

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

COMMITTEE ON FINANCIAL PRINCIPLES
WASHINGTON-HILTON HOTEL
GEORGETOWN-EAST ROOM
Connecticut Avenue at Columbia Road, N.W.
Washington, D.C. 20036
10:00 a.m. - 4:00 p.m.
Friday, June 27, 1969

AGENDA

- I. Call to Order: 10:00 a.m.
- II. Approval of Minutes of Meeting of March 28, 1969 as distributed on May 8, 1969 and June 20, 1969
- III. Introduction of New Members
- IV. Discussion and Initial Development of an AAMC Position on Reimbursement of Supervisory Physicians in a Teaching Setting.
 - a. Definition of Issues and Problems Related to Recent Third Party Statements on Reimbursement of Supervisory Physicians in a Teaching Setting.
 1. Proper Delineation of the Concept of "Personal and Identifiable" Services.
 2. Role of the Supervisory Physicians to the Resident in the Conduct of Medical and Surgical Procedures.
 3. Financing of House Staff and Supervisory and Attending Physicians Under Medicare.
 - b. Determination of Action Priorities Among the Defined Issues and Problems.
 - c. Alternate Methods of Approach to the Resolution of the Problems and Issues
 - d. Initial Development of an AAMC Position on the Reimbursement of Supervisory Physicians in a Teaching Setting.
- V. Other Business.
- VI. New Business.
- VII. Date of Next Meeting.
- VIII. Adjournment: 4:00 p.m.

TAB A

TAB B

TAB C

TAB D

1. Pay for service is warranted
#372 then
2. maintenance

1. Communicate
2. Deal with immediate problem
3. Plan for future change

COUNCIL OF TEACHING HOSPITALS
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1346 Connecticut Avenue, N.W.
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MEETING OF COMMITTEE ON FINANCIAL PRINCIPLES
Dupont Plaza Hotel
Washington, D.C.
March 28, 1969
10:00 a.m. - 4:00 p.m.

Present:

Charles R. Goulet, Chairman
Richard D. Wittrup, Vice-Chairman
Vernon L. Harris, COTH
William D. Mayer, M.D., COD
Gerhard Hartman, Ph.D., COTH
Arthur J. Klippen, M.D., COTH
Francis J. Sweeney, Jr., M.D., COTH
Lawrence E. Martin, COTH
Reid T. Holmes, COTH
Irvin G. Wilmot, COTH
Robert C. Linde, AHA Representative

Excused:

Robert H. Felix, M.D., COD
Leon O. Jacobson, M.D., COD
Bernard J. Lachner, COTH
Roger B. Nelson, M.D., COTH
Charles C. Sprague, M.D., COD

Also Present:

Howard W. Houser, Instructor, Graduate Program in Hospital and Health
Administration, University of Iowa
Gordon D. Brown, Instructor, Graduate Program in Hospital and Health
Administration, University of Iowa

Staff:

Robert C. Berson, M.D.
Matthew F. McNulty, Jr.
Fletcher H. Bingham, Ph.D.
Richard M. Knapp, Ph.D.
Armand Checker
Howard R. Veit

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

II. Introduction and Welcome of New Committee Members:

Mr. Goulet, Chairman welcomed William D. Mayer, M.D., Dean, The University of Missouri School of Medicine as a new member of the committee representing the Council of Deans. It was indicated that three other COD representatives had incurred last minute commitments and thus could not be present. A complete roster of the reconstituted Committee is attached to these minutes.

III. Meeting of November 21, 1968:

The minutes of the November 21, 1968 meeting were approved as distributed.

IV. Report on Action Items of November 21, 1968 Meeting:

The Chairman reviewed the action items from the November 21st meeting and asked Dr. Bingham to comment on the action taken on the following items:

Action #1 The Committee directed the staff to prepare a questionnaire to be sent to selected institutions for the purpose of assessing the current situation with regard to house staff financing and the financial patterns of part-time and full-time clinical medical faculty practice. The staff will solicit evaluations of the proposed questionnaire from members of the Committee. Other data relevant to this issue will also be summarized in a manner meaningfully related to the dimensions of the questionnaire.

Action #2 The Committee directed the staff to prepare a General Membership Memorandum indicating the present and future

Action #2
continued

implications of the issue of "Dual Payment". Member institutions should be encouraged to examine their accounting systems to ensure an avoidance of duplicate payments.

Action #3

The Committee directed its chairman to work with staff to evolve staggered membership terms in order to provide an orderly opportunity for committee participation by all interested individuals.

Action #4

Because the charge to review this issue (financial support of the medically indigent) originated with the AAMC Executive Council and the COTH Executive Committee, the staff was directed to prepare an appropriate response to these two bodies.

Action #5

This issue (financial support for the medically indigent) was recommended for further review at the COTH Southern Regional Meeting in Atlanta on April 30, 1969.

Dr. Bingham indicated that a draft questionnaire had been developed, but that the Committee might wish to review implementation of the survey in view of recent developments. A General Membership Memorandum of payment was prepared, and included in the agenda book for Committee evaluation.

Staggered terms have been worked out for the Committee members which are attached to these minutes. Additionally, the staff has prepared appropriate responses to the AAMC Executive Council and the COTH Executive Committee regarding the Committee's discussion and review of "financial support for the medically indigent". The issue will receive further discussion at the COTH Southern Regional Meeting in Atlanta on April 30, 1969.

V. Report on the February 26th Meeting at the National Institutes of Health on General Clinical Research Centers:

The Chairman and Dr. Bingham, both of whom attended the meeting, reviewed the proceedings of that meeting. The purpose of the meeting was to discuss an October 1, 1968 memorandum from William R. DeCesare, M.D., Chief, General Clinical Research Centers Branch regarding the policy of admission of service patients to general clinical research centers. Both Mr. Goulet and Dr. Bingham stated that the issue did not receive the discussion in depth that was necessary. Thus, it was felt that very little in the way of constructive action resulted from the meeting.

Mr. Martin, reported that the Grants Administration Advisory Committee had also reviewed this issue. He noted that the question to be resolved is whether third party payments should be sought to support the GCRC's. Admissions may be generally classified as follows:

1. the strict research patient who would not otherwise be hospitalized;
2. the patient whose research status is incidental to hospitalization;
3. the strict service patient.

Mr. Martin reported that a consensus was reached by the GAAC that in the latter two cases, third party payment should be sought to the extent possible. The first type of patient clearly should be financed through GCRC funds. It was agreed that the GCRC Committee should be reconvened, selecting those who are fiscally oriented to be present.

ACTION #1 MR. MARTIN AGREED TO MAKE THIS RECOMMENDATION TO
DR. JOHN SHERMAN. THE STAFF WAS ADVISED TO WRITE
TO JOHN SHERMAN CONVEYING A SIMILAR RECOMMENDATION.

The question of who is responsible for the decision of classifying patients into one of the three aforementioned categories was discussed, but remained unresolved. The virtues of "utilization review" and "research protocol"

committees for this function were explored briefly. It was agreed that these two committees should not be placed in a position which could lead to competition or conflict.

- VI. Report on Correspondence Received from Ernest N. Boettcher, M.D. and William D. Mayer, M.D. -- Possible Action:
- VII. Discussion of Request to Committee from the AAMC Committee on Federal Health Programs:

The Chairman suggested, and the Committee agreed, that these two items (VI and VII) be discussed jointed. Dr. Berson stated that the AAMC Committee on Federal Health Programs had reviewed the issues of Medicare and Medicaid at its most recent meeting on March 11, 1969. It was the consensus of that committee that responsibility of these issues should most effectively be handled by an enlarged COTH-COD Committee on Financial Principles. Dr. Berson further indicated that the probability of hearings before the Senate Finance Committee required that this issue be given high priority.

Intensive discussion ensued, particularly with regard to supervisory physician fees. The underlying dimension of the debate concerned the large number of complex institutional arrangements which are in use to accommodate the funding and administration of house staff and medical faculty private practice. Thus, the result in some cases implies that "duplicate payment" may exist, or at least appear to exist. It was pointed out that the same issue existed in NIH financial negotiations, but that debate is now centered in a more public area with substantially larger dollars involved.

Several avenues of defense were explored and discussed, including the possibility of removing all physicians' fees from Part A. Immediately prior to adjourning for lunch, Dr. Berson indicated that two decisions were necessary:

- 1- the decision of whether or not to respond to the SSA Memorandum:
if so, what approach should be pursued?
- 2- How should the Senate Finance Committee Hearings on Medicaid and Medicare be approached?

At 12:30 p.m. the Committee adjourned for lunch.

Following adjournment for lunch, the Chairman reconvened the meeting at 1:45 p.m.

Lengthy discussion continued regarding reimbursement by the Federal Government for the professional fees of supervisory physicians. The Chairman reiterated Dr. Berson's question concerning a response to the SSA Memorandum and also recommended that guidelines for principles of reimbursement for the supervisory service of physicians in teaching hospitals be developed by the Committee. Before these questions were specifically answered, several pertinent points were raised. It was mentioned that the supervisory services being discussed could be treated as an institutional cost reimbursed to the teaching hospital, which in turn would compensate faculty members. It was generally agreed, however, that this type of reimbursement would have to remain "fee for service" basis because the prevailing attitude among most professional medical organizations, and specifically state medical societies, was in support of the principle of the solo practice of medicine.

Furthermore, it was mentioned that, in fact, the practice of medicine has not been greatly institutionalized in teaching hospitals; and, in most cases, remains essentially solo.

Discussion continued concerning the manner in which supervisory physician's fees were billed. Mr. McNulty mentioned that all Part B intermediaries were recently briefed by the central SSA Office. The group was told to be especially alert to avoid "duplicate payment". Mr. McNulty urged that hospitals be likewise alert to be sure that duplicate billing is avoided. It was mentioned

that much of the confusion over whether physician's services should be billed through Part A or Part B centered around lack of agreement on the part of hospitals, carriers, and intermediaries and the SSA as to the definition of "hospital-based physicians". Does this term include only radiologists, pathologists, etc. or, for the purpose of reimbursement; is it extended to include cardiologists, for example, who are interpreting EKG reports? Evidence was cited from experience that SSA and the carriers do not agree on this matter.

As this discussion concluded it was recommended that the AAMC should not respond to the SSA. Reasons were given in support of this decision:

1. The Chairman stated that he did not think the Committee was yet in a position to speak for the entire membership on these guidelines;
2. Since the SSA's final position on the principles are not yet clear and since there is evidence that SSA and the carriers disagree on certain vital points it is possible that the final interpretations of SSA may be somewhat less severe than anticipated.

Following this decision it was recommended that the following action items be taken:

ACTION #2 THE COTH STAFF SHOULD INFORM SSA REGARDING ITS CONCERN OVER THE MISUNDERSTANDING BETWEEN SSA AND SOME INTER-MEDIARIES REGARDING BILLING PROCEDURES FOR SUPERVISORY PHYSICIANS.

ACTION #3 THE STAFF SHOULD COMMUNICATE TO COTH, COD AND CAS REGARDING THE IMPLICATIONS TO THEM OF SSA'S PRESENT EFFORTS TO DEFINE THE PRINCIPLES OF REIMBURSEMENT OF SUPERVISORY PHYSICIANS. A MEMO TO ACCOMPLISH THIS HAD BEEN DRAFTED BEFORE THE PRESENT MEETING AND IT WAS REVIEWED BY THE COMMITTEE.

- ACTION #4 THE STAFF AND CHAIRMAN WILL DRAFT A POSITION PAPER TO PROPOSE ITS OWN GUIDELINES FOR THE REIMBURSEMENT FOR TEACHING SUPERVISORY SERVICES IN HOSPITALS.
- THE INSTRUMENT FOR FRAMING THE PAPER WILL BE A SMALL COMMITTEE OF COD, CAS AND COTH REPRESENTATIVES.
- MR. McNULTY AND THE CHAIRMAN WILL SEE THAT SUCH A COMMITTEE IS ASSEMBLED.
- ACTION #5 EFFORTS TO EXPLAIN AAMC POSITION TO THE SENATE FINANCE COMMITTEE WILL BE CONTINUED. SINCE PREVIOUS EFFORTS TO PERSUADE SENATOR LONG HAVE BEEN UNSUCCESSFUL AAMC WILL PURSUE IT WITH OTHER MEMBERS OF THE COMMITTEE.
- ACTION #6 THE CHAIRMAN AND THE STAFF WILL BE RESPONSIBLE FOR CONTACTING WITNESSES TO PRESENT CONGRESSIONAL TESTIMONY REGARDING REIMBURSEMENT FOR TEACHING HOSPITAL PHYSICIANS SUPERVISORY SERVICES.

VIII. Review and Revisions of Previously Prepared Memorandum to be Distributed to Accomplish Action #3 Above:

The corrected draft of this memorandum to be sent to COTH, CAS and COD members appears as an attachment to these minutes.

- IX. It was agreed that the next meeting of the Committee would be at the call of the Chairman.
- X. There being no further business, the meeting was adjourned at 3:30 p.m.

~~Add~~
AMEND
Refine action #4 to be more specific to getting a position paper on #322

Attachments: List of Members of Committee on Financial Principles
Memo on Dual Payment

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

COMMITTEE ON FINANCIAL PRINCIPLES
1968 - 1969

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Vice-Chairman

Richard D. Wittrup**
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(1968-1971)

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Committee on Financial Principles
1968-1969

Two-Year Term
(Continued)

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Committee on Financial Principles
1968-1969

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** Indicates one-year (1968-1969) term on Committee

228 Medical Science Building
Columbia, Mo. 65201

SCHOOL OF MEDICINE
Office of the Dean

Telephone
314 442-5111 Ext. 611

June 3, 1969

Mr. Matthew F. McNulty, Jr.
Associate Director
Association of American Medical Colleges
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear Matt:

I received a telephone call last week from John Cooper bringing me up to date on some of the proposed activities of the AAMC in relationship to Medicare and other third party pay organizations. He pointed out that the staff of the AAMC would be drafting a preliminary document in this area and suggested that if I had any further thoughts I might get them to you.

We have continued to have major discussions with our staff in preparation for the implementation of the recent Social Security Administration intermediary letter to Part B carriers. With these further deliberations, obvious problems have come to light not only as they affect our institution, but as they affect others as well. I will attempt to relate these thoughts as best I can under the pressures of graduation and other activities of schools of medicine at this time hoping that even in their disorganized state they may be of some assistance.

Perhaps the single most encompassing concern, from which most of the subsequent problems arise, is the rigorous definition of the "conditions" by which a teaching physician can be classified as an attending physician in the eyes of the SSA. I understand some of the origins of the concept of the attending physician and the desire on the part of SSA that individuals under Medicare receive something better than the "clinic" or "ward type" care that existed for some of the indigent in the past in some institutions. However, the attempt to get at this issue through the rigid application of the concept of "attending physician" may cause more difficulty than is warranted in terms of gain. With the development of the concept of the group practice of medicine in the private sector as well as with marked improvements in the concepts of group practice within university medical centers this approach may well be moving in direct conflict with the trends of practice in medicine. Obviously, there are groups within the profession who would like to reverse these trends who might see Medicare and its regulations as one of the devices by which to accomplish reversal. However, I think the trend is sufficiently clear that to deny it (as the intermediary letter does) is grievous error.

It would seem to me that the obvious focus of concern of the SSA should appropriately be methods of insuring that high quality patient care is being provided to those for whom they have a responsibility. They have seemingly chosen the rigorous definition of "attending physician" as the primary method of accomplishing this. In so doing they have potentially set up a system which will damage significantly one of the major elements of health care and physician manpower production - the teaching hospital. What I am attempting to say is that the search for mechanisms of insuring quality care for Medicare beneficiaries, while not only laudatory and mandatory, may have led to a mechanism which has potential far reaching implications to the entire fiber of health care in this country. We should at some time give strong consideration to alternative pathways of meeting the necessary goals of SSA in the assurance of quality of health care. I suspect that the majority of teaching hospitals in this country are not now currently in total compliance with the specific details of the intermediary letter. I find it difficult to believe, however, that they are not providing extremely high quality medical care to Medicare beneficiaries.

As I indicated at the outset, most of the problems of the intermediary letter do stem from the basic issue of definition of "attending physician," but it may be worthy to comment on some of these. For example, on the one hand it has been felt that resident physicians are not worthy of inclusion as eligible participants under Part B presumably because of the inadequacy of their training. On the other hand the intermediary letter goes to great lengths to require that the presence of the attending physician must be "medically necessary" in order for him to be able to bill. The implications here are that there may be some procedures in which the resident can provide high quality care which to me seems to be in conflict with the original thesis that they should not be included. It is unclear who will define what procedures are medically necessary and which are not. It has been my assumption that my medical staff will make those determinations, but the possibility of further definition by SSA may be in the wings and needs to be pursued.

An extremely important by-product of these considerations is the concept of graded responsibility for resident physicians as we train them to provide high quality patient care to their patients as they leave the confines of the teaching hospital. There is no question that rigid interpretation of the relationship of attending physician (teaching physician) and resident physician may well interfere with the very basis upon which the training of competent physicians has been developed in this country. The apparent lack of acknowledgement of this fact in the search of mechanisms of assuring high quality care is one of the most critical by-products of the "overkill" nature of the document.

We have had some lengthy discussions relative to the requirements for documentation of services provided by our teaching physicians as outlined or implied in the intermediary letter. It is quite clear that the efforts in documentation by our teaching physicians are going to be of sufficient magnitude to decrease the amount of time that they will have available for their health care, teaching and other functions. Some more satisfactory, less time-consuming method of documentation will need to be developed other than that which I at least imply from the intermediary letter. We have even given consideration to the possible

development of rubber stamps which say "I have provided the direct in-person supervision which was medically necessary for the above procedure." However, I must admit that when you arrive at this kind of conclusion it suggests that we may be simply going through documentation for documentation's sake which leaves me a little cold.

Another major issue that is raised by the document is the concept that the procedures required by Medicare to "insure" quality for Medicare patients must also be applied to all other patients within the teaching hospital setting. This linkage somehow is to provide them comfort that the patients for which they have responsibility are not receiving "second class" care. I not only have the jurisdictional problem with this one that this is not a concern of the Social Security Administration (their concern should relate only to those mechanisms of assuring high quality care for their patients), but also I have the philosophic concern that this linkage of and by itself cannot assure them of that which they desire assurance. Another example of where the linkage approach may create some problems for some teaching hospitals is in the issue of the usual and customary fee. Obviously in an attempt to assure the public that Medicare funds are being spent appropriately, B.2 of the intermediary letter has been developed. If the linkage to the lowest common denominator is pursued to its ultimate, there is at least the possibility in some institutions that "free" care may be appropriate for Medicare patients as far as professional fees are concerned. I assume that there are still some teaching hospitals in the country in which, in the sense of physician billing at least, the majority of patients are receiving "free" care. Again, I would concur that it is quite appropriate for SSA to insure that exorbitant fee schedules are not established for the professional services rendered to their patients. However, I firmly believe that it is appropriate that usual and customary fees should be provided if high quality care is also being provided. That, after all, was certainly one of the bases upon which Title XVIII was enacted in the first place.

Along the same lines, although not apparently implied in the intermediary letter, I think we should be ever alert to the need for relationship of professional fees to that which is usual and customary rather than another attempt at linkage to fee charges potentially on the basis of the source and amount of income of the "attending physician." As you know, I was vitally concerned about this possible misinterpretation which occurred by our own Part B intermediary carrier. This principle will need to be made clear over and over again in our discussions.

This has not been a total critique of the intermediary letter, but I have tried to address myself to what we have felt to be some of the main issues. As I have indicated to you and John, I do feel that this is one of the major issues with which the university medical centers and teaching hospitals of this country are now faced. I would hope that the AAMC will continue to pursue these issues with real vigor. I personally stand ready and willing to provide whatever assistance you may desire from me.

Sincerely yours,

William D. Hoyer, M.D.
Dean and Director

cc: John A. D. Cooper ✓

FHS

DATE: June 2, 1969

To : Robert A. Chase, M.D.

FROM : Robert J. Glaser, M.D.

SUBJECT:

Dear Bob:

In connection with your note of May 26th regarding payment for services of Medicare patients, I talked with John Cooper, and he is working very actively to try to get the whole issue reexamined in the hope that we can come out with a more sensible plan. I think it is absolutely critical that we do, and I just wanted you to know that John is really working on it.

I am sending him a copy of this letter to suggest that if he needs a vigorous advocate from a major clinical department, I would suggest that he get you.

While I am writing let me acknowledge your second note of May 26th relative to the failure of Medical to pay up on patient Fong Lin because the surgery was primarily done by a fifth-year resident. This is a typical example of the kind of situation that it really is intolerable, and I think I will send John Cooper a copy of this note too simply to give him additional ammunition.

Sincerely yours,

Robert J. Glaser, M.D.

RJE:mv

cc: John A.D. Cooper, M.D.

DATE: May 26, 1969.

To : Robert J. Glaser, M.D., Dean, M-121.

FROM : Robert A. Chase, M.D., A-256.

SUBJECT:

Dear Bob:

Just a note to let you know that we are now beginning to feel the impact of the new guidelines on Medicare MediCal I mentioned to you. To be specific, one of our patients, Fong LIM, had a huge stasis ulcer of the left pretibial and malleolar areas which was totally excised on October 7, 1968 by Dr. Wilson Kerr, a fifth year resident, with Donald Laub of our faculty in attendance. It required total excision and primary skingrafting.


Request for payment by the usual form was made. In this case a bill of \$300 for the surgery performed and in addition, there was a bill of \$110 for the professional services rendered by Anesthesia.

Glenn Pursell, our representative, pointed out to me that MediCal will not pay because Wilson Kerr, a fifth year resident, actually performed surgery. Dr. Donald Laub was, in fact, present in the operating room and participated in the decision although I think that this fact is actually superfluous.

The condition being cited under the new guidelines for Part B payments for services of supervising physicians is in Paragraph A under 1e where it states "For the physician to be an 'attending physician,' his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint.

This presents exactly the paradox I'm talking about that on the one hand they are stating that Wilson Kerr, a fifth year resident, is qualified to do the procedure and yet it is obvious that they do not consider him a competent physician to collect for these services under Part B. If these regulations stand, we are going to be in real financial trouble in this school. I think we must raise a fuss.

Very truly yours,


Robert A. Chase, M.D.

RAC:gtl

cc: Mr. Glenn Pursell
Dr. Donald Laub
Mr. Lindee
Mr. Kneepkens

John Purcell
Donald Laub
Indee
McPheens
O'Brien

P.S. - If it were not for
Medicine - Blue Shield, this insurance
and parties will soon follow.

DATE: May 26, 1969

TO : Robert J. Glaser, M.D., Dean

FROM : Robert A. Chase, M.D.

SUBJECT:

Dear Bob:


I appreciated it very much getting a copy of Bob Berson's note to you making comments on my April 25th memo.

It would serve no useful purpose to debate water that is over the dam, but I disagree with Berson's comments that neither the AAMC nor any of the organizations made up largely of medical faculties participated actively in the very prolonged and largely political tug-of-war which preceded the passage of Medicare in 1965. It may be that no such organizations were involved in discussions prior to the passage of the law; nevertheless, there was an advisory group to HEW made up of individuals in medical teaching for the expressed purpose of discussing utilization of Medicare patients in the training of surgeons.

The Committee on Graduate Education of the American College of Surgeons also had a subcommittee which worked very hard on this and reported to the advisory group of the HEW. It happened to be the group that came up with a watered-down approach to the whole problem which talked about the role of the teaching physician and identifiable service that he rendered. I objected vigorously at that time to this; since once again it seemed to be an attempt to get around the primary problem which was the proper payment for services rendered.

I have not changed my mind one bit on this and I daresay we ought to be able to mobilize major support for treating all licensed physicians equally. Several schools are now once again addressing themselves to the problem by throwing down sandbags to control inundation rather than going back to the level of building a flood control dam. Perhaps I ought to stop worrying so much about this since it is not my primary job to see that proper income from patient care continues. I just think that some of us at the patient-care faculty level have got to. I am now trying to locate the letter I wrote to the Committee on Graduate Education looking at utilization of Medicare patients for training surgeons many years back. I think my opinion was the same then as it is now.

With very best regards,



Robert A. Chase, M.D.
Professor and Chairman
Department of Surgery

RAC:s1

HOSPITAL of the UNIVERSITY of PENNSYLVANIA

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John Rhea Barton Prof. of Surgery
Chairman, Department of Surgery

I. S. RAVEN, M.D.
Emeritus Professor of Surgery

BROOKS ROBERTS, M.D.
Professor of Surgery

WILLIAM S. BLAKEMORE, M.D.
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CLETUS W. SCHWETMAN, M.D.
Professor of Clinical Surgery

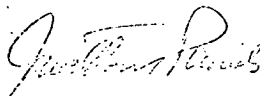
June 6, 1969

Robert J. Glaser, M.D., Chairman
Association of American Medical Colleges
Office of the Dean
Stanford University
School of Medicine
Palo Alto, California 94304

Dear Bob:

I heartily share the position which Bob Chase has taken and would endorse the idea that the A.A.M.C. should come out clearly for a transposition of charges for residents to go under Part B of Medicare, with the understanding that there would be one fee which would be apportioned internally between the cost of the trainee and the cost of the physician supervising him.

Sincerely yours,


Jonathan E. Rhoads, M.D.

JER:nvm

CC: Drs. Berson, Chapman, Cooper, Kinney and Testeson and Mr. McNulty.

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PHILADELPHIA 1969

Blind copy to Mr. Mathew F. McNulty, Jr.

May 23, 1969

Mr. Thomas M. Tierney, Director
Bureau of Health Insurance
Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235

Re: SSA Guidelines on Part B
Payments for Services of
Supervising Physicians in
a Teaching Setting
(April 1969)

Dear Mr. Tierney:

The Council of Medical Specialty Societies takes exception to certain sections of these guidelines as distributed to intermediary carriers, particularly to the examples cited in paragraph A-1.

The Council believes that the fact that a trainee is disqualified under the Medicare law from being reimbursed under Part B implies that he is not competent to carry the full responsibility for the patient. For this reason we believe that supervision by an attending physician is not superfluous but is an essential ingredient of care of the patient by a resident.

The Council further believes that the revised regulations will result in a serious decrease in the number of patients who can be safely involved in a teaching program and will place these programs in jeopardy.

The Council hopes to be permitted an opportunity for its representatives to meet with appropriate officials of the Social Security Administration to discuss these matters.

The CMASS is composed of official representatives of the following specialty societies:

The American Academy of Pediatrics
The American College of Obstetricians & Gynecologists
The American College of Physicians
The American College of Surgeons

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AAMC-WASH, D. C.

Mr. Thomas M. Tierney
May 23, 1969

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The American Psychiatric Association
The American Proctologic Society
The American Urologic Association
The College of American Pathologists

Respectfully yours,

John Paul North, M.D., F.A.C.S.
Secretary, Council of Medical
Specialty Societies

JPN/jm

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Recommendations Re: Principles governing the Payment for Services
of Interns, Residents, Supervising Physicians and Attending
Physicians in Teaching Settings under the Medicare Program

Introduction

The drafting of Principles is made more difficult because of the need to separate teaching services from the services of Attending Physicians in the teaching setting in order to conform to the distinctions made in these services in the Medicare law and in the regulations governing the administration of the law. The difficulties involved in classifying the services of each physician involved in the care of a patient in a teaching setting and in the computing of the costs and/or the reasonableness of professional fees for each are well known to faculties, Deans and hospital administrators. These difficulties are not simplified when one contemplates the variety of fiscal, educational and professional relationships between house officers, faculty members, medical schools, teaching hospitals and patients.

It was, therefore, tempting to approach these issues with the intent of recommending modifications in the basic law and thus the Medicare Program as it applies to the care of patients in teaching hospitals. However, it seemed clear to the staff and the Committee on Financial Principles of the Council on Teaching Hospitals of the AAMC that there were two problems inherent in such an approach.

First, there is little hope that alternatives acceptable to all

medical schools, their faculties, teaching hospitals and the Congress could be drafted without endless discussions with individual schools, hospitals and faculty groups in order to understand and rationalize the differences in arrangements that mark the relationships between house officers, faculty members, schools, hospitals and patients in the member institutions. Indeed, such an approach might well conclude that changes must first be made in the internal relationships of some schools and hospitals if changes in the law are to be proposed that would be universally applicable to the schools and their faculties.

Secondly, it seems clear that there is little hope that the administration and/or the Congress would favorably consider any major change in the law at this time.

For these reasons these recommendations conform to the law as it is now written and the premise upon which it is based; private fee for service medical practice.

This decision should in no way deter the Association from a continuing discussion of these complex matters in the hope that a consensus might emerge that will provide for a more rational basis for reimbursement for the services of professionals providing patient care and education in the teaching hospital setting.

Principles

1. Post-graduate Medical Education including the Costs of Supervising Physicians

It is proposed that all costs associated with the appointment, service, and education of interns and residents should be reimbursed as hospital costs on an actual cost basis. (Part A)

-- The commonly accepted definitions of intern and resident should be used to distinguish these individuals from others who may be appointed as salaried members of the hospital's professional staff.

-- The costs of physicians "supervising" the post-graduate (graduate) educational programs of interns and residents should be allowable costs.

-- Both of the foregoing costs should be allowable provided the following conditions are met:

- (a) The costs are uniformly applied in the determination of the cost of the care of all patients whose care involves the service of interns and/or residents.
- (b) The costs are actual costs - not imputed costs.
- (c) The costs are auditable. That is, the basis for the determination and the allocation of costs, especially those associated with supervising physicians, conforms to the actual services rendered and the basis for allocation is available for audit.

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2. Services of Attending Physicians

Attending physicians caring for patients in teaching hospital settings should be permitted to levy fees for their professional services which should be reimbursable as professional services. (Part B)

-- The attending physician may not be an intern or resident since the cost of their services and education are reimbursed as hospital costs. --

-- An attending physician relationship exists whenever the tests of a patient-physician relationship can be demonstrated and this relationship is understood by the patient and is similar to that of any other "private" patient with his attending physician. (It should be emphasized that the medicare patient who has Part B coverage for professional services has paid a monthly premium for this coverage and therefore is eligible to be treated as a "private" patient of an attending physician if a professional fee is to be earned by the physician.)

-- The attending physician rendering "personal and identifiable" services to his patient should document these services in the patient's medical record, so that his relationship to the patient may be professionally audited.

-- All patients of the attending physician should be subject to a professional fee not just those who have insurance or medicare coverage. (Whether collection is made and the magnitude of the fee should continue to be based upon the physician's evaluation of his patient's economic,

social, and medical condition.)

-- The attending physician has the right to charge a fee for his professional services even though at the time he rendered the service he was a salaried member of a hospital's medical staff or a faculty of a school of medicine.

-- The attending physician should be allowed to charge a "usual and customary" fee for his professional services even though he is salaried.

-- The method by which an attending physician renders his bill for professional services should not be a factor in determining whether an attending physician relationship exists between himself and his patient. (The physician may bill individually, or through a group practice, a medical corporation or medical school.)

-- The disposition of fee income by the physician, group, etc. shall not be a factor in determining whether an attending physician relationship exists or the appropriateness of the level of the fee.

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5-1-69

A PROPOSED PLAN FOR PART "B" MEDICARE PAYMENTS FOR SERVICES OF PHYSICIANS IN A TEACHING SETTING

A. The Need For Revision

It is apparent that revisions are in order in the methods being used by and the circumstances under which the Social Security Administration makes Part B payments for services rendered to patients by physicians participating in a graduate clinical teaching setting. These revisions are warranted mainly because of the following circumstances:

1. The basic Medicare law, Public Law 89-97, was designed primarily to provide reimbursement for services rendered to Social Security beneficiaries in a non-teaching setting and does not fit at all well the circumstances surrounding the professional care received by patients in a teaching setting.
2. The initial regulations concerning physician reimbursement in a teaching setting were quite vague both as to philosophy and implementation and thus did not provide a basis for uniform and reasonable interpretation by either fiscal intermediaries or providers of service.
3. Providers of service as well as Part B fiscal intermediaries have obviously interpreted the existing Social Security Administration's regulations concerning Part B payment for services rendered by physicians in a teaching setting in a wide variety of manners. This situation has understandably resulted in considerable confusion across the country. The interpretations have ranged all the way from quite liberal to very rigid and payments to physicians in a teaching setting have varied accordingly.

B. Purpose of this Proposal

The purpose of this document is to propose an alternative method for Part B payments for services of physicians who are participating in an institutional teaching setting. The method would have as its justification simplicity, ease of administration and equitable reimbursement--attributes not possible under the approach which has been taken by the Social Security Administration to this matter in the past. One of the major obstacles to designing a system to encompass such Part B payments in a teaching setting is that there exists no logical line which can consistently and uniformly be drawn between clinical graduate education and physician services to patients. This distinction varies from patient to patient, from day to day, from physician to physician, and certainly from institution to institution. With this number of variables it is extremely difficult, if not impossible, to evolve a set of detailed guidelines such as proposed by Social Security Administration, which would be appropriate in each and every case and which would adequately protect the rights and interest of the Social Security Administration, the patient, and the providers of services.

C. Basic Assumptions

This proposal is based upon the following assumptions:

1. It was not the intent of Congress when enacting the Medicare law nor the Social Security Administration in administering it to pay for cost of graduate medical education, except for appropriate cost of internship and residency programs. Any proposal must insure that payments are being

made for physician services to patients and not for solving the financial problems relating to graduate medical education.

2. Provisions must be made and safeguards applied to insure that physician services received by the patient in a teaching setting are at least equal to those available to the patient in a non-teaching setting in both quantity and quality.

3. It should not be the purpose of the Social Security Administration to dictate the specific manner in which these physician services are provided to the patient or to attempt to regulate the supervisory techniques which are used in a given teaching institution to appropriately apply to the patients medical condition the variety of physician talent available in the teaching setting.

4. It should be recognized that every teaching institution is very closely inspected by the Council on Medical Education of the American Medical Association. This Council regulates the quality of the institution's medical education program and insures that the medical education program does in fact provide the organization for and the delivery of excellent physician care to all patients treated in the teaching setting. In addition, the teaching institution must meet all the requirements of the Joint Commission on Accreditation of Hospitals.

5. Medicare patients will not be singled out for special treatment with respect to charges for services of physicians in the teaching setting.

Physician charges to patients must be applied on an institution-wide basis rather than to Medicare patients as a special group.

D. The Proposal

It is proposed that teaching institutions be offered an alternative arrangement under which charges could be rendered and payments made for physician services under Part B of the Medicare Program in a teaching setting. This alternative arrangement would need to be an institutional decision concurred in by all physicians who met certain requirements in that teaching institution and the institution could elect to change from, or to, this alternative arrangement only at the beginning of a fiscal year. It would be the responsibility of the institution to supply through the appropriate fiscal intermediary necessary documentation to insure that the conditions outlined above were being met and that the program was being equitably administered within that institution. It would also be the responsibility of the institution to insure that the physicians who were appropriately included in such an institutional arrangement met all appropriate requirements of the Social Security Administration with respect to existing Part B payments for services to physicians in a teaching setting. The following specific components are proposed:

1. An institution, hospital or medical school could enter into an agreement with the Social Security Administration whereby all salaried full-time or part-time physicians on its staff would bill professional fees under a common institutional provider number for all patients who

Program as applicable to Medicare beneficiaries.

The net result of the above arrangement would be a recognition by the Social Security Administration that a community prevailing usual and customary professional fee should be paid on behalf of Medicare beneficiaries receiving their care in a teaching setting in the same manner as such fees are paid on behalf of Medicare beneficiaries in the non-teaching setting. The cost to the program would thus be no more or no less for each patient than would have been experienced had that patient been seen and treated in some other setting.

E. Conclusions

The above proposal assumes that the Social Security Administration has a responsibility to pay a usual and customary fee on behalf of all its beneficiaries who receive a given quantity and quality of physician services. It retains under the Part A mechanism as required by Public Law 89-97 that portion of the payment which relates to costs associated with intern and resident training. In addition, it reimburses under the Part B mechanism a professional fee over and above the cost of intern and resident training to bring total payments of services rendered by physicians in the teaching setting up to a level equal to but not in excess of the level that would be experienced in a non-teaching setting.

It is obvious that a number of additional details would need to be worked out in such a proposal as is made above. Criteria would need to be established concerning which institutions would be eligible to elect this alternative arrangement. Certainly one would need to be more specific in terms of which patients

receiving care within an institution would be covered under such an arrangement. Very clear guidelines would have to be developed concerning which physicians within an institution would be required to participate in such an arrangement before the institution could enter into an agreement with the Social Security Administration as well as which physicians would be ineligible to participate in such a program.

It should be possible in consultation with various individuals representing different kinds of teaching institutions to arrive at equitable and reasonable answers to these problem areas without a great deal of difficulty.

It is hoped that a fair, equitable, easily administered plan for "Part B Payments for Services of Physicians in a Teaching Setting," along the lines as proposed here, can be mutually worked out by the United States Senate Finance Committee, the Social Security Administration and the teaching institutions of this country that would insure quality care at a reasonable cost for the many patients who choose the teaching setting for their medical care.