

FAX TRANSMISSION COVER SHEET

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REMARKS:

*Per our conversation, call
if you have any follow-up questions.*

Medicaid Payment for Graduate Medical Education (GME)

While there is no requirement that states make Medicaid GME payments (there is no GME provision in Title XIX and no Medicaid GME provision in BBA 97), most States do make additional payments to hospitals with GME programs, in recognition of the higher costs associated with providing services to Medicaid patients treated in these facilities. Where a state elects to fund a proportionate share of GME for its Medicaid population, Federal matching funds are available.

As more and more Medicaid beneficiaries are enrolled in managed care, States are seeking ways to encourage primary care and ambulatory care training programs and are creating incentives for hospitals to place a greater emphasis in these areas by developing payment methodologies which reflect their objectives. HCFA is supportive of these efforts to align GME funding strategies with State health care needs. Where these efforts can be supported by HCFA in the context of the traditional Medicaid fee-for-service (FFS) program, via amendments to the Medicaid state plan, we make every effort to accommodate them. Where an innovative approach is beyond the boundaries of this program we support state research and demonstration proposals through the 1115 waiver program.

In the next few years we anticipate changes in the health professional workforce which will necessitate parallel changes and in graduate medical education as well. We recognize that the education of physicians and other health care professionals is costly, requiring substantial funding. We also recognize that having a sufficient number of high caliber medical professionals is a public benefit to us all. We in the federal government have assumed a large measure of responsibility in this area and expect to continue to do so. However, it is only realistic to point out that the public benefits extend beyond Medicaid and Medicare beneficiaries to include the entire population of our country. When I mentioned a moment ago that Medicaid will continue to support a proportionate share of GME and where a State elects to participate in that funding for its Medicaid population, Federal matching funds are available, The key phrase here is proportionate share. Other large purchasers of health care, whose insured also share in the benefits of an educated medical workforce have a responsibility to share in the costs of this training as well.

**National Association of Children's Hospitals (NACH)
Meeting with HHS and HCFA leadership
February 18, 10:30-11:30 AM**

Discussion Focus: How to obtain increased federal support for Graduate Medical Education (GME) in Children's Hospitals. Note: It may be Medicare rather than Medicaid which is of priority interest to NACH at this time because of the BBA '97 Medicare GME Consortia Demonstration (see 5 below)

Background

There is no GME provision in Title XIX of the Social Security Act and no requirement that States pay for GME under Medicaid. However, most do make additional payments to hospitals with GME programs, in recognition of the higher costs associated with providing services to Medicaid patients treated in these facilities. Where a state elects to fund a proportionate share of GME for its Medicaid population, Federal matching funds are available.

GME Questions and Answers

Q 1 How do States currently pay for Graduate Medical Education in their Medicaid programs?

A States vary in their payment approaches. In some cases they use add-ons to a per discharge or per diem payment. In others GME is calculated and paid separately. For direct costs of GME, a number of states use Medicare's approach and pay a hospital-specific per resident amount. That amount is multiplied times the number of FTE residents serving in a hospital and Medicare's share is determined based on its share of annual bed days in the hospital. States are not required to use Medicare rules and have considerable flexibility to develop their own payment methodologies. In one state, the DSH allotment is used to finance GME.

Increasingly, States are looking at ways to encourage primary care and ambulatory care training as more and more Medicaid beneficiaries are enrolled in managed care programs. They are seeking to provide incentives for hospitals to place a greater emphasis on training programs in these areas and are developing payment methodologies which reflect these objectives.

Q 2 What is the extent of Medicaid funding for GME?

A. A March 1997 GAO report on the subject of Medicaid GME payments estimated fiscal year 1995 expenditures for Medicaid GME to be as high as \$2.2 billion (GAO attributed this estimate to the National Association of Children's Hospitals)

A hard copy of GAO's March 1997 report on Medicaid and GME Payments is available and will be forwarded on request.

Q 3 May States direct Medicaid GME funds to certain types of teaching hospitals, for example programs in children's hospitals, whether those hospitals are private or public?

A Yes. A state may structure its payment methodology to channel more of its training dollars to one or more categories of hospitals, such as children's hospitals and include both private and public teaching hospitals.

Q 4 Under what authority do states make GME payments?

A If the payments are made under the Medicaid fee-for-service program, the payment methodology needs to be included in the Medicaid State plan. Some states are seeking to test innovative approaches to funding GME and have used the 1115 waiver program for this purpose. In these situations, the state would submit a demonstration proposal and negotiate the terms and conditions with HCFA.

Q 5 How do the Medicare GME provisions of BBA 97 effect Medicaid? (There are no Medicaid GME provisions of BBA 97.)

A. The Medicare GME provisions of BBA 97 include the following:

(section 4623) a hospital-specific cap on the number of residents based on the number in the hospital in the most recent cost reporting period ending on or before 12/31/96.

(section 4625) direct GME payments may be made to non-hospital providers such as federally-qualified health centers (FQHCs), rural health clinics (RHCs) and Medicare+Choice organizations.

(section 4628) the Secretary is to conduct a GME Consortium Demonstration Project in which the consortia would receive the payments instead of having them go directly to teaching hospitals. A consortia is defined as a teaching hospital with one or more of the following: a medical school, another teaching hospital **which may be a children's hospital** (emphasis added), an FQHC, a medical group practice, a managed care entity, an entity furnishing outpatient services or other entities authorized by the Secretary. (there is no date by which the demonstration must be established.) (section 4628)

While there were no Medicaid GME provisions in BBA of 97, States frequently follow Medicare policy in this area. As noted above, states have been looking at ways to encourage primary care and ambulatory care training and to provide incentives for hospitals to place a greater emphasis on these areas. Changes in the Medicare program which advance these objectives will assist states seeking to move their Medicaid programs in the same direction.

PROVIDING ADDITIONAL GRADUATE MEDICAL EDUCATION (GME) FUNDING TO CHILDREN'S HOSPITALS

Option One: Creating a New Disbursement Formula

This proposal uses general appropriation funds to provide GME funds to children's hospitals based upon a formula that is similar to the Medicare formula currently used to disburse GME funds. Children's hospitals would receive GME funds for costs associated with both direct and indirect medical education. The proposal provides the Secretary with the authority to limit the expenditures under this proposal to the amount specified in statute; if the appropriation is insufficient to provide the total payments that are due to the children's hospitals, she must reduce the amounts paid to the hospitals. This proposal was introduced in the Senate in May of 1998. (Cost: \$100 million the first year; \$285 million each succeeding year.)

Option Two: Using an Institution Specific, Per Resident Rate

This proposal would develop institution specific, per resident rates using methodology similar to that presently used by the Veterans Administration. *I don't have information on this but will get it in the morning. pays residents salaries*

Option Three: Developing a Medical Education Trust Fund

This proposal would establish a medical education trust fund from which payments would be made to teaching hospitals for both their direct and indirect medical education expenditures. [I looked at this one, and am not sure that it applies -- probably because I don't understand Medicare. See my notes on the copy of the bill.]

Option Four: Expanding Current State Options in Medicaid

Although there is no requirement that States make Medicaid GME payments, many States do make additional payments to hospitals with GME programs, in recognition of the higher costs associated with providing services to Medicaid patients treated in these facilities. Federal matching funds are available for GME expenditures for Medicaid patients. This proposal would require States to provide GME funds to teaching hospitals treating Medicaid patients and increase the Federal match for these expenditures to 100 percent. Funds would be disbursed through a mechanism similar to the one used in Medicare. [When I get the GAO report and additional information, I bet we can make this option better.]

Option Five: Modifying the GME Consortium Demonstration Project

The BBA provided the Secretary with the authority to establish a GME consortium demonstration project. A consortia is defined as a teaching hospital working in conjunction with a variety of different provider entities. Children's hospitals can participate in these consortium projects. Presently, the amount of funding the consortium can receive is limited to the amount the teaching hospital would have received otherwise. This proposal would remove that requirement, allowing for more flexibility in the distribution of funds to consortia members. This proposal would be funded by the Medicare trust fund.

public stream argument? no, just \$.

interim payments & settlement of cash reports.

trend towards integration & remain free standing is what this proposal would allow.

BBA proposal in 95

Medicaid:

states can reimburse for MC upper payment limit; DSH is ~~does not~~ not mechanism.

pay an add on per discharge or per diem; tied to actual AVCs.
don't keep track of ~~SPending~~ \$2.2B 1995.

define what children's hospital
doe out per resident.

grant process; addtl
workload on FIs but not
much.

Option Six: Modifying the Existing Formula Allocating GME Funds

This proposal would change the formula currently used to allocate GME funds so that it no longer included Medicare specific variables (rather than using the number of Medicare bed days in the calculation, it would use total number of bed days). This proposal would be funded by the Medicare trust fund.

Option Seven: Separating the Indirect Costs of Medical Education From Reimbursement Rates

This proposal would develop a formula to determine the level of additional resources required by children's hospitals to support functions beyond ordinary patient care.

Kerrey proposal

sum of direct & indirect medical education
payment

per resident amt

req. sec to calculate # residents —

would pay children's hospitals for
all of their costs

200 - 230 M / year; just for

administrative prob w/ cap, retrospec. adj.

sec should calculate average IME
payments — ~~\$461M~~ 244 IME

total \$461 M.

doesn't cap
of residents.

Medicare only pays part
of direct.

timing
issues
w/ data.

Paying for all & not a share.

① SHARE ② BOTH DME & IME

③ ENTITLEMENT?

IME intended to be addtl payment for
these hospitals. is IME already part
of their rate? profit margins comparable
to teaching hospitals.

American Medical Association

Physicians dedicated to the health of America



Issue

Graduate Medical Education Financing

Background

Graduate medical education describes the internship/residency period of medical education. Interns and residents are paid a salary in recognition of their dual role as a student and provider. The majority of funding to pay for residents comes from inpatient revenue and faculty physician billing. About 30% of funding comes from the federal government, largely by way of Medicare. Profits from inpatient revenue from insurance companies and other payers of care delivered at teaching hospitals may be shifted to pay for resident training. Medicare, however, pays set fees for services regardless of the hospital, and then makes explicit payments to teaching hospitals to cover its "share" of the cost of training residents.

Medicare pays for its share in two ways: (1) The direct graduate medical education (DGME) payment, which covers Medicare's share (the portion of Medicare inpatient days/all inpatient days) of all costs directly attributable to training residents: the salary and fringe benefits of the resident and supervising faculty, administrative and clerical support, and allocated overhead. In FY 1995, this was about \$2 billion. The amount of DME varies from institution to institution, and national standardization of DME payments is a component of many reforms. (2) The indirect medical education (IME) adjustment is meant to reimburse teaching hospitals for their higher inherent operation costs, such as: more indigent care, more complex and severe cases, and increased diagnostic testing. The IME adjustment allows teaching hospitals to support their broader mission. In FY 1995, this was about \$4 billion. The federal government, mainly through the two Medicare payments, IME and DME, is the only explicit payer of graduate medical education, and federal contributions constitute about a third of all funding teaching hospitals allocate for GME.

Present situation

In an increasingly price-driven, competitive marketplace, insurance payments to teaching hospitals are decreasing, and the margin available to fund residency programs is becoming inadequate. The explicit payments from Medicare remain a steady source of support, but this may change. Because of Medicare's imminent financial troubles, Congress is looking for ways to cut Medicare expenditures. Many policy makers do not see the logic in being the only explicit payer, and one way to reduce Medicare expenditures is by cutting some of the \$6 billion used to fund GME.

The Players

1. American Medical Association - Part of the "Consensus Statement on the Physician Workforce," with other organizations: American Association of Colleges of Osteopathic Medicine, American

Osteopathic Association, Association of Academic Health Centers, Association of American Medical Colleges, and the National Medical Association. Statement calls for an all-payer pool which would pay places of training (hospitals or ambulatory care centers); transitional funds for hospital-based programs that lose residents to newly eligible ambulatory care centers; and replacement funding to maintain subsidies paid to teaching hospitals in place of the IME adjustment.

2. The AMA Council on Medical Education - Recommended the adoption of an "authorization system" in their 1996 Interim report on graduate medical education funding (CME Report 1-1-96). [See Glossary]
3. Sen. Daniel Patrick Moynihan (D-NY)-Introduced S.21,the "Medical Education Trust Fund Act of 1997."
4. Rep. Nita Lowey (D-NY) - Introduced H.R.881,the "Medical Education Trust Fund Act of 1997." The companion bill for Sen. Moynihan's bill (S.21).
5. Rep. Ken Bentsen (D-TX) - Introduced H.R. 106, the "Graduate Medical Education Trust Fund Act of 1997."
6. COGME - The Council on Graduate Medical Education, a Congressional advisory committee; 11-point plan including: cap DGME payments; reduce IME payments; allow ambulatory care centers as training sites.
7. ProPAC - Prospective Payment Assessment Commission (makes recommendations to Congress about Medicare budgetary items); suggests other explicit payers of GME; decrease amount of IME adjustment; did not call for a standardization of DGME rates.
8. The Clinton Administration (FY 1998 Budget) - Remove incentive to increase residencies by capping the level of funding at current levels; encourage training of residents in ambulatory care centers by making those settings eligible for DGME/IME payments.
9. The Institute of Medicine - Prestigious advisory committee of the National Academy of Sciences; Recommendation: "The federal system for funding doctors' training should be overhauled to help control costs and adapt to changes in the way health care is delivered." Supports trust fund.
10. Pew Health Professions Commission - Privately funded major player headed by major player and former Senator George J. Mitchell (D-ME) as chairman. The Commission's goal is to provide a plan for reducing the number of physicians trained each year and determine financing mechanisms for training health care professionals in non-hospitals settings.

Glossary

All-Payer System - Proposal to fund graduate medical education with cooperation from all players involved, since all patients will benefit from well trained physicians, it is reasonable to ask that all payers contribute to the costs of that training.

"Authorization" System - A prime example is the voucher system for graduate medical education funding where a "voucher" would serve as a proxy for a given payment to a residency program and at the same time serve as a certificate of eligibility for a resident to enter a training program. Specifically, a voucher system can be a mechanism for distributing funding from an all payer pool, incorporating the "pass through" of GME capitation rate money, and allowing GME funding for training in non-hospital settings. A voucher represents funding that would follow individuals rather than payments going first to teaching hospitals. A voucher system would not preclude programs from training physicians without vouchers, but programs would only receive Federal GME funding for those physicians possessing a voucher.

DME or DGME and IME - Medicare pays for its share of graduate medical education in two ways: 1. The direct graduate medical education (DGME) payment covers costs directly attributable to training residents: the salary and fringe benefits of the resident and supervising faculty, administrative and clerical support, and allocated overhead. 2. The indirect medical education adjustment from Medicare is meant to reimburse teaching hospitals for their higher inherent operation costs, such as: more indigent care, more complex and severe cases, and increased diagnostic testing.

GME - Graduate medical education; describes the internship/residency period of medical training.

HCFA - Health Care Financing Administration; the administrative agency of Medicare and Medicaid under the Department of Health and Human Services.

Further Resources

American Association of Medical Colleges - <http://www.aamc.org>

American Medical Association - <http://www.ama-assn.org>

Health Care Financing Administration - <http://www.hcfa.gov>

Institute of Medicine - <http://www2.nas.edu/iom>

Pew - <http://futurehealth.ucsf.edu/pewcomm.html>

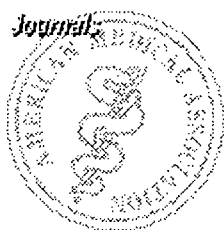
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*Archives of
General Psychiatry*

ARCHIVES OF GENERAL PSYCHIATRY

Editor
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News and Views - April 1998

Proposals for Funding Graduate Medical Education

The Institute of Medicine Report in Context

Roger C. Herdman, MD; Rosemary A. Stevens, MD

Federal support of graduate medical education (GME) has been accepted as an intrinsic ingredient of the Medicare program since that program's inception. Streams of clinical income generated by teaching hospitals, medical faculty practice plans, Medicaid, and other state and federal sources have also made important contributions to GME. Although it is difficult to ascribe legislative intent precisely, Medicare funding seems to have been based on a 2-fold assumption: that GME was socially beneficial and that there were legitimate costs to teaching hospitals associated with their educational missions, even though such costs were hard to identify specifically. The benefits and costs include the high quality generally ascribed to a teaching hospital environment; extra services and teaching costs; active, unsponsored research; a higher proportion of complex medical conditions and care; and technology development and introduction. The argument for Medicare support of GME is thus partly based on better service to all Medicare beneficiaries, and partly on a broader social investment in education and teaching hospitals, with benefits accruing to both present and future Medicare participants. Teaching hospitals and their young physicians in training are also important in providing care to underserved poor populations.

Arch Gen Psychiatry. 1998;55:299-302

Three interlocking sets of changes have challenged the system of graduate medical education (GME) funding in the last 7 years. First, the cost consciousness of managed care purchasers has constrained income from private payers, who have implicitly financed medical education at the undergraduate and graduate levels. Second, the substantially above-cost payments that Medicare, in particular, has been deliberately providing to nourish the teaching hospital sector are being questioned, and states have begun to review the structure and amount of their support as well. Third and concurrently, patient care and technology, and therefore opportunities for education, have increasingly moved out of the hospital to ambulatory sites, many of which are at distant locations. Moreover, the necessity to organize care with multiple professional providers in a variety of organizational settings that emphasize primary care has become more and more apparent. These changes have been taking place in the context of what many consider a current oversupply of and imbalance in physicians in

training and in practice.

The United States has no national (public or private) strategy for funding GME for the benefit of the population as a whole. Medicare is the only payer with an explicit nationwide mechanism to fund GME and the special services and patient care missions provided by teaching hospitals. In practice, teaching hospitals have received an adjustment to their Medicare Prospective Payment System payments. This indirect medical education (IME) adjustment is not based on any specific costs incurred by any particular hospital. It is intended as generic support for teaching hospitals and to compensate for the observed higher costs generated by intern and resident training programs in these hospitals. Indirect medical education payments accounted for about 6.2% of total Prospective Payment System operating payments in fiscal year 1996, or about \$4.3 billion. Medicare also pays teaching hospitals an amount, separate from Prospective Payment System payments, to offset direct medical education (DME) costs. These payments contribute to resident salaries and benefits, the salaries of supervising physicians, the cost of office space, and other overhead. Medicare DME payments for resident training totaled about \$2.2 billion in fiscal year 1996. All these payments have flowed through the traditional Medicare program.

However, as Medicare managed care has become the system for a growing proportion of Medicare beneficiaries, the method used to calculate premiums for plans (the "adjusted average per capita cost") has diverted that proportion of GME payments (and also the "disproportionate share" payments intended to compensate hospitals for service to poor populations) from teaching hospitals to managed care plans. There have been several other problems with the Medicare system of support for GME. Because the payments depend on the number of residents and there has been little if any control on those numbers, hospitals have had every incentive to continually add residents, the costs of the system have risen above inflation, and the supply of physicians in training and ultimately in practice has increased beyond declared national need. Criticism has also focused on excessive variation in per resident DME payments, current incentives to attract large numbers of international medical graduates, and undue emphasis on in-hospital, rather than comprehensive training. Last, there has been a continuing controversy over how vigorously and in what ways the Medicare GME support system should try to shape the nature, specialty mix, and size and quality of the physician workforce; that is, how far Medicare should act, by proxy, as a national physician supply agency.

Responding to the factors described earlier, and driven by the imperative to balance the federal budget and generate significant savings in the Medicare program, the 104th Congress began considering serious structural changes in GME support. The resulting GME provisions of the balanced budget act of 1995 (which was subsequently vetoed) would have created a number of separate GME funds and a general revenue source of support for GME, among other significant changes. As the 105th Congress began, balancing the budget and reducing Medicare expenditures continued to be at the top of the agenda. Within this context, the idea of a GME trust fund remained interesting and viable enough to suggest to the House Ways and Means Committee the value of asking the Institute of Medicine (IOM) to explore ways in which such a fund might work.

In responding to this request, the 1997 IOM report, *On Implementing a*

National Graduate Medical Education Trust Fund, identified a set of guiding principles for GME and recommended ways in which a trust fund might put them into practice. The report noted that the most important feature of a trust fund is its ability, through an annual appropriation, to set a fixed amount each year that both absolutely limits expenditures and ensures a predetermined total payment level. In short, in the case of GME, the traditional open-ended entitlement could become an annual appropriation, the amount of which could depend on information on the economics of academic health centers and any other factors.

The report was delivered in early spring 1997, as Congress began to develop the Medicare GME provisions of the Balanced Budget Act of 1997. These provisions reflect the principles and problems that are identified in the IOM report and that must also have been part of the prevailing understanding among congressional decision makers. As a first principle, the report strongly endorsed GME and related health care services as reasonable and necessary national investments deserving of public support. The Taxpayer Relief Act of 1997 reduced tax revenues and made it impossible to find general revenues for GME and thus to create a national GME trust fund. As a result, the reductions in Medicare GME payments made by the Balanced Budget Act to bring Medicare contributions to GME more in line with the Medicare share of total hospital reimbursement are not counterbalanced by revenues from other payers or general public funds, as the IOM report suggested. Nevertheless, the Medicare GME provisions of the Balanced Budget Act represent an attempt to continue support of GME and to make constructive changes. Many of the provisions are consistent with principles that the authors of the IOM report thought important. In addition, the Balanced Budget Act instructs the National Bipartisan Commission on the Future of Medicare to consider "alternative broad-based sources of funding" for GME in the future, even though such funding is not presently possible.

The IOM report also recognized that the principle of retaining distinct payments—one for identified resident costs, salaries, supervision, and overhead and one for the generally higher, but not specifically identified, hospital and patient care costs associated with training—had value. Both DME and IME deserve support, and their separation allows flexibility in reimbursing resident costs in new locations while continuing the teaching hospital subsidy that preserves the desirable, but more expensive, features of that setting. These separate funding streams are retained in the Balanced Budget Act.

The report's proposals for an annually defined trust fund and annually defined DME and IME funding would have limited total expenditures, expenditure growth, and the relative emphasis on DME and IME purposes simply by defining the absolute amounts available in each year. The Balanced Budget Act, on the other hand, limited spending by limiting the number of residents for which each hospital would receive payment to 1996 levels and made other changes in DME and IME funding to further control and shape spending within these categories. The Balanced Budget Act limits on numbers apply to both DME and IME systems of payment and should be an effective cap on total expenditures.

The IOM report listed 6 additional principles as a foundation for GME payment policy. First, GME funding should focus on education costs

and become more neutral with respect to shaping the health care workforce. Second, responsiveness to health system change should be encouraged by, among other things, opening DME eligibility to educational and health care service entities that are responsive to change and can provide the best education. Third, while Medicare should pay its share of GME support for all its beneficiaries, other funding sources should address the non-Medicare share proportionately. Fourth, nurse and physician DME should depend on the same principles and processes. Fifth, payments should be reasonably consistent from institution to institution and from region to region. And sixth, change should be gradual with transitions that avoid disruptive funding shifts. As noted earlier, both the IOM report's trust fund distribution plan and the Medicare GME provisions of the Balanced Budget Act reflect a general agreement and attempt to be consistent with these principles.

The report recommended that DME reimbursement move very slowly toward a uniform per resident payment over 5 years, during which time a system that considered the cost of local inputs would be designed and implemented. The uniform payment would simply have been that part of the trust fund dedicated to DME divided by the total number of residents. This plan would have had the effect of eliminating the excessive variation (approaching 10-fold) in per resident amounts, which are the basis of DME payments across the country. A uniform payment would also have eliminated the relationship between the DME payments and each individual teaching hospital's Medicare caseload; historically, hospitals' actual Medicare DME payment has been determined by the ratio of Medicare patient days to total patient days. The IOM report also recommended that any increase in resident numbers would have to be reimbursed at the lower of the uniform or existing DME payment rate, which, especially in the early phases of the transition, would have discouraged resident program expansion in hospitals with high DME payment rates. This proposal, therefore, moved a long way toward payment consistency, but it also recognized the importance of gradual change and strongly implied the desirability of contributions from other payers.

The Balanced Budget Act also recognized the value of greater uniformity. An earlier version included a provision to lower the "other than resident" salary components of DME payment part of the way toward a national average. The final version, however, instructed the secretary of the Department of Health and Human Services (DHHS) to study overhead and supervisory physician DME payment and suggest legislative ways to reduce inappropriate variation. Although progressive steps in DME financing were taken in the Balanced Budget Act, the variation in per resident amounts and their relationship to Medicare caseload remain unaffected. The consistency issue has significant financial implications for those hospitals with high per resident amounts, and the intent to study and ultimately address this issue within the framework of a cap on resident numbers signals an intent to implement cost reductions and provide a more defensibly consistent policy.

The IOM report recommended and the Balanced Budget Act enacted DME payment eligibility for nonhospital providers such as rural health clinics, federally qualified health centers, Medicare managed care organizations, and others at the DHHS secretary's discretion if they sponsor approved medical residency training programs. Similarly, the

Balanced Budget Act provides the secretary with authority for a demonstration project funding DME to qualifying consortia of one or more teaching hospitals with one or more of either schools of medicine, clinics, group practices, managed care entities, or others at the secretary's discretion. These provisions allow payments to flow to organizations that are responding to health system change with new and appropriate training opportunities or that are constructively coordinating and managing GME.

In an effort to influence GME in the direction of and thereby shape the physician workforce through shorter primary care residencies, DME payments for long-duration specialty residencies have historically been set at reduced levels. The IOM was not charged with deciding the size or composition of the physician workforce or with addressing the issues of international medical graduates. The nature of these problems is such that simple solutions have been elusive. A decision was made not to attempt to define the "correct" physician workforce or to impose additional DME payment incentives or disincentives to achieve it. No provisions were suggested to discourage or disadvantage international medical graduates. The Balanced Budget Act took some small steps toward influencing physician workforce by providing an additional year of DME for combined primary care residencies and including obstetrics and gynecology as part of a combined primary care program. Beyond these steps, however, the Balanced Budget Act chose to require the new Medicare Payment Advisory Commission to study and recommend policies on international medical graduates, to make 10-year projections of US needs regarding physician workforce supply and composition, to suggest methods for promoting an appropriate workforce, and to delineate GME payments for nursing in a form similar to DME payments for physicians (which the IOM report recommended in principle). Overall, the Balanced Budget Act moves further from the principle of neutrality and more toward intervention in influencing the workforce through Medicare GME payment than the IOM report's plan, which relied on market forces rather than national prescription to provide practical solutions.

Both the IOM report and the Balanced Budget Act recognized the need to restructure IME payments to control expenditures and provide incentives, or at least minimize financial losses, for residency reductions. The IME system of Prospective Payment System adjustments has been instructed by a formula that increased payment by 7.7% for each 10% increase in the ratio of residents to hospital beds. The report's trust fund distribution plan controlled total costs by the simple expedient of defining the size of the IME component of the trust fund. The report then left half of IME funding under the control of the existing formula, understanding that the individual elements of the formula, like the 7.7%, would have to fluctuate to fit the distribution within the amount of funding available. This provision allowed teaching hospitals some continued flexibility in structuring residencies and continued recognition of the greater financial obligations incurred by those academic medical centers with intense training responsibilities. The other half of IME funding was determined and distributed based on past resident numbers. This provision allowed hospitals to reduce residents (relative to beds) while retaining half of the reimbursement that had been based on original resident to bed ratios.

The Balanced Budget Act provisions actively reduce IME payment.

Added residents relative to beds will not be eligible for Medicare payment, and this will control total payout each year. In addition, the IME formula is reduced by 7% to 9% annually until the 7.7% becomes 5.5% in fiscal year 2001, almost a 30% reduction. Hospitals that are reducing residents are provided with a cushioning transition. Full-time equivalent resident counts will be the average of each current year and the preceding 2 years, a 3-year rolling average. In addition, hospitals will be allowed to participate in voluntary residency reduction plans that are approved by the DHHS. Although these hospitals will lose payment in full for the first 5% reduction in resident complement, if they meet certain requirements regarding total reductions (20%-25%) and preservation or enrichment of primary care training during the next 5 years, they will be reimbursed on a descending scale at 100%, 100%, 75%, 50%, 25%, and finally 0% of the difference between the current and the base year level. Furthermore, unlike the IOM report's plan, this provision more generously provides Medicare "hold harmless" transition payments through both IME and DME. However, it also reduces payment to zero, while the IOM report's plan would continue half of the previous IME distribution. The Balanced Budget Act plan has unfortunately and deceptively been characterized as paying hospitals not to train residents. It is in fact a slow, but consistent, reduction in GME payment over 5 years that gradually phases out reimbursement for legitimate GME costs according to the principle of gradual and nondisruptive transitions. It is analogous to many other transitions including, for example, the Balanced Budget Act's transition that phases out adjusted average per capita cost GME payments to health plans.

The IOM report suggested that GME and Medicare disproportionate share payments, which, as noted earlier, had been diverted through the adjusted average per capita costs to Medicare managed care plans, be restored to teaching hospitals. The Balanced Budget Act phases GME out of rates that health plans receive over 5 years and restores these funds, in 20% increments each year, to teaching hospitals in proportion to their service to Medicare managed care beneficiaries. Unfortunately, disproportionate share payments, which, because of the location of many major academic medical centers in central cities, were made substantially to the larger, major teaching hospitals that provided the most training, were not restored to teaching hospitals. Last, the IOM report recommended that residents, who in the past could not be included in the IME reimbursable complement of a teaching hospital when they served in outside ambulatory settings, be counted for such IME payments if the teaching hospital was responsible for all or most of their costs while in the outside training environment. This provision enhanced incentives for training in new, relevant, nonhospital sites and was enacted in the Balanced Budget Act.

Legislative provisions usually depend on many and varied inputs, and it is rarely possible to be certain of the origin of a particular enactment. Nevertheless, the Balanced Budget Act of 1997 reflects many of the principles identified as important by the IOM report, and many of the provisions recommended in the report were enacted. At the same time, others had articulated many of these principles and suggested or urged enactment of similar provisions. The final Medicare GME sections of the Balanced Budget Act leave much to the future. It reduces Medicare support for GME and retains the partial diversion of disproportionate share payments and (for a time) GME funding streams to Medicare managed care plans in an era when funding from private payers has

been and continues to be problematic. The IOM report strongly implies that in those circumstances a way should be found to include other payers or general revenues in the support of GME. Although the report favored market forces, many observers believe that a more aggressive payment system in terms of shaping the workforce, controlling the numbers of international medical graduates, and encouraging primary care is warranted. Most observers also believe, as the report suggested, that GME should be opened up further through consortia and incentives for training in primary care, ambulatory, and managed care sites, among others, and some have suggested that this include IME as well as DME incentives. A number of managed care organizations seem ready to provide increased training opportunities in this important new delivery system.

Graduate medical education is a national activity in the sense that it is supported by a national matching system, by national standards enforced through residency review committees, and funded in part by a national health care financing program. On the other hand, local autonomy and responsiveness to local needs are desirable. The IOM report's plan attempted a balance between local flexibility by not freezing resident numbers or increasing workforce provisions, but also recognized GME's national character by recommending definitive steps to eliminate wide disparities and move to a national average in DME per resident funding. The Balanced Budget Act has frozen numbers and added minor workforce provisions, and it has put off action on payment disparities until DHHS study recommendations are available. This has eliminated some local flexibility, while preserving substantial local reimbursement differences.

Although skepticism about timely congressional action is always prudent, it seems likely that continuing pressure to resolve the financing problems of Medicare and indeed the entire health system will drive action in the relatively near future on these and other important questions and problems in GME, and that these issues will be addressed in ways suggested by the legislatively mandated studies and deliberations of the DHHS and commissions. While the issues left for the future are important ones, recent legislative actions, whether by coincidence or design, seem to reflect some consistency with the IOM's report. As participants in that report we take that as an encouraging sign.

Accepted for publication December 14, 1997.

This work was supported by The Pew Charitable Trusts, Philadelphia, Pa; The Commonwealth Fund, New York, NY; and The Burroughs Wellcome Fund, Durham, NC.

We gratefully acknowledge the review of this article by Linda Fishman and Stuart Guterman.

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Policy Statement

Pediatrics

Volume 93, Number 6

June, 1994, p 1018-1020

Graduate Medical Education and Pediatric Workforce Issues and Principles (RE9418)

AMERICAN ACADEMY OF PEDIATRICS

Task Force on Graduate Medical Education Reform

The following principles were crafted by a special Task Force on GME convened by the American Academy of Pediatrics to develop policies and principles concerning GME and pediatric workforce issues. The Task Force met in the Washington office of the Academy on September 4, 1993. These principles have been reviewed at a meeting on September 9, 1993, revised and approved by the Federation of Pediatric Organizations. The Federation component organizations include: the Ambulatory Pediatric Association; American Academy of Pediatrics; American Board of Pediatrics; American Pediatric Society; Association of Medical School Pediatric Department Chairmen; Association of Pediatric Program Directors; and Society for Pediatric Research. These principles represent the consensus opinion of the American pediatric community comprising both academic and practicing physicians and residents.

OVERVIEW

The United States is presently poised to enact a universal health care program that could include the coverage of an additional 12 million children and adolescents. The passage of such a proposal might eliminate financial barriers to needed health care for many children and generate an increase in demand for primary care physicians. These children and adolescents will need quality health care, the provision of which is very complex. Pediatricians are the most appropriate providers of primary care for infants, children and adolescents. Today, nearly two-thirds of office (physician) visits made by children aged 5 years and younger are to pediatricians.

There is presently a national shortage and geographic maldistribution of pediatricians the effects of which could be acutely aggravated by health care reform. The federated pediatric community agrees that there is a need for increased support for primary care specialties as a whole, and pediatrics in particular. In contrast to adult medicine and surgery, the overwhelming majority of pediatricians practice primary care medicine; less than 20 percent of certified pediatricians are certified in subspecialties and even fewer are practicing subspecialties exclusively. Currently, and for the past decade, over 60 percent of graduating pediatric residents still choose to enter primary care.

It is important to recognize the need for training of pediatric generalists and pediatric subspecialists to meet the unique clinical, research and educational needs of child and adolescent populations in the next century. There will be an increased demand for subspecialists (in the face of existing shortages) due to the complex illnesses faced by children and adolescents--congenital anomalies, pediatric AIDS, derivatives of substance abuse, etc. Some pediatric fellowship training--such as general academic pediatrics, adolescent medicine, behavioral pediatrics, developmental pediatrics--is often undertaken to enhance the pediatrician's ability to provide optimal primary care services and many graduates of such programs actually practice primary care.

Population and incidence of disease limit the numbers of pediatric subspecialty patients and, because of this, the number and distribution of subspecialists the country needs. There is currently an

acute shortage of certain pediatric subspecialties (i.e., pediatric gastroenterologists, pediatric hematologist/oncologists and pediatric endocrinologists). In contrast to adult specialists, pediatric subspecialists are not usually found in private practice.

NATIONAL HEALTH CARE WORKFORCE COMMISSION

The federated pediatric community recommends that an independent National Health Care Workforce Commission be established, insulated from the political process and with broad representation from the primary care community, including pediatrics. This National Health Care Workforce Commission would be responsible for:

- * projecting the aggregate need of the medical care workforce for the health care delivery system;
- * determining the necessary number of residency positions on a national basis (including the number of International Medical Graduates (IMGs)) and maintaining the appropriate number of generalists and subspecialists;
- * allocating residency positions by specialty and subspecialty with regard to medical personnel and population needs;
- * implementing appropriate incentives to reinforce the selection of primary care;
- * conducting on-going research that will ensure the availability of appropriate data on which to base workforce decisions;
- * evaluating and monitoring the efficacy of all recommendations and their implementation; ensuring that the process allows for flexibility, particularly during the transition period; and reevaluating recommendations as appropriate.

The federated pediatric community recommends that this independent and autonomous National Health Care Workforce Commission have features of both the Federal Reserve Board and the Defense Base Closure and Alignment Commission. The statute creating this National Workforce Commission would require that its recommendations be sent to the President for approval or disapproval, and then require the Congress to take an "up" or "down" vote on its package of recommendations without amendment. Its decisions, if accepted in this manner, are binding as statute.

The composition of the National Commission should be balanced and should reflect the entire primary care community as well as include representation from non-primary care disciplines. Its membership should include practicing physicians, medical educators, allied health professionals, i.e., nurse practitioners and physicians assistants, hospital administrators and consumers.

The federated pediatric community believes that training and service needs should be disconnected. Therefore, distribution of residency training positions should be based on the quality of the training program. However, until there is appropriate distribution of training positions based on quality and primary care/specialty needs, we recognize that some service issues must still be considered.

The federated pediatric community believes that the ACGME and the RRC should maintain their current function and focus on quality, and should not be involved in the allocation of residency training positions.

ALLOCATION OF GME SLOTS

The principal goal of the federated pediatric community is to increase the number of primary care pediatricians. We support the need to prepare more generalists. Accordingly, whatever mechanism for allocating residency positions is selected must assure that there are at least as many residency positions in pediatrics as currently exists. We recognize the need to decrease the total number of GME training slots overall, while simultaneously increasing the number of primary care slots. However, reliable data for projecting future physician need are not available, particularly the need for pediatric generalists and subspecialists.

While the goal of limiting the number of filled first year resident positions to 110 percent of the number of US medical school graduates may be a reasonable initial target, the federated pediatric community believes that the National Health Care Workforce Commission should ultimately establish the total number of residency positions, including IMGs.

The federated pediatric community supports the limitation of residency positions only if it is implemented subsequent to the allocation of slots across specialties and pursuant to the

recommendations of the National Health Care Workforce Commission. The pediatric community is deeply concerned that, in some parts of the country, IMGs currently provide a significant portion of pediatric care especially in urban hospitals in under-served communities. In these communities, IMGs may provide more than 50 percent of care. The health of children in these communities must not be compromised by the reduction of residency positions while awaiting alternative health care providers.

The federated pediatric community believes the phasing in period, accompanied by transition funding, is vitally important to hospitals that lose a larger percentage of their residency positions through the allocation process or with the assignment of residents to ambulatory care sites.

PAYMENT FOR GME

The federated pediatric community concurs with the Physician Payment Review Commission's (PPRC) 1993 Annual Report to Congress in its support of the concept that "all payers should share the costs of graduate medical education."

Within the limits of the national goals established by the National Commission, the pediatric community is in favor of maintaining as much flexibility of choice by resident applicants as possible. Operating under the allocation of residency slots established by the National Health Care Workforce Commission, the federated pediatric community supports a continuation of the current matching system.

One option to assist in assuring a distribution of residency specialties that will meet the future health needs of the nation is to explore the use of a voucher/certificate system given to medical students in conjunction with the National Resident Matching Program as suggested in a 1985 Report by the Task Force on Academic Health Centers of The Commonwealth Fund. Alternatively, funds could be allocated directly to programs or to regional or local consortia as proposed by the PPRC and the Council on Graduate Medical Education. Any one of these proposals would help assure that monies for medical education are used for that purpose.

Whatever the mechanism, it is preferable that the funds are allocated in a manner that facilitates the training of primary care physicians, including expanding the training venues outside of the hospital setting.

INCENTIVES, INCLUDING WEIGHTING OF PRIMARY CARE POSITIONS

The federated pediatric community believes that primary care residents should receive total compensation that is equal to or greater than other residency positions in the institution.

The federated pediatric community believes that the use of differential weights in calculating payments for primary care residency positions could provide an incentive for teaching institutions to increase the number of primary care residency positions. However, these weights must be large enough to encourage the development of additional primary care positions and education sites outside of the teaching hospital. Funding must be specifically designated for this purpose.

This short term strategy must be accompanied by long term incentives for medical students, residents, and physicians (especially under-represented minority groups) to choose primary care. A full array of support for primary care should be considered including: expansion of the National Health Services Corp; continuation and expansion of primary care training programs, such as Title VII; loan forgiveness in return for practicing in identified under-served areas; loan repayment based on a percentage of earnings; forbearance and deferment of low interest loans for entering primary care; development and implementation by all payers of a pediatric RBRVS and increased payment for pediatric services; increased funding for primary care research and other system-wide supports for pediatric and other primary care specialties including the reduction in administrative burden to primary care physicians.

RETRAINING

Unlike adult medicine and surgery, retraining for pediatricians is not a significant issue because all pediatricians are initially trained as generalists and some take additional training in a subspecialty. Renewal of subspecialty certification in pediatrics also requires recertification in general pediatrics. However, the federated pediatric community strongly believes that the setting of standards for retraining other specialists in fields which include the care of children must involve the federated pediatric community. This is to ensure that the same quality of care is provided to all children and adolescents.

CONCLUSION

The Federation of Pediatric Organizations supports designing a program to ensure quality health care to all children by developing appropriate guidelines and funding for GME.

FEDERATION OF PEDIATRIC ORGANIZATIONS

The **Ambulatory Pediatric Association** (APA) is an organization of individuals dedicated to research, education and service in general pediatrics addressing the needs of children and their families.

The **American Academy of Pediatrics** (AAP) is an organization of 47,000 physicians dedicated to health, safety and well-being of infants, children, adolescents and young adults.

The **American Board of Pediatrics'** (ABP) purpose, through the certification process, is to provide assurance to the public and to the medical profession that a certified pediatrician has successfully completed an accredited education program, an evaluation, including an examination, and possess the knowledge, skills, and experience requisite to the provision of high-quality care in pediatrics.

The **American Pediatric Society** (APS) is an organization bringing together academic pediatricians for the advancement of the study of child health and illness, for the promotion of health and the prevention of illness, and for the advancement of pediatric education and research, and for the recognition of those who by their contributions to pediatrics, have aided in its advancement.

The **Association of Pediatric Program Directors** (APPD) is an organization of individuals responsible for residency training programs in pediatrics. The mission of the Association is to advance and enhance the graduate medical education of pediatricians.

The **Association of Medical School Pediatric Department Chairmen** (AMSPDC) is an organization of chairs of medical school pediatric departments who are responsible for the conduct of teaching, patient care, research and service within American medical schools and their clinical services.

The **Society for Pediatric Research** (SPR) is an international society for scientists whose purpose is to encourage investigation of a broad range of areas involving the health and well being of children.

TASK FORCE ON GRADUATE MEDICAL EDUCATION REFORM

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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PUBLIC POLICY



Federal Advocacy Issues Graduate Medical Education

Background Information

Following graduation from medical schools, a physician undergoes "graduate medical education" (GME) by serving as a "resident" in the training program of a teaching hospital. Depending on the area of specialization, a resident's training may last two to three years. In some instances it is followed by a "fellowship" for more specialized training for additional years. The cost of training is borne by the teaching hospitals, which pay for it through patient care revenues.

Pediatric residents undergo three years of training in pediatrics – medical care for children – before becoming eligible for certification as a pediatrician. Extra years of fellowship training are required for a pediatrician to become a pediatric subspecialist.

Since most children are healthy, they need largely primary and preventive care. Thus, pediatricians are trained as primary care physicians who specialize in the care of children, and most enter into primary care practice after residency training. Fewer than 80% of pediatricians receive additional training to become pediatric subspecialists, such as a pediatric cardiologist or pediatric pulmonologist.

The freestanding acute care children's hospitals and the pediatric departments of university hospitals provide the bulk of pediatric GME. There are fewer than 60 freestanding acute care and specialty children's hospitals, but they train more than a quarter of all pediatricians and the majority of many pediatric subspecialists.

N.A.C.H. Public Policy Position

N.A.C.H. supports efforts to achieve comprehensive GME financing reform by establishing an "all-payer system" in which all payers of health care would contribute their fair share of the cost of graduate medical education. Currently, more and more payers of health care are unwilling to cover the extra costs of teaching, which places all teaching programs, including pediatric GME programs, at increasing financial risk in the competitive market place.

Until comprehensive GME reform is achieved, N.A.C.H. supports efforts to provide on an interim basis commensurate federal GME funding for children's teaching hospitals that do not share a Medicare provider number with a larger hospital. Currently, the federal government pays, on average, over \$76,000 in combined direct and indirect medical education payments for the training of a resident in a teaching hospital. But it pays less than \$400, on average, for the training of a resident in a freestanding children's hospital, only because it

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cares for children instead of the elderly. The absence of commensurate federal GME support places these children's teaching hospitals at a significant competitive disadvantage in the health care marketplace.

N.A.C.H. supports enactment of the "Children's Hospitals Education and Research Act," S. 2049 by Sens. Bob Kerrey (D-NE) and Kit Bond (R-MO), as well as H.R. 3855 by Reps. Sherrod Brown (D-OH), Nancy Johnson (R-CT), and Jim Greenwood (R-PA). These bills would provide on a time-limited, capped basis, \$285 million annually.

For More Information

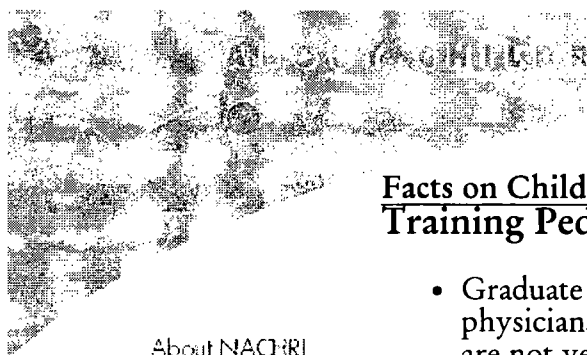
Contact Ann Langley at al@hps1.com, Pete Willson at pwillson@nachri.org, or Bruce Lesley at blesley@nachri.org.

Related Documents:

- "The Need for Commensurate Federal GME Financing for Freestanding Children's Hospitals." August 24, 1998
- "Support for Commensurage, Federal Graduate Medical Education Funding for Independent Children's Teaching Hospitals," August 27, 1998.
- Cosponsors of H.R. 3855, "Children's Hospitals Education and Research Act" of August 27, 1998
- Cosponsors of S. 2049, "Children's Hospitals Education And Research Act" of August 27, 1998
- N.A.C.H. Sponsored Legislation (as of May 20, 1998)

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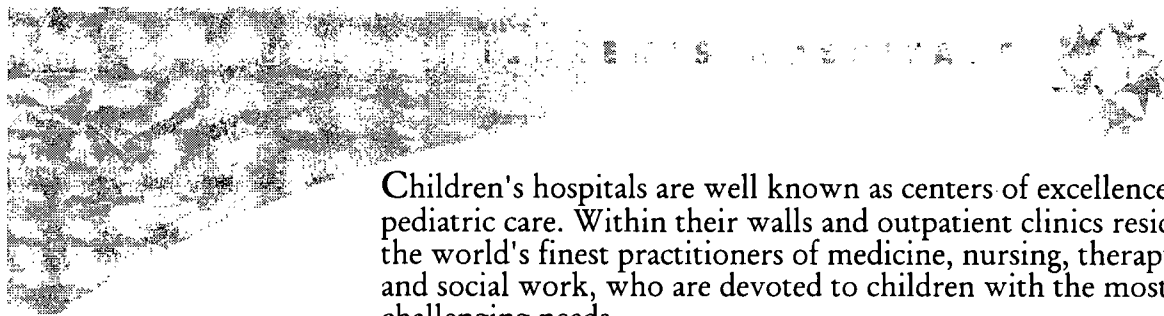
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Facts on Children's Hospitals Training Pediatricians

- Graduate medical education (GME) is the training of physicians who have graduated from medical school but are not yet ready for unsupervised medical practice. Teaching hospitals organize such training, and pediatric GME is different from the training of physicians devoted to caring for adults because it focuses on primary care, because children have different health care needs and because it takes longer to train to be a pediatrician
- Because Medicare pays for the health care of adults, and Medicaid pays for the health care of children, teaching hospitals that specialize in caring for children – such as children's hospitals – are at risk of losing public support for their GME programs, while teaching hospitals that specialize in caring for elderly patients continue to receive Medicare GME payments
- Only about 30% of all physicians practice primary care – a proportion that falls far short of the nation's need and results in a surplus of specialists. But the distribution of pediatricians among primary care and subspecialty practice is different. About 84% of all pediatricians are in primary care practice full-time. Only 16% are "subspecialists," and many of them engage at least part-time in primary care practice. Instead of a surplus of pediatric subspecialists, there actually are shortages in some areas of pediatric subspecialty care
- A teaching hospital incurs extra costs to train medical residents while also delivering care to patients, extra costs that under "fee for service" were subsidized through clinical care reimbursement. But in the increasingly competitive market, in which managed care plans often compete for contracts based on the lowest cost, plans have an incentive to contract with hospitals that don't carry the extra costs of teaching. Thus teaching hospitals now face financial challenges to their training programs
- Any proposal to establish a teaching hospital fund with general revenues should address the special issues in pediatric GME, including the fact that it does not have guaranteed federal funding, focuses on primary care and requires longer specialty care training

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Children's hospitals are well known as centers of excellence in pediatric care. Within their walls and outpatient clinics reside the world's finest practitioners of medicine, nursing, therapy and social work, who are devoted to children with the most challenging needs.

Children's hospitals represent only 1% of all hospitals, but freestanding – self-governing – children's hospitals serve about 12% of all hospitalized children and train about 25% of all pediatricians in the United States. More than 8.3 million times a year, a child benefits, as well, from a variety of outpatient services provided by children's hospitals.

Children's hospitals are expert in the most basic health care needs of all children. Because they are on the front lines of medical care, education and research, they serve the majority of the nation's children with special needs. In most states, they serve a disproportionate share of children who are uninsured and those who rely on the Medicaid program to pay for their health care.

Children's hospitals are centers of medical education and research, training one-quarter of the nation's pediatricians and most pediatric specialists and pioneering new approaches to organ transplants, open heart surgery and the treatment of trauma.

Founded more than a century ago as charitable refuges for sick and abandoned children, children's hospitals today remain the bedrock of a community's response to children's health care needs. Besides healing and discovering cures, children's hospitals are leading the fight against the many social pathologies threatening America's children, including violence, tobacco and drug use, inadequate parenting skills and lack of access to appropriate health care.

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	A	B	C
1	Projected Cost of the Kerry Proposal *		
2			
3	Direct GME		
4		Weighted	Unweighted
5	Per Resident Amount	\$82,283	\$76,817
6	Full Time Equivalents	2,823	2,823
7	Payments	\$232,284,909	\$216,854,391
8			
9	IME		
10			
11	Average IME/Resident	\$33,902	\$70,812
12	FTES	3,458	3,458
13	Payments	\$117,233,116	\$244,867,896
14			
15	DGME + IME	\$349,518,025	\$461,722,287
16			
17	* Kerry proposal limits payments to \$100 million		
18	in FY 1999 and \$285 million in FY 2000 to FY 2002.		
19	These tables illustrate the impact of the bill w/o capped expenditure		
20			
21	Note: The unweighted column uses the methodology in		
22	the Kerry bill. The weighted column illustrates the		
23	impact of the provision by weighting by the number of		
24	residents.		

	A	B	C	D
1				
2	Margins for Classes of Hospitals			
3				
4				Operating
5		Total	Operating	Revenue Minus
6		Margin	Margin	Total Expenses
7				
8	ACADEMIC MEDICAL CENTERS	3.6	-7.8	-9.9
9	CHILDRENS	7.9	-6.3	-6.9
10	OTHER TEACHING	4.7	-3.4	-4.7
11	NON-TEACHING	3.1	-3.6	-4.3
12	Average	3.4	-3.7	-4.5
13				
14	Total Margin = (Total Revenue - Total Expenses) / Total Expenses			
15				
16	Operating Margin = (Operating Revenue - Operating Expenses) / Operating Expenses			
17				
18	Total Revenue less Contributions, Donations, Bequests etc... less Income from			
19	Investments equals Operating Revenue			
20				
21	The difference between operating and total expenses are nonpatient care expenses			
22	such as cafeteria, parking garage, gift shop etc...			
23				
24	AMC = Academic Medical Center			

CHILDREN'S TEACHING HOSPITALS NEED CONGRESS' LEADERSHIP ON FEDERAL GRADUATE MEDICAL EDUCATION (GME) FUNDING

Children's teaching hospitals with their own Medicare provider number need leadership to help them address a growing competitive risk — health care's conversion to managed care that does not pay for physician training. Although they train 5% of all residents, including 25% of pediatricians and the majority of many pediatric subspecialists, independent children's hospitals receive almost no federal GME funds. In contrast, teaching hospitals overall receive on average more than \$76,000 in direct and indirect Medicare GME payments per resident. Without federal support, children's teaching hospitals are at a serious competitive disadvantage.

Which children's hospitals are at risk? — Fewer than 60. Fewer than 60 children's teaching hospitals have their own Medicare provider number. They do not file a joint Medicare cost report with an adult teaching hospital when they seek reimbursement. They include the nation's leading children's teaching hospitals.

How are they at risk? — In the face of intense market competition, they alone have no significant federal GME support. Rapid growth in market competition makes it increasingly difficult for all teaching hospitals to fulfill their teaching missions while maintaining financial viability. But this problem is severe for children's teaching hospitals with no significant federal GME support.

Why don't they receive significant federal GME support? — Since they serve only children, they do not qualify for significant Medicare GME support. Their only Medicare patients are children with end stage renal disease. They are virtually the only teaching hospitals that do not receive significant federal GME support. On average, they receive less than \$400 per resident in annual Medicare GME funds. The average teaching hospital receives over \$76,000. Independent children's teaching hospitals are the most vulnerable in cost driven market competition. That puts the nation's future supply of pediatricians at risk.

What has Congress done? — Assigned the issue to two Medicare commissions for study. In the 1997 Balanced Budget Act, Congress established two new commissions to address several Medicare issues, including the need to develop alternative financing for GME and the GME reimbursement needs of children's hospitals. Recommendations are due in 1999.

Why does more need to be done? — In the time it takes a study to be issued and acted upon, children's hospitals teaching programs could be in jeopardy. While it helps that Congress wants to study this issue, commission recommendations may be years away. In the meantime, the survival of the teaching programs of independent children's hospitals is in jeopardy. Until it reforms GME financing for all teaching hospitals, Congress needs to provide interim, commensurate federal funds to these children's hospitals.

Who in Congress supports addressing this problem? — Members of both parties. In 1998, Sens. Bob Kerrey (D-NE) and Kit Bond (R-MO) introduced S. 2049, the "Children's Hospitals Education and Research Act," with the support of 21 other Senators. Reps. Sherrod Brown (D-OH), Nancy Johnson (R-OH), and Jim Greenwood (R-PA) has introduced the House version, H.R. 3855. They have the support of nearly 100 members of the House. Both bills would provide \$285 million annually, on a time-limited, capped basis, to provide commensurate federal GME funding to eligible children's teaching hospital on an interim basis until comprehensive GME reform.

Who else supports addressing this problem? — Hospital and pediatric leaders nationwide. They include the American Academy of Pediatrics, American Hospital Association, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairmen, National Association of Children's Hospitals, National Association of Community Health Centers and more.

ISSUES RELATING TO MEDICARE SUPPORT FOR GRADUATE MEDICAL EDUCATION

The Medicare Commission, as part of its mandate, will review the advisability of maintaining or modifying Medicare's investment in support of graduate medical education (GME). GME restructuring was included as an option to improve Medicare's financial solvency because its funding represents a significant burden on the Medicare Trust fund and relying only on traditional Medicare savings may be insufficient. This memo provides background on Medicare funding of GME and describes and discusses major issues and options for GME restructuring.

BACKGROUND

Care in teaching hospitals is generally recognized as costlier¹ than similar care in non-teaching facilities. Medicare has recognized the additional costs associated with training and paid its share since its inception. As noted in the 1965 Ways and Means Committee report on the original Medicare legislation:

“Many hospitals engage in substantial educational activities. . . Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.”

Prior to the prospective payment system (PPS), expenses related to training programs were part of Medicare's allowable costs. When Medicare moved to PPS, the program continued to recognize its share of the direct and indirect costs of graduate medical education (GME). In 1997, total GME costs were estimated to be \$18.6 billion, according to research by Lewin for the Commonwealth Fund -- a significant portion of which is explicit funding through Medicare.

Medicare and, to a much lesser extent, Medicaid have played a key role in financing GME. Direct graduate medical education (DGME) covers Medicare's share of costs directly associated with operating resident training programs (e.g., salaries, fringe benefits). Medicare's Part A DGME payments are estimated to be \$2.56 billion in federal fiscal year (FY) 1998. The second component of Medicare's GME payments recognizes the indirect costs of graduate medical education (IME), including the more expensive practice pattern associated with teaching

¹For example two reasons generally noted as explaining the higher costs are the higher number of tests that interns and residents order and other inefficiencies associated with inexperience and a sicker patient population.

programs. The IME adjustment is a percentage add-on to the hospital's Medicare payment. Medicare IME payments are estimated to be \$5.3 billion in FY 1998. Over five years (FY 1999-2003), the HCFA Actuary estimates that Medicare Part A spending on direct and indirect medical education will be about \$42 billion. In addition to the Part A payment for DGME, a portion of Medicare's payments to hospitals for DGME is from Part B. DGME payments from Part B are estimated to be roughly \$360 million for FY 1998, and roughly \$2 billion over five years (FY1999-2003). GME is projected to represent 3.8% of total Medicare benefits in FY1998.

OVERVIEW OF ISSUES

Medicare's medical education payments have both sustained a high-quality medical education system and assisted the hospitals that have trained providers. Medicare bears the primary cost of **explicit** financing of direct and indirect medical education. While it is recognized that private payers also support GME, this is not done explicitly. Thus, it is difficult to accurately ascertain the relative share that various payers bear.

An argument can be made that medical education is a social benefit -- society at-large benefits from medical training -- and that these explicit payments should not be made by Medicare alone. The equity issue becomes even more compelling in light of the concern about the future status of the Medicare Hospital Insurance Trust Fund, which is the major source of GME payments. There is also concern that the current structure of funding through Medicare hospital payments may not be responsive to policy objectives in terms of training the right numbers and mix of specialties and providing support for academic health centers.

Because of similarities in the issues involved, the consideration of how to handle support for graduate medical education is likely to engender a discussion as well around Medicare disproportionate share hospital (DSH) payments. The issue of Medicare DSH payments is significant and merits separate attention.

SOURCE OF FINANCING

A major question that has been raised is should payments for GME (direct and indirect) be removed from Medicare?

Options:

1. **Continue to use Medicare as a financing stream.** Support of graduate medical education through Medicare provides a reliable and predictable source of funding. Given that graduate medical education training requires institutional commitments over long periods of time, reliability of a financing stream is an important consideration. In addition, the Medicare payment system has avoided the Federal government being in the business of micro-managing the Nation's medical education programs. At the same

time, there has been recognition, reflected in part in the changes included in the Balanced Budget Act (see later discussion), that Medicare GME financing can be improved to more closely align incentives in Medicare payment policy to help achieve certain goals.

2. **Finance GME through general revenues as a discretionary program.** This option recognizes that everyone benefits from support of graduate medical education. Under this approach, GME funding would compete annually with other spending priorities as part of the discretionary appropriations process. This approach has the advantage that it would make it easier to adjust GME support in response to current needs. However, this approach would make the GME revenue stream more uncertain compared to the current situation, making it harder for institutions to plan. In addition, as discretionary funds they would be subject to the discretionary caps. If no adjustment were made to the caps, other programs would need to be reduced to fund GME.
3. **Transfer spending to Medicare Part B and continue GME “entitlement” status.** Since 75 percent of Part B funding comes from general revenue, this approach would spread part of the costs of graduate medical education through a more progressive tax structure than the payroll tax. This approach to GME funding under Part B would maintain its mandatory spending nature, which would not provide for an annual discussion of the “right” level of spending. The transfer to Part B, however, would increase the premiums paid by Medicare beneficiaries, raising the equity issue in a new way. In addition, this approach is inconsistent with the traditional role of Part A paying for costs associated with hospitals (which bear most of the cost of medical education).
4. **All-Payer Pool / Self-funded Trust Fund.** As with general revenue, funding a trust fund would recognize that everyone, not just Medicare beneficiaries, benefits from support for GME. A graduate medical education trust fund would probably be funded by dedicated revenue sources (e.g., through contributions from all payers and self-funded employer plans or mandatory general revenue contributions). For purposes of the Federal contribution on behalf of Medicare, a decision would be made as to whether the public share should come from general revenue appropriations or as a special payment from the Medicare trust fund(s). A combined approach could also be used where, in addition to a payment from Medicare, general funds could be appropriated to the trust fund (as proposed in the 1995 balanced budget bill).

LEVEL OF FINANCING

Beyond the issue of the source of financing is the question of the amount of resources that should be devoted to support for GME.

Options:

1. **Current Level of Financing.** Medicare payments for DGME and IME in FY 1998 are estimated to be nearly \$7.9 billion. If the current structure is modified, Medicare's contribution could be set equal to the current projected expenditures for GME, assuming that this amount is sufficient to finance today's system.
2. **Additional Financing.** Increases in funding could be directed towards graduate medical education that some consider underfunded. Possible uses of additional funding include: a set-aside for payments to new programs in non-traditional sites; greater funding for programs with providers with very low Medicare utilization such as children's hospitals; demonstration projects; or incentives for the type of training that will be needed to create the best medical workforce in the future. Alternatively, consideration could be given to maintaining the current, overall level of financing but supporting training of fewer physicians, allowing the remaining balance to be used for these purposes. However, reallocation in a budget-neutral manner would have a negative financial impact on institutions used to current reimbursement practices.
3. **Reducing Medicare Payment Level.** There is broad consensus that there are too many physicians in general and too many specialists in particular (Commonwealth Fund, Council on Graduate Medical Education, PPRC). Medicare's support for GME was, until enactment of the Balanced Budget Act, open-ended. The Balanced Budget Act includes caps on the number of FTE residents used to calculate direct GME and IME payments, incentives to downsize residency training programs and reductions in Medicare IME payments. The Act also expands the types of entities eligible (e.g., rural health clinics, community health centers) to receive Medicare support in an attempt to redirect some funds to support training in non-hospital settings. HCFA's Actuary estimates that the Balanced Budget Act will produce a 3 percent decrease in the number of residents.

Some argue that the projected reduction in the number of residency training positions due to the Balanced Budget Act is modest compared to suggestions that there is a need to curb slots by one-quarter to one-third. (Commonwealth Fund, October 1997) Another point made is that since PPS was implemented, teaching hospitals' PPS margins (i.e., the difference between PPS payments and costs) have exceeded those of other hospitals. (MEDPAC, 1998) Others note that the reduction in GME financing may provide incentives to training programs to develop more efficient practice patterns.

The BBA reduces the level of IME adjustment from 7.7% to 5.5% for every 10% increase in the hospitals intern to bed ratio by FY 2001. Analysis of hospital cost functions documents that teaching hospitals have higher costs. While there was general agreement that an adjustment of 7.7% overcompensated hospitals for their indirect costs, a 5.5% adjustment may still be too high particularly since hospitals may count residents for IME when they are not providing services in inpatient settings. In the context of dealing with the federal support for graduate medical education, further reductions in Medicare expenditures for GME may need to be considered.

METHOD OF ALLOCATION

Some of the goals that have been proposed for GME funding are:

- The nation's health workforce should be more equitably distributed in order to provide reasonable access to care for all Americans.
- The nation's health workforce should be as diverse as the nation's population in order to help meet the service needs of vulnerable and diverse populations.
- Certain components of the health workforce should be augmented while other components should be reduced in order to provide balanced access to care for certain Americans.
- The settings for health workforce education and training should be reflective of the settings in which services are delivered to assure that the health workforce is competent. The content of training should be reflective of the care needs of the populations served today and in the future.

The options of continuing to distribute GME funding based on current policy or using alternative approaches need to be considered against the goals.

Options:

1. **Maintain Current Medicare Policies.** There are separate policies for IME and DGME. The IME is an add-on to hospitals' operating payments with the amount determined based on several factors including the number of residents per bed, Medicare volume, Medicare case mix, and wage index and cost-of-living adjustment levels. An adjustment is also made to PPS capital payments. Payment for DGME is made as a separate amount from PPS payments. DGME payments are based on a formula related to the number and specialty of trainees, hospital-specific historical costs, and Medicare volume.

Although, it is asserted that Medicare payment policies have not adequately fostered these goals, Medicare policies may be somewhat better aligned with achieving these goals as a result of changes made under the Balanced Budget Act (BBA). For example, caps established under the BBA on the number of residents paid for by Medicare for IME and DGME may limit the future rate of increase in physician supply in areas of the country which have an over-supply of doctors. The BBA also enables the hospital to count resident training time in non-hospital sites for DGME and IME if the hospital incurs the cost of the training, and for some clinics and managed care plans to receive DGME from Medicare. These provisions may encourage training in more diverse settings and training of a specialty mix that matches service needs.

However, several shortcomings remain in current Medicare policies:

- There are large variations in the per resident amounts which are used as the basis for DGME payments. These variations, which ultimately derive from large variations in the historic costs of these programs, are difficult to justify on the basis of the goals for GME payment.
- Since Medicare finances the majority of GME, GME support is related to Medicare services, depriving facilities with low Medicare utilization, such as children's hospitals, of any significant GME support.
- There are no direct policies to make programs accountable for promoting a better geographical distribution and a more appropriate mix of specialties in the physician workforce.

2. **Use an Alternative Payment Method.** There are a number of ways of distributing DGME and IME funds. For instance, separate average prospective payment per resident rates based on the current IME and DGME payment levels could be developed and paid either to the site of training, the sponsor of the program (which could be a medical school), or even the residents themselves. Payments could also be provided under a block grant system related to each institution's percentage of historical Medicare graduate medical education payments. (Such a proposal was part of the balanced budget legislation proposed in 1995. HCFA had major concerns about how to adjust payments to all hospitals when other hospitals which newly participate in training become entitled to payments). Whatever alternative payment mechanism is developed, it is important to recognize:

- The alternative formulae would inevitably produce redistributions of graduate medical education payments.
- There is no broad consensus supporting specific alternatives. Proposals to allocate funds based on historical Medicare payments do not hold teaching hospitals accountable for meeting policy goals and build-in current payment inequities. Other proposals continue to link payment to resident counts and provide incentives for increasing the size of residency programs (within the limits established by the BBA caps).
- Depending upon the nature of the allocation system developed, it potentially could involve dealing with such micro-level issues as the number of trainees and specialties for which particular sites would receive support.
- Any significant funding redistributions would likely require a transition period to mitigate the impact.

DISCUSSION

The issues of support for graduate medical education and the impact of the changing health system on academic health centers have received attention on a number of occasions, and have lead to modest changes and improvements in Medicare's financing of GME. Attention will again turn to this area in the context of the Medicare Commission because of Medicare's financial status and its significant role in support of GME. Consideration in the context of Medicare's financial status will need to balance a number of factors.

For example, in the context of a changing health system, the financial support from Medicare for graduate medical education has provided some stability for teaching hospitals. Managed care, for example, often does not compensate for the extra costs of teaching hospitals, so a significant reductions in Medicare support for GME could be disruptive. The academic medical centers are not likely to support the removal of DGME and IME from the Part A Trust Fund, particularly if there is a risk that funding may be reduced. In addition, the political opposition to the effects of any related redistributions might confound, for example, the prospects for establishing a new trust fund structure. Changes from the current system can be expected to pose difficult issues around allocation decisions and government micro-management, something that has been avoided in the Medicare GME financial support structure. However, concerns might be mitigated depending on the structure of future payments. If a self-funded trust fund included funding from other payers plus a dedicated revenue stream (e.g., the 1995 proposed balanced budget bill closed several tax loopholes and used the resulting savings to fund the trust fund), the teaching hospitals may be less likely to object because they would gain access to a larger funding source.

There is also the fundamental question of how much of Medicare's support for GME is solely related to paying on behalf of Medicare beneficiaries the fair share of the costs for patients treated in teaching hospitals versus using public funding (in this case from payroll taxes) to support a "social good" and relying on the public insurance program simply as a relatively straight forward revenue delivery mechanism. In addressing the financial concerns of the program there needs to be recognition of the broader "social goods" that have been achieved under Medicare's auspices. Consideration of alternatives needs to carefully weigh the advantages and disadvantages of any a change.

Academic health centers provide a national resource for clinical and basic science research, education of health professionals and highly sophisticated and scientifically advanced patient care.

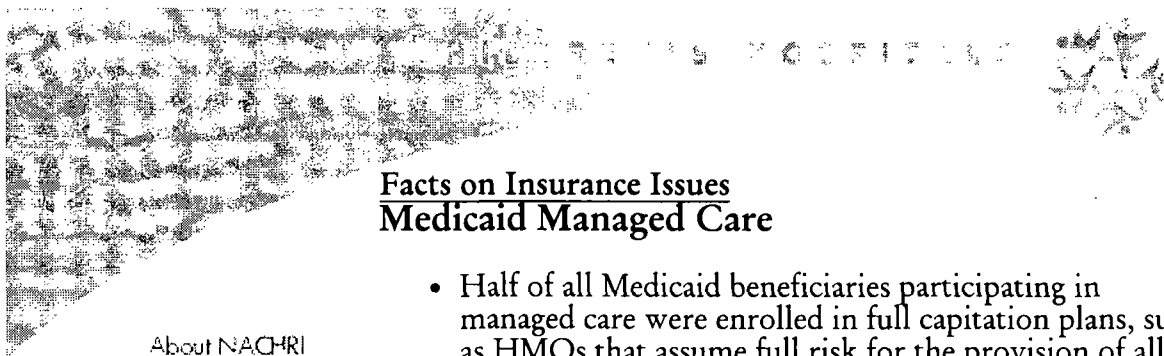
Because of their multiple missions, academic health centers are more expensive than competing hospitals. Supporting these missions is not in the interest of any particular purchaser of health care services.

Therefore, health reform allows academic health centers to compete with other health providers on the basis of ordinary patient costs but creates a new method of paying the costs unique to academic health centers. It segregates these costs from ordinary patient costs and funds them through a national surcharge on insurance premiums:

- Modeled on the formula through which the Medicare program provides additional resources to academic health centers, health reform adopts a national formula to determine the level of additional resources required by academic health centers to support functions beyond ordinary patient care.
- Under this formula, resources are obtained through a surcharge on insurance premiums in the region served by the academic health center, allocated across plans based on anticipated use of the academic health center and adjusted retrospectively based on actual use.
- Plans in other geographic areas pay a portion of the surcharge based on actual utilization of academic health centers by their patients.
- Health reform precludes accountable health plans from systematically discouraging patients from using academic health centers or discriminating against those institutions.

INVESTIGATIONAL TREATMENTS

Academic health centers develop, conduct and analyze much of the nation's clinical research, primarily relying on grants for funding. However, grants ordinarily do not cover medical care costs associated with clinical research.



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Facts on Insurance Issues **Medicaid Managed Care**

- Half of all Medicaid beneficiaries participating in managed care were enrolled in full capitation plans, such as HMOs that assume full risk for the provision of all services for a monthly per member payment
- States must obtain a federal waiver to "require" individuals assisted by Medicaid to enroll in a managed care plan. There are two types of waivers, "Section 1115" Demonstration waivers and "1915(b)" program waivers. Fourteen states, Arizona, District of Columbia, Delaware, Florida, Hawaii, Kentucky, Massachusetts, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont – have approved Section 1115 waivers although only six (Arizona, District of Columbia, Hawaii, Oregon, Rhode Island and Tennessee) are operational. States also use "Sec. 1915(b) waivers" for more limited mandatory managed care initiatives. As of June 1994, only seven states did not have experience with any form of managed care program – Alaska, Connecticut, Maine, Nebraska, Oklahoma, Vermont, Wyoming
- Between one-quarter and one-third of poor women and children are enrolled in managed care. Between 1993 and 1994, enrollment in managed care among the Medicaid population grew 62% and continues to expand dramatically
- Managed care can shift children's care from clinics and hospital emergency rooms to physicians' offices and more regular, coordinated care. It can reduce hospital use and increase access to primary and preventive care
- Estimated cost savings from managed care range between 5% and 15%. Managed care may be able to stretch limited Medicaid dollars without reductions in services or eligibility
- In states that require all children be enrolled in managed care, children with special needs may be at risk because managed care plans have little experience with disabled children. Financial incentives favor decreased referrals, and there are no standards for specialty care access or pediatric risk adjustment
- The finances of children's hospitals are being jeopardized by Medicaid managed care policies. Neither HCFA nor states require managed care plans to make graduate medical education or disproportionate share payments to hospitals

- States should demonstrate that Medicaid managed care plans have an adequate network of pediatric primary and specialty care providers, including centers of excellence for children to assure timely access to medically necessary care
- States should not require that children with special health care needs enroll in managed care plans until more experience is developed in serving this population. under capitation. Families should have the option to enroll their special needs children voluntarily in managed care plans

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N · A · C · H ·

November 2, 1998

Vice President Albert Gore, Jr.
The White House
Washington, DC 20500

Dear Mr. Vice President:

The National Association of Children's Hospitals (N.A.C.H.) seeks your leadership in recommending that the Administration's FY 2000 budget request address a serious inequity in federal graduate medical education (GME) policy, which risks the future of children's health. Left unchanged, federal GME policy puts independent children's teaching hospitals at a serious competitive disadvantage that can jeopardize their ability to train a significant portion of the nation's pediatric workforce.

Specifically, N.A.C.H. seeks the Administration's budget support for a bipartisan proposal to provide \$285 million annually for commensurate, federal GME funding for eligible children's teaching hospitals, paid for out of general revenues on a time-limited, capped basis. Ian Burr, M.D., Chairman of the Department of Pediatrics at Vanderbilt University Medical Center, discussed this proposal with you at your Family Re-Union conference last summer.

Health care competition is based more and more on the cost of care. Most payers of health care are increasingly unwilling to cover the added costs of GME. That means teaching hospitals rely more and more on Medicare GME support, which averages about \$76,000 in direct and indirect GME funds per resident trained in a teaching hospital. But independent children's teaching hospitals, which do not share a Medicare provider number with a larger medical center, receive on average less than \$400 in Medicare GME support per resident, only because they care for children, instead of the elderly. In today's competitive market place, this enormous difference in federal GME support creates a very unlevel playing field for these children's hospitals.

This is more than just an issue of survival for the teaching programs of individual children's hospitals. It also is an issue for the overall pediatric workforce. There are only about 55 independent children's teaching hospitals – fewer than 1% of all hospitals – but they train more than 25 percent of all pediatric residents and the majority of many pediatric subspecialists. That is why the American Academy of Pediatrics, American Hospital Association,

Vice President Albert Gore, Jr.
November 2, 1998
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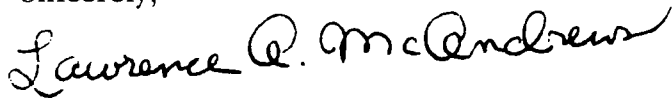
Association of American Medical Colleges, Association of Medical School Pediatric Department Chairmen, and others support establishing commensurate federal GME funding for independent children's teaching hospitals. It needs to be part of long-term GME financing reform as well as a short-term, interim solution until Congress enacts overall GME reform.

There is strong, bipartisan support for H.R. 3855 and S. 2049, the "Children's Hospitals Education and Research Act," which would provide interim, commensurate federal GME funding for two to four years, at a cost of \$285 million annually when fully funded. There are more than 100 members of the House who support H.R. 3855, including its original sponsors Sherrod Brown (D-OH), Nancy Johnson (R-CT), and Jim Greenwood (R-PA). There are 23 Senators who support S. 2039, including the original sponsors Bob Kerrey (D-NE), Kit Bond (R-MO), Edward Kennedy (D-MA), Richard Durbin (D-IL), Mike DeWine (R-OH), and Daniel Patrick Moynihan (D-NY).

Independent children's teaching hospitals very much need commensurate GME funding for their teaching programs to be included in the FY 2000 budget. The Administration can advance this goal significantly by making it a priority in the President's FY 2000 budget request to Congress.

I am enclosing for you background material on our request. Please call upon Peters Willson on our staff or me if we can be of assistance to you in reviewing our request for your leadership on behalf of children's health. We appreciate your consideration very much.

Sincerely,

A handwritten signature in cursive script that reads "Lawrence A. McAndrews". The signature is written in dark ink and is positioned above the printed name.

Lawrence A. McAndrews

**SUPPORT FOR COMMENSURATE,
FEDERAL GRADUATE MEDICAL EDUCATION FUNDING
FOR INDEPENDENT CHILDREN'S TEACHING HOSPITALS**

November 2, 1998

National Organizations and Leaders The leading national organizations representing pediatricians and pediatric subspecialists, children's hospitals, teaching hospitals, and pediatric graduate medical education (GME) leaders strongly support congressional efforts to establish commensurate, federal GME funding for independent children's teaching hospitals that do not share a Medicare provider number with a larger institution. In addition, other health care advocates as well as individual public officials have given their support:

- American Academy of Pediatrics, representing more than 53,000 pediatricians;
- American Hospital Association, representing more than 4,900 hospitals;
- Association of American Medical Colleges, representing the nation's medical schools and teaching hospitals;
- Association of Medical School Pediatric Department Chairmen, representing the academic leaders of graduate medical education for pediatricians and pediatric subspecialists;
- Governor John Rowland (R) of Connecticut and Mayor Deedee Corradini (D) of Salt Lake City, UT;
- National Association of Children's Hospitals, representing over 100 children's hospitals;
- National Association of Community Health Centers, representing over 700 centers; and
- Utah Medical Education Council, the state legislature's expert advisory panel on medical education, and the Conference of Boston Teaching Hospitals.

Bipartisan Congressional Support As of November 2, 23 Senators and more than 100 Representatives had committed to co-sponsoring the "Children's Hospitals Education and Research Act," to provide on a time-limited, capped basis commensurate federal GME support for children's hospitals. There is strong, bipartisan support on each of the three committees of jurisdiction. For example:

House Ways and Means Committee: Reps. Nancy Johnson (R-CT), Xavier Becerra (D-CA), Dave Camp (R-MI), Mac Collins (R-GA), William Coyne (D-PA), Jennifer Dunn (R-WA), Philip English (R-PA), Barbara Kennelly (D-CT), Jerry Kleczka (D-WI), John Lewis (D-GA), Richard Neal (D-MA), Rob Portman (R-OH), Jim Ranstad (R-MN), Pete Stark (D-CA), and Karen Thurman (D-FL).

House Commerce Committee: Reps. Sherrod Brown (D-OH), Brian Bilbray (R-CA), Nathan Deal (R-GA), Diana DeGette (D-CO), Peter Deutsch (D-FL), John Dingell (D-MI), Anna Eshoo (D-CA), Gene Green (D-TX), Paul Gillmore (R-PA), Jim Greenwood (R-PA), Edward Markey (D-MA), Karen McCarthy (D-MO), James Rogan (R-CA), Bobby Rush (D-IL), Tom Sawyer (D-OH), Dan Schaefer (R-CA), Ted Strickland (D-OH), and Henry Waxman (D-CA).

Senate Finance Committee, Sens. Bob Kerrey (D-NE), Bob Graham (D-FL), Connie Mack (R-FL), Daniel Patrick Moynihan (D-NY), Carol Moseley-Braun (D-IL), and Frank Murkowski (R-AK).

**23 SENATE COSPONSORS OF S. 2049,
THE "CHILDREN'S HOSPITALS EDUCATION AND RESEARCH ACT"
As of November 2, 1998 (9:00 a.m.)**

* = official cosponsors according to Congress' Bill Status Office or the bill sponsor
+ = committed to cosponsor but not yet officially listed

S. 2049

The Kerrey/Bond Bill

Alabama

* Sen. Jeff Sessions (R)

Alaska

* Sen. Frank Murkowski (R)

California

* Sen. Barbara Boxer (D)
* Sen. Dianne Feinstein (D)

Connecticut

* Sen. Chris Dodd (D)
* Sen. Joseph Lieberman (D)

Florida

* Sen. Bob Graham (D)
* Sen. Connie Mack (R)

Georgia

* Sen. Max Cleland (D)

Hawaii

* Sen. Daniel Inouye (D)

Illinois

* Sen. Richard Durbin (D)
* Carol Moseley-Braun (D)

Kansas

* Sen. Pat Roberts (R)

Massachusetts

* Sen. Edward Kennedy (D)
* Sen. John Kerry (D)

Michigan

* Sen. Carl Levin (D)

Minnesota

* Sen. Paul Wellstone (D)

Missouri

* Sen. Kit Bond (R)

Nebraska

* Sen. Bob Kerrey (D)

New York

* Sen. Daniel Patrick Moynihan (D)

Ohio

* Sen. Mike DeWine (R)
* Sen. John Glenn (D)

Washington

* Sen. Patty Murray (D)

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* Sen. John Glenn (D)

Washington

* Sen. Patty Murray (D)

ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN, INC.

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Coordinator

American Board of Pediatrics
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Phone: (919) 942-1993
Fax: (919) 929-9255

June 19, 1998

Dear Senator:

The Association of Medical School Pediatric Department Chairs (AMSPDC) represents the chairs of the departments of pediatrics at medical schools throughout the country. Together, they are responsible for leading the training of each new generation of pediatricians and pediatric subspecialists for our nation's children.

AMSPDC strongly supports the recommendation of the National Association of Children's Hospitals (N.A.C.H.) for the establishment of interim, commensurate federal funding for the graduate medical education (GME) programs of those independent children's teaching hospitals, which do not share a Medicare provider number with an adult health care institution.

The training programs of these institutions are critical to our future pediatric workforce and therefore to the future health of all children, because they train a disproportionate number of the nation's pediatricians. Representing less than one percent of all hospitals, they train approximately a quarter of all pediatricians and the majority of pediatric subspecialists in a number of areas of subspecialty training, according to N.A.C.H.

However, because these children's teaching hospitals do not care for elderly patients, they do not qualify for the substantial GME support, which the federal government provides through the Medicare program. In 1997, the average teaching hospital in the United States received more than \$ 76,000 in combined direct and indirect medical education reimbursement per resident. In contrast, the average children's teaching hospital with its own Medicare provider number received less than \$ 400 per resident on average. In the highly competitive health care market place of today, such an enormous differential in federal GME support can only place the pediatric training programs of these children's hospitals at increasing competitive risk.

American Academy of Pediatrics



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Liaison
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800/338-5475
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Web Site: <http://www.aap.org>

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Donald E. Cook, MD
Greeley, Colorado

Lucy S. Crain, MD
San Francisco, California

June 1, 1998

Dear Senator/Representative:

I am writing on behalf of the American Academy of Pediatrics to join in the recommendation of the National Association of Children's Hospitals (N.A.C.H.) for the establishment of interim federal support for the graduate medical education (GME) programs for freestanding, independent children's hospitals. These freestanding children's hospitals are those that do not share a Medicare provider number with an adult health care institution.

Because, the American Academy of Pediatrics is an organization of 53,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well being of infants, children, adolescents, and young adults we are invested in the education of future pediatricians. To this end, the Academy is participating in supporting the work of the *Task Force on the Future of Pediatric Education*. Its purpose is to address the health needs of children in the 21st Century and the changing roles of pediatrics and pediatric education in meeting those needs.

In that light, we regard the education programs of independent children's hospitals as important to our pediatric workforce and therefore to the future health of all children, because they educate an important proportion of the nation's pediatricians. According to the N.A.C.H., representing less than one percent of all hospitals, independent children's hospitals educate approximately a quarter of all pediatricians.

However, because these independent children's teaching hospitals do not care for elderly patients, they do not qualify for the substantial GME support, which the federal government provides through the Medicare program. In 1997, the average teaching hospital in the United States received on average more than \$76,000 in combined direct and indirect medical education reimbursement per resident. In contrast, the average children's teaching hospital, with its own Medicare provider number, received less than \$400 per pediatric resident on average. In the highly competitive health care marketplace of today, such an enormous differential in federal GME support has placed the pediatric education programs of children's hospitals at increasing risk.

Given the importance of the independent children's hospitals to the pediatric workforce, it is appropriate that Congress has directed both the new Medicare Payment Advisory Commission (MedPAC) and the Bipartisan Commission on

OPINION

Close med-student funding gap

Utah's congressional delegation should strongly support the Children's Hospitals Education and Research Act, which would level the funding field for Primary Children's Medical Center and other independent children's teaching hospitals.

Unlike adult facilities, Primary Children's and other similar institutions receive little federal funding for graduate medical education. The cost of educating residents comes off their bottom lines. That is because funding for residents' education is through Medicare, and pediatric hospitals treat few, if any, Medicare patients.

Teaching hospitals nationally receive an average of \$76,000 per resident from the federal government to help pay for training. Primary Children's and others like it are accorded, on average, less than \$400 per resident. The problem is exacerbated by the current climate of managed care, where penny-pinching payers are reticent to recognize and help cover the costs of a medical education.

Such inequity is unfair and needs to be quickly remedied for the long-term health of children's teaching hospitals. HR3855 and a companion bill in the Senate, S2049, would do

that for three years, until the problem is permanently remedied as part of overall Medicare reform.

Primary Children's Medical Center annually takes some \$1 million from its bottom line to help pay these costs of graduate medical students. That is money that could go toward providing indigent care or for other critical needs. It is not right to have the feds paying to educate all other types of physicians except for pediatricians.

In Utah, there already is a shortage of children's doctors that, with a booming population, could become worse. Most pediatricians who practice in this state and the surrounding region received their training at Primary Children's. Without adjusting the current inequitable funding structure, the ability to deliver needed training could be jeopardized.

The Children's Hospitals Education and Research Act would stabilize the funding system until a permanent, fair funding solution is worked out nationally. Utah's representatives and senators, with their strong vested interests, should be at the forefront of pushing that measure through Congress. Rep. Merrill Cook is on board as a co-sponsor. The others should follow suit.

Deseret News

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AKRON BEACON JOURNAL

Founded April 16, 1839

C.L. Knight, June 18, 1867-September 26, 1933

John S. Knight, October 26, 1894-June 18, 1981

Janet C. Leach
Editor

John L. Dotson Jr.
Publisher

David B. Cooper
Associate Editor

OUR OPINION

Child-centered?

• *The squeeze on funds for children's hospitals jeopardizes their ability to train young doctors*

Children top just about every list of those the government should make its first priority. Liberals often deflect criticism of their proposals by insisting that kids would benefit. Conservatives point to their support of child-friendly policies as proof that they are not as hard-hearted as some would suggest.

You'd think with all this devotion to children, the nation's children's hospitals would have little trouble tapping into federal and state sources of money to meet their needs. The truth is, these institutions, including Children's Hospital Medical Center of Akron, face a budget squeeze that should alarm any advocate of family values.

One critical mission of many children's hospitals is the practical training of young doctors to become pediatricians and pediatric specialists. In no small way, these institutions are teaching hospitals, ensuring the kind of quality care, even seeming miracles, that Americans have come to expect from medicine.

Such training isn't cheap. Most teaching hospitals are not children's hospitals. They are general care facilities, and they receive \$78,000 a year from the federal Medicare program for each resident, or doctor-in-training. The amount reflects the many Medicare recipients who are patients at these hospitals.

The money is used to pay residents (around \$35,000 a year) and support staff and programs.

As might be expected, children's hospitals care for very few Medicare recipients. The program provides health care for Americans age 65 and older. As a result, a hospital such as Children's of Akron receives just \$350 per year for each resident, or roughly 0.5 percent of the sum that goes to general hospitals.

Children's hospitals do care for

many Medicaid patients. Medicaid is the program that combines federal and state money to provide health care to the poor. With the recent push to enroll Medicaid clients in health maintenance organizations, or HMOs, Children's of Akron has lost at least \$1 million a year in funds for medical education.

As a matter of public policy, the use of managed care in Medicaid makes sense. What is far less sensible is the penalty suffered by children's hospitals — and, if truth be told, communities as a whole. The practice merely compounds the inequities elsewhere in the flow of public money to teaching hospitals.

U.S. Rep. Sherrod Brown, a Lorain Democrat, visited Akron last week to highlight the problem and the risks it poses for the care of children over the long run. He has proposed that the feds spend an additional \$285 million over the next two years on medical education at children's hospitals. That would ease the pressure on hospitals to make cuts in services or scale back their residency programs.

Even more important is an enduring approach that ends the inequities and ensures the highest training of young doctors looking to care for children. In that pursuit, Brown should expect bipartisan support. Sen. Mike DeWine, an Ohio Republican, has expressed his concern. Together, they can proclaim: Do it for our children. Those words usually open doors in Washington.



A call for help

As the co-chair of the Concerned Citizens Committee of Southeast Ohio opposing the installation of Larry Baker's Muskie Genetics facility in Noble County, I would like to thank Beacon Journal writer Bob Downing for bringing this issue to the attention of the people of Northeast Ohio who come to our area for recreation, hunting and fishing (Beacon Journal, May 28, "Hog farmer to trim Noble County plans").

Farmers in Southeast Ohio recognize the attempt being made to consolidate the livestock industry.

Pigs are raised by the farmers of Noble County without problems, but they have no desire to see their livelihoods, their property values or their quality of life destroyed by an absentee owner of a facility that creates more waste and animals than it has the technology to handle.

The latest business decision from this man is to circumvent the permit process that requires a public hearing and gives residents the option to require protective measures such as monitoring wells and

Funding for G-M-E-

~~PROVIDING COMMENSURATE FEDERAL GME FINANCING FOR~~
FREESTANDING CHILDREN'S HOSPITALS

SUMMARY

The option we choose will be inserted here.

BACKGROUND

- [This should be 3-5 bullets]
- ① Combine
- ~~The Federal government~~ ^{Medicare} has traditionally provided teaching hospitals with financial support. Care in teaching hospitals is generally recognized as costlier than similar care provided in non-teaching facilities, because of the greater number of tests ordered by interns and residents and other inefficiencies associated with inexperience and a sicker patient population. The Federal government has recognized that educational activities enhance the quality of care in an institution and the Medicare program ~~has~~ assumed a portion of the net cost of these training activities. Medicare's medical education payments have sustained both a high-quality medical education system and assisted the hospitals that have trained providers.
 - **Federal support is critical to the financial health of teaching hospitals.** An increasingly competitive health care market dominated by managed care is often unwilling to support the cost of graduate medical education. The Federal support teaching hospitals receive allows them to maintain their academic mission without sacrificing their financial health.
 - **Freestanding children's hospitals share the academic mission of other teaching hospitals, but are denied the same level of Federal support.** The children's hospitals play a critical role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists, pioneering new approaches to organ transplant, open heart surgery, and trauma treatment. However, because the current system of Federal reimbursement for graduate medical education is dependant on the number of Medicare patients seen, it creates a dramatic competitive disadvantage for children's hospitals. Based on the most recent HCRIS data, teaching hospitals receive an average of \$76,000 in Federal GME funding per resident, as opposed to the \$400 per resident recieved by freestanding teaching hospitals.

- Combine
- **The absence of Federal support makes children's hospitals financially vulnerable.** Because of this inequity in Federal financing, children's hospitals have been forced to depend on non-patient care revenue to a much greater extend than other teaching hospitals. [According to HCRIS data, non-patient care revenue represents 14.1% of the children's hospitals total revenue. Other teaching hospitals receive only 8.6% of their total revenue from non-patient care related sources. This makes children's hospitals much more vulnerable than other teaching hospitals to an economic downturn that could threaten their financial health. GME losses for each children's hospital run in the millions of dollars per year and cannot be sustained.]

2

I checked into the operating margins info & this was the best I could do; maybe you have a better idea.
Can we talk about it?

- **Children's hospitals are an essential part of the safety net.** Although they represent only 1 percent of all hospitals, children's hospitals serve 12 percent of all hospitalized children. In addition, because children's hospitals are dedicated to caring for all children regardless of economic or medical condition, they provide a significant amount of care to children enrolled in Medicaid. Over the three most recent years for which data is available, almost half the care these hospitals provided was to children who were enrolled in the Medicaid program or uninsured.
- **Without GME support, children's hospitals may be forced to abandon their academic and charitable missions.** Without GME support, children's hospitals would not be able to remain financially viable in an increasingly competitive market. For some of the children's hospitals, this is an issue of immediate, serious, financial concern. Others will be forced to scale back their current efforts supporting community services, such as child abuse treatment, poison control centers, and other activities that promote the health and well-being of all the children in the community they serve. [Still other hospitals will be forced to reduce their residency programs.]

*I am calling NACHRI
to see if they have a
on this.*

POLICY DESCRIPTION

The option we choose will be inserted here.

RATIONALE

This section will change based on the option we pick, but here's one that stays regardless.

- **Medical education is a social benefit.** Academic health centers provide a national resource for clinical and basic science research, education of health professionals, and highly sophisticated and scientifically advanced patient care. Because society at large benefits from their pursuit of these multiple missions, Federal support for GME should no longer be dependant on the type of provider being trained.

I can do pros & cons if you want. Let me know.

OPTIONS FOR PROVIDING FEDERAL GME FINANCING TO FREESTANDING CHILDREN'S HOSPITALS

- **Modify the Kerrey proposal to provide reimbursement for those GME costs associated with providing care to publicly insured patients.** Under the Kerrey proposal, children's hospitals receive DME reimbursement based on a flat per resident amount, without consideration for the percentage of their expenditures associated with providing care to Medicare or Medicaid patients. This option would modify the DME formula in the Kerrey legislation to ensure that the children's hospitals only received reimbursement for the portion of their DME expenses associated with providing care to Medicare and Medicaid patients. The IME formula could be modified in a similar fashion. *Make prospective, limited funds, separate Admin. through MCR*
- **Eliminate IME reimbursement from the Kerrey proposal.** The Kerrey proposal requires the Federal government to provide approximately \$76,000 per resident for DME costs alone. This is as much as we presently provide to other teaching hospitals for both their direct and indirect medical education costs. The proposal could be modified to exclude reimbursement for IME and reimburse for only DME costs. This would provide the children's hospitals with the commensurate funding they are seeking.
- **Require Medicare to disburse GME funds based on a flat, per resident amount.** This proposal would provide children's hospitals with graduate medical education funding according to a flat, per resident amount to be determined by HCFA. The amount of funding an institution received would be dependant solely on the number of residents it had enrolled. Funds would be provided through a general appropriation, and there would be a cap on the amount of funds that could be disbursed.
- **Create a discretionary grant program to provide GME funds.** This proposal would require children's hospitals to submit an application to receive a GME grant. Based on Federal review of the grant proposal, hospitals could receive different levels of funding.

this is more detail than was discussed... let me know about changes. also -

RE OPTION 1: I know you had concerns that just changing the formula to include Medicaid pts would open it up to everyone, but the Kerrey proposal is limited to children's hospitals, so I think it's okay

RE OPTION 3: I did a little research re: geographic variation & will discuss w/you if you want, but I don't think we need to worry about it.

	A	B	C
1	Projected Cost of the Kerry Proposal *		
2			
3	Direct GME		
4		Weighted	Unweighted
5	Per Resident Amount	\$82,283	\$76,817
6	Full Time Equivalents	2,823	2,823
7	Payments	\$232,284,909	\$216,854,391
8			
9	IME		
10			
11	Average IME/Resident	\$33,902	\$70,812
12	FTES	3,458	3,458
13	Payments	\$117,233,116	\$244,867,896
14			
15	DGME + IME	\$349,518,025	\$461,722,287
16			
17	* Kerry proposal limits payments to \$100 million		
18	in FY 1999 and \$285 million in FY 2000 to FY 2002.		
19	These tables illustrate the impact of the bill w/o capped expenditure		
20			
21	Note: The unweighted column uses the methodology in		
22	the Kerry bill. The weighted column illustrates the		
23	impact of the provision by weighting by the number of		
24	residents.		

	A	B	C	D
1				
2	Margins for Classes of Hospitals			
3				
4				Operating
5		Total	Operating	Revenue Minus
6		Margin	Margin	Total Expenses
7				
8	ACADEMIC MEDICAL CENTERS	3.6	-7.8	-9.9
9	CHILDRENS	7.9	-6.3	-6.9
10	OTHER TEACHING	4.7	-3.4	-4.7
11	NON-TEACHING	3.1	-3.6	-4.3
12	Average	3.4	-3.7	-4.5
13				
14	Total Margin = (Total Revenue - Total Expenses) / Total Expenses			
15				
16	Operating Margin = (Operating Revenue - Operating Expenses) / Operating Expenses			
17				
18	Total Revenue less Contributions, Donations, Bequests etc... less Income from			
19	Investments equals Operating Revenue			
20				
21	The difference between operating and total expenses are nonpatient care expenses			
22	such as cafeteria, parking garage, gift shop etc...			
23				
24	AMC = Academic Medical Center			

red background -
is this better?

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

SUMMARY

The option we choose will be inserted here.

BACKGROUND

- **Medicare has traditionally provided teaching hospitals with financial support.** Care in teaching hospitals is generally recognized as costlier than similar care provided in non-teaching facilities, because of the greater number of tests ordered by medical students and other inefficiencies associated with inexperience and a sicker patient population. Recognizing that educational activities enhance the quality of care in an institution, Medicare has assumed a portion of the net cost of these training activities. Because an increasingly competitive health care market dominated by managed care is often unwilling to support the cost of graduate medical education, the Federal medical education payments ~~allow teaching hospitals to maintain their academic mission without sacrificing their financial health.~~ *are increasingly important in allowing* Reverse
- **Freestanding children's hospitals share the academic mission of other teaching hospitals, but are denied a commensurate level of Federal support.** The children's hospitals play a critical role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists. However, the current system of Federal reimbursement for graduate medical education is dependant on the number of Medicare patients seen, creating a significant competitive disadvantage for children's hospitals. Based on the most recent HCRIS data, teaching hospitals receive an average of \$76,000 in Federal GME funding per resident, as opposed to the \$400 per resident recieved by freestanding children's hospitals. Because of this inequity in Federal financing, children's hospitals depend on non-patient care revenue to a much greater extent than other teaching hospitals. ~~This makes children's hospitals more vulnerable than other teaching hospitals to an economic downturn that could threaten their financial health.~~ *lower private plan payments (said in Next point*
- **Children's hospitals are an essential part of the safety net.** Although they represent only 1 percent of all hospitals, children's hospitals serve 12 percent of all hospitalized children. In addition, over the three most recent years for which data is available, almost half the care these hospitals provided was to children who were either enrolled in the Medicaid program or uninsured. Without GME support, children's hospitals will not be able to remain finacially viable in an increasingly competitive market. For some of the children's hospitals, this is an issue of immediate, serious, financial concern. Others will have to scale back current efforts supporting community services, such as child abuse treatment, poison control centers, and other activities promoting the health and well-being of all the children in the community they serve. Still other hospitals will be forced to reduce their residency programs. shorter & better.

D. Goun - *you might want to pull together a little Fact Sheet ->*

on: # hospitals
Margin Data

MCR Formula

Verity Formula

Just Bullets w/ INfr., Not
words.

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Children's Hospitals Education and Research Act of 1998 (Introduced in the Senate)

S 2049 IS

105th CONGRESS

2d Session

S. 2049

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

IN THE SENATE OF THE UNITED STATES

May 7, 1998

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

A BILL

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

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

SECTION 1. SHORT TITLE.

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

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

(a) PAYMENTS-

(1) IN GENERAL- The Secretary shall make payment under this section to each children's hospital for each hospital cost reporting period beginning after fiscal year 1998 and before fiscal year 2003 for the direct and indirect expenses associated with operating approved medical residency training programs.

(2) CAPPED AMOUNT- The payment to children's hospitals established in this subsection

for cost reporting periods ending in a fiscal year is limited to the extent of funds appropriated under subsection (d) for that fiscal year.

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

(b) AMOUNT OF PAYMENT-

(1) IN GENERAL- The amount payable under this section to a children's hospital for direct and indirect expenses relating to approved medical residency training programs for a cost reporting period is equal to the sum of--

(A) the product of--

(i) the per resident rate for direct medical education, as determined under paragraph (2), for the cost reporting period; and

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

(B) the product of--

(i) the per resident rate for indirect medical education, as determined under paragraph (3), for the cost reporting period; and

(ii) the number of full-time equivalent residents in the hospital's approved medical residency training programs for the cost reporting period.

(2) PER RESIDENT RATE FOR DIRECT MEDICAL EDUCATION-

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

(B) COMPUTATION OF UPDATED RATE- The Secretary shall--

(i) compute a base national DME average per resident rate equal to the average of the per resident rates computed under section 1886(h)(2) of the Social Security Act for cost reporting periods ending during fiscal year 1998; and

(ii) update such rate by the applicable percentage increase determined under section 1886(b)(3)(B)(i) of such Act for the fiscal year involved.

(C) ADJUSTMENT FOR VARIATIONS IN LABOR-RELATED COSTS- The Secretary shall adjust for each hospital the portion of such updated rate that is related to labor and labor-related costs to account for variations in wage costs in the geographic area in which the hospital is located using the factor determined under section 1886(d)(3)(E) of the Social Security Act.

(3) PER RESIDENT RATE FOR INDIRECT MEDICAL EDUCATION-

(A) IN GENERAL- The per resident rate for indirect medical education for a hospital for a cost reporting period ending in or after fiscal year 1999 is the updated amount

determined under subparagraph (B).

(B) COMPUTATION OF UPDATED AMOUNT- The Secretary shall--

(i) determine, for each hospital with a graduate medical education program which is paid under section 1886(d) of the Social Security Act, the amount paid to that hospital pursuant to section 1886(d)(5)(B) of such Act for the equivalent of a full twelve-month cost reporting period ending during the preceding fiscal year and divide such amount by the number of full-time equivalent residents participating in its approved residency programs and used to calculate the amount of payment under such section in that cost reporting period;

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

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

(c) MAKING OF PAYMENTS-

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

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

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

(d) LIMITATION ON EXPENDITURES-

(1) IN GENERAL- Subject to paragraph (2), there are hereby appropriated, out of any money in the Treasury not otherwise appropriated, for payments under this section for cost reporting periods beginning in--

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

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

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

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

(2) CARRYOVER OF EXCESS- If the amount of payments under this section for cost reporting periods ending in fiscal year 1999, 2000, or 2001 is less than the amount provided under this subsection for such payments for such periods, then the amount available under this subsection for cost reporting periods ending in the following fiscal year shall be increased by the amount of such difference.

(e) RELATION TO MEDICARE AND MEDICAID PAYMENTS- Notwithstanding any other

provision of law, payments under this section to a hospital for a cost reporting period--

(1) are in lieu of any amounts otherwise payable to the hospital under section 1886(h) or 1886(d)(5)(B) of the Social Security Act to the hospital for such cost reporting period, but

(2) shall not affect the amounts otherwise payable to such hospitals under a State medicaid plan under title XIX of such Act.

(f) DEFINITIONS- In this section:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM- The term `approved medical residency training program' has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(A)).

(2) CHILDREN'S HOSPITAL- The term `children's hospital' means a hospital described in section 1886(d)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iii)).

(3) DIRECT GRADUATE MEDICAL EDUCATION COSTS- The term `direct graduate medical education costs' has the meaning given such term in section 1886(h)(5)(C) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(C)).

(4) SECRETARY- The term `Secretary' means the Secretary of Health and Human Services.

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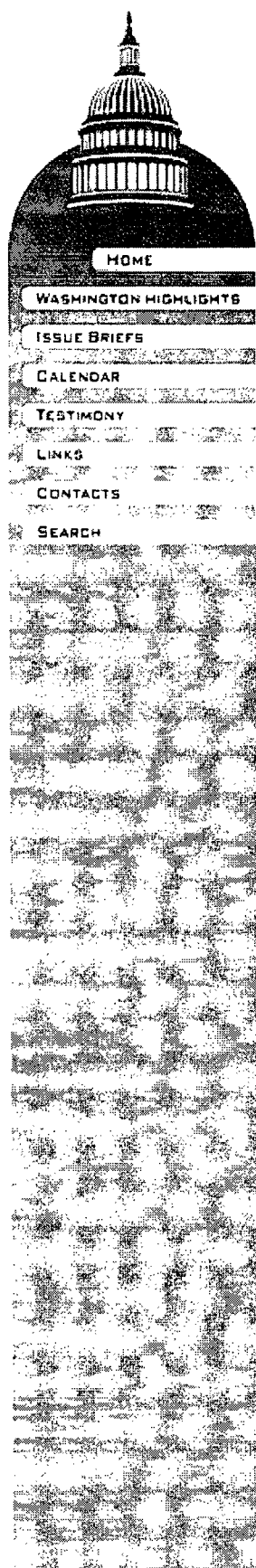
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Testimony

Statement on Medicare's Role in Financing Graduate Medical Education

Presented by: Jordan J. Cohen, M.D., President, Association of American Medical Colleges

Presented to: GME Study Group of the National Bipartisan Commission on the Future of Medicare

Date: September 15, 1998

Mr. Chairman and distinguished members of the commission, I am Jordan J. Cohen, M.D., President and Chief Executive Officer of the Association of American Medical Colleges (AAMC). The AAMC welcomes the opportunity to testify on the Medicare program's future role in financing graduate medical education (GME). The Association represents all of the nation's 125 medical schools, approximately 400 major teaching hospitals, including 75 Veterans Affairs medical centers, 88,000 faculty of these institutions represented by 86 constituent academic societies, and more than 160,000 men and women in medical education as students and residents.

Medicare has provided long-term, stable support of GME and its related activities, such as care for the severely ill, availability of highly specialized services around-the-clock and provision of an environment in which research can flourish. Medicare's support has been indispensable in permitting teaching hospitals and their affiliated medical schools to claim world leadership in physician education, research and advanced patient care. Whether perusing the list of the 50 Best Hospitals in *US News and World Report* or learning about the latest innovation in medical care on the evening news, chances are that a teaching hospital or medical school is the highlighted institution.

As you know, the health care system is undergoing unprecedented change. Some have suggested that the nation's medical schools and teaching hospitals have been slow to recognize the need to respond to changes, but I assure you that our institutions are among the most active participants in the revolution. Later, during our discussion, I hope to expand on how our institutions have responded to the new realities in health care by redefining our educational objectives and by redesigning the ways in which we educate and train physicians and other health care professionals.

From what I know of your deliberations to date, most commissioners are in general agreement that teaching hospitals fulfill valuable social

missions that should be supported. The debate, as I understand it, is over how to finance GME--and the valuable set of activities closely related to it--and how to provide appropriate oversight for the system so that Medicare beneficiaries and society can be assured that they are getting their monies worth. I've been asked to address several specific issues this afternoon, including:

- whether Medicare GME funding should be maintained as an entitlement or be subject to the annual appropriations process;
- whether an entitlement structure should be limited or unlimited;
- what methods exist for improving accountability by teaching institutions and oversight by the federal government; and
- whether federal funding should "follow the resident," as with some form of voucher system, or should stay with the institution.

The Association has long held the view that all purchasers of health care services should pay for their fair share of direct and indirect GME costs. It's accurate to say that all payers currently do participate, to some degree, in the financing of GME. Many, but not all, state Medicaid programs make payments for GME-related costs; however, some states that have been making payments are backing away from their commitments. Private insurance companies historically have contributed implicitly to direct and indirect GME costs by paying teaching hospitals higher prices than they would have paid to non-teaching hospitals for services provided to enrollees. In the newly price-sensitive environment, however, there is increasing pressure on private payers to avoid paying higher patient care rates to fund the additional products of teaching hospitals that go beyond direct patient care. Medicare is the only nationally recognized payer that makes two explicit payments for GME-related costs, direct graduate medical education (DGME) and indirect medical education (IME) payments. With passage of the Balanced Budget Act of 1997, Medicare now pays its share of DGME and IME costs associated with both its fee-for-service and its Medicare+Choice enrollees.

One fairly recent legislative proposal that addressed the current pressures on GME financing was the Teaching Hospital and Graduate Medical Education Trust Fund in the Balanced Budget Act of 1995. The AAMC supported, and continues to support, the proposal's general structure and its basic payment methodology which mirrors the current Medicare system. The proposal would have created a trust fund with five separate accounts, each with its own funding level and payment methodology. The two Medicare accounts retained the distinct and separate purposes and formula-driven methodologies of DGME and IME. Three additional accounts were created, two of which contained appropriated funds for the payment-equivalents of DGME and IME. The third account, which is no longer needed due to changes made in the Balanced Budget Act of 1997, recognized Medicare's contribution on behalf of its managed care enrollees.

Another proposal, the Medical Education Trust Fund Act of 1997, was introduced by Senator Daniel Patrick Moynihan (D-NY) last year. It would create a trust fund to support both teaching hospitals and medical schools. Contributions to the trust fund would come from three sources: Medicare, Medicaid and an assessment on health insurance premiums. The AAMC supports the Moynihan bill. A trust fund along these or similar designs would be an important step in

re-establishing a truly shared responsibility for the costs of clinical education and its related activities.

Entitlement or appropriation? Some commissioners have advocated removing the GME payments from the Medicare program and making them subject to the annual appropriations process. The AAMC strongly believes that the entitlement aspect of Medicare GME funding must be maintained. The Association closely follows the appropriations process each year because of our interest in funding for the National Institutes of Health (NIH), health professions education programs, and many health services programs on which our members depend. While the NIH and several other programs are generally well-supported, they compete for funding with many worthy causes and are inevitably vulnerable to the changing interests of Congress. Investment in physician education can reap short- and long-term dividends for today's Medicare beneficiaries and tomorrow's retirees only if a reliable and predictable source of funding can be assured.

Some commissioners have noted that the entitlement nature of GME funding and the ability to adapt to changing market circumstances are fundamentally contradictory. I submit that long term, dependable GME financing is necessary to ensure that teaching institutions have the ability to adapt to changing market conditions. Accredited, high quality training programs may take several years to establish. Moving residency training from hospital to non-hospital settings takes time. Arrangements between the program sponsor and the teaching site must be made. Faculty must be recruited and trained, and plans to ensure the quality of teaching must be implemented in a variety of diverse settings. Sponsors of GME training can adjust the specialty mix and size of their programs over time, but need stable funding to plan and fulfill the ethical and moral obligations they have made to physicians currently-in-training. It also takes time to do the long range planning to adapt programs to produce the number and specialty mix that the market demands. The length of training programs varies from three to seven or more years, depending on the specialty.

Under the current entitlement system, when Congress determines that shifting priorities require a change in GME financing, it enacts legislation and the requisite changes are implemented. For example, several provisions in the 1997 Balanced Budget Act are intended to stimulate training in non-hospital settings and will, over time, do just that. Subjecting GME to an annual appropriations process would introduce inordinate uncertainty into an activity that demands careful planning.

A Limited or Unlimited Entitlement Structure? Some policy makers have criticized Medicare's "open-ended" approach to GME financing. They have maintained that hospitals have added residents to increase DGME or IME payments because Medicare imposed no limit on the total number of residents it supported. The Medicare program terminated its "open-ended" support with enactment of the Balanced Budget Act of 1997. Teaching hospitals now are responding to the most significant and complex changes in Medicare GME payment policy in decades. Chief among the changes is the placement of limits, using 1996 as a base year, on the number of residents hospitals may count for both DGME and IME payments. The AAMC has no problem with this policy change, although its implementation

is more complicated than might be expected. The limit on residency numbers, along with several other changes, including an overall 29 percent reduction in IME payments over the next several years, is causing many teaching hospitals to take a fresh look at their involvement in physician training, including their ability to support as many residents as they have in the past and to place residents in non-hospital educational settings.

The AAMC firmly believes that Medicare's contribution in support of DGME and IME funding should be based on the total volume of Medicare patients receiving care in teaching institutions. As the number of Medicare beneficiaries grows, and to the extent these individuals are treated in teaching institutions, Medicare DGME and IME payments should vary with increases or decreases in the number of Medicare patients treated at a given teaching institution. The AAMC recognizes that the needs of teaching institutions with little Medicare utilization, such as children's hospitals and some public municipal hospitals, need to be addressed. A trust fund with multiple accounts, including separate Medicare and general (non-Medicare) accounts, would provide a source of non-Medicare funding for institutions that have not benefitted historically from Medicare's significant participation in GME.

Accountability and Oversight. Understandably, the commission has questioned what accountability and oversight mechanisms ensure that the \$7 billion in DGME and IME payments is being well spent. Teaching institutions can demonstrate relatively easily how they spend DGME payments. They keep detailed records of the number of residents they train in each specialty and their associated costs. IME payments, because they serve multiple and very different purposes, are more difficult to disaggregate. Congress specifically identified the rationale behind the IME adjustment in the prospective payment legislation:

This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of other factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

Teaching hospitals are held accountable for their GME responsibilities in a number of ways. To maintain accreditation, training programs must meet a series of requirements at the institutional and program (specialty) levels. Teaching hospitals must adhere to Medicare's requirements, including sustained accreditation of training programs, to receive DGME and IME payments. Governmental or public institutions are accountable for meeting established needs in their communities.

The AAMC recognizes that accountability is central to maintaining public trust. One approach to demonstrating increased accountability would be to have Congress encourage each teaching institution to

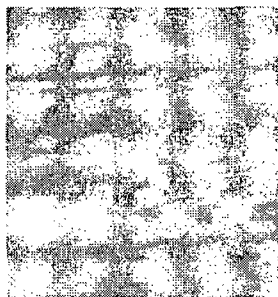
conduct an annual self-assessment of its performance in fulfilling its education mission. Such voluntary self-assessments, while not legally binding, could be very influential in aligning educational outcomes with public policy. The assessments would have to pass muster by the institution's board of trustees, could be filed with a national independent health professions workforce advisory body, and could be made available to the local community and the general public. In this way, teaching institutions could declare publicly how GME-related dollars, and monies from other funding sources, were used to support the educational and patient service activities in their communities. An example of such a system exists in Massachusetts. In that state, hospitals voluntarily file similar reports on the community benefits they provide locally to justify their tax-exempt status. Most Massachusetts hospitals now are attempting to quantify the benefits they provide to their communities and believe that the program has helped them focus on greater accountability to the public. This proposed self-assessment of educational activities could have a similar positive effect with respect to the support of physician and health professions training.

Payments to Institutions or Vouchers to Residents? Some policy makers suggest that the GME system would be more accountable if hospitals were forced to compete for residents. Residents, each empowered with a voucher upon graduation from medical school, would "shop around" for a training program, giving the voucher to the chosen institution which then would submit the voucher in exchange for payment. Proponents of vouchers believe that they would give residents the freedom to choose non-hospital settings for their training.

In many respects, a voucher system is, in essence, currently in place. While the resident does not possess an actual voucher certificate, the Medicare program only makes a payment to a teaching institution when a resident has chosen to train there. The teaching institution includes the resident in its count for payments only if he or she selects an approved training program at that particular teaching institution. To encourage non-hospital training, the Balanced Budget Act of 1997 allows non-hospital entities, including Medicare+Choice organizations, federally qualified health centers, and rural health clinics, to receive DGME payments. While vouchers are conceptually simple and appealing on the surface, their use would require a series of decisions that would lead to a greater degree of federal regulation.

Institutions, not individual programs, are the sponsors of graduate physician training. Institutional oversight of individual programs is critically important for maintaining the high standards required by accrediting agencies. Optimal training of residents requires an academic milieu that encourages the exchange of knowledge and experience among faculty and residents training in different specialties, particularly now that practice in multi-disciplinary settings is increasingly the norm.

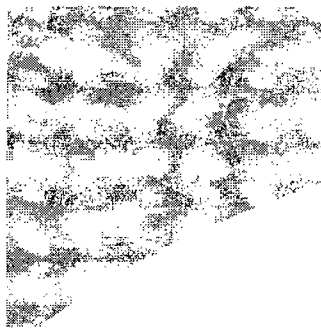
Conclusion. The AAMC believes that Medicare should continue to support its share of the costs related to physician training in a stable, dependable way that is not subject to the appropriations process. The program should maintain its critical role in financing graduate medical education through both DGME and IME payments based on payment formulas that recognize differences in cost structures,



teaching intensities and volume of Medicare utilization. A trust fund with revenue from non-Medicare sources would help spread the costs of GME equitably among Medicare and other payers. The AAMC appreciates the commission's efforts to address the financing of GME, including the consideration of broad-based sources of funding, while making recommendations for the appropriate financial structure of Medicare. We look forward to working with you to ensure that the American health care system continues to provide the best health care in the world.

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Revised: 25 September 1998
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PUBLIC POLICY



N.A.C.H. - The Public Policy Affiliate of NACHRI

The National Association of Children's Hospitals (N.A.C.H.) is a nonprofit trade association of more than 100 children's hospitals across the country, including freestanding acute care children's hospitals, children's hospitals organized within larger hospitals, and freestanding children's specialty and rehabilitation hospitals.

Children's Hospitals

Children's hospitals are centers of excellence in clinical care, graduate medical education, research and advocacy devoted to children's unique health care needs. On average, a freestanding acute care children's hospital devotes nearly 50% of its care to children who are assisted by Medicaid or uninsured and more than 75% of its care to children with one or more chronic or congenital conditions. It trains, on average, more than 75 graduate medical residents annually.

The N.A.C.H. Name

N.A.C.H. is the public policy affiliate of the National Association of Children's Hospitals and Related Institutions (NACHRI). The N.A.C.H. acronym is pronounced letter by letter - N - A - C - H. It is not pronounced "Natch" or "Nak."

Mission and Vision Statements

Mission

The National Association of Children's Hospitals supports children's hospitals in addressing public policy issues that affect their ability to fulfill their missions to serve children and their families.

Vision

N.A.C.H. and its members are driven by the vision of a society in which all children and their families have access to the full continuum of pediatric health care services needed to allow each child to achieve optimum health status. In achieving this vision, N.A.C.H. champions for public policy that promotes high quality, cost effective clinical care, education, research and advocacy for children and their families.

Goals

N.A.C.H. will fulfill its mission and vision through federal advocacy, collaboration and communication services designed to strengthen the ability of children's hospitals and health systems to:

- Influence public policymakers' understanding and

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support for improved children's health and the missions of children's hospitals and health systems

- Inform the children's hospitals and health systems leadership on the latest relevant developments in federal and state policy issues, as well as public and private grants opportunities
- Advance access and quality of health care for all children
- Sustain financially their missions of clinical care, education, research and advocacy

N.A.C.H. Member Services

N.A.C.H. provides to its member hospitals an array of services, including federal advocacy, state policy services, and more. For information about joining N.A.C.H., contact [member services](#).

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Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

SEC. 3. AMENDMENTS TO MEDICARE PROGRAM.

(a) IN GENERAL- Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended--

(1) in subsection (d)(5)(B), in the matter preceding clause (i), by striking 'The Secretary shall provide' and inserting the following: 'For discharges occurring before October 1, 1997, the Secretary shall provide';

(2) in subsection (h)--

(A) in paragraph (1), in the first sentence, by striking 'the Secretary shall provide' and inserting 'the Secretary shall, subject to paragraph (6), provide'; and

(B) by adding at the end the following new paragraph:

“(6) LIMITATION-

“(A) IN GENERAL- The authority to make payments under this subsection shall not apply with respect to--

“(i) cost reporting periods beginning after September 30, 1997; and

“(ii) any portion of a cost reporting period beginning on or before such date which occurs after such date.

“(B) RULE OF CONSTRUCTION- This paragraph may not be construed as authorizing any payment under section 1861(v) with respect to graduate medical education.”; and

(3) by adding at the end the following new subsection:

“(j) TRANSFERS TO MEDICAL EDUCATION TRUST FUND-

“(1) INDIRECT COSTS OF MEDICAL EDUCATION-

“(A) TRANSFER-

“(i) IN GENERAL- From the Federal Hospital Insurance Trust Fund, the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, transfer to the Medical Education Trust Fund an amount equal to the amount estimated by

the Secretary under subparagraph (B).

`(ii) ALLOCATION- Of the amount transferred under clause (i)--

`(I) there shall be allocated and transferred to the Medical School Account an amount which bears the same ratio to the total amount available under section 2102(b)(1) for the fiscal year (reduced by the balance in such account at the end of the preceding fiscal year) as the amount transferred under clause (i) bears to the total amounts transferred to the Medical Education Trust Fund under title XXI (excluding amounts transferred under subsections (c)(3) and (d) of section 2101) for such fiscal year; and

`(II) the remainder shall be allocated and transferred to the Medicare Teaching Hospital Indirect Account.

`(B) DETERMINATION OF AMOUNTS- The Secretary shall make an estimate for each fiscal year involved of the nationwide total of the amounts that would have been paid under subsection (d)(5)(B) to hospitals during the fiscal year if such payments had not been terminated for discharges occurring after September 30, 1997.

`(2) DIRECT COSTS OF MEDICAL EDUCATION-

`(A) TRANSFER-

`(i) IN GENERAL- From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, transfer to the Medical Education Trust Fund an amount equal to the amount estimated by the Secretary under subparagraph (B).

`(ii) ALLOCATION- Of the amount transferred under clause (i)--

`(I) there shall be allocated and transferred to the Medical School Account an amount which bears the same ratio to the total amount available under section 2102(b)(1) for the fiscal year (reduced by the balance in such account at the end of the preceding fiscal year) as the amount transferred under clause (i) bears to the total amounts transferred to the Medical Education Trust Fund under title XXI (excluding amounts transferred under subsections (c)(3) and (d) of section 2101) for such fiscal year; and

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Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

SEC. 4. AMENDMENTS TO MEDICAID PROGRAM.

(a) IN GENERAL- Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended--

(1) by redesignating section 1931 as section 1932; and

(2) by inserting after section 1930, the following new section:

TRANSFER OF FUNDS TO ACCOUNTS

SEC. 1931. (a) TRANSFER OF FUNDS-

(1) IN GENERAL- For fiscal year 1998 and each subsequent fiscal year, the Secretary shall transfer to the Medical Education Trust Fund an amount equal to the amount determined under subsection (b).

(2) ALLOCATION- Of the amount transferred under paragraph (1)--

(A) there shall be allocated and transferred to the Medical School Account an amount which bears the same ratio to the total amount available under section 2102(b)(1) for the fiscal year (reduced by the balance in such account at the end of the preceding fiscal year) as the amount transferred under paragraph (1) bears to the total amounts transferred to the Medical Education Trust Fund under title XXI (excluding amounts transferred under subsections (c)(3) and (d) of section 2101) for such fiscal year; and

(B) the remainder shall be allocated and transferred to the Non-Medicare Teaching Hospital Indirect Account and the Non-Medicare Teaching Hospital Direct Account, in the same proportion as the amounts transferred to each account under section 1886(j) relate to the total amounts transferred under such section for such fiscal year.

(b) AMOUNT DETERMINED-

(1) OUTLAYS FOR ACUTE MEDICAL SERVICES DURING PRECEDING FISCAL YEAR- Beginning with fiscal year 1998, the Secretary shall determine 5 percent of the total amount of Federal outlays made under this title for acute medical services, as defined in paragraph (2), for the preceding fiscal year.

(2) ACUTE MEDICAL SERVICES DEFINED- The term 'acute medical services' means items and services described in section 1905(a) other than the following:

`(A) Nursing facility services (as defined in section 1905(f)).

`(B) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

`(C) Personal care services (as described in section 1905(a)(24)).

`(D) Private duty nursing services (as referred to in section 1905(a)(8)).

`(E) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

`(F) Home and community care furnished to functionally disabled elderly individuals under section 1929.

`(G) Community supported living arrangements services under section 1930.

`(H) Case-management services (as described in section 1915(g)(2)).

`(I) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous subparagraph.

`(J) Services furnished in an institution for mental diseases (as defined in section 1905(i)).

`(c) ENTITLEMENT- This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to the Non-Medicare Teaching Hospital Indirect Account, the Non-Medicare Teaching Hospital Direct Account, and the Medical School Account of amounts determined in accordance with subsections (a) and (b).'

(b) EFFECTIVE DATE- The amendment made by subsection (a) shall be effective on and after October 1, 1997.

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TRANSFER OF FUNDS TO ACCOUNTS

SEC. 1931. (a) TRANSFER OF FUNDS-

(1) IN GENERAL- For fiscal year 1998 and each subsequent fiscal year, the Secretary shall transfer to the Medical Education Trust Fund an amount equal to the amount determined under subsection (b).

(2) ALLOCATION- Of the amount transferred under paragraph (1)--

(A) there shall be allocated and transferred to the Medical School Account an amount which bears the same ratio to the total amount available under section 2102(b)(1) for the fiscal year (reduced by the balance in such account at the end of the preceding fiscal year) as the amount transferred under paragraph (1) bears to the total amounts transferred to the Medical Education Trust Fund under title XXI (excluding amounts transferred under subsections (c)(3) and (d) of section 2101) for such fiscal year; and

(B) the remainder shall be allocated and transferred to the Non-Medicare Teaching Hospital Indirect Account and the Non-Medicare Teaching Hospital Direct Account, in the same proportion as the amounts transferred to each account under section 1886(j) relate to the total amounts transferred under such section for such fiscal year.

(b) AMOUNT DETERMINED-

(1) OUTLAYS FOR ACUTE MEDICAL SERVICES DURING PRECEDING FISCAL YEAR- Beginning with fiscal year 1998, the Secretary shall determine 5 percent of the total amount of Federal outlays made under this title for acute medical services, as defined in paragraph (2), for the preceding fiscal year.

(2) ACUTE MEDICAL SERVICES DEFINED- The term 'acute medical services' means items and services described in section 1905(a) other than the following:

(A) Nursing facility services (as defined in section 1905(f)).

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(D) Private duty nursing services (as referred to in section 1905(a)(8)).

`(E) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

`(F) Home and community care furnished to functionally disabled elderly individuals under section 1929.

`(G) Community supported living arrangements services under section 1930.

`(H) Case-management services (as described in section 1915(g)(2)).

`(I) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous subparagraph.

`(J) Services furnished in an institution for mental diseases (as defined in section 1905(i)).

`(c) ENTITLEMENT- This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to the Non-Medicare Teaching Hospital Indirect Account, the Non-Medicare Teaching Hospital Direct Account, and the Medical School Account of amounts determined in accordance with subsections (a) and (b).'

(b) EFFECTIVE DATE- The amendment made by subsection (a) shall be effective on and after October 1, 1997.

SEC. 5. ASSESSMENTS ON INSURED AND SELF-INSURED HEALTH PLANS.

(a) GENERAL RULE- Subtitle D of the Internal Revenue Code of 1986 (relating to miscellaneous excise taxes) is amended by adding after chapter 36 the following new chapter:

`CHAPTER 37--HEALTH RELATED ASSESSMENTS

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Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

SEC. 5. ASSESSMENTS ON INSURED AND SELF-INSURED HEALTH PLANS.

(a) GENERAL RULE- Subtitle D of the Internal Revenue Code of 1986 (relating to miscellaneous excise taxes) is amended by adding after chapter 36 the following new chapter:

`CHAPTER 37--HEALTH RELATED ASSESSMENTS

`SUBCHAPTER A. Insured and self-insured health plans.

`Subchapter A--Insured and Self-Insured Health Plans

`Sec. 4501. Health insurance and health-related administrative services.

`Sec. 4502. Self-insured health plans.

`Sec. 4503. Transfer to accounts.

`Sec. 4504. Definitions and special rules.

`SEC. 4501. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

`(a) IMPOSITION OF TAX- There is hereby imposed--

 `(1) on each taxable health insurance policy, a tax equal to 1.5 percent of the premiums received under such policy, and

 `(2) on each amount received for health-related administrative services, a tax equal to 1.5 percent of the amount so received.

`(b) LIABILITY FOR TAX-

 `(1) HEALTH INSURANCE- The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

 `(2) HEALTH-RELATED ADMINISTRATIVE SERVICES- The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

`(c) TAXABLE HEALTH INSURANCE POLICY- For purposes of this section--

`(1) IN GENERAL- Except as otherwise provided in this section, the term `taxable health insurance policy' means any insurance policy providing accident or health insurance with respect to individuals residing in the United States.

`(2) EXEMPTION OF CERTAIN POLICIES- The term `taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to--

`(A) liabilities incurred under workers' compensation laws,

`(B) tort liabilities,

`(C) liabilities relating to ownership or use of property,

`(D) credit insurance, or

`(E) such other similar liabilities as the Secretary may specify by regulations.

`(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE- In the case of any taxable health insurance policy under which amounts are payable other than for accident or health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium paid under such policy, there shall be excluded the amount of the charge for the nonaccident or nonhealth coverage if--

`(A) the charge for such nonaccident or nonhealth coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and

`(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium paid under such policy shall be subject to tax under subsection (a)(1).

`(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS-

`(A) IN GENERAL- In the case of any arrangement described in subparagraph (B)--

`(i) such arrangement shall be treated as a taxable health insurance policy,

`(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and

`(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

`(B) DESCRIPTION OF ARRANGEMENTS- An arrangement is described in this subparagraph if under such arrangement--

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`CHAPTER 37--HEALTH RELATED ASSESSMENTS

`SUBCHAPTER A. Insured and self-insured health plans.

`Subchapter A--Insured and Self-Insured Health Plans

`Sec. 4501. Health insurance and health-related administrative services.

`Sec. 4502. Self-insured health plans.

`Sec. 4503. Transfer to accounts.

`Sec. 4504. Definitions and special rules.

`SEC. 4501. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

`(a) IMPOSITION OF TAX- There is hereby imposed--

`(1) on each taxable health insurance policy, a tax equal to 1.5 percent of the premiums received under such policy, and

`(2) on each amount received for health-related administrative services, a tax equal to 1.5 percent of the amount so received.

`(b) LIABILITY FOR TAX-

`(1) HEALTH INSURANCE- The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

`(2) HEALTH-RELATED ADMINISTRATIVE SERVICES- The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

`(c) TAXABLE HEALTH INSURANCE POLICY- For purposes of this section--

`(1) IN GENERAL- Except as otherwise provided in this section, the term 'taxable health insurance policy' means any insurance policy providing accident or health insurance with respect to individuals residing in the United States.

`(2) EXEMPTION OF CERTAIN POLICIES- The term `taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to--

- `(A) liabilities incurred under workers' compensation laws,
- `(B) tort liabilities,
- `(C) liabilities relating to ownership or use of property,
- `(D) credit insurance, or
- `(E) such other similar liabilities as the Secretary may specify by regulations.

`(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE- In the case of any taxable health insurance policy under which amounts are payable other than for accident or health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium paid under such policy, there shall be excluded the amount of the charge for the nonaccident or nonhealth coverage if--

- `(A) the charge for such nonaccident or nonhealth coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and
- `(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium paid under such policy shall be subject to tax under subsection (a)(1).

`(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS-

`(A) IN GENERAL- In the case of any arrangement described in subparagraph (B)--

- `(i) such arrangement shall be treated as a taxable health insurance policy,
- `(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and
- `(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

`(B) DESCRIPTION OF ARRANGEMENTS- An arrangement is described in this subparagraph if under such arrangement--

- `(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, and

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`Subchapter A--Insured and Self-Insured Health Plans

`Sec. 4501. Health insurance and health-related administrative services.

`Sec. 4502. Self-insured health plans.

`Sec. 4503. Transfer to accounts.

`Sec. 4504. Definitions and special rules.

`SEC. 4501. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

`(a) IMPOSITION OF TAX- There is hereby imposed--

`(1) on each taxable health insurance policy, a tax equal to 1.5 percent of the premiums received under such policy, and

`(2) on each amount received for health-related administrative services, a tax equal to 1.5 percent of the amount so received.

`(b) LIABILITY FOR TAX-

`(1) HEALTH INSURANCE- The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

`(2) HEALTH-RELATED ADMINISTRATIVE SERVICES- The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

`(c) TAXABLE HEALTH INSURANCE POLICY- For purposes of this section--

`(1) IN GENERAL- Except as otherwise provided in this section, the term 'taxable health insurance policy' means any insurance policy providing accident or health insurance with respect to individuals residing in the United States.

`(2) EXEMPTION OF CERTAIN POLICIES- The term 'taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to--

- `(A) liabilities incurred under workers' compensation laws,
- `(B) tort liabilities,
- `(C) liabilities relating to ownership or use of property,
- `(D) credit insurance, or
- `(E) such other similar liabilities as the Secretary may specify by regulations.

`(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE- In the case of any taxable health insurance policy under which amounts are payable other than for accident or health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium paid under such policy, there shall be excluded the amount of the charge for the nonaccident or nonhealth coverage if--

- `(A) the charge for such nonaccident or nonhealth coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and
- `(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium paid under such policy shall be subject to tax under subsection (a)(1).

`(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS-

`(A) IN GENERAL- In the case of any arrangement described in subparagraph (B)--

- `(i) such arrangement shall be treated as a taxable health insurance policy,
- `(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and
- `(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

`(B) DESCRIPTION OF ARRANGEMENTS- An arrangement is described in this subparagraph if under such arrangement--

- `(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, and
- `(ii) substantially all of the risks of the rates of utilization of services is assumed by such person or the provider of such services.

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S.21

Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

`SEC. 4501. HEALTH INSURANCE AND HEALTH-RELATED ADMINISTRATIVE SERVICES.

`(a) IMPOSITION OF TAX- There is hereby imposed--

`(1) on each taxable health insurance policy, a tax equal to 1.5 percent of the premiums received under such policy, and

`(2) on each amount received for health-related administrative services, a tax equal to 1.5 percent of the amount so received.

`(b) LIABILITY FOR TAX-

`(1) HEALTH INSURANCE- The tax imposed by subsection (a)(1) shall be paid by the issuer of the policy.

`(2) HEALTH-RELATED ADMINISTRATIVE SERVICES- The tax imposed by subsection (a)(2) shall be paid by the person providing the health-related administrative services.

`(c) TAXABLE HEALTH INSURANCE POLICY- For purposes of this section--

`(1) IN GENERAL- Except as otherwise provided in this section, the term 'taxable health insurance policy' means any insurance policy providing accident or health insurance with respect to individuals residing in the United States.

`(2) EXEMPTION OF CERTAIN POLICIES- The term 'taxable health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to--

`(A) liabilities incurred under workers' compensation laws,

`(B) tort liabilities,

`(C) liabilities relating to ownership or use of property,

`(D) credit insurance, or

`(E) such other similar liabilities as the Secretary may specify by regulations.

`(3) SPECIAL RULE WHERE POLICY PROVIDES OTHER COVERAGE- In the case of any taxable health insurance policy under which amounts are payable other than for accident or health coverage, in determining the amount of the tax imposed by subsection (a)(1) on any premium paid under such policy, there shall be excluded the amount of the charge for the nonaccident or nonhealth coverage if--

`(A) the charge for such nonaccident or nonhealth coverage is either separately stated in the policy, or furnished to the policyholder in a separate statement, and

`(B) such charge is reasonable in relation to the total charges under the policy.

In any other case, the entire amount of the premium paid under such policy shall be subject to tax under subsection (a)(1).

`(4) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS-

`(A) IN GENERAL- In the case of any arrangement described in subparagraph (B)--

`(i) such arrangement shall be treated as a taxable health insurance policy,

`(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a taxable health insurance policy, and

`(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

`(B) DESCRIPTION OF ARRANGEMENTS- An arrangement is described in this subparagraph if under such arrangement--

`(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, and

`(ii) substantially all of the risks of the rates of utilization of services is assumed by such person or the provider of such services.

`(d) HEALTH-RELATED ADMINISTRATIVE SERVICES- For purposes of this section, the term 'health-related administrative services' means--

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S.21

Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

SEC. 2103. PAYMENTS TO TEACHING HOSPITALS.

(a) FORMULA PAYMENTS TO ELIGIBLE ENTITIES-

(1) IN GENERAL- In the case of any fiscal year beginning after September 30, 1997, the Secretary shall make payments to each eligible entity that, in accordance with paragraph (2), submits to the Secretary an application for such fiscal year. Such payments shall be made from the Trust Fund, and the total of the payments to the eligible entity for the fiscal year shall equal the sum of the amounts determined under subsections (b), (c), (d), and (e).

(2) APPLICATION- For purposes of paragraph (1), an application shall contain such information as may be necessary for the Secretary to make payments under such paragraph to an eligible entity during a fiscal year. An application shall be treated as submitted in accordance with this paragraph if it is submitted not later than the date specified by the Secretary, and is made in such form and manner as the Secretary may require.

(3) PERIODIC PAYMENTS- Payments under paragraph (1) to an eligible entity for a fiscal year shall be made periodically, at such intervals and in such amounts as the Secretary determines to be appropriate (subject to applicable Federal law regarding Federal payments).

(4) ADMINISTRATOR OF PROGRAMS- The Secretary shall carry out responsibility under this title by acting through the Administrator of the Health Care Financing Administration.

(5) ELIGIBLE ENTITY- For purposes of this title, the term 'eligible entity', with respect to any fiscal year, means--

(A) for payment under subsections (b) and (c), an entity which would be eligible to receive payments for such fiscal year under--

(i) section 1886(d)(5)(B), if such payments had not been terminated for discharges occurring after September 30, 1997;

(ii) section 1886(h), if such payments had not been terminated for cost reporting periods beginning after September 30, 1997; or

(iii) both sections; or

(B) for payment under subsections (d) and (e)--

- `(i) an entity which meets the requirement of subparagraph (A); or
- `(ii) an entity which the Secretary determines should be considered an eligible entity.

`(b) DETERMINATION OF AMOUNT FROM MEDICARE TEACHING HOSPITAL
INDIRECT ACCOUNT-

`(1) IN GENERAL- The amount determined for an eligible entity for a fiscal year under this subsection is the amount equal to the applicable percentage of the total amount allocated and transferred to the Medicare Teaching Hospital Indirect Account under sections 1876(a)(7) and 1886(j)(1), and subsections (c)(3) and (d) of section 2101 for such fiscal year.

`(2) APPLICABLE PERCENTAGE- For purposes of paragraph (1), the applicable percentage for any fiscal year is equal to the percentage of the total payments which would have been made to the eligible entity in such fiscal year under section 1886(d)(5)(B) if--

`(A) such payments had not been terminated for discharges occurring after September 30, 1997; and

`(B) such payments included payments for individuals enrolled in a plan under section 1876, except that for fiscal years 1998, 1999,

and 2000, only the applicable percentage (as defined in section 1876(a)(7)(B)) of such payments shall be taken into account.

`(c) DETERMINATION OF AMOUNT FROM MEDICARE TEACHING HOSPITAL DIRECT
ACCOUNT-

`(1) IN GENERAL- The amount determined for an eligible entity for a fiscal year under this subsection is the amount equal to the applicable percentage of the total amount allocated and transferred to the Medicare Teaching Hospital Direct Account under sections 1876(a)(7) and 1886(j)(2), and subsections (c)(3) and (d) of section 2101 for such fiscal year.

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S.21

Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE- This Act may be cited as the 'Medical Education Trust Fund Act of 1997'.

(b) TABLE OF CONTENTS- The table of contents of this title is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Medical Education Trust Fund.

Sec. 3. Amendments to medicare program.

Sec. 4. Amendments to medicaid program.

Sec. 5. Assessments on insured and self-insured health plans.

Sec. 6. Medical Education Advisory Commission.

Sec. 7. Demonstration projects.

SEC. 2. MEDICAL EDUCATION TRUST FUND.

The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding after title XX the following new title:

'TITLE XXI--MEDICAL EDUCATION TRUST FUND

'TABLE OF CONTENTS OF TITLE

'Sec. 2101. Establishment of Trust Fund.

'Sec. 2102. Payments to medical schools.

'Sec. 2103. Payments to teaching hospitals.

'SEC. 2101. ESTABLISHMENT OF TRUST FUND.

'(a) IN GENERAL- There is established in the Treasury of the United States a fund to be known as the Medical Education Trust Fund (in this title referred to as the 'Trust Fund'), consisting of the

following accounts:

- `(1) The Medical School Account.
- `(2) The Medicare Teaching Hospital Indirect Account.
- `(3) The Medicare Teaching Hospital Direct Account.
- `(4) The Non-Medicare Teaching Hospital Indirect Account.
- `(5) The Non-Medicare Teaching Hospital Direct Account.

Each such account shall consist of such amounts as are allocated and transferred to such account under this section, sections 1876(a)(7), 1886(j) and 1931, and section 4503 of the Internal Revenue Code of 1986. Amounts in the accounts of the Trust Fund shall remain available until expended.

`(b) EXPENDITURES FROM TRUST FUND- Amounts in the accounts of the Trust Fund are available to the Secretary for making payments under sections 2102 and 2103.

`(c) INVESTMENT-

`(1) IN GENERAL- The Secretary of the Treasury shall invest amounts in the accounts of the Trust Fund which the Secretary determines are not required to meet current withdrawals from the Trust Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

`(2) SALE OF OBLIGATIONS- The Secretary of the Treasury may sell at market price any obligation acquired under paragraph (1).

`(3) AVAILABILITY OF INCOME- Any interest derived from obligations held in each such account, and proceeds from any sale or redemption of such obligations, are hereby appropriated to such account.

`(d) MONETARY GIFTS TO TRUST FUND- There are appropriated to the Trust Fund such amounts as may be unconditionally donated to the Federal Government as gifts to the Trust Fund. Such amounts shall be allocated and transferred to the accounts described in subsection (a) in the same proportion as the amounts in each of the accounts bears to the total amount in all the accounts of the Trust Fund.

`SEC. 2102. PAYMENTS TO MEDICAL SCHOOLS.

`(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS-

`(1) IN GENERAL- In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for fiscal year 1998 or any subsequent fiscal year, the Secretary shall make payments for such year to the medical school for the purpose specified in paragraph (3). The Secretary shall make such payments from the Medical School Account in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

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- Sec. 7. Demonstration projects.

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`TITLE XXI--MEDICAL EDUCATION TRUST FUND

`TABLE OF CONTENTS OF TITLE

`Sec. 2101. Establishment of Trust Fund.

`Sec. 2102. Payments to medical schools.

`Sec. 2103. Payments to teaching hospitals.

`SEC. 2101. ESTABLISHMENT OF TRUST FUND.

**`(a) IN GENERAL-** There is established in the Treasury of the United States a fund to be known as the Medical Education Trust Fund (in this title referred to as the `Trust Fund'), consisting of the following accounts:

- `(1) The Medical School Account.**
- `(2) The Medicare Teaching Hospital Indirect Account.**
- `(3) The Medicare Teaching Hospital Direct Account.**

`(4) The Non-Medicare Teaching Hospital Indirect Account.

`(5) The Non-Medicare Teaching Hospital Direct Account.

Each such account shall consist of such amounts as are allocated and transferred to such account under this section, sections 1876(a)(7), 1886(j) and 1931, and section 4503 of the Internal Revenue Code of 1986. Amounts in the accounts of the Trust Fund shall remain available until expended.

`(b) EXPENDITURES FROM TRUST FUND- Amounts in the accounts of the Trust Fund are available to the Secretary for making payments under sections 2102 and 2103.

`(c) INVESTMENT-

`(1) IN GENERAL- The Secretary of the Treasury shall invest amounts in the accounts of the Trust Fund which the Secretary determines are not required to meet current withdrawals from the Trust Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

`(2) SALE OF OBLIGATIONS- The Secretary of the Treasury may sell at market price any obligation acquired under paragraph (1).

`(3) AVAILABILITY OF INCOME- Any interest derived from obligations held in each such account, and proceeds from any sale or redemption of such obligations, are hereby appropriated to such account.

`(d) MONETARY GIFTS TO TRUST FUND- There are appropriated to the Trust Fund such amounts as may be unconditionally donated to the Federal Government as gifts to the Trust Fund. Such amounts shall be allocated and transferred to the accounts described in subsection (a) in the same proportion as the amounts in each of the accounts bears to the total amount in all the accounts of the Trust Fund.

`SEC. 2102. PAYMENTS TO MEDICAL SCHOOLS.

`(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS-

`(1) IN GENERAL- In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for fiscal year 1998 or any subsequent fiscal year, the Secretary shall make payments for such year to the medical school for the purpose specified in paragraph (3). The Secretary shall make such payments from the Medical School Account in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

`(2) APPLICATION FOR PAYMENTS- For purposes of paragraph (1), an application for payments under such paragraph for a fiscal year is in accordance with this paragraph if--

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Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

SEC. 2. MEDICAL EDUCATION TRUST FUND.

The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding after title XX the following new title:

`TITLE XXI--MEDICAL EDUCATION TRUST FUND

`TABLE OF CONTENTS OF TITLE

`Sec. 2101. Establishment of Trust Fund.

`Sec. 2102. Payments to medical schools.

`Sec. 2103. Payments to teaching hospitals.

`SEC. 2101. ESTABLISHMENT OF TRUST FUND.

`(a) IN GENERAL- There is established in the Treasury of the United States a fund to be known as the Medical Education Trust Fund (in this title referred to as the `Trust Fund'), consisting of the following accounts:

- `(1) The Medical School Account.
- `(2) The Medicare Teaching Hospital Indirect Account.
- `(3) The Medicare Teaching Hospital Direct Account.
- `(4) The Non-Medicare Teaching Hospital Indirect Account.
- `(5) The Non-Medicare Teaching Hospital Direct Account.

Each such account shall consist of such amounts as are allocated and transferred to such account under this section, sections 1876(a)(7), 1886(j) and 1931, and section 4503 of the Internal Revenue Code of 1986. Amounts in the accounts of the Trust Fund shall remain available until expended.

`(b) EXPENDITURES FROM TRUST FUND- Amounts in the accounts of the Trust Fund are available to the Secretary for making payments under sections 2102 and 2103.

`(c) INVESTMENT-

`(1) IN GENERAL- The Secretary of the Treasury shall invest amounts in the accounts of the Trust Fund which the Secretary determines are not required to meet current withdrawals from the Trust Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

`(2) SALE OF OBLIGATIONS- The Secretary of the Treasury may sell at market price any obligation acquired under paragraph (1).

`(3) AVAILABILITY OF INCOME- Any interest derived from obligations held in each such account, and proceeds from any sale or redemption of such obligations, are hereby appropriated to such account.

`(d) MONETARY GIFTS TO TRUST FUND- There are appropriated to the Trust Fund such amounts as may be unconditionally donated to the Federal Government as gifts to the Trust Fund. Such amounts shall be allocated and transferred to the accounts described in subsection (a) in the same proportion as the amounts in each of the accounts bears to the total amount in all the accounts of the Trust Fund.

`SEC. 2102. PAYMENTS TO MEDICAL SCHOOLS.

`(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS-

`(1) IN GENERAL- In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for fiscal year 1998 or any subsequent fiscal year, the Secretary shall make payments for such year to the medical school for the purpose specified in paragraph (3). The Secretary shall make such payments from the Medical School Account in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

`(2) APPLICATION FOR PAYMENTS- For purposes of paragraph (1), an application for payments under such paragraph for a fiscal year is in accordance with this paragraph if--

 `(A) the medical school involved submits the application not later than the date specified by the Secretary; and

 `(B) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

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'Sec. 2101. Establishment of Trust Fund.

'Sec. 2102. Payments to medical schools.

'Sec. 2103. Payments to teaching hospitals.

'SEC. 2101. ESTABLISHMENT OF TRUST FUND.

'(a) IN GENERAL- There is established in the Treasury of the United States a fund to be known as the Medical Education Trust Fund (in this title referred to as the 'Trust Fund'), consisting of the following accounts:

- '(1) The Medical School Account.
- '(2) The Medicare Teaching Hospital Indirect Account.
- '(3) The Medicare Teaching Hospital Direct Account.
- '(4) The Non-Medicare Teaching Hospital Indirect Account.
- '(5) The Non-Medicare Teaching Hospital Direct Account.

Each such account shall consist of such amounts as are allocated and transferred to such account under this section, sections 1876(a)(7), 1886(j) and 1931, and section 4503 of the Internal Revenue Code of 1986. Amounts in the accounts of the Trust Fund shall remain available until expended.

'(b) EXPENDITURES FROM TRUST FUND- Amounts in the accounts of the Trust Fund are available to the Secretary for making payments under sections 2102 and 2103.

'(c) INVESTMENT-

'(1) IN GENERAL- The Secretary of the Treasury shall invest amounts in the accounts of the Trust Fund which the Secretary determines are not required to meet current withdrawals from the Trust Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at

the issue price, or by purchase of outstanding obligations at the market price.

`(2) SALE OF OBLIGATIONS- The Secretary of the Treasury may sell at market price any obligation acquired under paragraph (1).

`(3) AVAILABILITY OF INCOME- Any interest derived from obligations held in each such account, and proceeds from any sale or redemption of such obligations, are hereby appropriated to such account.

`(d) MONETARY GIFTS TO TRUST FUND- There are appropriated to the Trust Fund such amounts as may be unconditionally donated to the Federal Government as gifts to the Trust Fund. Such amounts shall be allocated and transferred to the accounts described in subsection (a) in the same proportion as the amounts in each of the accounts bears to the total amount in all the accounts of the Trust Fund.

`SEC. 2102. PAYMENTS TO MEDICAL SCHOOLS.

`(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS-

`(1) IN GENERAL- In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for fiscal year 1998 or any subsequent fiscal year, the Secretary shall make payments for such year to the medical school for the purpose specified in paragraph (3). The Secretary shall make such payments from the Medical School Account in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

`(2) APPLICATION FOR PAYMENTS- For purposes of paragraph (1), an application for payments under such paragraph for a fiscal year is in accordance with this paragraph if--

 `(A) the medical school involved submits the application not later than the date specified by the Secretary; and

 `(B) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

`(3) PURPOSE OF PAYMENTS- The purpose of payments under paragraph (1) is to assist medical schools in maintaining and developing quality educational programs in an increasingly competitive health care system.

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`Sec. 2101. Establishment of Trust Fund.

`Sec. 2102. Payments to medical schools.

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`SEC. 2101. ESTABLISHMENT OF TRUST FUND.

`(a) IN GENERAL- There is established in the Treasury of the United States a fund to be known as the Medical Education Trust Fund (in this title referred to as the `Trust Fund'), consisting of the following accounts:

- `(1) The Medical School Account.
- `(2) The Medicare Teaching Hospital Indirect Account.
- `(3) The Medicare Teaching Hospital Direct Account.
- `(4) The Non-Medicare Teaching Hospital Indirect Account.
- `(5) The Non-Medicare Teaching Hospital Direct Account.

Each such account shall consist of such amounts as are allocated and transferred to such account under this section, sections 1876(a)(7), 1886(j) and 1931, and section 4503 of the Internal Revenue Code of 1986. Amounts in the accounts of the Trust Fund shall remain available until expended.

`(b) EXPENDITURES FROM TRUST FUND- Amounts in the accounts of the Trust Fund are available to the Secretary for making payments under sections 2102 and 2103.

`(c) INVESTMENT-

`(1) IN GENERAL- The Secretary of the Treasury shall invest amounts in the accounts of the Trust Fund which the Secretary determines are not required to meet current withdrawals from the Trust Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

`(2) SALE OF OBLIGATIONS- The Secretary of the Treasury may sell at market price any obligation acquired under paragraph (1).

`(3) AVAILABILITY OF INCOME- Any interest derived from obligations held in each such account, and proceeds from any sale or redemption of such obligations, are hereby appropriated to such account.

`(d) MONETARY GIFTS TO TRUST FUND- There are appropriated to the Trust Fund such amounts as may be unconditionally donated to the Federal Government as gifts to the Trust Fund. Such amounts shall be allocated and transferred to the accounts described in subsection (a) in the same proportion as the amounts in each of the accounts bears to the total amount in all the accounts of the Trust Fund.

`SEC. 2102. PAYMENTS TO MEDICAL SCHOOLS.

`(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS-

`(1) IN GENERAL- In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for fiscal year 1998 or any subsequent fiscal year, the Secretary shall make payments for such year to the medical school for the purpose specified in paragraph (3). The Secretary shall make such payments from the Medical School Account in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

`(2) APPLICATION FOR PAYMENTS- For purposes of paragraph (1), an application for payments under such paragraph for a fiscal year is in accordance with this paragraph if--

`(A) the medical school involved submits the application not later than the date specified by the Secretary; and

`(B) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

`(3) PURPOSE OF PAYMENTS- The purpose of payments under paragraph (1) is to assist medical schools in maintaining and developing quality educational programs in an increasingly competitive health care system.

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Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

`SEC. 2101. ESTABLISHMENT OF TRUST FUND.

`(a) IN GENERAL- There is established in the Treasury of the United States a fund to be known as the Medical Education Trust Fund (in this title referred to as the `Trust Fund'), consisting of the following accounts:

- `(1) The Medical School Account.
- `(2) The Medicare Teaching Hospital Indirect Account.
- `(3) The Medicare Teaching Hospital Direct Account.
- `(4) The Non-Medicare Teaching Hospital Indirect Account.
- `(5) The Non-Medicare Teaching Hospital Direct Account.

Each such account shall consist of such amounts as are allocated and transferred to such account under this section, sections 1876(a)(7), 1886(j) and 1931, and section 4503 of the Internal Revenue Code of 1986. Amounts in the accounts of the Trust Fund shall remain available until expended.

`(b) EXPENDITURES FROM TRUST FUND- Amounts in the accounts of the Trust Fund are available to the Secretary for making payments under sections 2102 and 2103.

`(c) INVESTMENT-

`(1) IN GENERAL- The Secretary of the Treasury shall invest amounts in the accounts of the Trust Fund which the Secretary determines are not required to meet current withdrawals from the Trust Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

`(2) SALE OF OBLIGATIONS- The Secretary of the Treasury may sell at market price any obligation acquired under paragraph (1).

`(3) AVAILABILITY OF INCOME- Any interest derived from obligations held in each such account, and proceeds from any sale or redemption of such obligations, are hereby appropriated to such account.

`(d) MONETARY GIFTS TO TRUST FUND- There are appropriated to the Trust Fund such

amounts as may be unconditionally donated to the Federal Government as gifts to the Trust Fund. Such amounts shall be allocated and transferred to the accounts described in subsection (a) in the same proportion as the amounts in each of the accounts bears to the total amount in all the accounts of the Trust Fund.

`SEC. 2102. PAYMENTS TO MEDICAL SCHOOLS.

`(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS-

`(1) IN GENERAL- In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for fiscal year 1998 or any subsequent fiscal year, the Secretary shall make payments for such year to the medical school for the purpose specified in paragraph (3). The Secretary shall make such payments from the Medical School Account in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

`(2) APPLICATION FOR PAYMENTS- For purposes of paragraph (1), an application for payments under such paragraph for a fiscal year is in accordance with this paragraph if--

`(A) the medical school involved submits the application not later than the date specified by the Secretary; and

`(B) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

`(3) PURPOSE OF PAYMENTS- The purpose of payments under paragraph (1) is to assist medical schools in maintaining and developing quality educational programs in an increasingly competitive health care system.

`(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS-

`(1) AVAILABILITY OF TRUST FUND FOR PAYMENTS- The following amounts shall be available for a fiscal year for making payments under subsection (a) from the amount allocated and transferred to the Medical School Account under sections 1876(a)(7), 1886(j), 1931, 2101 (c)(3) and (d), and section 4503 of the Internal Revenue Code of 1986:

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S.21

Medical Education Trust Fund Act of 1997 (Introduced in the Senate)

SEC. 2102. PAYMENTS TO MEDICAL SCHOOLS.

(a) FEDERAL PAYMENTS TO MEDICAL SCHOOLS FOR CERTAIN COSTS-

(1) IN GENERAL- In the case of a medical school that in accordance with paragraph (2) submits to the Secretary an application for fiscal year 1998 or any subsequent fiscal year, the Secretary shall make payments for such year to the medical school for the purpose specified in paragraph (3). The Secretary shall make such payments from the Medical School Account in an amount determined in accordance with subsection (b), and may administer the payments as a contract, grant, or cooperative agreement.

(2) APPLICATION FOR PAYMENTS- For purposes of paragraph (1), an application for payments under such paragraph for a fiscal year is in accordance with this paragraph if--

(A) the medical school involved submits the application not later than the date specified by the Secretary; and

(B) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(3) PURPOSE OF PAYMENTS- The purpose of payments under paragraph (1) is to assist medical schools in maintaining and developing quality educational programs in an increasingly competitive health care system.

(b) AVAILABILITY OF TRUST FUND FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS-

(1) AVAILABILITY OF TRUST FUND FOR PAYMENTS- The following amounts shall be available for a fiscal year for making payments under subsection (a) from the amount allocated and transferred to the Medical School Account under sections 1876(a)(7), 1886(j), 1931, 2101 (c)(3) and (d), and section 4503 of the Internal Revenue Code of 1986:

(A) In the case of fiscal year 1998, \$200,000,000.

(B) In the case of fiscal year 1999, \$300,000,000.

(C) In the case of fiscal year 2000, \$400,000,000.

(D) In the case of fiscal year 2001, \$500,000,000.

`(E) In the case of fiscal year 2002, \$600,000,000.

`(F) In the case of each subsequent fiscal year, the amount specified in this paragraph in the previous fiscal year updated through the midpoint of the year by the estimated percentage change in the general health care inflation factor (as defined in subsection (d)) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected health care inflation factor.

`(2) AMOUNT OF PAYMENTS FOR MEDICAL SCHOOLS-

`(A) IN GENERAL- Subject to the annual amount available under paragraph (1) for a fiscal year, the amount of payments required under subsection (a) to be made to a medical school that submits to the Secretary an application for such year in accordance with subsection (a)(2) is an amount equal to an amount determined by the Secretary in accordance with subparagraph (B).

`(B) DEVELOPMENT OF FORMULA- The Secretary shall develop a formula for allocation of funds to medical schools under this section consistent with the purpose described in subsection (a)(3).

`(c) MEDICAL SCHOOL DEFINED- For purposes of this section, the term 'medical school' means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as defined in such section).

`(d) GENERAL HEALTH CARE INFLATION FACTOR- The term 'general health care inflation factor' means the consumer price index for medical services as determined by the Bureau of Labor Statistics.

`SEC. 2103. PAYMENTS TO TEACHING HOSPITALS.

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—
peds - gME
Mark Hartstien

free standing children's
hospitals are disadvantaged
b/c of the formula

Medicare supports gME
since 1966; 2 ways for
past 15 years (IME $\neq$ DME)

IME for indirect costs ass.
w/ training

Medicare PPS - fixed payment
per DRG charge -
that amt based on #
residents &

freestanding children's
hospitals get very
little
—

DMED

compensate for costs
of running training hosp
take / resident amt (MC
inpatient days) (total inpatient
days)

\$300M → Childrens
hospitals until
commission reform.
general revenue
mechanism for distributing

Medicaid prog. possibility

Please send us your questions and comments.

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

October 1998

ALABAMA

Children's Hospital of Alabama
Birmingham

ARKANSAS

Arkansas Children's Hospital
Little Rock

CALIFORNIA

Children's Hospital Oakland
Oakland

Childrens Hospital Los Angeles
Los Angeles

Lucile Salter Packard Children's Hospital at
Stanford
Palo Alto

Children's Hospital of Orange County
Orange

Children's Hospital and Health Center
San Diego

Valley Children's Hospital
Fresno

COLORADO

The Children's Hospital
Denver

National Jewish Center
Denver

CONNECTICUT

Connecticut Children's Medical Center
Hartford

DELAWARE

Alfred I. duPont Institute
Wilmington

DISTRICT OF COLUMBIA

Children's National Medical Center
Washington

FLORIDA

All Children's Hospital
St. Petersburg

Miami Children's Hospital
Miami

GEORGIA

ESR Children's Health Care System
Atlanta

HAWAII

Kapiolani Women's and Children's Medical
Center
Honolulu

ILLINOIS

Children's Memorial Hospital
Chicago

LaRabida Children's Hospital and Research
Center
Chicago

LOUISIANA

Children's Hospital
New Orleans

MARYLAND

Kennedy Krieger Children's Hospital
Baltimore

MASSACHUSETTS

Children's Hospital
Boston

MICHIGAN

Children's Hospital of Michigan
Detroit

MINNEAPOLIS

Children's Health Care
Minneapolis and St. Paul

Gillette Children's Specialty Healthcare
St. Paul

MISSOURI

St. Louis Children's Hospital
St. Louis

The Children's Mercy Hospital
Kansas City

NEBRASKA

Children's Hospital
Omaha

Boys Town National Research Hospital
Omaha

NEW JERSEY

Children's Specialized Hospital
Mountainside

NEW MEXICO

Carrie Tingley Hospital
Albuquerque

NEW YORK

Blythedale Children's Hospital
Valhalla

OHIO

Children's Hospital
Columbus

Children's Hospital Medical Center of
Akron
Akron

Children's Hospital Medical Center
Cincinnati

Children's Medical Center of Northwest
Ohio
Toledo

Rainbow Babies and Childrens Hospital
Cleveland

The Children's Medical Center
Dayton

Tod Children's Hospital
Youngstown

OKLAHOMA

Children's Medical Center
Tulsa

PENNSYLVANIA

Children's Hospital of Pittsburgh
Pittsburgh

St. Christopher's Hospital for Children
Philadelphia

The Children's Hospital of Philadelphia
Philadelphia

PUERTO RICO

University Pediatric Hospital
San Juan

TEXAS

Children's Medical Center of Dallas
Dallas

Cook Children's Medical Center
Fort Worth

Driscoll Children's Hospital
Corpus Christi

Santa Rosa Children's Hospital
San Antonio

Texas Children's Hospital
Houston

UTAH

Primary Children's Medical Center
Salt Lake City

VIRGINIA

Children's Hospital of the King's Daughters
Norfolk

WASHINGTON

Children's Hospital and Regional Medical
Center
Seattle

Mary Bridge Children's Health Center
Tacoma

WISCONSIN

Children's Hospital of Wisconsin
Milwaukee