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



MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

April 2-3, 1975

Wednesday, April 2

| | | |
|---|---|---|
| 6:30 p.m. | Administrative Board Discussion<br>Mr. Carl Wm. Vogt | Dupont Room<br>Dupont Plaza Hotel |
| 7:30 p.m. | Cocktails and Dinner | |

Thursday, April 3

| | | |
|---|---|---|
| 9:00 a.m. | Administrative Board<br>Business Meeting<br>(Coffee and Danish) | Gallery Room<br>Dupont Plaza Hotel |
| 1:00 p.m. | Joint CAS/COD/COTH/OSR<br>Administrative Board<br>Luncheon | Dupont Room |
| | Executive Council Meeting<br>(All Administrative Board members invited to stay as late as their travel schedule permits) | |
| 5:00 p.m. | Adjourn | |

AGENDA
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

April 3, 1975

| | | |
|---|---|---|
| I. | Call to Order | |
| II. | Consideration of Minutes | PAGE 1 |
| III. | COTH Membership | |
| | A. Application for Membership | Page 13 |
| | The Memorial Hospital<br>Worcester, Massachusetts | |
| | B. Dropped Membership | Page 27 |
| | M.D. Anderson Hospital and Tumor Institute<br>Houston, Texas | |
| | C. Preliminary Report of the COTH Ad Hoc Membership Committee | Dr. Thompson |
| IV. | OSR Recommendation to Establish an Office of Women's Affairs | COUNCIL AGENDA (23) |
| V. | Role of Research in Medical School Education | COUNCIL AGENDA (21) |
| VI. | National Health Insurance and Medical Education | COUNCIL AGENDA (25) |
| VII. | Health Services Advisory Committee Recommendation | COUNCIL AGENDA (30) |
| VIII. | Status Report: Section 223 of P.L. 92-603 | Mr. Everhart |
| IX. | Status Report: Proposed Section 227 Regulations | Dr. Knapp - 28 |
| X. | Status Report: COTH Housestaff Unionization Workshop | Dr. Pointer |

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH Administrative Board Meeting
Dupont Plaza Hotel
Washington, D.C.
January 15, 1975

PRESENT:

Sidney Lewine, Chairman
Charles B. Womer, Chairman-Elect
Robert A. Derzon, Immediate Past Chairman
Daniel W. Capps
John W. Colloton
Leonard W. Cronkhite, Jr., M.D.
David A. Gee
S. David Pomrinse, M.D.
Malcom Randall
John M. Stagl
David D. Thompson, M.D.
Robert E. Toomey
William T. Robinson, AHA Representative

ABSENT:

David L. Everhart
Baldwin G. Lamson, M.D.
J. W. Pinkston, Jr.

GUEST:

John W. Westerman

STAFF:

Robert A. Carow
Armand Checker
James I. Hudson, M.D.
Richard M. Knapp, Ph.D.
Dennis D. Pointer, Ph.D.
Steven J. Summer
Catharine A. Rivera

I. Call to Order:

Mr. Lewine called the meeting to order at 8:30 a.m. in the Gallery Room of the Dupont Plaza Hotel.

II. Consideration of Minutes:

The minutes of the November 12, 1974 Administrative Board meeting were approved as circulated.

III. Report of the Ad Hoc Committee to Review the JCAH 1971 Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations:

John Westerman, Director, University of Minnesota Hospitals and Chairman of the Ad Hoc Committee, presented the Report of the Committee to the COTH Administrative Board. The Administrative Board discussed the Report and noted general approval of Sections I, II, V and VI, but had some questions regarding the wording of two sections: The Delineation of Medical Staff Privileges (Section III) and The Right to Due Process (Section IV).

In the discussion which followed, the Board noted that one change in document should be that the hospital's termination process be reflective of the appointment process. It was the Administrative Board's recommendation that COTH staff obtain the views of CAS and COD Administrative Boards in addition to the changes noted by the COTH Administrative Board, and rework the Ad Hoc Committee Report in light of these additional comments.

In reference to a letter from Dr. Robert Heyssel, Executive Vice President and Director of Johns Hopkins Hospital, the Board took the following action:

ACTION #1 — IT WAS MOVED, SECONDED AND CARRIED THAT DR. ROBERT HEYSSEL'S LETTER (ATTACHED) BE UTILIZED AS A GUIDELINE FOR COTH STAFF IN THEIR DEVELOPMENT OF RECOMMENDATIONS FOR CONSIDERATION OF THE JCAH GUIDELINES FOR THE FORMULATION OF MEDICAL STAFF BYLAWS, RULES AND REGULATIONS.

The Board recommended that staff communicate to the Joint Commission that further analysis of the JCAH Medical Staff Guidelines is required and that the AAMC Report will be completed following this additional review. It was also requested that a redraft of the Ad Hoc Committee Report be placed on the agenda of the April Administrative Board and Executive Council meetings after consultative review by the CAS and COD Administrative Board.

IV. Committee Appointments:

Mr. Lewine reviewed COTH appointments to AAMC committees and appointed David D. Thompson, M.D., chairman of a new committee to once again consider COTH membership criteria. Other members of that committee are: Ivan Bennett, M.D., Malcom Randall, Daniel Capps and David Gee.

The Administrative Board agreed to discharge the Ad Hoc Committee to Review the JCAH Medical Staff Guidelines and the previous Ad Hoc Committee on COTH Membership.

ACTION #2 IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD TAKE THE FOLLOWING COMMITTEE ACTION:

1) DISCHARGE THE FIRST AD HOC COMMITTEE ON COTH MEMBERSHIP CRITERIA, CHAIRED BY CHARLES WOMER;

2) APPOINT A NEW COMMITTEE TO CONSIDER COTH MEMBERSHIP CRITERIA WITH DAVID THOMPSON, M.D. AS CHAIRMAN; MEMBERS OF THIS COMMITTEE WILL BE IVAN BENNETT, M.D., MALCOM RANDALL, DANIEL CAPPS AND DAVID GEE;

3) DISCHARGE THE AD HOC COMMITTEE TO REVIEW THE JCAH MEDICAL STAFF GUIDELINES CHAIRED BY JOHN WESTERMAN.

V. Membership Applications:

The Board reviewed one application for membership and took the following action:

ACTION #3 IT WAS MOVED, SECONDED AND CARRIED THAT THE CROZER-CHESTER MEDICAL CENTER IN CHESTER, PENNSYLVANIA BE APPROVED FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS.

VI. AAMC Task Force on Manpower and Survey Results:

Dr. Knapp distributed results of the AAMC Health Manpower Survey and highlighted the COTH responses of particular interest. Dr. David Thompson, a member of the Task Force, reviewed the draft report for the Administrative Board.

In the discussion which followed, the COTH Administrative Board voiced concern over the conclusions and recommendation of the Task Force's legislative proposal. After considerable debate and as a result of Administrative Board deliberation over the Report, the following action was taken:

ACTION #4 IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING RECOMMENDATIONS BE BROUGHT BEFORE THE AAMC EXECUTIVE COUNCIL:

1) THE FIFTY PERCENT OBJECTIVE FOR PRIMARY CARE RESIDENCIES IS APPROPRIATE, BUT DISTRIBUTION AND TYPES OF GRADUATE MEDICAL EDUCATION PROGRAMS SHOULD BE DISASSOCIATED WITH AND SEPARATE FROM UNDERGRADUATE CAPITATION REQUIREMENTS.

2) THE CCME OR SOME OTHER BODY SHOULD BE GIVEN THE RESPONSIBILITY TO ADDRESS THE SPECIALTY DISTRIBUTION QUESTION, AND DISTRIBUTION OF

RESIDENCY POSITIONS SHOULD BE ON A NATIONAL BASIS TIED TO HOSPITAL REIMBURSEMENT. (THE BOARD INDICATED THAT A PROVISION SIMILAR TO THAT EMBODIED IN THE ROGER'S MANPOWER LEGISLATION MAY BE APPROPRIATE.)

3) DIRECT SUPPORT SHOULD BE GIVEN FOR THE ESTABLISHMENT OF NEW PRIMARY CARE RESIDENCY PROGRAMS.

4) REMOVAL OF THE SPECIAL PREFERENCE VISAS FOR ALIEN PHYSICIANS SHOULD BE WITHHELD PENDING A FULL ANALYSIS OF WHAT THE IMPACT OF THIS PROVISION WOULD BE; CONCERN WAS EXPRESSED FOR THE NUMBER OF POSITIONS THAT WOULD BE AFFECTED AND THE NEED FOR INCLUSION OF A PRINCIPLE FOR GRADUAL REDUCTION RATHER THAN COMPLETE TERMINATION.

VII. 1975 Constituent Meetings:

The Board reviewed the format for the 1975 annual meeting and schedule outline as included in the agenda. The Board decided to eliminate the regional meetings this year and solicit membership input on the efficacy of these gatherings.

The COTH Administrative Board strongly endorsed a staff-initiated proposal for holding a Conference on Housestaff Collective Bargaining. Dr. Pointer reviewed the tentative schedule which he had prepared and noted that the conference is scheduled for April 11, 1975 in Washington, D.C. Initial registration will be limited to two participants from each hospital with a maximum of sixty registrants. The Board suggested that if registration is heavy, staff should consider reducing it to one participant per institution. The Board also suggested that this type of activity - issue oriented conferences - be pursued this year instead of the traditional spring COTH regional meetings.

VIII. CCME Procedures:

The COTH Administrative Board approved the procedure for approval of the CCME report which recommends an item-by-item approval mechanism. This allows the parent organization to propose a change in the recommendation or report and submit the proposed change for subsequent consideration rather than limiting the decision to approval or disapproval only, of the entire report.

IX. CCME Report: The Role of the Foreign Medical Graduate:

Members of the Administrative Board discussed the Report of the Coordinating Council on Medical Education entitled, "The Role of the Foreign Medical Graduate." The Board agreed that they should recommend disapproval of the CCME Report and therefore took the following action.

ACTION #5 — IT WAS MOVED, SECONDED AND CARRIED THAT THE CCME REPORT, "THE ROLE OF THE FOREIGN MEDICAL GRADUATE," BE TABLED UNTIL A NATIONAL INVITATIONAL CONFERENCE, AS SUGGESTED IN THE REPORT, BE HELD. THE BOARD ALSO REQUESTED THAT AAMC STAFF PREPARE A BRIEF ANALYSIS OF EACH OF THE FORTY-FOUR RECOMMENDATIONS CONTAINED IN THE CCME REPORT BEFORE ANY FURTHER ACTION IS TAKEN.

X. LCGME Report on NIRMP:

In reviewing the Report of the National Intern and Resident Matching Program Subcommittee of the Liaison Committee on Graduate Medical Education, the COTH Administrative Board took the following action:

ACTION #6 — IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING ACTION BE TAKEN REGARDING THE LCGME REPORT ON NIRMP:

1) RECOMMENDATION II SHOULD INCLUDE THE WORDS "FOR THE FIRST YEAR ONLY" SO AS TO READ: "THE ALL OR NONE PRINCIPLE SHOULD BE SUPPORTED FOR THE FIRST YEAR ONLY;"

2) RECOMMENDATION III SHOULD BE DELETED IN ENTIRETY;

3) RECOMMENDATIONS I, IV AND V SHOULD BE SUPPORTED AS RECOMMENDED.

XI. Report of the Task Force on Groups:

The COTH Administrative Board reviewed the Report of the Task Force on Groups and took the following action:

ACTION #7 — IT WAS MOVED, SECONDED AND CARRIED THAT THE REPORT OF THE TASK FORCE ON GROUPS BE APPROVED AS SUBMITTED.

XII. ORS Actions:

The COTH Administrative Board reviewed the actions of the OSR Administrative Board and took the following action:

ACTION #8 — IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING ACTIONS BE TAKEN IN REGARD TO THE FIVE OSR STATEMENTS:

1) IT IS RECOMMENDED THAT THE EXECUTIVE COUNCIL DISAPPROVE STATEMENT I, SINCE THE RESPONSIBILITY OF THE FULL FACULTY FOR PROMOTION AND GRADUATION REQUIRES ACCESS TO THE STUDENTS' RECORDS.

2) IT IS RECOMMENDED THAT ANY ACTION ON STATEMENTS II AND III BE DEFERRED IN VIEW OF THE INFEASIBILITY OF IMPLEMENTING THEM FOR THE OVER 7,500 APPROVED PROGRAMS OF GRADUATE MEDICAL EDUCATION. THESE RECOMMENDATIONS WOULD BE MORE APPROPRIATE AT SOME TIME IN THE FUTURE WHEN INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION IS A REALITY.

3) IT IS RECOMMENDED THAT STATEMENT IV BE FORWARDED TO THE MEMBERS OF THE GROUP ON MEDICAL EDUCATION FOR CONSIDERATION AT THE INSTITUTIONAL LEVEL.

XIII. Retreat Agenda and National Health Insurance Task Force:

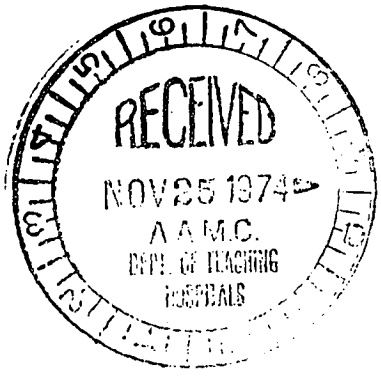
In response to a recommendation regarding the need for a special task force to look at the educational component of a National Health Insurance plan, the COTH Administrative Board recommended that in the absence of any concrete movement towards National Health Insurance and the lack of a clearly formulated issue, there does not appear to be a need for such a task force. In addition, most of the issues which would be addressed were covered by the previous task force and are outlined in the current AAMC position on National Health Insurance.

XIV. Adjournment:

There being no further business, the meeting was adjourned at 1:00 p.m.

ATTACHMENT A

The Johns Hopkins Hospital




November 19, 1974

Richard M. Knapp, M.D.
Director
Department of Teaching Hospitals
Association of American
Medical Colleges
One DuPont Circle, N.W.
Washington, D. C. 20036

Dear Dick:

I want to go on record as being strongly opposed to including as a part of Hospital Medical Staff Bylaws - "due process" provision for physicians in hospitals acting in an administrative capacity as is being proposed by the JCAH. I strongly endorse the protection of physician staff from arbitrary or capricious loss of staff privileges through formal mechanisms defined by the medical staff and approved by the Boards of Trustees of hospitals. Physicians acting for the hospitals in managerial roles (i.e., Chiefs of Services, Directors of Emergency Rooms, Directors of ICU's etc.) should be subject to removal from those managerial responsibilities on the same basis as any lay managerial level employee of the hospital. The question of staff privileges or academic appointment in a university are quite separate issues and are matters which the medical staff has a proper concern. Any attempt, however, to treat physicians as a different group with regard to responsibility for the consequences of inadequate managerial performance is wrong both as a matter of equity and as a matter of proper management of our institutions.

Sincerely,

Robert M. Heyssel, M.D.

ATTACHMENT B

February 12, 1975

Ms. Susan Weagly
Project Director for Health Law Research
Professional Education Program
Joint Commission on the Accreditation
of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Susan:

The Administrative Board of the Council of Teaching Hospitals reviewed page 7 and 40 of the draft "Guidelines for Medical Staff Bylaws" dated December 11, 1974, at its meeting on January 15, 1975. While no formal specific action was taken the following represents the sense of the discussion of this issue.

There was general agreement that dismissal of medio-administrative officers should follow the same process as appointment to these positions, subject, of course, to institutional personnel policies or the terms of an individual's contract. Thus, if the appointment of a medio-administrative position was made by the institution's chief executive officer, dismissal should likewise be his responsibility, again subject to usual personnal policies and contractual agreements. Further, such an action should be unrelated to clinical privileges and medical staff membership. Such a policy would eliminate the need for a joint conference process as outlined in section 8.3 on page 40 of the draft JCAH bylaws.

On behalf of the COTH Administrative Board, I wish to thank you for the opportunity to comment on these draft guidelines.

Sincerely,

RICHARD M. KNAPP, Ph.D.
Director
Department of Teaching Hospitals

RMK:car

cc: Sidney Lewine, Chairman
COTH Administrative Board

DRAFT 1

# GUIDELINES FOR MEDICAL STAFF BYLAWS

December 11, 1974
Joint Commission on
Accreditation of Hospitals

3.2-4 Nondiscrimination

Medical staff membership shall not be denied on the basis of sex, race, creed, color or national origin or on the basis of any other criterion lacking professional justification.

3.2-5 Administrative and Medico-Administrative Practitioners

A practitioner employed by the hospital in a purely administrative capacity with no clinical duties is subject to the regular personnel policies of the hospital and to the terms of his contract or other conditions of employment, and need not be a member of the medical staff. A medico-administrative officer must be a member of the medical staff, achieving this status by the procedure provided in Article V. His clinical privileges should be delineated in accordance with Article VI. The medical staff membership and clinical privileges of any medico-administrative officer shall (not) be contingent on his continued occupation of that position.

3.3 DURATION AND INCIDENTS OF APPOINTMENT

3.3-1 Duration

Initial appointments shall be for a period extending to the end of the current medical staff year. Reappointments shall be made for a period of not more than (two) medical staff year(s).

*Comment*

The two-year reappointment cycle eliminates the necessity for annual reappointment of each staff member, thus easing the workload and making periodic reappraisal the comprehensive and meaningful activity it must be. Some hospitals may, however, still prefer to have reappointments on an annual basis and, in some instances, may be required to do so by state law.

A hospital may find it desirable to provide for more frequent evaluation of the older practitioner. If so, the nature and circumstances of this review should be specifically stated in the bylaws.

hearing by a committee appointed by the board. If such hearing does not result in a favorable recommendation, he shall then be entitled, upon request, to an appellate review by the board before a final decision is rendered.

8.2-3 Procedure and Process

All hearings and appellate reviews shall be in accordance with the safeguards set forth in the Due Process Plan appended to these bylaws.

8.2-4 Exceptions

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges shall give rise to any right to a hearing or appeal.

.3 DISMISSAL OF MEDICO-ADMINISTRATIVE OFFICERS

Dismissal of a medico-administrative officer shall be subject to review and, if requested, a Section 8.1 interview by a joint conference of _____ board representatives and _____ representatives selected by the members of the medical staff *(specify the manner of selection agreeable to the staff)*. The joint conference shall determine the nature of the reason for the action and whether both his administrative position and medical staff membership and privileges or either shall be affected. When the reason for the action is determined to involve the individual's clinical competence, the procedures provided in Article VII and Section 8.2 shall operate. When the reason for the action is determined to be purely administrative in nature and does not involve the individual's clinical competence, the board's usual personnel policies, or the terms of the individual's contract, if there is one, shall apply.

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue Chicago, Illinois 60611
John D. Porterfield, M.D. Director
(312) 642-6061

Quality Review Center
Charles M. Jacobs, J.D. Director

March 18, 1975

Richard M. Knapp, Ph. D.
Director
Department of Teaching Hospitals
Association of American Medical Colleges
Suite 200, One DuPont Circle, N.W.
Washington, D.C. 20036

Dear Dick:

This is to acknowledge receipt of your letter of February 12 indicating the COTH Administrative Board's reaction to the medico-administrative provisions contained in the December 11 draft of the guidelines for medical staff bylaws. We appreciate the time and effort the Board spent in reviewing and discussing these provisions, and thank you and your staff as well for your efforts.

Sincerely,

Susan Weagly
Project Director, Health Law Research
Quality Review Center

SW/ph

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C., 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

(a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

(b) The hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions.

I. MEMBERSHIP INFORMATION

The Memorial Hospital
HOSPITAL NAME

119 Belmont St. Worcester,
STREET CITY

Ma. 01605 617 -793-6611
STATE ZIP CODE TELEPHONE NUMBER

Chief Executive Officer David A. Barrett
NAME

Executive Director
TITLE

Date hospital was established: 1871

APPROVED FIRST POST-GRADUATE YEAR

| TYPE[2] | Date of Initial Approval by CME of AMA** | Total F.T.E.[1] Positions Offered | F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads | F.T.E.[1] Total Positions Filled by FMG's |
|---|---|---|---|---|
| Flexible | | | | |
| Categorical | 1973 | 10 (1974 | 2 | 8 |
| Categorical* | 1973 | 2 (1975) | | |

** Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

1. Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.

2. Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program directpr; Categorical*-graduate program under supervision of single program director but content is flexible.)

APPROVED RESIDENCIES

| TYPE | Date of Initial Approval by CME of AMA** | Total F.T.E.[1] Positions Offered | F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads | F.T.E.[1] Total Positions Filled by FMG's |
|---|---|---|---|---|
| Medicine | 1954 | 16 | 1 | 15 |
| Surgery | ~~1954~~ | 16 | 3 | 13 |
| Ob-Gyn | 1973 | 4 | 0 | 4 |
| Pediatrics | | | | |
| Psychiatry | | | | |
| Family Practice | | | | |
| Other (List): | | | | |
| Pathology | 1954 | 4 | 1 | 3 |
| | | | | |

II. PROGRAM DESCRIPTION

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specifici reference to the following questions.

A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).

B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).

C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).

D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristids and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: The University of Massachusetts Medical School

55 Lake Ave. N. Worcester, Ma. 01605

Name of Dean: Lamar Soutter, M. D.

Information Submitted by: Gunter L Spanknebel MD

Gunter L. Spanknebel, M. D. — Director of Medical Education

NAME — TITLE OF PERSON SUBMITTING DATA

February 12, 1975 — David A. Barrett

DATE — SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

**The Memorial Hospital**
119 Belmont Street
Worcester
Massachusetts 01605
(617) 793-6611



Section II -

A. Extent of activity for undergraduate medical education of students:

The following clerkships are offered to the students of the University of Massachusetts Medical School:

| | |
|---|---|
| Medicine: | 3 clerkships (12 weeks each - 2 students at a time) |
| Surgery: | 3 clerkships (3 months at a time) |
| Ob/Gyn: | 4 students at a time for a 6 weeks period |

Other electives are offered on request from students from other medical schools (e.g., cardiology - renology - medicine)

Physical Diagnosis course for the 2nd year students of the University of Massachusetts Medical School - September through March (1974-75 -- 10 students participating.

Proportion of medical staff time committed to medical students:

100% (Medicine - Surgery and Ob/Gyn)

**The Memorial Hospital**
119 Belmont Street
Worcester
Massachusetts 01605
(617) 793-6611



Section II -

B. The full-time salaried chiefs of service in The Memorial Hospital are:

| | | |
|---|---|---|
| Dr. Roger B. Hickler | - | Medicine |
| Dr. Robert S. Harper | - | Pathology |
| Dr. Gunter L. Spanknebel | - | Director of Medical Education |

Dr. Roger B. Hickler is also Professor and Chairman of the Department of Medicine at The University of Massachusetts Medical School.

Dr. Robert S. Harper, Assistant Professor of Pathology, University of Massachusetts Medical School

Dr. Gunter L. Spanknebel, also Chief of Gastroenterology at The Memorial Hospital and Assistant Professor of Medicine at the University of Massachusetts Medical School.

Dr. Oscar E. Starobin, (part-time) Chief, Cardiology; Assoc. Professor University of Massachusetts Medical School

Dr. Peter J. Pletka, Chief, Renal Laboratory; Assist. Professor UMMS.

Dr. Joel M. Seidman, Chief, Pulmonary Medicine; Assist. Professor UMMS.

Dr. Raj K. Anand, Chief, Non-invasive Cardiology; Assist. Professor UMMS.

Dr. Braden Griffin, Chief, Neonatology Division; Assist Professor UMMS.

**The Memorial Hospital**
119 Belmont Street
Worcester
Massachusetts 01605
(617) 793-6611



Section II -

C. Hospital's financial support of medical education costs...

In 1974 the costs attributed to the medical education program were $1,067.178. Of this, $934,296 was direct and indirect expenses for the teaching program including the salaries of the house officers, the cost of the Director of Medical Education office and the Chief of Medicine. The additional amount of $132,882 represents operating losses on teaching related laboratory services.

The total hospital expense for 1974 was $15,081,018. The percentage of expenses for medical education was 7.07. The cost of medical education per patient day was $10.04 on the base of 106,268 patient days.

In 1975 proposed changes in the medical education program, both for additional house officers and full time teachers will increase costs approximately $469,000. This will increase the percentage of total expenses of our Medical Education to approximately 10.18%.

Attached is a copy of the hospital's agreement with the University of Massachusetts Medical School. Under this agreement the Medical School reimburses the hospital $32,500 for salaries of faculty men. In addition to this, the medical school funded two residents in internal medicine during the 1974 fiscal year.

UNIVERSITY OF MASSACHUSETTS

MEDICAL SCHOOL

and

THE MEMORIAL HOSPITAL

Hospital Affiliation Agreement

BOWDITCH, GOWETZ & LANE

340 MAIN STREET

WORCESTER, MASSACHUSETTS

# HOSPITAL AFFILIATION AGREEMENT

THIS AGREEMENT made and entered into May 19 , 1971, between UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL (hereinafter referred to as the "Medical School") having its principal office in Worcester, Massachusetts, and THE MEMORIAL HOSPITAL, a Massachusetts non-profit corporation having its principal office in Worcester, Massachusetts (hereinafter referred to as the "Hospital").

WHEREAS, the Medical School commenced teaching and instructional operations in the Fall of 1970 with a full faculty and has enrolled its first entering class of students; and

WHEREAS, the Hospital is an existing hospital serving the greater Worcester community through programs of patient care, has a qualified and licensed medical staff and has accredited teaching programs; and

WHEREAS, it is the belief of the Medical School and Hospital that each can supplement the other by offering services not presently available and each will benefit by such affiliation in the present and the future;

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and obligations herein contained the parties

agree as follows:

1. TERM - This agreement shall remain in full force and effect until June 30, 1972, and shall be automatically renewed on a year-to-year basis unless notice of termination has been forwarded by either the Medical School or the Hospital to the other prior to January 1 of the year in which such termination is to be effective with such termination occurring on June 30. Notice of termination may cover the entire agreement or be limited to departments and services as defined in Paragraph 2 below.

2. DEPARTMENTAL AFFILIATION - The Medical School departments and corresponding Hospital services to be affiliated under this agreement shall be determined from time to time by joint approval of the Medical School, the Hospital, and the head of the hospital service involved, and upon such approval shall be listed in a schedule to be attached hereto. The Medical School shall designate the head of the affiliated Medical School department. The head of each affiliated service at the Hospital at the time this agreement becomes effective as to such service will continue in that capacity subject to the provisions of Paragraph 7 herein. The head of each affiliated service in the Hospital and the head of the corresponding

department in the Medical School shall determine jointly the following:

(a) Staff members of the Hospital who will be invited to instruct, together with assignment of teaching schedule;

(b) The patients in the Hospital that will be utilized for teaching purposes, subject to the full knowledge and approval of the patient and of the attending physician, and arrangements relating thereto; and

(c) All related matters pertaining to the foregoing.

3. FACULTY APPOINTMENTS - Appointment of staff members of the Hospital to faculty rank will be subject to approval by the Executive Committee of the faculty of the Medical School, the Dean of the Medical School, and Trustees of the University of Massachusetts. Recommendations for such appointments may be made by the Hospital.

4. SPECIAL APPOINTMENTS - The Medical School may make special appointments to its faculty of members of the staff of non-affiliated services of the Hospital.

5. SUBSEQUENT APPOINTMENTS - After the effective date of this agreement between the Hospital and the Medical School all subsequent appointments of new personnel to the medical staff of an affiliated service of the Hospital shall require the approval of both the Medical School and the Hospital. Yearly reappointment and promotion of members of the medical staff of

the Hospital other than heads of affiliated services will not require approval of the Medical School. The Hospital may appoint staff members to an affiliated service who will not participate in the affiliated teaching programs of the Hospital and the Medical School provided that the Medical School shall approve such appointments.

6. NON-AFFILIATED DEPARTMENT APPOINTMENTS - The Hospital prior to making appointments to its medical staff in services not affiliated with departments of the Medical School agrees to request the recommendations of the Medical School.

7. APPOINTMENT OF HEAD OF SERVICE - After the effective date of this agreement between the Hospital and the Medical School, the Head of an affiliated service of the Hospital shall continue to function as such until his appointment ceases by expiration of term of appointment or otherwise. Nothing herein contained shall preclude the right of the Hospital to make re-appointments of heads of services for a period not to exceed five (5) years. For purposes of further reappointment or selection of a successor to head such service the Hospital and the Medical School shall establish an ad hoc committee which group shall make recommendations to the Hospital and Medical School with respect to the following:

(a) The purposes and functions of the service within the

Hospital in the future;

(b) Qualifications for a head of service to carry out the purposes and functions as established under sub-paragraph (a) above; and

(c) The names of one or more individuals who meet the qualifications under sub-paragraph (b) above.

The appointment and terms and conditions thereof shall require joint approval of the Hospital and the Medical School.

8. SALARIES AND REMUNERATION - Payments of salary and remuneration, other than reimbursement for out-of-pocket expenses, to members of the Hospital medical staff by the Medical School for administrative and/or teaching assignments rendered to the Medical School will not be made without prior notice to the Hospital.

9. NOTICES - Any notices required hereunder will be deemed sufficiently given if forwarded by mail, postage prepaid, and shall be deemed given as of the date of mailing. All notices directed to the Medical School shall be addressed to the Medical School, Office of the Dean, 419 Belmont Street, Worcester, Massachusetts 01604. All notices directed to the Hospital shall be addressed to the Office of the Administrator, The

Memorial Hospital, 119 Belmont Street, Worcester, Massachusetts 01605.

IN WITNESS WHEREOF the parties hereunto duly authorized have caused these presents to be executed as of the day and year first above written.

UNIVERSITY OF MASSACHUSETTS
MEDICAL SCHOOL

Dean

THE MEMORIAL HOSPITAL

President

**The Memorial Hospital**
119 Belmont Street
Worcester
Massachusetts 01605
(617) 793-6611



Section II -

D. Degree of affiliated medical school's involvement in...

The attached letter from Acting Dean R. W. Butcher, Ph.D, of the University of Massachusetts Medical School clearly shows the medical school's involvement in and reliance upon The Memorial Hospital's education program. 43 of our Staff Physicians and Surgeons are on the faculty of the Medical School. They, as well as visiting faculty are active in many hospital oriented activities such as in-service education for other departments of the hospital as well as conferences, seminars and teaching functions for members of the house staff and the student body. Many are actively involved in medical staff committees at the hospital as well as the school.

The Commonwealth of Massachusetts
University of Massachusetts
Worcester 01601

Medical School
Department of Medicine
419 Belmont Street

February 14, 1974

Gunter L. Spanknebel, M.D.
Director, Medical Education
The Memorial Hospital
119 Belmont Street
Worcester, Massachusetts 01605

Dear Dr. Spanknebel:

It is my great pleasure to write in support of the importance of The Memorial Hospital becoming a member of the Council of Teaching Hospitals of the Association of American Medical Colleges. The Memorial Hospital is one of several major teaching affiliates of the University of Massachusetts Medical School, and has an enormously important responsibility in the instruction of our growing body of medical students. Indeed, at the moment, it is carrying between 1/3 and 1/4 of all of our students on its wards for instruction in physical diagnosis and history taking, and for our third year students during their clinical clerkships in medicine. Beyond that, The Memorial Hospital is making a major contribution in the form of clinical electives during the fourth year.

In the future, the teaching role of The Memorial Hospital can only grow in importance as our student body expands. On behalf of the entire faculty, let me take this opportunity to thank you for the contributions of your hospital to our teaching program, not only in Medicine, but in Surgery, Obstetrics and Pathology alike.

Sincerely yours,

R. W. Butcher, Ph.D
Acting Dean

RBH:ro

# THE UNIVERSITY OF TEXAS SYSTEM CANCER CENTER

*Texas Medical Center Houston, Texas 77025*

Vice President for Business and Hospital Affairs


March 10, 1975

Mr. J. Trevor Thomas
Director of Business Affairs
Association of American Medical Colleges
Suite 200, One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Mr. Thomas:

Your letter of March 6, 1975 indicated dues have not been paid by this institution for membership in the Council of Teaching Hospitals.

I regret that I failed to notify you earlier that a decision to discontinue membership in this council was made prior to the start of the current dues period.

Very truly yours,

Joe E. Boyd, Jr.
Vice President for Business
and Hospital Administration

JEBJr:sd

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #75-13 March 15, 1975

TO: Members of the Assembly

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

SUBJECT: Proposed Regulations - Teaching Physician Cost Based Reimbursement

I have attached proposed federal regulations that permit teaching hospitals to receive Medicare reimbursement for physician services on the basis of cost rather than charges. A cost-based reimbursement arrangement, as provided for in these proposed regulations, may be exercised at the discretion of the facility if it deems cost reimbursement to be more favorable; such a method of reimbursement is not mandatory. The proposed regulations (20 CFR, Part 405, Regulation No. 5) were published March 7, 1975, in the Federal Register; the standard thirty day period has been allowed for comment. A copy of my letter to Secretary Weinberger requesting that the formal comment period be extended for an additional sixty days (to June 7, 1975) is attached.

The substance of these regulations were first proposed on July 19, 1973, in an attempt to implement Section 227 of P.L. 92-603 (the 1972 amendments to the Social Security Act). As a result of an AAMC study, the implementation of these regulations were delayed until accounting periods beginning after June 30, 1976, pending the completion of a study by the Institute of Medidine of the National Academy of Sciences. In delaying implementation of the 227 regulations, Congress provided that hospitals would be provided the option of electing cost-based physician reimbursement under Medicare if they desired. The present regulations seek to specify the rules regarding the selection of such an option and the manner of subsequent reimbursement.

Under the proposed rules, teaching hospitals may elect cost reimbursement for reporting periods beginning from June 30, 1973 to July 1, 1976. The option to receive Medicare reimbursement on the basis of reasonable cost is available to hospitals only if all physicians who render services in the hospital agree in writing not to bill Medicare for their services. Hospitals can include as reasonable cost the costs associated with: the provision of direct medical services; administrative activities; and the supervision of interns and residents. The regulations also permit Medicare payment for volunteer patient care services under certain circumstances.

We are in the process of preparing our response to these proposed regulations which will be made available to you as soon as it is completed. Your comments on these proposed regulations should be sent directly to:

Commissioner of Social Security
Department of Health, Education
and Welfare
Fourth andIndepencence Avenue, S.W.
Washington, D.C. 20201

Since we do not know if an extension to the comment period will be granted, your comments to the Commissioner should be received by April 7. Please send copies of your comments to the AAMC Department of Teaching Hospitals. If you have any questions or comments regarding these regulations, please feel free to contact Dick Knapp (202/466-5126) or Dennis Pointer (202/466-5122) in the Department of Teaching Hospitals.

Attachment:

loans, and loan guarantees for the construction and modernization of hospitals and other medical facilities under the Hill-Burton Act (Title VI of the Public Health Service Act; 42 U.S.C. 291 *et seq.*), that they will provide a reasonable volume of care to persons unable to pay therefor.

The proposal would amend § 53.111 in two respects:

1. Subparagraph (f)(1) would be revised. The current language of § 53.111 (f)(1), the so-called "billing provision", was recently declared invalid by the United States District Court for the Southern District of New York in Corum, et al. v. Beth Israel Medical Center, et al., 373 F. Supp. 557, S.D.N.Y. (1974). The current paragraph (f)(1) would permit Hill-Burton-aided facilities to include as uncompensated services those services for which determination of inability to pay had been made after a bill had been rendered so long as no further collection effort was made. In declaring that provision invalid, the court in the Corum case stated:

> In view of the strong interest of plaintiffs in a preadmission determination of inability to pay, and in the absence of any valid reason for postponement of the decision, we hold that it must be made before rendition of services * * *.

The revised language of paragraph (f)(1) would require that a determination of indigency be made prior to the provision of the service except in certain specified circumstances.

2. In order that persons who are or may be unable to pay for services may be made aware of the obligation of recipients of Hill-Burton assistance to provide a reasonable volume of care to persons unable to pay therefor in accordance with § 53.111, a new paragraph (l) would be added, requiring that Hill-Burton-assisted facilities post notices informing the public of that obligation.

The proposed amendments to § 53.111 were approved by the Federal Hospital Council on November 12, 1974.

Interested persons are invited to submit written comments, suggestions or objections regarding the proposed amendments to § 53.111 to the Division of Facilities Utilization, Health Resources Administration, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852, on or before April 7, 1975. Comments received will be available for public inspection at Room 12-11 Parklawn Building, during regular business hours.

It is therefore proposed to amend 42 CFR 53.111 as set forth below.

Dated: January 27, 1975.

CHARLES C. EDWARDS,
*Assistant Secretary for Health.*

Approved: February 27, 1975.

CASPAR W. WEINBERGER,
*Secretary.*

In § 53.111, paragraph (f)(1) is revised, paragraphs (i) and (j) are redesignated as paragraphs (j) and (k) respectively, and a new paragraph (l) is added as follows:

**§ 53.111 Services for persons unable to pay.**

* * * * *

(f) *Qualifying services.* (1) In determining the amount of uncompensated services provided by an applicant, there shall be included only those services provided to an individual with respect to whom the applicant has made a written determination prior to the provision of such services that such individual is unable to pay therefor under the criteria established pursuant to 42 CFR 53.111 (g), except that:

(i) such determination may be made after the provision of such services in the case of services provided in emergency departments of applicants: *Provided,* That when billing is made for such service, such billing must be accompanied by substantially the information required in the posted notice under paragraph (l) 2 of this section; and

(ii) such determination may be made after the provision of such services in the case of a change in circumstances as a result of the illness or injury occasioning such services (e.g., the patient's financial condition has changed due to a loss of wages resulting from the illness) or in case of insurance coverage or other resources being less than anticipated or the costs of services being greater than anticipated. *Further,* in all cases where such determination was not made prior to the provision of services, such services may not be included as uncompensated services if any collection effort has been made other than the rendering of bills permissible in the above exceptions: *Provided,* That such a determination may be made at any time if the determination was hindered or delayed by reason of erroneous or incomplete information furnished by or in behalf of the patient.

* * * * *

(l) *Posted notice.* The applicant shall post notice (which shall be multilingual where the applicant serves a multilingual community), in substantially the following form, in appropriate areas within the facility (admissions, office, emergency department and business office) for the purpose of informing patients or potential patients that criteria for eligibility and applications are available upon request:

NOTICE OF HILL-BURTON OBLIGATION

Under the Hill-Burton program, this hospital is obligated to render a reasonable volume of services at no cost or less than full charges to persons meeting eligibility criteria. Should you believe you may be eligible for such services, you should contact our business office (or designated person or other office). If you are dissatisfied with the determination in your case you may contact the State Hill-Burton agency (supply address).

[FR Doc.75-5963 Filed 3-6-75;8:45 am]

## Social Security Administration

[ 20 CFR Part 405 ]

[Regs. No. 5]

## FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

### Payment for Services of Physicians in Teaching Hospitals, for Physicians' Costs to Hospitals and Medical Schools, and for Volunteer Services

Notice is hereby given, pursuant to the Administrative Procedure Act (5 U.S.C. 553) that the amendments to the regulations set forth in tentative form below are proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare.

On July 19, 1973, there was published in the FEDERAL REGISTER (38 FR 19230) a notice of proposed rule making with proposed amendments to Subparts D and E of Regulations No. 5, implementing section 227 of Pub. L. 92-603, enacted October 30, 1972 (entitled "Payment Under Medicare for Services of Physicians Rendered at a Teaching Hospital") and statements of congressional intent contained in the Report of the Committee on Finance, United States Senate Report No. 92-1230, 92d Cong., 2d Sess., pp. 194-198 (1972).

The 1972 legislation made two major changes in the original Medicare statute with regard to the payment for the services of physicians in teaching hospitals. First, it added to the requirements for charge reimbursement the further requirement that the patient be a "private patient" as defined by regulation. Second, where a private patient relationship did not exist and the patient was determined to be a "nonprivate patient" or where the hospital elected not to seek charge reimbursement, the 1972 legislation provided reasonable cost reimbursement to hospitals that expect such payment to be more favorable than would be possible under the present system of charge reimbursement for some services and cost reimbursement for others.

Interested parties were given the opportunity to submit within 30 days data, views, or arguments with regard to the proposed amendments. On August 28, 1973, there was published in the FEDERAL REGISTER (38 FR 22980) a notice of extension of the period for comment through October 17, 1973.

However, both of the provisions of the 1972 legislation have been modified by Pub. L. 93-233, enacted December 31, 1973, and by Pub. L. 93-368, enacted August 7, 1974. Pub. L. 93-233 deferred until cost-reporting periods beginning after December 31, 1974, the requirement that reasonable charges are payable only where a private patient relationship is established, and Pub. L. 93-368 further deferred this provision until hospital cost-reporting periods beginning after June 30, 1976. This was done so that the National Academy of Sciences would

have sufficient time to undertake and report on a study, the results of which are expected to help in assessing the potential impact of the 1972 legislation on teaching hospitals and their health care delivery systems.

Also, the 1973 legislation restricts the availability of the more favorable cost reimbursement provisions of the 1972 legislation to hospitals that elect cost payments in lieu of any reasonable charge reimbursement which otherwise would be appropriate. A hospital may make this election only where all of the physicians who render services in the hospital agree in writing not to bill charges under the Medicare program for such services. Where these requirements are satisfied by a hospital, reasonable cost reimbursement is appropriate for all physicians' services provided to Medicare beneficiaries. However, the 1974 legislation provides that except where the hospital makes such an election, the 1972 changes are deferred until hospital cost-reporting periods beginning after June 30, 1976. Therefore, the proposed amendments to Subpart E dealing with the definition of a "private patient" which were published in proposed form in the FEDERAL REGISTER on July 19, 1973, to implement the 1972 legislation, are being withdrawn.

Because of the above described amendments to the Social Security Act in 1973 and 1974 the Commisioner of Social Security and the Secretary of Health, Education, and Welfare have determined that a new notice of proposed rule making should be published to afford interested parties an opportunity to submit within 30 days data, views, or arguments with regard to the proposed amendments. Any comments submitted in connection with the notice of proposed rule making of July 19, 1973, have already been taken into consideration and need not be resubmitted.

The following changes have been made as a result of comments and suggestions received with regard to the July 19, 1973, notice of proposed rule making and as a result of the 1973 and 1974 legislation:

1. The proposed regulations were revised to (a) include, in the base to which the 105 percent limitation applies, certain salary-related taxes and payments as well as physicians' direct salaries and fringe benefits, and (b) emphasize that this limitation applies only where a hospital is unrelated to a medical school and does not pay the medical school for services to all patients. Hospitals related to medical schools by common ownership and control and hospitals that are unrelated to medical schools but pay the medical schools for services to all patients will continue to be permitted reimbursement without regard to this limit, but only, of course, to the extent that the costs are not found to be unreasonable.

2. The proposed regulations were revised to allow physicians who are compensated by the hospital or medical school for some, but not all, of the services they render, to be considered volunteer physicians with respect to some of their services but with limitations. The payments for donated services will be made provided their compensation from the hospital and medical school is only for other than direct medical and surgical services rendered to individual patients and, during a cost-reporting period, the sum of imputed value of the volunteer services and the physician's actual compensation from the hospital and the medical school does not exceed the rate of $30,000 per year. A limit is placed on the amount recognized under this provision to avoid claims of reimbursement of the volunteer services of a physician that would be unreasonable in terms of the compensation a hospital would be willing to pay to employ a physician to perform the same services. It is intended that the limitations provided for will be reviewed periodically and may be adjusted.

3. To reflect the effects of Pub. L. 93-233 on the teaching hospital provisions, provision is made (1) for a teaching hospital for cost-reporting periods beginning after June 30, 1973, and before July 1, 1976, to elect cost reimbursement for physicians' direct medical and surgical services, and (2) for a savings clause which deems that Medicare payments are proper if, appropriately made under the provisions of Pub. L. 92-603 for services rendered after June 30, 1973 (the effective date of the teaching hospital provision of the law), and prior to the enactment of Pub. L. 93-233.

4. As a result of various comments made concerning the allocation of teaching physician compensation in determining reasonable cost under the proposed amendments, a new paragraph was added to § 405.465(j) to explain the way in which a physician's compensation must be allocated among the various services he performs in a teaching hospital.

5. Some changes have also been made in the interest of clarity.

The following comments, although considered, have not been accepted:

1. Concern was expressed that the "salary equivalent" rate based on the average salary of the full-time physicians in the hospital (to be used as the basis for payment for physicians' volunteer services) would not be adequate. However, the law and the Report of the Committee on Finance of the United States Senate clearly prescribe that the "salary equivalent" amount will be derived in this way. Hence, the provision regarding the "salary equivalent" rate is retained.

2. Comments were received concerning the technique to be used in the computation of the costs of physicians' direct medical and surgical services. This technique involves averaging somewhat the per diem cost of such services. Specifically, the comments suggested that the weight given to the day of admission for reimbursement purposes should be the equivalent of 2.0 days rather than 3.5 days. It was suggested that 2.0 days is a more appropriate reflection of the intensity of medical care on that day. However, the original provision is retained because, after careful consideration, counting the day of admission as if it were 3.5 days still appears to more adequately reflect the degree of intensity of medical care received in relation to admisisons as compared with duration of stay after admission.

Prior to the final adoption of the proposed amendments to the regulations, consideration will be given to any data, views, or arguments pertaining thereto which are submitted in writing in triplicate to the Commissioner of Social Security, Department of Health, Education, and Welfare Building, Fourth and Independence Avenue, SW., Washington, D.C. 20201, on or before April 7, 1975.

Copies of all comments received in response to this notice will be available for public inspection during regular business hours at the Washington Inquiries Section, Office of Public Affairs, Social Security Administration, Department of Health, Education, and Welfare, North Building, Room 4146, 330 Independence Avenue SW., Washington, D.C. 20201.

The proposed amendments are to be issued under the authority contained in sections 1102, 1833(a), 1842(b), 1861, and 1871 of the Social Security Act, section 15 of Public Law 93-233, and section 7 of Public Law 93-368; 49 Stat. 647, as amended, 79 Stat. 302, as amended, 79 Stat. 309, as amended, and 79 Stat. 331, 87 Stat. 965, 88 Stat. 422; 42 U.S.C. 1302, 1395l(a), 1395u(b), 1395x, 1395hh, and 1395x note.

(Catalog of Federal Domestic Assistance Program No. 13.800, Health Insurance for the Aged—Hospital Insurance; No. 13.801, Health Insurance for the Aged—Supplementary Medical Insurance)

Dated: December 13, 1974.

J. B. CARDWELL,
*Commissioner of Social Security.*

Approved: February 24, 1975.

CASPAR W. WEINBERGER,
*Secretary of Health, Education, and Welfare.*

Regulations No. 5, Subpart D of the Social Security Administration, as amended (20 CFR Part 405), are further amended as follows:

1. Paragraph (c) of § 405.402 is amended by adding paragraph (c)(9) to read as follows:

§ 405.402 Cost reimbursement; general.

* * * * * * *

(c) * * *

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) rendered in a teaching hospital may be reimbursed as a provider cost (see § 405.465) where elected as provided for in § 405.521 of this Part.

* * * * * * *

2. Section 405.465 is added to read as follows:

**§ 405.465 Determining reimbursement for certain physician and medical school faculty services rendered in teaching hospitals.**

(a) *General.* Payments for services of physicians in teaching hospitals rendered to patients will be made by the health insurance program on the basis of reasonable cost where the hospital exercises the election as provided for in § 405.521 of this Part. Where such election is made:

(1) Payments for services donated by volunteer physicians to health insurance program patients will be made to a fund designated by the organized medical staff of the teaching hospital or medical school provided certain conditions are met, and

(2) Reimbursement for certain medical school costs may be made as provided for in paragraph (c) of this section.

(b) *Reasonable cost of direct medical and surgical services (including supervision of interns and residents) rendered in a teaching hospital by physicians on the hospital staff.* Direct medical and surgical services to patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the hospital staff are reimbursable as provider services on a reasonable-cost basis. For purposes of this paragraph, reasonable cost is defined as the direct salary paid to such physicians, plus applicable fringe benefits. Such costs must be allocated to such services as provided by paragraph (j) of this section and apportioned to program beneficiaries as provided by paragraph (g) of this section. Other allowable costs incurred by the provider related to the services described in this paragraph are reimbursable subject to the requirements applicable to all other provider services.

(c) *Reasonable costs incurred by a teaching hospital for the services rendered by a medical school or related organization in a hospital.* An amount not in excess of the reasonable cost (as defined in paragraphs (c) (1) and (2) of this section) incurred by a teaching hospital for services rendered by a medical school or organization related thereto within the meaning of § 405.427 for certain costs to the medical school (or such related organization) in rendering services in the hospital are reimbursable to the hospital by the health insurance program provided that such costs would be reimbursable if incurred directly by the hospital rather than under such arrangement.

(1) *Reasonable costs of direct medical and surgical services (including supervision of interns and residents in the care of individual patients) rendered in a teaching hospital by physicians on the faculty of a medical school or organization related to the medical school.*

(i) In situations where the medical school (or organization related to the medical school) and the hospital are related by common ownership or control in accordance with § 405.427, the cost of such services are allowable costs to the hospital under the provisions of § 405.427 and the reimbursable costs to the hospital are determined under the provisions of this section in the same manner as the costs incurred for physicians on the hospital staff and without regard to payments made to the medical school by the hospital.

(ii) Where the medical school and the hospital are not related organizations under the provisions of § 405.427 and the hospital makes payment to the medical school for the costs of such services rendered to all patients, reimbursement will be made by the health insurance program to the hospital for the reasonable cost incurred by the hospital for its payments to the medical school for services to health insurance beneficiaries. Costs incurred under such an arrangement must be allocated to the full range of services provided to the hospital by the medical school physicians on the same basis as provided for under paragraph (j) of this section and cost so allocated to direct medical and surgical services to hospital patients must be apportioned to health insurance beneficiaries as provided for under paragraph (g) of this section. Where the medical school and the hospital are not related organizations under the provisions of § 405.427 and the hospital makes payment to the medical school only for the costs of such services rendered to health insurance program patients, costs of the medical school not to exceed 105 percent of the sum of physicians' direct salaries, applicable fringe benefits, employer's portion of FICA taxes, federal and state unemployment taxes, and workmen's compensation paid by the medical school or an organization related thereto may be recognized as allowable cost of the medical school. Such allowable medical school costs must be allocated to the full range of services rendered by the physicians of the medical school or organization related thereto as provided by paragraph (j) of this section. Costs so allocated to direct medical and surgical services to hospital patients must be apportioned to health insurance program beneficiaries as provided by paragraph (g) of this section.

(2) *Reasonable costs of other than direct medical and surgical services rendered in a teaching hospital by medical school faculty (or organization related to the medical school).* Such costs are determined in accordance with paragraph (c) (1) of this section except that: (i) where the hospital makes payment to the medical school for other than direct medical and surgical services rendered to all patients, such payments are subject to the required cost-finding and apportionment methods applicable to the cost of other hospital services (excepting direct medical and surgical services rendered to patients), or (ii) where the hospital makes payment to the medical school only for such services rendered to health insurance program patients, then the cost of services which are so reimbursed are not subject to cost-finding and apportionment as otherwise provided by this subpart and the reasonable cost reimbursed by the health insurance program must be determined on the basis of the health insurance ratio(s) used in the apportionment of all other provider costs (excepting physicians' direct medical and surgical services rendered to patients) applied to the allowable medical school costs incurred by the medical school for the services rendered to all patients of the hospital.

(d) *"Salary Equivalent" payments for physicians' direct medical and surgical services rendered to health insurance program patients in a teaching hospital by physicians on the voluntary staff of the hospital (or medical school or organization related thereto under arrangement with the hospital).*

(1) Payments will be made to a fund as defined in § 405.466 for direct medical and surgical services rendered on a regularly scheduled basis by physicians on the unpaid voluntary medical staff of the hospital (or medical school under arrangement with the hospital) to health insurance program patients. Such payments represent compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a reimbursable basis. Payments for volunteer services are determined by applying to the regularly scheduled contributed time an hourly rate not to exceed the equivalent of the average direct salary (exclusive of fringe benefits) paid to all full-time, salaried physicians (other than interns and residents) on the hospital staff or, where the number of full-time salaried physicians is minimal in absolute terms or in relation to the number of physicians on the voluntary staff, to physicians at like institutions in the area. This "salary equivalent" is a single hourly rate covering all physicians regardless of specialty, and is applied to the actual regularly scheduled time contributed by the physicians in rendering direct medical and surgical services to health insurance program patients including supervision of interns and residents in such care. A physician on the hospital staff or on the medical school faculty who receives any compensation from the hospital or the medical school for direct medical and surgical services rendered to health insurance program patients will not be considered an unpaid voluntary physician for purposes of this paragraph. Where, however, a physician receives compensation from the hospital or medical school or organization related thereto and the time spent by the physician in the hospital and medical school is less than full time, a salary equivalent payment for his regularly scheduled direct medical and surgical services to health insurance program patients of the hospital may be imputed (except where the compensation covers the provision of some direct medical or surgical care). However, the sum of the imputed value for volunteer services and his actual compensation from the hospital and the medical school may not exceed the rate of $30,000 per year.

(2) The following examples illustrate how the allowable imputed value for volunteer services is determined. In each example, it has been assumed that the average salary equivalent hourly rate is equal to the hourly rate for the individual physician's compensated services.

*Example No. 1.* Dr. Jones received $9,000 a year from Hospital X for services other than direct medical services to all patients, e.g., utilization review, administrative services, etc. Dr. Jones also voluntarily rendered direct medical services to health insurance program patients. The imputed value of the volunteer services amounted to $10,000 for the cost-reporting period. The full imputed value of Dr. Jones' volunteer direct medical services would be allowed since the total amount of the imputed value ($10,000) and the compensated services ($3,000) does not exceed $30,000.

*Example No. 2.* Dr. Smith received $25,000 from Hospital X for services as a department head in a teaching hospital. Dr. Smith also voluntarily rendered direct medical services to health insurance program patients. The imputed value of the volunteer services amounted to $10,000. Only $5,000 of the imputed value of volunteer services would be allowed since the total amount of the imputed value ($10,000) and the compensated services ($25,000) exceeds the $30,000 maximum amount allowable for all his services.

Computation:

| | |
|---|---|
| Maximum amount allowable for all services performed by Dr. Smith for purposes of this computation | $30,000 |
| Less compensation received from hospital X for other than direct medical services to individual patients | 25,000 |
| Allowable amount of imputed value for the volunteer services rendered by Dr. Smith | 5,000 |

*Example No. 3.* Dr. Brown is not compensated by Hospital X for any services rendered in the hospital. Dr. Brown voluntarily rendered direct surgical services to health insurance program patients for a period of 6 months and the imputed value of these services amounted to $40,000. The allowable amount of the imputed value for volunteer services rendered by Dr. Brown would be limited to $15,000 ($30,000 × 6/12).

(3) The amount of the imputed value for volunteer services applicable to health insurance program beneficaries and payable to a fund will be determined in accordance with the Aggregate Per Diem Method described in paragraph (g) of this section.

(4) Health insurance payments to a fund will be used by the fund solely for improvement of care of hospital patients or for educational or charitable purposes (which may include but are not limited to medical and other scientific research). Expenses met from contributions made to the hospital from such a fund will not be included as a reimbursable cost when expended by the hospital, and depreciation expense will not be allowed with respect to equipment or facilities donated to the hospital by such a fund or purchased by the hospital from monies in such a fund.

(e) *Requirements for reimbursement for physicians' direct medical and surgical services (including supervision of interns and residents) in the care of individual patients rendered in a teaching hospital.*

(1) *Physicians on the hospital staff.* The requirements under which the costs of physicians' direct medical and surgical services (including supervision of interns and residents) in the care of individual patients rendered to health insurance program patients will be allowed are the same as those applicable to the cost of all other covered provider services except that the costs of these services are separately determined as provided by this section and are not subject to cost-finding as described in § 405.453.

(2) *Physicians on the medical school faculty.* Reimbursement will be made to a hospital by the health insurance program for the costs of these services, provided that in situations where the medical school is not related to the hospital (within the meaning of § 405.427) and the hospital does not make payment to the medical school for services rendered to all patients:

(i) There is a written agreement between the hospital and the medical school or organization related thereto, specifying the types and extent of services to be furnished by the medical school and specifying that the hospital must pay to the medical school an amount at least equal to the reasonable cost (as defined in paragraph (c) of this section) of providing such services to health insurance program patients,

(ii) Such costs are paid to the medical school by the hospital no later than the date on which the cost report covering the period in which the services were rendered is due, and

(iii) Payment for such services furnished under such an arrangement would be made by the health insurance program to the hospital had such services been furnished directly by the hospital.

(3) *Physicians on the voluntary staff of the hospital (or medical school under arrangement with the hospital).* Payments will be made by the health insurance program on a "salary equivalent" basis (as defined in paragraph (d) of this section) to a fund where the conditions outlined in § 405.466 are met.

(f) *Requirements for reimbursement for medical school faculty services other than physicians' direct medical and surgical services rendered in a teaching hospital.* Reimbursement will be made to a hospital by the health insurance program for the costs of medical school faculty services other than physicians' direct medical and surgical services rendered in a teaching hospital where the requirements described in paragraph (e) of this section are met.

(g) *Aggregate per diem methods of apportionment for physicians' direct medical and surgical services (including supervision of interns and residents) in the care of individual patients, rendered in a teaching hospital.*

(1) *Aggregate per diem method of apportionment for the costs of physicians' direct medical and surgical services (including supervision of interns and residents) in the care of individual patients.* The cost of physicians' direct medical and surgical services rendered in a teaching hospital to health insurance program beneficiaries is determined on the basis of an average cost per diem as defined in paragraph (h)(1) of this section for physicians' direct medical and surgical services to all patients (see § 405.521) for each of the following categories of physicians:

(i) Physicians on the hospital staff.

(ii) Physicians on the medical school faculty.

(2) *Aggregate per diem method of apportionment for the imputed value of physicians' volunteer direct medical and surgical services.* The imputed value of physicians' direct medical and surgical services rendered to health insurance program beneficiaries in a teaching hospital is determined on the basis of an average per diem, as defined in paragraph (h)(1) of this section, for physicians' direct medical and surgical services to all patients except that the average per diem will be derived from the imputed value of the physician volunteer direct medical and surgical services rendered to all patients.

(h) *Definitions.*—(1) *Average cost per diem for physicians' direct medical and surgical services (including supervision of interns and residents) rendered in a teaching hospital.* Average cost per diem for physicians' direct medical and surgical services rendered in a teaching hospital to patients in each category of physicians' services as described in paragraphs (g)(1)(i) and (ii) of this section means the amount computed by dividing total reasonable costs of such services in each category by the sum of:

(i) Inpatient days (as defined in paragraph (h)(2) of this section) and,

(ii) Outpatient visit days (as defined in paragraph (h)(3) of this section).

(2) *Inpatient days.* Inpatient days will be determined by counting the day of admission as 3.5 days and each day subsequent to a patient's day of admission except the day of discharge, as 1 day.

(3) *Outpatient visit days.* Outpatient visit days will be determined by counting only one visit day for each calendar day that a patient visits the outpatient department.

(i) *Application.* (A) The following illustrates how apportionment based on the Aggregate Per Diem Method for cost of physicians' direct medical and surgical services rendered in a teaching hospital to patients will be determined.

TEACHING HOSPITAL Y

| | |
|---|---|
| Statistical and financial data: | |
| Total inpatient days as defined in paragraph (h)(2) of this section and outpatient visit days as defined in paragraph (h)(3) of this section | 75,000 |
| Total inpatient part A days applicable to program beneficiaries | 20,000 |
| Total inpatient part B days applicable to program beneficiaries where part A coverage is not available | 1,000 |
| Total outpatient part B visit days applicable to program beneficiaries | 5,000 |

| | |
|---|---|
| Total cost of direct medical and surgical services rendered to all patients by physicians on the hospital staff as determined in accordance with paragraph (j) of this section. | $1,500,000 |
| Total cost of direct medical and surgical services rendered to all patients by physicians on the medical school faculty as determined in accordance with paragraph (j) of this section | 1,650,000 |
| Computation of cost applicable to program for physicians on the hospital staff: | |
| Average cost per diem for direct medical and surgical services to patients by physicians on the hospital staff: $1,500,000 ÷ 75,000 = $20 per diem. | |
| Cost of physicians' direct medical and surgical services rendered to inpatient beneficiaries covered under part A: $20 per diem × 20,000 | 400,000 |
| Cost of physicians' direct medical and surgical services rendered to inpatient beneficiaries covered under part B: $20 per diem × 5,000 | 100,000 |
| Cost of physicians' direct medical and surgical services rendered to outpatient beneficiaries covered under part B: $20 per diem × 5,000 | 100,000 |
| Computation of cost applicable to program for physicians on the medical school faculty: | |
| Average cost per diem for direct medical and surgical services to patients by physicians on the medical school faculty: $1,650,000 ÷ 75,000 = $22 per diem. | |
| Cost of physicians' direct medical and surgical services rendered to inpatient beneficiaries covered under part A: $22 per diem × 20,000 | 440,000 |
| Cost of physicians' direct medical and surgical services rendered to inpatient beneficiaries covered under part B: $22 per diem × 1,000 | 22,000 |
| Cost of physicians' direct medical and surgical services rendered to outpatient beneficiaries covered under part B: $22 per diem × 5,000 | 110,000 |

(B) The following illustrates how the imputed value of physicians' volunteer direct medical and surgical services rendered in a teaching hospital applicable to health insurance program patients will be determined.

*Example:* The physicians on the medical staff of Teaching Hospital Y donated a total of 5,000 hours in rendering direct medical and surgical services to patients of the hospital during a cost-reporting period and did not receive any compensation from either the hospital or the medical school. Also, the imputed value for any physician's volunteer services did not exceed the rate of $30,000 per year per physician.

| | |
|---|---|
| Statistical and financial data: | |
| Total salaries paid to the physicians of the hospital (excluding interns and residents | $800,000 |
| Total physicians who were paid for an average of 40 hours per week or 2,080 (52 weeks × 40 hours per week) hours per year | 20 |
| Average hourly rate equivalent: $800,000 ÷ 41,600 (2,080 × 20) | $19.23 |
| Computation of total imputed value of physicians' volunteer services applicable to all patients: | |
| (Total donated hours × average hourly rate equivalent): 5,000 × $19.23 | $96,150 |
| Total inpatient days (as defined in paragraph (h)(2) of this section) and outpatient visit days (as defined in paragraph (h)(3) of this section | 75,000 |
| Total inpatient part A days applicable to program beneficiaries | 20,000 |
| Total inpatient part B days applicable to program beneficiaries where part A coverage is not available | 1,000 |
| Total outpatient part B visit days applicable to program beneficiaries | 5,000 |
| Computation of imputed value of physicians' volunteer direct medical and surgical services applicable to program beneficiaries: | |
| Average per diem for physicians' direct medical and surgical services to patients: $96,150 ÷ 75,000 = $1.28 per diem. | |
| Imputed value of physicians' direct medical and surgical services rendered to inpatient beneficiaries covered under part A: $1.28 per diem × 20,000 | $25,600 |
| Imputed value of physicians' direct medical and surgical services rendered to inpatient beneficiaries covered under part B: $1.28 per diem × 1,000 | 1,280 |
| Imputed value of physicians' direct medical and surgical services rendered to outpatient beneficiaries covered under part B: $1.28 per diem × 5,000 | 6,400 |
| Total | 33,280 |

(j) *Allocation of compensation paid to physicians in a teaching hospital.* In determining reasonable cost under this section, the compensation paid by a teaching hospital, or a medical school or related organization under arrangement with the hospital, to physicians in a teaching hospital must be allocated to the full range of services implicit in the physicians' compensation arrangements. (However, see paragraph (d) of this section for the computation of the "salary equivalent" payments for volunteer services rendered to patients.) Such allocation must be made and must be capable of substantiation on the basis of the proportion of each physician's time spent in rendering each type of service to such hospital and/or medical school.

3. Section 405.466 is added to read as follows:

**§ 405.466 Payment to a fund.**

(a) *General.* Payment for certain voluntary services by physicians in teaching hospitals (as such services are described in § 405.521(d)(2) will be paid on a salary equivalent basis (as described in § 405.465(d)) subject to the conditions and limitations contained in this Part 405 and title XVIII of the Act, to a single fund (as defined in paragraph (b) of this section) designated by the organized medical staff of the hospital (or, where such services are furnished in such hospital by the faculty of a medical school, to such fund as may be designated by the faculty), if:

(1) The hospital (or medical school furnishing the services under arrangement with the hospital) incurs no actual cost in furnishing the services; and

(2) The hospital has an agreement with the Secretary under § 405.602; and

(3) The intermediary, or the Social Security Administration, as appropriate, has received written assurances that:

(i) The payment will be used solely for the improvement of care of hospital patients or for educational or charitable purposes; and

(ii) Neither the individuals who are furnished the services nor any other persons will be charged for the services (and if charged, provision will be made for the return of any monies incorrectly collected).

(b) *Definition of a fund.* For purposes of paragraph (a) of this section, a fund is an organization which meets either of the following requirements:

(1) Has and retains exemption, as a governmental entity or under section 501(c)(3) of the Internal Revenue Code (nonprofit educational, charitable, and similar organizations), from Federal taxation; or

(2) Is an organization of physicians who, under the terms of their employment by an entity which meets the requirements of paragraph (b)(1) of this section, are required to turn over to that entity all income which the physician organization derives from the physicians' services.

(c) *Status of a fund.* A fund approved for payment under paragraph (a) of this section has all the rights and responsibilities of a provider under title XVIII of the Act except that it does not enter into an agreement with the Secretary under § 405.602.

4. Regulations No. 5, Subpart E of the Social Security Administration, as amended (20 CFR Part 405) is further amended by redesignating the material in § 405.521(d) as § 405.521(d)(1) and adding (d)(2) and (d)(3) to read as follows:

**§ 405.521 Services of attending physicians supervising interns and residents.**

* * * * *

(d) * * *

(2) For cost-reporting periods beginning after June 30, 1973, and before July 1, 1976, a hospital may elect to receive reimbursement on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of any payment on the basis of reasonable charges which might otherwise be payable for such services. A hospital may make this election to receive cost reimbursement only where all physicians who render services in the hospital which are covered under the health insurance program agree not to bill charges for such services (or where as a condition of employment the physicians are precluded

from billing for such services). Where the requirements of this paragraph (d)(2) are satisfied by a hospital, the reimbursement provisions of § 405.465 are applicable.

(3) Where payments for services of physicians in teaching hospitals rendered after June 30, 1973, and before December 31, 1973, would be improper by virtue of section 15(a) of Pub. L. 93-233 (87 Stat. 965), such payments are deemed proper even though they may not meet the requirements which are based on section 15(a) of Pub. L. 93-233, if they are appropriately made under the provisions of section 227 of Pub. L. 92-603 (86 Stat. 1404).

[FR Doc.75-5964 Filed 3-6-75;8:45 am]

## DEPARTMENT OF TRANSPORTATION

### Coast Guard

### [ 46 CFR Parts 10, 12 ]

### [CGD 74-226]

### LICENSING & CERTIFICATION OF MERCHANT MARINE PERSONNEL

### Extension of Comment Deadline

The Coast Guard published a notice of proposed rulemaking in the January 29, 1975 issue of the FEDERAL REGISTER (40 FR 3610). This notice of proposed rule-making solicited comments on a new method of qualifications for a license as Third Mate of ocean steam or motor vessels with a rating of "apprentice mate."

A comment has been received requesting that the comment deadline be extended for thirty (30) days. Since this is a reasonable request, the comment deadline for this notice of proposed rulemaking is hereby extended 30 days to April 9, 1975.

Dated: March 4, 1975.

W. M. BENKERT,
*Rear Admiral, U.S. Coast Guard,*
*Chief, Office of Merchant Marine Safety.*

[FR Doc.75-6109 Filed 3-6-75;8:45 am]

### Federal Aviation Administration

### [ 14 CFR Part 71 ]

### [Airspace Docket No. 75-RM-6]

### TRANSITION AREA

### Proposed Designation

The Federal Aviation Administration is considering an amendment to Part 71 of the Federal Aviation Regulations which would designate a transition area at Gwinner, N. Dak.

Interested persons may participate in the proposed rule making by submitting such written data, views, or arguments as they may desire. Communications should be submitted in triplicate to the Chief, Air Traffic Division, Federal Aviation Administration, Park Hill Station P.O. Box 7213, Denver, Colorado 80207. All communications received on or before April 7, 1975, will be considered before action is taken on the proposed amendment. No public hearing is contemplated at this time, but arrangements for informal conferences with Federal Aviation Administration officials may be made by contacting the Regional Air Traffic Division Chief. Any data, views, or arguments presented during such conferences must also be submitted in writing in accordance with this notice in order to become part of the record for consideration. The proposal contained in this notice may be changed in the light of comments received.

A public docket will be available for examination by interested persons in the office of the Regional Counsel, Federal Aviation Administration, 10455 E. 25th Avenue, Aurora, Colorado 80010.

A public instrument approach procedure has been developed using a non-Federal, non-directional radio beacon at Gwinner, No. Dak. It is necessary to establish a transition area to provide controlled airspace protection for aircraft executing this procedure.

In consideration of the foregoing, the FAA proposes the following airspace action:

In Federal Aviation Regulation § 71.181 (40 FR 441) add the following transition area:

GWINNER, NO. DAK.

That airspace extending upward from 700 feet above the surface within an 8.5-mile radius of the Gwinner Municipal Airport (latitude 46°13'10" N, longitude 97°38'27" W); and that airspace extending upward from 1200 feet above the surface within a 12-mile radius of the Gwinner Municipal Airport, and within 9.5 miles west and 4.5 miles east of the 167°T bearing from the Gwinner NDB (latitude 46°13'24" N, longitude 97°38'35" W), extending from the 12-mile radius area to 18.5 miles south of the NDB.

(Sec. 307(a), Federal Aviation Act of 1958, as amended (49 U.S.C. 1348(a)); sec. 6(c), Department of Transportation Act (49 U.S.C. 1655(c)))

Issued in Aurora, Colorado, on March 11, 1975.

M. M. MARTIN,
*Director, Rocky Mountain Region.*

[FR Doc.75-5999 Filed 3-6-75;8:45 am]

### [ 14 CFR Part 71 ]

### [Airspace Docket No. 75-GL-6]

### TRANSITION AREA

### Proposed Designation

The Federal Aviation Administration is considering amending Part 71 of the Federal Aviation Regulations so as to designate a transition area at Ottawa, Ohio.

Interested persons may participate in the proposed rule making by submitting such written data, views or arguments as they may desire. Communications should be submitted in triplicate to the Director, Great Lakes Region, Attention: Chief, Air Traffic Division, Federal Aviation Administration, 2300 East Devon Avenue, Des Plaines, Illinois 60018. All communications received on or before April 7, 1975 will be considered before action is taken on the proposed amendment. No public hearing is contemplated at this time, but arrangements for informal conferences with Federal Aviation Administration officials may be made by contacting the Regional Air Traffic Division Chief. Any data, views or arguments presented during such conferences must also be submitted in writing, in accordance with this notice in order to become part of the record for consideration. The proposal contained in this notice may be changed in the light of comments received.

A public docket will be available for examination by interested persons in the Office of the Regional Counsel, Federal Aviation Administration, 2300 East Devon Avenue, Des Plaines, Illinois 60018.

A new instrument approach procedure has been developed for the Putnam County Airport based on a non-Federal non-directional radio beacon. Consequently, it is necessary to provide controlled airspace protection for aircraft executing this new procedure by designating a transition area at Ottawa, Ohio.

In consideration of the foregoing, the Federal Aviation Administration proposes to amend Part 71 of the Federal Aviation Regulations as hereinafter set forth:

In § 71.181 (39 FR 440), the following transition area is added:

OTTAWA, OHIO

That airspace extending upward from 700 feet above the surface within a 5-mile radius of the Putnam County Airport (Latitude 41°02'08" N., Longitude 83°59'01" W.); within 3 miles each side of the 090° bearing from the airport extending from the 5-mile radius area to 8.5 miles east of the airport.

(Sec. 307(a), Federal Aviation Act of 1958 (49 U.S.C. 1348); sec. 6(c), Department of Transportation Act (49 U.S.C. 1655(c)))

Issued in Des Plaines, Illinois, on February 18, 1975.

R. O. ZIEGLER,
*Acting Director,*
*Great Lakes Region.*

[FR Doc.75-6000 Filed 3-6-75;8:45 am]

### [ 14 CFR Part 71 ]

### [Airspace Docket No. 75-RM-6]

### TRANSITION AREA

### Proposed Alteration

The Federal Aviation Administration is considering an amendment to Part 71 of the Federal Aviation Regulations which would alter the control zone and transition area at Laramie, Wyoming.

Interested persons may participate in the proposed rule making by submitting such written data, views, or arguments as they may desire. Communications should be submitted in triplicate to the Chief, Air Traffic Division, Federal Aviation Administration, Park Hill Station, P.O. Box 7213, Denver, Colorado 80207. All communications received on or before April 7, 1975, will be considered before action is taken on the proposed amendment. No public hearing is contemplated at this time, but arrangements for informal conferences with Federal Aviation Administration officials may be made by contacting the Regional Air Traffic Division

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

WASHINGTON: 202: 466-5175

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

March 11, 1975

Honorable Caspar W. Weinberger
Secretary of Health, Education
and Welfare
HEW North Building, Room 5246
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

The Association of American Medical Colleges requests an extension to June 7, 1975, for filing formal comments regarding proposed Social Security Administration regulations entitled, "Payment for Services of Physicians in Teaching Hospitals, for Physicians Costs to Hospitals and Medical Schools, and for Volunteer Services," subpart D as amended. These proposed regulations appear in the March 7, 1975 Federal Register (20 CFR, Part 405, Regulation No. 5).

The Association represents all of the nation's 115 schools of medicine, 400 major teaching hospitals affiliated with medical schools and 58 academic societies. We have corresponded on numerous occasions over the last two years, with the Social Security Administration on proposed rules regarding the payment of teaching physicians for services rendered to Medicare beneficiaries. The Association feels that the rules proposed will have a profound impact upon patients, medical staffs, medical schools and teaching hospitals, and the process of medical education.

Due to both the complexity of the proposed regulations and the system to which these regulations are addressed, a considerable amount of analysis must be undertaken to provide a meaningful assessment of the impact of the proposed rules. It is for these reasons that the Association is requesting a sixty day extension of the formal comment period. Input from those institutions to whom the proposed rules apply is critical to preparing formal comments that will be helpful to the Social Security Administration.

Almost eighteen months have passed since regulations proposing to implement Section 227 of P.L. 92-603 were issued. During this period, the Institute of Medicine of the National Academy of Sciences was commissioned to undertake a study to assess the potential impact of the 1972 legislation on medical centers mandated by P.L. 93-233. Because of the lengthy intervening time period, the original deferrment of Section 227 until July 1, 1976, and the initiation of the Institute of Medicine study, there is confusion regarding the status of these proposed regulations. The Association would like to question why the regulations are being proposed before the report of the study and any actions taken by the Congress in response to its findings.

In a meeting on November 6, 1974, with representatives of ten health care organizations, including the AAMC, you indicated that you would give serious consideration to an extended comment period for regulations when a reasonable basis could be established for the request. It is our feeling that these regulations are of a nature that necessitates a longer period for comment than is normally allotted. As you requested at that meeting, a copy of this letter is being forwarded to Mr. David Lissy.

As always, my staff and I would be pleased to supply you with any additional information that you may require in considering this matter.

Sincerely,

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

JOHN A. D. COOPER, M.D.

cc: Mr. David Lissy

AUPHA

ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION
ONE DUPONT CIRCLE/WASHINGTON, D.C. 20036/SUITE 420/ (202) 659-4354

February 26, 1975

John A. D. Cooper, M.D., Ph.D., President
Association of American Medical Colleges
1 Dupont Circle, Suite 200
Washington, D. C. 20036

Dear Dr. Cooper:

The input of your association is requested to a major project addressing the future training of health services administrators. The Association of University Programs in Health Administration (AUPHA) is a consortium of more than sixty-four colleges and universities offering formal training programs for Hospital and Health Services Administrators. AUPHA is presently conducting a study, funded by the Bureau of Health Resources Development, DHEW, "to define the appropriate health and behavioral sciences curriculum components of graduate programs in health services administration." A brief summary of the overall project, including operating definitions of health and behavioral sciences, is enclosed.

As part of the health and behavioral sciences project, papers are being solicited from selected professional societies and organizations concerned about the training of health administrators. These papers will provide vital input for deliberations leading to final recommendations. Project findings and recommendations will be used by faculty in curriculum assessment and revision, by the Bureau of Health Resources Development in evaluating grant and traineeship applications for funding in health administration, and will be carefully reviewed by the Accrediting Commission on Graduate Education for Hospital Administration for possible input into accreditation criteria.

You are requested to present your views on one or more aspects of health and behavioral sciences education in the form of a position paper. Specific questions with which we are concerned, some of which you may want to address in a position paper, are outlined as enclosed.

Position papers may be submitted on behalf of organizations, working groups or individuals. Our primary concern is that adequate input is obtained to insure a full range of considerations in our findings and recommendations for educational change.

Each response will be published by AUPHA with wide distribution among health services administration faculty. If you plan a response to this invitation we would like to receive by May 1, 1975, a rough estimate of its total length and the date it will be submitted, in order to make publication arrangements.

Your actual response (letter/position paper/chapter) must be received no later than September 15, 1975. This will allow adequate time for review and discussion by the staff, Advisory Committee, study groups, program faculty, etc., before publication in early 1976.

Depending upon the length and nature of your response, you may subsequently be asked to make a presentation at a national institute or meeting for health administration faculty on the topic of Health and Behavioral Sciences Education. Would you be willing to do so if asked?

Thank you for your participation and cooperation. If at any time you should have a question or desire more information, please feel free to call us collect.

Sincerely,

Kent W. Peterson, M.D.
Project Director

KWP/iks
Encl. (1) Project Summary
(2) Position Paper Guidelines

AUPHA

Health and Behavioral Sciences Education Project

POSITION PAPER GUIDELINES

The following questions are intended to stimulate discussion and to focus recommendations as to the appropriate health and behavioral sciences curriculum components of graduate programs in health services administration. Although by no means limited to these general questions, writers are encouraged to take positions on these issues:

1. What, in your opinion, are or will be key administrative functions necessitating knowledge of health sciences? Please describe specific situations where this knowledge will be required in decision-making processes.

2. What role, <u>if any</u>, should health sciences play in the training of future health care administrators? Are there unique aspects of health care and the health care system that administrators will need to understand in order to function effectively? If so, what are these unique aspects and should they be taught in graduate programs or can they be quickly learned "on the job?"

3. What specific health sciences and health sciences courses do you feel are most important for the training of future health services administrators? Which are least essential?

4. What, in your opinion, are key functions of future health services administrators which will necessitate knowledge of the behavioral and social sciences? Please describe specific situations where this knowledge will be required in decision-making processes.

5. What role, if any, should the behavioral and social sciences have in the training of future health services administrators? How important are the behavioral and social sciences vis-à-vis accounting, financial management, quantitative methods and other more technical management skills?

6. What specific behavioral and social sciences and courses do you feel are most important for training future administrators? Which are less relevant?

7. Considering both Health and behavioral sciences contributions, which curriculum components do you feel should be stressed in order to broaden the field of hospital administration into truly <u>health</u> services oriented administration?

AUPHA

HEALTH AND BEHAVIORAL SCIENCES EDUCATION PROJECT

In early 1976 AUPHA's Office of Academic Research will complete a major undertaking to define the appropriate health, behavioral and social sciences components of graduate curricula in health services administration. Funded by the Bureau of Health Resources Development, DHEW, this project will translate relevant contributions of a wide range of approaches into educational terms.

Health sciences have been operationally defined as those focusing upon health, illness and the intervention process; behavioral and social sciences as those focusing upon man and his behavior in relationship to others and his environment. Disciplines, approaches, or "knowledge clusters" relevant to health and behavioral sciences include:

- o epidemiology
- o environmental health
- o biological sciences
- o medical and patient care practices
- o preventive & community medicine
- o health services organization
- o mental health, illness, therapy
- o human ecology
- o medical sociology/demography
- o psychology/social psychology
- o cultural anthropology
- o health economics
- o political science
- o health policy/public policy
- o health law
- o ethics, values
- o organization theory/development
- o health team development
- o general systems theory
- o education & communications

In short, health and behavioral sciences have been broadly defined in order to avoid unnecessary limitation of the scope in inquiry.

Key project activities include:

1) identifying important administrative functions, problem areas and decision-making situations in which health and behavioral sciences may be required by future health care managers;

2) commissioning scholarly papers assessing the potential contributions of many of the above disciplines or approaches, relating them to key administrative functions/problems by use of a two dimensional matrix or "grid";

3) soliciting position papers from faculty, other individuals and selected organizations dealing with the evolution, appropriate role, future direction, priorities and specific components of health and behavioral sciences in health administration curricula;

4) surveying and assessing current health and behavioral sciences teaching efforts in health administration programs, as well as reviewing approaches in business, medical and other health professions education;

5) examining alternative approaches to teaching health and behavioral sciences knowledge and skills, including a look at student prerequisites, faculty resources, learning objectives, curriculum formulation and content, teaching methods, interdisciplinary education, evaluation and periodic revision;

6) developing specific recommendations regarding acceptable alternative future educational strategies, with suggestions for assessing and improving current efforts -- by an Advisory Committee, with input from study groups, paper writers, faculty, staff and other current studies of future administrative roles.

B. Jon Jaeger, M.H.A., Ph.D., director of the Duke University Department of Health Administration and a member of AUPHA's Executive Committee is serving as chairman of the Advisory Committee. This committee includes educators from health administration, medicine and allied health, public health and the behavioral sciences; practicing administrators and behavioral scientists from various settings, and a public representative. Kent W. Peterson, M.D., Associate Director of AUPHA, is serving as project director, bringing experience in private medical practice, occupational and public health; teaching in medicine, allied health and health administration; health services research and health policy development. Gail P. Feaster, B.A., and Ione Smith provide research and administrative assistance.

The Health and Behavioral Sciences project should help to define unique characteristics of the health care system that distinguish "health" from "hotel" administration and other areas of administrative activity. By considering basic concepts such as health, illness, factors contributing to disease, health promotion, health maintenance and the articulation of health and human services, this study should be a major value to educators attempting to readjust their focus beyond institutional management to health oriented community services. Finally, its grid approach of interfacing theoretical disciplines with practical administrative problems may offer a widely useful model for curriculum assessment and development in other areas.