
Call Barbara Woolley

for phone #.

452-8290

file GME

**Children's Hospitals
Graduate Medical Education Act of 1999**

Section-by-Section Analysis

SECTION 1. SHORT TITLE.

Section 1 gives the bill the short title, the "Children's Hospitals Graduate Medical Education Act of 1999".

SEC. 2. PROGRAM AUTHORIZED.

Section 2 adds to Part C of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) a new Section 749, with the following provisions:

SEC. 749 GRADUATE MEDICAL EDUCATION IN CHILDREN'S HOSPITALS.

IN GENERAL. Subsection (a) authorizes the Secretary of Health and Human Services (HHS) to make grants to qualified children's hospitals to support programs of graduate medical education.

ELIGIBILITY CONDITIONS. Subsection (b) states the conditions under which an children's hospital will be eligible for a grant.

ANNUAL APPLICATION. The hospital must submit, by November 1, an application demonstrating that it is a children's hospital, and including an annual report, as described below, and such other information as the Secretary may require.

ANNUAL REPORT. The hospital must submit a report annually stating the number of full-time-equivalent medical residents it had participating in a residency training program in the previous fiscal year, computed in the same manner as is done under the Medicare provisions allowing hospitals to claim direct costs of graduate medical education. The report must also include such documentation as the Secretary may need to verify the hospital's asserted number and to resolve any discrepancy between the computations of resident numbers for this program and the number of residents reported for purposes of Medicare.

REPORTING CONCERNING MEDICAL RESIDENCY TRAINING PROGRAM. The hospital must report such other information as the Secretary may require regarding the medical residency program in which it participates.

SECRETARIAL REVIEW AND ADJUSTMENT OF NUMBERS OF FTE RESIDENTS. Subsection (c) allows the Secretary to adjust the number of residents as computed by the hospital, based on the hospital's reports or on audits. Before making any adjustment, the Secretary must provide notice and 30 days' opportunity to contest the

proposed adjustment.

GRANT PAYMENTS. Subsection (d) states the formula for the grant payment and prescribes the timing of the payment.

ANNUAL PAYMENT AMOUNT. The amount paid to an eligible hospital is determined by dividing the appropriation for the program among the eligible hospitals in proportion to each hospital's share of the total full-time-equivalent residents at all eligible hospitals.

ADJUSTMENT FOR PRIOR FISCAL YEAR. This annual amount may be adjusted if there was an overpayment or underpayment in a previous fiscal year.

DEFINITIONS. Subsection (e) defines terms as follows:

QUALIFIED CHILDREN'S HOSPITAL. A hospital is a "qualified children's hospital" if it is a hospital (as defined under Medicare) whose inpatients are predominantly under 18; it does not share a Medicare provider number with any other entity; it either participates in Medicare or is accredited by the Joint Commission on Accreditation of Health Care Organizations; and it participates in an approved medical residency training program.

APPROVED MEDICAL RESIDENCY TRAINING PROGRAM. A residency training program is considered approved under the same conditions as apply under the Medicare provisions for paying direct graduate medical education costs.

NUMBER OF FTE RESIDENTS. The number of full-time-equivalent residents in the training program is determined the same way as under Medicare.

AUTHORIZATION OF APPROPRIATIONS. Subsection (f) authorizes appropriations of \$40,000,000 for FY 2000, and such sums as necessary for each of FYs 2001 and 2002.

STUDY. Subsection (g) requires the Secretary to conduct a study of the effectiveness of the Act.

December 5, 1999

Bill Signing Ceremony for S. 580, the Healthcare Research and Quality Act of 1999

Date: December 6, 1999
Location: Oval Office
Time: 1:05 pm
From: Larry Stein

I. PURPOSE

To sign into law S.580, legislation that reauthorizes the Agency for Health Care Policy and research and establishes a new grant program to finance the cost associated with the training of pediatricians at children's hospitals. We are inviting representatives of the children's hospitals to join you at this signing, as they strongly believe that this is a landmark initiative that could not have passed without the Administration's support and the leadership of the First Lady.

II. BACKGROUND

S. 580 establishes within the Public Health Service an Agency for Healthcare Research and Quality to replace the current Agency for Health Care Policy and Research. This legislation also authorizes \$40 million for a new grant program providing graduate medical education funds to freestanding children's hospitals.

The Agency for Healthcare Research and Quality is designated as the lead agency to coordinate the Federal Quality Interagency Coordination (QuIC) Task Force and will be the recipient of an executive order signed by you on Tuesday, which directs the QuIC to report back, through the Vice President, recommendations to you within 60 days to improve health care quality through the prevention of medical errors and enhancements in patient safety. You may recall that you established the QuIC as part of a series of initiatives that followed the release of the quality commission report last year.

The creation of a new graduate medical education grant program was included as a priority in your FY 2000 budget at the encouragement of the First Lady and is a longstanding priority of the children's hospitals. In an increasingly competitive health care market dominated by managed care, teaching hospitals struggle to cover the significant costs associated with training and research as private reimbursements decline. Millions of American children each year are treated by physicians affiliated with or trained in one of 60 independent children's hospitals across the country. While other teaching hospitals receive support for these costs through Medicare, children's hospitals receive virtually no Federal funds, even though they train nearly 30 percent of the nation's pediatricians and nearly 50 percent of all pediatric specialists.

This inequity exacerbates an already difficult financial situation for children's hospitals who often serve the poorest, sickest and most vulnerable children. In many cases, they provide the regional safety net for children, regardless of medical or economic need, and they are the major centers of research on children's health problems. The creation of a new grant program for graduate medical education at children's hospitals is an important and long overdue first step towards addressing these inequities.

III. PARTICIPANTS

Pre-Brief

YOU

The First Lady

John Podesta

Chris Jennings

Larry Stein

Ceremony

YOU

The First Lady

Lawrence A. McAndrews, President of the National Association of Children's Hospitals

Ann Langley, Policy Consultant for the National Association of Children's Hospitals

Edwin K. Zechman, Jr., President and CEO of the Children's National Medical Center

David S. Weiner, President and CEO of Children's Hospital

Randall L. O'Donnell, Ph.D., President and CEO of Children's Mercy Hospital

IV. PRESS PLAN

Stills only.

V. SEQUENCE OF EVENTS

-- **YOU** greet guests.

-- **YOU** sign the bill.

-- Guests depart.

VI. REMARKS

None.

VII. ATTACHMENTS

Office of Management and Budget Enrolled Bill memorandum.

FIRST LADY HILLARY CLINTON UNVEILS NEW, \$40 MILLION PROGRAM TO SUPPORT GRADUATE MEDICAL EDUCATION AT FREESTANDING CHILDREN'S HOSPITALS

January 28, 1999

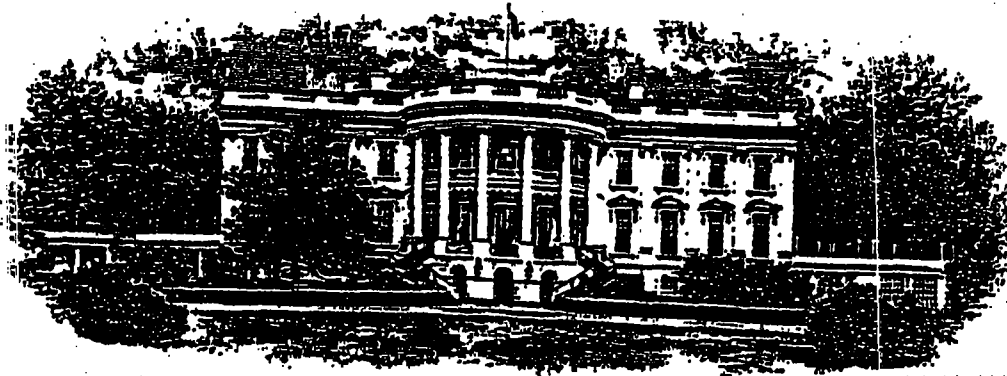
Today, First Lady Hillary Clinton unveiled a new, \$40 million program to support critical graduate medical education activities to ensure that America's physician workforce is trained to address children's special health care needs. These new funds would be used to provide freestanding children's hospitals, which play an essential role in the education of the nation's physicians, with \$40 million dollars for graduate medical education activities to be distributed on a per resident basis.

CURRENT INEQUITIES IN FEDERAL FUNDING

In an increasingly competitive health care market dominated by managed care, teaching hospitals struggle to cover the significant costs associated with training and research as private reimbursements decline. While other teaching hospitals receive support for these costs through Medicare, children's hospitals receive very little Medicare funding; teaching hospitals receive an average of \$76,000 in federal GME funding per resident, while children's hospitals receive an average of \$400 per resident. In addition, while some states have funded GME through Medicaid, most of those programs are ending as more states move to Medicaid managed care programs. These inequities exacerbate an already difficult financial situation for children's hospitals who often serve the poorest, sickest and most vulnerable children.

CRITICAL FINANCIAL SUPPORT FOR ESSENTIAL PROVIDERS

Today, the First Lady announced a new \$40 million program to address the pressing financial needs of children's hospitals. The President's FY 2000 budget proposes a new, \$40 million formula grant program that will provide freestanding children's hospitals with long overdue Federal financing for graduate medical education. Children's hospitals, who train 25 percent of pediatricians and over half of many pediatric subspecialists, will receive funds on a per resident basis. Hospitals will receive approximately \$9,380 per resident, for a total average payment of \$689,000 per hospital.



The White House
Office of Public Liaison

Barbara Woolley
Special Assistant to the President
Phone (202) 456-2930
Fax (202) 456-6218

Number of Pages (Including cover): 3

Date: 1-27-98

To: Jennifer Klein

Fax Number: 63878

Office Number: _____

Comments: Boos Seating Chart

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Ted Frey

James Anderson

Brock Nelson

Kimberly Cripe

Thomas Hansen, MD

Jon Vice

Larry Fleischmann, MD

Antonie Paap

Dennis Sexton

Patrick Magoon

J. D. Northway, MD

Calvin Bland

Ned Zechman, Jr.

DAVID Weiner

The First Lady

Sec. Shalala

West
Randall O'Donnell, PhD

Larry Gold

William Considine

Walter Noce, Jr.

Christopher Dawes

Doris Biester RN Ph

Gail Larson

Edmond Notebaert

Steve Worley

Robert Boanr, Jr.

Ronald Violi

Thomas Rozek

Robert Felter, MD

Treuman Katz

Margaret Perryman

**Please note, other
representatives of the
Children's Hospitals in
chairs around the room.



National Association of
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and Related Institutions

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this list

is complete

- IS 1 list OK

NACHRI

DATE: January 27, 1999

PAGES: 3 including cover

TO: Barbara Woolley / Jennifer Klein

FAX: 202-456-6682 / 202-456-2878

FROM: Melinda Lee

SUBJECT: List of Attendees for Meeting on Thursday, January 28, 1999

Here is the information Pete Willson asked me to fax to you.

I have put an "*" next to the Hospital Members, which include Larry McAndrews. The people who do not have an "*" next to their names are N.A.C.H. and NACHRI staff or outside parties.

If you have any questions, please give me a call.

456
202-456-2878
255

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Mr. Patrick Magoon, President and Chief Executive Officer, The Children's Memorial Hospital, Chicago, IL

Mr. Brock Nelson, Chief Executive Officer, Children's Hospitals and Clinics, Minneapolis, MN

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Ms. Margaret Perryman, President and Chief Executive Officer, Gillete Children's Specialty Healthcare, St. Paul, MN

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Mr. David S. Weiner, Chief Executive Officer, Children's Hospital, Boston, MA

Marilyn Yager, Director of Health Policy Development, Office of the Vice Chancellor for Health Affairs, Vanderbilt Children's Hospital, Nashville, TN

Mr. Lawrence A. McAndrews, President and Chief Executive Officer, National Association of Children's Hospitals and Related Institutions (NACHRI)

Mr. Walter W. Noce, Jr., President and Chief Executive Officer, Children's Hospital Los Angeles, Los Angeles, CA

Randall L. O'Donnell, Ph.D, President and Chief Executive Officer, The Children's Mercy Hospital, Kansas City, MO

Mr. Jon E. Vice, President and Chief Executive Officer, Children's Hospital of Wisconsin, Milwaukee, WI

Mr. Edward K. Zechman, Jr., President and Chief Executive Officer, Children's National Medical Center, Washington, DC

Ms. Blanche Moore, Director of Governmental Relations, Arkansas Children's Hospital, Little Rock, AR

J.D. Northway, M.D., President and Chief Executive Officer, Valley Children's Hospital, Madera, CA

Mr. Antonie H. Papp, President and Chief Executive Officer, Children's Hospital Oakland, Oakland, CA

Mr. Thomas M. Rozek, President and Chief Executive Officer, Miami Children's Hospital,
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Ronald Violi, Chief Executive Officer, Children's Hospital Pittsburgh, Pittsburgh, PA

Mr. Steve Worley, President and Chief Executive Officer, Children's Hospital, New Orleans, LA

Also attending are:

Ms. Ann Langley, N.A.C.H. Public Policy Consultant, Health Policy Strategies, Washington,
D.C.

Paul Hogan, Vice President and Economist, The Lewin Group, Fairfax, VA

Bruce Lesley, Director, Congressional Affairs, National Association of Children's Hospitals and
Related Institutions

Ms. Gillian Ray, Associate Director, Communications, National Association of Children's
Hospitals and Related Institutions

Peters (Pete) D. Wilson, Vice President, Public Policy, National Association of Children's
Hospitals and Related Institutions

January 27, 1999

**MEETING ON FUNDING FOR MEDICAL EDUCATION
AT CHILDREN'S HOSPITALS**

DATE:	January 28, 1999
TIME:	4:00 p.m.
LOCATION:	The Vice President's Ceremonial Office
FROM:	Jennifer Klein

I. PURPOSE

To announce the proposal in the President's fiscal year 2000 budget to create a new \$40 million grant program to provide federal financing for graduate medical education (GME) for freestanding children's hospitals.

II. BACKGROUND

You will meet with senior representatives of children's hospitals and will announce that the President's budget will include this new program to provide federal financing for graduate medical education for freestanding children's hospitals. Winning funding for medical education costs has been children's hospitals' highest legislative priority, and they are aware that this proposal is in the President's budget in large part because of you.

Funding for Graduate Medical Education for Children's Hospitals

FY 2000 Budget Proposal. The budget will include \$40 million in discretionary funding to provide grants to the 53 freestanding children's hospitals to support the costs of graduate medical education (GME). Children's hospitals would be paid on a per resident basis, and would receive approximately \$9,380 per resident, for a total average payment of \$689,000 per hospital. The amount they receive would be roughly equivalent to the portion of their direct medical education costs (approximately 42 percent) associated with providing care to Medicaid patients. Hospitals receiving grants would also be required to provide data to HHS on number of issues, including: financial status; the percentage of medical resident training taking place in ambulatory settings; and the percentage of patients served who are uninsured or living in poverty.

As you have long argued, children's hospitals across the country are in desperate need of this funding. In an increasingly competitive health care market dominated by managed care, teaching hospitals struggle to cover the significant costs associated with training and research as private reimbursements decline. While other teaching hospitals receive support for these costs through Medicare, children's hospitals receive very little Medicare funding; teaching hospitals receive an average of \$76,000 in federal GME funding per resident, while children's hospitals receive an average of \$400 per resident. In addition, while some states have funded GME through Medicaid, most of those programs are ending as more states move to Medicaid managed care

programs. These inequities exacerbate an already difficult financial situation for children's hospitals who often serve the poorest, sickest and most vulnerable children. This proposal is designed to address the current inequity.

Recent Legislation. The President's proposal is similar to the "Children's Hospitals Education and Research Act of 1998" introduced last year by Senators Kennedy, Bob Kerrey, Bond, Durbin, DeWine, and Moynihan, and Representatives Sherrod Brown, Nancy Johnson, and Greenwood. Senator Dodd and Representatives Stark, Dingell, and Moakley have also strongly supported this initiative.

Interaction with Larger Deliberations on Graduate Medical Education. The most likely criticism of this new program will be that it will signal the Administration's willingness to move federal support for graduate medical education out of Medicare and to provide only discretionary funding for it. However, we see this policy as simply an interim solution to the longstanding inequity in federal support.

Other Issues of Interest to Children's Hospitals

Children's Health Insurance Program (CHIP). Children's hospitals have long worked with us to reach out to families with children who are eligible for but unenrolled in Medicaid or CHIP. The Administration's FY 2000 budget includes \$1 billion over five years to fund state initiatives to expand enrollment, including simplifying enrollment systems, educating community volunteers, stationing eligibility workers in places like schools and child care centers, and conducting advertising campaigns. The Vice President has already announced the outline of this proposal, and the details will be unveiled with the President's budget.

Safety Net Proposal. The budget also includes \$1 billion over five years to help community health centers, rural health clinics, public hospitals, and academic health centers provide comprehensive, coordinated health care to the uninsured. This initiative could provide substantial investments in the health care infrastructure in over 100 communities, deliver nearly 3 million primary care visits to a total of 700,000 uninsured people, and deliver over 1 million inpatient and outpatient mental health or substance abuse treatments to more than 28,000 people.

III. PARTICIPANTS

- The First Lady
- Secretary Shalala
- Attached list of children's hospitals representatives. Also attached are the bios of Dr. Edwin (Ned) Zechman, President and CEO, Children's National Medical Center, and Dr. Rand O'Donnell, President and CEO, Children's Mercy Hospital.

NOTE: Senator Kennedy had wanted to come to this meeting. Because he was unable to attend, we asked his staff to sit in on the meeting.

IV. SEQUENCE OF EVENTS

- The First Lady opens, makes brief remarks, and introduces Secretary Shalala.
- Secretary Shalala makes brief remarks.
- The First Lady opens for discussion.

V. PRESS PLAN

Closed.

VI. REMARKS

Talking points provided by Jennifer Klein.

Medical Center (CNMC)



Edwin K. Zechman, Jr.

*President and
Chief Executive Officer*

Mr. Zechman joined the Executive Management Staff of Children's National Medicine Center in September 1994 as President and Chief Executive Officer. His experiences include holding the positions of President and Chief Executive Officer of the Children's Hospital of Pittsburgh, Executive Director of the Children's Hospital of Alabama, and Executive Director of the Children's Hospital of New Orleans. Mr. Zechman is a Fellow of the American College of Healthcare Executives and a member of the American Hospital Association. He received Bachelor of Science and Master of Education degrees from Shippensburg State College, and a Master of Science degree from Ohio State University. Mr. Zechman and wife, Denise, have two children.

Randall L. O'Donnell, Ph.D.

Dr. O'Donnell is President and Chief Executive Officer at Children's Mercy Hospital, Kansas City, Missouri. Previous positions included Associate Administrator, The Children's Hospital of Buffalo, and Chief Executive Officer, Arkansas Children's Hospital.

Dr. O'Donnell earned his bachelor's degree from California Lutheran College, Magna Cum Laude, 1973 and a Ph.D. in Hospital and Health Administration from The University of Iowa, 1977.

The Children's Mercy Hospital is a pediatric medical center which provides comprehensive and specialized services for children in Western Missouri and Eastern Kansas. In 1997, over 7,000 admissions were recorded. The hospital employs approximately 1,850 people. Children's Mercy is a major teaching affiliate of the University of Missouri-Kansas City School of Medicine.

Dr. O'Donnell is a member of the Children's Hospital Executive Council. He is an honorary board member of the Association for the Care of Children's Health and chairman of the ACCH Hospital Leadership Advisory Council. Dr. O'Donnell is a member of the Midwest Research Institute Board of Trustees. He is a former board member of the National Association of Children's Hospitals and Related Institutions and former Chairman, member of the Board of Directors and the Executive Committee of the Osmond Foundation/Children's Miracle Telethon, Salt Lake City.

January, 1998

THE WHITE OFFICE
Office of the Press Secretary

For Immediate Release

September 27, 1995

REMARKS BY FIRST LADY HILLARY RODHAM CLINTON
AT THE CIRCLE OF CARE CONFERENCE
THE NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND

MRS. CLINTON: Thank you very much. Doctor Varmus it is a pleasure as it always is for me and my family to be here at one of the premiere institutions that represents the vital partnership between our public and private sectors in this country. I appreciate very much what Scott Oki has said today, because it clearly and personally put forth the challenge that confronts this new and very important organization.

I am a great admirer and partisan of children's hospitals. I think they play an essential and vital role in our health care system. And when I first heard about the plans for this new organization, I was delighted and very hopeful that it would not only through its commitment to supporting these 19 children's hospitals make a difference to the giving of so many of you and others like you in our two countries, but that it would stand for the belief we share that children's hospitals must be preserved and strengthened.

I have, as many of you, experienced children's hospitals as a parent and know how well they serve in taking care of both our children and ourselves because of the family-oriented approach they take to health care.

I know from my experience on the board of the Arkansas Children's Hospital, what it takes to raise private funds in order to support the many functions that are not paid for through either private insurance or government support. It is only because of dedicated, concerned citizens like all of you, that these hospitals continue to lead in the research and treatment of children's diseases. They are also essential in the training of doctors and specialists to care for our children.

I also know that the continued existence of these children's hospitals, which we love and are devoted to, depends on government support -- support that appreciates the important differences that go into the treatment of children and adults.

It is fitting that this first Circle of Care conference is being held here at NIH, an institution that is synonymous with so much of the cutting edge medical research being done in the world.

It is a symbol of our government's historic commitment to medical research. Similarly, all of the physicians, the specialists who do research and work in the children's hospitals represented here, were able to develop their expertise and training because the federal government decided to help defray the costs of training these medical specialists more than twenty years ago.

It is precisely this commitment to medical research, to academic health centers, and to children's hospitals that is at risk in the current debate going on in our country over health care today.

It is a debate filled with statistics, policy statements, and budget numbers. But behind the charts and graphs and position papers, it is really a debate about our core values as Americans -- about what we believe in, how we define ourselves as a people, and how we envision our future.

Throughout our history, we have thought of ourselves as an American family -- a family whose greatest priority was our children. As Scott spoke so eloquently earlier, a family whose encircling love and support gave children the tools they needed to make their own way in the larger world.

And so we have always prided ourselves on our compassion and on the high expectations and aspirations we hold for our children and for ourselves as a people.

For decades, this has been the American way: to put people, especially children, first. And because we have adhered to the American way, the American Dream has stayed alive for generation after generation and our country has remained strong.

Today, we are losing a sense of ourselves as an American family. We are allowing ourselves to be torn apart, divided, put in competition with each other over resources.

As the traditional underpinnings of our larger family are undermined, individual families are being jeopardized.

Most parents in America, and I would add Canada, are working as hard as they can to be good parents. I have met with working men and women across our country over the last years. I know the sacrifices they make to put food on the table, pay the mortgage or rent, cover the medical bills, and instill an ethic of work

and responsibility in their children.

Of course, parents bear the primary responsibility for their children. But it is also true that as parents struggle against all the forces that work today -- the layoffs, the downsizing, the danger in the streets -- that they face challenges that they can not meet alone.

As the National Council of Catholic Bishops said in a pastoral letter in 1991 entitled, Putting Children First: "No government can love a child, and no policy can substitute for a family's care."

But at the same time, "Government can either support or undermine families as they cope with the moral, social, and economic stresses of caring for children."

Let's not fool ourselves. National policies -- whether they are about education, health care, work, or welfare -- are mirrored every day in the lives and experiences of our children.

And unfortunately, what is happening today is no less than a historic rejection of America's commitment to children.

Today, the social safety net known as Medicaid is being dismantled at breakneck pace. It is being dismantled with very little discussion and no real dialogue. Decisions are being made in haste -- not only about who pays for health care in America -- but about who gets health care and who doesn't.

We are all for balancing the budget; we are all for giving states greater flexibility to administer programs.

But as the President has said many times, there is a right way and a wrong way to get our economic house in order.

The wrong way is to cut health care coverage for millions of children, disabled citizens, and the poorest of older Americans -- all to finance a \$245 billion tax cut for the wealthiest families in our country.

Let's not confuse flexibility with what is really going on here. We are talking about unjustified and inexplicable cuts that will affect real people and institutions like the ones represented in this room.

Medicaid is the primary source of health care coverage for nearly a quarter of all children in America -- and one third of all children under age three. More than half of those children live in families with working parents -- parents who are not receiving welfare checks.

Medicaid is the primary source of health care coverage for millions of children who are disabled or who suffer from chronic illnesses -- the kinds of illnesses that children's hospitals can take care of better than anywhere else.

Medicaid is the primary source of health coverage for nine out of 10 children with HIV and AIDS.

Medicaid is the primary source of prenatal and maternal health care for low-income pregnant women.

Medicaid is also an important source of coverage for older Americans living in extreme poverty or with serious disabilities, and the largest insurer for over two-thirds of nursing home residents.

It is a lifeline -- literally -- for millions of children and families in America.

Ripping apart this lifeline is not the American way.

It is not the American way to deny infants the shots they need to stay healthy.

It is not the American way to deny treatment to children who are disabled or desperately ill.

It is not the American way to punish hard-working parents whose family health coverage vanishes with a job change.

The number of uninsured working Americans and their children continues to go up. For every extraordinary breakthrough here at NIH that finds, for example, the genetic marker for a disease, the threat of lost private health care coverage goes up. Because as we learn more about what causes the diseases that so many of you have helped us all to fight, we will find more and more people who under current standards are uninsurable.

It is not the American way to make the oldest among us give up their possessions and live a life of poverty to pay for a spouse's nursing home costs.

The median income for older American women over the age of 65 is less than \$9000. Many of them rely for their health care, especially in nursing homes where they are the predominant population, on Medicaid.

Cutting \$182 billion from the Medicaid program will force families to make grim choices -- choices between health care for their children or nursing home care for their parents; choices between education and vaccinations, between food and prescription drugs.

You of all people know it will also force grim choices for children's hospitals. Children's hospitals represent only one percent of all hospitals, but they provide vital health care services to many children -- including the poorest, sickest and the most vulnerable.

Like Bob, I am always moved when I go into a children's hospital anywhere. Moved by the combination of terrible tragedy and extraordinary challenge, and the love and attention and skill that goes into meeting those. I walk through halls, I visit the children, I talk to the parents, and I see in their eyes that feeling that finally they are in a place that will take care of them.

Children's hospitals devote nearly half of their care to children of low income and uninsured families and more than three-quarters of their care to children with chronic or congenital conditions.

I will never forget being in the children's hospital in Cleveland, talking to a group of parents with chronically ill children. One parent, himself a professional who ran a small business, provided health insurance to his own employees, told me about his own family -- he had a healthy older son and two daughters with cystic fibrosis. Everywhere he went to find health insurance he met the same answer: his daughters were uninsurable.

And finally, the very last broker he spoke to said something he couldn't get out of his mind, and I never have gotten out of mine. He looked at this father, and said, "What you don't understand is that we don't insure burning houses."

I thought to myself, were it not for that children's hospital, who would help this family take care of their children? And I thought what if I, in a similar position that there but for the grace of God my husband and I could be, had been told the same thing?

Children's hospitals care for the premature baby who needs intensive care for the first months of life and extensive rehabilitation for years to come; for the small child who is severely injured when hit by a car and sent to a pediatric intensive care unit.

They care for the eight year old boy who contracts encephalitis, loses his health insurance, and is covered by Medicaid because of his high medical costs and severe disabilities.

The proposed cuts in Medicaid will be particularly devastating for children's hospitals. Medicaid patients on

average account for 46 percent of the inpatient days in these hospitals.

As you know, it costs more to care for sick children than adults. And children's hospitals are not able to shift those higher costs to adult patients like other hospitals could, but maybe still now won't be able to.

Already Medicaid pays children's hospitals on average less than 80 cents for every dollar spent to care for a child. The impact of a \$182 billion cut in Medicaid is clear: children's hospitals simply will not be able to provide the crucial health services they do today.

And despite your heroic efforts to double the numbers over ten thousand, to increase that line going up as high and fast as you can, there is no way that private philanthropy can pick up this enormous gap.

We need to protect the safety net provided by children's hospitals. We need to make sure that our children continue to have access to desperately needed specialized care.

We need to be sure that those specialists are continued to be trained and that we pursue research in the prevention and treatment of childhood diseases.

As this health care debate continues in the weeks and months ahead, I hope that policy makers, whatever they are or wherever they are, begin to think about these issues not as partisans, but as parents.

I hope they will not get so wrapped up in statistics and policy papers and sound bites that they forget the most basic concern of all: the well-being of all of our children.

Many of you know from your own personal experience what it is like when your child is very sick. Nothing else in the world matters to you. Will your son or your daughter, your grandchild get better? Is the illness something that will pass or is it threatening? When you face that situation, you want answers and you need them.

As parents, we use our wisdom and knowledge to plan ahead for the health of our children. We try, if we're able to, to make sure they get the shots they need and to get them to eat right and to avoid exposing them to dangers. And when they do get sick, we try to get the treatment from doctors and nurses that they need.

But suddenly, when it comes time to legislate and make policy, good parental instincts retreat.

Would we ever say as parents that only one out of four of our own children could go to the doctor, or get a vaccination, or have a hearing test? Of course not. We would demand the right to take care of each one of them.

Would we ever say with our own child, that has spina bifida or cerebral palsy, that he or she no longer deserved treatment or would have to wait and suffer the cutbacks? Of course not. We would give up the summer vacation or trading in that old car so that our child's life could be as pain-free and fulfilling as possible.

But in a precipitous and even reckless attempt to meet fixed budget targets, we are now as a society doing things we would never do as parents. We are ratcheting back medical care to children and the most vulnerable. We are violating our most sacred duty and value: caring for our young.

How can we legislate what we would not approve of as parents? How can we feel secure because we can take care of our children, when there are children around us whose parents are working as hard as they know how, but can't have that same sense of security?

There is much that this organization can do, and I am delighted to help celebrate this opening because I see it as an opportunity not only for people of like minds and commitments to come together, and to raise additional funds that are always needed in our children's hospitals.

But I hope you will raise your voices as well. Those of you who have walked those corridors as I have, those of you who have sat in waiting rooms, those of you who have held the hands of parents who don't know what is happening to them and their children, those of you who have seen the look of relief on the faces of fathers who realize that they if they can't afford the entire care, will be taken care of in that children's hospital.

I hope you will raise your voices, so that all of us will speak loudly and clearly, that our children are not only our present and our future -- they are a test of our humanity and our faith. And each of us deserves to give them all that we can and by your support of children's hospital, you are saying, "We believe in children. Help us to make that belief a reality."

Thank you very much.

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Date: 1/27/99**FAX****Health Division**

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

To: **JEN KLEIN**

Fax:

Phone:

5-4929From: **BARBARA MENARD**(Phone: **REDACTED**)

Number of Pages (not including cover):

Subject:

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Children's Hospitals Graduate Medical Education Program

Authorizing Legislation - Legislation is being proposed.

	1998 <u>Actual</u> BA	1999 <u>Appropriation</u> BA	2000 <u>Estimate</u> BA	Increase or <u>Decrease</u> BA
BA	\$---	\$---	\$40,000,000	+\$40,000,000
FTE	--	--	12	+12

2000 Authorization.....Legislation is being proposed

Purpose and Method of Operation

The purpose of the Children's Hospitals Graduate Medical Education Program is to provide a more adequate level of support for health professions training in U.S. children's teaching hospitals that have a separate Medicare provider number ("free-standing" children's hospitals). Children's hospitals are statutorily defined under Medicare as those whose inpatients are predominantly under the age of 18. There are approximately 50 to 55 such hospitals. Under current statutory funding formulas, these hospitals receive very small amounts from Medicare for graduate medical education (GME) and other health professions training. Children's hospitals that share Medicare provider numbers with other teaching hospitals receive more typical amounts of GME support from Medicare.

This differential is a matter of increasing concern to children's teaching hospitals. As managed care organizations become increasingly unwilling to pay for GME, "free-standing" children's teaching hospitals are at a competitive disadvantage, in the absence of a similar level of support from Medicare that other hospitals receive, and are coming under increasing pressure to reduce their current level of residency training. The monies are intended to make the level of federal GME support more consistent with other teaching hospitals, including children's hospitals which share provider numbers with other teaching hospitals.

Moreover, many children's hospitals have negative operating margins, in part because they have unusually high proportions of Medicaid patients, and the lack of equitable support for GME compared with other teaching hospitals. Children's hospitals also provide uncompensated care; while not large, at four percent of patients nationally, these patients are increasing in proportion.

Payments will be determined by formula, based on a national per-resident amount with adjustments as appropriate. It will support training of resident physicians as defined by Medicare in both ambulatory and inpatient settings. Payment will be related to individual performance relative to the accomplishments of these hospitals as a group. In addition to performance outcome data, the following data elements will be collected from the grantee hospitals:

- Financial status of hospitals (operating margins)
- Percentage of residents' training that is supported in ambulatory settings
- Percentage of patients served living in poverty
- Percentage of uninsured patients
- Data on shortages (if any) of pediatric health care providers in the area of the facility

A goal of the program will be to increase the number of children with acute illnesses receiving appropriate care in their communities.

Outputs:

	<u>FY 1998</u> <u>Actual</u>	<u>FY 1999</u> <u>Appropriation</u>	<u>FY 2000</u> <u>Estimate</u>
Health outcome measures:	--	--	To be determined
- hospitalizations for ambulatory care sensitive conditions*			
- Health Plan Employer Data and Information Set (HEDIS) measures of performance**			
Education measures:	--	--	To be determined
- time spent and other education measures of continuity and community-based training			
Graduate outcome measures:	--	--	To be determined
- Graduates serving underserved populations			
- Graduates serving as primary care providers			

* Immunization-preventable conditions; congenital syphilis; grand mal status and other epileptic convulsions; severe ear, nose and throat infections; bacterial pneumonia; asthma; tuberculosis; cellulitis; diabetes; hypoglycemia; gastroenteritis; kidney/urinary infection; dehydration; iron deficiency anemia; nutritional deficiencies; and failure to thrive

** HEDIS measures include:

- childhood and adolescent immunization status
- children's access to primary care providers
- patient satisfaction
- well child and adolescent visits

The following are data from various sources about the number of residents in children's teaching hospitals:

- Medicare cost-report data from the most recent year, FY 1995, show a total of 3,458 residents; 2,823 FTEs when weighted for Medicare DME. However, the Medicare numbers are unaudited and may not be wholly accurate.
- Data from the Lewin Group suggest that there were 4,300 Medicare FTE-weighted residents, equivalent to approximately 4,700 total, in teaching children's hospitals in 1996. Their data showed that:
 - 2,662 residents were in general pediatrics and combined internal medicine-pediatrics programs sponsored by the hospitals
 - 813 were in pediatric subspecialty training
 - Their residency programs trained 29 percent of all general pediatric residents in the U.S.
 - Six percent of residents in these hospitals were international medical graduates
 - The "free-standing" children's teaching hospitals in the 1993 study trained 4,263 FTE residents for an average of 74.8 per hospital; these included both pediatric and non-pediatric residents

The residents training in children's hospitals represent four to five percent of all residents and is nearly one-half of the number of FTE residents supported by the Veterans Administration. This number is not far short of the number of OB/Gyn or of psychiatry residents in the U.S.

To prevent as much as a one-third decline in the 4,500 residents being trained in pediatric children's hospitals (Medicare supports approximately 35 percent of DME nationally), by supporting 1,500 residents.

To increase the number of FTE residents being trained in ambulatory settings (data are not available on the current distribution of training).

Medicare GME payments to children's hospitals since 1992 have been as follows:

Fiscal Year	Medicare GME Payments
1992	\$1.14 million
1993	\$1.18 million
1994	\$1.26 million
1995	\$1.33 million
1996	\$1.56 million

Rationale for the Budget Request

The FY 2000 request of \$40,000,000 from general revenues appropriations is an increase of \$40,000,000 over the FY 1999 appropriation. The increase will help make the level of support for GME in children's teaching hospitals more consistent with that received from Medicare by teaching hospitals that have higher proportions of Medicare patient days.

Medicare GME payment policy is designed to pay only Medicare's share of GME costs. Accordingly, all payers contribute to GME. However, only Medicare nationally and some state Medicaid programs explicitly identify support for GME. Other payers do not explicitly identify GME payment components. At the same time, although identified as GME support, Medicare GME funds go to hospital general revenues and may not necessarily be used for GME.

Discussion of GME support is usually framed by the Medicare GME payment system. Medicare payments are made up of:

- Direct medical education (DME) payments, paid as a per-resident amount determined individually for each teaching hospital based on:
 - the hospital's total 1983 DME costs trended forward, and
 - the proportion of Medicare to total patient-care days
- Indirect medical education payments, as a percentage added to the base payment for each Medicare patient admitted to the hospital; the percentage is determined individually for each hospital from the ratio of interns or residents per bed

Medicare's share of a hospital's total per-resident DME amount depends on the proportion of Medicare patient-days in that hospital, as noted above. However, Medicare patient days are virtually non-existent at most children's hospitals. Accordingly, "free-standing" children's teaching hospitals have only a minute percentage to factor into their Medicare DME payment. As a result, Medicare DME payments in 1993 (the latest year for which such estimates are available, in a study by the Lewin Group) to the "free-standing" hospitals averaged less than \$400 per resident annually.

In contrast, children's hospitals that share ownership and provider numbers with other teaching hospitals, are able to utilize the much higher Medicare patient-day proportion of the combined hospitals, to receive the more typical higher Medicare payments for DME. Children's teaching hospitals that shared a provider number with other teaching hospitals received a more typical \$23,600 per-resident, compared with \$400 received by the "free-standing" hospitals.

TEMPORARY ASSISTANCE IN FINANCING GRADUATE MEDICAL EDUCATION AT INDEPENDENT CHILDREN'S HOSPITALS

Program Goal: Finance temporary graduate medical education assistance at free-standing children's hospitals until comprehensive GME reform is completed.

Program Discretionary Budget / Timeline: \$40 million annually for three years. Authorization for program would sunset in FY 2002.

[Both H.R. 3855 (original sponsors: Reps Sherrod Brown, Nancy Johnson, & Jim Greenwood) and S. 2049 (original sponsors: Kerrey, Bond, Kennedy, Durbin DeWine, & Moynihan), which were introduced in the 105th Congress, called for an "interim solution" of 2-4 years of financing for Children's Hospitals until comprehensive GME reform could take place. Both of these proposals were endorsed by the National Association of Children's Hospitals and the Association of American Medical Colleges.]

*- Safety net | helping children
- Stability to institutions
- Supporting graduate medical education*

Structure:

- HRSA Competitive grant program with three-year grant awards.
- Grants would be referred to as partial payment for costs of training health professionals.
- 30 Grants of \$1.3 million each over three years, with an expectation of financing 15-20 FTE at each facility. [There were 55 Independent Children's Hospitals in 1998 - this will provide assistance to over half of that total.]
- No new grant solicitation or awards in year two or year three of the program. No agreement that non-funded grants in year one would be funded in year two or year three.

Criteria for Competitive Grants:

Required for successful grant application:

- Demonstrated financial need (including non-governmental funds). [Measured by an operating deficit of above the national average for teaching hospitals during the latest fiscal year.]
- Percentage of Medicaid patients served must be above the national average for children's hospitals (to target those hospitals which have a high low-income patient share.)

Preference would be given to applicants where:

- Hospital is in a health professions shortage area (HPSA).
- Majority of patients served living in poverty (possible measures: qualification

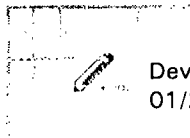
- for TANF, SSI, Medicaid.)
- Facility can demonstrate that states are not already reimbursing for GME costs through Medicaid.
- Demonstrated commitment to evaluating performance and measuring outcomes.
- State or facility matching grant commitment.

Performance Measure:

- Increase Number of children with acute illnesses receiving appropriate care in their communities.

Baseline:

HRSA will develop a baseline for this performance measure in FY 1999, against which this program can be managed when it is launched in FY 2000.



Devorah R. Adler
01/26/99 12:53:01 PM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP

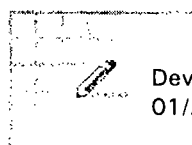
cc:

Subject: gme information for speechwriting -- okay?

This proposal would create a new, \$40 million formula grant program through the Public Health Service to provide freestanding children's hospitals with Federal financing for graduate medical education. Children's hospitals will be paid on a per resident basis to support their graduate medical education programs.

This grant program would be administered by the the Health Resources and Services Administration (HRSA). HRSA presently administers a number of different formula grant programs associated with graduate medical education, including the Professional Nurse Traineeships (\$15.5 million), the Health Education and Training Centers (\$3 million), Public Health Traineeships (\$2.3 million), and the Nurse Anesthetists Traineeship (\$1.3 million).

Each grantee will be required to submit information on their financial status; the percentage of residents' training supported that is in ambulatory settings; the percentage of patients served living in poverty; the percentage of patients they serve that are uninsured; and information on shortages (if any) of pediatric health care providers in the area of the facility.



Devorah R. Adler
01/27/99 09:37:06 AM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP

cc:

Subject: if you need problem statement

here is some information

The Federal government has traditionally provided teaching hospitals with financial support for graduate medical education. Care in teaching hospitals is generally recognized as costlier than similar care provided in non-teaching facilities, because the inefficiencies associated with inexperience and a sicker patient population. Because a competitive health care market dominated by managed care is often unwilling to assume the costs of graduate medical education, the Federal government has assumed a portion of the cost of these training activities. These medical education payments allow teaching hospitals to maintain their academic mission without jeopardizing their financial health.

Freestanding children's hospitals train the majority of essential pediatric providers. The children's hospitals play an essential role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists. Since there are physician shortages in some areas of pediatric subspecialty care, these hospitals are critical to maintaining an adequate practitioner supply.

Although children's hospitals share the academic mission of other teaching hospitals, they are denied a commensurate level of Federal support. The current system of Federal reimbursement for graduate medical education is dependant on the number of Medicare patients seen, creating a significant competitive disadvantage for children's hospitals. Teaching hospitals receive an average of \$76,000 in Federal GME funding per resident, as opposed to the \$400 per resident recieved by children's hospitals.

Alternate sources of GME financing are ending. Children's hospitals in some States receive GME funding through the Medicaid program. However, as more States move to Medicaid managed care programs, Medicaid is no longer a viable source of funding for these providers.

Children's hospitals sustain significant financial losses because of their GME activities. Despite the fact that children's hospitals maintain a significant pediatric

market share, their patient care revenues are falling short of covering their patient care costs. Children's hospitals operating margins are -6.2 percent, as opposed to -3.9 percent for other teaching hospitals. A significant percentage of this loss is attributable to unreimbursed GME costs, which run in the millions of dollars per year per hospital.

Some children's hospitals are financially vulnerable. The inequity in Federal financing forces children's hospitals to depend on non-patient care revenue to a greater extent than other teaching hospitals. Children's hospitals receive almost 15 percent of their total funding from revenues unrelated to patient care. Other teaching hospitals only receive 8.6 percent of their revenue from these sources. This makes children's hospitals more vulnerable to an economic downturn that could threaten their financial health.

IMPROVING ACCESS FOR UNINSURED WORKERS

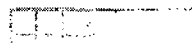
This initiative invests \$1 billion over 5 years in comprehensive health care delivery systems that address the needs of the 32 million adult Americans that are still without health insurance. This program would provide funds to public and private entities to enhance the ability of providers that traditionally provide services to the uninsured to provide comprehensive, coordinated health care to a greater number of uninsured people. Funds would be available to assist communities and community based providers to develop and expand integrated systems that will coordinate delivery of care to uninsured, and to provide additional health care services which address service gaps within integrated systems so that a greater number of uninsured people have access to a continuum of core health care services.

- **Development of financial, information, and telecommunication systems.** Networks could receive funds to develop the financial, information, and telecommunication systems that are necessary to appropriately monitor and manage patient needs. This support will improve the efficiency and effectiveness of service delivery within the safety net, permitting more clients to be served with existing resources and strengthening the financial standing of the safety net providers by enhancing their ability to compete for business from Medicaid and commercial managed care arrangements.
- **Providing additional services to the uninsured.** The initiative would also target substantial funding towards service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the focus will be on expanding access to primary health care and assuring that it is coordinated with other health care including mental health / substance abuse service needs.
- **Grants will be awarded to a variety of different grantees.** Grants will be available to public or private entities. An important goal of the program is to encourage local public officials to work closely with providers of care to better coordinate service delivery and establish accountability within the system for assuring adequate patient care. Applicants will be expected to demonstrate how clients will be provided with a continuum of core health care services and link primary, specialty, and tertiary care. Applicants will also be required to document existing funding and resources and demonstrate that new funds will be used to supplement and not supplant existing resources.

This initiative has the potential to make substantial infrastructure investments in over 100 communities, deliver nearly 3 million primary care visits to a total of 700,000 uninsured people, and deliver over 1 million inpatient and outpatient mental health or substance abuse treatments to a cumulative total of more than

28,000 uninsured people.

In addition to these direct impacts, the initiative will improve the efficiency and effectiveness of service delivery to uninsured patients and produce savings that can be used to expand the number of clients served. One community that has moved to integrate its indigent care services estimated a 5 percent savings in clinical services and a 20 percent savings in inpatient services. If other communities can achieve comparable savings, hundreds of thousands of uninsured people could be served due to the efficiencies produced under this initiative.



Jeanne Lambrew
01/27/99 12:04:46 PM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP

cc:

Subject: Re: 

No -- it includes direct medical education (DME) and indirect medical education (IME).

Medicare and, to a much lesser extent, Medicaid have played a key role in financing GME. Direct graduate medical education (DGME) covers Medicare's share of costs directly associated with operating resident training programs (e.g., salaries, fringe benefits). Medicare's Part A DGME payments are estimated to be \$2.56 billion in federal fiscal year (FY) 1998. The second component of Medicare's GME payments recognizes the indirect costs of graduate medical education (IME), including the more expensive practice pattern associated with teaching programs. The IME adjustment is a percentage add-on to the hospital's Medicare payment. Medicare IME payments are estimated to be \$5.3 billion in FY 1998. Over five years (FY 1999-2003), the HCFA Actuary estimates that Medicare Part A spending on direct and indirect medical education will be about \$42 billion. In addition to the Part A payment for DGME, a portion of Medicare's payments to hospitals for DGME is from Part B. DGME payments from Part B are estimated to be roughly \$360 million for FY 1998, and roughly \$2 billion over five years (FY1999-2003). GME is projected to represent 3.8% of total Medicare benefits in FY1998.

OFFICE OF THE FIRST LADY

Ann Langley

Jennifer Klein

PHONE #

OF PAGES (including cover)

COMMENTS

FY 2000 Budget Proposal. The budget will include \$40 million in discretionary funding to provide grants to the 53 freestanding children's hospitals to support the costs of graduate medical education (GME). Children's hospitals would be paid on a per resident basis, and would receive approximately \$9,380 per resident, for a total average payment of \$689,000 per hospital. The funding is roughly equivalent to the portion of these hospitals' direct medical education costs (approximately 42 percent) associated with providing care to Medicaid patients. Hospitals receiving grants would also be required to provide data to HHS on number of issues, including: financial status; the percentage of medical resident training taking place in ambulatory settings; and the percentage of patients served who are uninsured or living in poverty.

105TH CONGRESS
2D SESSION

S. 2049

To provide for payments to children's hospitals that operate graduate medical education programs.

IN THE SENATE OF THE UNITED STATES

MAY 7, 1998

Mr. KERREY (for himself, Mr. BOND, Mr. DURBIN, Mr. KENNEDY, Mr. DEWINE, and Mr. MOYNIHAN) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide for payments to children's hospitals that operate graduate medical education programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Children's Hospitals
5 Education and Research Act of 1998".

6 **SEC. 2. PROGRAM OF PAYMENTS TO CHILDREN'S HOS-**
7 **PITALS THAT OPERATE GRADUATE MEDICAL**
8 **EDUCATION PROGRAMS.**

9 (a) PAYMENTS.—

1 (1) IN GENERAL.—The Secretary shall make
2 payment under this section to each children's hos-
3 pital for each hospital cost reporting period begin-
4 ning after fiscal year 1998 and before fiscal year
5 2003 for the direct and indirect expenses associated
6 with operating approved medical residency training
7 programs.

8 (2) CAPPED AMOUNT.—The payment to chil-
9 dren's hospitals established in this subsection for
10 cost reporting periods ending in a fiscal year is lim-
11 ited to the extent of funds appropriated under sub-
12 section (d) for that fiscal year.

13 (3) PRO RATA REDUCTIONS.—If the Secretary
14 determines that the amount of funds appropriated
15 under subsection (d) for cost reporting periods end-
16 ing in a fiscal year is insufficient to provide the total
17 amount of payments otherwise due for such periods,
18 the Secretary shall reduce the amount payable under
19 this section for such period on a pro rata basis to
20 reflect such shortfall.

21 (b) AMOUNT OF PAYMENT.—

22 (1) IN GENERAL.—The amount payable under
23 this section to a children's hospital for direct and in-
24 direct expenses relating to approved medical resi-

1 dency training programs for a cost reporting period
2 is equal to the sum of—

3 (A) the product of—

4 (i) the per resident rate for direct
5 medical education, as determined under
6 paragraph (2), for the cost reporting pe-
7 riod; and

8 (ii) the weighted average number of
9 full-time equivalent residents in the hos-
10 pital's approved medical residency training
11 programs (as determined under section
12 1886(h)(4) of the Social Security Act) for
13 the cost reporting period; and

14 (B) the product of—

15 (i) the per resident rate for indirect
16 medical education, as determined under
17 paragraph (3), for the cost reporting pe-
18 riod; and

19 (ii) the number of full-time equivalent
20 residents in the hospital's approved medi-
21 cal residency training programs for the
22 cost reporting period.

23 (2) PER RESIDENT RATE FOR DIRECT MEDICAL
24 EDUCATION.—

1 (A) IN GENERAL.—The per resident rate
2 for direct medical education for a hospital for
3 a cost reporting period ending in or after fiscal
4 year 1999 is the updated rate determined under
5 subparagraph (B), as adjusted for the hospital
6 under subparagraph (C).

7 (B) COMPUTATION OF UPDATED RATE.—
8 The Secretary shall—

9 (i) compute a base national DME av-
10 erage per resident rate equal to the aver-
11 age of the per resident rates computed
12 under section 1886(h)(2) of the Social Se-
13 curity Act for cost reporting periods end-
14 ing during fiscal year 1998; and

15 (ii) update such rate by the applicable
16 percentage increase determined under sec-
17 tion 1886(b)(3)(B)(i) of such Act for the
18 fiscal year involved.

19 (C) ADJUSTMENT FOR VARIATIONS IN
20 LABOR-RELATED COSTS.—The Secretary shall
21 adjust for each hospital the portion of such up-
22 dated rate that is related to labor and labor-re-
23 lated costs to account for variations in wage
24 costs in the geographic area in which the hos-
25 pital is located using the factor determined

1 under section 1886(d)(3)(E) of the Social Secu-
2 rity Act.

3 (3) PER RESIDENT RATE FOR INDIRECT MEDI-
4 CAL EDUCATION.—

5 (A) IN GENERAL.—The per resident rate
6 for indirect medical education for a hospital for
7 a cost reporting period ending in or after fiscal
8 year 1999 is the updated amount determined
9 under subparagraph (B).

10 (B) COMPUTATION OF UPDATED
11 AMOUNT.—The Secretary shall—

12 (i) determine, for each hospital with a
13 graduate medical education program which
14 is paid under section 1886(d) of the Social
15 Security Act, the amount paid to that hos-
16 pital pursuant to section 1886(d)(5)(B) of
17 such Act for the equivalent of a full twelve-
18 month cost reporting period ending during
19 the preceding fiscal year and divide such
20 amount by the number of full-time equiva-
21 lent residents participating in its approved
22 residency programs and used to calculate
23 the amount of payment under such section
24 in that cost reporting period;

(ii) take the sum of the amounts determined under clause (i) for all the hospitals described in such clause and divide that sum by the number of hospitals so described; and

(iii) update the amount computed under clause (ii) for a hospital by the applicable percentage increase determined under section 1886(b)(3)(B)(i) of such Act for the fiscal year involved.

(c) MAKING OF PAYMENTS.—

(1) INTERIM PAYMENTS.—The Secretary shall estimate, before the beginning of each cost reporting period for a hospital for which a payment may be made under this section, the amount of payment to be made under this section to the hospital for such period and shall make payment of such amount, in 26 equal interim installments during such period.

(2) FINAL PAYMENT.—At the end of each such period, the hospital shall submit to the Secretary such information as the Secretary determines to be necessary to determine the final payment amount due under this section for the hospital for the period. Based on such determination, the Secretary shall recoup any overpayments made, or pay any

1 balance due. The final amount so determined shall
2 be considered a final intermediary determination for
3 purposes of applying section 1878 of the Social Se-
4 curity Act and shall be subject to review under that
5 section in the same manner as the amount of pay-
6 ment under section 1886(d) is subject to review
7 under such section.

8 (d) LIMITATION ON EXPENDITURES.—

9 (1) IN GENERAL.—Subject to paragraph (2),
10 there are hereby appropriated, out of any money in
11 the Treasury not otherwise appropriated, for pay-
12 ments under this section for cost reporting periods
13 beginning in—

14 (A) fiscal year 1999 \$100,000,000;

15 (B) fiscal year 2000, \$285,000,000;

16 (C) fiscal year 2001, \$285,000,000; and

17 (D) fiscal year 2002, \$285,000,000.

18 (2) CARRYOVER OF EXCESS.—If the amount of
19 payments under this section for cost reporting peri-
20 ods ending in fiscal year 1999, 2000, or 2001 is less
21 than the amount provided under this subsection for
22 such payments for such periods, then the amount
23 available under this subsection for cost reporting pe-
24 riods ending in the following fiscal year shall be in-
25 creased by the amount of such difference.

1 (e) RELATION TO MEDICARE AND MEDICAID PAY-
2 MENTS.—Notwithstanding any other provision of law,
3 payments under this section to a hospital for a cost report-
4 ing period—

5 (1) are in lieu of any amounts otherwise pay-
6 able to the hospital under section 1886(h) or
7 1886(d)(5)(B) of the Social Security Act to the hos-
8 pital for such cost reporting period, but

9 (2) shall not affect the amounts otherwise pay-
10 able to such hospitals under a State medicaid plan
11 under title XIX of such Act.

12 (f) DEFINITIONS.—In this section:

13 (1) APPROVED MEDICAL RESIDENCY TRAINING
14 PROGRAM.—The term “approved medical residency
15 training program” has the meaning given such term
16 in section 1886(h)(5)(A) of the Social Security Act
17 (42 U.S.C. 1395ww(h)(5)(A)).

18 (2) CHILDREN’S HOSPITAL.—The term “chil-
19 dren’s hospital” means a hospital described in sec-
20 tion 1886(d)(1)(B)(iii) of the Social Security Act
21 (42 U.S.C. 1395ww(d)(1)(B)(iii)).

22 (3) DIRECT GRADUATE MEDICAL EDUCATION
23 COSTS.—The term “direct graduate medical edu-
24 cation costs” has the meaning given such term in

1 section 1886(h)(5)(C) of the Social Security Act (42
2 U.S.C. 1395ww(h)(5)(C)).

3 (4) SECRETARY.—The term “Secretary” means
4 the Secretary of Health and Human Services.

○

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IN THE SENATE OF THE UNITED STATES
AS INTRODUCED IN THE SENATE****S. 2049****1998 S. 2049; 105 S. 2049****Retrieve Bill Tracking Report****SYNOPSIS:**

A BILL To provide for payments to children's hospitals that operate graduate medical education programs.

DATE OF INTRODUCTION: MAY 7, 1998**DATE OF VERSION: MAY 11, 1998 -- VERSION: 1****SPONSOR(S):**

Mr. KERREY (FOR HIMSELF, MR. BOND, MR. DURBIN, MR. KENNEDY, MR. DEWINE, AND MR. MOYNIHAN) introduced the following bill; which was read twice and referred to the Committee on Finance

TEXT:

* Be it enacted by the Senate and House of Representatives of the United*
* States of America in Congress assembled, *

SECTION 1. SHORT TITLE.

This Act may be cited as the "Children's Hospitals Education and Research Act of 1998".

SEC. 2. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

(a) PAYMENTS.

(1) IN GENERAL.-THE SECRETARY SHALL MAKE PAYMENT UNDER THIS SECTION TO EACH CHILDREN'S HOSPITAL FOR EACH HOSPITAL COST REPORTING PERIOD BEGINNING AFTER FISCAL YEAR 1998 AND BEFORE FISCAL YEAR 2003 FOR THE DIRECT AND INDIRECT EXPENSES ASSOCIATED WITH OPERATING APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.

(2) CAPPED AMOUNT.-THE PAYMENT TO CHILDREN'S HOSPITALS ESTABLISHED IN THIS SUBSECTION FOR COST REPORTING PERIODS ENDING IN A FISCAL YEAR IS LIMITED TO THE EXTENT OF FUNDS APPROPRIATED UNDER SUBSECTION (D) FOR THAT FISCAL YEAR.

(3) PRO RATA REDUCTIONS.-IF THE SECRETARY DETERMINES THAT THE AMOUNT OF FUNDS APPROPRIATED UNDER SUBSECTION (D) FOR COST REPORTING PERIODS ENDING IN A FISCAL YEAR IS INSUFFICIENT TO PROVIDE THE TOTAL AMOUNT OF PAYMENTS OTHERWISE DUE FOR SUCH PERIODS, THE SECRETARY SHALL REDUCE THE AMOUNT PAYABLE UNDER THIS SECTION FOR SUCH PERIOD ON A PRO RATA BASIS TO REFLECT SUCH SHORTFALL.

(B) AMOUNT OF PAYMENT.

(1) IN GENERAL.-THE AMOUNT PAYABLE UNDER THIS SECTION TO A CHILDREN'S HOSPITAL FOR DIRECT AND INDIRECT EXPENSES RELATING TO APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS FOR A COST REPORTING PERIOD IS EQUAL TO THE SUM OF-

(A) THE PRODUCT OF-

(I) THE PER RESIDENT RATE FOR DIRECT MEDICAL EDUCATION, AS DETERMINED UNDER PARAGRAPH (2), FOR THE COST REPORTING PERIOD; AND

(II) THE WEIGHTED AVERAGE NUMBER OF FULL-TIME EQUIVALENT RESIDENTS IN THE HOSPITAL'S APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS (AS DETERMINED UNDER SECTION 1886(H)(4) OF THE SOCIAL SECURITY ACT) FOR THE COST REPORTING PERIOD; AND

(B) THE PRODUCT OF-

(I) THE PER RESIDENT RATE FOR INDIRECT MEDICAL EDUCATION, AS DETERMINED UNDER PARAGRAPH (3), FOR THE COST REPORTING PERIOD; AND

(II) THE NUMBER OF FULL-TIME EQUIVALENT RESIDENTS IN THE HOSPITAL'S APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS FOR THE COST REPORTING PERIOD.

(2) PER RESIDENT RATE FOR DIRECT MEDICAL EDUCATION.

(A) IN GENERAL.-THE PER RESIDENT RATE FOR DIRECT MEDICAL EDUCATION FOR A HOSPITAL FOR A COST REPORTING PERIOD ENDING IN OR AFTER FISCAL YEAR 1999 IS THE UPDATED RATE DETERMINED UNDER SUBPARAGRAPH (B), AS ADJUSTED FOR THE HOSPITAL UNDER SUBPARAGRAPH (C).

(B) COMPUTATION OF UPDATED RATE.-THE SECRETARY SHALL-

(I) COMPUTE A BASE NATIONAL DME AVERAGE PER RESIDENT RATE EQUAL TO THE AVERAGE OF THE PER RESIDENT RATES COMPUTED UNDER SECTION 1886(H)(2) OF THE SOCIAL SECURITY ACT FOR COST REPORTING PERIODS ENDING DURING FISCAL YEAR 1998; AND

(II) UPDATE SUCH RATE BY THE APPLICABLE PERCENTAGE INCREASE DETERMINED UNDER SECTION 1886(B)(3)(B)(I) OF SUCH ACT FOR THE FISCAL YEAR INVOLVED.

(C) ADJUSTMENT FOR VARIATIONS IN LABOR-RELATED COSTS.-THE SECRETARY SHALL ADJUST FOR EACH HOSPITAL THE PORTION OF SUCH UPDATED RATE THAT IS RELATED TO LABOR AND LABOR-RELATED COSTS TO ACCOUNT FOR VARIATIONS IN WAGE COSTS IN THE GEOGRAPHIC AREA IN WHICH THE HOSPITAL IS LOCATED USING THE FACTOR DETERMINED UNDER SECTION 1886(D)(3)(E) OF THE SOCIAL SECURITY ACT.

(3) PER RESIDENT RATE FOR INDIRECT MEDICAL EDUCATION.-

(A) IN GENERAL.-THE PER RESIDENT RATE FOR INDIRECT MEDICAL EDUCATION FOR A HOSPITAL FOR A COST REPORTING PERIOD ENDING IN OR AFTER FISCAL YEAR 1999 IS THE UPDATED AMOUNT DETERMINED UNDER SUBPARAGRAPH (B).

(B) COMPUTATION OF UPDATED AMOUNT.-THE SECRETARY SHALL-

(I) DETERMINE, FOR EACH HOSPITAL WITH A GRADUATE MEDICAL EDUCATION PROGRAM WHICH IS PAID UNDER SECTION 1886(D) OF THE SOCIAL SECURITY ACT, THE AMOUNT PAID TO THAT HOSPITAL PURSUANT TO SECTION 1886(D)(5)(B) OF SUCH ACT FOR THE EQUIVALENT OF A FULL TWELVE-MONTH COST REPORTING PERIOD ENDING DURING THE PRECEDING FISCAL YEAR AND DIVIDE SUCH AMOUNT BY THE NUMBER OF FULL-TIME EQUIVALENT RESIDENTS PARTICIPATING IN ITS APPROVED RESIDENCY PROGRAMS AND USED TO CALCULATE THE AMOUNT OF PAYMENT UNDER SUCH SECTION IN THAT COST REPORTING PERIOD;

(II) TAKE THE SUM OF THE AMOUNTS DETERMINED UNDER CLAUSE (I) FOR ALL THE HOSPITALS DESCRIBED IN SUCH CLAUSE AND DIVIDE THAT SUM BY THE NUMBER OF HOSPITALS SO DESCRIBED; AND

(III) UPDATE THE AMOUNT COMPUTED UNDER CLAUSE (II) FOR A HOSPITAL BY THE APPLICABLE PERCENTAGE INCREASE DETERMINED UNDER SECTION 1886(B)(3)(B)(I) OF SUCH ACT FOR THE FISCAL YEAR INVOLVED.

(C) MAKING OF PAYMENTS.-

(1) INTERIM PAYMENTS.-THE SECRETARY SHALL ESTIMATE, BEFORE THE BEGINNING OF EACH COST REPORTING PERIOD FOR A HOSPITAL FOR WHICH A PAYMENT MAY BE MADE UNDER THIS SECTION, THE AMOUNT OF PAYMENT TO BE MADE UNDER THIS SECTION TO THE HOSPITAL FOR SUCH PERIOD AND SHALL MAKE PAYMENT OF SUCH AMOUNT, IN 26 EQUAL INTERIM INSTALLMENTS DURING SUCH PERIOD.

(2) FINAL PAYMENT.-AT THE END OF EACH SUCH PERIOD, THE HOSPITAL SHALL SUBMIT TO THE SECRETARY SUCH INFORMATION AS THE SECRETARY DETERMINES TO BE NECESSARY TO DETERMINE THE FINAL PAYMENT AMOUNT DUE UNDER THIS SECTION FOR THE HOSPITAL FOR THE PERIOD. BASED ON SUCH DETERMINATION, THE SECRETARY SHALL RECOUP ANY OVERPAYMENTS MADE, OR PAY ANY

balance due. The final amount so determined shall be considered a final intermediary determination for purposes of applying section 1878 of the Social Security Act and shall be subject to review under that section in the same manner as the amount of payment under section 1886(d) is subject to review under such section.

(d) LIMITATION ON EXPENDITURES.-

(1) IN GENERAL.-SUBJECT TO PARAGRAPH (2), THERE ARE HEREBY APPROPRIATED, OUT OF ANY MONEY IN THE TREASURY NOT OTHERWISE APPROPRIATED, FOR PAYMENTS UNDER THIS SECTION FOR COST REPORTING PERIODS BEGINNING IN-

- (A) FISCAL YEAR 1999 \$100,000,000;
- (B) FISCAL YEAR 2000, \$285,000,000;
- (C) FISCAL YEAR 2001, \$285,000,000; AND
- (D) FISCAL YEAR 2002, \$285,000,000.

(2) CARRYOVER OF EXCESS.-IF THE AMOUNT OF PAYMENTS UNDER THIS SECTION FOR COST REPORTING PERIODS ENDING IN FISCAL YEAR 1999, 2000, OR 2001 IS LESS THAN THE AMOUNT PROVIDED UNDER THIS SUBSECTION FOR SUCH PAYMENTS FOR SUCH PERIODS, THEN THE AMOUNT AVAILABLE UNDER THIS SUBSECTION FOR COST REPORTING PERIODS ENDING IN THE FOLLOWING FISCAL YEAR SHALL BE INCREASED BY THE AMOUNT OF SUCH DIFFERENCE.

(E) RELATION TO MEDICARE AND MEDICAID PAYMENTS.-NOTWITHSTANDING ANY OTHER PROVISION OF LAW, PAYMENTS UNDER THIS SECTION TO A HOSPITAL FOR A COST REPORTING PERIOD-

(1) ARE IN LIEU OF ANY AMOUNTS OTHERWISE PAYABLE TO THE HOSPITAL UNDER SECTION 1886(H) OR 1886(D)(5)(B) OF THE SOCIAL SECURITY ACT TO THE HOSPITAL FOR SUCH COST REPORTING PERIOD, BUT

(2) SHALL NOT AFFECT THE AMOUNTS OTHERWISE PAYABLE TO SUCH HOSPITALS UNDER A STATE MEDICAID PLAN UNDER TITLE XIX OF SUCH ACT.

(F) DEFINITIONS.-IN THIS SECTION:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.-THE TERM "APPROVED MEDICAL RESIDENCY TRAINING PROGRAM" HAS THE MEANING GIVEN SUCH TERM IN SECTION 1886(H)(5)(A) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395WW(H)(5)(A)).

(2) CHILDREN'S HOSPITAL.-THE TERM "CHILDREN'S HOSPITAL" MEANS A HOSPITAL DESCRIBED IN SECTION 1886(D)(1)(B)(III) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395WW(D)(1)(B)(III)).

(3) DIRECT GRADUATE MEDICAL EDUCATION COSTS.-THE TERM "DIRECT GRADUATE MEDICAL EDUCATION COSTS" HAS THE MEANING GIVEN SUCH TERM IN SECTION 1886(H)(5)(C) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395WW(H)(5)(C)).

(4) SECRETARY.-THE TERM "SECRETARY" MEANS THE SECRETARY OF HEALTH AND HUMAN SERVICES.

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Bill Tracking Report

105th Congress
2nd Session

U. S. Senate

S 2049

1998 Bill Tracking S. 2049; 105 Bill Tracking S. 2049

CHILDREN'S HOSPITALS EDUCATION AND RESEARCH ACT OF 1998

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DATE-INTRO: May 7, 1998

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LAST-ACTION-DATE: May 7, 1998

Bill Tracking Report

STATUS: Pending

105th Congress
2nd Session

SPONSOR: Senator J. Robert Kerrey D-NE

U. S. Senate

S 2049

TOTAL-COSPONSORS: 18 Cosponsors: 13 Democrats / 5 Republicans

1998 Bill Tracking S. 2049; 105 Bill Tracking S. 2049

CHILDREN'S HOSPITALS EDUCATION AND RESEARCH ACT OF 1998

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SYNOPSIS: A BILL To provide for payments to children's hospitals that operate graduate medical education programs.

ACTIONS:

Committee Referrals:

05/07/1998 Senate Committee on Finance

Legislative Chronology:

1st Session Activity:

2nd Session Activity:

05/07/1998 144 Cong Rec S 4528

Referred to the Senate Committee on Finance

05/07/1998 144 Cong Rec S 4535

Remarks by Sen. KERREY, J ROBERT (D-NE)

05/07/1998 144 Cong Rec S 4537

Remarks by Sen. BOND, CHRISTOPHER S (R-MO)

05/07/1998 144 Cong Rec S 4538

Remarks by Sen. KENNEDY, EDWARD M (D-MA)

05/07/1998 144 Cong Rec S 4538

Remarks by Sen. MOYNIHAN, DANIEL PATRICK (D-NY)

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Moynihan D-NY

Durbin D-IL

Added 06/04/1998:

Cleland D-GA

Added 06/11/1998:

Graham D-FL

Mack R-FL

Added 06/26/1998:

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Added 07/07/1998:

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105TH CONGRESS
2D SESSION

H. R. 3855

To provide for payments to children's hospitals that operate graduate medical education programs.

IN THE HOUSE OF REPRESENTATIVES

MAY 13, 1998

Mr. BROWN of Ohio (for himself, Mrs. JOHNSON of Connecticut, and Mr. GREENWOOD) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for payments to children's hospitals that operate graduate medical education programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; FINDINGS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Children's Hospitals Education and Research Act of
6 1998”.

7 (b) **FINDINGS.**—Congress finds the following:

1 (1) Freestanding children's teaching hospitals
2 receive almost no Federal graduate medical edu-
3 cation funding.

4 (2) Increasingly, Federal graduate medical edu-
5 cation funding, through the medicare program, has
6 become the major source of support for the academic
7 missions of all teaching hospitals as the medical
8 marketplace has led to a growing inability to gain
9 such support from other payers.

10 (3) With few medicare patients, these children's
11 teaching hospitals receive less than \$400 in Federal
12 funds for each medical resident they train, while
13 other teaching hospitals receive on average more
14 than \$79,000 for each resident they train, creating
15 a very serious inequity in the competitive market for
16 these children's hospitals.

17 (4) Children's teaching hospitals make an es-
18 sential contribution to training our children's doc-
19 tors. Although less than one percent of all hospitals,
20 they train 5 percent of all physicians, 25 percent of
21 all pediatricians, and the majority of most pediatric
22 specialists.

23 (5) They serve as regional and national pedi-
24 atric referral centers and provide research discov-
25 eries and technological advancements which benefit

all children, conducting along with their affiliated departments of pediatrics almost 20 percent of all pediatric research sponsored by the National Institutes of Health.

(6) Their ability to sustain their academic and patient care missions is increasingly threatened by the lack of graduate medical education funding, which represents the major source of shortfall between patient costs and patient revenues for many children's hospitals with significant teaching programs, even as these hospital strive to reduce their costs.

SEC. 2. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

(a) PAYMENTS.—The Secretary shall make payment under this section to each children's hospital for each hospital cost reporting period beginning during fiscal year 1999 or fiscal year 2000 for the direct and indirect expenses associated with operating approved medical residency training programs.

(b) AMOUNT OF PAYMENT.—

(1) IN GENERAL.—Subject to paragraph (3), the amount payable under this section to a children's hospital for direct and indirect expenses relat-

ing to approved medical residency training programs
for a cost reporting period is equal to the product
of—

(A) the per resident rate, as determined
under paragraph (2); and

(B) the weighted average number of full-
time equivalent residents in the hospital's ap-
proved medical residency training programs (as
determined under section 1886(h)(4) of the So-
cial Security Act) for the cost reporting period.

(2) PER RESIDENT RATE.—

(A) IN GENERAL.—The per resident rate
under this paragraph for a cost reporting pe-
riod is equal to the sum of the direct medical
education component (computed under subpara-
graph (B)), and the indirect medical education
component (computed under subparagraph
(C)(iii).

(B) DIRECT MEDICAL EDUCATION COMPO-
NENT.—The Secretary shall compute the direct
medical education component described in this
subparagraph for a hospital as follows:

(i) COMPUTATION OF BASE NATIONAL
DME AVERAGE PER RESIDENT RATE.—The
Secretary shall compute a base national

DME average per resident rate equal to the simple average of the per resident rates computed under section 1886(h)(2) of the Social Security Act for cost reporting periods ending during fiscal year 1997.

(ii) UPDATING RATE.—The Secretary shall update such rate by the estimated percentage increase in the consumer price index for all urban consumers during the period beginning October 1997 and ending with the midpoint of the hospital's cost reporting period that begins during fiscal year 1999.

(iii) ADJUSTMENT FOR VARIATIONS IN LABOR-RELATED COSTS.—For each hospital the Secretary shall adjust the portion of such updated rate that is related to labor and labor-related costs to account for variations in wage costs in the geographic area in which the hospital is located using the factor determined under section 1886(d)(4)(E) of the Social Security Act for discharges occurring during fiscal year 1998.

1 (iv) DIRECT MEDICAL EDUCATION
2 COMPONENT.—The direct medical edu-
3 cation component described in this sub-
4 paragraph for a hospital is the updated
5 rate, computed under clause (ii), as ad-
6 justed under clause (iii) for the hospital.

7 (C) INDIRECT MEDICAL EDUCATION COM-
8 PONENT.—The Secretary shall compute the in-
9 direct medical education component described
10 in this subparagraph for a hospital as follows:

11 (i) COMPUTATION OF HOSPITAL AVER-
12 AGE TIME PER RESIDENT PAYMENTS.—The
13 Secretary shall determine, for each hospital
14 with a graduate medical education pro-
15 gram which is paid under section 1886(d)
16 of the Social Security Act, the amount
17 paid to that hospital pursuant to section
18 1886(d)(5)(B) of such Act for its cost re-
19 porting period ending during fiscal year
20 1997, and shall divide such amount by the
21 number of FTE residents participating in
22 its approved residency programs and used
23 to calculate the amount of payment under
24 such section in that cost reporting period.

1 (ii) COMPUTING NATIONAL AVER-
2 AGE.—The Secretary shall take the sum of
3 the amounts determined under clause (i)
4 for all the hospitals described in such
5 clause and divide that sum by the number
6 of hospitals so described.

7 (iii) UPDATING.—The Secretary shall
8 update the amount computed under clause
9 (ii) for a hospital by applicable percentage
10 increase (as defined in section
11 1886(b)(3)(B)(i) of the Social Security
12 Act) during the period between October
13 1997 and ending with the midpoint of the
14 hospital's cost reporting period that begins
15 during fiscal year 1999.

16 (iv) INDIRECT MEDICAL EDUCATION
17 COMPONENT.—The indirect medical edu-
18 cation component described in this sub-
19 paragraph for a hospital is the average
20 computed under clause (ii), updated under
21 clause (iii).

22 (3) PRO RATA REDUCTIONS.—If the Sec-
23 retary determines that the amount of funds
24 provided under subsection (d) for cost reporting
25 periods ending in a fiscal year is insufficient to

1 provide the total amount of payments otherwise
2 due for such periods, the Secretary shall reduce
3 the amount payable under this section for such
4 period on a pro rata basis to the extent to as-
5 sure that the aggregate of such payments does
6 not exceed the amount of funds provided under
7 subsection (d) for such cost reporting periods.

8 (c) MAKING OF PAYMENTS.—

9 (1) INTERIM PAYMENTS.—The Secretary shall
10 estimate, before the beginning of each cost reporting
11 period for a hospital for which a payment may be
12 made under this section, the amount of payment to
13 be made under this section to the hospital for such
14 period and shall make payment, in 26 equal interim
15 installments during such period, of the amounts obli-
16 gated to be paid.

17 (2) FINAL PAYMENT.—At the end of each such
18 period, the hospital shall submit to the Secretary
19 such information as the Secretary determines to be
20 necessary to determine the final payment amount
21 due under this section for the hospital for the pe-
22 riod. Based on such determination, the Secretary
23 shall recoup any overpayments made, or payment
24 balances due. The final amount so determined shall
25 be considered a final intermediary determination for

1 purposes of applying section 1878 of the Social Se-
2 curity Act and shall be subject to review under that
3 section in the same manner as the amount of pay-
4 ment under section 1886(d) of such Act is subject
5 to review under such section.

6 (d) LIMITATION ON EXPENDITURES.—

7 (1) IN GENERAL.—Subject to paragraph (2),
8 there are hereby appropriated, out of any money in
9 the Treasury not otherwise appropriated, for pay-
10 ments under this section for cost reporting periods
11 ending in each of fiscal years 1999 and 2000
12 \$285,000,000.

13 (2) CARRYOVER OF EXCESS.—If the amount of
14 payments under this section for cost reporting peri-
15 ods ending in fiscal year 1999 is less than the
16 amount provided under this subsection for such pay-
17 ments for such periods, then the amount available
18 under this subsection for cost reporting periods end-
19 ing in fiscal year 2000 shall be increased by the
20 amount of such difference.

21 (e) RELATION TO MEDICARE AND MEDICAID PAY-
22 MENTS.—Notwithstanding any other provision of law,
23 payments under this section to a hospital for a cost report-
24 ing period—

1 (1) are in lieu of any amounts otherwise pay-
2 able to the hospital under section 1886(h) or
3 1886(d)(5)(F) of the Social Security Act to the hos-
4 pital for such cost reporting period, but

5 (2) shall not affect the amounts otherwise pay-
6 able to such hospitals under a State medicaid plan
7 under title XIX of such Act.

8 (f) DEFINITIONS.—In this section:

9 (1) APPROVED MEDICAL RESIDENCY TRAINING
10 PROGRAM.—The term “approved medical residency
11 training program” has the meaning given such term
12 in section 1886(h)(5)(A) of the Social Security Act
13 (42 U.S.C. 1395ww(h)(5)(A)).

14 (2) CHILDREN’S HOSPITAL.—The term “chil-
15 dren’s hospital” means a hospital described in sec-
16 tion 1886(d)(1)(B)(iii) of the Social Security Act
17 (42 U.S.C. 1395ww(d)(1)(B)(iii)).

18 (3) DIRECT GRADUATE MEDICAL EDUCATION
19 COSTS.—The term “direct graduate medical edu-
20 cation costs” has the meaning given such term in
21 section 1886(h)(5)(C) of the Social Security Act (42
22 U.S.C. 1395ww(h)(5)(C)).

23 (4) SECRETARY.—The term “Secretary” means
24 the Secretary of Health and Human Services.

○

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Bill Tracking Report**105th Congress
2nd Session****U. S. House of Representatives****HR 3855****1998 Bill Tracking H.R. 3855; 105 Bill Tracking H.R. 3855****CHILDREN'S HOSPITALS EDUCATION AND RESEARCH ACT OF 1998**

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DATE-INTRO: May 13, 1998**LAST-ACTION-DATE:** May 13, 1998**STATUS:** In committee**SPONSOR:** Representative Sherrod Brown D-OH**TOTAL-COSPONSORS:** 89 Cosponsors; 66 Democrats / 23 Republicans

SYNOPSIS: A bill to provide for payments to children's hospitals that operate graduate medical education programs

ACTIONS:

Committee Referrals:

05/13/1998 House Committee on Commerce

05/13/1998 House Committee on Ways and Means

Legislative Chronology:

1st Session Activity:

2nd Session Activity:

05/13/1998 144 Cong Rec H 3246

Referred to the House Committee on Commerce

05/13/1998 144 Cong Rec H 3246

<http://web.leda-basis.com/cong...>

Referred to the House Committee on Ways and Means

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CO-SPONSORS:**Original Cosponsors:**

Greenwood R-PA Johnson R-CT

Added 05/21/1998:

Bachus R-AL	Berry D-AR	Dooley D-CA
Neal D-MA	Pryce R-OH	Sawyer D-OH

Added 05/22/1998:

Barrett D-WI

Added 06/03/1998:

Blagojevich D-IL	Degette D-CO	Frost D-TX
Kennelly D-CT	Maloney D-CT	Portman R-OH

Added 06/09/1998:

Gejdenson D-CT Ney R-OH

Added 06/11/1998:

Abercrombie D-HI	Bilbray R-CA	Kennedy II D-MA
Moakley D-MA	Poshard D-IL	Waxman D-CA

Added 06/17/1998:

Delahunt D-MA	Filner D-CA	Frank D-MA
Oberstar D-MN	Olver D-MA	Shays R-CT

Added 07/14/1998:

Costello D-IL	Deal R-GA	Dunn R-WA
Jackson, Jr. D-IL	Klaczka D-WI	Lantos D-CA
McGovern D-MA	Meehan D-MA	Meek D-FL
Rush D-IL	Skelton D-MO	

Added 07/17/1998:

Bentsen D-TX	DeLauro D-CT	English R-PA
Eshoo D-CA	Green D-TX	McCarthy D-MO

Rodriguez D-TX

Added 07/22/1998:

Hilliard D-AL Young R-FL

Frank D-MA
Shays R-CT

Added 07/27/1998:

Dingell D-MI
Lewis D-GAHutchinson R-AR
Quinn R-NYKaptur D-OH
Strickland D-OH

Added 07/31/1998:

Coyne D-PA
Tierney D-MA

Markey D-MA

Mink D-HI

Added 08/06/1998:

Collins R-GA
Miller D-CACook R-UT
Torres D-CA

Dixon D-CA

Added 09/14/1998:

Kennedy D-RI
Rogan R-CA
Skaggs D-COLofgren D-CA
Schaffer R-COMartinez D-CA
Sherman D-CA

Added 09/23/1998:

Camp R-MI
Farr D-CA
Pelosi D-CAHutchinson R-AR
Danner D-MO
Hastings D-FL
Ros-Lehtinen R-FLKaptur D-OH
Strickland D-OH
Emerson R-MO
Kilpatrick D-MI
Vento D-MN

Added 10/01/1998:

Berman D-CA
Harman D-CA
Traficant, Jr. D-OHDeutsch D-FL
Pickett D-VAGillmor R-OH
Thurman D-FL

Added 10/07/1998:

Aderholt R-AL

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Document 1 of 1.**FULL TEXT OF BILLS****105TH CONGRESS; 2ND SESSION
IN THE HOUSE OF REPRESENTATIVES
AS INTRODUCED IN THE HOUSE****H. R. 3855****1998 H.R. 3855; 105 H.R. 3855****Retrieve Bill Tracking Report****SYNOPSIS:**

A BILL To provide for payments to children's hospitals that operate graduate medical education programs.

DATE OF INTRODUCTION: MAY 13, 1998**DATE OF VERSION: MAY 19, 1998 -- VERSION: 1****SPONSOR(S):**

Mr. BROWN of Ohio (for himself, Mrs. JOHNSON of Connecticut, and Mr. GREENWOOD) introduced the following bill, which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

TEXT:

* Be it enacted by the Senate and House of Representatives of the United*
*States of America in Congress assembled, *

SECTION 1. SHORT TITLE; FINDINGS.

(a) **SHORT TITLE.**-THIS ACT MAY BE CITED AS THE "CHILDREN'S HOSPITALS EDUCATION AND RESEARCH ACT OF 1998".

(B) **FINDINGS.**-CONGRESS FINDS THE FOLLOWING:

(1) FREESTANDING CHILDREN'S TEACHING HOSPITALS RECEIVE ALMOST NO FEDERAL GRADUATE MEDICAL EDUCATION FUNDING.

(2) INCREASINGLY, FEDERAL GRADUATE MEDICAL EDUCATION FUNDING, THROUGH THE MEDICARE PROGRAM, HAS BECOME THE MAJOR SOURCE OF SUPPORT

FOR THE ACADEMIC MISSIONS OF ALL TEACHING HOSPITALS AS THE MEDICAL MARKETPLACE HAS LED TO A GROWING INABILITY TO GAIN SUCH SUPPORT FROM OTHER PAYERS.

(3) WITH FEW MEDICARE PATIENTS, THESE CHILDREN'S TEACHING HOSPITALS RECEIVE LESS THAN \$400 IN FEDERAL FUNDS FOR EACH MEDICAL RESIDENT THEY TRAIN, WHILE OTHER TEACHING HOSPITALS RECEIVE ON AVERAGE MORE THAN \$79,000 FOR EACH RESIDENT THEY TRAIN, CREATING A VERY SERIOUS INEQUITY IN THE COMPETITIVE MARKET FOR THESE CHILDREN'S HOSPITALS.

(4) CHILDREN'S TEACHING HOSPITALS MAKE AN ESSENTIAL CONTRIBUTION TO TRAINING OUR CHILDREN'S DOCTORS. ALTHOUGH LESS THAN ONE PERCENT OF ALL HOSPITALS, THEY TRAIN 5 PERCENT OF ALL PHYSICIANS, 25 PERCENT OF ALL PEDIATRICIANS, AND THE MAJORITY OF MOST PEDIATRIC SPECIALISTS.

(5) THEY SERVE AS REGIONAL AND NATIONAL PEDIATRIC REFERRAL CENTERS AND PROVIDE RESEARCH DISCOVERIES AND TECHNOLOGICAL ADVANCEMENTS WHICH

BENEFIT ALL CHILDREN, CONDUCTING ALONG WITH THEIR AFFILIATED DEPARTMENTS OF PEDIATRICS ALMOST 20 PERCENT OF ALL PEDIATRIC RESEARCH SPONSORED BY THE NATIONAL INSTITUTES OF HEALTH.

(6) THEIR ABILITY TO SUSTAIN THEIR ACADEMIC AND PATIENT CARE MISSIONS IS INCREASINGLY THREATENED BY THE LACK OF GRADUATE MEDICAL EDUCATION FUNDING, WHICH REPRESENTS THE MAJOR SOURCE OF SHORTFALL BETWEEN PATIENT COSTS AND PATIENT REVENUES FOR MANY CHILDREN'S HOSPITALS WITH SIGNIFICANT TEACHING PROGRAMS, EVEN AS THESE HOSPITALS STRIVE TO REDUCE THEIR COSTS.

SEC. 2. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

(a) **PAYMENTS.**-THE SECRETARY SHALL MAKE PAYMENT UNDER THIS SECTION TO EACH CHILDREN'S HOSPITAL FOR EACH HOSPITAL COST REPORTING PERIOD BEGINNING DURING FISCAL YEAR 1999 OR FISCAL YEAR 2000 FOR THE DIRECT AND INDIRECT EXPENSES ASSOCIATED WITH OPERATING APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.

(B) **AMOUNT OF PAYMENT.**-

(1) **IN GENERAL.**-SUBJECT TO PARAGRAPH (3), THE AMOUNT PAYABLE UNDER THIS SECTION TO A CHILDREN'S HOSPITAL FOR DIRECT AND INDIRECT EXPENSES RELATING TO APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS FOR

A COST REPORTING PERIOD IS EQUAL TO THE PRODUCT OF-

(A) THE PER RESIDENT RATE, AS DETERMINED UNDER PARAGRAPH (2);

AND

(B) THE WEIGHTED AVERAGE NUMBER OF FULL-TIME EQUIVALENT

RESIDENTS IN THE HOSPITAL'S APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS (AS DETERMINED UNDER SECTION 1886(H)(4) OF THE SOCIAL SECURITY ACT) FOR THE COST REPORTING PERIOD.

(2) PER RESIDENT RATE.-

(A) IN GENERAL.-THE PER RESIDENT RATE UNDER THIS PARAGRAPH FOR A COST REPORTING PERIOD IS EQUAL TO THE SUM OF THE DIRECT MEDICAL EDUCATION COMPONENT (COMPUTED UNDER SUBPARAGRAPH (B)), AND THE INDIRECT MEDICAL EDUCATION COMPONENT (COMPUTED UNDER

SUBPARAGRAPH

(C)(III).

(B) DIRECT MEDICAL EDUCATION COMPONENT.-THE SECRETARY SHALL COMPUTE THE DIRECT MEDICAL EDUCATION COMPONENT DESCRIBED IN THIS SUBPARAGRAPH FOR A HOSPITAL AS FOLLOWS:

(I) COMPUTATION OF BASE NATIONAL DME AVERAGE PER RESIDENT RATE.-THE

Secretary shall compute a base national DME average per resident rate

equal to the simple average of the per resident rates computed under section 1886(h)(2) of the Social Security Act for cost reporting periods ending during fiscal year 1997.

(ii) UPDATING RATE.-THE SECRETARY SHALL UPDATE SUCH RATE BY THE ESTIMATED PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS DURING THE PERIOD BEGINNING OCTOBER 1997 AND ENDING WITH THE MIDPOINT OF THE HOSPITAL'S COST REPORTING PERIOD THAT BEGINS DURING FISCAL YEAR 1999.

(III) ADJUSTMENT FOR VARIATIONS IN LABOR-RELATED COSTS.-FOR EACH HOSPITAL THE SECRETARY SHALL ADJUST THE PORTION OF SUCH UPDATED RATE THAT IS RELATED TO LABOR AND LABOR-RELATED COSTS TO ACCOUNT FOR VARIATIONS IN WAGE COSTS IN THE GEOGRAPHIC AREA IN WHICH THE HOSPITAL IS LOCATED USING THE FACTOR DETERMINED UNDER SECTION 1886(D)(4)(E) OF THE SOCIAL SECURITY ACT FOR DISCHARGES OCCURRING DURING FISCAL YEAR 1998.

(IV) DIRECT MEDICAL EDUCATION COMPONENT.-THE DIRECT MEDICAL EDUCATION COMPONENT DESCRIBED IN THIS SUBPARAGRAPH FOR A HOSPITAL IS THE UPDATED RATE, COMPUTED UNDER CLAUSE (II), AS ADJUSTED UNDER CLAUSE (III) FOR THE HOSPITAL.

(C) INDIRECT MEDICAL EDUCATION COMPONENT.-THE SECRETARY SHALL COMPUTE THE INDIRECT MEDICAL EDUCATION COMPONENT DESCRIBED IN THIS SUBPARAGRAPH FOR A HOSPITAL AS FOLLOWS:

(I) COMPUTATION OF HOSPITAL AVERAGE IME PER RESIDENT PAYMENTS.-THE SECRETARY SHALL DETERMINE, FOR EACH HOSPITAL WITH A GRADUATE MEDICAL EDUCATION PROGRAM WHICH IS PAID UNDER SECTION 1886(D) OF THE SOCIAL SECURITY ACT, THE AMOUNT PAID TO THAT HOSPITAL PURSUANT TO SECTION 1886(D)(5)(B) OF SUCH ACT FOR ITS COST REPORTING PERIOD ENDING DURING FISCAL YEAR 1997, AND SHALL DIVIDE SUCH AMOUNT BY THE NUMBER OF FTE RESIDENTS PARTICIPATING IN ITS APPROVED RESIDENCY PROGRAMS AND USED TO CALCULATE THE AMOUNT OF PAYMENT UNDER SUCH SECTION IN THAT COST REPORTING PERIOD.

(II) COMPUTING NATIONAL AVERAGE.-THE SECRETARY SHALL TAKE THE SUM OF THE AMOUNTS DETERMINED UNDER CLAUSE (I) FOR ALL

THE HOSPITALS DESCRIBED IN SUCH CLAUSE AND DIVIDE THAT SUM BY THE NUMBER OF HOSPITALS SO DESCRIBED.

(III) UPDATING.-THE SECRETARY SHALL UPDATE THE AMOUNT COMPUTED UNDER CLAUSE (II) FOR A HOSPITAL BY APPLICABLE PERCENTAGE INCREASE (AS DEFINED IN SECTION 1886(B)(3)(B)(I) OF THE SOCIAL SECURITY ACT) DURING THE PERIOD BETWEEN OCTOBER 1997 AND ENDING WITH THE MIDPOINT OF THE HOSPITAL'S COST REPORTING PERIOD THAT BEGINS DURING FISCAL YEAR 1999.

(IV) INDIRECT MEDICAL EDUCATION COMPONENT.-THE INDIRECT MEDICAL EDUCATION COMPONENT DESCRIBED IN THIS SUBPARAGRAPH FOR A HOSPITAL IS THE AVERAGE COMPUTED UNDER CLAUSE (II), UPDATED UNDER CLAUSE (III).

(3) PRO RATA REDUCTIONS.-IF THE SECRETARY DETERMINES THAT THE AMOUNT OF FUNDS PROVIDED UNDER SUBSECTION (D) FOR COST REPORTING PERIODS ENDING IN A FISCAL YEAR IS INSUFFICIENT TO provide the total amount of payments otherwise due for such periods, the

Secretary shall reduce the amount payable under this section for such period on a pro rata basis to the extent to assure that the aggregate of such payments does not exceed the amount of funds provided under subsection (d) for such cost reporting periods.

(c) MAKING OF PAYMENTS:-

(1) INTERIM PAYMENTS.-THE SECRETARY SHALL ESTIMATE, BEFORE THE BEGINNING OF EACH COST REPORTING PERIOD FOR A HOSPITAL FOR WHICH A PAYMENT MAY BE MADE UNDER THIS SECTION, THE AMOUNT OF PAYMENT TO BE MADE UNDER THIS SECTION TO THE HOSPITAL FOR SUCH PERIOD AND SHALL MAKE PAYMENT, IN 26 EQUAL INTERIM INSTALLMENTS DURING SUCH PERIOD, OF THE AMOUNTS OBLIGATED TO BE PAID.

(2) FINAL PAYMENT.-AT THE END OF EACH SUCH PERIOD, THE HOSPITAL SHALL SUBMIT TO THE SECRETARY SUCH INFORMATION AS THE SECRETARY DETERMINES TO BE NECESSARY TO DETERMINE THE FINAL PAYMENT AMOUNT DUE UNDER THIS SECTION FOR THE HOSPITAL FOR THE PERIOD. BASED ON SUCH DETERMINATION, THE SECRETARY SHALL RECOUP ANY OVERPAYMENTS MADE, OR PAYMENT BALANCES DUE. THE FINAL AMOUNT SO DETERMINED SHALL BE CONSIDERED A FINAL INTERMEDIARY DETERMINATION FOR PURPOSES OF APPLYING SECTION 1878 OF THE SOCIAL SECURITY ACT AND SHALL BE SUBJECT TO REVIEW UNDER THAT SECTION IN THE SAME MANNER AS THE AMOUNT OF PAYMENT UNDER SECTION 1886(D) OF SUCH ACT IS SUBJECT TO REVIEW UNDER SUCH SECTION.

(D) LIMITATION ON EXPENDITURES.-

(1) IN GENERAL.-SUBJECT TO PARAGRAPH (2), THERE ARE HEREBY APPROPRIATED, OUT OF ANY MONEY IN THE TREASURY NOT OTHERWISE APPROPRIATED, FOR PAYMENTS UNDER THIS SECTION FOR COST REPORTING PERIODS ENDING IN EACH OF FISCAL YEARS 1999 AND 2000 \$285,000,000.

(2) CARRYOVER OF EXCESS.-IF THE AMOUNT OF PAYMENTS UNDER THIS SECTION FOR COST REPORTING PERIODS ENDING IN FISCAL YEAR 1999 IS LESS THAN THE AMOUNT PROVIDED UNDER THIS SUBSECTION FOR SUCH PAYMENTS FOR SUCH PERIODS, THEN THE AMOUNT AVAILABLE UNDER THIS SUBSECTION FOR COST REPORTING PERIODS ENDING IN FISCAL YEAR 2000 SHALL BE INCREASED BY THE AMOUNT OF SUCH DIFFERENCE.

(E) RELATION TO MEDICARE AND MEDICAID PAYMENTS.-NOTWITHSTANDING ANY

OTHER PROVISION OF LAW, PAYMENTS UNDER THIS SECTION TO A HOSPITAL FOR A COST REPORTING PERIOD-

(1) ARE IN LIEU OF ANY AMOUNTS OTHERWISE PAYABLE TO THE HOSPITAL UNDER SECTION 1886(H) OR 1886(D)(5)(F) OF THE SOCIAL SECURITY ACT TO THE HOSPITAL FOR SUCH COST REPORTING PERIOD, BUT

(2) SHALL NOT AFFECT THE AMOUNTS OTHERWISE PAYABLE TO SUCH HOSPITALS UNDER A STATE MEDICAID PLAN UNDER TITLE XIX OF SUCH ACT.

(F) DEFINITIONS.-IN THIS SECTION:

(1) **APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.**-THE TERM "APPROVED MEDICAL RESIDENCY TRAINING PROGRAM" HAS THE MEANING GIVEN SUCH TERM IN SECTION 1886(H)(5)(A) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395WW(H)(5)(A)).

(2) **CHILDREN'S HOSPITAL.**-THE TERM "CHILDREN'S HOSPITAL" MEANS A HOSPITAL DESCRIBED IN SECTION 1886(D)(1)(B)(III) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395WW(D)(1)(B)(III)).

(3) **DIRECT GRADUATE MEDICAL EDUCATION COSTS.**-THE TERM "DIRECT GRADUATE MEDICAL EDUCATION COSTS" HAS THE MEANING GIVEN SUCH TERM IN SECTION 1886(H)(5)(C) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395WW(H)(5)(C)).

(4) **SECRETARY.**-THE TERM "SECRETARY" MEANS THE SECRETARY OF HEALTH AND HUMAN SERVICES.

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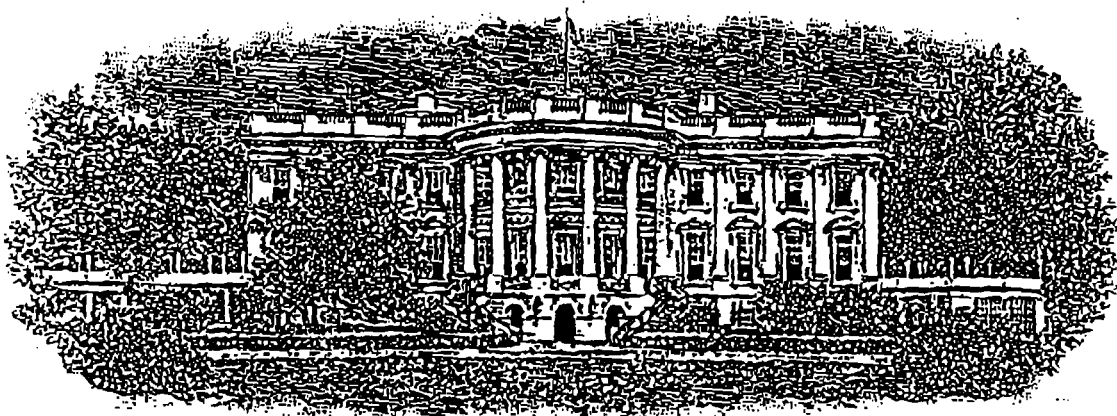
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The White House



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COMMENTS: NACAP Letter - as promised
Deborah



National Association of
Children's Hospitals

401 Wythe Street
Alexandria, VA 22314
(703)684-1355 Fax (703)684-1589

N.A.C.H. FAX

DATE: 12/17/98

PAGES (including cover page): 3

TO: Jean Lambrew
Domestic Policy Staff

FAX: (202) 456-5557

PHONE: (202) 456-5560

FROM: Peters D. Willson
Vice President for Public Policy
Phone: 703-684-1355
Fax: 703-684-1589
E-mail: pwillson@nachri.org

SUBJECT: Jean -
Attached is a letter from Reps.
Womack, Dingell, and Starks
in support of funding for children's
hospitals in the President's
FY 2000 budget.

If there are any transmission problems with this fax, please call me at 703-684-1355.

P.S. Reps. Dingell and Grijalva also
are calling Jack here.

Pete

Congress of the United States
Washington, DC 20515

December 14, 1998

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

As you prepare for your fiscal year 2000 budget, we are writing to request the inclusion of funding for graduate medical education for our country's independent children's hospitals. As you know, these 53 institutions do not share a provider number with another larger adult institution for purposes of billing Medicare. As a result, they receive little to no support from Medicare for their teaching programs.

We are committed to recognizing and supporting the public good that all teaching hospitals provide through their graduate medical education (GME) programs, a commitment that needs to be maintained through any reforms considered to assure future stability to the Medicare program. We also must move forward with providing some form of federal GME support for these few children's hospitals, on an interim basis now and as part of any larger reform.

Medicare has increasingly become the one reliable source of GME support for teaching hospitals, as the competitive market has made it almost impossible to recover those costs from private payers. Medicaid in some states provides some support for the direct costs of GME, but this varies from state to state, particularly as states move to Medicaid managed care. The result has been a serious competitive disadvantage for all of these children's hospitals, as other teaching hospitals received \$76,000 per resident on average from Medicare in 1996 and they received \$400.

Many of these children's hospitals are experiencing losses on patient operations which are heavily attributable to GME. The lack of GME support exacerbates the competitive challenges they also face as safety net institutions and regional tertiary care centers. Medicaid, even with disproportionate share payments, on average, covers only 85 percent of the costs of caring for the children it covers in these institutions. And, Medicaid and private payer rates only rarely account for the higher costs of caring disproportionately for children with more severe and more chronic illnesses.

Of these 53 children's hospitals, 43 have significant GME programs. They represent less than one percent of all teaching hospitals; but they train five percent of all residents, almost a third of all pediatric residents, and the majority of all pediatric specialists. They also provide required pediatric rotations for many other residents. The hospital, teaching hospital and pediatric communities have joined the National Association of Children's Hospitals in recognizing the

Page 2

Letter to the Honorable William Jefferson Clinton

equity and need for providing these institutions with federal GME support, commensurate with that provided to other teaching hospitals.

We ask that you join us in working towards that goal. Including such support in the Administration's fiscal year 2000 budget would provide an essential step for a successful effort. Last year's bills, H.R. 3855 and S. 2049, which provided one approach for children's hospital GME, achieved significant bipartisan sponsorship. Those bills would have provided a time-limited, \$285 million in annual GME support. The inclusion of this, or any other, funds for GME for these children's hospitals in the Administration's budget will give us the critical support needed to move this effort forward.

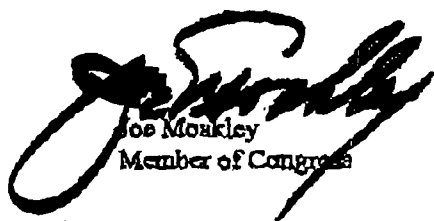
Many of these children's hospitals have existed for decades, some for a century, developed by our communities and pediatric professionals because they believed that centers devoted to the care of children were essential to the advancement of pediatric medicine. In keeping with this objective, they have consistently had a threefold mission -- patient care, research, and teaching -- which has benefited all children.

Even counting the children's hospitals that are a part of other larger institutions and the large pediatric units with multi-specialties in other hospitals, the number of children's medical centers is relatively small, about 250 such programs nationwide. With fewer numbers than adults and fewer numbers who are ill, children, in particular, require such specialized regional care when they are ill. And, the regionalization of their care provides the critical mass of experience needed for research and training as well.

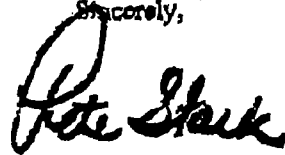
The development of these institutions, and their alignments with others in today's ever-changing market, needs to continue to be decided based on sound market decisions devoted to maintaining and strengthening systems for delivering care for children. It should not be driven by the anomalies of our financing for GME, or our inability to move forward with broader-based financing. Until we achieve the latter, we should move federally to provide GME support for these children's hospitals now.

We thank you in advance for your consideration and attention to this request.

Sincerely,



Joe Moakley
Member of Congress



Pete Stark
Member of Congress



John D. Dingell
Member of Congress

GME

Talking Points

Briefing

- list of CEOs
- ~~list of~~ other issues they may raise
- bio for speaker

Members - who to invite? -- Kennedy, Kerry, Dodd, Moynihan.
- who to acknowledge? R?

Policy - One page description

→ Call Dodd to warn - Get name from Chris

→ Call Rich
T.

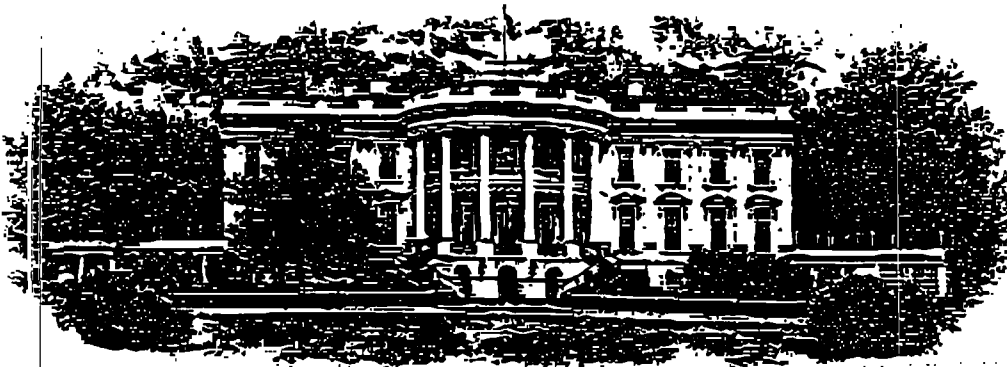
~~CHIP - Talk to Marsha~~

→ List of Members from Deborah

→ Ann - Child. Hospital people to be at AM event

→ HRC shld raise strategy to get this done.

→ Talking points - - also raise CHIP, safety net
proposal



The White House
Office of Public Liaison

Barbara Woolley
Special Assistant to the President
Phone (202) 456-2930
Fax (202) 456-6218

Number of Pages (Including cover): 4

Date: 1/22/99

To: Jennifer Klein

Fax Number: _____

Office Number: _____

Comments: Re: Children's Hospitals

**CHILDREN'S TEACHING HOSPITALS
WITH THEIR OWN MEDICARE PROVIDER NUMBER**

January 1999

ALABAMA

The Children's Hospital of Alabama
Birmingham

ARKANSAS

Arkansas Children's Hospital
Little Rock

CALIFORNIA

Valley Children's Hospital
Fresno

Childrens Hospital Los Angeles
Los Angeles

Children's Hospital Oakland
Oakland

Children's Hospital of Orange County
Orange

Lucile Packard Children's Health Services
Palo Alto

Children's Hospital and Health Center
San Diego

COLORADO

The Children's Hospital
Denver

National Jewish Center
Denver

CONNECTICUT

Connecticut Children's Medical Center
Hartford

DELAWARE

Alfred I. duPont Hospital for Children
Wilmington

DISTRICT OF COLUMBIA

Children's National Medical Center
Washington

FLORIDA

Miami Children's Hospital
Miami

All Children's Hospital
St. Petersburg

GEORGIA

ESR Children's Health Care System, Inc.
Atlanta

HAWAII

Kapiolani Women's and Children's Medical
Center
Honolulu

ILLINOIS

The Children's Memorial Hospital
Chicago

GAN-21-99 20:07 FROM:

ID:

LaRabida Children's Hospital and Research
Center
Chicago

LOUISIANA

Children's Hospital
New Orleans

MARYLAND

Kennedy Krieger Children's Hospital
Baltimore

MASSACHUSETTS

Children's Hospital
Boston

MICHIGAN

Children's Hospital of Michigan
Detroit

MINNEAPOLIS

Children's Hospitals and Clinics
Minneapolis and St. Paul

Gillette Children's Specialty Healthcare
St. Paul

MISSOURI

The Children's Mercy Hospital
Kansas City

St. Louis Children's Hospital
St. Louis

NEBRASKA

Children's Hospital
Omaha

Boys Town National Research Hospital
Omaha

NEW JERSEY

Children's Specialized Hospital
Mountainside

NEW MEXICO

Carrie Tingley Hospital
Albuquerque

NEW YORK

Blythedale Children's Hospital
Valhalla

OHIO

Children's Hospital Medical Center of
Akron
Akron

Children's Hospital Medical Center
Cincinnati

Rainbow Babies and Children's Hospital
Cleveland

Children's Hospital
Columbus

The Children's Medical Center
Dayton

Tod Children's Hospital
Youngstown

OKLAHOMA

Children's Medical Center
Tulsa

PENNSYLVANIA

St. Christopher's Hospital for Children
Philadelphia

The Children's Hospital of Philadelphia
Philadelphia

WISCONSIN

Children's Hospital of Pittsburgh
Pittsburgh

Children's Hospital of Wisconsin
Milwaukee

PUERTO RICO

University Pediatric Hospital
San Juan

TEXAS

Driscoll Children's Hospital
Corpus Christi

Children's Medical Center of Dallas
Dallas

Cook Children's Medical Center
Fort Worth

Texas Children's Hospital
Houston

Santa Rosa Children's Hospital
San Antonio

UTAH

Primary Children's Medical Center
Salt Lake City

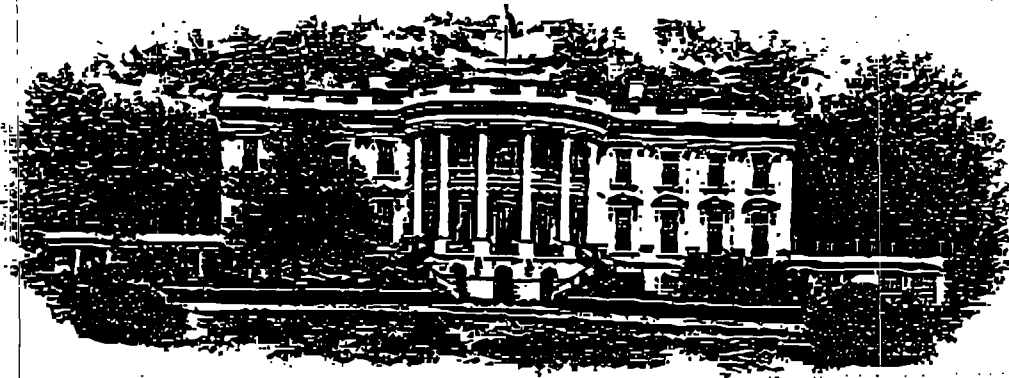
VIRGINIA

Children's Hospital of the King's Daughters
Health System
Norfolk

WASHINGTON

Children's Hospital and Regional Medical
Center
Seattle

Mary Bridge Children's Health Center
Tacoma



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PROVIDING FEDERAL FINANCING FOR GRADUATE MEDICAL EDUCATION PROVIDED BY FREESTANDING CHILDREN'S HOSPITALS

SUMMARY

This proposal would provide freestanding children's hospitals with Federal financing for graduate medical education commensurate to that received by other teaching hospitals. Attached are four options to address the current inequities in financing. (Cost: depending on option chosen, \$50 to \$285 million).

BACKGROUND

- **The Federal government has traditionally provided teaching hospitals with financial support for graduate medical education.** Care in teaching hospitals is generally recognized as costlier than similar care provided in non-teaching facilities, because the inefficiencies associated with inexperience and a sicker patient population. Because a competitive health care market dominated by managed care is often unwilling to assume the costs of graduate medical education, the Federal government has assumed a portion of the cost of these training activities. These medical education payments allow teaching hospitals to maintain their academic mission without sacrificing their financial health.
- **Freestanding children's hospitals train the majority of essential pediatric providers.** The children's hospitals play an essential role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists. Since there are physician shortages in some areas of pediatric subspecialty care, these hospitals are critical to maintaining an adequate practitioner supply.
- **Although children's hospitals share the academic mission of other teaching hospitals, they are denied a commensurate level of Federal support.** The current system of Federal reimbursement for graduate medical education is dependant on the number of Medicare patients seen, creating a significant competitive disadvantage for children's hospitals. Teaching hospitals receive an average of \$76,000 in Federal GME funding per resident, as opposed to the \$400 per resident received by children's hospitals.
- **Alternate sources of GME financing are ending.** Children's hospitals in some States receive GME funding through the Medicaid program. However, as more States move to Medicaid managed care programs, Medicaid is no longer a viable source of funding for these providers.
- **Children's hospitals sustain significant financial losses because of their GME activities.** Despite the fact that children's hospitals maintain a significant pediatric market share, their patient care revenues are falling short of covering their patient care costs. Children's hospitals operating margins are -6.2 percent, as opposed to -3.9 percent for other teaching hospitals. A significant percentage of this loss is attributable to unreimbursed GME costs, which run in the millions of dollars per year per hospital.

- **Many children's hospitals are financially vulnerable.** The inequity in Federal financing forces children's hospitals to depend on non-patient care revenue to a greater extent than other teaching hospitals. Children's hospitals receive almost 15 percent of their total funding from revenues unrelated to patient care. Other teaching hospitals only receive 8.6 percent of their revenue from these sources. This makes children's hospitals more vulnerable to an economic downturn that could threaten their financial health.

POLICY OPTIONS

NOTE: All of these options except Option Four will be funded through a capped mandatory grant program.

Option 1: Modify the Kerrey proposal to provide reimbursement for those GME costs associated with providing care to publicly insured patients.

The Kerrey proposal provides the children's hospitals with DME reimbursement based on a flat per resident amount, without consideration for the percentage of their expenditures associated with providing care to Medicare or Medicaid patients. Under this option, children's hospitals will only receive reimbursement for the portion of their DME and IME expenses associated with providing care to Medicare and Medicaid patients. The Kerry proposal distributes IME payment as an average payment per resident. Indirect medical education is paid as a percentage add-on to the payment for a Medicare discharge. Under this option, we would modify the Kerry proposal to provide an IME adjustment to the payment made for a Medicaid or Medicare patient. This option would also have the Secretary prospectively limit the funds disbursed to the amount appropriated, rather than recover overpayments retrospectively. (Cost: unclear. HCFA is developing estimates.)

Option 2: Eliminate IME reimbursement from the Kerrey proposal.

The Kerrey proposal requires the Federal government to provide approximately \$76,000 per resident for DME costs alone. This is as much as we presently provide to other teaching hospitals for both their direct and indirect medical education costs. The proposal could be modified to exclude reimbursement for IME and reimburse for only DME costs. This would provide the children's hospitals with the commensurate funding they are seeking while making limited changes to the Kerrey proposal. The proposal would include a provision that would require the Secretary to prospectively limit the funds disbursed to the amount appropriated. Funds could be placed in an account that would close when tapped out, or the Secretary could hold back a percentage of each hospital's funds to protect themselves from going over the cap and having to recoup funds. This option would perpetuate the flaw in the DME formula. (Cost: \$285 million)

Option 3: Require Medicare to disburse GME funds based on a flat, per resident amount.

This proposal would provide children's hospitals with graduate medical education funding according to a flat, per resident amount adjusted for geographic variation in health care costs that would be determined by HCFA and disbursed through the current GME reimbursement system used by HCFA. The amount of funding an institution received would be dependant solely on the number of residents it had enrolled. There would be a cap on the amount of funds that could be disbursed. This is a simpler formula than the Kerrey proposal and essentially has the same distributional effects. However, the children's hospitals may prefer the formula to resemble the one used to distribute funds to other teaching hospitals. (Cost: \$285 million)

Option 4: Create a discretionary grant program to provide GME funds through the PHS.

This option could use either the Kerrey formula or the flat, per resident distribution formula. Alternatively, it could require children's hospitals to submit an application to receive a GME grant. Potential grantees would submit a summary detailing the extent of their financial need, an overview of their curriculum and training, and their previous experience in providing graduate medical education. Based on Federal review of the grant proposal, hospitals could receive different levels of funding. (Cost: could vary, depending on funds available.)