

JULIA/DEVORAH: A) YOU ARE ARCHIVING, IT WOULD BE GREAT IF YOU COULD KEEP A SEPARATE PIECE OF PAPER THAT ADDS TO OUR CHRONOLOGY. IF THERE ARE PAPERS FOR EVENTS, BIG MEETINGS, OUR REPORTS, ETC., WRITE THEM DOWN.
 CLINTON ADMINISTRATION HEALTH POLICY (KEYWORDS. ↓

DATE	TOPIC(S)		TYPE OF EVENT	DESCRIPTION
March 18, 2000	Medicare	Reform	Legislative	Administration sends legislation on Medicare plan to Congress (check date)
March 30, 2000	Medicare	Reform	Other	Medicare Trustees' Report: Medicare solvent through 2025 (originally released as 2023), POTUS statement
April 7, 2000	Coverage	Medicaid	Other	HHS releases letters requiring state to reinstate people losing Medicaid due to TANF changes
April 10, 2000	Medicare	Drugs	Report	"Prescription Drug Coverage, Spending, Utilization and Prices: Report to the President" HHS, Room 450 (POTUS)
April 12, 2000	Medicare	Drugs	Legislative	House Republican Leadership release outline of drug plan, universal but uses private insurers
April 30, 2000	Medicare	PBOR	Radio Address	Calls for action on prescription drugs, PBOR
May 9, 2000	Medicare	Drugs	Legislative	Breaux-Frist 2000 concept paper introduced; like Republican House bill but includes 25 percent premium subsidy. Combined with Board and competition proposal similar to Administration's
May 13, 2000	Medicare	Drugs	Report	GAO letter to Congressman Dingell on Medigap premiums for prescription drugs [check on event]
May 16, 2000	Medicare	Drugs	Event	POTUS statement on prescription drugs for military retirees -- supporting it but saying that we need to cover all seniors
June 13, 2000	Medicare	Drugs	Report	"Prescription Drug Coverage and Rural Medicare Beneficiaries: A Critical Unmet Need", Room 450 (POTUS, Baucus)
June 20, 2000	Medicare	BBA	Press	Leak \$40 b / 10 commitment to Medicare / Medicaid provider payment restorations
June 20, 2000	Medicare	Drugs	Legislative	Senators Graham, Baucus, Bryan, Conrad, Robb, Rockefeller, Chafee, Lincoln introduce multiple PBM prescription drug plan
June 21, 2000	Medicare	Drugs	Legislative	House Ways and Means Committee marks up private insurance prescription drug benefit. Vote: 23-14 (party lines)
June 28, 2000	Medicare	Drugs	Legislative	House Floor vote on HR 4680 prescription drug proposal. Passed 217-214.
June 27, 2000	Medicare	Drugs	Legislative	Breaux-Frist 2000 legislation introduced (S. 2807); Landrieu and Kerrey cosponsor

5/11

MEDICARE
 MEDICAID
 COVERAGE
 CHIP
 DRUGS
 BBA

REFORMS
 QUALITY
 INSURANCE REFORM
 4 PUBLIC HEALTH
 BUDGET

Call w/
 question

January 27, 1999

Meeting on Funding for Medical Education at Children's Hospitals

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

I. PURPOSE

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

II. BACKGROUND

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

Funding for Graduate Medical Education for Children's Hospitals

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

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

hospitals who often serve the poorest, sickest and most vulnerable children. This proposal is designed to address the current inequity.

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

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

Other Issues of Interest to Children's Hospitals

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

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

III. PARTICIPANTS

The First Lady

Secretary Shalala

Attached list of children's hospitals representatives

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

IV. SEQUENCE OF EVENTS

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

- National
 - Some best pdz
 - Core policy + what they should be - (most ranges)
 - Geographic Allocation (workload)
-

- From Robert Pomeroy
- 160,000 (scale)

50% of priority

- IRS advised.

V. PRESS PLAN

Closed.

VI. REMARKS

Talking points provided by Jennifer Klein.

→ Distance been narrowed

- can go Grand: Break / compromise [either way] &

- NO MIAA

- [Amount / Duration / Scope] Get started - 10%

- All Day
- Sunday

Bell Clinton - legacy:

- Reform - need to choose. Leave behind
- some benefit entitlement. req percentage
- 80 / 12 split
- LIR

provides 9380/resident
689,000/
hospital

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

January 28, 1999

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

CURRENT INEQUITIES IN FEDERAL FUNDING

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

**PROVIDING CRITICAL FINANCIAL SUPPORT TO ESSENTIAL
PROVIDERS**

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

Congress of the United States
Washington, DC 20515

*Children's Hospital
GME file*

December 14, 1998

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

Dear Mr. President:

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

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

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

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

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

Letter to the Honorable William Jefferson Clinton

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

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

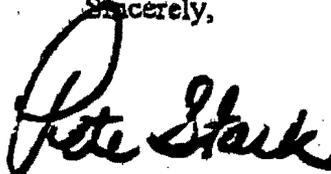
Many of these children's hospitals have existed for decades, some for a century, developed by our communities and pediatric professionals because they believed that centers devoted to the care of children were essential to the advancement of pediatric medicine. In keeping with this objective, they have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

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

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

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

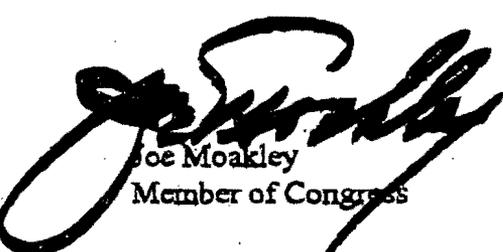
Sincerely,



Pete Stark
Member of Congress



John D. Dingell
Member of Congress



Joe Moakley
Member of Congress

- Alan
Kibly Higgins

Medicare Commission



N • A • C • H •

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

November 24, 1998

What is the case for commensurate federal GME support?

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

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

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

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

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

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

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

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

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

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

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

Who are these institutions?

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

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

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

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

What is the inequity with current GME financing?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary

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

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

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

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

Y. 20

Baron

Men's Forum

~~→ 10-30-40~~

→ What issues

→ 2 meetings

①

[Principles]

A. D. m.

January 23, 1998

DRAFT

The Honorable Donna Shalala, Ph.D.
Secretary
U.S. Department of Health and Human Services
615-F Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Shalala:

As chief executive officers of six of the nation's major children's teaching hospitals, we respectfully request an opportunity to meet with you during the weeks of February 16 or February 23 on an urgent matter affecting the nation's children.

We seek to brief you regarding the serious threat facing our graduate medical education (GME) missions, which are essential to training the nation's physicians in the care of children. Our hospitals are representative of the community of independent children's teaching hospitals, only 60 in number, which train a quarter of all pediatricians and the majority of many pediatric subspecialists, as well as provide pediatric rotations for many other residents.

At a time when the competitive marketplace challenges the ability of all teaching hospitals to finance their GME programs, the children's teaching hospitals alone do so without significant federal support. Through Medicare, the average teaching hospital received over \$77,000 in annual GME payments per medical resident in 1996. In contrast, Medicare paid an average of just \$230 per resident in a children's hospital such as our own. This disparity in federal support – at a time when other payers are reducing their support for GME – is increasingly jeopardizing the sustainability of our teaching missions.

We have appreciated the opportunity the National Association of Children's Hospitals (N.A.C.H.) has had to meet with Gary Claxton, as well as White House staff, on this issue. We want to build on these productive discussions by bringing directly to you our strong, personal appeal for the Administration's help in addressing this issue.

Please have your staff contact Peters Willson with N.A.C.H., 703/684-1355, for any information you may require in considering our request for a February appointment.

Sincerely,

Calvin Bland
President and CEO
St. Christopher's Hospital for Children
Philadelphia, PA

Randall O'Donnell, Ph.D.
President and CEO
Children's Mercy Hospital
Kansas City, MO

DRAFT

The Honorable Donna Shalala
January 23, 1998
Page 2

Larry M. Gold
President and CEO
Children's Medical Center of Connecticut
Hartford, CT

Walter W. Noce, Jr.
President and CEO
Childrens Hospital Los Angeles
Los Angeles, CA

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

Edwin K. Zechman, Jr.
President and CEO
Children's National Medical
Center
Washington, DC

cc: Gary Claxton, Department of Health and Human Services
Christopher Jennings, The White House
The Honorable Edward M. Kennedy
The Honorable Christopher Dodd

National Association of
Children's Hospitals

file Children's
Hospital

LAWRENCE A. McANDREWS, FACHE
President & Chief Executive Officer



N · A · C · H ·

January 26, 1998

The Honorable Donna Shalala, Ph.D.
Secretary
U.S. Department of Health and Human Services
615-F Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

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The Honorable Donna Shalala

January 26, 1998

Page 2

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Sincerely,

Calvin Bland
President and CEO
St. Christopher's Hospital for Children
Philadelphia, PA

Larry M. Gold
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Hartford, CT

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President and CEO
Children's Mercy Hospital
Kansas City, MO

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

Edwin K. Zechman, Jr.
President and CEO
Children's National Medical
Center
Washington, DC

cc: Marty Rouse, Office of the Secretary, Department of Health and Human Services
Gary Claxton, Office of Health Policy, Department of Health and Human Services
Christopher J. Jennings, Domestic Policy Staff, The White House
The Honorable Edward M. Kennedy, U.S. Senate
The Honorable Christopher Dodd, U.S. Senate



N · A · C · H ·

MEMO TO: Calvin Bland, St. Christopher's Hospital for Children
Larry Gold, Connecticut Children's Medical Center
Bill Noce, Childrens Hospital Los Angeles
Rand O'Donnell, Children's Mercy Hospital
David Weiner, Children's Hospital
Ned Zechman, Children's National Medical Center

FROM: Pete Willson *Pete*

DATE: January 22, 1998

SUBJECT: Update on Request for White House Meeting;
Request for Permission to Seek Secretary Shalala Meeting
on GME Support for Children's Teaching Hospitals

White House health policy staff Chris Jennings called last night in response to our request for a meeting with the President Clinton. He has asked us to seek a meeting with HHS Secretary Shalala first, which he will help us obtain, during the weeks of either February 16 or February 23.

I have drafted a letter to Secretary Shalala in the names of each of you, similar to the letter we have sent to President Clinton. I will call your staff to make sure I have your approval before sending out the letter. Please let me know if you have any questions or would like additional information.

Background

In our many conversations with Chris Jennings over the last several months, he repeatedly has emphasized his recommendation that we focus more on the Department of Health and Human Services (DHHS). We know from our meetings with DHHS staff that we cannot presume the Secretary's support.

On Tuesday night, he called to respond to our request for a meeting with the President, recommending that we seek to meet with Secretary Shalala. He made two points. First, he promised again to work with us on a White House letter to Congress that will speak positively to the need for GME support for children's teaching hospitals. Second, he wants us to meet with DHHS first, because if DHHS is not supportive it will create problems down the line for both White House and Congressional support, which is our ultimate objective. We want to pursue the meeting with Chris' assistance, while continuing to press for both White House support and congressional sponsorship of legislation that we are seeking to have introduced. Sen. Chris Dodd's (D-CT) is also assisting with the meeting.



National Association of Children's Hospitals

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

N.A.C.H

FAX

DATE: 1/22/98

PAGES: 2

TO: Chris Jennings
The White House

FAX: 202-456-5557

PHONE: 202-456-5560

FROM: Peters D. Willson
Vice President for Public Policy

Telephone Number: (703) 684-1355
Facsimile Number: (703) 684-1589

COMMENTS: Chris -

Ann asked me to fax to you the sample of a possible White House letter to the members of Congress who wrote to the President on children's teaching hospitals and give I hope it's helpful.

We're also seeking a meeting with Secretary Spalala

If there are any transmission problems with this fax, please call me at 703-684-1355 as you suggested. I'll get that letter to you soon

Thanks, P.D.

Draft letter from The White House

DRAFT

December 21, 1997

The Honorable Edward M. Kennedy
The Honorable Christopher J. Dodd
The Honorable Dianne Feinstein
The Honorable Max Cleland
The Honorable Patty Murray
The Honorable Paul Wellstone
The Honorable Richard J. Durbin
The Honorable Rick Santorum
U.S. Senate
Washington, DC 20510

The Honorable John D. Dingell
The Honorable Henry A. Waxman
U.S. House of Representatives
Washington, DC 20515

Dear Senators:

Dear Representatives:

Thank you for your letter of December 17, requesting budget support for the graduate medical education (GME) programs of independent children's teaching hospitals.

I am committed to working with you in Congress this year to identify a way to provide federal GME support for these children's teaching hospitals, until such time as there is broad GME financing reform encompassing these and other teaching institutions.

My administration has always recognized that the children's hospitals serve several essential roles in our nation's delivery of health care to children. They are not only centers of health care for the sickest and poorest children but also major centers of pediatric graduate medical education and research. The health professionals they train and the results of their research are essential to the health of all of our children.

Despite these essential roles, children's teaching hospitals do not receive significant federal GME support, since it is primarily made through Medicare, which pays for the health care of the elderly, not the patients of children's hospitals.

Clearly, comprehensive reform of the financing of GME is the long-term answer for this problem and many others. For this reason, I look forward to the recommendations of MedPAC and the Bipartisan Commission on the Future of Medicare regarding potential GME reform. However, comprehensive reform will take some time to become a reality. In the interim, the teaching missions of children's hospitals are in serious jeopardy. Thus, my administration supports the development of policies to provide interim, financial assistance to them.

Hillary and I have long been strong, personal supporters of Arkansas Children's Hospital, and we have been pleased to have the opportunity to meet the patients and caregivers of many other children's hospitals around the country. I look forward to working with you to address the GME financing needs of these important pediatric teaching institutions.

Sincerely,

**CHILDREN'S TEACHING HOSPITALS NEED YOUR LEADERSHIP
FOR FEDERAL GRADUATE MEDICAL EDUCATION (GME) FUNDING**

Children's teaching hospitals with their own Medicare provider number need leadership to help them address a mounting crisis -- health care's conversion to managed care that does not pay for physician training, which seriously erodes the ability of these hospitals to maintain their GME programs. Although they train 5% of all residents, including 25% of pediatricians and the majority of pediatric subspecialists, they receive almost no federal GME funds. Yet, overall, teaching hospitals receive an average of \$77,000 per resident. Without federal support, children's teaching hospitals are at risk.

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, such as Arkansas Children's Hospital and Children's Mercy Hospital in Kansas City.

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 \$230 per resident in annual Medicare GME funds. The average teaching hospital receives \$77,000. 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.

Who in Congress supports addressing this problem? -- Members of both parties. Twenty Senators asked the Finance Committee to address the issue -- Bond, Boxer, Brownback, DeWine, Kennedy, and others. The Ohio and Massachusetts delegations also urged House as well as Senate committees to act.

What has Congress done? -- Assigned the issue to two new Medicare commissions for study. In the budget reconciliation act, Congress established two new commissions to address several Medicare issues, including the need to develop alternative financing for GME. Both bills identify GME financing of children's teaching hospitals as one of the many issues to be studied.

Why does more need to be done? -- In the time it takes a study to be done, children's hospitals' teaching programs will 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.

How much would commensurate federal GME support cost? -- About \$300 million annually. According to The Lewin Group, the annual cost of commensurate federal GME support to independent children's teaching hospitals would be about \$300 million annually, based on an analysis using Medicare's own direct and indirect medical education formulas.

How can leadership make a difference? -- By including funding in the FY 1999 budget and by directing the Department of Health and Human Services to identify a sustainable mechanism for providing such funding.

BAKER
&
HOSTETLER LLP
COUNSELLORS AT LAW

Washington Square, Suite 1100 • 1050 Connecticut Avenue N.W. • Washington, D.C. 20036 • (202) 861-1500
Fax (202) 861-1783 • Telex (650) 2357276

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TELECOPIER COVER SHEET

DATE: December 19, 1997 CLIENT CODE: 85824-97001 LAW #: 0081

TO: CHRIS JENNINGS

FROM: FRED GRAEFE

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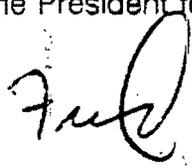
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&
HOSTETLER LLP

(202) 861-1725

VIA TELEFAX

December 19, 1997

MEMORANDUM FOR CHRISTOPHER C. JENNINGS
Deputy Assistant to the President for
Health Policy

FROM: Frederick H. Graefe 

SUBJECT: Children's Teaching Hospitals With Their Own Medicare
Provider Number

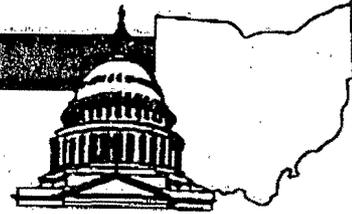
The President's FY99 budget will be submitted to the Congress on February 2, 1998, following his State of the Union Address on January 27. It is vital, in my view, that our proposal be included in that document.

Policy arguments in support of the Children's Mercy Hospital Medicare proposal:

1. The Congress created a new Title XXI of the Social Security Act, the State Children's Health Insurance Program, in the Balanced Budget Act of 1997, Pub.L.No. 105-33. Thus, it is logical for Medicare, Title XVIII of the Social Security Act, to help fund graduate medical education for the providers of health care to children; and
2. Proposing Medicare GME for these 60 hospitals helps fulfill the promise and legacy of this year's children health insurance initiative, and to ensure the education of pediatricians for the 21st century.

UNITED STATES SENATOR • OHIO

Mike DeWine



SUBCOMMITTEE ON EMPLOYMENT AND TRAINING

SENATOR MIKE DEWINE-CHAIRMAN

608 Hart
Washington, DC 20510
Phone: (202) 224-2962
Fax: (202) 228-0412

FROM:

DWAYNE SATTLER _____
(Majority Staff Director)

SAIRA SULTAN X
(Chief Counsel)

KARI KERN _____
(Professional Staffer)

BARRY DEHLIN _____
(Professional Staffer)

AARON GRAU _____
(Professional Staffer)

JANICE BLANCHARD _____
(Legislative Fellow)

PAMELA MAIMER _____
(Legislative Fellow)

JAN BURRUS _____
(Legislative Fellow)

INTERN _____

YOLANDA ROGERS _____
(Office Manager/Clerk)

PLEASE DELIVER TO: CHRIS JENNINGS

FAX# 456-5557

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PAGE(S): 3 (including this cover sheet)

MIKE DEWINE
OHIO

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United States Senate

WASHINGTON, DC 20510-3503

December 19, 1997

COMMITTEES:

JUDICIARY

CHAIRMAN, SUBCOMMITTEE ON ANTI-TRUST

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CHAIRMAN, SUBCOMMITTEE ON
EMPLOYMENT AND TRAINING

INTELLIGENCE

President William J. Clinton
The President of the United States
The White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Mr. President:

We are writing on behalf of independent children's teaching hospitals, which train so many of our nation's pediatricians but receive virtually no federal support for their graduate medical education (GME) programs. It is critical that we address the need to support the teaching missions of these hospitals in the fiscal year (FY) 1999 budget.

All teaching hospitals face serious challenges in fulfilling their teaching missions at a time when competitive markets make it increasingly difficult to shift the costs of these programs to other payers. In addition, as they move to managed care, state Medicaid programs are less likely to pay for GME.

As a consequence, Medicare's financial support for GME is more important than ever. However, since children's hospitals care for children, they see very few Medicare patients -- only children with end-stage renal disease. That means they receive little Medicare GME support. The competitive disadvantage is dramatic. In 1996, Medicare paid on average \$77,370 per medical resident to teaching hospitals. But it paid an average of only \$230 per resident to independent children's teaching hospitals.

This enormous disparity affects about 60 independent children's hospitals in the country. Although these institutions make up less than one percent of all hospitals, they train a quarter of all pediatricians and in many cases the majority of pediatric subspecialists. They also are many of the nation's leading centers for pediatric research.

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December 19, 1997

Page Two

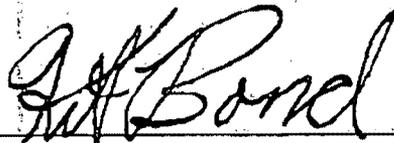
Congress has recognized the seriousness of this problem and has instructed the two new Medicare commissions to study the issue as part of their overall review of the need for comprehensive GME reform. But while we wait for those recommendations and potential action on them, teaching programs at independent children's hospitals need interim, commensurate GME support from the federal government, which is estimated to equal about \$300 million per year.

We want to work with you on the FY 1999 budget to address this serious problem which affects all of our nation's children.

Very respectfully yours,



MIKE DeWINE
U.S. Senator



CHRISTOPHER BOND
U.S. Senator



National Association of
Children's Hospitals

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

N . A . C . H

F A X

DATE: 12 / 19 / 97

PAGES: 7

TO: Chris Jennings
The White House

FAX: (202) 456 - 5557

PHONE: (202) 456 - 5560

FROM: Peters D. Willson
Vice President for Public Policy

Telephone Number: (703) 684-1355
Facsimile Number: (703) 684-1589

COMMENTS: Chris -

Attached are three letters expressing support for
game funding for children's hospitals in the FY99 budget.

Two letters are from the Hill, signed by fourteen
Senators and Representatives -- 9 Democratic Senators,
3 Republican Senators, and 2 Democratic Reps, including
Kennedy, Dodd, Durgell, Waxman, Bond, and DeWine.

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

The third letter is from six children's hospital CEOs
urging the President's support. I hope these are helpful.
Xite

Congress of the United States

Washington, DC 20515

December 17, 1997

The Honorable William J. Clinton
The White House
Washington, DC 20500-0005

Dear Mr. President:

We are writing to urge your assistance in providing needed aid for the nation's independent children's hospitals which currently have little or no support at all for their graduate medical education programs to train medical residents.

Currently, Medicare is the only source of federal funds which contributes to the costs of graduate medical education. Increasingly fewer states pay for such education through Medicaid, as the program moves to managed care. No hospital, in this current competitive marketplace, can afford to shift these costs to other payers.

Independent children's hospitals have only a very few Medicare patients, based on Medicare's coverage of children with end-stage kidney disease. The competitive disadvantage facing these hospitals is stark and unacceptable. In 1996, Medicare provided an average of \$77,000 per resident to all teaching hospitals, compared to an average of \$230 per resident at independent children's hospitals.

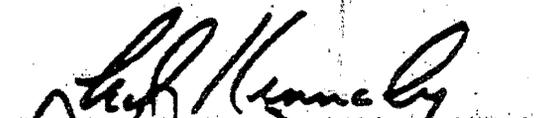
We strongly support the federal government's commitment to graduate medical education through Medicare. But we also strongly support steps to provide fair support for such education by children's hospitals.

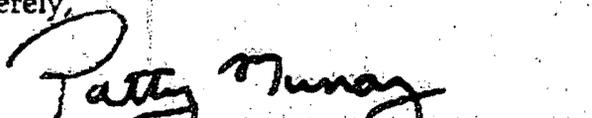
Communities across the country are devoting major efforts to build and sustain health care institutions to meet the needs of children. We must not, inadvertently, contribute to their demise. There are less than 60 of these independent children's hospitals nationwide. Yet, they train 25 percent of all general pediatricians and the majority of all pediatric specialists. Their academic mission is essential to advances in research, innovations in technology, and specialty care to benefit children.

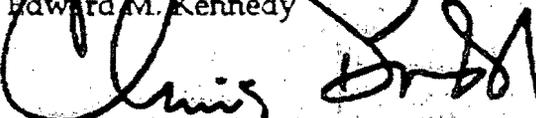
We estimate that \$300 million a year in federal aid would provide independent children's hospitals with support for graduate medical education commensurate with that provided to all other teaching hospitals. We urge you to include this assistance in your budget for FY 1999, so that we can do all we can to keep this inequitable gap from growing wider.

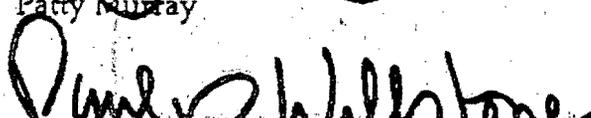
With our respect and appreciation,

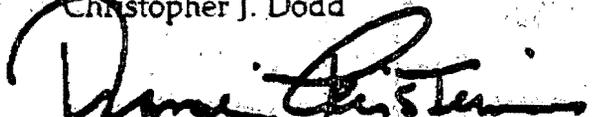
Sincerely,


Edward M. Kennedy

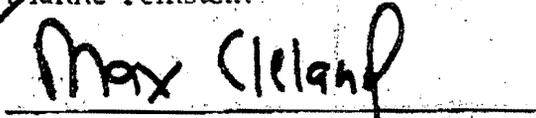

Patty Murray

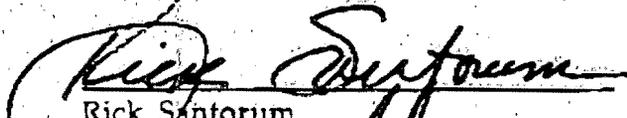

Christopher J. Dodd

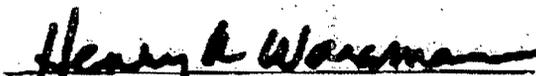

Paul Wellstone

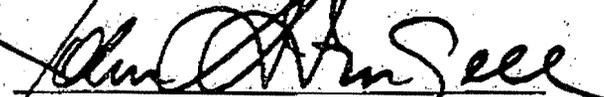

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WASHINGTON, DC 20510-3503

December 19, 1997

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CHAIRMAN, SUBCOMMITTEE ON
EMPLOYMENT AND TRAINING

INTELLIGENCE

President William J. Clinton
The President of the United States
The White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Mr. President:

We are writing on behalf of independent children's teaching hospitals, which train so many of our nation's pediatricians but receive virtually no federal support for their graduate medical education (GME) programs. It is critical that we address the need to support the teaching missions of these hospitals in the fiscal year (FY) 1999 budget.

All teaching hospitals face serious challenges in fulfilling their teaching missions at a time when competitive markets make it increasingly difficult to shift the costs of these programs to other payers. In addition, as they move to managed care, state Medicaid programs are less likely to pay for GME.

As a consequence, Medicare's financial support for GME is more important than ever. However, since children's hospitals care for children, they see very few Medicare patients -- only children with end-stage renal disease. That means they receive little Medicare GME support. The competitive disadvantage is dramatic. In 1996, Medicare paid on average \$77,370 per medical resident to teaching hospitals. But it paid an average of only \$230 per resident to independent children's teaching hospitals.

This enormous disparity affects about 60 independent children's hospitals in the country. Although these institutions make up less than one percent of all hospitals, they train a quarter of all pediatricians and in many cases the majority of pediatric subspecialists. They also are many of the nation's leading centers for pediatric research.

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December 19, 1997

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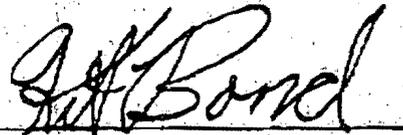
Congress has recognized the seriousness of this problem and has instructed the two new Medicare commissions to study the issue as part of their overall review of the need for comprehensive GME reform. But while we wait for those recommendations and potential action on them, teaching programs at independent children's hospitals need interim, commensurate GME support from the federal government, which is estimated to equal about \$300 million per year.

We want to work with you on the FY 1999 budget to address this serious problem which affects all of our nation's children.

Very respectfully yours,



MIKE DeWINE
U.S. Senator



CHRISTOPHER BOND
U.S. Senator

National Association of
Children's Hospitals



N . A . C . H

December 17, 1997

The President
The White House
Washington, DC 20500

Dear Mr. President:

As chief executive officers of six of the nation's major children's teaching hospitals, we respectfully request an opportunity to meet with you on an urgent matter affecting the nation's children. We seek to brief you regarding the serious threat facing our graduate medical education (GME) missions, which are essential to training the nation's pediatricians, and our urgent need for your FY 1999 budget to address it.

Our hospitals are representative of the community of independent children's hospitals, only 60 in number, which train a quarter of the nation's pediatricians and the majority of many pediatric subspecialists. At a time when the competitive marketplace challenges the ability of all teaching hospitals to finance their GME programs, these children's hospitals alone do so without significant federal support.

Through Medicare, the average teaching hospital received over \$70,000 in annual GME payments per medical resident in 1996. In stark contrast, Medicare paid an average of just \$230 per resident in a children's hospital such as our own. Such dramatic disparity in federal support jeopardizes the sustainability of our teaching missions.

We have appreciated the opportunity you have afforded the National Association of Children's Hospitals to meet with Christopher Jennings on your staff. He understands the threat we face. We want to build on these productive discussions with Chris by bringing to you directly our strong, personal appeal for your support.

Please have your staff contact Peters Willson with N.A.C.H., 703-684-1355, for any information you may require in considering our urgent request for an appointment.

Sincerely,

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

Calvin Bland
President and CEO
St. Christopher's Hospital for Children
Philadelphia, PA

The President
December 17, 1997
Page 2

Larry M. Gold
President and CEO
Children's Medical Center of Connecticut
Hartford, CT

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

Walter W. Nocc, Jr.
President and CEO
Childrens Hospital Los Angeles
Los Angeles, CA

Edwin K. Zechman, Jr.
President and CEO
Children's National Medical Center
Washington, DC

cc: Christopher Jennings, The White House
Barbara Woolley, The White House
Joshua Gotbaum, Office of Management and Budget
Gary Claxton, Department of Health and Human Services

GAME for Children File

**FOLEY LARDNER
WEISSBURG & ARONSON**

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Writer's Direct Line:
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FOR: Barbara Wooley
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**FEDERAL GRADUATE MEDICAL EDUCATION FUND
FOR CHILDREN'S HOSPITALS**

Rationale: Children's teaching hospitals with their own Medicare provider number face a mounting crisis -- a dramatic decline in payors willing to directly or indirectly pay for the costs of graduate medical education (GME). The current major source of support for the academic mission of teaching hospitals, Medicare, does not substantially benefit these children's hospitals because they have so few Medicare patients. While Medicare paid all teaching hospitals an average of \$77,000 per resident for GME in 1996, freestanding children's hospitals received \$230. Medicaid in some, not all, of the states, has paid for a portion of its share of the direct costs of GME; but that support is disappearing in many states as Medicaid moves to managed care. Negotiating higher rates to encompass the costs of teaching is increasingly impossible in the private market.

The rapid constriction of their ability to finance GME presents these freestanding children's hospitals with an immediate and growing dilemma. They must remain competitive while sustaining their academic missions. These children's hospitals serve as regional referral centers, providing many specialty and critical care services to children not available elsewhere. Their academic programs are central to their ability to offer these services, as well as to their ability to advance pediatric care. The research discoveries and technological innovations they provide benefit all children. In addition, their academic programs train a significant proportion of the Nation's pediatricians, most of whom are in primary care. Representing less than one percent of all hospitals, these approximately 60 children's hospitals train five percent of all residents, 25 percent of all pediatricians, and the majority of all pediatric specialists. They have teaching programs equal in size, on average, to other teaching hospitals. Considering their FTE resident to bed ratio, their teaching load is twice that of other teaching hospitals.

Cost cutting and efficiencies cannot be a sustainable source of financing for these hospitals' teaching programs. Much of those savings must go to maintaining their ability to survive in a competitive market which often does not recognize the cost of treating more severely ill patients or patients with more complex, chronic conditions. They devote 70% of their care to children with chronic or congenital conditions. 30% of their beds are devoted to intensive care and 45% of their revenues to children with "catastrophic cases" (more than \$50,000 a case), compared to 12% intensive care beds and 20% revenues for catastrophic cases in general hospitals. In addition, they also serve as a major source of primary and tertiary care for the low income children in their communities, with half their gross revenues devoted to children covered by Medicaid or uncompensated care. In light of the above, it is not surprising that the average total margin for freestanding acute children's hospitals is 2.4% -- below that for all hospitals (5.6%), major teaching hospitals (3.7%), and DSH hospitals in large urban areas (3.6%).

The federal government has recognized the importance of payer financing for GME through Medicare. The expansion of managed care and an increasingly competitive health care market is highlighting the need for broader financing mechanisms. Congress has directed both MedPAC and the Bipartisan Commission on the Future of Medicare to look at GME and consider its reform, including mechanisms for support for GME in children's hospitals. However, their recommendations and actual GME reforms may be years away. The immediacy of the GME problem for children's hospitals calls for an interim solution, until broader reform can be achieved. As you can see from the attached letter to the Senate Finance Committee, we have reason to believe that, at least in concept, we have bipartisan support across the political spectrum.

Options for addressing the provision of federal GME support for freestanding children's hospitals in the President's budget:

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This proposal would create a time - limited, capped, federal source of funding for graduate medical education in freestanding children's hospitals, commensurate with federal graduate medical education funding provided to other teaching hospitals, until such time as broader graduate medical education financing mechanisms which encompass children's hospitals are established.

(We are assuming that no dollars for this fund would come from the HI Trust Fund. Funds currently provided through Medicare for ESRD patients at these institutions would be rolled into the new capped fund.)

Specifications:

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(4) If funds provided are insufficient to provide for such payments, the Secretary would reduce the payments on a pro rata basis to the extent necessary for payments to equal the budget authority. If they are less than the authority allows, the unobligated funds would be carried over for payments in subsequent years.

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Recognizing current trends in proposed graduate medical education reforms, the capped nature of the fund would provide no incentive to expand residency programs. Basing payments on a national average, adjusted only for area wages, would address concerns about inequities in per resident payments based on historical data. The limited nature of the fund would be in keeping with its intent to serve as an interim solution to a current crisis until such time as broader based graduate medical education financing mechanisms and reforms which encompass these children's hospitals are in place. The fund would terminate should comprehensive reform be enacted.

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"The Administration intends to work with Congress to develop, beginning in FY1999, a mechanism for providing interim, commensurate federal support for graduate medical education (GME) to our Nation's freestanding children's hospitals until broader based GME reforms which encompass these institutions are enacted. The current competitive health care market is resulting in the declining ability of all teaching hospitals to receive support from payers for the cost of graduate medical education; but the problem of graduate medical education financing has hit hardest on the freestanding children's hospitals. With few Medicare patients, they receive few GME funds from the one major source of GME support for other teaching hospitals. Because these hospitals provide training for a substantial portion of our pediatric physicians and because they provide essential services and research which benefit all children, the Administration supports moving forward with federal funding for GME for children's hospitals which is commensurate with that provided to other teaching hospitals. In addition, the Administration will work closely with Congress and the Bipartisan Commission on the Future of Medicare to assure that overall graduate medical education reforms include financing for children's hospitals."

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JUDICIARY
INTELLIGENCE
LABOR AND HUMAN RESOUR

United States Senate

WASHINGTON, DC 20510-3503

April 28, 1997

The Honorable William Roth
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Bill and Pat:

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These children's teaching hospitals, which are not affiliated with any other hospital for Medicare payment purposes, include over 40 acute-care hospitals and 13 specialty hospitals nationwide. Although few in number -- only about one percent of all hospitals -- they make a significant contribution to graduate medical education. They train over five percent of all residents nationally, over 25 percent of all pediatricians, and over half of all pediatric specialists. They train a substantial number of the pediatricians in many of our states.

Most of these children's teaching hospitals are major academic hospitals with residency programs that are, on average, the same size as major teaching hospital programs overall. They have the same missions as other major academic centers: education, research, and high-quality patient care (provided without regard to ability to pay). They also face the same financial pressures from severe price competition and reluctance of insurers to pay for medical education.

There is, however, one notable difference. Independent children's teaching hospitals do not receive Medicare support for medical education. While teaching hospitals overall received an average of \$77,370 per resident from Medicare in 1996, children's teaching hospitals received just \$230 per resident from Medicare.

The children's teaching hospitals in my state, like others, have long been distinguished for their leadership in children's health. They serve as essential providers for the low-income children in their communities. They serve as regional and national centers of excellence in pediatric medicine and children's health care. And they are essential sites of pediatric training for our health professionals.

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234 NORTH SUMMIT
ROOM 716
TOLEDO, OH 43604
(419) 259-7535

Page Two

April 28, 1997

Children's teaching hospitals are adapting quickly to a market-driven health care system. But efficient and cost-conscious delivery of services cannot alone erase the competitive disadvantage brought about by added responsibilities of education, research, and specialized and low-income care -- especially without significant federal GME support.

The ability of independent children's teaching hospitals to sustain their important missions depends on an approach to federal GME financing, which can include them and provide them with commensurate GME support.

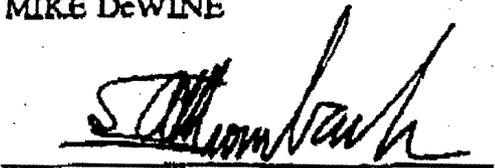
As you consider proposals to restructure federal support for GME, please consider approaches to provide these children's hospitals with federal GME support commensurate with other major teaching programs.

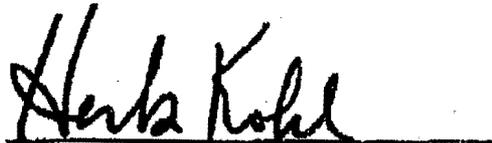
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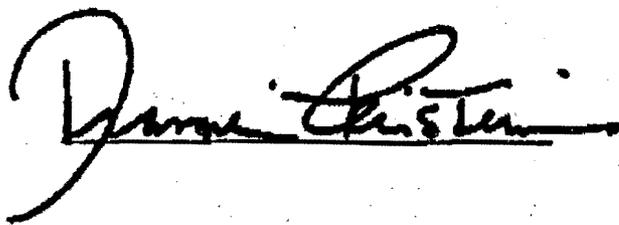
Very respectfully yours,

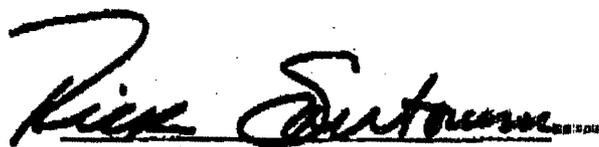

MIKE DeWINE


CHRISTOPHER BOND

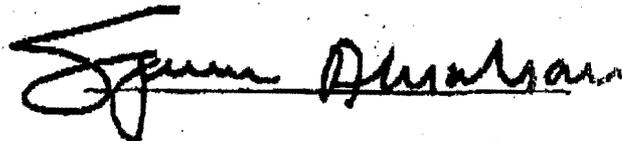








RMD/bwd



Robert

David

Robert Boxer

Wally

Paul D. Wellstone

Chris Dodd

Patty Murray

Max Cleland

Barbara

List of Signatures:

Mike DeWine
Christopher Bond
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Daniel Inouye
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Paul Coverdell

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GME for children's File
United States Senate
WASHINGTON, DC 20510-3503

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April 28, 1997

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April 25, 1997

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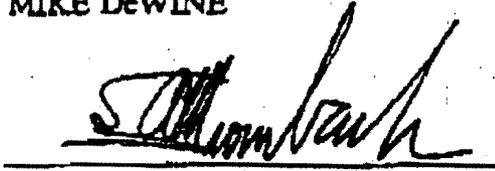
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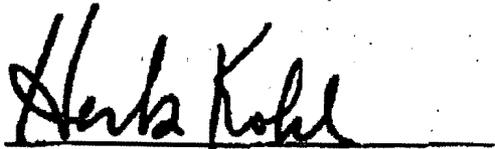
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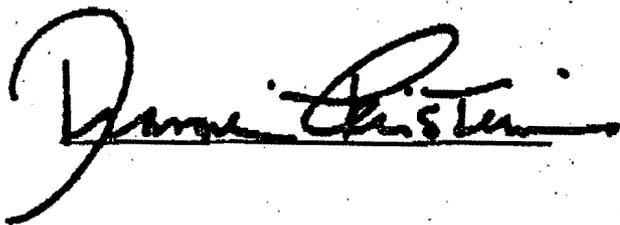
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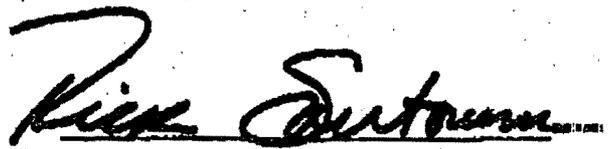

MIKE DeWINE


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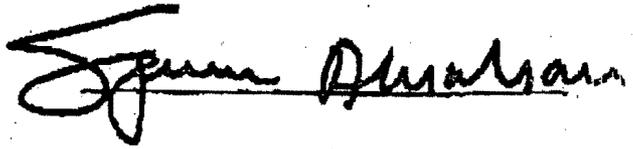








RMD/bwd



Congress of the United States

Washington, DC 20515

December 17, 1997

The Honorable William J. Clinton
The White House
Washington, DC 20500-0005

Dear Mr. President:

We are writing to urge your assistance in providing needed aid for the nation's independent children's hospitals which currently have little or no support at all for their graduate medical education programs to train medical residents.

Currently, Medicare is the only source of federal funds which contributes to the costs of graduate medical education. Increasingly fewer states pay for such education through Medicaid, as the program moves to managed care. No hospital, in this current competitive marketplace, can afford to shift these costs to other payers.

Independent children's hospitals have only a very few Medicare patients, based on Medicare's coverage of children with end-stage kidney disease. The competitive disadvantage facing these hospitals is stark and unacceptable. In 1996, Medicare provided an average of \$77,000 per resident to all teaching hospitals, compared to an average of \$230 per resident at independent children's hospitals.

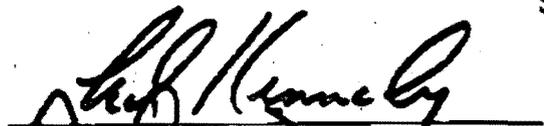
We strongly support the federal government's commitment to graduate medical education through Medicare. But we also strongly support steps to provide fair support for such education by children's hospitals.

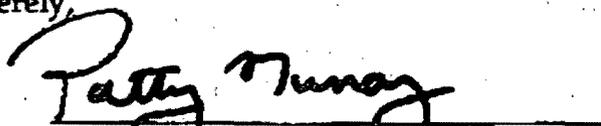
Communities across the country are devoting major efforts to build and sustain health care institutions to meet the needs of children. We must not, inadvertently, contribute to their demise. There are less than 60 of these independent children's hospitals nationwide. Yet, they train 25 percent of all general pediatricians and the majority of all pediatric specialists. Their academic mission is essential to advances in research, innovations in technology, and specialty care to benefit children.

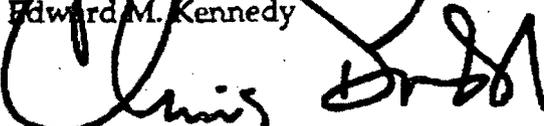
We estimate that \$300 million a year in federal aid would provide independent children's hospitals with support for graduate medical education commensurate with that provided to all other teaching hospitals. We urge you to include this assistance in your budget for FY 1999, so that we can do all we can to keep this inequitable gap from growing wider.

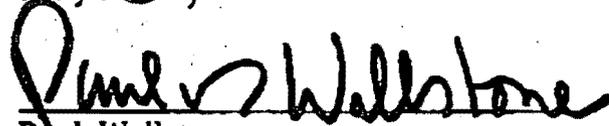
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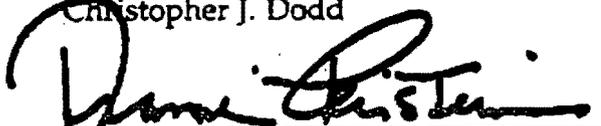
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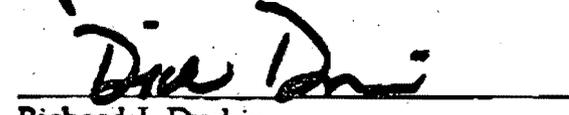

Edward M. Kennedy

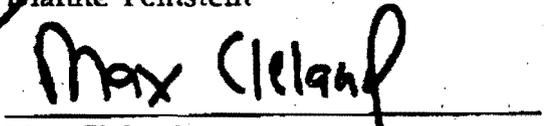

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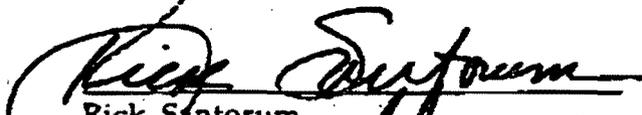

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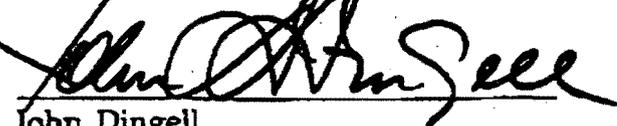

Dianne Feinstein


Richard J. Durbin


Max Cleland


Rick Santorum


Henry A. Waxman


John Dingell

FEDERAL GRADUATE MEDICAL EDUCATION FUND FOR CHILDREN'S HOSPITALS

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Kids health

NSR 250 + 5²

DSP Easy