

*to write  
Sherman &  
Suggs adv. comm  
to G.C.R.C.*

*7/10 of Chicago*

AGENDA  
COTH COMMITTEE ON FINANCIAL PRINCIPLES  
FOR TEACHING HOSPITALS.

Seven Continents V.I.P. Lounge  
O'Hare Airport  
Chicago, Illinois  
January 25, 1968  
10:00 a.m. - 4:00 p.m.

*How many who  
subscribe to  
basis for  
calculating  
G.C.R.C. Rate  
Negotiate  
Rate  
Agreement*

- I. Call to Order: 10:00 a.m.
- II. Approval of Minutes: Meeting of October 17, 1967 Tab 1
- III. Discussion: Selected Financial Principles for Teaching Hospitals, Mr. Goulet Tab 2
- IV. Discussion: P.P.B.S. -- A Design Potential for Teaching Hospitals, Dr. Hartman Tab 3
- V. Selected Problems of Medicare Reimbursement, Mr. Wittrup
- VI. Problems of Inadequate Overhead on Direct Research Grants and Training Grants Tab 4
- VII. Report: Recent Developments Regarding "A Guide for Hospitals: Establishing Indirect Cost Rates for Research Grants and Contracts with the Department of Health, Education and Welfare", Mr. McNulty Tab 5  
*DR. X. R. Lewis (cc to Bob, Lide)*
- VIII. Report: Activities of Committee to Develop Implementing Procedures for Hospital Cost Principles and Subcommittee Tab 5
- IX. Report: Recent (12/18/67) Revision of Protocol for AAMC-HEW Cost Information Study Tab 6
- X. Physician Services for "Staff" or "Service" Patients Tab 7
- XI. Other Business
- XII. Date of Next Meeting *4/5*
- XIII. Adjournment: 4:00 p.m.

*8/10  
with L.R.  
37  
Ex. C. AAMC  
Support  
Removal  
9/8/70*

*4/5  
need  
Thur  
6/6*

Copies to: Committee Membership  
Thomas Campbell, Division of Operational Studies, AAMC  
A.J. "Gus" Carroll, Division of Operation Studies, AAMC

*Send out  
Protocol  
to Committee*

COUNCIL OF TEACHING HOSPITALS  
ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
1346 Connecticut Avenue, N.W.  
Washington, D.C. 20036  
202/223-5364

MEETING OF COMMITTEE ON FINANCIAL PRINCIPLES  
FOR TEACHING HOSPITALS  
SEVEN CONTINENTS V.I.P. LOUNGE  
O'HARE AIRPORT  
CHICAGO, ILLINOIS  
October 17, 1967  
10:00 a.m. - 4:00 p.m.

*ARTHUR J. KLIPPA, JR.  
M.D.  
Y.A. Hosp. Fed  
Ann Arbor*

Present:

Charles R. Goulet, Chairman  
Richard D. Wittrup, Vice-Chairman  
V.L. Harris  
Gerhard Hartman, Ph.D.  
Bernard J. Lachner  
Lawrence E. Martin  
Roger B. Nelson, M.D.  
Irvin G. Wilmot

Staff:

Matthew F. McNulty, Jr., Director, COTH  
Fletcher H. Bingham, Assistant Director, COTH  
A.J. Carroll, Assistant Director, Division of Operational Studies, AAMC  
(morning only)

Also present:

Roger L. Amidon  
John W. Colloton

Absent:

Reid T. Holmes

I. Call to Order:

The meeting was called to order at 10:00 a.m. by Charles R. Goulet,  
Chairman.

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## II. Background Information Relating to the Formation of the Committee on Financial Principles for Teaching Hospitals

The Chairman indicated that the COTH Executive Committee, in considering the development of the Committee on Financial Principles, had recognized the need for the preparation of selected broad principles of a fiscal nature that would be applicable to teaching hospitals. He indicated further that there were two events that contributed to the appropriateness of timing for such a meeting. The first such event was the drawing to completion of the Yale-New Haven Study being conducted by Mr. A.J. Carroll, Assistant Director, Division of Operational Studies, AAMC. Mr. Goulet further indicated that while this study developed more detail than would be necessary, or helpful, to this Committee, it was anticipated that certain broad guidelines, as uncovered by this study, would have the attention of the Committee.

The second event which precipitated interest in the development of the Committee was the AAMC-HEW Program Cost Information Study. The Chairman then reviewed the history of this study and noted that the makeup of the Committee was predominantly those representatives of institutions participating in the study. Mr. McNulty reported that Mr. Thomas J. Campbell, Administrator and Associate Director, Kansas City General Hospital and Medical Center, had been recruited to serve in the capacity of staff for this study. He indicated further, that while Mr. Campbell would be located at the Division of Operational Studies in Evanston, he would necessarily work closely with the staff of the Council of Teaching Hospitals.

## III. Documents and Studies of Interest to the Activities of the Committee

The following items were presented for informational purposes to the Committee:

1. Yale-New Haven Study
2. Protocol for Teaching Hospital Section of HEW-AAMC Program  
Cost Information Study
3. Bureau of Budget Circulars A-21 and A-74
4. American Hospital Association's Statement of Reimbursement -  
Approved by Board of Trustees - August 28, 1965
5. A Guide for Hospitals: Establishing Indirect Cost Rates for Research Grants and Contracts with the Department of Health, Education and Welfare.

The Chairman indicated that the first two items had been discussed largely under Item II. Mr. McNulty noted that the Bureau of the Budget Circulars A-21 and A-74 were included as evidence of the working relationships that had necessarily developed between universities and the Federal Government.

Mr. Martin indicated that he has served as a member of the American Hospital Association's Committee charged with the responsibility of reviewing the Statement of Reimbursement. He indicated further that the new AHA statement relating to standards of financing were being developed, and that the Board of Trustees of AHA was to receive and act on the new statement on November 14 and 15. He noted that although he had not seen the final draft of the statement, it had come to his attention that there were several areas contained within the position that could have material influence on present methods of financing care. Following full discussion of this item the following action was taken:

ACTION #1: THERE WAS UNANIMOUS AGREEMENT THAT A STAFF MEMBER OF THE AHA SHOULD BE ASKED TO PARTICIPATE IN THE COTH COMMITTEE MEETINGS IN AN EX-OFFICIO

*Area-wide Plng  
Res mb - Capital operations  
Licensure*

CAPACITY. IT WAS AGREED THAT MR. McNULTY ASCERTAIN FROM DR. CROSBY  
WHAT INDIVIDUAL WOULD BEST SERVE IN A LIAISON CAPACITY FOR THE AHA.

Mr. Martin indicated that, because he was serving as a member of the President's Committee on Hospital Effectiveness, he had certain information that he believed would be of interest to the committee. Following a lengthy discussion of the charge of activities to this presidential committee, it was agreed that:

ACTION #2: MR. McNULTY WOULD WRITE TO MR. THOMAS M. TIERNEY (DIRECTOR, BUREAU OF HEALTH INSURANCE) INFORMING HIM OF THE EXISTENCE OF THE COMMITTEE, AND REQUESTING FROM HIM A COPY OF THE RECOMMENDATIONS PRESENTED BY THE BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION, TO THE PRESIDENT'S COMMITTEE ON HOSPITAL EFFECTIVENESS.

ACTION #3: MR. MARTIN, AS A MEMBER OF THE PRESIDENTIAL COMMITTEE, WOULD REVIEW THE SUBSTANTIVE RECOMMENDATIONS INCLUDED IN THE DRAFT OF THE COMMITTEE'S REPORT AND IF, IN HIS OPINION, THERE ARE ISSUES THAT THE COTH COMMITTEE WOULD FIND OF CONCERN, HE WILL CONTACT THE COTH CHAIRMAN AND STAFF, IN ORDER THAT THE COMMITTEE COULD BE CALLED TO MEET AND DISCUSS ANY ITEMS OF ISSUE.

IV. Discussion of Purposes and Development of Objectives and Goals of the Committee

The Chairman suggested that in developing this area for discussion that both the long-range, as well as short-term, objectives of the Committee be considered. Following a full and wide-ranging discussion, the following were agreed to:

ACTION #4: COTH STAFF WOULD DEVELOP FOR COMMITTEE REVIEW A POSITION, SUITABLE FOR USE AS A "WHITE PAPER," ON THE UNIQUE SOCIAL RESPONSIBILITY OF TEACHING HOSPITALS AND THE INFLUENCE WHICH THIS PARTICULAR SOCIAL RESPONSIBILITY HAS ON THE FINANCING OF RESEARCH, EDUCATION AND PATIENT CARE RENDERED IN TEACHING HOSPITALS.

ACTION #5: DR. HARTMAN AGREED TO HAVE HIS STAFF PREPARE A PAPER ON THE APPLICATION OF COST BENEFIT ANALYSIS TO DECISION-MAKING IN TEACHING HOSPITALS. THE PURPOSE OF SUCH A PAPER IS FOR REVIEW BY VARIOUS GOVERNMENTAL AGENCIES AND BUREAUS AS AN INDICATION OF RELATIVE SOPHISTICATED, IN FINANCIAL MANAGERIAL TECHNIQUES, DISPLAYED BY THE ADMINISTRATION OF TEACHING HOSPITALS.

Chairman Goulet then left the meeting and Vice-Chairman Wittrup took the chair.

The Committee then discussed various discrete areas of financing that should be considered by the Committee. Following a full discussion, and the development of tentative items to which the Committee should address itself, it was agreed that:

ACTION #6 COTH STAFF WOULD DEVELOP THE ITEMS DISCUSSED, AS WELL AS A LISTING OF ADDITIONAL ITEMS WHICH WOULD SERVE AS A FRAMEWORK FOR COMMITTEE DELIBERATION AND RECOMMENDATION. IT WAS AGREED THAT THIS LIST WOULD BE CIRCULATED TO THE COMMITTEE PRIOR TO THE NEXT MEETING.

V. New Business

Chairman Wittrup called for any items of new business to be introduced. There were none.

VI. Date of Next Meeting

The Chairman recommended and the members concurred that the next meeting be called for Thursday, January 25, 1968, at 10:00 a.m. in Chicago, Illinois.

VII. Adjournment

The meeting adjourned at 3:45 p.m.

identifiable programs  
HISAC

Research hospitals

and Community Services

1. Because of the multiple purposes of a medical center, it is essential that costs related to research, education, ~~and~~ patient services, be ~~separated~~ identified and allocated in accordance with
- \*2. The separation of costs should not only be made by major <sup>element of the medical center</sup> category, but should also be made by specific programs within each <sup>category, e.g. in-patient services, out-patient services, etc.</sup> element
3. The separation of costs should be based upon sound cost accounting principles. *allocation of service units to revenue producing units*
4. The bases for allocation of costs should be well understood within the institution and, where necessary, within the community and by third parties. *inter institution*
- \*5. Although it is essential that a number of the functions in a modern medical center ~~must~~ be carried out simultaneously, and indeed it is essential that they be done so, institutions should arrive at reasonable bases for the allocation of expenses between the major functions and programs. *??*
6. <sup>direct or indirect</sup> The costs of <sup>and of</sup> general educational research <sup>accomplished in a medical center</sup> costs should be borne by the University, <sup>financial</sup> except where there is clear <sup>and definitely assigned</sup> assignment of such educational or research responsibilities to the hospital. *medical center and/or*
7. If research and educational costs are <sup>clearly and definitely</sup> assigned to the hospital, full reimbursement for these costs should be provided from available sources whether from the community, university or institutional sources. *by appropriate*
8. The costs related to education and research, where conducted within the hospital setting, should include costs associated with the provision, replacement and maintenance of capital facilities.
- \*9. Distribution of costs for physicians' services should be carefully considered by the medical school and the hospital in relation to service, education and research. The method of apportionment should be well understood and should be based upon a realistic appraisal of the prevailing situation. The costs associated with undergraduate educational programs should be separated from the costs of graduate medical education.

System should be adaptable to parties

Insurance Principle



THE UNIVERSITY OF CHICAGO HOSPITALS AND CLINICS

950 EAST 59TH STREET  
CHICAGO • ILLINOIS 60637  
MUSHUM 4-6100

January 11, 1968

Mr. Gerhard Hartman  
Director  
University Hospitals  
The University of Iowa  
Iowa City, Iowa 52240

Dear Gerry:

Thanks for sending the paper on "P.P.B.S.". Matt McNulty is including this on the agenda for our next meeting of the Committee.

Thanks for your Christmas wish. Best wishes from all of us here in Chicago to you and your family for the new year.

Cordially,



Charles R. Goulet  
Superintendent

crg:flk  
cc: Mr. M. McNulty

P. P. B. S. --- A DESIGN POTENTIAL FOR TEACHING HOSPITALS

Submitted by Gerhard Hartman, Ph.D.

Director: University Hospitals

Professor and Director

Graduate Program in Hospital and Health Administration

University of Iowa

Iowa City, Iowa

## P. P. B. S. --- A DESIGN POTENTIAL FOR TEACHING HOSPITALS

A Planning - Programming - Budgeting System (PPBS) is a method for defining and achieving clearly stated quantitative objectives. The design of the system focuses on alternative means for attaining objectives and permits continuous comparison of results in relating means to ends. It is a system which permits the tools of financial management to be maximized in the development of a programmed and balanced budget.<sup>1</sup>

The system's prime goal according to Massey is "to 'bridge the gap' between planning and programming on the one hand, and financial management and budgeting on the other." It introduces economic resource considerations into the decision-making process in a timely and meaningful manner. Charles J. Hitch and others have pointed out that budget decisions are inherently program decisions. This system endeavors to make the reverse true--to have program decisions consciously made as budget decisions.<sup>2</sup>

### The Essence of the System

The essential features of PPBS include multi-year planning, alternative means for achieving objectives, cost effectiveness analysis, and continuous review and comparison of results in relating means to ends. The components of the system, as identified by the Council for

Economic Development<sup>3</sup> are:

1. Definition of the program in terms of the specific results, or outputs desired.
2. Identification of alternative methods.
3. Comparison of costs between methods.
4. Development of measures for appraising effectiveness in achieving desired results.
5. Organization of information for continuous comparison of results with costs.
6. Facilitation of revision of plans and programs.

#### Program Structure

The first step in program budget analysis is the development of program "packages" or "structures" which represent output-oriented classifications of organizational expenditures instead of the traditional classifications by line item (e. g. personnel, maintenance), by function (e. g. pharmacy or laboratory), or by agency and department of origin (e. g. the Department of Medicine or the Department of Surgery). Each program package lists and interrelates all programs designed to achieve a broad, common objective.<sup>4</sup>

The program structure originates with a broad, general objective which is composed of more specific objectives and sub-objectives which are realized through "program elements". These elements represent the most detailed and specific activities essential to goal accomplishment. A "program element" can be defined as an integrated activity, a combination of personnel and physical resources, whose

effectiveness can be related to the general program objectives. It is described in terms of physical characteristics and capabilities to permit cost effectiveness comparisons.<sup>5</sup> The essential point is that at each level of objective there is consideration of alternatives in the composition of the appropriate mix of components to accomplish the overall goal.

The following example is illustrative of the components of a program structure in the health field: Optimum health care is the general objective. Enhanced Medical Care and Dental Care are more specific objectives. Under Dental Care, Preventive Dentistry and Operative Dentistry are examples of sub-objectives. Preventive Dentistry might well be composed of such "program elements" as fluoridation of water, clinical application of fluorides, periodic oral examinations, and oral hygiene education. In determining the optimum mix of elements and the appropriate levels of financial support, one must consider the short-, mid-, and long-range goals. Within this context, trade-offs between "program elements" and the most appropriate levels of financial support for each element within a given time-frame are determined. For example, what levels of financial support should be given to the clinical application of fluorides, oral examinations, and the educational programs in oral hygiene to provide the greatest return in dental health for a given investment. PPBS fosters such analysis at each level of the program structure.

Another example which illustrates the application of this technique in broader perspective is provided by Marvin Frankel.<sup>6</sup> As a tentative first step, he conceptualizes the federal government's achievement of national health goals under five major programs:

(1) Prevention and control of disease; (2) Treatment of illness and injury to restore health; (3) The provision of long term care (both inpatient and outpatient) for the chronically ill, the disabled, and the aged; (4) Training (not classifiable to previous items); (5) Research (not classifiable to previous items).

#### CONTROL AND PREVENTION

Infectious and allergic diseases  
Neurologic and degenerative diseases  
Chronic diseases and those of age  
Accidents and occupational hazards  
Food and drug hazards  
Child health and nutrition  
Other (including Environmental Health)

#### TREATMENT AND RESTORATION

Rehabilitation and development  
Chronic diseases  
General illnesses  
Other (including unallocable facilities costs)

#### LONG-TERM CARE AND DOMICILIARY MAINTENANCE

Chronic diseases  
Care of aged  
Mental illness

#### TRAINING

Infections and allergic diseases  
Neurologic and degenerative diseases  
Mental illness  
Chronic diseases and those of age

#### RESEARCH

Infectious and allergic diseases  
Neurologic and degenerative diseases  
Mental illness  
Chronic diseases and those of age  
Occupational and other hazards

The program structure facilitates an analysis within and between programs. Michael Levy states:

"Once a complete package has been developed, the current expenditures as well as future projected costs of each program element can be determined. Thus the overall costs of each component are revealed and may be compared with those of other components. By relating program costs to their respective outputs, the equivalent of what in business is termed "unit cost" can be determined."<sup>7</sup>

In the fully developed program each element is evaluated as to its cost and estimated output. This evaluation is made by cost effectiveness analysis which compares each element to alternative elements on the basis of quality and quantity of output per dollar expenditure. By utilizing this principle, alternative management programs can be ranked according to their economic efficiency.<sup>8</sup> This orientation differs completely from the traditional object classification or functional classification which tells what an organization buys but not why.

#### Measurement Classifications

Whatever an organization accomplishes may be measured by either end-products or activities. If the assessment is to utilize end-products as criteria, the end-products must be identifiable, measureable, and significant. For example, the number of oral examinations performed per year within the Preventive Dentistry Program illustrates measurement by end-product. There are, however, aspects of medical care which do not lend themselves to end-product measurement. Dental research illustrates one such facet which does not lend itself in all

cases to satisfactory end-product measurement. Some research projects are by nature heterogeneous and no common base for measurement exists. Pure research is measured in terms of activity performance; whereas certain aspects of applied research may in fact lend themselves to end-product measurement. Activity schedules may be established to measure processes, purposes, or projects. Much research lends itself to measurement by purpose.

#### A Tool: Not A Panacea

Care must be taken to recognize the limitations of program budgeting. It is not a cure-all for management's problems, but merely one tool of many available to the administrator. It has several inherent limitations and several difficulties in being applied. Program budgeting by itself doesn't guarantee decreased expenditure nor optimal allocation of funds. Although program budgeting considers the quality and quantity of output per dollar expenditure for a program, it does not evaluate the goal for which the program was designed. While it can determine that a certain means is more effective for achieving a specific end, it cannot decide which end is more desirable. Thus, the question of competing ends (i. e. Is research project A more desirable than research project B?) is the crux of the decision-making process. The system may provide the most economically efficient program under existing conditions, but it is not sensitive to factor changes. Such factors might include changes in the level of educational program achievement or in the number of outpatients seen.



Once applied, program budgeting identifies potential deficiencies in the allocation of resources. The budgeting process must be adapted to an output rather than an input or orientation. Frequently, this leads to over-refinement and arbitrary categorization; hence, an overflow of data. Massey finds that program budgeting "also tends to encourage over-decentralizing, over-simplifying the appropriation structure, and consolidation of functional categories for purely budgetary purposes or for ease in supporting the budget with cost data".<sup>9</sup>

The shift away from the standard budgeting system (i. e. one which is incremental, fragmented, non-programmatic, and sequential) naturally implies changes in the allocation of funds. There will be a change in the political process and a re-evaluation of existing hospital activities. Wildavsky states, "Far from being a neutral matter of better budgeting, proposed reforms (such as program budgeting) inevitably contain important implications for the political system; that is, for the 'who gets what' of organizational decision."<sup>10</sup> Thus, some departments stand to gain, others to lose through a change in the budgeting function. As expected, some administrators would be more eager than others for a new method of allocation. Differences will be accentuated through the "all or nothing" approach, where a program may be accepted or rejected instead of added to or subtracted from.

### Acceptability of Program Budgeting

Program budgeting should have a great appeal to all concerned with administering a teaching hospital. In the case of University Hospitals, legislative or board review is eased considerably. The persons responsible for the appropriation of funds are better able to see programs in a cost-benefit perspective; hence, they are better able to control the flow of funds. The complexity of multi-funded programs is reduced to a comprehensible level for both legislators or board members and the public. Accordingly, responsibility and cost consciousness of management are increased. Through the overview provided by the cost-benefit analysis a relatively balanced program mix may be established among teaching, research, and patient care functions in the hospital. Once installed, the program budget is seen to contain numerous benefits for the teaching hospital. No longer does the administrator relegate financial considerations to the periphery, making decisions regarding inputs without regard to their economic effect on the final cost benefit equation. With financial considerations playing such an influential role in the decision making process, budgeting moves to the center of management responsibility. Seeing the effects of various inputs of the cost benefit equation, the administrator simultaneously goes through the complementary processes of decision making and budgeting.

**NEW ENGLAND MEDICAL CENTER HOSPITALS**

The Clinical Unit of the Tufts-New England Medical Center

*Outling the Boston District  
to Tufts Medical Center  
for Payment of Clinical  
and Staff Unit Expenses  
Center Hospital*

171 Harrison Avenue, Boston, Massachusetts 02111 Area code 617 542-5600

6 November 1967

Fletcher H. Bingham, Ph.D.  
Assistant Director, COTH  
Association of American Medical Colleges  
1346 Connecticut Avenue, N.W.  
Washington, D. C. 20036

Dear Fletcher:

In Matt's absence I am sending you some material on research overhead about which Matt and I had a brief discussion.

The problem of inadequate research overhead affects only those hospital which receive direct research grants and which have training grants. However, I think this is a significant proportion of the teaching hospitals and in many cases I do not think that they are fully aware of the problem. The enclosed letter from Mr. Frank E. Parkin, Associate Administrator of the New England Medical Center Hospitals, to Mr. Nathaniel H. Karol of the Division of Grant Administration Policies, Health, Education and Welfare, dated September 8, 1967, and Mr. Karol's reply dated September 29, 1967, outline the problem.

I have been impressed in talking Mr. Lawrence Martin, Associate Director and Comptroller of the Massachusetts General Hospital, that he also believes it an important problem and that Frank Parkin's letter is an excellent statement.

*Set-up of  
pooling  
arrangements  
can be  
Indirect  
pool  
Arrangements*

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6 November 1967

I am attempting to arrange a meeting with Mr. Irving J. Lewis at the Bureau of the Budget and/or his associates regarding this matter, on December 11th. If I am successful I will have a report for our committee meeting on December 12th, but in any case I would suggest that it be put on the agenda for our meeting.

Sincerely yours,

DICK

Richard T. Viguers  
Administrator

RTV:ea  
Enc.

# NEW ENGLAND MEDICAL CENTER HOSPITALS

*The Clinical Unit of the Tufts-New England Medical Center*

*Caring the Boston Deafensary,  
Boston Floating Hospital  
for Infants and Children,  
and Pratt Clinic, New England  
Center Hospital*

171 Harrison Avenue, Boston, Massachusetts 02111 Area code 617 542-5600

September 8, 1967

Mr. Nathaniel H. Karol, Executive Secretary  
Director, Division of Grant Administration Policy  
Department of Health, Education and Welfare  
Washington, D. C. 20201

Dear Mr. Karol:

The Board of Governors and the Administration of the New England Medical Center Hospitals are deeply concerned with the inadequacy of the present ceiling of 8% overhead allowance on training grants. It is our contention, in the presentation of this material, that this inequity can be resolved by administrative interpretations within the principles established in the "A Guide for Hospitals," published June 1967.

Since I participated in the revision of A-21 for hospitals, I see nothing in Section VII-C Negotiated lump sum for overhead (p.22) which would prevent HEW from negotiating an agreed upon figure as to the indirect cost of training grants.

The inclusion of the training grant indirect cost and the training grant salaries and wages, significantly reduces the calculation of the overhead percentage rate on all other research grants.

The New England Medical Center Hospitals will suffer a cash loss in the research overhead pool of \$140,000 for the fiscal year ending September 30, 1967. The budget for the fiscal year beginning October 1, 1967 forecasts a cash deficit in the research overhead pool of \$175,000. We have to increase our room and care charges to in-patients, by a like amount, in order to finance research indirect cost losses from research grants.

If I may exaggerate an example, I am sure that you will quickly see the dilemma. Granted this is an oversimplification; but if our research indirect cost pool amounted to \$500,000 and we were conducting research which incurred \$2,000,000 of direct salaries, then our

Mr. Nathaniel H. Karel  
September 8, 1967

research overhead rate on a salary and wage basis would be 25%. If \$1,000,000 of these direct salaries were in training grant stipends, then the training indirect costs awarded would amount to \$80,000. On the balance of the \$1,000,000 of direct salaries and wages for project-type grants, our overhead awards would amount to \$250,000. There would be available overhead income of \$330,000 against operating expenses of \$500,000, and we would experience an operating deficit in the research pool of \$170,000.

It seems to me that there are only two alternatives to avoid the calamity of underfinancing the research overhead pool. The first alternative is to pay full cost on all training grants, placing both the project-type grant and the training grant into a common research overhead pool. On this basis the Federal Government would no longer pay merely 8% overhead on training grants, but true and full cost. Since this might take mountains of legislative maneuvering, I suggest an administrative interpretation, which can be applied to the regulations you have promulgated in "A Guide for Hospitals."

If the Federal Government is paying 8% on training grants, then it must truly believe that this is a reasonable expression of the cost involved in the overhead component of the award. If not, then what is the qualification? The administrative interpretation of Section VII ("Determination and Application of Indirect Cost Rate or Rates" - paragraph C, page 22 of the Regulations entitled, Regulations lump sum for overhead) if applied as interpreted above, would permit a segregation of the research overhead pool into two components. One component would be the pool for training grants and the other, all types of research grants. One could then assume that the 8% allowance for indirect cost on training grants, represented the portion of the research overhead expense pool which should be removed from the general overhead cost pool. The residual of all other salaries and wages, and the net residue of the overhead expense, would be used to recalculate the overhead rate on all other project-type grants.

In the illustration above we start out once again with an overhead cost for the entire institution of \$500,000. By subtracting from it the \$80,000 of indirect cost awards on the training grants (which once again total \$1,000,000) it leaves an indirect cost pool for all other project grants of \$420,000. Dividing the remainder in the indirect cost pool by the \$1,000,000 of salaries and wages in the project-type grants, provides an indirect cost rate for this component of the pool of 42%. Thus the institution remains in a self-funding condition so that the 8% x \$1,000,000 of training grants provides income from those sources of \$80,000. The 42% rate on all other project grants, which in this illustration total \$1,000,000, would provide \$420,000 of income. The combination of the two would equal the \$500,000 in the combined research overhead pool.

Mr. Nathaniel H. Karol

September 8, 1967

In the case of the New England Medical Center Hospitals, we have some \$2,000,000 of HEW grants with an overhead pool, on a combined basis, of some \$771,000. For the previous fiscal year ending September 30, 1966 we submitted a cost finding report which showed our indirect cost rate to be 37.3% of salaries and wages. Our training grant component within these figures included \$141,000 of salaries and wages, from which we received only \$35,000 of indirect cost support. The recalculation of project indirect cost, as segregated from training grant on a two separate pool basis, would show that the true project overhead rate for the New England Medical Center Hospitals for the period ending last year, should have been 45.2%. This 8% difference in the two-rate determinations would have meant as much as \$130,000 in additional research overhead income to the Hospital during this fiscal year.

We respectfully request that you permit us to re-petition for a new rate based upon the above proposals, for the period October 1, 1966 through September 30, 1967. In this way we need not overcharge Hospital in-patients extra amounts on their room and care in order to provide the only available source of revenue.

I note finally, one further bit of irony. I understand that certain institutions have been permitted to eliminate the trainee stipends from the denominator in calculating the overhead rate as a percentage of salaries and wages. I see no reason why in fairness, this information is not published. In that way, all hospitals would have an opportunity, on an equal basis, to keep the research overhead deficits as low as possible.

Sincerely yours,

Frank E. Parkin  
Associate Administrator

FEP:elt

cc: Dr. Samuel Proger  
Mr. R. T. Viguers  
Mr. Larry Martin

NEW ENGLAND MEDICAL CENTER HOSPITALS

RESEARCH OVERHEAD DETERMINATION

YEAR ENDED SEPTEMBER 30, 1967

BASED ON RESULTS OF YEAR ENDED SEPTEMBER 30, 1966

	<u>Total</u> <u>Grants</u>	<u>Training</u> <u>Grants</u>	<u>Net Other</u> <u>Grants</u>
Payroll	\$2,072,229	\$441,131	\$1,631,098
Overhead Expense	771,831	35,290*	736,541
Overhead Rate on Basis of Payroll Dollars	<u>37.3%</u>	<u>8.0%</u>	<u>45.2%</u>

\* Training Grant overhead expenses assumed to be 8% of Training Grant Payroll.





DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

SEP 20 1967

Mr. Frank E. Parkin  
Associate Administrator  
New England Medical Center Hospitals  
171 Harrison Avenue  
Boston, Massachusetts 02111

Dear Mr. Parkin:

This is in reference to your letter dated September 8.

I understand Hank Kirschenmann has discussed the subject of the letter with you at some length and advised you of the Department's position on the approach you have proposed.

As you are probably aware, the Bureau of the Budget has been studying the question of indirect costs on training grants and will issue guidance for the development of indirect cost rates as a supplement to its Circular A-21. This matter has also been made the subject of a formal resolution of the Department's Grant Administration Advisory Committee and will be further considered by the Department.

However, in the interim, we cannot entertain a procedure which would, in effect, circumvent Department policy.

Sincerely,

Nathaniel H. Karol  
Director  
Division of Grant Administration Policy

cc: Mr. Larry Martin

*Mr. McNulty*

# Memorandum

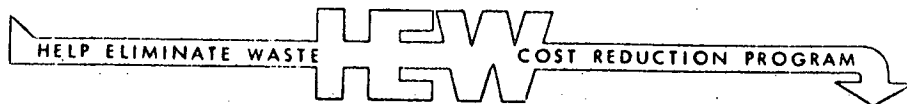
TO : See Attached List "A"

DATE: OCT 26 1967

FROM : H. T. Bozzonetti  
Division of Grant Administration Policy

SUBJECT: Minutes of the Committee to Develop Implementing Procedures for Hospital Cost Principles

1. The initial meeting of the Committee was held on October 23. Attachment A lists the attendees except that (a) William C. Neal substituted for Albert Rotundo, (b) Ralph R. Pardee substituted for Wendall Doll and (c) Charles R. Coulet could not attend.
2. The Committee has been formed for the following purposes:
  - A. Devise implementing procedures for the development of indirect cost rates for research.
  - B. Devise implementing procedures for the development of patient care costs.
  - C. Devise implementing procedures for the development of costs applicable to training agreements including the development of a training supplement to the hospital principles.
  - D. Assess the budgetary impact of the principles on:
    1. Research agreements
    2. Research patient costs
    3. Training agreements
3. Mr. Karol opened the meeting by presenting background material that led to the development of the hospital cost principles. It was emphatically noted that the Committee would not be considering recommendations for possible revision to the principles since we had not yet had an opportunity to accumulate experience with the principles, but that the Committee was charged with the tasks listed in 2 above.
4. The meeting progressed along the outline presented in the meeting agenda which is enclosed as Attachment B. It was determined that implementing instructions would utilize existing cost data already generated by hospitals, to the extent possible, (especially data generated for the Medicare Program). Mr. Anderson noted other areas that warranted attention as a result of the principles and their implementation:



- A. Necessity for coordinating the transition from the three methods currently being used for determining patient care costs under the general clinical research grant program to the method(s) that will result from implementing the principles.
  - B. Determination as to feasibility of continued use of predetermined patient care rates.
  - C. Possible consolidation within the Department of rate determination for both indirect cost and patient care costs.
5. There was some concern expressed that a training supplement for hospitals should await BOB action on a training supplement for educational institutions. However, I indicated that it was the intent of the Department to proceed with the development of a training supplement for hospitals without waiting for publication of the BOB supplement.
  6. It was suggested by Mr. Linde that a representative of a hospital from the west coast should be included as a member of the Committee. While there was no intent to exclude a hospital representative from the west coast, it was deemed necessary by the Department to restrict hospital representative membership to four members plus representation from the AIA and COTI in order to keep total representation within workable bounds.
  7. It was determined that a subcommittee would be established to actually perform the detail work necessary to fulfill the purposes set out in 2 above. The subcommittee will report their findings to the full committee as soon as the findings become available. The subcommittee chairman will keep the committee chairman informed of progress. It was determined that the decisions of the full committee would probably not require approval of the operating agencies for items of a procedural nature. However, subsequent discussions have indicated that items of a substantive nature, such as (a) incorporation into the principles of a training supplement, and (b) possible realignment of rate determining responsibilities will require coordination with interested parties outside the committee. It was suggested that the subcommittee be restricted to three people, a representative each from the government and a hospital and a representative from either the AIA or the COTH. However, AIA and COTH expressed an interest to serve as ex-officio members of the subcommittee which was accepted. The members of the subcommittee are:

- (a) Kenneth A. Anderson, Chairman
- (b) John D. Glavas
- (c) Leon Zucker
- (d) Individual from SSA to be designated  
by Abraham Fox

Another meeting will be convened as soon as sufficient data is developed by the subcommittee.

Attachment

✱

## ATTACHMENT A

Nathaniel H. Karol	-	Director, Division of Grant Administration Policy
Henzo T. Bozzonetti	-	Division of Grant Administration Policy, OS-OC
Kenneth A. Anderson	-	Grants Management Officer, DRFR-NIH
William W. Brownholtz	-	Chief, Cost Advisory Branch, FIN-PHS
Abraham Fox	-	Chief, Hosp. Ins. Reim. Branch, Div of Reim, BHI-SSA
Albert Rotundo	-	Chief, Div of Grants Management, Office of Research & Demo, SRS
Wendall Doll	-	Chief, Adm. Methods, Chief, Div of Health Services: Childrens Bureau, SRS
John D. Glavas	-	Controller, Passavant Memorial Hospital Chicago, Illinois
Charles R. Goulet	-	Superintendent, The Univ of Chicago Hospitals & Clinics, Chicago, Illinois
Matthew F. McNulty Jr.	-	Director, Council of Teaching Hospitals, Assoc. of American Medical Colleges, Washington, D.C.
Leon Zucker	-	Vice President for Finance, Memorial Hospital for Cancer & Allied Diseases, New York, N. Y.
Larry E. Martin	-	Associate Director & Comptroller, The Massachuset General Hospital, Boston, Massachusetts
Fletcher H. Bingham	-	Assistant Director, Council of Teaching Hospitals: Association of American Medical Colleges, Washington, D.C.
Robert E. Linde	-	Director, Div of Finance, American Hospital Association, Chicago, Illinois

## A G E N D A

October 23, 1967

- I. What cost documents do hospitals now prepare that generate data needed to apply the cost principles:
  - A. Reimbursement forms under Title 18
    1. Departmental RCC method.
    2. Combination method.
  - B. Cost data submitted to intermediaries for reimbursement of patient costs for other than medicare patients.
  - C. Other
- II. Does cost data as now generated lend itself without change to the development of cost data required by the cost principles,
  - A. for the development of an indirect cost rate for research,
  - B. for the development of patient care costs applicable to research patients (such as general clinical research support grants), and
  - C. for the development of costs allocable to training grants.
- III. What cost documents now being generated would most easily provide the data needed in II above with the least modifications?
  - A. Major or minor changes.
  - B. Additional manhours needed to effect modifications.
  - C. Should consideration be given to development of new cost data rather than adapt existing data.
- IV. What additional administrative problems are envisioned if medicare cost data or other data is used?
- V. What fiscal problems do you foresee?
  - A. Provisional vs. final rates.
  - B. Availability of Medicare/Intermediary audit data and/or negotiation data.
- VI. Assessment of potential budgetary impact of the principles on,
  - A. Research agreements.
  - B. Research patient costs.
  - C. Training agreements.

RECEIVED  
AAMC - WASHINGTON, D. C.

Dr. Lee Powers  
Associate Director  
Association of American  
Medical Colleges  
2530 Ridge Avenue  
Evanston, Illinois 60201

JAN 16 1968

Dear Dr. Powers:

You may find the enclosed paper on the Department of Health, Education, and Welfare/Association of American Medical Colleges Cost Information Study useful. It was prepared by my office at the request of Secretary Gardner.

I have sent copies directly to the other members of the Design Review Committee. Would you pass on copies to the seven medical centers participating in the study?

Sincerely yours,

Nathaniel H. Karol  
Director, Division of Grants  
Administration Policy

Enclosures

cc: Dr. Robert Berson, AAMC  
Dr. Chevas Smythe, AAMC  
Mr. Matthew McNulty, AAMC

DEC 18 1967

DESCRIPTION OF DHEW/AAMC  
COST INFORMATION STUDY

The Department of Health, Education, and Welfare and the Association of American Medical Colleges are engaged in a study of program cost information needs and capabilities at seven selected university medical centers. This joint effort, financed by means of a cost-sharing contract, was prompted by the recognition:

- 1) on the part of medical centers that they need more and better information on the costs of the varied programs which they conduct to make more knowledgeable decisions on the allocation of their limited resources;
- 2) on the part of the DHEW that many existing Federal cost information requirements arising from the grantor/grantee relationships are unduly burdensome on the medical centers, in large part because these requirements do not mesh with the internal needs and procedures of the institutions.

Objectives

The study's principal objective is to develop a model system of program cost finding for each component of the medical center complex, i.e., the medical school, the teaching hospital, and the various other health related professional schools. This model system should satisfy both internal information needs of the medical centers, and external needs such as those of sponsoring agencies and parent universities. A corollary of this will be a reassessment of present Federal cost information requirements so that these requirements may be as consonant as practicable with the output of an optimal institutional cost information system.

Design Review Committee

The study is under the general supervision of the Design Review Committee, which is responsible for:

- 1) approving the study design and procedures
- 2) reviewing and approving the progress of the study
- 3) approving the final study report

Members of the Committee are:

Mr. Thomas Fitzgerald, Assistant Controller  
New York University Medical Center

Mr. Charles R. Coulet, Superintendent  
University of Chicago Hospitals and Clinics

Dr. Robert C. Hardin, Dean  
University of Iowa College of Medicine

Dr. Lee Powers, Associate Director  
Association of American Medical Colleges

Dr. Barnes Woodhall, Vice Provost for Medical Affairs  
Duke University School of Medicine

Mr. Nelson A. Wahlstrom, Consultant to the  
Department of Health, Education, and Welfare

Mr. James F. Kelly, Assistant Secretary, Comptroller  
Department of Health, Education, and Welfare

Mr. Nathaniel H. Karol, Director, Division of Grants  
Administration Policy, Office of the Assistant Secretary,  
Comptroller, Department of Health, Education, and Welfare

Dr. Ernest M. Allen, Director, Office of Extramural Programs  
Public Health Service, Department of Health, Education, and Welfare

Dr. Leonard D. Fenninger, Director, Bureau of Health Manpower,  
Public Health Service, Department of Health, Education, and Welfare

Dr. John F. Sherman, Associate Director for Extramural Programs  
National Institutes of Health, Public Health Service  
Department of Health, Education, and Welfare

#### Participating Medical Centers

The following institutions are participating in the study:

Bowman Gray School of Medicine of Wake Forest College  
University of Iowa Medical School  
Jefferson Medical College of Philadelphia  
University of Michigan Medical School  
New York University Medical School  
Ohio State University Medical School  
University of Utah Medical School



Each of these has entered into a cost-sharing subcontract with AAMC under the latter's prime contract. A key feature of both the prime and subcontracts is the provision that the information developed will not be used for general auditing purposes or to hold the schools accountable for any expenditures listed in their reports.

#### Financing

The cost-sharing contract under which the study is conducted obligates the Government to provide not more than \$125,000, which includes \$98,000 for seven subcontracts of \$14,000 each. AAMC is to absorb all indirect costs, and all direct costs in excess of \$125,000.

#### Study Procedures

12  
A natural starting point for the study was the AAMC publication "Medical College Costs and Manual of Procedures - a Program Cost Finding System". Analogous manuals have been developed for the other medical center components.

2  
Correct  
Each of the seven participating centers will use these manuals to make a special program cost allocation study for each of its units. This phase of the study began in October, 1967. Presently utilized cost finding and reporting procedures will be described in detail and compared with those used in the special study, identifying the strengths and weaknesses of each. Special attention will be devoted to evaluating existing methods of satisfying Federal information requirements in such areas as indirect cost rates, cost-sharing, and effort reporting, and to suggesting possible alternatives.

Upon completion of this phase of the study, DREW and AAMC staff will evaluate the reports of the medical centers, and develop a model program cost finding procedure manual which could be used by any medical center. This manual and the final staff report will then be submitted to the Design Review Committee for approval in June, 1968.

#### Cost Finding

A basic premise of the study is the belief that cost finding, as opposed to cost accounting, is the most appropriate technique for obtaining the desired information in the medical center context. Cost accounting is a formal and relatively precise method of computing costs through the continuous day-to-day use of accounting records. Cost finding, on the other hand, approximates costs by informally applying special calculations to existing data at intervals of as much as a year.

Among the advantages of cost finding which led to this belief are:

- 1) It does not require changing existing accounting systems, many of which are prescribed by parent universities or State agencies.
- 2) It is less expensive than cost accounting, but can nevertheless produce sufficiently precise data.
- 3) It is simpler and less technical, and can usually be accomplished without additional personnel, and with relatively minor interference with the work of existing personnel.

#### Ultimate Benefits

The availability of a better means of determining how the medical center dollar is being spent will be of benefit to many. For the medical centers themselves, it will provide a firmer basis for financial decision making. Those to whom the medical center are accountable should obtain a better accounting. There will be a more rational basis for passing the costs of programs on to those who are expected to pay for them.

The corollary reassessment of Federal financial information requirements should improve the grantor/grantee relationship by reducing present areas of friction, and should serve as an added inducement for medical centers to adopt the proposed model system.

All in all, the study constitutes a highly constructive joint endeavor between the Department and the medical center community.

OC/DCAP JFeinglass.spp:12/13/67

UNIVERSITY OF KENTUCKY

LEXINGTON, KENTUCKY 40506

MEDICAL CENTER  
UNIVERSITY HOSPITAL  
OFFICE OF THE ADMINISTRATOR

December 29, 1967

Mr. Matthew F. McNulty, Jr., Director  
Council of Teaching Hospitals  
Associate Director, AAMC  
1346 Connecticut Avenue, N.W.  
Washington, D. C. 20036

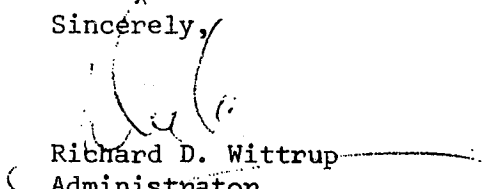
Dear Matt:

I have just finished reading the datagram on "Educational Support Needs of Schools with Limited Financial Resources" and was reminded again of the cost which many schools must be bearing in connection with providing physician services to "service" patients.

Undoubtedly this is a sensitive issue but perhaps the Division of Operational Studies could make a contribution by collecting some facts about it. For example, it might be of interest to study the number of inpatient days (or admissions) and outpatient visits for which physician coverage was provided under medical school auspices, classified according to whether or not professional fees were collected by anybody.

I believe this to be a most important subject, first because of the drain against educational resources which might be involved, and second because of the financial leverage, comparable to that resulting from research grants, which a medical school might acquire with professional fee income.

Sincerely,

  
Richard D. Wittrup  
Administrator  
University Hospital

RDW/cf

*McNulty*

January 2, 1968

Mr. Richard D. Witrup  
Administrator, University Hospital  
University of Kentucky  
Lexington, Kentucky 40506

Dear Dick:

Your reference by letter of December 29 to the costs being borne by the medical schools and/or teaching hospitals in the process of providing physician services for "staff" or "service" patients continues to be valid though with varying degrees of application, as in some parts of the country the "service" patient load is greatly reduced.

One method of getting at some of the statistical data you suggested would be in connection with the cost-finding study for the seven medical centers -- the project for which Tom Campbell is just joining the Association. We hope to have Tom at the meeting of Thursday, January 25. Presuming no objection on your part, I am sending to him an informational copy of this letter as well as your letter of December 29. Finally, I shall have the item on the agenda so that we may test the reaction of our colleagues and the general disposition of the committee concerning the matter.

Greetings to you and yours for many rewards in the New Year.

Cordially,

MATTHEW F. McNULTY, JR.  
Director, Council of Teaching Hospitals  
Associate Director, AAMC

cc-Mr. Thomas J. Campbell  
Division of Operational Studies, Association of American Medical Colleges

MM p

bc Mr. Charles R. Goulet, Superintendent, Univ. of Chicago Hosp. and Clinics  
Xerox and carbon to Mr. McNulty