTY OF LOS ANGELES / HARBOR GENERAL HOSPITAL

1000 WEST CARSON STREET • TORRANCE, CALIFORNIA, 90509 • PHONE 328-2380

DEPARTMENT
OF
HOSPITALS

LESLIE R. SMITH
ADMINISTRATOR

WILLIAM H. SWANSON, M.D.
MEDICAL DIRECTOR

November 12, 1969

Mr. Fletcher H. Bingham
Council of Teach Hospitals
1346 Connecticut Avenue, N.W.
Washington, D. C. 20036

Dear Fletcher:

Thank you for dropping by and briefly participating in our session on Friday evening, October 31, for Public Teaching Hospitals.

As you recommended, and as we discussed, we did come up with a proposal that I feel has merit. It was the consensus of those there that sufficient change is taking place in the manner in which public teaching hospitals (that is, municipal, county and in some cases state) are being funded, governed and otherwise managed to warrant gathering of information by a central agency. This information could be available on a clearinghouse or other appropriate basis so that we might exchange concepts and know what is going on regionally and nationally in our sister hospitals. It was proposed that the Teaching Hospitals Information Center be used in this capacity, for example.

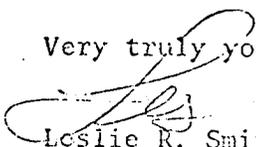
I think it would be appropriate that a small subcommittee be appointed to develop a suitable questionnaire to inventory current status in these problem areas and plans and proposals for future operations. These should relate to means whereby the governing authority may be modified as has been proposed in Memphis, Cook County, New York, Boston and other locations; how capital construction is to be funded where bond issues have failed; proposed state legislation to provide for the broadening of the public hospital's role into a direct community medical center; and other similar areas.

Those of us who participated on the panel, as well as those in the audience, expressed concern that we might be re-inventing the wheel in certain parts of the country when, in fact, there is available to us through our council a means of exchanging ideas with persons who are trying to solve similar problems.

I think this carries a rather high priority and would hope that this matter could be brought to the attention of the executive committee at an early opportunity. By copy of this letter to Dave Odell I am suggesting that he propose such an item for the committee's agenda.

If I can be of any assistance please feel free to contact me.

Very truly yours,


Leslie R. Smith, Administrator

LRS:bc



ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

2001 JEFFERSON DAVIS HIGHWAY, SUITE 909

ARLINGTON, VIRGINIA 22202

PHONE: (703) 521-1133

December 5, 1969

PRESIDENT

Angelo P. Angelides, M.D.
Lankenau Hospital
Philadelphia, Pennsylvania

VICE-PRESIDENT

Jack H. Hall, M.D.
Methodist Hospital
Indianapolis, Indiana

SECRETARY-TREASURER

Woodbury Perkins, M.D.
Mercy Hospital
San Diego, California

EXECUTIVE DIRECTOR

Theodore G. Kummer

COPY

Dear Administrator:

The Association for Hospital Medical Education has functioned since 1956 as a spokesman for hospital centered medical education and quality of care programs. It is a national association, founded in the belief that sound educational programs in hospitals result in an improved level of patient care and that such programs are necessary on a continuing basis.

Quality educational programs and resulting quality of patient care demands hospital-wide commitment and involvement. The Association for Hospital Medical Education is now initiating a membership program for institutions. The memberships being offered will provide a firm support base which will increase clarity, efficiency and magnitude of the voice which speaks for hospital medical education on the national scene.

AHME functions primarily by representing affiliated and non-affiliated hospitals with their special problems of administration, funding, medical staff organization and activity on both a local and national level. This involves continuing interaction with organizations such as the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the American Academy of General Practice, the American College of Physicians, the Federal Government, the Federation of State Boards of Medical Education and Licensure, and others. Thus, the singular attributes, capabilities and productivity of these hospitals is adequately voiced in the public sphere. The needs and problems of hospitals, particularly in the areas of graduate and continuing education are also continually represented to accrediting agencies, other educational organizations and both philanthropic and Governmental funding agencies.

The enclosed brochure further describes the benefits your hospital can derive from AHME membership. They include consultation services at cost, institutes and programs for individuals in many capacities

Hospital Administrator
December 5, 1969
Page 2

on your professional staff, guides and reports on medical education and health services research, and representation for your hospital on the various commissions and agencies planning the standards for the future quality of health care and its inseparable companion--education.

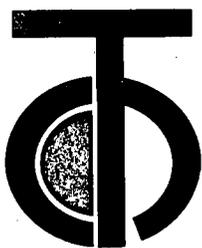
Membership for institutions costs \$250.00 per year. These members will appoint a representative to the Association who will have voting privileges and enjoy the status of active membership within the Association, if eligible according to the Bylaws of the Association.

We believe we have a valuable program to offer and that your hospital will derive extensive benefit from AHME membership. We invite you to carefully review the enclosed brochure and consider your participation. May we hear from you?

Sincerely,

Theodore G. Kummer
Executive Director

TGK/bs
Enclosure



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

Special Membership Memorandum
No. 70-1S
December 10, 1969
Subject: Meeting With Representatives of
NIH - General Clinical Research
Center Branch

On Wednesday, December 3rd, several member representatives of COTH met with officials from the N.I.H. - G.C.R.C. Branch. The purpose of the meeting was to review and discuss the attached statement, "Background and Material Concerning Hospitalization Reimbursement Methods Affecting the General Clinical Research Center Branch".

Primary motivation for the development of this statement appears to be the research flexibility it will provide the G.C.R.C. Program in use of its limited funds. COTH representatives stressed the need for the development of equitable guidelines in determining the "space leasing" or "rent" factor. Several hospitals have been selected to develop comparative cost figures in order to document the effects of this proposal as opposed to reimbursement now received under their existing agreement with the G.C.R.C. Branch.

We would appreciate very much any comments you may have on the attached, after you have had the opportunity of review. Officials at N.I.H. have recommended continued exploration of the concept by their staff, in consultation with the Council of Teaching Hospitals. In order for COTH Staff, as well as those members invited by N.I.H. to continue reviewing the proposal, we would welcome any comments you may wish to make.

FLETCHER H. BINGHAM, PH.D.
Associate Director
Council of Teaching Hospitals

Attachment: "Background and Material Concerning Hospitalization Reimbursement Methods Affecting the General Clinical Research Center Branch"

P.S. As has been our custom with this series of Special Membership Memoranda, this memorandum is being mailed to all COTH members so as to be informational to those who do not have Clinical Research Centers.

Memorandum

TO Participants in December 3 General Clinical
Research Centers Meeting

DATE: December 3, 1969

FROM General Clinical, Research Centers Branch

SUBJECT Background Material Concerning Hospitalization Reimbursement Methods
Affecting the General Clinical Research Centers Program

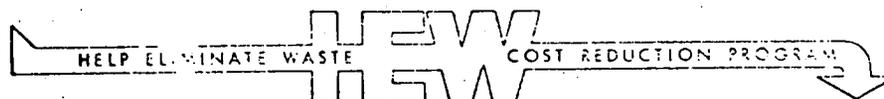
I. Purpose of the December 3 Meeting

This meeting will be the first of a series to evaluate alternative reimbursement methods that are applicable to the unique aspects of the General Clinical Research Centers Program. Those that seem most appropriate would be analyzed in depth by participating hospitals. Guidelines for determining which "costs" to include in this analysis will be formulated so that comparable data can be generated.

II. Background Information

In order to provide a common base for discussion, the presently available hospital reimbursement accounting methods governing research admissions to General Clinical Research Centers are defined as follows:

1. Fixed-variable -- The rates determined by this method are produced by allocating the fixed inpatient costs of the hospital to the available bed days and allocating the variable inpatient costs to total patient days. Using this reimbursement method, the grant pays the fixed rate times the number of beds in the General Clinical Research Center times 365 days, regardless of patient utilization. The reimbursement for the variable cost is the variable rate times the actual number of patient days utilized in the center.
2. Per Diem -- This method of reimbursement is based on the averaging of all inpatient costs in the hospital. Using this method, the grant pays a fixed per diem rate for each patient admitted to the General Clinical Research Center regardless of the services rendered.
3. A fee-adjustment method -- This method of reimbursement is available to hospitals having regular schedules of fees for determining all charges. This method is based on the ratio of total inpatient charges to total inpatient costs. The allowable inpatient costs are compared to the total revenue from inpatient charges to determine a percentage factor that is applied to gross fees charged to research patients. In addition to this adjustment factor, an offset from adjusted gross billing is made for all components of costs paid directly by the grant, i.e., nursing, dietary, etc.



The Department of Health, Education, and Welfare has proposed that all future negotiations involving hospital reimbursement should be made according to Medicare cost principles. These principles encompass an after-the-fact adjustment to actual cost figures. The Department decision to implement a single reimbursement method according to Medicare cost principles is still pending.

Recently, the General Clinical Research Center Committee and the National Advisory Research Resources Council unanimously recommended to the National Institutes of Health that grantees be allowed the option of reallocating a portion of existing grant monies for ambulatory research patient admissions. This proposal is under consideration by the National Institutes of Health administration. Should such a policy be implemented, a varying mixture of inpatients and outpatients would be admitted to clinical research centers, depending upon the needs of the most meritorious clinical investigations at each institution. It is believed that an outpatient complement to the existing program will greatly enhance the flexibility and effectiveness of the overall program as well as provide a more economical mechanism for conducting some types of clinical investigation.

The many types of research patients admitted to general clinical research centers necessitate some flexibility in developing policies of reimbursement schedules. Inpatient and outpatient research admissions thus range from normal controls to acutely ill individuals, and include all age groups. An extensive study over the past six months indicates that perhaps 10% of General Clinical Research Center research patients would have required hospitalization regardless of their research admissions and might therefore be eligible for third party billings. A large number of admissions involve normal controls who do not require routine services from the hospital.

In formulating guidelines for outpatient admissions to general clinical research centers, alternative proposals for hospital reimbursement schedules encompassing outpatient research admissions should be evaluated. One proposed reimbursement method is the concept of leasing a discrete geographical area for admission of research patients -- inpatients and outpatients. Under this arrangement, clinical research center space would be rented on an annual basis. Ancillary services would be purchased from the hospital on a fees-adjusted-to-cost basis. The advantages and disadvantages of such a reimbursement method are discussed below.

III. The Fee Adjustment Method vis-a-vis a Space-Leasing Arrangement

Because the space-leasing method is a new concept for clinical research centers, we would like to elaborate on some of its advantages and disadvantages and compare them with the fee-adjustment method using Medicare cost principles.

A. The Fee Adjustment Method

Overall, the fee adjustment method probably relates more to actual costs than the other methods currently in use by the program (all-inclusive per diem and fixed variable). However, it has some disadvantages because of the unique aspects of the General Clinical Research Centers Program. From the Program's perspective, the three most important disadvantages are:

1. The application of Medicare cost principles to the determination of research hospitalization costs assumes that research patient days and patient care days are comparable for accounting purposes. However, as noted previously, only about ten percent of General Clinical Research Center research patient admissions require routine inpatient hospitalization services eligible for third party billings. Generally, these latter patients are admitted as "service patients" (see Appendix I for guidelines). The vast majority of patients are admitted purely for research determinations.

The development of rate structures for individual centers must include consideration of the degree to which research requirements are directly funded in lieu of utilization of general hospital services. It is also apparent that a large number of the studies conducted in general clinical research centers may not require many of the services provided the patient hospitalized for routine hospital care.

2. Rate determinations for ambulatory research patient (outpatients) admissions would be difficult. Like the hospitalized research patient, the activities of ambulatory patients often lie outside the mainstream of routine care. They are admitted to a General Clinical Research Center or another designated discrete geographical area, not to service outpatient facilities where usual cost data are determined.

3. Most National Institutes of Health programs operating within an annual appropriation require fixed predetermined rates for budgeting grants. It is essential that the program director be able to determine at the initiation of each grant year the number of units of hospital service he will be able to purchase, i.e., patient days, x-rays, laboratory tests, etc. Medicare rates are settled on after-the-fact basis and it is our understanding that these rates are not finalized until well after the completion of the hospital fiscal year.

B. Space-Leasing Arrangements

This method is proposed as a complement to the fee-adjustment method since neither applies to all situations encountered in the program. The availability of alternative methods would enable greater flexibility to adapt these reimbursement schedules to the unique aspects of General Clinical Research Centers. The variables encountered include the types of hospitals (private, state, city, etc.), the varying demand for routine hospital services (from normal controls to acutely ill patients), and the types of patient admissions (inpatients or outpatients). The space-leasing arrangements allow a single predetermined rate that is not fixed to inpatient or outpatient utilization. The director of these centers would have a greater flexibility to admit a mixture of inpatients or outpatients, depending upon the needs of the most meritorious investigators. These needs will vary from protocol to protocol, from patient to patient within a certain protocol, and for a single patient during the course of his disease under study. In addition, the grant does not pay routine service rates for hospital services it does not need. The space-leasing arrangement also guarantees payment of actual cost to the hospital, which has reserved this space exclusively for research patient admissions.

Two disadvantages of this method are:

1. The government guarantees payment of actual cost for renting the space on an annual basis. If the research space is underutilized, the cost per patient may be higher than with the fee adjustment method.
2. Under the fee-adjustment method, the billings and collections for paying research patients are made to the hospital, just as they would if the patient were admitted to a general hospital ward. Under a space-leasing arrangement, billings and collections would have to be made through the General Clinical Research Center grant since the grant is paying all costs. This means the grant would underwrite bad debts when collection for services are not made.

In summary, the space-leasing arrangement seems advantageous when 1) there are both inpatient and outpatient research admissions and 2) a reasonable expectancy of good utilization of the research space. Under other conditions, the fee-adjustment method would apply. If the government cannot live up to its obligation to meet actual costs of this reserved research area, the National Institutes of Health would permit a limited number of service patient admissions to maintain effective utilization of personnel and assist in the recovery of overhead costs.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
NATIONAL INSTITUTES OF HEALTH
DIVISION OF RESEARCH FACILITIES AND RESOURCES
BETHESDA, MARYLAND 20014

Date: October 1, 1968

To: Principal Investigators, General Clinical Research Centers

From: Chief, General Clinical Research Centers Branch, Division of
Research Facilities and Resources, NIH

Subject: Policy of Admission of Service Patients to General Clinical
Research Centers

Since its inception in 1960 the General Clinical Research Centers program of the National Institutes of Health has maintained each unit as a discrete center, available exclusively for the hospitalization of research patients. All justified costs of center operations have been reimbursed within the limits provided in the annual statement of award. During the coming grant year funds available to the program will be insufficient to maintain effective operation at the level recommended by the National Advisory Research Resources Council. In order to permit effective operations at a reduced funding level while maintaining the discrete character of the unit, centers may elect the option of hospitalizing a limited number of "service" patients.

Centers wishing to exercise this option during the period October 1, 1968 to September 30, 1969 should submit a written proposal in accordance with the following guidelines.

1. To achieve optimal utilization of the Clinical Research Center, the Director of the Clinical Research Center and the hospital administration may agree to admit "service" patients to the Clinical Research Center. Such service patients who require treatment and hospital care and who are able to pay for hospital care either directly or through third parties may be billed by the hospital at its standard rate. Hospitalization for "service" patients shall not be chargeable by the hospital to the grant.
2. Admission of all patients to the Clinical Research Center will continue to be at the discretion of the Program Director of the Clinical Research Center. Patients, such as dialysis and intensive care patients who require an extraordinary share of directly funded operating services, shall not be admitted except on an approved research protocol.

3. The hospital will reimburse the grant for each patient day a "service" patient is housed in the Clinical Research Center at the then current rate of offset for bedside nursing salaries and fringe benefits provided in the approved rate agreement.
4. The number of patient days allocated to "service" patients shall not exceed one-fourth of the total patient days on the center in any one month period except by prior written agreement with the General Clinical Research Centers Branch.
5. Utilization of center beds for service patients should be accounted for on a monthly basis and included in the Annual Report. In addition, a tabulation of the annual number of patient bed days by patient diagnosis should be included for each admitting physician.


William R. DeCesare, M.D.

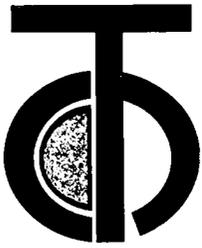
cc:

Program Directors

Financial Officers

Hospital Administrators

General Clinical Research Center Committee Members



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

Special Membership Memorandum
70-2S

January 16, 1970

Subject: Continued Meetings With Rep-
resentatives of NIH-General
Clinical Research Centers
Branch (Supplement to SMM 70-1S)

In follow-up of the December 3, 1969 meeting with representatives of the NIH G.C.R.C. Branch, reported in Special Membership Memorandum No. 70-1S, a subsequent meeting was held on January 7, 1970 to further discuss a concept which has been termed a "Space Usage Charge".

The attached document represents the most recent thinking by the G.C.R.C. staff in the development of this concept. As stated on page 2 it is believed that from a program standpoint, the following benefits would accrue: Increased Flexibility and Utilization; Increased Efficiency; and Increased Effectiveness.

COTH Staff and those of membership who have participated during the development of this concept would appreciate your comments and observations on the proposal. Of particular importance, we believe, is the section of page 3 entitled "The Methodology of a Space Usage Charge". Comments relating to the potential effects of this costing methodology as compared to that currently in use at your institution would be particularly useful in continued deliberations.

This item will be on the agenda for the February 6, 1970 meeting of the COTH Executive Committee, and we would therefore appreciate any comments you may wish to make as quickly as possible so that they may be included for consideration.

FLETCHER H. BINGHAM, PH.D.
Associate Director
Council of Teaching Hospitals

P.S. As has been our custom with this series of Special Membership Memoranda, this memorandum is being mailed to all COTH members so as to be informational to those who do not have Clinical Research Centers

Attachment: Space Usage Charge

SPACE USAGE CHARGE

A New Concept of Hospital Reimbursement for General Clinical Research Centers

The General Clinical Research Centers Program has developed a new concept of hospitalization reimbursement for general clinical research centers. This reimbursement method, termed a "space usage charge," is based upon the annual cost of maintaining clinical research centers space. The space usage charge recognizes the discrete research center (patient area, laboratories, dietary facilities, etc.) as a separate cost unit from other routine service areas. Costs applicable to the research units can easily be derived using existing cost-finding methods. Ancillary services would be purchased as necessary by the grant on a fees-adjusted-to-cost basis.

Two separate proposals currently under study directly interact with the concept of a space usage charge: 1) a Single Cost Report for hospital reimbursement and 2) ambulatory patient admissions to clinical research centers.

The Grants Administration Policy Office of the Department of Health, Education, and Welfare is studying a proposal for a single hospitalization reimbursement method (fees-adjusted-to-cost) using Medicare cost principles. This method would apply to all DHEW grants-in-aid programs involving research patient admissions. Both the space usage charge and the fees-adjusted-to-cost method can be derived using the same step-down cost-finding schedule. The proposed space usage charge is an optional alternative to the fees-adjusted-to-cost reimbursement method and complements the Department's efforts to simplify and unify hospital reimbursement methods into a Single Cost Report.

The National Advisory Research Resources Council recently recommended to the Director, NIH, that the General Clinical Research Centers Program develop a capability in ambulatory patient research. This would represent an important complement to existing inpatient clinical investigations (e.g., for screening and follow-up studies) and provide a unique environment for purely outpatient investigations. The addition of ambulatory patient admissions to clinical research centers further necessitates the development of a hospitalization reimbursement method that permits a flexible admission policy. Such a hospitalization reimbursement method for ambulatory research patient admissions should relate to actual costs. Using present reimbursement methods, rate negotiations would be difficult since the activities of ambulatory research patients often lie outside the mainstream of routine care where usual cost data are determined. The proposed space usage charge avoids this problem by paying the cost of maintaining the research space, regardless of its utilization by inpatients or outpatients.

From a Program standpoint, a space usage charge has a number of interrelated advantages:

Increased Flexibility and Utilization

The Program Director would have a greater flexibility to admit a mixture of patients depending upon the interests and research requirements of the most meritorious investigators. Inpatient and outpatient admissions range from normal controls to acutely ill individuals, and include all age groups. Using present reimbursement methods, the number of patient admissions is limited by a charge per patient. As a result, these valuable facilities and their research staff are, in many instances, underutilized. With the space usage charge, there are no individual inpatient or outpatient admission charges; the limiting factor involves personnel time to perform the necessary research and patient care procedures. Undoubtedly, this will result in the more effective use of these highly skilled research personnel.

Increased Efficiency

Preliminary studies indicate that the annual hospitalization cost using a space usage charge is approximately comparable to present methods of reimbursement (where there is a charge per patient day). The increased flexibility inherent to the space usage charge would permit a significantly increased utilization of center space and personnel time. An increased utilization of clinical research centers at approximately the same annual cost results in a lower cost per patient. Under the terms of a space usage charge, the grant purchases ancillary services as needed, rather than paying average patient care rates, which sometimes include routine services not used by research patients or which the grant has provided directly.

Increased Effectiveness

A space usage charge represents a flexible hospitalization reimbursement method for an inpatient and outpatient research facility. Such a program encompasses a larger number of research interests. The increased flexibility and utilization of the center by a larger group of investigators at a lower cost per patient can only result in a more comprehensive, productive program in clinical research.

From a hospital standpoint, a space usage charge would seem to provide a more stable and reliable form of reimbursement. The hospital has reserved the clinical research center space exclusively for research patient admissions. Under present reimbursement methods, a finite number of research patients must be admitted to the unit before the hospital realizes the cost of maintaining that space, whereas a space usage charge pays total and actual costs to the hospital on a yearly basis. Both the hospital

administrator and the clinical research center Program Director know the annual costs for hospitalization and personnel at the beginning of the grant year. The only variable is the purchase of ancillary services. This increased fiscal predictability and simplified accounting procedures would result in better management by both parties.

The Methodology of a Space Usage Charge

To simplify accounting procedures, a space usage charge embodies the costing principles presently used by hospitals, government agencies, and others. To compute General Clinical Research Center hospitalization cost, it is proposed to use Cost Finding Schedules (Form SSA-1562) used for determining Medicare costs, or an equivalent format. This form would be slightly modified so that Inpatient Cost Centers (lines 32 and 33, worksheet B) would also include a line for Discrete Research Centers. The suggested bases and order of allocating costs used in Form 1562 Cost Finding Schedules appear adequate to effect proper cost distributions, although any equitable bases may be substituted for a given cost category. All allowable costs for Medicare determinations will be utilized. Raw food and other necessary dietary services not provided directly by the grant should be included in the dietary step-down.

Review

The concepts and methodology of the space usage charge have been developed with the assistance of hospital administrators and financial officers during two ad hoc conferences. A list of participants who assisted in the formulation of this proposed policy is appended.

First Ad Hoc Conference to Discuss Hospital Reimbursement Policy
General Clinical Research Centers Program
December 3, 1969

PARTICIPANTS

Dr. Fletcher Bingham
Associate Director
Council of Teaching Hospitals
American Association of
Medical Colleges

Dr. Roger Black
Associate Director
Clinical Center
National Institutes of Health

Mr. Walton Devine
Director of Fiscal Affairs
Children's Hospital, Boston

Mr. Thomas Gletner
Financial Manager
Georgetown University Hospital

Mr. Jerry Huddleson
Director of Fiscal Services
Ohio State University Hospital

Mr. Peter Hughes
Director of Health Services
Research and Planning
New York University Medical
Center

Mr. John Imirie
Hospital Administrator
Georgetown University Hospital

Mr. Bernard Lachner
Administrator
Ohio State University Hospital

Mr. Lawrence Martin
Associate Director and Comptroller
Massachusetts General Hospital

Mr. David Weiner
Assistant to the General Director
Children's Hospital, Boston

Mr. Irvin Wilmot
Associate Director
New York University Medical
Center

Second Ad Hoc Conference to Discuss Hospital Reimbursement Policy
General Clinical Research Centers Program
January 7, 1970

PARTICIPANTS

Dr. Fletcher Bingham
Associate Director
Council of Teaching Hospitals
American Association of Medical
Colleges

Dr. Roger Black
Associate Director
Clinical Center
National Institutes of Health

Mr. H. G. Bozzonetti
Division of Grants Administration
Policy
Office of the Assistant Secretary,
Comptroller
Department of Health, Education,
and Welfare

Mr. Paul L. Broughton
Controller
Boston Children's Hospital

Mr. Albert Conn
Acting Hospital Administrator
Georgetown University Hospital

Mr. Harold Emrich
Associate Comptroller
Massachusetts General Hospital

Mr. Thomas Gletner
Financial Manager
Georgetown University Hospital

Mr. Jerry Huddleson
Director of Fiscal Services
Ohio State University Hospital

Mr. Peter Hughes
Director of Health Services
Research and Planning
New York University Medical
Center

Mr. H. G. Kirschenmann
Division of Grants Administration
Policy
Office of the Assistant Secretary,
Comptroller
Department of Health, Education,
and Welfare

Mr. Irvin Wilmot
Associate Director
New York University Medical
Center

TAB I

Synopsis of Negotiations Committee of Interns and Residents
of New York City

In 1968 an Agreement was signed between the City and the Committee which extended from July, 1968 through September, 1969. The major points, in addition to the salary schedules shown below, were the recognition of the Committee as the collective bargaining unit for House Officers at Municipal hospitals, the participation by two house officers on each Hospital board, and the establishment of a House Staff Affairs Committee.

In February, 1969, the AMA was asked to comment on the situation. They advised that there was nothing illegal about the agreement but expressed reservations at the departures from tradition.

In April, 1969, the Advisory Committee on Graduate Medical Education convened. It reported the need for several items such as better communications, grievance systems, and participation in policy making by House Officers.

In March, 1969, a test case concerning the legality of the Committee was decided. The New York State Labor Relations Board found for the Committee, i.e. the house staff had the right as employees of the Brooklyn Eye and Ear Hospital to elect a collective bargaining unit.

The 1969 Contract demands by the Committee incorporated the salaries listed below plus several other demands. Some of the more important conditions were:

1. Increased contributions toward a Welfare Fund
2. Unlimited sick leave
3. Improved nursing ratios for staffing
4. Laboratory reports within 24 hours

SALARIES

	<u>Demanded</u>	<u>1968 Contract</u>		<u>1969 Contract</u>
		<u>7/68</u>	<u>7/69</u>	
Interns	\$ 12,000	\$ 7,500	\$ 7,750	\$ 12,500
1st Yr. Res.	13,000	8,000	8,250	13,750
2nd Yr. Res.	14,500	8,500	8,750	15,000
3rd Yr. Res.	15,000	9,000	9,250	16,250
4th Yr. Res.	16,000	9,500	9,750	17,500
5th Yr. Res.	17,000	10,000	10,250	18,750
6th Yr. Res.	18,000	10,500	10,750	20,000
Chief	+1,000	+500	+500	+1,250

*Not bad for a group of
as clearly as
"5" students*

1968 Contract

1969 Demands

CONTRACT DEMANDS

1. Salaries

		7/1/68	7/1/69	
Interns	\$12,000	\$7,500	\$7,750	\$12,500
1st Yr. Res.	\$13,000	\$8,000	\$8,250	\$13,750
2nd Yr. Res.	\$14,000	\$8,500	\$8,750	\$15,000
3rd Yr. Res.	\$15,000	\$9,000	\$9,250	\$16,250
4th Yr. Res.	\$16,000	\$9,500	\$9,750	\$17,500
5th Yr. Res.	\$17,000	\$10,000	\$10,250	\$18,750
6th Yr. Res.	\$18,000	\$10,500	\$10,750	\$20,000
Chief	+\$1,000	+\$500		+\$1,250 for Chief

2. Living Out Allowance

\$1,800 per year \$1,500 granted Maintenance of \$1,500 allowance *OK*

3. CBA Welfare Fund

\$125 per member \$110 granted \$200 demanded *Should be 125*

4. Continuation of Existing Privileges

- hospital meals not granted same as 1968 demand
- laundry
- storage space
- on-call sleep-in facilities *OK*

5. Security

- One police officer at each City Hospital (24 hours) not granted same as 1968 demand
- One extra police officer at hospitals with psychiatric admissions

6. Unlimited Sick Leave

no provision granted same as 1968 demand *OK*

7. Provision of Out-of-Hospital living facilities at "reasonable" rental

not granted same as 1968 demand *OK*

8. Establishment of appropriate grievance procedures

granted 1 step grievance procedure not demanded since granted *OK*

<u>1968</u>	<u>1968 Contract</u>	<u>1969 Demands</u>
9. 10% Night Differential	not granted	not demanded in 1969
10. Para-medical teams to be supplied for: Blood EKG IV Crows	not mentioned	not demanded in 1969
11. Central Stenographic Pool for House Staff report transcription	not mentioned	same as 1968 demand
12. Increase number of OPD Clerks for maintenance of patient records	not mentioned	not demanded in 1969
13. Adequate increase in the number of Ward Clerks	not mentioned	not demanded in 1969
14. All terms of Collective Bargaining agreement into a contract	done so in 1968-1969 contract	same as 1968 demand

NEW DEMANDS IN 1969

1. Annuity Fund

Intern	\$275
1st Yr. Res.	\$300
2nd Yr. Res.	\$325
3rd Yr. Res.	\$350
4th Yr. Res.	\$375
5th Yr. Res.	\$400
6th Yr. Res.	\$425
Chief	+\$25

2. Vacation Minimum

Interns -- 3 weeks
Residents -- 4 weeks

3. Assignment of 1 RN per Nursing Unit per tour

- a. Plus LPN, Nurse's Aides in "appropriate ratio"
- b. Ratio to be determined by joint board of CIR and Department of Hospitals

4. Contribution of \$500 used for attendance at professional conferences

- a. Balance left to be credited to account of House Staff Officer
- b. If left over when House Staff Officer leaves, goes to fund for lectures at hospital

5. Provision of a "beeper" service

6. Parking Improvements

- a. Provision of adequate facilities at the hospital
- b. Or use of "sticker" system for parking in vicinity of the hospital

COMPREHENSIVE HEALTH PLANNING

It appears that the Association has three options available to it with regard to a position on the relationship between medical schools and teaching hospitals and a comprehensive health planning program:

I. MAINTENANCE OF PRESENT POLICY

Dr. Thomas B. Turner's testimony registers the Association as:

- opposed to a state planning agency having the power to enforce their plans on or withhold federal funds from institutions engaged in the education of health personnel and the facilities essential to such educational pursuits.

II. ENDORSEMENT OF STATE & LOCAL CONTROL, - EXCLUDING FEDERAL FUNDS

Such a policy, in effect, endorses:

- the concept that although medical schools and teaching hospitals are national resources, whether state supported or not, they should be subject to control by a local or state planning agency when state or local resources are in question, but not federal funds.

III. ENDORSEMENT OF THE CONCEPT OF COMPREHENSIVE HEALTH PLANNING

Title IV of the Intergovernmental Cooperation Act of 1968, Section 401 (c):

"To the maximum extent possible, consistent with national objectives, all Federal aid for development purposes shall be consistent with and further the objectives of State, regional, and local comprehensive planning. Consideration shall be given to all developmental aspects of our total national community, including but not limited to housing, transportation, economic development, natural and human resources development, community facilities, and the general improvement of living environments."

BLUE CROSS ASSOCIATION

840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • 664-2457

June 9, 1969

TO: Chief Plan Executives and Medicare Coordinators
FROM: George N. Hasapes, Assistant Medicare Coordinator
SUBJECT: GUIDELINES FOR DETERMINING COST AND AUDITING OF MEDICAL-RELATED SCHOOL PROVIDERS

Attached are guidelines and a comprehensive questionnaire for determining costs and auditing of Medical-School related providers. This material, developed by a task force of Plan and ECA personnel, was designed to facilitate the audit process for this type of provider.

We acknowledge the assistance provided by Plan personnel from Oakland, St. Paul, Omaha, Cincinnati and Philadelphia.

In some settings the faculty member may be involved in additional programs which claim part of his normal working time. Regulation Section 405.421 (c) states in part:

"...it is not intended that this program should participate in increased costs resulting from a re-distribution of costs from educational institutions or units to patient care institutions or units to patient care institutions or units."

Any costs incurred by the hospital for services rendered by the medical school faculty must be reviewed from the standpoint of reasonableness and value for actual services rendered.

There are some faculty members who are paid a gross salary by the medical school or university out of a departmental fund. All earnings of the faculty member from research projects and from rendering personal services to patients are credited to the departmental fund. The faculty member has no identifiable interest in the fund; he can't withdraw part of the fund when he retires, he can't will any part of the fund to surviving heirs. The fund bills the medical school and others for the services of the faculty member.

This department fund is a management tool for segregating income and expenses of segments of the services provided by professional personnel. As such, it cannot be separated from the university or medical school. Therefore, each member of such a departmental group is subject to the rules of a provider-based physician. All the billings rendered in his name or on his behalf to patients are compensation earned for his personal services as a

physician. Such compensation for personal medical services as a physician is automatically an offset against expense on the expense adjustment schedule of the provider's statement of reimbursable cost.

The income to and the expenditures from the departmental funds must be analyzed to determine to which units of the complex the income or expenses must be ascribed. Since the use of the departmental fund device is an administrative tool encompassing several units of the complex and since it has no substance of its own, all its financial activities must be distributed properly to the respective units of the complex.

Some faculty members, in addition to receiving compensation from the university or medical school, are privileged to treat private patients on their own account. Time spent in such private practice is not included in the compensable time of the faculty member, neither is the income earned from such practice used as an offset against compensation paid by the university or medical school. In some cases, faculty members have special arrangements for the use of hospital space for the treatment of private patients. These arrangements between the physician and the hospital should be reviewed for possible audit adjustment.

Interns and Residents:

No one may bill for the services of an intern or resident who is included under an approved teaching program. If, in an audit, any such billings by anyone, including a departmental group, are disclosed, the amounts billed are an offset against the stipends paid to the residents or interns.

Residents and interns who are on the payroll of the hospital frequently provide services to the medical school, the degree-granting nursing school, other paramedical training to schools of the university and to research projects.



SAINT LOUIS UNIVERSITY HOSPITALS

1325 South Grand Boulevard

Saint Louis, Missouri 63104

PR 1-7600

Firmin Desloge Hospital

David P. Wohl Memorial Mental Health Institute

October 23, 1969

Ernest N. Boettcher, M.D.

Director

Mr. Carl J. Nowacki, Director
Provider Reimbursement Division
Blue Cross Hospital Service, Inc.
1205 Olive Street
St. Louis, Missouri 63103

Dear Mr. Nowacki:

I would like to express my sincere appreciation for the generous amount of time granted by you and your staff, as well as the personnel from General American, to discuss the complexities of interpretations of the Medicare Law, its regulations and the many interpretations as they pertain to provider cost with regard to both hospital based physicians and physicians associated with this Hospital as a result of its relationship to the Medical School. At the conclusion of our lengthy discussion, I indicated to you that I could, under no circumstances, accept final settlement for Medicare reimbursement for our fiscal year ending August 31, 1966 until there is some resolution to what I regard as faulty interpretations of certain of the regulations.

I refer in particular to the August 1969 revision to the Provider Reimbursement Manual (#10) and Section 2108.3 C4 which states in part: "However, if amounts assigned to a restricted fund inured solely to the benefit of the physician, e.g., a pension fund, such amounts would properly be included in the physician's compensation." This sentence does not, of itself, raise any difficulty where the physician is clearly a hospital based physician.

However, the "Guidelines for Determining Costs and Auditing of Medical School Related Providers" issued last June, a copy of which you kindly provided to me last August, has applied the concept of hospital based physicians to mean provider based physicians which is a term also used in the Hospital Manual. In considering the reimbursable costs of provider based physicians for medical school related providers, the critical

Mr. Carl J. Nowacki
October 23, 1969
Page #2.

question is the definition of "provider". In our discussions you indicated the "Guidelines" imply that the university or at least the medical school hospital combination is the provider. If such is the case, there must be a policy determination as to why the net cost of education of medical students should not be includable in the reimbursable costs of the provider as defined.

On the other hand, the "Guidelines" are somewhat ambiguous when they state in the Introduction:

"It will be helpful to recognize that the institution which is at the uppermost point of the complex is legally and philosophically the actual provider. However, if this recognition is the basis for the determination of reasonable cost of patient care, the reporting problems and the ensuing audit problems are practically insurmountable."

This suggests to me that in the case of Saint Louis University Hospitals which is a separate and identifiable entity, particularly in accounting and record keeping the audit problems are surmountable only if the hospital, and only the hospital, is regarded as the provider.

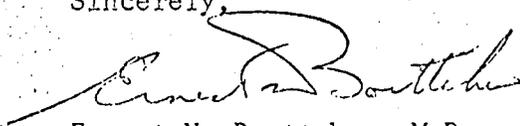
This would, of course, result in the determination that all members of the medical school faculty are not, in fact, provider based physicians.

I would submit my personal opinion that much of the difficulty is based on the lack of understanding of the role of full time clinical faculty who also participate in the provision of direct personal patient services. Such faculty members are primarily oriented toward academic excellence and as such must maintain their expertise in the direct application of current medical knowledge. It has been traditional that services provided by such outstanding physicians on the clinical faculty of our medical schools are paid for through the fee for service system and such fee income does not, in most instances, inure solely to the individual clinician since his orientation is academic rather than financial. As a result, funds received in the form of fees for services rendered to patients are intertwined with and form a major part of the fiscal resources of our medical education system. Any alteration of the fiscal basis for medical education demands the utmost care in reviewing the implications at a time when a number of medical schools, including this one, are critically concerned about their fiscal viability. I proffer this as my personal opinion and not the position of this institution.

Mr. Carl J. Nowacki
October 23, 1969
Page #3

I shall appreciate reconsideration of a final settlement of our Medicare reimbursement for the fiscal year ending 8/31/66 at any time you are in a position to present some new interpretations or alternative means of arriving at a final settlement.

Sincerely,



Ernest N. Boettcher, M.D.
Director

ENB:ms

cc: Dr. Fletcher Bingham
Association of American Medical Colleges
Mr. E. H. Borman
General American Life Insurance
Mr. James M. Ensign
Blue Cross Association
Mr. Michael Zuckerman
Social Security Administration
(Per phone conversation 10/15/69)

bcc: Rev. E. J. Drummond, S.J.
Mr. Joseph Lynch
Mr. Thomas V. Connelly

BLUE CROSS HOSPITAL SERVICE, INC.
1430 OLIVE STREET • ST. LOUIS, MO. 63103

*12 Mr. Ensign
Mr. Friedman
sent 1/21/69
sent Mr. Friedman
11/17/69*

November 19, 1969

*answered
17 letter of
Dec 23*
*Meatball
Friedman
Adm. Association
205*

RECEIVED
NOV 20 1969
DIRECTOR'S OFFICE

Mr. Bernard R. Tresnowski,
Senior Vice President
Government Programs
Blue Cross Association
340 North Lake Shore Drive
Chicago, Illinois 60611

RE: St. Louis University Hospitals
Professional Component - Physician Services

Dear Barney:

This letter supplements our telephone conversation in which we discussed some of the background pertaining to the letter from Dr. Ernest N. Boettcher, Director, St. Louis University Hospitals, dated October 23, 1969, a copy of which was furnished Mr. James M. Ensign.

The purpose of this letter was to point out the financial impact on the university if certain procedures contained in the "Guidelines for Determining Costs and Auditing of Medical School Related Providers" are used in the determination of reimbursable costs for this provider. Specifically, this refers to the procedures on pages 13 and 14 of these guidelines relating to the treatment of costs and revenues of departmental funds, and the requirement that "such compensation for personal medical services as a physician is automatically an offset against expense on the expense adjustment schedule of the provider's statement of reimbursable cost."

Dr. Boettcher has stated that if this provision is applied to the teaching faculty, the effect would be of such magnitude as to threaten the continued existence of this medical school and many other private medical schools which are dependent on the professional fees of teaching physicians in order to secure a balanced budget.

As Dr. Boettcher has indicated, "the critical question is the definition of the 'provider'". While there is no question that this provider is owned and operated by St. Louis University, which also owns and operates a School of Medicine, the hospital is essentially autonomous and hospital costs are generally well-defined without reference to the medical school or the university. This point was covered in my letter to Mr. Leo Hickman dated September 4, 1969 (per copy attached) relating to the allowability of interest expense.

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Mr. Bernard E. Trecnowski
Blue Cross Association
RE: St. Louis University Hospitals
Professional Component - Physician Services
November 19, 1969
-2-

It is recognized that the requirement in the guideline was to implement the requirements of 2108.3-C-4 of HIM-15. Hence, several questions can be identified:

- Reference to Admin. Code 205*
1. What is the extent of the provider entity?
 2. Can we distinguish between "hospital-based physicians" (such as radiologists, pathologists, etc.) and "provider-based physicians" (which might include all members of the medical school faculty)? *are used synonymously*
 3. The hospital computed professional components based on amounts paid by the hospital to the Department Development Fund. This exceeded the amount paid to the physician. Is reimbursement restricted to the amounts paid to the physician?
 4. *YES* [Must income produced as the result of personal services of the physician be used to offset against expense of the provider? It is difficult to support this requirement since such collections are attributable to the portion of the physician's time allocated to personal professional services. It would seem more appropriate to eliminate the salary and fringe cost attributable to this personal services.]
 5. *No* [Can the provider-entity be defined to include the hospital only? If so, perhaps the letter of Grete Schiodt dated September 23, 1969 concerning interest expense should be re-evaluated.]

Very truly yours,

Carl J. Nowacki, Director
Provider Reimbursement Division

CJM/rs
Attachment

bc: Dr. Ernest N. Boettcher, Director
St. Louis University Hospitals

RECEIVED

JAN 21 1970

JAN 2 1970

DIRECTOR'S OFFICE

BLUE CROSS ASSOCIATION

840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • 329-6000

December 23, 1969

Mr. Carl J. Nowacki, Director
Provider Reimbursement Division
Blue Cross Hospital Service, Inc., of Missouri
1430 Olive Street
St. Louis, Missouri, 63103

*Sends to Dr. Butterman
For your info
Carl*

Dear Carl:

This is in reply to your letter of November 19, 1969, addressed to Mr. Bernard R. Tresnowski concerning professional component-physician's services at St. Louis University Hospitals.

In responding, we will follow the sequence of questions listed on page 2 of your November 19, letter.

1. The extent of the Provider entity may be answered by reference to the last paragraph on page 3 of Administrative Bulletin No. 205 which states in part: "Recognition of the fact that the complex of institutions is the Provider means that costs incurred anywhere within the complex related to patient care are recognized as legitimate reimbursable costs." Thus the Provider extends to any unit or building which contributes to patient care.
2. The terms "hospital-based physicians" and "Provider-based physicians" are used synonymously. Any physician who renders direct patient care services within the Provider complex is considered a Provider-based physician. This concept is explained on pages 13 and 14 of Administrative Bulletin No. 205.
3. The first part of your question is not clear as it relates to the computation of professional components and amounts paid by the hospital to department development fund. Whatever salary is paid to the physician must be broken out as to that portion relating to the hospital. This portion must then be further broken down between the Provider component and the professional component. We do not see that it is possible for the professional component portion to exceed the total amount paid to the physician. A methodology as it relates to university hospitals is outlined on pages 13 and 14 of Administrative Bulletin No. 205. We also refer you to Provider Reimbursement Manual Section 2108 ff.
4. As to whether income produced as a result of personal services of the physician must be offset against expense to the Provider, the answer is yes. In the first place the schedule of charges must be designed to yield, in the aggregate, as nearly as may be possible, an amount equal to the portion of the physician's compensation represented by the professional component. This is outlined in Provider Reimbursement Manual Section 2108.4 B. As outlined in the last paragraph on page 13 of Administrative Bulletin No. 205, "all the billings rendered in his name or on his behalf to patients

Mr. Carl J. Nowacki

-2-

December 23, 1969

are compensation earned for his personal services as a physician." The third paragraph on page 14 of the Bulletin indicates that time spent in private practice and the income earned therefrom should not be offset against compensation paid by the university or medical school. The point to be remembered is that only those items relating to patient care activities within the Provider are to be considered.

5. The Provider entity cannot be defined to include the hospital only. The reasoning for this answer may be found in 1 above.

If we can be of further help, please let us know.

Sincerely,

Robert A. Snyder
Senior Director
Provider Reimbursement
Government Programs-Operations

RAS/GS/bb

cc: Lyle J. Rouse
Bernard Tresnowski

BLUE CROSS HOSPITAL SERVICE, INC.
1430 OLIVE STREET • ST. LOUIS, MO. 63103

*xe for Dingman
go Mr. Lynch
sub 1/27/70*

RECEIVED

JAN. 27 1970

DIRECTOR'S OFFICE

January 22, 1970

Mr. Robert A. Snyder,
Senior Director
Provider Reimbursement
Government Programs - Operations
Blue Cross Association
840 North Lake Shore Drive
Chicago, Illinois 60611

RE: St. Louis University Hospitals
Professional Component
Physician Services

Dear Bob:

This is a follow-up reply to your letter of December 23, 1969, relating to replies in your letter.

1. Extent of Provider Entity - In my letter of November 19, 1969, I asked that the extent of certification for Medicare purposes be defined. My question was perhaps inadequately explained, since it was based in part on questions in a letter from Dr. Ernest N. Boettcher dated October 23, 1969.

It is realized that certain portions of costs of the medical school and university administration which relate to hospital activities should be introduced into hospital costs. However, the problems of costing become virtually insurmountable if the entire university is treated as the provider-entity.

We believe that a definition of the provider-entity must be applied consistently in the determination of reimbursable costs. The hospital is in general agreement that only limited elements of costs of the rest of the university as are necessary should be introduced into the hospital's cost report. The area of significant concern relates to the required involvement of the department funds as indicated on pages 13 and 14 of Administrative Bulletin 205 - "Guidelines for Determining Cost and Auditing of Medicare-Related School Providers", particularly the requirement that "Such compensation for personal medical services as a physician is automatically an offset against expense on the expense adjustment schedule of the provider's statement of reimbursable cost."

The important element is to define the "provider" so that the term "provider-based physician" can be deduced therefrom. Our

COPY

Mr. Robert A. Snyder
Blue Cross Association
RE: St. Louis University Hospitals
Professional Component
Physician Services
January 22, 1970

-2-

position has been that certain physicians are typically "hospital-based" (radiologist, pathologist, etc.) since they perform normally in furnishing of hospital services.

Aside from providing hospital services, the university also employs full time clinical faculty who also participate in the provision of direct personal patient services. Fees for their services have been credited to the various department funds and, as such, have historically provided supplementary funds to assist in defraying costs of the medical school. These services have no direct relationship with hospital operations. Consequently, we see no reason to offset these fees against hospital expenses.

If such policy is enforced, then other related costs of these physicians, their clerical staffs, overhead, etc., must be also introduced in the cost report. Such complications would produce an insurmountable costing problem. It would also require an answer to the question posed by Dr. Boettcher as to "why the net cost of education of medical students should not be includable in the reimbursable costs of the provider as defined."

Beyond the above question, however, is the more practical and significant: offsetting such fee income against reimbursable hospital cost could have a significant effect on the "fiscal viability" of the medical school, one which we are certain was not intended.

2. Professional Component (Question No. 3) - The meaning of our question no. 3 was perhaps somewhat obscure. It was based on an arrangement whereby the hospital made payments into the various department development funds (such as radiology) based on an item-by-item basis. A professional component was established for each procedure. The physicians were paid a flat salary by the department development fund. The amounts paid by the hospital to the department development fund (and hence, included in the hospital expenses), exceeded the salaries paid to the physicians from the development fund. Under these conditions, we believe that the professional component must be based on the amounts actually paid to the physicians. Do you agree?

Mr. Robert A. Snyder
Blue Cross Association
RE: St. Louis University Hospitals
Professional Component
Physician Services
January 22, 1970
-2-

3. Offset of Income Produced As A Result of Personal Services Of The Physician (Question No. 4) - This is also related to the discussion in No. 1 above. At this institution, the income from such services does not accrue to the individual physician, but to the department fund. Your last sentence in answer to Question No. 4 states: "The point to be remembered is that only those items relating to patient care activities within the provider are to be considered." This emphasizes the importance of defining the "provider-entity".

We believe that only such portion of the physician salary which is involved in hospital activities should be introduced into hospital cost, and that this portion should be allocated between Part B and Part A activities. There should be no need to reduce this cost by collections by the university for his services which are paid into a department development fund.

4. Definition of Provider-Entity (Question No. 5) - It appears that the quote referred to on page 2 of Administrative Bulletin 205 is not as practical as the last paragraph of page 1 of the Guidelines. To some extent, we believe the two quotes to be contradictory in that one would restrict the costs to the hospital insofar as possible, while the other would expand to all functions with the complex which has some relationship to patient care. In those institutions where considerable inter-mingling exists, it may not be possible to restrict such costs. Where, however, the costs are well-defined, it would seem advisable to restrict the definition to the hospital.

Very truly yours,

Cari J. Nowacki, Director
Provider Reimbursement Division

CJN/rs

bc: Dr. Ernest N. Boettcher

TABL

STATE APPROPRIATIONS TO TEACHING HOSPITALS

On October 3, 1969 a brief questionnaire was mailed to each of thirty-seven major, general short-term teaching hospitals believed to be awarded a direct state appropriation to cover operating expenses. The question was phrased to reflect the total operating budget including equipment and routine operational expenditures, with capital appropriations being specifically excluded.

By November 15th, thirty-five administrators had responded to the survey. Cincinnati General Hospital was the only institution which reported no state appropriation. Of the thirty-four remaining respondents three reported they are not owned by a university. Stated another way, twenty-nine are owned by the state, four are nongovernment, nonprofit, and one is city owned. The data obtained through this survey are presented in the attached tables.

Indiana University Hospital, although state owned, does not receive a direct state appropriation. The \$60,000 listed is its expected appropriate share of the legislative support for graduate medical education on a statewide basis. Further, it should be noted that the University of Michigan award is earmarked for the operation of the psychiatric hospital. In this instance, these dollars comprise eighty-three percent of the psychiatric operating budget. The University of Alabama appropriation is divided as follows: Educational Fund - \$1,513,000; General Fund - \$1,000,000; Mental Health Fund - \$850,000.

No attempt has been made to relate the statistics in this report to institutional size, patient load or any other relative variable. Ratio relationships of this type might lead to specious comparisons or other misuse of the data.

The most important factors in this analysis are the percent of the total budget which is supported by the state appropriation, and the purpose for which the state appropriation is awarded. For example, the general appropriation of \$600,000 at Temple University Hospital is made through the medical school for the teaching of undergraduate medical students; the \$840,000 award to the University of Wisconsin Hospitals is also specifically earmarked for educational purposes.

Five of the administrators reported a state appropriation that is less than ten percent of their total operating budget. It seems clear that an appropriation of this type is awarded with a different legislative intent than in cases where the institution receives a very large proportion of its total operating budget through a state appropriation. It should be noted also that as a percentage of total operating expenditures, the responses were distributed as presented in the following table.

TABLE

State Appropriations As A Percentage Of Total Operating Expenditures

Institutions	<u>0-25%</u>	<u>26-50%</u>	<u>51-75%</u>	<u>Total</u>
	13	14	7	34

The variety of situations reported suggest that the phrase "state appropriations to cover operating expenses" is not precisely accurate. The following example of an institution which is awarded more than four million dollars by the state is an illustration. In this hospital, medically indigent patients with specified clinical conditions are selected for teaching purposes. Cost recovery rates are charged to these patients; such rates are usually more than the patients' financial resources, including third party payments. That portion of the bill which cannot be paid is charged to the state appropriation, which is often referred to as the Clinical Teaching Fund.

A variety of financial arrangements similar to the preceding example are utilized to account for the use of state funds. In short, these funds are "free and part pay" funds, and not "state appropriations to cover operating expenses" as many would define them. Additionally, the cost of providing care to these patients includes an appropriate share of the cost of the hospitals' teaching programs. These teaching costs are then charged against the state appropriation.

In order to provide data on a yearly trend basis, a follow-up survey will be undertaken annually. As an aid to further analyses it is requested that each hospital send a brief summary of the legislative intent of its appropriation.

This survey is one of several initiated under the auspices of the COTH Information Center which is supported by contract PH 110-68-41 with the National Center for Health Services Research and Development.

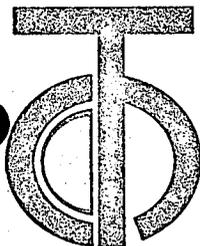
HOSPITAL	Fiscal Yr. Ending	Univ. Ownership	Total Hospital Operating Budget	Size of State Appropriation	State Approp. As %-age of Total
University of Alabama Hospitals & Clinics	Sept. 30 1970	yes	\$21,500,000	\$3,363,000	16%
University Hospital (Little Rock)	June 30 1970	yes	7,152,300	3,003 000	42%
U.C.L.A. Hospital	June 30 1970	yes	18,174,000	3,873,218	16%
University of California Hospitals (San Francisco)	June 30 1970	yes	26,100,000	5,264,000	20%
University Hospital of San Diego County	June 30 1970	no	17,750,000	1,987,933	11%
University of Colorado Medical Center	June 30 1970	yes	13,435,145	5,906,751	44%
University of Connecticut Hospital - McCook Division	July 1 1970	yes	5,690,000	1,390,000	25%
Shands Teaching Hospital and Clinics	June 30 1970	yes	11,357,692	3,308,120	29%
Eugene Talmadge Memorial Hospital	June 30 1970	yes	9,370,000	6,254,000	67%
University of Illinois Research and Educational Hospitals	June 30 1970	yes	14,639,941	8,791,691	60%

HOSPITAL	Fiscal Yr. Ending	Univ. Ownership	Total Hospital Operating Budget	Size of State Appropriation	State Approp. As %-age of Total
Indiana University Hospitals	June 30 1970	yes	\$16,764,552	\$60,000	.35%
University of Iowa Hospitals	June 30 1970	yes	21,137,600	8,700,000	41%
University of Kansas Medical Center	June 30 1970	yes	16,201,912	3,721,357	23%
University of Kentucky Hospital	June 30 1970	yes	11,149,362	4,300,000	39%
Charity Hospital of Louisiana	June 30 1970	no	32,094,806	22,774,185	71%
University of Maryland Hospital	June 30 1970	yes	20,047,847	8,182,738	41%
University Hospital (Ann Arbor)	June 30 1970	yes	39,607,272	4,815,000*	12%
University of Minnesota Hospitals	June 30 1970	yes	25,200,000	3,000,000	12%
University Hospital (Jackson, Mississippi)	June 30 1970	yes	9,400,000	2,505,000	27%
University of Missouri Medical Center	June 30 1970	yes	14,091,000	8,413,000	60%

*These dollars are earmarked as a psychiatric hospital operating appropriation; they comprise 83% of the psychiatric operating budget.

HOSPITAL	Fiscal Yr. Ending	Univ. Ownership	Total Hospital Operating Budget	Size of State Appropriation	State Approp. As %-age of Total
University of Nebraska Hospital	June 30 1970	yes	\$7,716,790	\$3,980,441	52%
State University-King's County Hospital Center	no response				
State University Hospital (Syracuse)	no response				
North Carolina Memorial Hospital	June 30 1970	yes	15,435,373	7,507,316	49%
Cincinnati General Hospital	June 30 1970	no	16,185,000	none	0%
Ohio State University Hospitals	June 30 1970	yes	30,613,000	7,834,700	26%
University of Oklahoma Hospitals	June 30 1970	yes	7,649,301	3,255,654	43%
University of Oregon Medical School Hospitals and Clinics	June 30 1970	yes	It has been requested that this information not be released on an individual basis.		60%
Temple University Hospital	June 1 1970	yes	24,200,000	600,000	3%
Medical College Hospital (Charleston, S.C.)	June 30 1970	yes	10,929,203	4,855,957	45%

HOSPITAL	Fiscal Yr. Ending	Univ. Ownership	Total Hospital Operating Budget	Size of State Appropriation	State Approp. As %-age of Total
University of Texas Medical Branch Hospitals	August 31 1970	yes	\$17,209,703	\$9,458,996	55%
University Hospital, University of Utah	June 30 1970	yes	9,000,000	275,000	3%
Medical College of Virginia Hospitals	June 30 1970	no	26,463,165	8,633,970	33%
University of Virginia Hospital	June 30 1970	yes	14,682,000	3,977,000	27%
University of Washington Hospital	June 30 1970	yes	12,929,000	3,908,000	30%
West Virginia University Hospital	June 30 1970	yes	7,049,079	350,000	5%
University of Wisconsin Hospitals	June 30 1970	yes	19,175,750	840,000	4%



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

General Membership Memorandum
No. 70-2G
December 19, 1969
Subject: Project Priorities For the
Coming Year

1. Special Projects to be Considered in Addition to Reported Program Development:

Last year at this time a brief survey was undertaken to determine what issues COTH members felt deserved the most time and attention. As a result of this survey several projects were initiated and completed during the recent administrative year. Additionally, the survey served well as an indicator for program planning and Annual Meeting presentations. Your staff is once again undertaking such a survey.

2. A Priority List for Your Consideration:

For that purpose a list of projects most frequently discussed with COTH staff is attached. The present order of this list is random and in no way reflects the preference of your staff.

3. Please Complete and Return Attached Form in Enclosed Envelope:

In order to establish an inventory and a priority, you are requested to rank the three most important issues in order of their relevance to your particular needs and interests. Space is available for additional issues which you may wish to identify as of importance to your institution. Suggestions are welcomed and would be appreciated.

JOHN M. DANIELSON
Director
Council of Teaching Hospitals
and Health Services

Attachments: Membership Survey of Special Project Preferences
Envelope for Return to COTH Headquarters

COTH
MEMBERSHIP SURVEY OF SPECIAL
PROJECT PREFERENCES

Please indicate your preference of the three most important issues in order of their importance, e.g. 1, 2, 3. Space for suggested issues is available.

RANK	ISSUE
_____	The effects of medical school curriculum changes as they relate to the future of the teaching hospital.
_____	The relationship of the teaching hospital and the comprehensive health planning agency.
_____	The organization and operational possibilities for medical faculty and/or staff group practice arrangements.
_____	Interns and residents: functions, finances and responsibilities.
_____	The effects of federal cutbacks in clinical and other research areas.
_____	The organizational relationship of the teaching hospital and the university medical center.
_____	Labor-management problems in teaching hospitals.
_____	The role of the teaching hospital in the regional medical program.
_____	Responsibility of the teaching hospital for education of the allied health professions.
_____	Sources of capital financing for teaching hospitals.
_____	The role of the teaching hospital in community service.
_____	Teaching Hospital responsibility for broad range ambulatory and extension services.
_____	The impact of federal and other third party hospital and professional reimbursement formulas as they relate to the financing and organization of medical education
_____	Other

SUMMARY OF RESPONSES
SPECIAL PROJECT PRIORITY PREFERENCES

SPECIAL PROJECT IN RANK ORDER BY NUMBER OF PREFERENCES	RANK ORDER RESPONSES			TOTAL
	(1)	(2)	(3)	
1. The organizational relationship of the teaching hospital and the university medical center.	46	37	30	113
2. The impact of federal and other third party hospital and professional reimbursement formulas as they relate to the financing and organization of medical education.	43	33	23	99
3. The role of the teaching hospital in community service.	33	29	32	90
4. Sources of capital financing for teaching hospitals.	22	32	24	78
5. Interns and residents: functions, finances and responsibilities.	31	22	26	77
6. Teaching Hospital responsibility for broad range ambulatory and extension services.	14	23	28	61
7. The organization and operational possibilities for medical faculty and/or staff group practice arrangements.	14	19	21	55
8. The relationship of the teaching hospital and the comprehensive health planning agency.	12	20	25	52
9. Responsibility of the teaching hospital for education of the allied health professions.	7	21	24	52
10. The effects of medical school curriculum changes as they relate to the future of the teaching hospital.	16	15	18	48
11. The role of the teaching hospital in the regional medical program.	0	5	21	24
12. Labor-management problems in teaching hospitals.	6	4	12	22
13. The effects of federal cutbacks in clinical and other research areas.	7	5	8	20

Data as of Feb. 2, 1970, on the basis of 267 responses received at 73.5 percent rate of response.

1 of the Association of American Medical Colleges, 1931 to
 2 1939, and of the Council of Teaching Hospitals, November
 3 2nd, 1939."

4 I couldn't say anything more than from the bottom
 5 of my heart most warmly -- and I am not usually known for lack
 6 of words -- thank you so much; it is really magnificent. We
 7 will cherish it, and on behalf of Holl and the children, who
 8 have really worked with me in making time available and so
 9 forth, it has been wonderful, and I hope that maybe going with
 10 this is a sort of a membership that will allow me to sit in
 11 with you and enjoy and watch as you continue to develop on
 12 behalf of our hospitals, so to speak.

13 Thank you again so much.

14 (Applause.)

15 THE CHAIRMAN: Does any member have any other bus-
 16 iness that he wishes to bring before this Assembly?

17 Dr. ~~Conner~~ ^{Hartman}

18 DR. ~~Conner~~ ^{Hartman}: If it wouldn't be an anticlimax,
 19 Mr. Chairman, I wonder if we are ready to consider at some
 20 future date the inclusion of clinics as members of the Council
 21 of Teaching Hospitals?

22 We can't help but be aware that the Mayos have a
 23 major contribution to medical education, and we certainly must
 24 be aware that the Joselyn Clinic in Boston, although it is
 25 a specialty group, has an equal commitment.

1 And I am sure that we are equally conscious of
2 the role of the neighborhood health centers, which are es-
3 sentially committed.

4 Accordingly, Mr. Chairman, I would like to submit
5 that the Executive Committee give consideration to the inclu-
6 sion of clinics as eligible members at a future date.

7 THE CHAIRMAN: Thank you very much. I can assure
8 you that it will be on the next agenda.

9 DR. ~~STANTON~~ ^{MARTIN}: May I offer a second thought that
10 perhaps may be a little bit farther out, but may be pertinent
11 here:

12 We can't help but be aware that we are more and
13 more engaged in health systems. We have heard Walter Reuther
14 indicate that the United States must propose its own National
15 Health Insurance scheme, with comparative disregard for on-
16 going -- or the experience of other national health schemes.

17 We have in the Association of American Medical Col-
18 leges an excellent International Section under the able di-
19 rection of Dr. Henry von Zile Hyde in the area of medical ed-
20 ucation, and I wonder if the time has not come where C. O.
21 T. H. -- or, if you will, the Council of Teaching Hospitals
22 and clinics at some future time -- would wish to undertake
23 the collection of significant information, and the comparison
24 of health systems in other countries, and the roles, the
25 of performance of teaching hospitals in those systems, to

1 that we as heads of our hospitals can at least be conversant
 2 with what has been happening throughout the world, and can
 3 allude or reference this data or these experiences, as we deter-
 4 mine the testimony in behalf of our future and our destiny.

5 THE CHAIRMAN: Thank you. The suggestion is well
 6 made.

7 Other questions or comments? If not, I declare the
 8 meeting adjourned.

9 (Whereupon, at 4:04 o'clock, p.m., the meeting was
 10 adjourned.)

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