

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

AGENDA

COMMITTEE ON FINANCIAL PRINCIPLES
FOR TEACHING HOSPITALS

Seven Continents V.I.P. Lounge
O'Hare International Airport
Chicago, Illinois
Thursday, November 21, 1968
10:00 a.m. - 4:00 p.m.

- I. Call to Order -- 10:00 a.m.
- II. Approval of Minutes, Meeting of June 6, 1968 Tab A
- III. Report on Action Items from June 6th Meeting Tab B
- IV. Further Charge to Committee on Financial Principles for Teaching Hospitals by COTH Executive Committee, Meeting of September 5 & 6, 1968 -- "It was agreed that the Committee on Financial Principles Study the Problems of Payment to House Staff and Attending Physicians, as well as the Definition of Includable Costs."
- V. Correspondence from Stuart M. Sessoms, M.D., and William G. Anlyan, M.D. Tab C
- VI. Correspondence from Reid T. Holmes, Administrator, North Carolina Baptist Hospitals, Inc. Tab D
- VII. Report -- Upcoming Meeting of Teaching Hospital Administrators with Representatives of Clinical Research Centers Branch and other NIH Personnel Tab E
- VIII. Report -- Design Review Committee Meeting (7 Medical Centers)
- IX. New Indirect Cost Payment System Tab F
- X. AHA Statement on Financial Requirements for Health Care Institutions Tab G
- XI. Future Meeting Dates
- XII. Other Old Business
- XIII. New Business
- XIV. Adjournment -- 4:00 p.m.

Luncheon will be served at 12:30 p.m.

COUNCIL OF TEACHING HOSPITALS
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MEETING OF COMMITTEE ON FINANCIAL PRINCIPLES
FOR TEACHING HOSPITALS
O'HARE AIRPORT
CHICAGO, ILLINOIS
JUNE 6, 1968
10:00 a.m. - 4:00 p.m.

Present:

Charles R. Goulet, Chairman
Richard D. Wittrup, Vice Chairman
Vernon L. Harris
Gerhard Hartman, Ph.D.
Reid T. Holmes
Arthur J. Klippen, M.D.
Bernard J. Lachner
Roger B. Nelson, M.D.
Francis J. Sweeney, Jr., M.D.
Irvin G. Wilmot
Robert C. Linde, AHA Representative
Ralph G. Meador, Ph.D., (Deputy Director, Research Administration and
Executive Secretary, Committee on Research, Massachusetts General Hospital,
Boston, Massachusetts) attended at Lawrence E. Martin's request because of
the latter's inability to be present.

Invited Guests from National Institutes of Health:

Thomas J. Kennedy, Jr., M.D., Director
Division of Research Facilities and Resources
National Institutes of Health

William R. DeCesare, M.D., Chief
General Clinical Research Centers Branch
Division of Research Facilities and Resources
National Institutes of Health

Kenneth A. Anderson, Grants Management Officer
Division of Research Facilities and Resources
National Institutes of Health

Robert B. Millman, M.D., Program Specialist
General Clinical Research Centers Branch
Division of Research Facilities and Resources
National Institutes of Health

Staff:

Matthew F. McNulty, Jr., Director, COTH; Associate Director, AAMC
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Thomas J. Campbell, Assistant Director, Division of Operational Studies, AAMC

Also Present:

John W. Colloton, Assistant Superintendent, University of Iowa Hospitals

I. The Chairman Convened the Meeting Promptly at 10:00 a.m.:

II. Approval of Minutes:

The minutes of the January 25, 1968 meeting were approved as revised and circulated on May 13, 1968

III. Welcome to New Members:

Mr. Goulet, Chairman, welcomed Francis J. Sweeney, Jr., M.D., Hospital Director, Jefferson Medical College Hospital, Philadelphia, Pennsylvania, as a new member of the committee.

IV. Discussion of Budgetary Problems Relating to General Clinical Research Centers:

The Chairman noted that this issue appeared on the agenda largely because of a Memorandum dated May 23rd from Dr. William R. DeCesare's office, addressed to Principal Investigators of CRC units with copies to Program Directors and Financial Officers. He noted additionally that an invitation to officials to attend a meeting of this Committee had been long considered and this event provided the most propitious opportunity to do so.

Serving as a framework for discussion, were the suggestions outlined in Dr. DeCesare's memorandum, a number of recommendations received by COTH headquarters in response to the COTH Special Memorandum of May 28th and possibilities developed in-house by staff (see attached list). A full, frank and cordial four-hour discussion was held at the meeting. Early in

the discussion it was agreed that the existing dynamic fiscal trend does not look promising for either the current grant period (Fiscal Year 1969) and, in all probability, through Fiscal Year 1970. It was also agreed early in the discussions that the concept of discreteness with regard to clinical research centers should be endorsed and preserved whenever possible. There was strong commitment by the entire committee in support of the need for more rather than less clinical research, and the additional need to develop at all levels, mechanisms to avoid "Robin Hood" economics through adequate and purposeful financing of clinical research. However, there was also general agreement that because of the severity of the existing fiscal problem, it is necessary for each grantee institution to assess the opportunities that are available to it within the available alternatives and to use those alternatives, plus any others that an imaginative and thorough review would suggest, in order to develop an individual approach to the resolution of the problem as it affects each particular organization.

Discussion of Alternatives:

The three alternatives suggested in Dr. DeCesare's memorandum: (1) limiting occupancy; (2) reducing levels of personnel funding; and (3) closing centers for limited periods of time, were discussed early. It was generally agreed that each of these suggested alternatives might introduce certain staffing problems and that each of these proposals would suggest the need for accommodation at the grantee institution. However, it was also agreed that each of these alternatives were entirely within the existing guidelines of the program, and that these measures may be those least controversial in their application.

With regard to the alternatives presented by COTH, the following captures the sense of the discussion:

NUMBER 1 - Use Vacant Beds as Revenue-Producing Beds

While this alternative is not available to grantee institutions within the "guidelines" as they exist at the present time, it was the item that possibly drew the most serious discussion. The feasibility of developing "mixed" units, (including CRC supported research patients as well as other patients) through continuing geographic discreteness was introduced as one of the most likely opportunities that could serve as a means resolving the fiscal deficit issue. As will be noted later through presentation of one example, there was discussion of "mixed" units in the discrete unit, maintaining discreteness but utilizing space vacated by closed beds for supportive or non-supportive but related non-bed (such as laboratories) clinical functions. There was discussion of the nature of discreteness, and the need for experimentation to determine whether mixed patient unit, under policies of controlled admissions, would have a detrimental effect on the level of scientific investigation. In general, however, this latter approach seemed to present the best possibility to the discussants. Another possibility, as indicated, was that of using a portion of the space contained within the geographic unit for patient care services closely allied to the function of clinical research. For instance, one institution is considering the feasibility of establishing a "mixed" patient unit by including additional renal transplant patients (the present CRC is already used as a research focus for certain types of renal transplant patients) utilizing the space thereby vacated for the treatment of other acute patients.

NUMBER 2- Deficit in Operation Being Financed by Some Other Funds

It was agreed that this alternative was not new and that a number of the sources

of funds specified had been used by certain institutions to support CRC activities in previous Fiscal Years. Principal investigator funds, categorical institute funds, local and regional foundation funds, individual donor funds, a revolving fund derived from smaller fund sources, state, county and local governmental funds which help support research that is of importance to the local and regional population were among a wide variety of approaches being used or considered.

NUMBER 3- Reduction in Activity of the Unit Tailored to the Availability of Funds

This option is permissible, and actually incorporates several alternatives outlined in Dr. DeCesare's memorandum. For instance it was noted that the closing of the unit for a period of two or more months might effect substantial saving in the individual institution's cost of operations. It was readily recognized that such a proposal would introduce the need for accommodation at the grantee institution level.

NUMBER 4- Elimination of the Unit, but not the Function Achieved Through Maintaining a Scatter-Bed Approach

It was reported that several institutions had been able to supplement CRC funding, with categorical support when the former funding levels were reduced. Again, however, it must be emphasized that there was unanimous endorsement by those at the meeting that the concept of discreteness regarding Clinical Research Centers should be preserved, if at all possible. However, it was also recognized, that in order to preserve the function of clinical investigation, it may be necessary to implement on a temporary basis, some organizational form other than that of a discrete unit.

NUMBER 5- Diversion of All Federal CRC Funds into Only Hospitalization Support

After discussion, it was agreed that there was minimal likelihood that a program of this nature could be effected at this time. There was reported though two instances where if the choice was narrowed to such proposals the Principal Investigators in those locations would "opt" for hospitalization support.

NUMBER 6 - Third-Party Payers

While this alternative appears very attractive as an immediate relief, it becomes extremely problematic after continuing consideration. Additionally, as Dr. DeCesare mentioned in his May 23rd Memorandum, the principle has "been strenuously opposed at all national advisory levels". However, there was agreement that any well-developed proposal would receive thorough consideration, so a plan that is well conceived, fully evaluated and totally endorsed at the institutional level, regarding the possibility of third-party payment, would be studied carefully.

NUMBER 7 - Curtail Activity, but Keep Unit Intact
e.g. 5 Day Operation of Unit

This option was viewed as one that might impose certain administrative difficulties, although it would serve to moderate unit activity. Apparently, from suggestions submitted by members of your COTH staff, there are several units that could operate effectively through a limited operational pattern such as this.

Submission of Budget Proposals:

The Committee discussion closed on the note, that while these seven (7) suggestions represent a compilation and distillation of many sub-groups submitted by COTH members for alternative courses of action as reviewed by this Committee, there was recognition that undoubtedly other measures not described

(or combination, modification, etc. of these seven (7) approaches) could be employed, on an individual basis as a format for a budgetary proposal to the office of Dr. DeCesare. The institutions involved should attempt to devise creative and well-structured recommendations for financing, tailored to the individual operational activity and submit such suggestions to the Clinical Research Centers Branch, Division of Research Facilities and Resources, NIH, Bethesda, Maryland, 20014.

V. Review of Statement of Financial Principles for Teaching Hospitals as Submitted by Subcommittee:

The Subcommittee, consisting of Richard D. Wittrup, Chairman, Bernard J. Lachner and Irvin G. Wilmot reported on the Statement of Financial Principles, (copy of the Subcommittee's draft statement is attached to these minutes). Following a careful review by the subcommittee members of the rationale that provided guidance in this deliberation and final draft statement there was a full discussion of the statement. The following items constitute the major points made by committee members.

1. Is there a need for inclusion of a statement on planning in either the preface or the body of the document?
2. The statement should stress the determination of financial principles within a cost framework rather than an income framework (See Principle #4)
3. Is the Statement sufficiently decisive to distinguish teaching hospitals from the AHA Statement on Financial Requirements for Health Care Institutions - is there a need to stress more distinctive aspects?
4. A greater emphasis should be placed on interns and residents and the attendant costs to teaching hospitals.

5. An area omitted from the Statement, and a distinctive cost to the teaching hospitals is the facilities and services provided to the faculty for their private practice. Should there be recognition of the fact that a portion of the hospital's cost is the medical school's faculty salary earned through private practice?
6. The item "Note" appearing on page 2 under Section 2d, which comments on the income side of the equation, is pertinent, but perhaps is more suited to the preface.
7. There is an absence of the importance on the dependence of patients and physicians in teaching hospitals or of new techniques of diagnosis and therapy.

Following this discussion, it was agreed that the Draft Statement would be referred to the Subcommittee for further refinement on the basis of the Committee's comments and review. It was further agreed that the subsequent draft would be circulated by mail to the full committee for further evaluation and comment. Additionally, it was noted that a draft position statement, being developed by the Committee on Modernization and Construction Funds for Teaching Hospitals would be included in this mailing to allow for comparative review.

ACTION #1

THE DRAFT "STATEMENT ON FINANCIAL PRINCIPLES" WAS REFERRED TO THE SUBCOMMITTEE FOR FURTHER REFINEMENT. UPON COMPLETION OF THIS ASSIGNMENT THE REVISED DOCUMENT WILL BE CIRCULATED TO THE FULL COMMITTEE BY MAIL FOR FURTHER EVALUATION AND COMMENT.

ACTION #2

THE COMMITTEE SHOULD BE WORKING TO MEET A SEPTEMBER 5 AND 6 DEADLINE, THE DATES OF THE NEXT MEETING OF THE COH EXECUTIVE COMMITTEE. AT THAT TIME, IT IS ANTI-

CIPATED THAT A DOCUMENT WILL BE PRESENTED FOR EXECUTIVE COMMITTEE REVIEW, COMMENT AND DISPOSITION.

VI. Other Business:

The Chairman reviewed the action items from the January 25th meeting and asked Mr. McNulty to comment on the action taken specifically on the following items:

Action #4 - There was an unanimous expression that the 8% ceiling on Indirect Costs for Training Grants was unnecessary hardship on hospitals.

Action #5 - That COTH staff contact Mr. Irving J. Lewis, Deputy Director BOB, strongly urging that the 8% ceiling be removed and further noting that the Council, through the cooperation of hospitals in the Boston area would be willing to provide additional information in support of this request as desired.

Mr. McNulty commented that the Council of Teaching Hospitals had stressed the importance of this issue to Mr. Lewis, as well as to Mr. Nathaniel H. Karol, Director, HEW, Division of Research Grant Policy. He noted that because of Mr. Lewis' departure from the BOB to join the Health Service and Mental Health Administration of HEW, it would not be necessary to develop an additional point of entry into the BOB. Additionally, Mr. McNulty reported that Mr. Lawrence E. Martin had forwarded an extensive financial statement, based on Massachusetts General Hospital's financial statistics, to Mr. Lewis defining clearly the magnitude of the problem.

Action #6 - That the American Hospital Association be urged to consider the advisability of contacting the various appropriate federal agencies in support of the removal of this ceiling.

Mr. Linde commented that he had discussed the issue with Madison E. Brown, M.D., Director, AHA Department of Planning and Development. He was uncertain as to the further action taken, but indicated that he would follow-up and report on the AHA's position on this item.

Mr. McNulty then commented that COTH staff had been receiving a large number of inquiries relating to the recently developed AHA Statement of Financial Requirements for Health Care Institutions and Services. He noted further that to date, he had attempted to maintain a position of neutrality in response to the issue, recognizing that it is representative of the position of another organization. He requested any guidance the committee might offer in this regard, and there was unanimous agreement that the position as he had outlined was the appropriate one.

VII. It was Agreed that the Next Meeting of the Committee Would be at the Call of the Chairman:

VIII. There being no Further Business, the Meeting Adjourned at 3:45 p.m.:

Attachment "A"

Proposals Presented by COTH
Relating to CRC Budgetary Problems

1. Use of Vacant Beds as Revenue Producing Beds
2. Deficit in Operation being Financed by Some Other Source
3. Reduction in Activity of the Unit Tailored to the Availability of Funds.
4. Elimination of the Unit, but not the Functions, Achieved Through Maintaining a Scatter-Bed Approach.
5. Division of All Federal CRC Funds into only Hospitalization Support
6. Third-Party Payers
7. Curtail Activity, but Keep Unit Intact, e.g. 5 Day Operation of Unit

Dictated by Telephone to COTH Office

May 23, 1968

TO: PRINCIPAL INVESTIGATORS

FROM: CHIEF, GENERAL CLINICAL RESEARCH CENTERS BRANCH
DIVISION OF RESEARCH FACILITIES AND RESOURCES

SUBJECT: ANNUAL REQUEST FOR CONTINUATION SUPPORT

National fiscal constraints will probably require modification of general clinical research centers program activity in fiscal year 1969. The impact of possible budgetary reduction can be minimized by a joint effort on the part of each center and the General Clinical Research Center Branch.

To prepare for possible budgetary contingencies, we are requesting that you submit by June 15, in addition to the usual application for continuation support due June 1st, two additional budgetary requests. The total ceilings of the appended budget should be as follows:

1. 87.5% of your current operating level
2. 75% of your current operating level

Acknowledged operational difficulties resulting from these reduced funding levels may necessitate different approaches in each case. Some measures which have been suggested to reduce program budget requirements include:

1. limiting occupancy
2. reducing levels of personnel funding
3. closing centers for limited periods of time

Suggestions that third party sources defray part of the hospitalization cost of parts on research centers have been strenuously opposed at all national advisory levels.

The Branch recognizes the need for individual consideration of centers and will be receptive to suggestions as to how best meet this situation.

William DeCesare, Chief, GCRC Branch

cc: Program Directors
Financial Officers

ATTACHMENT "C"

DRAFT STATEMENT OF FINANCIAL
PRINCIPLES FOR TEACHING HOSPITALS

June 6, 1968
Prepared by Subcommittee
Richard D. Wittrup, Chairman
Bernard J. Lachner, Member
Irvin G. Wilmot, Member

DRAFT

STATEMENT OF FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS

The Council of Teaching Hospitals, an integral component of the Association of American Medical Colleges, numbers among its membership the foremost teaching hospitals in the nation. These hospitals in addition to their responsibilities for patient care have a high degree of responsibility for both educational and research activities.

There has been a recognition by the membership of the Council that there is a need for a "Statement of Financial Principles for Teaching Hospitals" which emphasizes both the need for an identification of these costs and the need for reimbursement of such costs.

The following "Statement" is purposefully developed in a broad context to allow for individual institutional adaptation. It is recognized that teaching hospitals are located in a diversity of institution settings with a variety of administrative and organizational relationships. Additionally, as a result of the pressures of demand, growth and rising costs, the financial management problems of teaching hospitals have become more numerous and complex.

An awareness of these two issues; the need for individual institutional adaptation, and the demand for an increase in services have led to the development of the broad context within which the content of these principles are focused.

The membership of the Council is of the firm conviction that these principles can serve as useful guidelines for policy formation, as issues of financial nature are discussed with other individuals and agencies interested in the multipurposed activities that are accomplished in the teaching hospital.

GUIDELINES FOR THE IDENTIFICATION OF
PROGRAM COSTS IN TEACHING HOSPITALS

1. Teaching hospitals serve multiple purposes in the teaching, research, and service components of the health industry. A number of public and private agencies are responsible for providing the funds needed to support specific programs conducted by teaching hospitals. Teaching hospitals, therefore, have responsibility for identifying, to a reasonable extent, the costs associated with each program element being so supported. This responsibility is in addition to the general obligation of management to identify and evaluate program costs.

2. The specifics of organizational patterns and institutional objectives vary greatly among teaching hospitals so that each institution must determine for itself the criteria to be used in allocating costs, subject to the following:

- a. To safeguard the financial integrity of the institution it is essential that all costs, including such items as operating and capital costs as appropriate, be identified and allocated to programs.
- b. Criteria for allocating costs should be such as to produce an equitable distribution of costs among the various program elements.
- c. Criteria for allocating costs should be internally recorded and should be available to agencies which provide financial support to the hospital or which, for other reasons, have appropriate need for such information. Teaching hospitals, being public service institutions, should make every reasonable effort, consistent with these guidelines, to agree to the judgments of all agencies as to the reasonableness of the criteria being used. It is appropriate that the hospital's external auditor be required to examine and comment on the reasonableness of the criteria being used.

- d. Criteria for allocating costs, should be maintained with reasonable consistency from year to year. These criteria for allocating costs should be applied consistently among program elements to insure that all costs are allocated.

NOTE: Some agencies providing financial support to teaching hospitals exclude, or limit arbitrarily, certain cost items when calculating the amount of support to be provided. It must be recognized that these exclusions and limitations will make it impossible for teaching hospitals to conform fully to these guidelines.

3. The cost of any activity conducted by a teaching hospital should be allocated equitably among all of the major programs which benefit from it. This is in contradistinction to the incremental approach which allocates to a program only those added costs which a particular program element is believed to create. The incremental approach may be the only practical method applicable to minor and peripheral program elements, but when applied to basic programs tends to produce distorted cost figures and, consequently, to bias decision making procedures inappropriately.

NOTE: It is recognized that the incremental approach to cost allocation is widely prevalent in teaching hospitals and is the basis on which many agencies determine the amount of financial support which they provide to these institutions. It also is recognized that no generally accepted criteria currently exist by which costs may be allocated among programs with dissimilar outputs, i.e., patient care and research. However,

the consequences of the incremental approach are believed to be sufficiently undesirable that immediate effort should be directed towards the identification of methods by which these barriers can be overcome.

4. As a general rule, physician services to patients and hospital services to patients are financed from separate sources, e.g., Blue Cross and Blue Shield. A significant portion of physician services to patients in teaching hospitals commonly is provided by salaried physicians, including faculty members and house staff. Currently, methods of allocating the cost of these salaries vary considerably. To promote uniformity of approach and thus to facilitate the determination of responsibility for financing, teaching hospitals should identify the cost of physician services separately from the cost of hospital services.

5. Except when supported by funds provided specifically for the purpose, stipends and fringe benefits provided to individuals in learning capacities who also render services should be considered to represent the cost of such services and allocated accordingly.

6. The identification of program costs and the reimbursement of such costs to teaching hospitals does not, by itself, provide the institution with a source of funds to support additions to working capital and capital expenditures not financed by depreciation reserves. While the prevailing concept of cost excludes such needs, it is reasonable to expect that each program conducted by a teaching hospital should generate its reasonable share of funds needed for these purposes. The amount of funds to be so generated should be based on a formal plan developed by each teaching hospital which takes into account all sources of such funds, including anticipated grants and loans, and justifies the need for such additions by indicating the approval of recognized planning agencies, where such exist, and by other appropriate means.

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ACTION ITEMS

MEETING OF COMMITTEE ON FINANCIAL
PRINCIPLES FOR TEACHING HOSPITALS
O'Hare International Airport
Chicago, Illinois
June 6, 1968

ACTION #1 -- The Draft "Statement on Financial Principles was referred to the Subcommittee for further refinement. Upon completion of this assignment, the revised document will be circulated to the full Committee by mail for further evaluation and comment.

ACTION #2 -- The Committee should be working to meet a September 5 and 6 deadline, the dates of the next meeting of the COTH Executive Committee. At that time, it is anticipated that a document will be presented for Executive Committee review, comment and disposition.

GUIDELINES FOR ALLOCATING
PROGRAM COSTS IN TEACHING HOSPITALS

Recommended DRAFT -- Not for Publication
or Reproduction

Council of Teaching Hospitals
Association of American Medical Colleges
October 21, 1968

Introduction to
Guidelines for Allocating Program Costs in Teaching Hospitals

Several current studies are in process which are designed to provide a systematic methodology for accomplishing periodic cost allocation studies in teaching hospitals. These studies are concerned largely with the procedural development and accounting techniques and methods.

While these efforts are welcomed by the Council of Teaching Hospitals as invaluable aids in the implementation of cost allocation programs, the Council is cognizant of the need for selected guidelines that could serve the administrator as he takes a holistic approach to both his institution and to the environment of which it is a part.

The following guidelines are designed for that purpose. These guidelines identify matters of policy in program cost allocation and serve in a companion relationship to the studies that, when completed, will provide the procedural and methodological alternatives for implementations.

This statement on the program cost allocation in teaching hospitals is the first such statement of its nature offered by the Council of Teaching Hospitals. In order for it to be an effective action document, it is necessary that it be understood clearly by those agencies that provide financial support for teaching hospitals. The Council of Teaching Hospitals stands prepared to assist any of its membership in the implementation of the concept of program cost allocation, or in the institution's discussions with the providers of financial support regarding the responsibilities that are incumbent on the hospital and the financing agencies through this approach.

GUIDELINES FOR ALLOCATING
PROGRAM COSTS IN TEACHING HOSPITALS

The Council of Teaching Hospitals, an integral component of the Association of American Medical Colleges, includes among its membership most of the leading teaching hospitals in the nation. The Council has recognized the need for the development of general guidelines designed to assure that teaching hospitals are supported adequately and that their sources of financial support are treated equitably.

Many elements of teaching and research in the health field must be integrated operationally with patient care since the teaching function includes the involvement of students in patient care and since data generated by patient care is essential to research. Responsibility for the conduct of these integrated activities is held by the nation's teaching hospitals.

Teaching hospitals play an essential role in the provision of the nation's health manpower, the creation of new medical knowledge, and the development of methods by which such knowledge is applied to the diagnosis and treatment of patients. Because this role is unique, teaching hospitals are strategic to the health of the nation, and their special problems and needs must be of great concern to the public.

The financial support of teaching hospitals comes from many sources. In most cases, a particular source provides support for its specific segment of interest or responsibility within one of the broad program areas of teaching, research, or patient care. Usually, the amount of support provided by a particular source is based directly or indirectly on the cost of the program segment being supported. For the teaching hospital, which conducts these programs as a unified operation, the support received from multiple sources must combine to meet the hospital's total financial requirements.

In view of the above considerations, the Council of Teaching Hospitals has adopted this statement dealing with the subject of allocating program costs:

- (1) Teaching hospitals have responsibility for identifying the costs associated with each program element which they conduct.
- (2) Teaching hospitals are located in many types of institutional settings with a variety of administrative and organizational relationships, so that the specifics of cost allocation in individual situations may differ. Further, within a given hospital, changes in services and programs cause these specifics to vary over time. Therefore, each teaching hospital must determine for itself the bases to be used in allocating costs, subject to the following:
 - (a) Bases of allocation should be such as to produce an equitable distribution of costs among the various program elements.
 - (b) Bases of allocation should be documented and available to agencies which provide financial support to the hospital.
 - (c) Bases of allocation should be related, where appropriate, to generally accepted hospital accounting practice. It is appropriate that the hospitals external auditor examine and comment on the reasonableness of such bases.
 - (d) Bases of allocation should be maintained with reasonable consistency from year to year and should be applied consistently among program elements.

- (3) Physician services to patients in teaching hospitals are frequently provided by faculty members and house staff, who are financially supported in full or in part by the hospital. To promote uniformity, the cost of physician services to patients should be identified separately.

Duke University Medical Center

DURHAM, NORTH CAROLINA

August 21, 1968

OFFICE OF THE
HOSPITAL DIRECTOR

POSTAL CODE 27706
TELEPHONE 919-684-8111

Dr. Robert C. Eerson
Executive Director
Association of American Medical Colleges
1346 Connecticut Avenue, N. W.
Washington, D. C. 20036

Dear Eob:

The enclosed memo is the result of discussions here which Dr. Anlyan thought might serve as starting point for discussion at the next meeting of the Executive Council of the AAMC.

During the short time since leaving NIH the problem of financial support for "teaching beds" has appeared on more agendas than any other one topic. It is clearly a problem of major importance. I am looking forward to hearing more about this from your vantage.

Sincerely yours,


Stuart M. Sessoms,
Director

SMS:cw

CC: Dr. William G. Anlyan

OFFICE OF THE DEAN
SCHOOL OF MEDICINEPOSTAL CODE 27706
TELEPHONE 919-684-3133

August 22, 1968

TO: Dr. Robert C. Berson, Executive Director
Association of American Medical Colleges

FROM: Dr. William G. Anlyan, Dean
Duke University School of Medicine

SUBJECT: Teaching Hospitals - Financial Support for the
Medically Indigent

Statement of Current Problem:

"Teaching" or "staff" beds are essential components of the teaching hospital. These must be supported. Adequate financial support is not at present available from either educational or medical care resources. Therefore, the deficit created must be covered by funds usually intended and more appropriately used for other purposes. In the absence of such funds the teaching hospital is faced with serious operational difficulties.

History and Background:

It has been customary over the years to distribute among the various sources of teaching hospital income, its aggregate operating costs. Much of this has been from private patients. Through this process most of the costs of the teaching beds, frequently occupied by the medically indigent, were absorbed. The introduction of multiple sources of support for hospital costs (federal, state and private), and relevant accounting practices necessary, make this financial approach to the cost of teaching beds impossible in those instances in which the private patient is the major source of income. The hospital then must elect one of several courses of action, or possibly a combination, to meet the financial burden of the teaching beds when occupied by patients without adequate financial resources.

Some examples of the problems and the manner in which some hospitals are attempting to solve them are as follows:

Hospital A:

This 630 bed teaching hospital is University owned, has an annual budget of \$20 million and operates with an annual deficit of \$200,000 to \$400,000. This deficit is covered with University funds.

Hospital B:

This 1100 bed teaching hospital has an annual budget of \$34 million and operates with an annual deficit in excess of \$1 million. This has been covered by drawing upon endowment funds which has resulted in a \$20 million depletion of its \$50 million endowment over a period of 10-15 years. In 1967 the deficit was met to a major extent by Medicaid but as a result of a change in the level of funding from this source, the institution again faces a major deficit.

Hospital C:

This 300 bed teaching hospital which is operated as part of a State University Medical Center has an annual budget of \$10 million of which \$3.8 million comes from State appropriated funds.

Hospital D:

Another teaching hospital functioning as part of a State University Medical Center receives \$4.877 million of its annual operating costs from State appropriated funds.

Hospital E:

This teaching hospital is operated under a two-county authority. In 1967 the operating budget was \$16.5 million of which \$9.2 million came from the tax levies of the two counties concerned.

Alternatives:

- o Restrict admissions to those who have a guaranteed resource from which the hospital costs will be funded, and those who are appropriately classified as emergencies:

Unfortunately, this would deny medical care to those in geographic localities without other sources of medical care such as that financed through the operation of "city" or "county" hospitals. In addition, it would reduce to an inadequate level, or eliminate, that functional component of hospital beds essential to its teaching mission.

- o Direct operational support from state appropriated funds:

This mechanism is being used to some extent in state-supported teaching hospitals. However, it is a mechanism that is not available to private institutions and is, in general, as inappropriate operational mechanism for the funding of medical care and teaching in private institutions.

- o Endowment funds:

These funds are being used to meet, in part, some of the need. However, endowment resources are not growing at a rate sufficient to meet the needs of the medically indigent in teaching hospitals, do not constitute a logical means of meeting these financial needs of society, and are needed desperately for funding capital improvements and new ventures.

- o Expansion or modification of existing types of coverage:

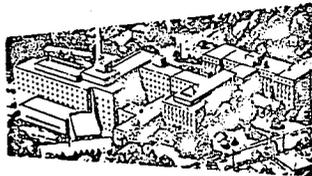
This would appear to be the most logical solution and, when viewed from the long range point of view, probably the only one. This might be accomplished through a broader definition of mechanisms such as Medicare, compulsory insurance coverage, or some appropriate modification of these or related mechanisms.

Recommended Action:

That this subject be brought to the Executive Council of the Association of American Medical Colleges for consideration as an issue of National importance that requires immediate attention.

/e

North Carolina



Baptist Hospitals, inc.

WINSTON-SALEM, NORTH CAROLINA 27103

PHONE 725-7251

October 28, 1968

MEMO TO: Mr. Fletcher H. Bingham, Ph.D., Assistant Director, Association of American Medical Colleges, Council of Teaching Hospitals

FROM: Mr. Reid T. Holmes, President and Chief Executive Officer, North Carolina Baptist Hospitals, Inc.

The North Carolina Baptist Hospitals, Inc., Winston-Salem, North Carolina, since 1941 has been the teaching hospital affiliated with the Bowman Gray School of Medicine of Wake Forest University. The hospital has 500 beds, extensive outpatient clinics and residency programs in all specialties. In addition, the hospital operates ten paramedical schools. Forty percent of the beds are for charity patients and the outpatient clinics are of a similar magnitude.

About 20 percent of the private patients are Medicare patients. The hospital has traditionally used the "Robinhood" method of paying for charity -- that is they charge private patients 25 percent more than their costs to help make up the difference between what charity patients can't pay through welfare, insurance, or personal funds. This is done in order to finance the teaching program conducted on the charity wards.

The Medicare formula excludes the cost of charity care in the cost formula.

In a talk with Mr. Ray E. Brown in Boston recently, he indicated that all medical school teaching hospitals were going broke. Some will have endowments, which we do not, and are dipping into their endowments in order to stay alive. Unless some bold program is put forth under the federal government to fund these teaching hospitals, and thereby pay the costs of the superior care to very ill patients, and for training doctors and paramedical personnel, we will have a national problem of large proportions on our hands.

I would suggest that the Social Security mechanism might be used to provide funds to keep these institutions alive and productive. If this is not possible, block grants from the federal government will be necessary through other funds. Our cost to charges ratio last year was such that we had to write off \$258,000 on Medicare patients alone. Our particular hospital has a cash deficit of over \$1 million at the bank. This has accumulated over the past four years.

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OCT 31 1968

AAMC-WASH., D. C.

Mr. Fletcher H. Bingham, Ph.D.

Page two

October 28, 1968

Our charity patients next year will have \$4 million in charges. Thirty-five percent of these charges will be paid by patients, 25 percent through agencies of the State or Federal government, leaving a 40 percent deficit in the charity category. If we were paid the full cost of charity, we could reduce the price to private patients as well as the cost to service patients.

The American hospital system demonstrated its capacity to rise to one of the greatest challenges in the history of our country when they absorbed the complete Medicare program for millions of people over 65 within the framework of the existing institutions. No other country could have done such a good job in so short a time. The teaching hospital's plight is probably the biggest single problem resulting from this broad program.

It is my opinion that we need to insist on charity and credit losses being included as a part of the cost of running a hospital and therefore reimbursed by government programs. In addition we need to fund depreciation on current replacement values of buildings and equipment, and we need to have some factor to provide money for new and innovative equipment for patient care. Also, we must be sure that there are funds available for paramedical education and house officer educational programs, either through a patient reimbursement formula or special grants on a continuing basis.

I am sure that there are others who feel this way and that we should initiate discussions with Mr. Arthur A. Kimbell, 4300 Old Dominion Road, Apartment 716, Arlington, Virginia, who has a great deal to do with Social Security in our field.

RTH/ec

Reid

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

Date: October 1, 1963

To: Principal Investigators, General Clinical Research Centers

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

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

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

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

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

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


William R. DeCesare, M.D.

cc:
Program Directors
Financial Officers
Hospital Administrators
General Clinical Research Center Committee Members

W. H. ...

● A NEW INDIRECT COST PAYMENT SYSTEM that would provide a single settlement of these costs during the fiscal year the grant was awarded, is being worked out by H-E-W's Div. of Grants Administration Policy and NIH financial management personnel. Indirect costs are now included with each individual grant on a provisional basis for funding purposes and have to be adjusted at the end of the year.

¶ The new system is scheduled to be applied to all of NIH, at least on paper, by July 1, 1969 and will eventually be put into effect on a dept.-wide basis. It will first be tested on a selected number of recipient institutions. The system is designed to cut red tape in administering grants.

"When you have 16,000 grants a year to distribute you can see the potential for error. This system will allow us to settle indirect costs at any institution for all research projects at one time," said one H-E-W official intimately involved in working out the mechanics of the system.

¶ A report proposing the indirect cost payment system was recommended in August by the Grants Administration Policy Advisory Cmte. It has since been approved by the secty's. Office. Grants Administration Policy and NIH financial management personnel are now owrking on a pilot study to determine the information that needs to be provided by the recipient institutions before the system can be operational.

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● "FINANCIALLY DEPENDENT" INSTITUTIONS' WAGE, VACATION, sick leave and accounting practices will likely be subjected to tighter H-E-W controls following a study now under way by the Div. of Grants Administration Policy.

¶ H-E-W defines "financially dependent" institutions as organizations formed to carry out federally sponsored projects. These organizations normally have no financial resources other than U.S. funds. The organizations are formed to allow institutions concerned about a problem to cooperate more than they otherwise might. Duplication of efforts is also avoided. Flexibility in coping with the problem at hand is often listed as another advantage of these organizations.

Grant Administration Policy officials say that if the govt. is to exercise proper stewardship of the U.S.-financed organizations it should examine the organizations' financial stability and management capability. The div. is now gathering information on these "financially dependent" institutions. After the raw data has been compiled and assessed, the division will attempt to map out guidelines for use at H-E-W.

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● SEN. HILL & DR. KORNBERG GET HIGHEST AAMC AWARDS at the assn.'s meeting in Houston. Hill, retiring chairman of the Senate Cmte. on Labor & Public Welfare, was cited for having "mastered the detail" of the multitude of U.S. health programs and being responsible "for no less than 60 major legislative accomplishments in the field." He received the Abraham Flexner Award.

¶ Dr. Kornberg, a Nobel prize winner at Stanford's biochemistry dept., received the Bordon Foundation award in recognition of outstanding clinical or lab research. He and his colleagues recently announced the synthesis of infective viral DNA.

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EXPOSURE DRAFT American Hospital Association

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October 18, 1968
COUNCIL ON FINANCING RECOMMENDED REVISIONS TO

STATEMENT ON THE FINANCIAL REQUIREMENTS OF
HEALTH CARE INSTITUTIONS AND SERVICES

Approved by Board of Trustees
February 9, 1968

Revised May 9 and June 24, 1968

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FOREWORD

The development of the prepayment movement, the growth of private health insurance, and the increased participation by government in the financing of hospitals quickly made it essential that, if equity were to be attained and the community needs met, a set of principles of payment for hospital care had to be formulated and promulgated.

After long discussions and explorations with many related agencies, the American Hospital Association's House of Delegates approved the Principles of Payment for Hospital Care in 1953. The document proved of great value and was widely used. The Association kept the Principles of Payment under constant study and revised the document from time to time. In each instance, the revision was approved by the Association's House of Delegates. In 1965, a Statement on Reimbursement was approved by the Board of Trustees. In 1966, the Association developed a companion document, Principles of Payment for Home Health Services. It also began to work on a set of principles of payment for extended care services.

It then became apparent that an overall statement applicable to the financial needs of all types of health care institutions, including home health care services, should be prepared as a master document replacing the Principles of Payment for Hospital Care, the Principles of Payment for Home Health Services, and the Statement on Reimbursement.

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PART I

CHAPTER I. FINANCING HEALTH CARE INSTITUTIONS AND SERVICES

Our health care system is a complex of institutions and services, sometimes integrated, sometimes fragmented. The delivery of high quality health care requires a vast array of professional services, institutions, allied health organizations and agencies, educational programs, research activities and community health projects. The system must guarantee that necessary services are provided to the public effectively, efficiently, and economically. Coordination and self-discipline are necessary to meet this end. One of the means of demonstrating such coordination and self-discipline is participation by all components of the health care system in the planning process, a process that is most effective when conducted under voluntary sponsorship.

The need for discipline in the health care system to assure delivery of high quality health care has a corollary: adequate financing for health care services and facilities. The system has multiple sources of payment — self-pay patients, contracting agencies*, private insurance, tax levies, governmental grants, donations, grants and endowments. From these various sources must come adequate financing — financing that (1) goes beyond current operating needs; (2) is sufficient to permit maintenance and, consonant with community needs, expansion, modernization and replacement of physical plant; and (3) recognizes educational and research programs having appropriate approval. Further, the sources of financing should recognize that health care institutions as community service organizations, must be financed at a level that supports the objectives of community service, including health services for needy patients.

*As stated in the Foreword, this and other words defined in the Glossary are italicized the first time they appear in the text.

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Community needs for health services change as the community changes through population shifts and through socioeconomic movements, and as medical knowledge increases. As the providers of health facilities and services must be sensitive to changing times, so must the purchasers of health care. Changing patterns of benefits and varying payment methods should provide incentives for the most appropriate use of health care services.

Services and the organization of services and facilities must change as the needs of the people and the capabilities of the system change. There is no virtue in change for change's sake alone. On the other hand, passivity in the face of needed change cannot preserve the status quo, it can only hobble the system's orderly progress. These points are pertinent to all elements of the system but especially to those charged with the orderly guidance of change, the planning agencies.

As can be seen from the above, all the organizations in the system — service, financing, planning — are increasingly interrelated and share the ultimate purpose of maintaining the highest standards of quality possible in the delivery of health care, guided by judicious use of available health care dollars.

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CHAPTER II. ELEMENTS OF FINANCIAL REQUIREMENTS

The purpose of this chapter is to delineate the elements of financial requirements of health care institutions that must be met if they are to (1) assure economic stability, (2) render needed services, and (3) obtain capital resources to preserve, improve and expand physical plant and equipment necessary to meet community needs, and to plan and initiate new services and programs in support of advances in medical science and technology. All of the elements apply to some institutions and some apply to all. Selective application of these elements where there is demonstrable financial need is inequitable and, therefore, is not in the interests of the community served by the health care institutions.

A. Current Operating Needs Related to Patient Care*

1. Direct Patient Care

Financial resources required to provide patient care include but are not limited to salaries and wages, employee fringe benefits, services and supplies, normal maintenance and ~~repairs~~ minor building modification, and applicable taxes. This includes the monetary value assigned to services provided through services of their members by religious orders and other organized religious groups.

2. Interest

Financial resources required to pay a reasonable rate of interest on necessary and properly borrowed funds for operating cash purposes and capital needs.

3. Educational Programs

Financial resources required to support educational programs having appropriate approval.

*(Capital needs are essential financial requirements and are discussed in Section B of this chapter.)

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4. Research Programs

Financial resources required to support research programs related to patient care provided that such programs have appropriate approval.

5. Credit Losses

Financial resources required by the institution for the unrecovered financial needs arising from the care of patients who fail to meet fully the obligation incurred for services received.

6. Patients Unable to Pay

Financial resources required by the institution for the unrecovered financial needs arising from the care of patients who, because of inability to pay, are relieved wholly or in part of financial responsibility for services received.

B. Capital Needs

1. Plant Capital

a. Preservation and Replacement of Plant and Equipment

The governing body of a health care institution must, legally and morally, protect all assets entrusted to its custody. Funds must be available, therefore, to finance projects involving plant capital assets that because of deterioration and obsolescence must be replaced in the best interest of the public.

b. Improvement of Plant

Advances in medical science and in the technology of delivering health care services often require expenditures for new units of equipment and facilities. Such expenditures represent a

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different element than expenditures for preservation and replacement of plant and equipment. Sufficient financial resources must be available for continued additional investment in the improvement of plant and equipment so that health care institutions can keep pace with changes in the health care system.

c. Expansion

Health care institutions are expected to meet increased demands that result from population growth, discontinuance of other existing services, and changes in the public's concept of the delivery of health care services. In order to be in a position to respond to changing community needs, health care institutions must anticipate their future growth patterns and plan for the needed expansion of their facilities. There must be assurance that adequate resources will be available to finance such individual programs, when consistent with areawide health planning.

d. Amortization of Plant Capital Indebtedness

Health care institutions increasingly use borrowed funds to meet plant capital needs. Prudent fiscal management requires health care institutions to provide sufficient resources so that funds can be specifically designated for the amortization of plant capital indebtedness.

2. Operating Cash Needs

Because of fluctuations in operating needs, the amount of operating cash required to meet fiscal obligations as they come due may be

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subject to frequent change. An adequate flow of funds to maintain a viable cash position is essential to current financial stability so that excessive short-term borrowing can be avoided.

3. Return on Investment

Investors in for-profit health care institutions are entitled to a fair return on their investments.

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CHAPTER III. IMPLEMENTATION

Selective application of necessary elements for financing of health care institutions could undermine their effective financing and place an unwarranted burden on others. Similarly, selective application of the guidelines set forth in this chapter is not consonant with meeting the needs of provider, purchaser, or the ultimate beneficiary, the community.

Because financial needs vary with the scope of operation, community service objectives, and many other factors, financial needs must be determined for each health care institution on an individual basis.

Collections from self-pay patients and payments from contracting agencies should result in receipt of funds in sufficient amounts to cover the unmet total financial needs of providing patient care. Evaluation of the role of the individual health care institution within the health care system, and identification by the individual health care institution of its own needs, are essential components of the establishment of rates for self-pay patients and negotiations with contracting agencies. Negotiations with reference to the measurements of the elements of financial need should be carried out with contracting agencies by groups of health care institutions at the appropriate level. This principle should not preclude direct discussions between individual health care institutions and contracting agencies.

A. Current Operating Needs Related to Patient Care*

1. Direct Patient Care

The financial needs arising out of providing patient care services account for the major portion of the dollar volume necessary for the

*Capital needs are essential financial requirements and are discussed in Section B of this chapter.

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operation of health care institutions. Necessary elements include but are not limited to salaries and wages, employee fringe benefits, services and supplies, normal maintenance and ~~repairs~~ minor building modification, and applicable taxes.

The amount included as representing the value of the services of members of religious orders and other organized religious groups should be equivalent to the amounts paid to ~~other~~ employees for similar work and should be identifiable in the records of the institution.

2. Interest

Financial needs include payment for interest charges arising from the use of funds properly borrowed from external or internal sources for capital needs and operating cash purposes. Interest charges on external loans for plant capital purposes should be reduced by income earned on investments of operating funds, endowments, gifts and grants when such income is not assigned for specific purposes by the governing body or the donors. This does not apply to funds borrowed for current operating cash needs, provided it can be demonstrated that the total amount and application of such borrowed funds is consistent with prudent fiscal management.

3. Educational Programs

Financial needs arising from the conduct of educational programs having appropriate approval should be met primarily through tuition, scholarships, grants, or other designated community resources. However, the method of payment should establish the responsibility of all

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purchasers of care for their appropriate share of any demonstrable financial need created by the failure of such resources to meet these needs.

4. Research Programs

Financial needs arising from the conduct of research should be met primarily from endowments, gifts, grants or other designated community sources.

However, the method of payment should establish the responsibility of all purchasers of care for their appropriate share of a demonstrable financial need created by the failure of such resources to support the costs of research programs involved in patient care provided that such programs have appropriate approval.

5. Credit Losses

All purchasers of care are responsible for their appropriate share of unrecovered financial needs for the care of patients who fail to fully meet the obligation incurred for services received.

6. Patients Unable to Pay

All purchasers of care are responsible for their appropriate share of the unrecovered financial needs for the care of patients who, because of inability to pay, are relieved wholly or in part of financial responsibility for services received.

B. Capital Needs

The capital needs of a health care institution should be continually evaluated in the context of its place in the community's health system by the nonprofit or governmental governing authority, or in the case

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of for-profit institutions, the owner or his representatives. A collaborative effort within the health care institution — governing authority or owner, administration, and medical staff — and between the health care institution and the planning agency is essential for the best results.

1. Plant Capital

The method of payment must reflect the financial requirements of health care institutions for preservation and replacement of plant, equipment and services; improvement of plant; and expansion of plant and equipment.

The financing system must provide a method whereby the dollars available for future plant capital needs are distributed to those health care institutions that should modernize, improve and expand, and are withheld from those institutions that should not. Therefore, the financing of plant capital should be coupled with the planning process.

The following method of financing provides for plant capital with respect to (a) equipment, (b) amortization, and (c) expansion. Whereas elements (a) and (b) are unrelated to planning agency review, (c) is coupled to it:

a. Equipment

The formula should include an appropriate share of an amount that, when funded, would be sufficient to provide each institution with a revolving fund to meet the ongoing costs incurred by the institutions for fixed and major moveable equipment.* This fund should adequately finance the replacement purchase of equipment for existing or supplementary services and facilities at current price levels.

*For a listing of fixed and major moveable equipment, see Chapter VII, "Chart of Accounts for Hospitals."

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b. Amortization

The formula should include an amount representing an appropriate share of the payment required for the amortization of existing capital indebtedness.

c. Expansion

~~The formula should include an appropriate share of the funds the health care institution needs to provide* (1) for the acquisition of land, (2) replacement and major modernization of buildings, and (3) expansion of plant, equipment and services. Such provision can be accomplished by prospective accumulation of funds or retrospective payments for debt amortization. The arrangement should be consistent with community precedent of financing, including the use of designated funds, e.g., gifts, legacies, and bequests. In determining the contracting agency's share, the contracting agency should be obligated to make payments for financial needs arising from projects that have been approved by the areawide health planning agency; it should not be obligated to make payments for financial needs arising from projects that have not been approved by the areawide health planning agency, except that this provision should apply only to those projects begun after the implementation of this document. Further, all payments made in excess of current expenditure for these purposes must be funded by the institution or its central management in the case of multi-institution organizations.~~

~~*"Provide"--in-this-sense-permits-prospective-accumulation-of-construction-funds or-retrospective-payments-through-debt-amortization.~~

New words underlined. Portions deleted crossed out.

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11a.

c. Expansion

Capital expenditures for (1) the acquisition of land, (2) replacement and major modernization of buildings, and (3) expansion of plant, equipment and services may be met by any or all of the following:

(i) philanthropy designated for capital purposes (e.g., gifts, legacies, and bequests), consistent with the community's resources.

(ii) grants and loans; federal, state, and local.

(iii) after application of (i) and (ii) above, the formula should include a provision for prospective accumulation of funds or retrospective payments for debt amortization. In determining the contracting agency's appropriate share, the contracting agency should be obligated to make payments for financial needs arising from projects that have been approved by the areawide health planning agency, where such an agency has been established. The contracting agency should not be obligated to make payments for financial needs arising from projects that have not been approved by the areawide health planning agency, except that in any particular health care institution this provision should apply only to those projects begun after the implementation of this document in its method of payment. Further, all payments made in excess of current expenditure for these purposes must be funded by the institution or its central management in the case of multi-institution organizations.

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11b.

In recognition of the governing authority's responsibilities to preserve the institution's assets, the sum of capital payments each year, described in paragraphs (a) Equipment, (b) Amortization, and (c.iii) Expansion, above, must be at least equal to the historical cost depreciation expense on facilities existing at the commencement of this financing program and all subsequent facilities built with planning agency approval, where such an agency has been established.

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It is recognized that, during a transitional period, a group or groups of institutions may elect, with the mutual agreement of contracting agencies, to be paid on the current negotiated basis, including the use of depreciation. When such an alternative is used, the payment for capital needs should be consistent with planning principles established for the community. It is recognized that areawide planning agencies have not been established in some areas and, therefore, the payment for capital needs in such areas should, during a transitional period, be on the current negotiated basis, including the use of depreciation. In areas where planning agencies do not yet exist, health care institutions and contracting agencies have an obligation to take leadership in establishing such agencies.*

2. Operating Cash Needs

The method of payment must meet operating cash needs by assuring a rapid flow of the cash paid for services provided to beneficiaries of contracting agencies and provide for a cash advance when the need for such has been demonstrated as essential for prudent financial management.

The formula must include a supplement to compensate for the time lag between the purchase of a good or service and receipt of payment for services. The amount of the supplement should be reviewed periodically and adjusted to reflect any change, such as inflation, improvement or expansion of services, that has taken place.

*See Chapter IV, D.1

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3. Return on Investment

The formula should provide for a reasonable return on investment of for-profit health care institutions.

For-profit institutions are subject to the same planning disciplines as nonprofit institutions; and, therefore, contracting agencies should not be obligated to provide a return on investment for capital projects not approved by the areawide planning agency, where such an agency has been established. This provision should only apply to those projects begun after the implementation of this document.

C. Income from Sources Other Than Patients

1. Restricted Endowment Funds, Specific Purpose Funds and Gifts

Income from endowment funds or gifts restricted by donors to provide for services for designated patients should be used to reduce the payment for those services.

2. Income from Invested Operating Funds, Unrestricted Funds and Gifts, and Nonpatient Services

Except as stipulated in Chapter III, A.2., income from invested operating funds, from general endowment funds, from unrestricted gifts, or net income from nonpatient services should not be used to reduce the payment made for patient services.

3. Special Projects Income

Income received to finance special projects or salaries paid to special employees should be deducted from financial requirements before determining the amount of payment to be made for patient services.

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D. Method of Payment

No one method of payment has emerged that combines the strengths and eliminates the weaknesses of all the others. The health care institution and the contracting agency should conduct ongoing analyses of the effect of the methods of payment on the institution and the agency. The agreement should achieve a sensitive balance that protects the equity of purchasers of care and preserves the rights and prerogatives of the management and governing authorities of health care institutions and contracting agencies.

The merits of any method of payment should be judged on the basis of public accountability, equity, simplicity, ease of administration, economy of implementation, and its ability to react to current conditions and to provide a rapid flow of funds from purchaser to provider.

~~The application of any method of payment must be preceded by justification of the individual health care institution's financial needs in a manner mutually acceptable to provider and purchaser. Such justification includes (a) the application of accepted accounting techniques, (b) development of short-range and long-range planning objectives, and (c) coordination of long-range planning objectives with the areawide health planning agency.~~

The financial stability of a health care institution may be jeopardized if contracting agencies apply differing methods of payment within an individual institution. Several methods of payment are employed by contracting agencies, e.g., charge-based, average per diem, ratio of charges applied to costs, inclusive rate, per capita, and combinations of

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the foregoing. Ordinarily, the method involved is determined by negotiation between groups of providers and the agencies. As a result, some of the apparent differences among these methods are minimized. However, selective application of different methods of payment by different contracting agencies can result in the health care institution's inability to obtain full payment for the sum of the services for which these agencies are cumulatively responsible. All contracting agencies in an area should use a single method of payment agreed upon by a group or groups of health care institutions. This proviso is not intended to discourage voluntary experimentation with alternative methods of payment.

Health care institutions and contracting agencies have a responsibility to work out an equitable method of retroactive adjustment, where appropriate, to cover underpayments or overpayments during specified periods of time.

The method of payment should be consistent with the institution's goal of providing high quality care. In addition, the method of payment should be designed to encourage sound and efficient management practices.

If a health care institution's costs depart substantially from those of other institutions of similar size, scope of services and utilization,

future maximum reimbursement may be established through agreement reached between contracting agencies and ~~the~~ institutions. It must be recognized that variation in cost can be attributed to a variety of circumstances and, therefore, decisions as to whether a cost is unreasonable or not become a matter of judgment. To assure a maximum degree of equity, health care institutions subject to such judgment must be provided an opportunity to have their situation reviewed and evaluated through an established and equitable appeal procedure.

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CHAPTER IV. OBLIGATIONS AND RESPONSIBILITIES

Health care institutions, areawide health planning agencies, and contracting agencies are involved in the continuing process of balancing provider consumer and consumer provider interests. All three have strong ties and community obligations. In this chapter the obligations to the community they serve and responsibilities of each, separately and jointly, are set forth.

A. Health Care Institutions

1. Standards of Care

Health care institutions have an obligation to provide high quality care as demonstrated by their meeting acceptable standards of service as set forth by the Joint Commission on Accreditation of Hospitals and other appropriate professional groups.

2. Utilization Review

Health care institutions through their medical staffs are responsible for ~~reviewing-the~~ promoting the effective utilization of patient care services. Their objectives should be to provide efficient and effective health care services while maintaining or upgrading the quality of those services.

3. Health Education

Health care institutions should, by individual and group action, conduct continuing community service programs designed to educate the public in health maintenance and the effective use of health care facilities.

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4. Development and Promotion of Joint Programs

Health care institutions should seek the most economical, efficient, and effective ways of delivering their services. When feasible, they should participate in joint programs such as group purchasing, shared laundry, shared computer facilities, and continuing experimentation with methods and systems.

5. Self-Analysis

Health care institutions should strive for higher levels of performance through a continuing program of self-analysis. Management and methods systems and comparative analyses can be used as effective tools in the process of self-analysis.

6. Audit and Public Disclosure

Health care institutions have an obligation to disclose to the public evidence that all their funds are being effectively utilized in accordance with their stated purpose of operation.

Such disclosure will be deemed to have been made if financial statements are made available on request to those with a legitimate interest in this information. These financial statements should be prepared in accordance with generally accepted accounting principles consistently applied, and should be accompanied by the stated opinion of an independent public accountant as to their fairness.

7. Short-Range Planning Requirements

Health care institutions should establish their operating cash needs and prepare formal statements setting forth their management and

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service objectives for the coming fiscal year. Supporting these objectives should be a time schedule for their implementation, an estimate of the amount of the funds required to finance their implementation and an indication of the anticipated sources of these funds.

8. Long-Range Planning Requirements

Health care institutions should develop a program of long-range planning under the direction of a governing board committee including administration and medical staff to delineate their future programs of health service to the people of the community or area and to take into account available and planned health service from other health care institutions or other health service sources. The program of long-range planning should include a regular review with the areawide health planning agency to assure consonance of institutional and community health objectives.

9. Verification of Cost Data

Health care institutions should provide cost data audited by their public accountants, capable of verification by those contracting agencies with which they have such agreements. This practice should obviate multiple audits by contracting agencies.

10. Credit and Collections

Health care institutions, through their governing boards, should formulate and apply policy with respect to credit and collections. These policies should set forth the collection procedures to be followed, including the aging of accounts and definition of the time intervals on which accounts should be ruled uncollectible.

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B. Contracting Agencies

1. Development of Broad Benefit Coverages

Contracting agencies should accelerate their exploration and development of the ways and means of making available to their beneficiaries the broadest spectrum of health care benefits possible, covering both inpatient and ambulatory and home health care needs. The benefits structure should be designed to encourage the most appropriate use of health services, manpower and facilities.

2. Promotion of Broad Benefit Coverages

Contracting agencies should conduct continuing educational programs designed to encourage the public to increase that portion of its income set aside to prepay its health care needs.

3. Beneficiary Responsibility

Contracting agencies should develop effective methods of advising beneficiaries of their role in the judicious use of health care facilities.

4. Effective Administration

Contracting agencies should strive through effective management systems to improve their administration of health care dollars for the purchase of services.

5. Public Disclosure

Contracting agencies have an obligation to disclose to the public evidence that all of their funds are being effectively utilized in accordance with their stated purpose of operation.

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6. Current Payment and Retroactive Adjustment

Contracting agencies must include in their method of payment a mechanism that will assure an adequate flow of cash to health care institutions. (See Chapter III. B.2.). The amounts paid by contracting agencies should be based on the total financial needs of the institution as defined for the fiscal period in which the services were provided and purchased. The method of payment should, when necessary, provide for the payment of retroactive adjustments by either the health care institution or the contracting agency.

C. Areawide Health Planning Agencies

1. Relationship with Health Care Institutions

The areawide health planning agency should recognize health care institutions as basic participants in planning for personal health services and should work closely and continually with all such institutions in the area it serves, to assist them in organizing their own internal planning units and developing the process of planning to meet community health needs. The health planning agency should work with the institutions in the area it serves to define community health needs; should encourage joint planning by all health care institutions; should provide liaison with other agencies engaged in broad community planning; should help define and select institutional service and planning areas in terms of all the people within the areas; and should help present factual health evidence to the entire community.

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2. Definition of Health Service Area

The areawide health planning agency should work with the leaders of the area and the health care institutions to define the area to be served, and should work with these leaders and the health care institutions and the health care system to set areawide health objectives, to consider area health programs needed to achieve the objectives, and to develop the means of evaluating the results.

3. Program Evaluation

The planning agency must effectively guide the community in planning to meet its health needs. It must take action with respect to the appropriateness, adequacy, priority, and location of health care services and facilities. An appeal mechanism must be provided to protect the equity of individual institutions.

4. Agency Evaluation

The areawide health planning agency must be concerned with the quality of planning in the community, and should enlist the help of community leadership in development of criteria for continuing self-evaluation of organization, function, and methodology of the planning agency, and the planning results that are related to the community's health objectives.

D. Joint Obligations

1. Participation in Areawide Planning

Health care institutions and contracting agencies have an obligation to participate in the areawide planning activity where agencies have been established and to actively promote the establishment of such agencies in areas where none exist.

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2. Incentive Programs

Health care institutions and contracting agencies should cooperatively develop incentive programs designed to assist health care institutions and the system in their efforts to provide the highest quality of services as efficiently and economically as possible.

3. Mutual Agreement

The method and amount of payment to health care institutions by contracting agencies should be established by mutual agreement of the parties concerned and should be based on this Statement on the Financial Requirements of Health Care Institutions and Services.

4. Availability of Fiscal and Statistical Data

There is a joint responsibility on the part of health care institutions, areawide health planning agencies, and contracting agencies to share data necessary for the operation and evaluation of community health programs.

5. Community Financing

Health care institutions, areawide health planning agencies, and contracting agencies should encourage philanthropic sources and lending institutions to support the concept of health planning and provide financing for the construction of community health facilities, and the development of community health services.

6. ~~Performance Standards~~ Implementation Criteria

Health care institutions, areawide health planning agencies, and contracting agencies shall cooperatively develop ~~standards~~ criteria to

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implement the obligations and responsibilities set forth in this document. The criteria should recognize the intent of this statement to preserve the managerial, operating integrity of each of the parties. Further, the criteria to be negotiated should specify the actions to be taken for noncompliance with these responsibilities and obligations. An appeal mechanism, equitable to all parties concerned, must be provided. It must be recognized that such an appeal mechanism may vary with locale, but in any circumstance the equity of the individual institution must be protected. As a last resort, health care institutions may refuse to contract with, or may terminate agreements with, contracting agencies that fail to meet such ~~standards~~ criteria, and contracting agencies may modify or reduce payment to institutions that fail to meet such ~~standards~~ criteria.

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PART 2

INTRODUCTION

Part I of this statement outlines the basic framework of a system for financing health care institutions and services; it identifies the elements of financial requirements, sets guidelines for meeting them, and identifies the obligations and responsibilities, individual and shared, of health care institutions, contracting agencies, and areawide health planning agencies. The purpose of Part 2 is to describe an accounting methodology for the implementation of this financing system. While other accounting techniques could be employed equally well, the purpose of this exposition is to describe the process of accumulating information necessary for the determination of a health care institution's total financial requirements and the use of accounting techniques for the apportionment of those requirements among the purchasers of services.

The financing principles described in Part 1 require the assembling of information in addition to that traditionally summarized in financial accounting reports. Financial requirements are defined as the total monetary resources the health care institution needs or will need to expend in fulfilling its community health service objectives. In other words, financial requirements are defined as cash expenditures, required increases in necessary cash reserves for capital items, and changes in current liabilities resulting from the operation of the health care institution during a given time period.

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It is important to recognize that the accounting references contained in Part 2 in no way alter the application of generally accepted accounting principles in the financial reporting practices of health care institutions. While traditional income accounting requires the matching of expired costs (expenses) with revenues, the measurement of financial requirements necessitates the managerial determination of required future resources and the means for obtaining these resources. For example, whereas in income accounting supplies expense is defined as the historical cost of supplies actually used in providing patient care services, the financial requirement related to these supplies arises at a much earlier stage in the productive process -- at the time of purchase of the required supplies. In a similar sense, the financial requirements associated with a new building occur prior to, or at the time of, the construction expenditures or as debt amortization payments are made, and not over the forty or fifty years in which the community receives the health care services through the use of the building.

The exposition of the accounting methodology to be used in measuring an individual institution's financial requirements is contained in Chapters I and II. Apportionment of these financial requirements to individual patients and categories of patients are discussed in Chapter III. A summary is included in Chapter IV.

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CHAPTER I. MEASURING CURRENT OPERATING NEEDS

Current operating needs, whether measured historically or estimated prospectively, should be organized in a manner consistent with formal charts of accounts available to health care institutions. Historical measurement is required for those methods of payment employing a retroactive adjustment and for financial and managerial accounting reports. Although historical measurement can be made with a degree of precision directly from the institution's accounting and statistical records, this information in itself is not sufficient for determining the financial requirements for the current and ensuing periods. For this reason, prospective estimation of a health care institution's financial requirements is essential for the determination of the institution's charge structure and interim payments from contracting agencies. A sound budgeting program is an excellent basis for prospective determination of these requirements.

The cumulation of historical measurements and prospective estimates of operating needs through account classification systems constitute the first step in determining current operating needs related to patient care. Financial requirements for current operations can be defined as the cost of acquiring current assets and services that are utilized in the activities of health care institutions.

The next step is the allocation of these costs to and among programs and services of the health care institution, and then, the further identification

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of those programs related to patient care. Part I establishes four elements of current operating financial requirements: direct patient care, interest, educational and research programs. In addition, Part I recognizes that the unrecovered financial requirements for credit losses and charity allowances must be apportioned among paying patients and contracting agencies.

Although financial requirements differ from traditional accounting expenses, current operating needs in this discussion employ expenses as a first approximation of the financial requirements for current operations. The remainder of these requirements is discussed in Chapter III under current operating cash needs.

A. Direct Patient Care

The expense portion of the financial needs arising out of programs and services for patient care can be accumulated directly through the health care institution's account classifications. As described in Part I, these classifications should permit the cumulation of amounts for salaries and wages (including the monetary value assigned to the services of members of religious orders and other organized religious groups), supplies, purchased services, applicable taxes, and other direct and indirect costs for patient care (~~excluding depreciation; see Chapter III, A.~~). These expenses will be allocated to revenue-producing centers using techniques similar to those outlined in Cost Finding and Rate Setting for Hospitals.

B. Interest

The financial needs arising from interest require the calculation of amounts due for the use of borrowed funds regardless of the sources from which the funds were obtained or the uses for which the funds are employed.

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These charges must be formally recorded in the accounts of the institution. Measurement of allowable amounts is based on an evaluation of the reasonableness of the rate and the propriety of the loan from standards developed by health care institutions and contracting agencies. Part I, Chapter III, A.2., states that certain investment incomes must be deducted in the calculation of interest charges on plant capital borrowings. Therefore, income earned on such investments, including realized capital gains and losses, must be identifiable in the records.

The amount of interest to be included in the current operating needs should be allocated to various programs, such as direct patient care revenue centers, and educational and research programs described below, in a manner similar to those outlined in Cost Finding and Rate Setting for Hospitals.

C. Educational Programs

The financial needs arising out of educational programs are accumulated through account classifications which identify the particular educational programs' direct and indirect costs (~~excluding-depreciation~~) as determined by cost finding techniques. In addition, accounts must be established to accumulate information about program income. Any aggregate net deficit for these programs must be included in the payment for patient care services.

D. Research Programs

The financial needs arising out of research programs are accumulated through account classifications which identify the particular research programs' direct and indirect costs (~~excluding-depreciation~~) as determined

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by cost finding techniques. Identification of the amounts of financial requirements for research programs related to patient care requires an agreement between health care institutions and contracting agencies on guidelines for identifying these research programs. The income earned for each particular program from endowments, gifts, grants or other designated community sources must be recorded. Any aggregate net deficit for programs related to patient care must be included in the payment for patient care services.

E. Credit Losses and Patients Unable to Pay

The technique for measuring financial requirements for credit and charity losses incurred in providing care for certain patients is the same. The income from endowments, gifts, grants, and donations designated for meeting the cost of care provided for these patients, as well as payments received directly from them, must be deducted in the calculation of the total financial requirements for self-pay patients and contracting agencies.

The health care institution must recover all financial requirements incurred for programs related to patient services. Consequently, the financial requirements arising from credit losses or patients unable to pay must be apportioned among all other patients (See Chapter IV).

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CHAPTER II. MEASURING CAPITAL NEEDS

In determining the financial requirements of health care institutions, it is essential that funds be available for replacement of plant and equipment; improvement of plant; expansion of plant and equipment; maintenance of operating cash needs; and a provision for return on owner's investment in for-profit institutions.

A. Plant Capital

Part I establishes three types of plant capital payments to health care institutions:

- a. Payment for ~~replacement~~ purchase of equipment for existing services and facilities.
- b. Payment for amortization of existing debt.
- c. Payment for acquisition of land, replacement and major modernization of buildings, expansion of plant and equipment to provide for additional services and facilities.

The establishment of these types of payments in no way changes the responsibility of the accountant to systematically record the depreciation of the institution's investment in plant and equipment in a manner consistent with generally accepted accounting principles.

Measurement for these payments is accomplished as follows:

- a. The determination of payments for ~~replacement~~ purchase of fixed and major movable equipment for existing or supplementary services and facilities is to be based on price level depreciation. The health care institution should set aside ~~equipment-replacement-funds~~ these payments and formally account for receipts and expenditures. Any income earned on these funds and the funds themselves should be restricted to expenditure for equipment plant capital purposes as designated by the governing authority.

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- b. The determination of payments for amortization of debt may be accomplished prospectively, by reference to the retirement schedule contained in the debt instrument, or retrospectively, by reference to payments actually made.

This procedure is also applicable to those leases which are in substance purchase contracts. The interest portion of these lease payments must be examined for the reasonableness and propriety of the debt agreement.

- c. Upon approval of the project by the areawide health planning agency, where such an agency exists, the determination of the way payments will be made for acquisition of land, replacement and major modernization of buildings, and expansion of plant, equipment, and services must be made jointly by health care institutions and contracting agencies. The measurement of these capital requirements will necessitate projections of resources required for various alternative objectives determined in cooperation with areawide health planning agencies. Next, alternative sources of community financing (such as philanthropic funds, grants, tax resources) and the institution's own designated plant capital funds are determined. Finally, the alternative arrangements for the residual financing requirements are quantified, discussed with contracting agencies, and built into the charge structure for self-pay patients and the formula for contracting agencies.

A problem of the timing of capital payment is inherent in this method of plant capital financing, especially with regard to payments for major expansion and replacement. The timing problem arises for an individual

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health care institution because the expenditures for expansion are made episodically. Strict payment according to need could result in extreme fluctuations in payments. Therefore, it is recommended that prospective accumulation of funds by the health care institution be undertaken through a specific capital expansion factor in the formula varying with the needs of the institution. Strict fund accounting for the earning and expenditure of these funds is required.

During the transitional period, measurement should continue on a locally determined basis of negotiation, employing various depreciation methods.

B. Operating Cash Needs

In the discussion of current operating needs in Chapter II, measurement of financial requirements is approximated by the use of accounting expense. This measurement ignores the institution's need to accumulate current resources, such as supplies and prepayments, to render health care services. Therefore, the formula must provide for cash payments required for the financing of the changes in current assets.

C. Return on Investment

The rate of return on investment is subject to negotiation between the contracting agency and the for-profit health care institution. The return may be calculated on traditional accounting measurement of owner's equity, including the capitlization of start-up costs, or on total assets. For institutions that are paid a return on total assets, no explicit charges for debt capital should be recognized and the contracting agencies may wish to place some limit on the total amount of debt financing.

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CHAPTER III. APPORTIONMENT OF FINANCIAL REQUIREMENTS

In Chapters I and II, an accounting methodology for measuring total financial requirements is outlined. The next step is to apportion a health care institution's total requirements among beneficiaries of contracting agencies and self-pay patients.

Part I of this statement defines the method of payment as the mechanism for apportioning to beneficiaries of contracting agencies their share of the health care institution's financial requirements. Although no recommendation is made for any single, universal method of payment, it is recognized that one method of payment should be employed by all contracting agencies with which an institution deals. That is, the method of payment should be selected on the basis of local negotiation between a group or groups of health care institutions and contracting agencies. Once this local option has been exercised, all contracting agencies serving the area should use this single method of payment.

A difficulty arises in the apportioning of financial requirements among self-pay patients and beneficiaries of contracting agencies. Both groups share the responsibility for meeting the health care institution's total financial requirements. However, the mechanics of payment may result in the application of different methods of payment. That is, the assessment of the self-pay patient's share is made at the time the service is performed, but the contracting agency's obligation may not be assessed until a later point in time, if the method of payment employed has a provision for a retroactive adjustment.

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One possible solution to the difficulty was presented in the Factors to Evaluate in the Establishment of Hospital Charges:

The hospital's overall revenue must be adequate to meet its financial needs. However, the rate charged for each individual service should reflect properly the operating expenses for service rendered plus an equitable share of the other financial needs for which the patient is responsible. Rates established on this uniform basis should be applied to all patients without differentiation.

That is, the financial requirements for both self-pay patients and the beneficiaries of contracting agencies could be apportioned on a charge basis. This alternative is illustrated below. The more complex problem of multiple payment systems is discussed later.

A. Charges as the Method of Payment

Financial requirements can be assigned to revenue-producing centers in a manner analogous to the approach outlined in Factors to Evaluate in the Establishment of Hospital Charges and Cost Finding and Rate Setting for Hospitals. As an illustration of how charges may be related to financial needs, the following procedures are outlined:

1. Cost finding is undertaken to determine the total expenses (including depreciation) of each revenue-producing center, educational and research programs, and other activities.
2. The measurement of total financial requirements to be derived from patients during the period is determined (see Chapter IV).

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3. The ratio of total financial requirements to total expenses is calculated; this ratio represents the relationship between the health care institution's required revenue and its operating expenses.*
4. The total required charges for each revenue-producing center is determined by multiplying the centers' expenses by the ratio calculated in 3. above.
5. Then, the generally accepted methods, such as those described in Cost Finding and Rate Setting for Hospitals, are employed to allocate total charges to specific items of service.

This methodology results in a system of charges in which the charge for a specific service is related to the financial requirements of providing that service. The same obligation for meeting the health care institution's total financial requirements will apply to all patients receiving the same service.

*Unrecovered financial requirements for credit and charity losses must be included in the charge structure. For example, the ratio could be adjusted in the following manner:

$$\frac{TFR}{TE - UE}$$

TFR = total financial requirements.

UE = unrecovered expenses resulting from credit losses and care provided to charity patients (the provision for uncollectibles and charity times the ratio of total patient care expense over total patient care revenue).

TE = total patient care expense.

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B. Other Method of Payment for Contracting Agencies

Several methods of payment may be employed by contracting agencies that differ from the charge method used for self-pay patients. The use of these methods requires the establishment of techniques for apportioning the financial requirements among the two categories of payors — contracting agencies and self-pay.

When the contracting agencies' share of inpatient services is assessed on an average per diem basis, the following apportionment method may be employed:

1. The rate for average per diem financial requirements is calculated by dividing total financial requirements (see Chapter IV) by total patient days.*
2. The contracting agencies' share of financial requirements is calculated by multiplying per diem financial requirements rate by the number of patient days rendered to beneficiaries of contracting agencies.
3. The self-pay patients' share of financial requirements is calculated by subtracting the contracting agencies' share of financial requirements from total requirements.
4. The charge structure for self-pay patients is established in a manner similar to that described in (A) by using the ratio of self-pay patients' financial requirements to the expense incurred in caring for these patients.

*Again the unrecovered financial requirements resulting from credit losses and providing care to charity patients must be included in making the apportionment. The method analogous to the illustrated technique in (A) above is:

$$\frac{TE \left(\frac{TFR}{TE - UE} \right)}{\text{Total Patient Days}}$$

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Any method of apportionment employing specific departmental charges, such as the ratio of charges to charges applied to costs, will result in the same apportionment as if charges were used by all categories of payors.

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CHAPTER IV. CONCLUSION AND SUMMARY

Part II describes the process of accumulating information necessary for the determination of a health care institution's total financial requirements and procedures for translating these requirements into charges for self-pay patients and the required amount of payment from contracting agencies. Financial requirements for the provision of patient care are summarized as follows:

1. Direct and indirect expenses (~~ether-than-depreeciation~~, see items 6, 7, and 8 for the inclusion of plant capital payment) of patient care allocated to revenue-producing centers.
2. Interest payments, less certain undesignated income earned on investments (see Part I, Chapter III, A.2), that are allocated to the patient care revenue-producing centers and education and research programs.
3. Any aggregate net deficit of educational programs, such deficit being defined as total revenue earned by these programs less total direct and indirect expenses (~~exeluding-depreeciation~~).
4. Any aggregate net deficit, as defined in (3) above, of research programs related to patient care.
5. Unrecovered financial requirements resulting from credit losses and patients unable to pay that must be apportioned to paying patients through the institution's charge structure and in the determination of the required amount of payment by contracting agencies.

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6. Payments for the ~~replacement~~ purchase of fixed and major movable equipment for existing or supplementary services and facilities exceeding historical cost depreciation on equipment.
7. Payment for amortization of debt.
8. Payment for capital expansion exceeding historical cost depreciation on buildings.
9. Payment to provide for the operating cash expended for the increase of current assets.
10. Payment for a return on investment in for-profit health care institutions.

The principal implications of Part II are the recognition of the need for prospective estimation of financial requirements — both operating and capital — and the development of techniques for the apportionment of the total financial requirements of health care institutions among purchasers of services. Both the conceptualization and the measurement of these requirements necessitates an extension of traditional accounting responsibility.

The "Statement on the Financial Requirements of Health Care Institutions and Services" is a document which establishes a framework for a financing mechanism for the nation's system of health care institutions. The mechanism provides for progressive transition from the present means of providing financing for these institutions, and for evolution toward improved financing of institutional health services.

The goal of the statement is the meeting of total financial requirements of health care institutions. To the degree that this goal is achieved through the voluntary assumption of obligations by the concerned parties, as defined in the document, there will be an improvement in the provision of health services.

New words underlined. Portions deleted crossed out.

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GLOSSARY OF TERMS

Acquisition

Acquirement of legal title to property or the legal right to use property through lease contract.

Appeal Mechanism

(Definition, including minimum acceptable standards, will be made by Advisory Panel of Hospital Attorneys for Studying Legal Implications of Statement on Financial Requirements of Health Care Institutions and Services.)

Appropriate Approval — Education

(1) Approval of the programs by a recognized professional organization, or licensure when required by state law, or (2) recognition that such programs quality their participants for state licensure examinations, or (3) demonstration of an acceptable contribution to the quality of care within an institution and to community need for medical and paramedical personnel.

Appropriate Approval — Research

Formal approval by (1) the governing authority or appropriate committee of the health care institution, or (2) support by a governmental agency or a philanthropic source, such as a foundation.

Appropriate Share

That share, at least proportionate, of an element of financial need to be borne by a purchaser of care.

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Areawide Health Planning Agency

An agency which provides organized assistance in the establishment of health goals and in the effective implementation of those goals within the limits of an area's available resources. Preferably, the agency is organized on a voluntary basis, but however organized should provide representation from the health professions, health institutions, and consumers, with the consumers in the majority.

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Capital Needs

The financial resources necessary for health care institutions for (1) replacement of plant, equipment and services, major modernization, expansion of plant and equipment; (2) operating cash needs, and (3) a return on owner's investment in for-profit institutions.

Contracting Agencies

Those organizations or agencies that contract for the purchase from health care institutions of services for their subscribers or beneficiaries. Contracting agencies include voluntary nonprofit prepayment health service plans, governmental agencies, and voluntary nonprofit social and welfare agencies.

Current Operating Needs

The financial resources necessary to maintain the day-to-day functions of a health care institution or service.

Financial Requirements

The total monetary resources that a health care institution or service needs or will need to fulfill its community health service objectives.

Formula

The delineation of elements of financial requirements to be recognized for reimbursement.

Governing Authority

The governing board or owner(s) of the health care institution or service, or a governmental agency which has charge, control, and management of the property, affairs, and funds of health care institutions or services.

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Health Care Institutions

Medical care institutions as defined in the American Hospital Association publication, "Classification of Health Care Institutions: "establishments with permanent facilities and with medical services for patients, including inpatient care institutions, outpatient care institutions with organized medical staffs, and home care institutions."

Method of Payment

The means for apportioning among all purchasers of care their share of the financial requirements of the health care institution or service.

Negotiation

The process by which a group or groups of health care institutions and a contracting agency select (1) the means for measuring the elements of the health care institution's financial requirement, and (2) the method of payment, and (3) the actions to be taken for noncompliance with the obligations and responsibilities set forth in this document.

Operating Cash Needs

The amount of cash required by the health care institution for current operating expenditures and for the provision of a reserve adequate to cover fluctuations in operating needs.

Price Level Depreciation

The methods of calculating depreciation that take cognizance of changes in the general purchasing power of the dollar and/or changes in the replacement cost of specific assets. For a more definitive discussion, see American Institute of Certified Public Accountants, "Reporting the Financial Effects of Price Level Changes," New York: AICPA, 1963.

New words underlined. Portions for deletion crossed out.

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Transitional Period

The time required for the adoption and full implementation by health care institutions, contracting agencies, and areawide health planning agencies of the Statement on the Financial Requirements of Health Care Institutions and Services. The period may vary from area to area but should be no longer than is necessary for the full acceptance by all parties concerned of the principles enunciated in the document so that, as rapidly as possible, a sound financial basis can be established for the nation's health care system.