
Rx for Physician Glut: Pay Hospitals Not to ...

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A Section

Rx for Physician Glut: Pay Hospitals Not to Train New Ones

Spencer Rich

Washington Post Staff Writer

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For years the federal government has been paying hospitals handsome subsidies to train medical school graduates to become doctors.

But last month, the Clinton administration startled the medical world by announcing that it would begin paying New York teaching hospitals \$400 million over the next six years not to train doctors.

- * With the nation facing a physician surplus, Medicare administrator Bruce C. Vladeck said it was time to stop "giving hospitals an incentive to hire more residents."
- * Instead, he suggested that Medicare is beginning to rethink its \$6.5 billion doctor-training program by approving a pilot project that
- * will reward New York hospitals if they reduce their resident load by
- * 2,000 slots to about 8,000. Under the arrangement, Medicare will save money, since it was subsidizing New York by training doctors the country doesn't seem to need.

Since last month's announcement, hospitals nationwide have been bombarding the administration in hopes of getting the same deal or something like it. Inquiries have come from Michigan, Ohio, New Jersey, Massachusetts, Delaware and other states, as well as Los Angeles.

The move reflects a growing consensus within the medical world that the nation faces a huge doctor glut, mainly of specialists. There are 684,000 doctors nationwide, and most health care experts have come to believe that's far more than America needs.

"Most studies of the adequacy of the physician work force for the past 15 years have concluded that the United States has an oversupply of physicians," the Institute of Medicine, part of the National Academy of Sciences, reported last year.

In a separate report last year, a government study group

estimated that by early next century the number of practicing doctors will exceed requirements by about 23 percent. The estimate is based on the assumption that by then two-thirds of Americans will be enrolled in managed-care plans with strict controls on the use of specialists. The entire excess, the group found, will be in specialties rather than primary care doctors.

In theory, anyway, it may seem to the public that the more doctors the better -- perhaps if they have to compete a bit more, physicians will provide better care and cut costs.

But there is little evidence this is the case. In some ways, the opposite actually occurs, according to some industry watchers.

There is "very little evidence that simply adding more physicians would improve quality, cost and access to care," said Don Detmer, a practicing surgeon and vice president of the University of Virginia, who was co-editor of the Institute of Medicine study.

When a physician glut occurs, said Detmer, it can often be patients who suffer the consequences.

For one thing, the quality of care may suffer, because doctors who don't see enough patients may have trouble maintaining skills.

Costs also can rise, as doctors hungry for work begin requiring tests or performing services that otherwise would not have been provided. Then, too, there is the sheer waste of resources involved in preparing doctors for a profession that does not need them.

"Training is expensive," said Detmer. "It costs \$1.5 million to train someone from the start of medical school to the completion of a * five-year residency. And once you're trained as a doctor, there is little else you are trained to do."

As concerns over the problem grow, the effort to combat the physician surplus is emerging on several fronts.

The administration's decision to pay hospitals to train fewer doctors is one. But why should hospitals be interested in this when, under current law, they automatically get sizable government subsidies * for training residents who as part of their education take care of many of the hospitals' patients, work long hours and collect meager salaries?

The answer, said the American Medical Association's James Bentley, is that hospitals know the deal they have now won't last.

With "literally every study saying we're training too many * [doctors], the subsidy from Medicare is likely to be decreased," said Bentley. "So the hospitals are trying to negotiate a less painful transition and avoid an abrupt cutoff" of government subsidies altogether.

In other words, hospitals want to ensure a soft landing when * the government does cut Medicare's doctor-training subsidies, as has been proposed frequently on Capitol Hill.

The Institute of Medicine recommended in 1996 that no new

medical schools be opened, that class sizes be frozen, and that
 * first-year residency slots be brought "much closer to the current number of graduates of U.S. medical schools."

Much of the difference is now filled by graduates of foreign medical schools.

Last week a powerful coalition of medical groups, including the American Medical Association and the Association of American Medical Colleges -- the umbrella group for medical schools -- proposed
 * their own plan. Their idea is to limit residency slots financed by
 * Medicare to the number needed for the 17,000 annual graduates of U.S. medical schools.

An additional 8,000 slots currently available each year -- occupied by graduates of foreign medical colleges, many of whom do not return to their own countries but stay and swell physician ranks here
 * -- would no longer be subsidized by Medicare. The effect of this provision would be to squeeze out foreign medical school graduates
 * from residencies because hospitals would receive no subsidy for them.

But the proposal is controversial, in part because nearly half the foreign medical college graduates are actually permanent U.S.
 * residents or citizens who studied abroad. In addition, many of the foreign medical graduates practice in "underserved" rural or inner city areas which often have a hard time finding doctors.

"It is a question of maldistribution. Even though there may be a general oversupply, in many specialties there is severe maldistribution geographically, and international medical graduates perform significant gap-filling roles in specific areas with high infant mortality rates, average to below-average socio-economic standards, low per-capita income, and large minority populations and many older people," said Neil Parsekh, legislative director of the 26,000-member American Association of Physicians of Indian Origin.

In addition, Clinton's budget, like many earlier proposals from members of both parties in Congress, would reduce the amount of
 * residency subsidies per person.

* One payment called the "indirect medical education" subsidy,
 * based on ratios of residents to patients, would be cut substantially,
 * for example. Clinton would also cap the number of residency positions at the current level.

<http://www.washingtonpost.com>

I0607 * End of document.

U.S. Will Pay To Reduce Doctor Glut; Teaching ...

DOCUMENT 4 OF 15

WP9723600123

A Section

U.S. Will Pay To Reduce Doctor Glut; Teaching Hospitals That Shrink
Programs To Receive Millions

Amy Goldstein

Washington Post Staff Writer

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The federal government has agreed to pay hospitals around the country hundreds of millions of dollars not to train doctors in a highly unorthodox initiative aimed at alleviating a growing glut of physicians.

The initiative, embedded in the new federal budget agreement, extends to all 1,025 of the nation's teaching hospitals an offer similar to a controversial experiment approved for New York earlier this year.

That experiment, which will pay hospitals in that state \$400 million over the next several years, while they gradually decrease the number of young doctors they train, drew an outcry from teaching hospitals elsewhere that felt New York had wangled a lucrative special deal. Their protests attracted the sympathy of congressional Republicans who decided that, instead of trying to block the money for New York, they would expand the opportunity nationwide.

The payments represent a rare attempt by the federal government to use subsidies as leverage to shrink a particular work force. "I know of no profession where there has been as much federal effort to regulate," said Uwe Reinhardt, a health economist at Princeton University. "You don't do it for economists, for architects, for engineers."

The payments also are the government's first effort to constrict the pipeline of people entering the medical profession. Several influential groups have warned lately that the nation has too many doctors, particularly specialists, and have urged the federal government to impose limits on the number of recent medical school * graduates, known as residents, who pursue several years of advanced training before beginning to work on their own. But until now that

advice has met with legislative resistance.

The New York experiment and the nationwide initiative hinge on
 * changes in Medicare, the large federal insurance program for the
 * elderly and disabled. Since it began, Medicare has underwritten
 * residency training programs heavily and has, in effect, made residents
 a prized, inexpensive kind of labor for their hospitals. Taxpayers
 spend \$7 billion a year on such training.

Until now, many teaching hospitals have been reluctant to cut
 * back, because every resident translates into an average subsidy of
 \$100,000 a year. "It has not been financially rewarding to downsize,"
 * said Muncy Wheby, associate dean for graduate medical education at
 the University of Virginia.

Under the budget agreement, hospitals that downsize will not
 get extra money outright. But if they volunteer to reduce their
 * residency programs by 20 percent or 25 percent over five years,
 * Medicare will cushion the financial blow. For the first two years, it
 * will pay the whole subsidy for the missing residents. After that, the
 payments will taper off for three years.

The agreement also for the first time essentially forbids
 * hospitals to increase the sizes of their residency programs.

Administration health officials and leading Republicans say
 that the initiative will give hospitals a powerful incentive to train
 * fewer doctors and that Medicare will save money in the long run. After
 five years, the payments will cease and the program will have fewer
 * residents to underwrite.

But others suggest that hospitals will be rewarded needlessly
 for cutbacks that some have started to make without being paid to do
 it. Some say the initiative is the medical equivalent of discredited
 agricultural programs that have paid farmers not to grow certain
 crops.

"I don't know where the hell a Republican Congress gets off
 doing labor force planning for the medical profession," said Robert E.
 Moffit, deputy director for domestic policy studies at the Heritage
 Foundation, a conservative think tank. "As an economic principle, it
 is absurd."

How many physicians the nation produces has important effects
 on the cost of the health care system. The greater the number of
 doctors, research has shown, the more medical tests and expensive
 specialty treatment patients tend to receive, because physicians find
 subtle ways to keep themselves employed.

With more than 700,000 physicians, the United States has more
 doctors per capita than virtually any other country. In particular, it
 has a vast supply of specialists, who are starting to find themselves
 in less demand as more patients are insured through "managed care"
 plans that favor treatment by lower-cost medical generalists.

In a sign of how dramatically the nation's health system is

changing, many teaching hospitals already have started to rethink the size of their training programs despite the economic costs. One reason is that doctors in certain specialties are having trouble finding jobs. And, as managed care shifts more patients' care outside hospitals, some hospitals are afraid they no longer will be able to

* give residents enough hands-on experience.

Mindful of such changes, the Greater New York Hospital Association last year approached the federal Health Care Financing

* Administration (HCFA), which runs Medicare, with a plan to pay

* hospitals for several years while they cut residents. Last February, Bruce C. Vladeck, HCFA's administrator, announced he had agreed to the experiment.

The New York hospital association predicted that perhaps a dozen of the state's 75 teaching hospitals would be interested.

Instead, 42 rushed to sign up. "A lot of institutions were sitting on

* the fence" about whether to train fewer residents, said Kenneth Raske, the association's president. "This pushed them over."

But the special arrangement for New York infuriated teaching hospitals in Boston, Texas and other parts of the country. For example, the parent company that owns Massachusetts General, and Brigham and Women hospitals in Boston, two of the country's most prestigious teaching hospitals, had just set in motion a plan to train 20 percent fewer specialists, with no federal help.

The experiment also angered the leadership of the House Ways and Means Committee, which had been considering its own ideas for cutting back the number of doctors and felt preempted by Vladeck.

"What the administration proposed was a sweetheart deal," said Ari Fleischer, spokesman for the committee's chairman, Rep. Bill Archer (R-Tex.).

But, Fleischer said, "the administration did put its finger on a growing national problem. So Congress thought it was better to extend a good policy to the nation." He said the subsidies were consistent with Republican preferences for market solutions to health care problems. "It remains a voluntary matter of choice for these teaching hospitals," he said. "It isn't a mandate."

Still, the idea has its critics. "It is voluntary, but it isn't voluntary for the taxpayer," said the Heritage Foundation's Moffit.

Others question whether it is necessary. The number of young doctors training to become anesthesiologists, for example, has declined from about 1,500 three years ago to 450 this year following well-publicized warnings that the field was saturated. Starting a few years ago, "people weren't able to get the plum jobs in the cities they wanted. [They] would have to take jobs in Idaho, Oklahoma," said James Kottrell, chairman of anesthesiology at the State University of New York Health Center in Brooklyn. On the other hand, Jane Matjasko, chairwoman of anesthesiology

at the University of Maryland Hospital in Baltimore, said her hospital had to spend extra money to hire 10 doctors after its training program * was reduced recently from 40 residents to 20. Without federal help, she said, the hospital could not afford similar cuts in many other programs.

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I0607 * End of document.

Should Some Medical Schools Be Closed?

DOCUMENT 3 OF 15

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Health

FORUM

Should Some Medical Schools Be Closed?

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Z19

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- * YES. Even if adjustments are made in the number of residency training positions to eliminate most of the positions taken by international medical graduates, there will still be too many physicians in the pipeline in this country. Even if we scaled back
- * residency training to only 110 percent of U.S. medical graduates, we are still graduating more than twice the number of new physicians as in 1970.

The Pew Commission has recommended closing 20 percent to 25 percent of medical schools. We based our conclusion on the current need for physicians and the projected change in that need, even with a modest movement to managed care.

The Institute of Medicine (IOM), the American Association of Medical Colleges and other major groups look at the same data as did the Pew Commission. But they represent the incumbent establishment in academic medicine, which wants the status quo. Cutting class size across the board treats weak and strong schools the same, making all schools less efficient. The Pew Commission maintains that entire schools, the weaker ones, should be closed in the name of quality and excellence.

- Of course medical schools are going to oppose shuttering
- * unneeded schools. Medical education is an industry that has a \$22 billion subsidy, with virtually no accountability. It is essentially run by physicians and professional and educational associations, with little, if any, federal regulation. The decision to close medical schools shouldn't be left to the physicians who run them.

The schools try to defend themselves by pointing to responsibilities beyond education, including tertiary care and world-class research. The schools that can stay in business by

providing these services should do so. But if they can't cut it, why shouldn't they be eliminated?

Edward O'Neil, PhD

Executive director, Pew Health Professions Commission;
Director, Center for the Health Professions, University of
California, San Francisco

NO. The Institute of Medicine's Committee on the U.S.
Physician Supply agrees that immediate steps are needed to reduce the
number of physicians-in-training.

However, the Pew Commission is far too drastic in calling for
up to a 25 percent reduction in the number of medical schools. Such an
action could cause serious complications and would be difficult to
reverse if the policy changes proved to be wrong. The IOM committee
calls for more cautious actions, including a freeze on class sizes in
medical schools.

Pew does not explain why it chose 25 percent rather than 5
percent or 50 percent, or any other figure. If you close schools, you
had better be sure you are absolutely correct about the work force
needs of the future, because schools cannot be easily reopened.

Medical schools do more than teach medical students. They teach
* residents, they teach allied health students, and they teach doctoral
students in the basic sciences. They do most of the biomedical
research in the United States.

The IOM felt it would be better to look at international
medical graduates. While the number of U.S. graduates has held steady
at about 17,500, the number of international medical graduates in
* residencies or fellowship positions increased by 80 percent -- from
12,433 to 22,706 -- from 1988 to 1993. If you close schools without
* dealing with international graduates, these residency slots will be
filled by the foreign students rather than U.S. grads.
* There must be a cap on the number of funded residency positions
to keep cash-strapped hospitals from increasing them.

Some schools may close because of financial problems or local
issues. Some have reduced the size of their classes. Some may merge.
Before implementing rash public policy to close schools, we should
wait and see what happens.

Neal Vanselow, MD

Co-chairman, IOM Committee on the U.S.

Physician Supply; professor of medicine, Tulane University

<http://www.washingtonpost.com>

I0607 * End of document.

Med School Millionaires

DOCUMENT 2 OF 15

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OP-ED

Med School Millionaires

Daniel S. Greenberg

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Don't expect anything but a hemorrhage at the Treasury from that new program to counter the doctor surplus by paying hospitals to
* reduce the number of residency slots for the final phase of medical training.

Reminiscent of the agricultural-support schemes that paid farmers for not growing crops, the medical plan was inspired by an immutable law of American medical practice: More doctors mean more medical spending, despite the penny-pinching tactics of managed care. So, stop them before they can start hustling patients, the Washington
* strategists concluded. The medical-education industry, however, is too profitable, inventive and resilient to yield to that tactic.

The major factor in the medical-production pipeline is medical-school enrollments. And data compiled by the American Medical Association show that these have remained virtually unchanged for more than 15 years, as have the number of medical schools.

In fact, medical schools have supplanted military bases as immortal institutions. In 1980-81, the 124 medical schools in the United States enrolled 65,497 students; in 1996-97, the number of schools remained at 124, and enrollments stood at 66,712 -- though a long succession of studies proclaimed a surfeit of doctors.

* The big change in medical education was a vast increase in revenues, much of it from so-called practice plans that pay medical faculty for attending to patients, usually in conjunction with their teaching duties. Over the past decade, this income total for faculty at the 124 schools has risen from \$5.2 billion to \$10.6 billion.

And, in accord with the Willie Sutton principle, the number of full-time faculty has soared, though the number of students remains almost unchanged. In 1983-84, the nationwide faculty totaled 56,564. In the current academic year, the number of faculty members is 95,568.

Where are they coming from? To a large extent, they were already there at the university on other payrolls, and were switched * to the more bountiful cash flow of medical education, which draws on patient fees, federal research and ample loans to finance runaway tuition fees -- to be repaid by high medical incomes.

A little-known fact of American higher education is that the highest paid people on many prestigious campuses are not university presidents. The big bucks go to the medical school professors. At Columbia University, according to the Chronicle of Higher Education, the president was paid \$317,187 in 1994-95, while one professor of surgery received \$1,526,397 and two others took in more than \$1 million apiece.

At Cornell University, the president received \$294,687 in pay and benefits in 1994-95. A professor of surgery at Cornell received \$1.7 million in pay that year, while two others each took in over \$1.2 million.

The president of New York University was paid \$379,000. The chairman of neurosurgery got \$748,342, while four other medical professors received more than \$600,000 each.

At universities without medical schools, pay scales don't approach these stratospheric medical incomes. At Princeton, for example, the presidential pay was tops, at \$305,538, and the next five highest salaries ranged between \$197,796 and \$240,713. At MIT, the president received \$285,000, and the next highest salary was \$236,000.

The medical-school industry, in alliance with local politicians, is eternally resistant to downsizing pleas. The Pentagon wants to close the medical school that was forced on it by Congress in 1972, the Uniformed Services University of the Health Sciences, in Bethesda. The General Accounting Office says the school is excessively expensive and satisfies only a tiny proportion of the armed services' physician requirements. But the school survives.

The Washington lobby for medical schools, the Association of American Medical Colleges, says the solution to the doctor surplus * is to exclude foreign-trained physicians from residency slots. The downside to that prescription is that foreigners are willing to train and practice in inner-city areas that home-grown physicians tend to shun.

But whatever is done in the quest for surplus reduction, the odds * are that it won't work. The medical-education industry is too smart and well-connected to be deprived of its golden goose.

Daniel S. Greenberg is editor of Science & Government Report, a Washington newsletter.

<http://www.washingtonpost.com>

I0607 * End of document.

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Teaching Hospitals in New York State To Cut ...

DOCUMENT 4 OF 4

J9704900023

Technology & Health

Teaching Hospitals in New York State

To Cut Doctor-Training Slots Up to 25%

By Ron Winslow

Staff Reporter of The Wall Street Journal

581 Words

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* 02/18/97

The Wall Street Journal

B6

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NEW YORK -- Teaching hospitals in New York state, including some of the nation's most prestigious medical centers, will reduce the number of doctor-training slots by 20% to 25% during the next six years.

- * The initiative, which is a pilot project with the federal Medicare program, is aimed at helping the hospitals overhaul what many experts consider outmoded doctor-education programs that are producing too many specialists in a market already bulging with highly trained physicians.

Moreover, current training programs focus on in-patient care even as more and more medical services are provided in an outpatient setting.

- * Over six years, the number of new residencies, as the training positions are called, will decline about 2,000 from the current 10,286 slots offered by the 41 hospitals participating in the project. All told, about 75 hospitals in New York currently train about 15% of the nation's future doctors, more than any other state.

Health policy experts have warned for more than two decades that

- * graduate medical-education programs are churning out more specialists than the nation needs, but the number of training slots for doctors has grown substantially, nevertheless, said Bruce C. Vladeck, administrator of the Health Care Financing Administration, which administers the Medicare program. Now the growing dominance of managed care and demand for efficiencies in the delivery of care is raising even more concern about the output of the nation's academic medical centers.

The new pilot program "is the most dramatic, concrete proposal we

- * have seen to turn around the trends and shrink the number of residency positions," Dr. Vladeck said.

After graduating from medical school, new doctors typically undergo

- * three years of residency training, and, for subspecialists, as many as four more years of fellowships before entering practice.
- * Currently, Medicare pays more than \$7 billion annually to teaching

hospitals nationwide to support this training. Because a hospital's
* share of the funds is based on the number of its residencies, the
subsidies have long been an incentive for an institution to increase the
number of training slots.

Under the demonstration project, HCFA will provide payments totaling
\$400 million over six years to the participating hospitals to provide
support for restructuring their training programs. When fully
* implemented, the effort would save Medicare about \$300 million a year in
New York state.

Many of the state's teaching hospitals have long wanted to downsize
their programs to decrease costs and increase their competitive edge in
the marketplace, said Kenneth Raske, president of the Greater New York
Hospital Association, a trade group which devised the pilot project.
* "But they were hung up because of the cross-incentives" from Medicare
that encouraged the larger-scale programs.

Mr. Raske said the \$400 million will enable participating hospitals
to hire or train doctors, nurses and other personnel to perform certain
* duties now handled by residents. At the same time, special provisions of
* the project enable hospitals to jettison fewer residency slots if they
bolster primary-care training or work collaboratively with other
institutions in restructuring their programs.

Mr. Raske noted that under managed care, in-patient hospital use is
shrinking. That is prompting a significant increase in outpatient
procedures and it also means that patients who need in-patient care are
more seriously ill on average than they have been in the past. One goal
of the pilot project, he said, is to reorient doctor training to
accommodate these changes in patient care.

Dr. Vladeck said if the New York program is successful, the ideas are
likely to be picked up by teaching hospitals elsewhere.



FAX COVER SHEET



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Number of Pages: 1Date: 9/18/97

To:

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REMARKS: This stuff relates to IMGs -- but we
don't talk about that -- but the basic
problem is the same. Note Section on NY
in NEJM article.

HEALTH CARE FINANCING ADMINISTRATION

200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

What are State Patterns in the Growth of GME?

1/24/91

STATE	1988-89 Count	1989-90 Count	1990-91 Count	1991-92 Count	1992-93 Count	1993-94 Count	1994-95 Count	1995-96 Count
ALABAMA	73	73	78	93	111	125	139	143
ALASKA	203	221	224	242	238	262	255	283
ARIZONA	2,354	2,433	2,457	2,541	2,598	2,666	2,741	2,689
ARKANSAS	298	305	338	358	382	392	428	441
CALIFORNIA	11,732	12,712	13,828	14,343	14,838	14,944	15,088	15,739
COLORADO	1,763	1,945	2,052	2,145	2,208	2,276	2,361	2,549
CONNECTICUT	95	102	102	115	119	126	117	125
DELAWARE	4,103	4,196	4,394	4,731	4,714	5,118	4,972	4,908
FLORIDA	660	671	653	664	681	706	733	721
GEORGIA	346	363	384	416	447	443	432	469
HAWAII	5,594	5,895	6,534	6,820	6,577	6,853	7,049	6,983
IDaho	734	737	785	795	778	777	748	764
ILLINOIS	461	467	504	535	570	613	673	686
INDIANA	777	821	840	854	908	970	959	920
IOWA	66	71	76	84	88	75	78	90
KANSAS	1,564	1,561	1,640	1,744	1,795	1,895	1,980	1,943
KENTUCKY	4,381	4,861	4,988	5,401	5,843	5,949	6,395	6,571
LOUISIANA	481	490	507	530	557	551	513	556
MAINE	223	230	234	240	264	237	236	239
MARYLAND	1,536	1,566	1,678	1,691	1,742	2,038	1,875	2,035
MASSACHUSETTS	1,009	1,037	1,254	1,336	1,413	1,472	1,513	1,548
MICHIGAN	452	457	441	463	493	531	559	609
MINNESOTA	1,378	1,440	1,502	1,511	1,576	1,610	1,639	1,652
MISSISSIPPI	37	40	43	42	38	37	37	44
MISSOURI	31	334	330	196	652	199	0	0
MONTANA	82,789	86,991	91,766	95,130	98,573	102,168	103,640	104,609
NEBRASKA	1,564	1,561	1,640	1,744	1,795	1,895	1,980	1,943
NEVADA	8.7%	14.4%	2.9%	95.9%	NEVADA			
NEW HAMPSHIRE	5.7%	1.9%	11.0%	38.0%	NEW HAMPSHIRE			
NEW JERSEY	2.6%	2.6%	-1.9%	14.2%	NEW JERSEY			
NEW MEXICO	6.4%	6.2%	3.0%	48.0%	NEW MEXICO			
NEW YORK	7.0%	1.7%	4.3%	34.2%	NEW YORK			
NORTH CAROLINA	6.7%	3.3%	8.0%	44.4%	NORTH CAROLINA			
NORTH DAKOTA	6.7%	0.7%	6.8%	31.6%	NORTH DAKOTA			
OHIO	4.9%	1.8%	-1.3%	19.6%	OHIO			
OKLAHOMA	0.2%	3.4%	-1.6%	9.2%	OKLAHOMA			
OREGON	4.1%	0.9%	5.9%	22.5%	OREGON			
PENNSYLVANIA	6.9%	1.2%	-0.9%	24.8%	PENNSYLVANIA			
PUERTO RICO	1.8%	-2.0%	2.1%	1.5%	PUERTO RICO			
RHODE ISLAND	5.1%	8.0%	1.9%	48.8%	RHODE ISLAND			
SOUTH CAROLINA	3.2%	4.0%	-4.1%	18.4%	SOUTH CAROLINA			
SOUTH DAKOTA	8.4%	-2.2%	15.4%	36.4%	SOUTH DAKOTA			
TENNESSEE	3.7%	4.3%	-1.9%	24.2%	TENNESSEE			
TEXAS	7.3%	5.8%	2.8%	50.0%	TEXAS			
UTAH	3.3%	2.7%	-3.0%	15.6%	UTAH			
VERMONT	2.5%	-0.2%	1.3%	7.1%	VERMONT			
VIRGINIA	3.1%	4.2%	8.5%	32.5%	VIRGINIA			
WASHINGTON	10.1%	6.2%	2.3%	55.4%	WASHINGTON			
WEST VIRGINIA	0.9%	6.5%	8.9%	34.7%	WEST VIRGINIA			
WISCONSIN	3.1%	2.6%	-0.4%	18.4%	WISCONSIN			
WYOMING	4.4%	-4.1%	18.9%	18.9%	WYOMING			
UNIDENTIFIED MILITARY	311.9%	27.3%	0.0%	-90.3%	UNIDENTIFIED MILITARY			
U.S. U.S.	4.7%	2.9%	0.9%	26.4%	TOTALS U.S.			

Average Annual Growth Rate			7 yr cumulative growth rate	STATE
1988-89 to 1990-91	1991-92 to 1993-94	1994-95 to 1995-96	1988-89 to 1995-96	
8.7%	14.4%	2.9%	95.9%	NEVADA
5.7%	1.9%	11.0%	38.0%	NEW HAMPSHIRE
2.6%	2.6%	-1.9%	14.2%	NEW JERSEY
6.4%	6.2%	3.0%	48.0%	NEW MEXICO
7.0%	1.7%	4.3%	34.2%	NEW YORK
6.7%	3.3%	8.0%	44.4%	NORTH CAROLINA
6.7%	0.7%	6.8%	31.6%	NORTH DAKOTA
4.9%	1.8%	-1.3%	19.6%	OHIO
0.2%	3.4%	-1.6%	9.2%	OKLAHOMA
4.1%	0.9%	5.9%	22.5%	OREGON
6.9%	1.2%	-0.9%	24.8%	PENNSYLVANIA
1.8%	-2.0%	2.1%	1.5%	PUERTO RICO
5.1%	8.0%	1.9%	48.8%	RHODE ISLAND
3.2%	4.0%	-4.1%	18.4%	SOUTH CAROLINA
8.4%	-2.2%	15.4%	36.4%	SOUTH DAKOTA
3.7%	4.3%	-1.9%	24.2%	TENNESSEE
7.3%	5.8%	2.8%	50.0%	TEXAS
3.3%	2.7%	-3.0%	15.6%	UTAH
2.5%	-0.2%	1.3%	7.1%	VERMONT
3.1%	4.2%	8.5%	32.5%	VIRGINIA
10.1%	6.2%	2.3%	55.4%	WASHINGTON
0.9%	6.5%	8.9%	34.7%	WEST VIRGINIA
3.1%	2.6%	-0.4%	18.4%	WISCONSIN
4.4%	-4.1%	18.9%	18.9%	WYOMING
311.9%	27.3%	0.0%	-90.3%	UNIDENTIFIED MILITARY
4.7%	2.9%	0.9%	26.4%	TOTALS U.S.

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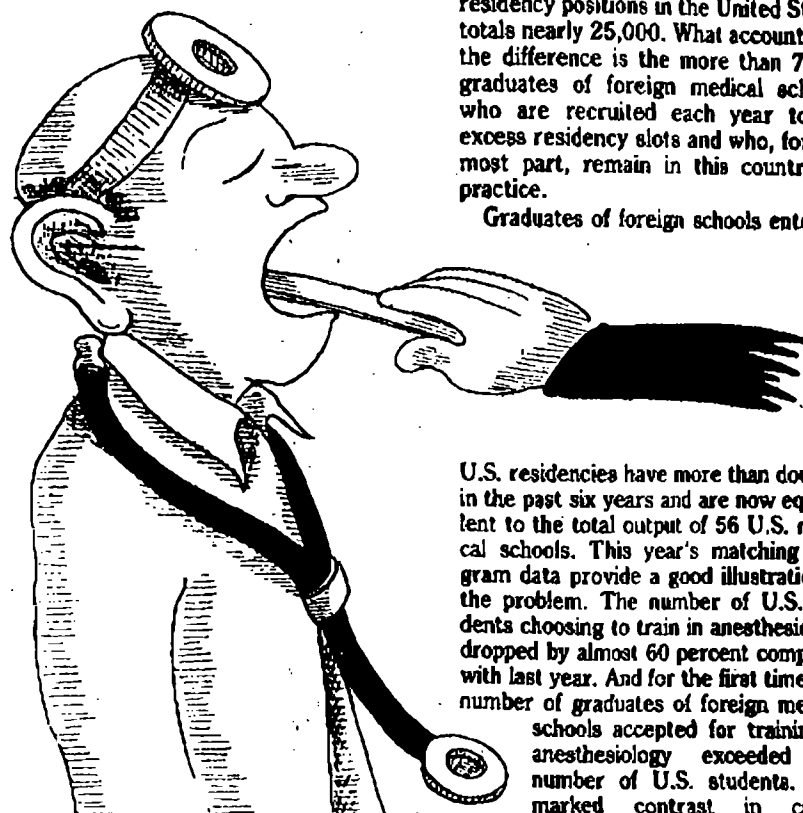
Jordan Cohen

False Diagnosis

Who says the ivy towers of medical academe are insulated from the demands of the health care marketplace? For the second year in a row, more than half of graduating U.S. medical school seniors will begin their training in one of the generalist disciplines, while the number of students entering such specialties as anesthesiology and diagnostic radiology dropped significantly. This information, recently released by the National Resident Matching Program—the route through which almost all U.S. medical school seniors secure residency positions—should be noted by both policymakers and the leaders in medical education who worry about an oversupply of physicians. Future doctors, educated in U.S. medical schools, are clearly receiving informed counsel, and by their career choices are demonstrating that they understand the needs of the evolving health care system.

The matching program data may also be instructive to those who have sought to grab headlines by recommending that closing U.S. medical schools is the way to curtail the supply of doctors. Their simplistic solution obscures more complicated issues.

As the data show, many institutions continue to fill specialty positions that the medical marketplace no longer wants or needs. And they are filling them with graduates of foreign medical schools—schools that have not withstood the rigors of our accreditation process. Before jeopardizing America's health care system by attacking U.S. medical schools, we must reduce both the number of residency positions in oversubscribed areas of medical practice and the number of graduates of foreign medical schools that we train.



BY MARGARET SCOTT

residency positions in the United States totals nearly 25,000. What accounts for the difference is the more than 7,000 graduates of foreign medical schools who are recruited each year to fill excess residency slots and who, for the most part, remain in this country to practice.

Graduates of foreign schools entering

U.S. residencies have more than doubled in the past six years and are now equivalent to the total output of 56 U.S. medical schools. This year's matching program data provide a good illustration of the problem. The number of U.S. students choosing to train in anesthesiology dropped by almost 60 percent compared with last year. And for the first time, the number of graduates of foreign medical schools accepted for training in anesthesiology exceeded the number of U.S. students. This marked contrast in career choices is borne out in other specialties such as diagnostic radiology and pathology.

Medical school faculties and teaching hospital executives should heed the signals from the marketplace and wean their institutions from their dependence on graduates of foreign medical schools. Clearly, those institutions that carry a heavy burden of indigent care must be given financial assistance as they find alternatives to foreign medical graduates

For more than a decade, our nation's 125 medical schools have graduated the same number—about 16,000—of new physicians a year, who then proceed to their next phase of training as residents in a teaching hospital. (The nation's osteopathic medical schools graduate an additional 1,700 students a year.)

In comparison, however, the number of new physicians entering first-year

Robert D. Novak

Clinton's Great Chance

HEALTH POLICY REPORT

THE QUANDARY OVER GRADUATES OF FOREIGN MEDICAL SCHOOLS IN THE UNITED STATES

JOHN K. IGLEHART

PROFESSIONAL and political concern about the increasing numbers of graduates of foreign medical schools entering U.S. residency programs has re-emerged during the past year. Previous attempts to limit the number of such graduates who fill residency positions have been thwarted by a practical but serious problem: who will care for the millions of people, many of whom are poor, in inner cities and rural communities, if the institutions serving these areas are unable to recruit foreign-trained physicians for the residencies and staff practices that are generally shunned by graduates of American medical schools? In this report, I will discuss the controversies surrounding the growing number of graduates of foreign medical schools, including the reluctance of the Clinton administration and many members of Congress to reduce the opportunities for these persons to train and practice here.

Graduates of foreign medical schools represent about 23 percent of actively practicing physicians in the United States (Table 1). These physicians fill an increasing number of U.S. residency training positions — the required gateway to medical practice in this country — and a majority of them remain here.¹ Three categories of such physicians participate in residency programs in the United States: citizens of other countries who are in the United States on temporary visas (H-1B or J-1 visas), immigrants who are naturalized American citizens or have permanent-resident status, and native-born American citizens who graduated from foreign medical schools and have returned to the United States for advanced training. Between 1988 and 1994, the number of graduates of foreign medical schools entering U.S. residency training programs more than doubled, from 2201 to 5891 (Table 2). Since the early 1980s, the number of graduates of U.S. medical schools has remained stable, at about 17,000 a year.

MEDICARE AND GRADUATE MEDICAL EDUCATION

Graduate medical education is financed through public and private revenues from third-party payments for medical care. Medicare, the federal health insurance program for the elderly and disabled, is a crucial source of funding for teaching hospitals, because it makes payments for graduate medical education and sets no limits on the number of residents it will support. The largest explicit source of funding for graduate medical education, Medicare makes direct medical-education payments to hospitals for residents' stipends, faculty salaries, related administrative expenses, and institutional overhead allocated to residency programs, as well as an indirect medical-education adjustment to

per-case payments. The indirect adjustment is meant to compensate teaching hospitals for the increased costs attributable to the involvement of residents in patient care and the severity of conditions in patients requiring the specialized services that teaching hospitals provide. In 1995, Medicare provided \$2 billion in direct medical-education payments and \$4 billion in indirect payments. Both sets of payments are based on the number of residents being trained in a hospital: the more residents, the higher the payments. Some teaching hospitals have responded to financial pressures by increasing the number of residency positions and, hence, their revenues.

These Medicare monies also finance substantial amounts of medical care, much of it for people who are poor but not among the program's 34 million beneficiaries. In a recent speech, Dr. Philip R. Lee, assistant secretary for health and scientific affairs in the Department of Health and Human Services, stated,

We know that in some institutions, particularly in New York and New Jersey, residents are being used, and these are largely or almost exclusively foreign medical graduates, to provide cheap care for poor people. It's a way to subsidize care through residency training and not actually fund the real costs.²

ATTEMPTS TO REDUCE MEDICARE SUPPORT

Over the past decade, there have been a number of unsuccessful attempts to reduce Medicare support for graduates of foreign medical schools in U.S. training programs. In 1985, Senator Robert Dole (R-Kans.) and two colleagues introduced legislation that would have terminated Medicare payments for residency positions filled by graduates of foreign medical schools who were not U.S. citizens³; the measure was never enacted. During the debate over health care reform in 1993 and 1994, proposals supported by the Clinton administration and several congressional committees called for a strict limit on the number of physicians allowed to enter residency programs (110 percent of the number of graduates of U.S. medical schools). This stricture, which would have effectively closed U.S. training positions to all but a few graduates of foreign medical schools, had been recommended to Congress by the

Table 1. Graduates of U.S. and Foreign Medical Schools Practicing as Allopathic Physicians in the United States.*

CATEGORY	1985	1989	1994
<i>no. of physicians</i>			
All graduates	511,090	559,988	632,121
Graduates of U.S. medical schools	398,430	437,165	483,039
Graduates of foreign medical schools	112,660	122,823	149,082
U.S.-born	16,344	18,905	19,275
Foreign-born	96,316	103,918	129,807

*Data, which are year-end numbers, are from the American Medical Association's Physician Masterfile.

Physician Payment Review Commission and the Council on Graduate Medical Education.^{4,5} The reform died, with no legislation enacted. The fiscal-year 1997 budget that the Clinton administration has submitted to Congress proposes a freeze on the current number of residencies supported by Medicare — a measure advocated by Dr. Kenneth I. Shine, president of the Institute of Medicine.⁶ It is uncertain whether Congress will act on this proposal in 1996.

In 1995, as part of the Republican effort to balance the federal budget, Congress again considered reducing Medicare support for residency positions filled by graduates of foreign medical schools. Testifying before the Senate Finance Committee in July on behalf of the Association of American Medical Colleges, its president, Dr. Jordan J. Cohen, said:

While the association should consider all available options for addressing this oversupply [of physicians], it should — first and foremost — pursue options to diminish the number of international medical graduates pursuing graduate medical education in the United States and remaining in the United States following the completion of their graduate training.⁷

Senator Daniel Patrick Moynihan of New York, the committee's ranking Democrat and former chairman, took exception to Cohen's testimony and made a strong case for maintaining the status quo, arguing, "The number of residents is, and should be, a function of medical science." On October 19, the House voted to reduce Medicare support for graduates of foreign medical schools with only temporary visas.

As the year wore on, however, congressional support for such actions waned. Finally, in November, a House-Senate conference committee, meeting to reconcile differences in Republican-sponsored budget bills approved by the two chambers, eliminated a provision that would have reduced Medicare payments to teaching hospitals for residency positions filled by graduates of foreign medical schools. Kenneth E. Raske, president of the Greater New York Hospital Association, declared the

action a major victory for the association's members and credited Senator Alfonse M. D'Amato and Representative Susan Molinari, both New York Republicans. On December 6, 1995, President Clinton vetoed the entire budget bill, thus ending the yearlong Republican effort to reform Medicare.⁸

THE POLITICAL ARENA

A wide variety of private and public interests, many with competing agendas, are represented in the debate over graduates of foreign medical schools, including teaching hospitals and their Washington, D.C., lobby, the National Institutes of Health and other biomedical research centers, other federal and state agencies, legislators, professional medical associations, accrediting bodies, and immigration lawyers. The academic community itself is divided. Whereas the Association of American Medical Colleges favors strict limits on the entry of foreign-trained physicians into residency positions, other academic groups oppose measures that restrict the number of scientists from other countries who are allowed to immigrate.^{9,10} Most of these parties, including Congress, do not consider the question in the context of the overall supply of physicians. Instead, they address narrow interests, such as expanding residency positions to generate revenue and provide service, staffing rural practices, or pressing the legal cases of individual doctors seeking entry into the United States.

The processing of the exchange-visitor visas for which graduates of foreign medical schools apply exemplifies the involvement of several federal agencies with different agendas. The U.S. Information Agency administers the exchange-visitor program and grants J-1 visas. Applicants must be guaranteed employment by an accredited educational institution, such as a teaching hospital, university, or the National Institutes of Health, before a visa is granted. All graduates of foreign medical schools must also obtain certification by the Educational Commission for Foreign Medical Graduates, which approves the credentials of graduates of some 900 foreign medical schools in approximately 130 countries. In 1994, the largest numbers of certificates were granted to doctors from India (accounting for 25.9 percent of the certificates granted), the Philippines (8.1 percent), Pakistan (5.9 percent), the countries of the former Soviet Union (4.2 percent), China (3.7 percent), and Egypt (2.6 percent). U.S. citizens, principally from medical schools in the Dominican Republic, Grenada, Mexico, and Montserrat, were granted 4.9 percent of all certifications in 1994.

On completion of their work or training, exchange visitors are required to return to their native countries for a minimum of two years before attempting to return to the United States on a permanent basis. This requirement can be waived, however, under circumstances deemed exceptional, if the waiver is requested by another federal agency. Since 1992, the number of

Table 2. Graduates of U.S. and Foreign Medical Schools Entering U.S. Residency Programs, 1988 to 1994.*

YEAR	GRADUATES OF U.S. MEDICAL SCHOOLS	GRADUATES OF FOREIGN MEDICAL SCHOOLS	
		U.S.-BORN FOREIGN-BORN	
		number	
1988	17,233	1401	2201
1989	17,292	1449	2875
1990	17,435	1531	3580
1991	16,923	1296	3791
1992	16,771	1236	4877
1993	17,086	1166	5517
1994	16,869	810	5891

*Data are from the Association of American Medical Colleges.

waivers granted by such agencies on behalf of exchange visitors has increased dramatically. The U.S. Information Agency estimates that at least 95 percent of the waiver applications were filed on behalf of foreign physicians (Ohlhausen W: personal communication). In 1992, the agency approved 486 waiver applications and disapproved none. The agency approved 666 waivers and disapproved 3 in 1993, approved 788 and disapproved 15 in 1994, and approved 1580 and disapproved 17 in 1995. Among the federal agencies that filed waiver applications in 1995, the Department of Agriculture submitted the largest number (651). Virtually all these applications were filed on behalf of rural communities and hospitals trying to attract physicians or lawyers representing doctors from other countries.

In 1991, immigration law was liberalized to permit graduates of foreign medical schools who intend to practice in the United States to obtain H-1B visas, which were previously available only for teaching or research. In 1995, the Immigration and Naturalization Service considered eliminating the practice option but backed off under pressure, citing the concern that some communities might otherwise not be able to attract physicians.¹¹ The Department of Health and Human Services recently tried to persuade other federal agencies that a standardized process and set of criteria should be used when seeking waivers. Standardized procedures might reduce the number of waivers, but the outcome is uncertain.

The political adversaries in the battle are divided along geographic lines more than along party lines. Almost half of all graduates of foreign medical schools participating in U.S. residency programs are in four states: New York, Illinois, Pennsylvania, and New Jersey (Table 3).

The two most influential private organizations favoring limits on the number of residency positions filled by graduates of foreign medical schools are the American Medical Association and the Association of American Medical Colleges. The memberships of both are divided on this issue. Consequently, neither organization lobbies Congress aggressively on behalf of its position. The testimony of Cohen, president of the Association of American Medical Colleges, certainly reflects unequivocal support for reducing the number of residents who are graduates of foreign medical schools. But most of the organization's New York members oppose the policy, and more important, the state's two senators both serve on the Finance Committee, which has jurisdiction over the matter. In short, as a key House staff member said in an interview, "New York has what is tantamount to veto power on this issue, because both of its senators serve on the Finance Committee." The American Medical Association counts among its 194,000 physician members (including residents) a total of 31,000 graduates of foreign medical schools, some of whom are very active in the associa-

tion's affairs. On Capitol Hill, the association devotes most of its lobbying to other economic issues.

WAYS AND MEANS SUBCOMMITTEE HEARING

The political complexity of the debate over graduates of foreign medical schools was apparent at the April 16 hearing convened by the House Ways and Means Subcommittee on Health, which has jurisdiction over Medicare but rarely addresses issues involving the overall supply of physicians. The subcommittee heard from Richard D. Lamm, chairman of the Pew Health Professions Commission, and Dr. Donald E. Detmer, cochairman of the Institute of Medicine's Committee on the U.S. Physician Supply. The Pew commission recently recommended substantially reducing the size of U.S. medical school classes (by 20 to 25 percent) by the year 2005 and the number of residencies (to 110 percent of the number of U.S. graduates), as well as tightening the visa-application process for graduates of foreign medical schools.¹² The Institute of Medicine committee recommended that immediate steps be taken to reduce the number of physicians in training, without diminishing the provision of health care to underserved populations.¹³

Virtually every committee member present at the hearing, from the most conservative Republican to the most liberal Democrat, was either critical of the proposal to curtail the numbers of graduates of foreign medical schools or reluctant to move toward this goal quickly. Representative Bill Thomas (R-Calif.), the subcommittee's chairman, asserted only that the federal government had created the problem, because Medicare pays teaching hospitals for graduate medical education on a per-resident basis, which encourages the hospitals to "make money" by creating more residency positions. Republican Nancy Johnson of Connecticut,

Table 3. States with the Highest Numbers of Foreign-Born Graduates of Foreign Medical Schools in Residency Positions. 1994-1995.*

STATE	TOTAL NO. OF RESIDENTS	FOREIGN-BORN RESIDENTS		
		NO.	% OF ALL RESIDENTS IN STATE	% OF ALL FOREIGN-BORN RESIDENTS IN U.S. (N = 21,176)
New York	15,088	5996	39.7	28.3
Illinois	5,797	1816	31.3	8.6
Pennsylvania	7,049	1463	20.8	6.9
New Jersey	2,741	1203	43.9	5.7
Michigan	4,129	1116	27.0	5.3
Texas	6,394	1045	16.3	4.9
Massachusetts	5,196	1015	19.5	4.8
Ohio	4,971	998	20.1	4.7
California	9,877	955	9.7	4.5
Connecticut	1,835	555	30.2	2.6

*Data are from the Graduate Medical Education Tracking Census, Student and Applicant Information Management Systems Database, of the Association of American Medical Colleges.

†All foreign-born residents who graduated from foreign medical schools.

who eight months earlier had proposed a strict curtailment of federally funded residency positions for graduates of foreign medical schools, said she was now less sanguine about whether the government should intervene. Struck by the acceleration of hospital mergers and residency-program consolidations, Johnson said, "I wonder whether this is a problem that we can leave to the market."

Representative Pete Stark of California, a liberal Democrat who chaired the subcommittee when his party held the majority, underscored the disconnection between an oversupply of physicians and the

millions of Americans [who] are poorly served. Rural communities and inner-city communities go begging for doctors, and minorities are underrepresented in the nation's medical schools. I hope that Congress will not just deal with problems of physician oversupply, but will also address problems of maldistribution and lack of access for so many of our fellow citizens.

Several Republican committee members pointed to the contributions made by foreign-born physicians in their own states. Representative Jon Christensen of Nebraska, a self-described Reagan Republican bent on reducing the size of the federal government, reducing taxes, and outlawing abortion, told of a Turkish oncologist who had treated his father in a hospital in Grand Island, Nebraska. "He extended my father's life, and I will be forever grateful to him for that." Another Republican, Amo Houghton of New York, who is a former chief executive officer of Corning Glass Works, said his hometown of 12,500 residents had come to depend on graduates of foreign medical schools for health care, because the town could not attract graduates of American medical schools. "I am loath to snuff out that flow of medical talent." Although such anecdotes certainly influence the thinking of legislators, it is well to remember that once they have completed their residency training, most graduates of foreign medical schools set up office-based practices in densely populated urban and suburban areas and pursue medical subspecialties with the same zest as their U.S. counterparts.¹

NEW YORK'S RELIANCE ON GRADUATES OF FOREIGN MEDICAL SCHOOLS

Maintaining Medicare funds for residency training is particularly important to teaching hospitals in New York State, because its Republican governor, George E. Pataki, has proposed a sharp reduction (from \$1.8 billion to \$325 million) in annual state support of graduate medical education. In addition, an advisory panel convened by New York Mayor Rudolph W. Giuliani recommended in May that the city reform the way it pays for medical care for the indigent — by subsidizing health insurance premiums for the uninsured rather than subsidizing hospitals that treat the poor.¹¹

The Pataki administration has proposed that New York deregulate its hospital-reimbursement system,

which now requires all insurers to pay similar amounts for care and also to support graduate medical education. The new proposal is based on the belief that teaching hospitals will be able to negotiate with managed-care plans to receive adjustments for graduate medical education. One state official conceded in an interview that there is no certainty that teaching hospitals will be successful in these negotiations, but he defended the proposed policy by pointing out, "Massachusetts and New Jersey deregulated their all-payer hospital-reimbursement systems, and there is little evidence to date that teaching hospitals have suffered financially as a result."

Over the years, New York City's hospitals have been unified in their opposition to changes in federal and state policies that would reduce the number of trainees or payments for graduate medical education. Recently, however, Dr. David B. Skinner, president of New York Hospital, an affiliate of Cornell University Medical School, broke ranks. In a letter prepared for his board that was distributed to hospital executives throughout the city, Skinner said:

In the regulatory climate of New York, funding for graduate medical education has been a surrogate for payment to hospitals for other purposes. Approximately \$190,000 per resident per year [from all sources] is put into hospital rates [for all payers, as an explicit form of support for graduate medical education], which is significantly more than the direct cost of residency programs. This has encouraged many hospitals without adequately developed teaching programs to establish residencies. As a result these programs are not of great quality and are attractive only to international graduates seeking to practice in the United States. Only one-third of GME (graduate medical education) funding goes to academic health centers committed to top quality education. While the magnitude of the Pataki budget proposal is large, it is a necessary step to addressing the proper sizing of graduate medical education in New York.

SEEKING SUBSTITUTE PROVIDERS

How many hospitals actually depend on residents who are graduates of foreign medical schools to provide care to the poor is uncertain; one recent estimate¹⁵ placed the number at 77. If residency positions for such graduates are curtailed, the most frequently recommended option is to expand the National Health Service Corps. The Clinton administration's proposed health care reform called for a fivefold expansion of the corps to provide personnel for medically underserved areas. Established by Congress in 1970 because of concern about a shortage of physicians in underserved areas, the National Health Service Corps has always been subject to the vicissitudes of politics and was even threatened with elimination during the Reagan administration. The corps has a budget of \$115.7 million for fiscal year 1996. Mullan recently argued that if the corps is expanded, hospitals dependent on graduates of foreign medical schools can be staffed with fully trained American physicians, financially strapped young doctors can pay off

their debts while providing service, and the United States can curtail its dependence on graduates of foreign medical schools to care for the poor.¹⁶

CONCLUSIONS

America's reliance on graduates of foreign medical schools represents a quandary for Congress, particularly the Republican members, who have misgivings about government intervention and believe strongly in private markets. But it is, after all, public policy — in the form of Medicare's open-ended support for residents — that exerts the greatest influence on teaching hospitals to create more training positions and fill them with graduates of foreign medical schools. Medicare's impact is becoming even greater as managed-care plans, which are transforming health insurance, resist contributing to the cost of graduate medical education.

Politicians are not enthusiastic about addressing the overall question of the supply of physicians, including the number of residents. Thus, it seems unlikely that Congress will soon curtail the number of graduates of foreign medical schools entering residency training or practice. That day may arrive, but not in this election year. Moreover, such a measure is likely to be part of an omnibus budget bill that pares overall Medicare spending, including open-ended support for residency training, but whether it will address the problem of people who lack health insurance is an open question.¹⁷

As Congress and the Clinton administration move hesitantly, the medical profession seems more prepared to grapple with work-force issues, particularly those involving the looming surplus of doctors, the growth of managed care and its stricter criteria for the use of practitioners, and low-quality training programs. Paradoxically, while U.S. residency programs accommodate an increasing number of graduates of foreign medical

schools, record numbers of American students applying to domestic medical schools are denied admission because of the concern that too many doctors are already being trained.

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Med School Millionaires

By Daniel S. Greenberg

Tuesday, September 9, 1997; Page A19
The Washington Post

Don't expect anything but a hemorrhage at the Treasury from that new program to counter the doctor surplus by paying hospitals to reduce the number of residency slots for the final phase of medical training.

Reminiscent of the agricultural-support schemes that paid farmers for not growing crops, the medical plan was inspired by an immutable law of American medical practice: More doctors mean more medical spending, despite the penny-pinching tactics of managed care. So, stop them before they can start hustling patients, the Washington strategists concluded. The medical-education industry, however, is too profitable, inventive and resilient to yield to that tactic.

The major factor in the medical-production pipeline is medical-school enrollments. And data compiled by the American Medical Association show that these have remained virtually unchanged for more than 15 years, as have the number of medical schools.

In fact, medical schools have supplanted military bases as immortal institutions. In 1980-81, the 124 medical schools in the United States enrolled 65,497 students; in 1996-97, the number of schools remained at 124, and enrollments stood at 66,712 -- though a long succession of studies proclaimed a surfeit of doctors.

The big change in medical education was a vast increase in revenues, much of it from so-called practice plans that pay medical faculty for attending to patients, usually in conjunction with their teaching duties. Over the past decade, this income total for faculty at the 124 schools has risen from \$5.2 billion to \$10.6 billion.

And, in accord with the Willie Sutton principle, the number of full-time faculty has soared, though the number of students remains almost unchanged. In 1983-84, the nationwide faculty totaled 56,564. In the current academic year, the number of faculty members is 95,568.

Where are they coming from? To a large extent, they were already there at the university on other payrolls, and were switched to the more bountiful cash flow of medical education, which draws on patient fees, federal research and ample loans to finance runaway tuition fees -- to be repaid by high medical incomes.

A little-known fact of American higher education is that the highest paid people on many prestigious campuses are not university presidents. The big bucks go to the medical school professors. At Columbia University, according to the Chronicle of Higher Education, the president was paid \$317,187 in 1994-95, while one professor of surgery received \$1,526,397 and two others took in more than \$1 million apiece.

At Cornell University, the president received \$294,687 in pay and benefits in 1994-95. A professor of surgery at Cornell received \$1.7 million in pay that year, while two others each took in over \$1.2 million.

The president of New York University was paid \$379,000. The chairman of neurosurgery got \$748,342, while four other medical professors received more than \$600,000 each.

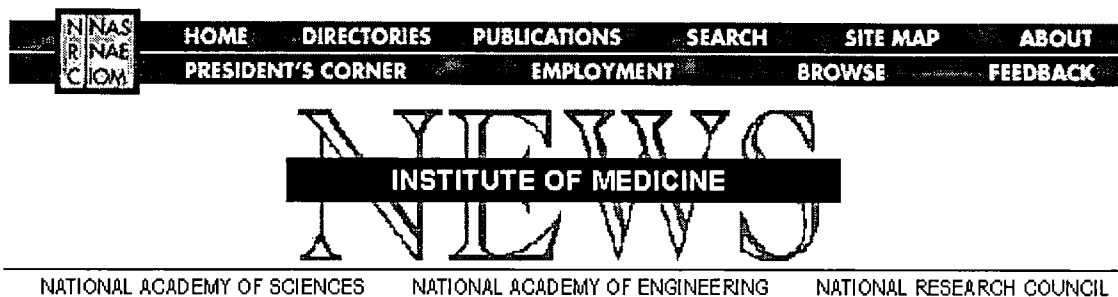
At universities without medical schools, pay scales don't approach these stratospheric medical incomes. At Princeton, for example, the presidential pay was tops, at \$305,538, and the next five highest salaries ranged between \$197,796 and \$240,713. At MIT, the president received \$285,000, and the next highest salary was \$236,000.

The medical-school industry, in alliance with local politicians, is eternally resistant to downsizing pleas. The Pentagon wants to close the medical school that was forced on it by Congress in 1972, the Uniformed Services University of the Health Sciences, in Bethesda. The General Accounting Office says the school is excessively expensive and satisfies only a tiny proportion of the armed services' physician requirements. But the school survives.

The Washington lobby for medical schools, the Association of American Medical Colleges, says the solution to the doctor surplus is to exclude foreign-trained physicians from residency slots. The downside to that prescription is that foreigners are willing to train and practice in inner-city areas that home-grown physicians tend to shun.

But whatever is done in the quest for surplus reduction, the odds are that it won't work. The medical-education industry is too smart and well-connected to be deprived of its golden goose.

Daniel S. Greenberg is editor of Science & Government Report, a Washington newsletter.



Date: Jan. 23, 1996

Contacts: Dan Quinn, Media Relations Associate
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FOR IMMEDIATE RELEASE

CUT RESIDENCY FUNDING, FREEZE MEDICAL SCHOOL SLOTS TO BETTER MATCH PHYSICIAN SUPPLY WITH REQUIREMENTS

WASHINGTON -- Immediate steps are needed to reduce the overall number of physicians-in-training in the United States, while protecting access to health care for underserved populations, a committee of the Institute of Medicine said in a report* released today. The report calls for a freeze on class sizes in medical schools, recommends that no new medical schools be opened, and says the federal government should reduce the number of medical residency positions it funds.

"In the past two decades, the number of physicians has grown 1.5 times the rate of the general population, increasing from 150 per 100,000 people in 1970 to 245 in 1992," said committee co-chair Don Detmer, senior vice president, University of Virginia, Charlottesville. "Yet for all this growth we have seen too little improvement in the cost or quality of, or access to, health care. Having more physicians has not meant having more care of the right kind, at the right place, or at the right cost."

The committee found little evidence of benefits from a significant oversupply of physicians. And problems can arise. Studies have shown that in a fee-for-service practice, increasing the number of doctors can lead to higher aggregate health care costs. Left unchecked, the rising number of physicians may crowd the physician labor market to the point where promising U.S. students might even forego a career in medicine, the report says.

The report says that finding a perfect balance between physician supply and societal needs is probably an unachievable goal. However, the prospect that an "appreciable surplus" of physicians will arise in coming years means that action is needed now to bring the demand and supply into better balance.

"Clearly, if the nation had to choose today between too many physicians and too few, it would prefer an excess, but we think there is little to be gained from a huge imbalance," said co-chair Neal Vanselow, professor of medicine, Tulane University, New Orleans. "Producing more physicians than the nation requires is a waste of both human resources and the federal resources spent on residency training."

The largest growth in the physician work force has been in the number of international medical graduates (IMGs) coming to the United States for government-funded residency training, and eventually, to practice. From 1988 to 1993, the total number of IMGs in residency or fellowship training increased by 80 percent -- from 12,433 to 22,706 -- while the number of U.S. graduates held steady at about 17,500. Seventy-five percent of IMGs who come to the United States for residency training remain here to practice.

The link between payments for health services and for graduate medical training needs to be broken, the committee said. Under today's system of funding, hospitals are compensated by the federal government for each resident they train. This system should be revamped to bring the total number of positions funded closer to the number of graduates from U.S. medical schools. With no cap on the number of residency positions funded, there is an incentive for cash-strapped hospitals to increase residency positions in order to bring in more federal funds.

Some hospitals -- particularly in the inner city and rural areas -- have trouble attracting U.S.-educated doctors for residency training. These institutions depend on an influx of IMGs and the funding they bring to help provide care for underinsured, uninsured, and poor populations. To make up for the loss of income and care that a cut in residency positions could bring in those cases, the federal government should develop a system of "replacement funding" that directly supports the health care of needy populations, rather than funneling such support through residency training, the committee said. Such replacement funding would enable hospitals to use federal support more efficiently by catering spending decisions to the needs of the patients. Some hospitals may elect, for example, to replace resident physicians with nurse practitioners and physician assistants.

The committee stressed that the demand for doctors will remain unpredictable and in flux as managed care continues to grow in relation to the traditional fee-for-service delivery system. Policy-makers, academic health centers, and prospective students

in relation to the traditional fee-for-service delivery system. Policy-makers, academic health centers, and prospective students need accurate data on the changing demand for and supply of physicians to judge the latest trends. In recognition of the fact that a record number of people are still applying to medical school in this country, despite an impending oversupply of physicians, the committee recommended that up-to-date information on career opportunities in medicine be made available to prospective medical students. The report also recommends that the U.S. Department of Health and Human Services (DHHS) fund research on physician work-force issues, including the relationships among physician supply and health care costs, quality, and access.

The study was funded by the National Research Council with support from DHHS. A committee roster is below. The Institute of Medicine is a private, non-profit organization that provides health policy advice under a congressional charter granted to the National Academy of Sciences.

*The report, *The Nation's Physician Workforce: Options for Balancing Supply and Requirements*, is available from the National Academy Press at the mailing address in the letterhead; tel. (202) 334-3313 or 1-800-624-6242. The cost of the report is \$22.00 (prepaid) plus shipping charges of \$4.00 for the first copy and \$.50 for each additional copy. Reporters may obtain copies from the Office of News and Public Information at the letterhead address (contacts listed above).

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Academic Health Centers: Planning for the 21st Century

Briefing Note from Brian Biles, M.D., Senior Vice President

May 1997

The nation's 125 academic health centers (AHCs) play a vital role in the health care system: training highly qualified physicians and other health professionals, conducting cutting-edge biomedical research, providing specialized services, and putting technological innovations into medical practice.

AHCs are in large part responsible for the reputation for excellence in U.S. medicine. In today's competitive market, however, with the shift from fee-for-service insurers to managed care plans, the continued ability of these university-affiliated teaching centers to carry out their missions is threatened.

In *Leveling the Playing Field: Financing the Missions of Academic Health Centers*, The Commonwealth Fund Task Force on Academic Health Centers reviews current analysis and makes policy recommendations that would enable AHCs to continue to provide graduate medical education and perform other social missions while competing in a managed care environment for patient care.

Due to the expenses of their special missions, AHC costs have historically run 30 percent or more higher than those of community hospitals. Recently, health maintenance organizations and other types of managed care, however, have been directing enrollees to less expensive health care providers and seeking lower payment rates.

Medicare, and in some states, Medicaid, have made explicit payments--roughly \$8.5 billion in 1997--to support graduate medical education and other mission-related activities. Recently suggested changes in the Medicare program could further threaten the financial stability of these centers, and results of upcoming policy decisions could have a profound influence on the future of all AHC missions.

The Task Force recommendations would provide explicit financing for the mission-related activities of AHCs and other teaching hospitals, thereby removing the necessity to finance these activities from extra patient care revenues. They could then compete in the managed care market on a price and quality basis. The Task Force also believes that AHCs must become more efficient and effective in conducting activities related not only to patient care, but also to their broader social missions.

The Task Force recommends the creation of an "Academic Health Services Trust Fund," which would pay for the higher costs associated with education, research, specialized services, and innovation. It would be financed through contributions from Medicare, Medicaid, and all private payers, or from general revenues.

The report also recommends that the level of trust fund support for the training mission of AHCs and teaching hospitals reflect the understanding that the nation's future requirements for new physicians is less than the number currently being trained. The amount of funds distributed from the trust fund would be updated annually to reflect inflation.

An independent Academic Services Payment Review Commission would be established to provide long-term advice on the amount and distribution of trust fund dollars.

Facts and Figures

- The added cost of carrying out special AHC missions is estimated to be \$18 billion in 1997.
- Medicare and Medicaid payments to support AHC mission-related activities will be roughly \$8.5 billion in 1997.

GME Payments to Children's Teaching Hospitals With Separate Provider Numbers:

Analysis and Findings

*Analysis prepared by
Paul Hogan, Vice President
The Lewin Group
(703) 218-5545*

Spring 1997

Outline

- ◆ Political Backdrop
- ◆ Purpose of Analysis
- ◆ Constraints/Caveats
- ◆ Executive Summary
- ◆ Data
- ◆ Methodology
- ◆ Actual DME and IME Payments
- ◆ Adjusted DME Payments
- ◆ Adjusted IME Payments
- ◆ Summary

Political Backdrop

- ◆ “General revenues” key
- ◆ Current Congressional GME activities
- ◆ Need documented proposal
- ◆ Lewin’s role

Purpose of Lewin Analysis

- ◆ To develop a mechanism to fund graduate medical education at Children's teaching hospitals with separate provider numbers at a level comparable to Medicare GME funding at non-children's teaching hospitals
- ◆ Provide funding estimate of mechanism

Constraints/Caveats

- ◆ Mechanism must be grounded in existing Medicare DME and IME framework.
- ◆ Mechanism is designed only for Children's teaching hospitals with separate provider numbers. That is, only those children's teaching hospitals that do not share a provider number with a larger, adult institution.
- ◆ Distributional effects among individual Children's hospitals will be addressed in future research.

Executive Summary

- ◆ In 1996, Medicare GME payments totaled approximately \$6.1 billion*
 - \$1.77 billion for Medicare DME
 - \$4.35 billion for Medicare IME
- ◆ In 1996, Children's teaching hospitals with separate provider numbers
 - trained approximately 5.4 % of all FTE hospital residents
 - received approximately \$1 million for DME (0.06 % of total DME payments)
 - received \$0 for IME
- ◆ The changes to the GME funding mechanism for Children's teaching hospitals with separate provider numbers would
 - increase DME payments to Children's hospitals to \$78 million (share:4.3%)
 - increase IME payments to Children's to \$249 million (share: 5.4%)
 - cost approximately \$327 million (a 5.3% increase in GME payments)

*Our estimate is within 3% of PROPAC's numbers

Data

◆ Hospital Cost Report Information System (HCRIS) Files*

- 1,004 non-children's teaching hospitals in HCRIS
- 44 Children's teaching hospitals with separate provider numbers in HCRIS
 - 10 of 44 have no Medicare DME payments
- Data is for PPS Year 1993

◆ Hospitals not in HCRIS

- identified 13 Children's teaching hospitals with separate provider numbers who did not file Hospital Cost Report
- data on number of residents was gathered by phone (approximately 860 residents in 13 hospitals)

*The HCRIS files are widely used for analytical research.

Data, continued

Teaching Hospitals

	All	Non-children's	Children's*
In HCRIS Database			
Hospitals	1,048	1,004	44
FTE Residents	78,254	74,851	3,403
Not in HCRIS			
Hospitals	13	0	13
FTE Residents	860	0	860
Total			
Hospitals	1,061	1,004	57
FTE Residents	79,114	74,851	4,263
FTE Residents/Hosp	74.6	74.6	74.8
FTE Resident/Beds**	0.19	0.19	0.38

* Children's teaching hospitals with separate provider numbers

** Estimate from HCRIS

Methodology

DME Equation

*DME = Medicare share of inpatient days * Residents * "Allowed Amt"'*

IME Equation

◆
$$IME = (DRG + outlier) * 1.89 * \left[\left(1 + \frac{Residents}{Beds} \right)^{0.405} - 1 \right]$$

Issues

- Medicare share of inpatient days
- DRG payments

¹ Note: "Allowed amount" is Medicare's calculation of a hospital's cost per resident based on 1984 hospital data trended forward. For purposes of this analysis, Lewin algebraically determined the "allowed amount" for those hospitals that reported Medicare DME payments. The average allowed amount for these hospitals was used as a proxy for those hospitals that did not report DME payments.

Methodology, continued

◆ DME

➤ allowed amount

- estimated allowed amount for Children's teaching hospitals with separate provider numbers and who receive DME payments
- use estimated average allowed amount for those Children's teaching hospitals for which there are no data

➤ Medicare patient day share

- used average for non-children's teaching hospitals as the "proxy" to align payments to Children's hospitals with payments to non-children's teaching hospitals within constraint of existing Medicare GME framework

Methodology, continued

◆ IME

- estimate substitute (or “proxy”) for Medicare DRG payments to Children’s teaching hospitals with separate provider numbers
 - based on relationship between DRG payments and *total* discharges for non-children’s teaching hospitals
 - based on total discharges at Children’s teaching hospitals
- proxy to align payments to Children’s hospitals with payments to non-children’s teaching hospitals within constraint of existing Medicare GME framework

Lewin's Cost Estimates

- ◆ Based on resident count for all 57 Children's teaching hospitals with separate provider numbers
 - data for 44 Children's teaching hospitals with separate provider numbers in HCRIIS
 - extrapolated for 13 Children's teaching hospitals with separate provider numbers not in HCRIIS, but based on actual residents at these hospitals
- ◆ Inflated to 1996 dollars
 - average allowed amount inflated by CPI
 - DRG payments inflated by MCPI

Estimated DME and IME Payments Before Adjustments to Children's Hospitals

DME Payments

	All	Non-children's	Children's*
Aggregate: 1993	\$1,619,482,349	\$1,618,584,048	\$898,301
Aggregate: 1996	\$1,766,199,904	\$1,765,220,221	\$979,683
Per hospital: 1996	\$1,664,656	\$1,758,187	\$17,187
Per resident: 1996	\$22,325	\$23,583	\$230

IME Payments

	All	Non-children's	Children's*
Aggregate: 1993	\$3,790,889,425	\$3,790,889,425	\$0
Aggregate: 1996	\$4,354,845,617	\$4,354,845,617	\$0
Per hospital: 1996	\$4,104,473	\$4,337,496	\$0
Per resident: 1996	\$55,045	\$58,180	\$0

* Children's teaching hospitals with separate provider numbers

Adjusted DME Payments: Simulated for Children's Teaching Hospitals With Separate Provider Numbers

	All	Non-children's	Children's*
Aggregate: 1996	\$1,844,616,353	\$1,765,220,221	\$79,396,131
Per hospital	\$1,738,564	\$1,758,187	\$1,392,915
Per resident	\$23,316	\$23,583	\$18,623
Change in aggregate	\$78,416,448	\$0	\$78,416,448

◆ Assumptions:

- use actual allowed amounts for Children's teaching hospitals for which an allowed amount can be computed
- use average allowed amount for computable Children's teaching hospitals for all other Children's
- use non-children's average Medicare share of inpatient days

◆ DME payments per resident at Children's teaching hospitals with separate provider numbers are slightly below that for non-children's because allowed amount is lower at Children's.

* Children's teaching hospitals with separate provider numbers

DME Costs vs. Payments

	All	Non-children's	Children's*
Average cost per hospital: 1996	\$7,041,534	\$7,102,615	\$5,647,777
DME payments / costs (before adjustments)	23.9%	24.8%	0.4%
DME payments / costs (after adjustments)	24.8%	24.8%	25.9%

- ◆ Ratio of DME payments to estimate of DME costs is about the same at Children's and non-children's teaching hospitals, under mechanism

* Children's teaching hospitals with separate provider numbers

** HCRIIS data; includes residents' stipends, insurance, salaries of teaching faculty and support staff, other.

Summary

◆ Status quo

- 5.4 % of total FTE residents at teaching hospitals are at Children's teaching hospitals with separate provider numbers
- Children's teaching hospitals with separate provider numbers currently receive about 0.02 % of GME payments
 - 0.06 % of Medicare DME payments
 - no Medicare IME payments

◆ These policy changes would

- add approximately \$78 million to Medicare DME
 - Children's teaching hospitals with separate provider numbers would receive 4.3 % of total Medicare DME funds
- add approximately \$249 million to Medicare IME
 - Children's teaching hospitals with separate provider numbers would receive 5.4 % of total Medicare IME funds
- cost approximately \$327 million in 1996 dollars

Adjusted IME Payments: Simulated for Children's Hospitals

	All	Non-children's	Children's*
Aggregate: 1996	\$4,603,685,472	\$4,354,845,617	\$248,839,856
Per hospital	\$4,339,006	\$4,337,496	\$4,365,612
Per resident	\$58,190	\$58,180	\$58,368
Change in aggregate	\$248,839,856	\$0	\$248,839,856

◆ Assumption:

- DRG predicted for Children's teaching hospitals based on relationship between DRG payments and *total* discharges for non-children's teaching hospitals

◆ IME payments per resident are about the same

* Children's teaching hospitals with separate provider numbers

**104 HOUSE COSPONSORS OF H.R. 3855,
THE "CHILDREN'S HOSPITALS EDUCATION AND RESEARCH ACT"
As of November , 1998 (9:00 a.m.)**

* = official cosponsors according to Congress' Bill Status Office or the bill sponsor
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index

Kerry bill

NE

Date: 10/23

FAX



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

To: *Devorah Adler*
Fax:
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From: *Cassie Davis*

Number of Pages (not including cover): *4*

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*Attached is the hand-out from the M'Care Commission's
GME task force meeting on GME for children's
hospitals. This is the statement supplied by
the NACt.*

Please call if there are any problems with this transmission:

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National Association of Children's Hospitals



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THE NEED FOR COMMENSURATE FEDERAL GME FINANCING FOR FREESTANDING CHILDREN'S HOSPITALS

September 23, 1998

Children's Teaching Hospitals at a Glance

Freestanding children's hospitals are hospitals that serve primarily children and do not share a Medicare provider number for purposes of third party payment with another institution. In 1998, there are 55 such institutions nationwide, consisting of 45 acute care children's hospitals and 10 children's long-term specialty hospitals. These hospitals include the leading pediatric medical centers in the country.

Like other teaching hospitals and, in particular, academic medical centers, children's hospitals tend to treat the most severe, costly cases, while supporting high quality research and teaching programs. An increasingly competitive health care market dominated by managed care tends not to recognize these differences. Moreover, unlike adult teaching hospitals, children's hospitals have few Medicare patients, and therefore receive almost no federal graduate medical education (GME) funding for their residency positions. Caught in a financial vise between the pressures of market competition and the demands of teaching, research and high quality care programs, some dimensions of the children's hospitals' mission will begin to suffer.

Children's hospitals were established to provide centers for medical care that put the needs of children foremost. From the beginning, they have provided family-centered care, delivering the full range of services needed to care for the child and to support the family throughout the child's course of treatment. They have provided health professionals experienced in the care of children, who recognize that a child's illnesses, treatments, and health care needs are often significantly different than adults. And, they have provided regional centers for highly specialized pediatric care. Since few children require such care, these regional centers are often essential to assuring its availability.

The children's hospitals have assumed three major missions -- patient care, research and teaching -- all devoted to children's unique health care needs. They are committed to providing quality health care for all children, regardless of their families' ability to pay. Today, on average, almost 50 percent of the patient care that freestanding children's hospitals provide is for low income children, either those covered by Medicaid or those who are uninsured. More than 75 percent of the inpatient care provided by children's hospitals is devoted to children with one or more chronic conditions.

The acute care children's hospitals offer the complete range of patient care services for children, from inpatient to ambulatory care. They are regional and national referral centers for very sick children, often serving as the only source for many critical pediatric services. They also serve as the major source of pediatric care in many of their service areas and are often the largest providers of primary care to youngsters in their communities, with clinics serving area neighborhoods.

It is their commitment to children and the close tie between their patient care, research and teaching that truly set these hospitals apart. As major teaching hospitals, they train a substantial portion of our

country's pediatric workforce – more than 25 percent of all pediatricians and over half of many pediatric subspecialists, as well as a substantial number of required pediatric rotations for many other residency programs. As academic medical centers devoted to children, they have developed “bench to bedside” research environments that have led to scientific discoveries, which, in turn, have helped to set the standard for pediatric care and research around the world. The freestanding children's hospitals and their affiliated pediatric departments account for one-quarter of all National Institutes of Health (NIH)-sponsored pediatric research.

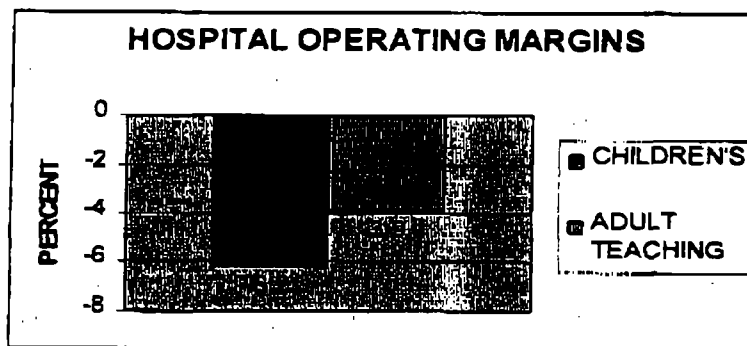
Current Challenges

The rapid expansion of a competitive marketplace driven primarily by price is posing significant challenges for all health care providers. Children's hospitals face many of the same problems of other “safety net” providers and teaching hospitals. They care for a significant portion of the low-income, vulnerable population that often requires special consideration. They maintain essential community and critical care services, whose costs are never fully covered. And, they provide a higher level of complex care to more severely ill patients than other institutions. (See attached “Indicators...”)

The higher costs resulting from the greater staffing and equipment needs of pediatric care make the last point an even greater problem for the freestanding children's hospitals. For example, a child under age two can require on average 40 percent more nursing care per hour of an inpatient stay in a hospital than an adult inpatient will require. These differences in cost are increasingly unrecognized by a more competitive medical marketplace.

For teaching hospitals, no challenge is greater than their growing inability to recover the costs of GME. Medicare has become the mainstay of GME funding as Medicaid's moves to managed care have resulted in fewer states paying even the direct costs of GME. Other, private payers are increasingly unwilling to support GME costs at all. For the freestanding children's hospitals, with only a very few Medicare patients – children with end stage renal disease -- the GME financing issue is critical.

Even as children's hospitals maintain, and often increase, pediatric market share, their patient care revenues are falling short of covering their patient care costs. A significant percentage of this loss, half or more in many cases, is attributable to unreimbursed GME costs. This is reflected in children's teaching hospitals' operating margins, which are substantially lower than other teaching hospitals. According to 1995 Hospital Cost Report Information System (HCRIS) data, children's hospitals' operating margins were negative 6.2 percent, on average, compared to negative 3.9 percent for other teaching hospitals. GME losses per hospital run in the millions of dollars per year and cannot be sustained.



Data reported to the National Association of Children's Hospitals and Related Institutions (NACHRI) suggest that freestanding children's teaching hospitals' net patient revenues in FY1996 accounted for

about 94% of total operating expenses. The freestanding children's hospitals' total margins still remain sound in most cases, because they and their trustees have devoted themselves to building resources to assure the hospitals' future and missions. However, operating margins that continue at this negative rate eventually erode endowment income, as increasing proportions of charitable contributions and endowment income must be diverted simply to cover operating margin deficits.

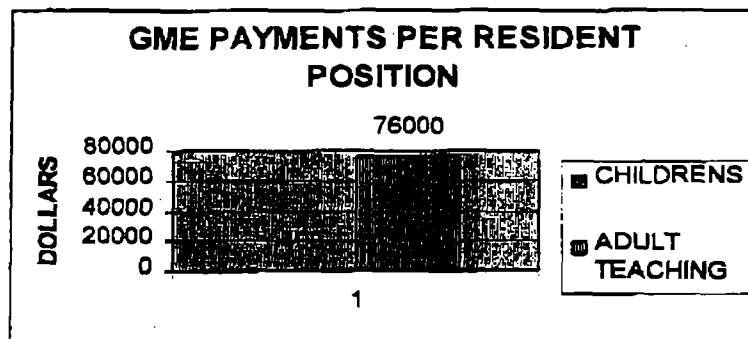
Endowment income and charitable contributions vary widely among institutions, but their intended purpose is typically the same:

- They support both primary and specialty care services for children who have inadequate or no health care insurance, as well as related services that often are needed to ensure that children of low income families have access to the services they need, such as transportation and social services.
- They provide the investments in start-up and uncovered indirect costs, which research programs must have, and they support unsponsored research, which funds new investigations, serving as a source of funds for creative research topics.
- They support essential facilities maintenance and improvements, which often are an important part of the hospital's overall efforts to remain competitive with other facilities.
- They support community services, including services for children for which reimbursement often is inadequate or non-existent, such as child abuse treatment, child life, and poison control centers.
- They make possible many of the hospitals' efforts to promote the health and well-being of all of the children of the community, not just their patients, such as public education programs for car seat and seat belt safety, motorcycle and bike helmet safety, immunizations, hot water and pool safety, firearms safety, children abuse prevention, and more.

Often, these resources are significantly restricted for specific purposes. The demands on this income have never been greater, particularly at a time when the hospital industry overall is experiencing a significant decline in philanthropic support in recent years, according to the Association for Healthcare Philanthropy. And, often, the hospitals possess neither the flexibility nor the capacity to create or sustain donor or operating income endowments to support GME.

Finding a Solution

The National Association of Children's Hospitals (N.A.C.H.) has long supported a broad-based financing system for graduate medical education, an approach that could include our nation's freestanding children's hospitals. If such a broad-based system is not imminent, however, the children's hospitals must seek an interim solution.



The current system of financing GME has created a serious inequity for these institutions. Competitors either have no academic missions or they receive federal support for GME through Medicare in combined direct and indirect medical education payments. Based on the most recent HCRIS data, teaching hospitals overall receive on average over \$76,000 per resident a year from Medicare, while the freestanding children's hospitals receive less than \$400, on average. However unintended it may be, this huge difference in federal support creates a dramatic competitive disadvantage for these children's hospitals.

Providing a level playing field for GME for the freestanding children's hospitals would enable them to remain competitive in an increasingly tight market, allow them to offer a better value for the consumer, and prevent fragmentation of pediatric services. For some of the freestanding children's hospitals, this is an issue of immediate, serious financial concern. For others, it is an issue of diverting other critical resources to GME. For many, decisions to reduce residents are being made.

The field of pediatrics cannot afford the risk of freestanding children's hospitals being forced -- by a federal GME funding policy tied largely to patients they do not serve -- to reduce or abandon their academic missions. Not only do they train a significant portion of the nation's pediatric health professionals, most of whom are in primary care, they provide this training in an environment where residents can experience the entire range of pediatric care. It takes a substantial pediatric patient population to provide this range. In addition, the hospitals' academic programs provide the underpinning of their research programs and contributions to the advancement of pediatric medicine. Eliminating their teaching programs would fundamentally alter the missions of these institutions.

Because of the significance of this problem, not just for the affected children's hospitals but for the entire field of pediatric medicine and the future pediatric workforce, the American Academy of Pediatrics, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, Conference of Boston Teaching Hospitals, Utah Medical Education Council, and National Association of Children's Hospitals strongly support efforts to provide commensurate federal direct and indirect medical education support for freestanding children's teaching hospitals, including interim support until comprehensive GME financing reform is achieved.

Request to The Bipartisan Commission and MedPAC

As the National Bipartisan Commission on the Future of Medicare and the Medicare Payment Advisory Commission consider their recommendations to Congress on graduate medical education, N.A.C.H. asks that the freestanding children's hospitals be included in the deliberations. Currently, proposed bipartisan legislation in the House and Senate, the "Children's Hospitals Education and Research Act," H.R.3855 and S.2049, would provide federal GME funding to the children's hospitals on an interim basis -- two to four years -- prior to the achievement of any broad-based reform. (See attachment "Support for...")

N.A.C.H. would appreciate the opportunity to assist the Commission in assessing both interim and long-term approaches to equitable GME financing for these institutions.



N • A • C • H •

**THE CASE FOR COMMENSURATE FEDERAL GME SUPPORT
FOR INDEPENDENT CHILDREN'S TEACHING HOSPITALS**

November 24, 1998

What is the case for commensurate federal GME support?

The independent or freestanding children's teaching hospitals -- those that do not share a Medicare provider number with another institution -- find themselves in an increasingly and seriously disadvantaged competitive position because of the evolution of graduate medical education (GME) financing in this country.

However unintended, the current marketplace has increasingly come to rely on Medicare as the payer for GME. Medicaid may, depending on the state, pay for the direct costs of GME. But this is changing with the advent of Medicaid managed care. Private payers are no longer paying rates that allow for offsets for GME costs.

The freestanding children's hospitals, with their own provider numbers for purposes of Medicare billing, have few if any Medicare patients -- only children with end stage renal disease. Thus, they do not benefit from federal GME support provided through Medicare.

These hospitals need some broader reform to encompass them in GME financing, and the federal government is the one national source of GME reform. Congress recognized both the need for broader approaches and the children's hospitals' issues when it authorized the National Bipartisan Commission on Medicare and included an assessment of GME financing in its charge.

The National Association of Children's Hospitals' (N.A.C.H.) request for equitable inclusion of the freestanding children's teaching hospitals in such reform is not to give them special treatment. Instead, it is to give them some degree of equitable treatment in competing with other teaching programs.

The children's hospitals do not deserve commensurate federal GME support, because they are "special" or in need of "financial propping up because they can't compete." They need it, because they are supporting GME programs as large on average as those of other teaching hospitals, in a GME financing system that by and large does not recognize their contributions. Commensurate federal GME support for their training programs is essential to their ability to compete.

in the health care market place on a relatively level playing field and recognition of their contribution to the public good – training our nation's health professionals.

What is the GME contribution of these children's teaching hospitals?

The freestanding children's teaching hospitals -- about 53 institutions, including 43 acute care children's teaching hospitals and 10 specialty hospitals -- train over 25% of the nation's pediatricians and the majority of many pediatric specialists.

They also provide training to a substantial number of residents of other institutions, who require pediatric rotations. These rotations represent almost as many resident FTEs as do the pediatric residents in the children's teaching hospitals own programs.

This is a significant contribution to our nation's pediatric workforce by a very small number of institutions. Less than 1% of all hospitals, the freestanding children's teaching hospitals train over 5% of all residents in the country.

Who are these institutions?

There are relatively few children's hospitals in the United States – fewer than 250 children's medical centers of any significant size, including freestanding acute care children's hospitals, children's hospitals organized within larger medical centers, freestanding children's specialty hospitals – rehabilitation and chronic care facilities -- and freestanding children's psychiatric hospitals. The freestanding children's *teaching* hospitals – acute care and specialty -- comprise about 20% of all children's hospitals.

Although no one children's hospital is better than another simply because it is freestanding or organized within a larger medical center, the historically freestanding children's acute care hospitals do tend to be the largest in terms of volume of clinical care, depth and breadth of specialty services, and size of their teaching and research programs. They and their affiliated pediatric departments account for about 20% of all NIH-funded pediatric research. If only clinical research were considered, that percentage would be substantially higher.

Like all children's hospitals, these hospitals provide significant care to low income children – about 44% of their gross patient revenue is devoted to patients covered by Medicaid, bad debt, or charity. Medicaid amounted to about 40% of gross patient revenues for this group of institutions in FY1997, according to data collected by the National Association of Children's Hospitals and Related Institutions (NACHRI), while bad debt and charity represented about 4% of gross patient revenues for the same time. On average, total net Medicaid revenues, including disproportionate share hospital (DSH) payment adjustments, accounted for less than 86% of their Medicaid expenses.

Like other academic centers, freestanding children's teaching hospitals provide specialized services that may be available only at their facilities. They also must contend with a competitive market that often does not recognize the higher costs of the patients they serve. On average, children's hospitals are much more likely to serve more seriously ill children with more complex cases. Over 75% of their inpatient care is devoted to children who have at least one or more chronic or congenital conditions. Freestanding children's hospitals have a case mix index of 1.47, compared to 1.29 for children in all teaching hospitals and 0.74 for children in community hospitals.

What is the inequity with current GME financing?

Medicare has become the one explicit payer for GME in the current market, except for those states in which Medicaid pays for direct GME through cost-based reimbursement, or in a few cases, through some explicit add-on. On average, federal Medicare direct and indirect GME payments per resident FTE in all teaching hospitals amounted to about \$76,000 in FY 1996 compared to less \$400 for per resident FTE for the freestanding children's teaching hospitals. This creates an unintended but severe imbalancing of the competitive playing field for the children's teaching hospitals with their own Medicare provider numbers.

Non-teaching hospitals do not have the direct and indirect costs of academic institutions. Community hospitals may have little teaching and comparatively fewer severely ill children. The children's hospitals organized within other hospitals that share a provider number with a larger institution are able to count their residents – both pediatric and non-pediatrics residents -- for federal GME to the extent that the overall entity is allowed for Medicare patients. A resident rotating to a freestanding children's hospital from another program would receive no federal GME support, while a resident rotating to another hospital, or outpatient facility would.

In other words, the federal government now contributes significantly to adult teaching hospitals for the training of both pediatric and non-pediatric residents. It contributes to community health centers and other non-hospital based training sites for their training of both pediatric and non-pediatric residents who rotate through them. In New York State, the federal government pays to help teaching hospitals to reduce the number of resident it trains. But the federal government contributes virtually nothing in GME support for the training of both pediatric and non-pediatric residents in freestanding children's teaching hospitals – the institutions that train a disproportionately large share of the nation's pediatric and pediatric specialty workforce.

So what if it is unfair, why should the federal government worry about it? Medicare is the federal government's responsibility.

The federal government is the one source of comprehensive GME reform. Until the federal government acts, little progress can be made. New York may have

managed to establish a GME financing pool from all payers, but no other state has. Moving state by state would take forever. Since the federal government holds the keys to GME reform, freestanding children's teaching hospitals need to turn to the federal government for support if reform is not achieved. And, it is Medicare policy that is creating the current perverse, however unintended, inequity in GME payments that puts the freestanding children's teaching hospitals at serious competitive disadvantage.

Why don't the freestanding children's teaching hospitals just merge with larger medical centers and give up their separate Medicare provider number?

One might well ask why the freestanding children's hospitals do not simply "merge" with another institution and give up their separate Medicare number. There are several reasons:

- For a few, already part of larger systems, it is a question of balancing payment incentives, as well as their ability to negotiate with payers independent of their system.
- As regional specialized centers for children, children's hospitals require larger service areas and need to be broadly available to all children.
- For many of the freestanding children's teaching hospitals, merging with any one system or other institution may not be a realistic possibility in their competitive markets.

In any event, the decision to merge and give up a separate Medicare number should be based on the best decision for children's services and overall system synergy/efficiency, not on the current status of the shoals of federal GME financing.

Equity or "fairness" aside, why do freestanding children's teaching hospitals need commensurate federal GME support? They aren't "hurting" financially.

FY1995 Hospital Cost Report (HCRIS) data and FY 1997 NACHRI member hospital data demonstrate that the *total* margins for this group of hospitals were positive. According to The Lewin Group, the FY 1995 HCRIS data revealed weighted average total margins of 7.3% for the freestanding children's teaching hospitals, better than for other hospital groups.

However, the weighted *operating* margins tell a different story. According to The Lewin Group's analysis of FY 1995 HCRIS data, children's hospitals' operating margins were (-6.2%), and they were lower than for other groups of hospitals. According to NACHRI FY 1997 member hospital data, net patient revenues for

freestanding acute care children's hospitals represented about 95% of total operating expenses, slightly down from the previous fiscal year.

More striking is the fact that according to FY 1997 NACHRI data, a significant proportion of freestanding acute care children's teaching hospitals are facing financial shortfalls on their patient care operations:

- More than 58% or 25 of the 43 freestanding acute care teaching hospitals had patient care operating losses -- patient revenues were less than total operating expenses.
- More than 23% or 10 of such hospitals had total operating losses -- combined patient revenues and other operating revenues were less than total operating expenses.
- More than 11% or 5 of such hospitals had total losses -- total revenues were less than total expenses.

Over half of these institutions have negative patient care operating margins, some significantly more than others. Although NACHRI data differ from HCRIS data to a certain extent, it is still possible to say that this picture appears to have remained almost the same for the last two years, although worsening for some as patient care operating margins and total operating margin deficits worsened.

These operating shortfalls are not the result of "losing business." Instead, they are the result of patient revenues not keeping pace with patient expenses, even as the hospitals work to reduce those expenses. On average, the hospitals are doing better than ever with increasing hospital admissions offsetting reductions in patient days and trends towards more outpatient care to keep fairly level occupancy rates of about 69%. Outpatient visits have increased substantially, and gross inpatient and outpatient revenues have increased.

In addition, the positive margins of many freestanding acute care children's hospitals are heavily dependent on two unreliable factors -- endowment/philanthropic income and Medicaid disproportionate share hospital (DSH) payment adjustments. Both can be misleading indicators of financial strength of sustainable, operating entities.

Endowment income has had banner years recently due to the strong stock market, but that performance will not continue predictably. This income is also quite restricted in its use, making it often unavailable for purposes of covering operating losses. DSH may still be strong for many hospitals, but it also is increasingly unpredictable with changing systems of payment, managed care, state and institutional DSH caps, and the significant, declining federal contribution to DSH over the next four years.

One significant, unrecoverable cost for these children's hospitals is GME. In many institutions with shortfalls, it can account for as much as half or more of their losses. Whether to find support for uncovered costs to reduce revenue shortfalls or to stop inequitable draining of revenues needed for essential investments in care, facilities and/or cost reductions, the freestanding children's teaching hospitals need equitable support for GME if they are to keep their commitment to teaching in an increasingly competitive environment.

Summary

Providing equitable support across all teaching programs would assure that all children's teaching hospitals could continue their obligations to training their significant share of health professionals for our nation's children. The freestanding children's teaching hospitals would have a level GME playing field and be assured that they would be able to make decisions regarding the future of their missions of service to the children of their communities on the basis of what is the best for the soundness of their institution and the care of the children they serve.

It is for these reasons that the National Association of Children's Hospitals (N.A.C.H.) seeks the Administration's support for including some direction and proposal for commensurate federal GME funding for freestanding children's teaching hospitals in the FY 2000 budget. The Administration's leadership on this issue is essential to our success with Congress. If overall GME reform does happen, it still may be several years away, and there is no guarantee that it will not continue to be simply Medicare-based.

N.A.C.H. is joined in its support for commensurate federal GME funding for freestanding children's teaching hospitals by the Association of American Medical Colleges and the American Hospital Association, as well as the American Academy of Pediatrics and others in the pediatric community, and many members of both parties in Congress because of the basic equity of commensurate GME support and the importance of the freestanding children's hospitals in training children's physicians.

N.A.C.H.'s full membership – freestanding acute care children's hospitals, acute care children's hospitals organized within larger medical centers, and children's specialty hospitals – strongly support this effort.

FACSIMILE COVER PAGE

Date: 2/9/99
Time: 16:19:00
Pages: 3

To: Chris Jennings
Company: White House
Fax #: 202-456-7431

From: Bruce Lesley
Title: Director, Congressional Relations
Company: National Assoc. of Children's Hospitals
Address: 401 Wythe Street
Alexandria , VA 22314
USA
Fax #: 5484907

Message:

Chris and Jeanne,

Various children's advocates, including the National Association of Children's Hospitals (NACH), the American Academy of Pediatrics (AAP), and the Association of Maternal and Child Health Programs (AMCHP), the March of Dimes, Children's Defense Fund (CDF), Families USA, the National Association of Public Hospitals (NAPH) and the Center on Budget and Policy Priorities worked together over the past few months on consensus language that we might all support in the SCHIP improvement bill. I will certainly not characterize all the aforementioned groups as having endorsed the bill since DeGette and Morella decided to allow pregnant women to be covered (which CDF opposes). However, I think the DeGette-Morella bill is something that you should certainly look at closely. It contains many of the proposals advocated by the Administration. Also, you might be able to help DeGette with any technical problems. Attached is our draft endorsement letter. Best wishes and THANKS SO VERY MUCH FOR PEDIATRIC GME!

-Bruce

LAWRENCE A. McANDREWS, FACHE
President & Chief Executive Officer

February 9, 1999

The Honorable
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative

The National Association of Children's Hospitals (N.A.C.H.), which represents more than 100 children's hospitals across the country, strongly supports the "Improved Maternal and Children's Health Coverage Act of 1999" – bipartisan legislation to be introduced by Representatives Diana DeGette (D-CO) and Constance Morella (R-MD) that will improve the outreach to and enrollment of children into the Medicaid and State Children's Health Insurance Program (SCHIP). We urge you to cosponsor this extremely important legislation that builds on and improves SCHIP. Virtually identical legislation is to be introduced by Senator Christopher "Kit" Bond (R-MO) in the Senate.

Over 11 million of our nation's children remain uninsured despite the passage of SCHIP as part of the Balanced Budget Act (BBA) of 1997. The linkages between improved health and insurance coverage are well documented for children. Numerous studies have demonstrated that health insurance coverage increases children's access to preventive, primary, and acute care. More importantly, health insurance coverage has been shown to improve health and save lives.

Unfortunately, various administrative and informational barriers remain that keep many of our nation's uninsured children from receiving the health care they need. The bipartisan DeGette-Morella legislation attempts to remove many of these barriers and streamline other obstacles that families face in order to get their children health insurance coverage.

As the Health Care Financing Administration has noted, "A key to successfully enrolling children at a wide range of sites is a simple application and

enrollment process. One barrier to enrollment in Medicaid is the complexity of the application. Some States have applications over 20 pages long, posing an often insurmountable challenge for families." Our nation should not accept the fact that 5 million children are eligible for Medicaid but unenrolled because of enrollment barriers such as lengthy applications. All states should move toward a system that is far more user friendly for families to ensure that all children, particularly low-income children, are receiving the health care services they need.

N.A.C.H. also strongly supports the provisions in the DeGette-Morella bill that give states additional flexibility to support and devise enrollment and outreach campaigns to find and enroll hard-to-reach children. This includes a provision from legislation by Senator John McCain (R-AZ) giving states additional flexibility in designating additional enrollment sites by which to enroll children through presumptive eligibility.

Finally, the DeGette-Morella bill provides families with help in negotiating the health care system and the various governmental systems. To ensure children receive the care they need, families should not be burdened with having to overcome unnecessary administrative barriers in what already are terribly complicated health and government systems. To the extent possible, these burdens should be lifted from families and the DeGette-Morella bill takes many important steps to achieve that goal.

Finally, N.A.C.H. supports language in the DeGette-Morella bill, which comes from legislation introduced by Representatives Henry Hyde (R-IL) and Nita Lowey (D-NY), that would grant states the option to cover low-income pregnant women through SCHIP. The linkages between the care to pregnant women and healthy children have long been understood in American social policy, including the Medicaid program. As the General Accounting Office found in its report *Health Insurance: Coverage Leads to Increased Health Care Access for Children*, Medicaid coverage of maternal and child health improved health care access but also decreased infant and child mortality. For these reasons, N.A.C.H. supports giving states the option of covering pregnant women through SCHIP and also the provision that establishes automatic enrollment of the infant upon birth through that critical first year of life.

Again, N.A.C.H. strongly supports the DeGette-Morella bipartisan legislation and encourages you to cosponsor that bill, which will improve the health coverage and lives of children. For more information, please call Bruce Lesley at 703-684-1355.

Sincerely,

Lawrence A. McAndrews