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File
Children's Hospital



David S. Weiner
President

Children's Hospital

November 26, 1997

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

We are writing to ask your help and the Administration's leadership on an issue that is critically important to the future of our nation's children's hospitals. Increasingly, we have little to no funding sources for Graduate Medical Education (GME). This presents a substantial problem not only for our hospital, but also for pediatric medical education.

About 60 children's hospitals nationwide are freestanding. Because we see few Medicare patients, we receive virtually no Medicare GME--the only significant source of GME funding in today's market. Yet children's hospitals train 25 percent of all pediatricians and the great majority of pediatric specialists, although they make up less than one percent of all U.S. hospitals.

The rapid growth of market competition is making it increasingly difficult for teaching hospitals to fulfill their teaching missions while maintaining their competitive financial viability. This problem is especially severe for children's hospitals such as ours because of our payor mix. As a pediatric hospital with few Medicare patients, we receive virtually no Medicare GME payments. As the market moves to managed care, private payers are refusing to pay for the costs of GME, leaving Medicare as the only reliable GME payor. Teaching hospital, on average, receive \$77,000 per resident per year through Medicare. Children's Hospital, Boston receives approximately \$600. If we were to receive the national reimbursement for each of our 250 full time equivalent resident positions, our revenue would increase by \$19 million. As you can see, this issue has enormous implications for our continued financial viability, even in the near term.

Mrs. Hillary Rodham Clinton

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We are facing a considerable dilemma. Our academic mission is interrelated with our level of excellence in patient care and research. Our financial health is essential to our ability to care for low-income children and often to serve as the only resource for certain critical and specialized services. To solve this dilemma, we must find a solution for funding GME.

For the past few years, we hoped that a solution for funding GME would be possible through some broader-based financing mechanism. Now, with the Bipartisan Commission on the Future of Medicare and MedPAC tasked with reviewing such reform, a children's hospital solution under overall GME reform appears unlikely in the near future. That is why Children's Hospital of Boston is joining with the National Association of Children's Hospitals (NACH) in asking that the Administration include some short-term, capped source of federal funds for GME for freestanding children's hospitals in its fiscal 1999 budget.

We have supported the Clinton Administration in its efforts to advance the health of children. In addition, we know that you, in particular, understand and appreciate the contribution that children's hospitals make to the health of all of our children. As both the center of excellence and safety net provider for the children we serve, we train health professionals and provide breakthroughs in science, treatment, and technology for all children.

The Administration's leadership on children's hospital GME can make a substantial difference to our future.

Very truly yours,



David S. Weiner
President



Philip A. Pizzo, M.D.
Physician-in-Chief
Chair, Department of Medicine

PROVIDING FEDERAL FINANCING FOR GRADUATE MEDICAL EDUCATION AT CHILDREN'S HOSPITALS

BACKGROUND

- **The Federal government has traditionally provided teaching hospitals with financial support for graduate medical education.** Care in teaching hospitals is generally recognized as costlier than similar care provided in non-teaching facilities, because the inefficiencies associated with inexperience and a sicker patient population. Because a competitive health care market dominated by managed care is often unwilling to assume the costs of graduate medical education, the Federal government has assumed a portion of the cost of these training activities. These medical education payments allow teaching hospitals to maintain their academic mission without sacrificing their financial health.
- **Freestanding children's hospitals train the majority of essential pediatric providers.** The children's hospitals play an essential role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists. Since there are physician shortages in some areas of pediatric subspecialty care, these hospitals are critical to maintaining an adequate practitioner supply.
- **Although children's hospitals share the academic mission of other teaching hospitals, they are denied a commensurate level of Federal support.** The current system of Federal reimbursement for graduate medical education is dependant on the number of Medicare patients seen, creating a significant competitive disadvantage for children's hospitals. Teaching hospitals receive an average of \$76,000 in Federal GME funding per resident, as opposed to the \$400 per resident recieved by children's hospitals.
- **Alternate sources of GME financing are ending.** Children's hospitals in some States receive GME funding through the Medicaid program. However, as more States move to Medicaid managed care programs, Medicaid is no longer a viable source of funding for these providers.
- **Children's hospitals sustain significant financial losses because of their GME activities.** Despite the fact that children's hospitals maintain a significant pediatric market share, their patient care revenues are falling short of covering their patient care costs. Children's hospitals operating margins are -6.2 percent, as opposed to -3.9 percent for other teaching hospitals. A significant percentage of this loss is attributable to unreimbursed GME costs, which run in the millions of dollars per year per hospital.
- **Many children's hospitals are financially vulnerable.** The inequity in Federal financing forces children's hospitals to depend on non-patient care revenue to a greater extent than other teaching hospitals. Children's hospitals receive almost 15 percent of their total funding from revenues unrelated to patient care. Other teaching hospitals only receive 8.6 percent of their revenue from these sources. This makes children's hospitals more vulnerable to an economic downturn that could threaten their financial health.

QUESTIONS AND ANSWERS

Details of the Policy

Q: What is the \$40 million for?

A: The current system of Federal reimbursement for graduate medical education is dependant on the number of Medicare patients seen; however, because the children's hospitals see very few Medicare patients, they receive very little Federal support for their critical graduate medical education activities. As a first step towards addressing this long-standing inequity, and because the children's hospitals serve a disproportionate number of Medicaid patients, we are providing the children's hospitals with funding that is roughly equivalent to the portion of their direct medical education costs (approximately 42 percent) that are associated with providing care to Medicaid patients.

Q: Isn't this a first step towards making the GME program a discretionary program?

A: Absolutely not. 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. Although the children's hospitals play an essential role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists, they receive an average of \$400 per resident in Federal GME funding, as opposed to the \$76,000 per resident received by most other teaching hospitals. This new policy is simply an interim solution to a long standing inequity in Federal support.

Medicare Commission

Q: What is your position on the graduate medical education reforms that are being considered by the Commission?

A: The President and the Congress created the Bipartisan Medicare Commission in recognition of the complexity of addressing Medicare's problems. He believes it would be premature and inappropriate to contemplate any specifics prior to the conclusion of the Commission's work.

Budget Cuts

Q: Given the huge new infusion of funds to the Trust Fund, why is your budget proposing \$8 billion in hospital cuts?

A: The Administration has an ongoing fiduciary and management responsibility to ensure that Medicare payments are fair, adequate and not excessive. The President's proposal for the surplus in no way changes this responsibility. For this reason, the President has already announced a multi-billion dollar, anti-fraud, waste and abuse Medicare program

integrity proposal. His budget will contain additional proposals.

Outreach to Enroll Children in Medicaid and CHIP

Q: The Vice President announced a new, \$1 billion initiative to identify and enroll eligible children in Medicaid and the Children's Health Insurance Program (CHIP). Do you have more details on the policies?

A: The Administration is committed to addressing the needs of millions of uninsured children who are eligible for but unenrolled in Medicaid or CHIP -- because their families don't know about the options, cannot easily get information, or struggle with the application process. To address this problem, the Administration's FY 2000 budget would provide additional funding for state outreach activities. These new funds will enable States to simplify enrollment systems, launch ad campaigns, educate community volunteers, outstation eligibility workers, and conduct outreach campaigns to identify and enroll uninsured children in both Medicaid and CHIP. The actual details of the policies will be unveiled on February 1st, when the budget is released.

Increasing Access to Health Care for Working Families

Q. How will the public health infrastructure initiative provide additional services and access to basic health care for the uninsured?

A: By investing \$1 billion over 5 years to better coordinate and provide community-based health services, this initiative will help community health centers, rural health clinics, public hospitals, academic health centers and other providers to pool resources and better target and serve vulnerable populations. A number of communities across the nation (e.g., the Sunset Park Community Health Center, which serves over 80,000 residents of S.W. Brooklyn) have taken advantage of these kind of systems to more effectively use their limited resources to provide a greater range of services to the uninsured. They are able to offer a much fuller array of primary and preventive care services, including rehabilitation, early intervention programs, health promotion, mental health, and substance abuse services. This initiative recognizes that our health care infrastructure is being asked to serve increasing numbers of uninsured and responds to this pressing need.

Premium Support

→ National

→ Best Price

→ Core Support (cost sharing)

GRADUATE MEDICAL EDUCATION AND CHILDREN'S HOSPITALS

- Number of hospitals and distribution of resident FTE.**

	CHILDREN'S TEACHING HOSPITALS	OTHER TEACHING HOSPITALS
NUMBER OF HOSPITALS	57	1,004
RESIDENT FTE	4,623	74, 851
RESIDENT FTE PER HOSPITAL	74.8	74.6
RESIDENT FTE PER BED	0.38	0.19

- Total and operating margins by hospital type (1995 HCRIS)**

	CHILDREN'S TEACHING HOSPITALS	OTHER TEACHING HOSPITALS
TOTAL MARGIN	7.9%	4.7%
OPERATING MARGIN	-6.3%	-3.4%

- Formulas currently used by Medicare to distribute GME funds**

Direct Medical Education (DME) :

(Per Resident Amount * Resident FTE)/(Medicare inpatient days / total number of inpatient days)

Indirect Medical Education (IME):

$((1 + (\text{total number of residents}/\text{total number of beds})^{.405}) - 1)^{1.6}$

- Kerrey proposal formulas for distribution of GME funds**

Direct Medical Education (DME):

(Per Resident Amount * Weighted average of Resident FTE)

Indirect Medical Education (IME):

(Per Resident Rate for IME * Total Resident FTE)

- Projected Cost of the Kerrey Proposal**

The Kerrey proposal limits payments to \$100 million in FY 1999 and \$285 million in FY 2000 through FY 2002, for a 5 year total of \$955 million. This table indicates the impact of the bill without the cap on expenditures.

	DME	IME
PER RESIDENT AMOUNT	\$76, 817	\$70,812
PAYMENTS	\$216,854,391	\$244,867, 896
TOTAL EXPENDITURES	\$461, 722, 287	



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September 5, 1997

John M. Eisenberg, M.D.
Acting Principal Deputy Assistant Secretary for Health
U.S. Department of Health and Human Services
716-G Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Dear Dr. Eisenberg:

I am writing to respond to your request for more specific recommendations for commensurate federal graduate medical education (GME) support for children's teaching hospitals with their own Medicare provider number, in follow-up to my testimony on this subject to you at the department's August 27 Chicago hearing on the future of academic health centers.

In responding, I would like to outline specific principles N.A.C.H. believes should guide the development of commensurate GME support for this small but critical population of pediatric teaching hospitals. I also would like to offer a specific proposal as an example of how such support might be structured.

We are scheduled to discuss this issue with Chris Jennings at The White House on September 9, and we would welcome the opportunity to discuss it with you and other DHHS officials at your convenience.

Principles

N.A.C.H. recommends the following principles to guide federal action to help sustain the teaching responsibilities of children's teaching hospitals, which do not share a Medicare provider number with a larger institution for purposes of Medicare billing. Such federal action should result in "interim," "timely," "commensurate," and "sustainable" GME support for these hospitals:

- **Interim Support** N.A.C.H. supports comprehensive GME reform to address the financing needs of all teaching hospitals. However, until such time as comprehensive reform becomes a reality, the federal government should commit to establishing "interim" GME support for

children's teaching hospitals with their own provider number. The teaching missions of these institutions are in the greatest risk, both because the biggest growth in managed care enrollment is now among children and the hospitals committed to serving children are the least supported by Medicare GME funds. These hospitals cannot afford to remain at serious competitive disadvantage until 1999, when the new Medicare commissions report on GME funding, or later for federal support to help sustain their teaching.

- **Timely Support** The Clinton Administration should commit to making GME support for children's teaching hospitals with their own provider number a priority in its FY 1999 budget request to Congress. Such an initiative is the critical first step to the federal government establishing interim commensurate GME support for these children's teaching hospitals.
- **Commensurate Support** The federal government should commit to providing GME support to these children's teaching hospitals which is "commensurate" to the level of combined DME and IME support other teaching institutions receive through Medicare. Should the level of Medicare GME support change, commensurate support for children's teaching hospitals with their own Medicare provider number should change to maintain parity. According to The Lewin Group, under Medicare GME policy prior to the 1997 budget reconciliation act, commensurate federal GME support would amount to about \$337 million annually. Under the new budget law, which revised Medicare IME reimbursement, commensurate federal GEM support would amount to about \$300 million annually.
- **Sustainable Support** Interim commensurate GME support for these children's hospitals should be sustainable and reliable. It should not be subject to the annual appropriations process. Instead, just as is true of Medicare GME support, the funding for children's teaching hospitals should be available as hospitals qualify, based on a multi-year entitlement of funds.

Proposal

There are different ways in which GME support could be structured to meet these principles. One approach we would recommend for consideration is a separate, capped entitlement fund. We developed this proposal at the request

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of staff of Senators Kennedy and McDermott last June, both of whom have been very supportive of efforts in this area. A copy of the amendment to establish such a fund, as part of the Social Security Act, is attached.

Under this proposal, Congress would establish a new fund for children's teaching hospitals with their own provider number:

- **Separate from Medicare** This fund should *not* be financed by Medicare trust fund dollars.
- **Multi-Year Funding** The fund would have sustainable, multi-year funding, guaranteed at a level that would enable eligible hospitals to receive GME support commensurate to what comparable teaching hospitals receive under the new Medicare GME formulas.
- **Capped Dollar Amount** The fund would be capped at an absolute dollar level, so that if the number of eligible institutions were to increase over time, the level of available funding would not increase. The size of current residency programs could be capped, in accordance with Medicare policy as well.
- **Allocation Based on Per Resident Amount** Funds would be allocated to eligible hospitals based on a fixed amount per qualifying FTE resident per hospital, commensurate to combined Medicare DME and IME payments per resident in all teaching hospitals. (The Lewin Group also has developed an alternative methodology for using the Medicare formulas to allocate funds among eligible children's teaching hospitals.)

We would welcome very much the opportunity to meet with you and your colleagues to discuss this and alternative approaches. Given the increasing cost-based market pressures facing all teaching hospitals, it is imperative that a commitment to establish interim commensurate federal GME support for children's teaching hospitals be part of the administration's FY 1999 budget. Such a commitment should begin with DHHS identifying financing methodologies and sources of support, which the administration might recommend.

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As additional background to this letter and the August 27th testimony I presented in August, I am enclosing a copy of the overhead presentation summarizing the GME analysis of children's teaching hospitals with their own provider number, which N.A.C.H. commissioned Al Dobson and Paul Hogan of The Lewin Group to prepare. It demonstrates the dramatic difference between the national average Medicare GME payments received by all teaching hospitals -- about \$77,000 per resident in 1996 -- and the average Medicare GME Payments for children's teaching hospitals with their own provider number -- \$230 per resident.

Thank you very much for your interest and for the opportunity to testify to the department on August 27.

Sincerely,

Lawrence A. McAndrews

LAM/PDW/kw

Enclosure

cc: Ciro V. Sumaya, M.D., M.P.H.T.M., Deputy Assistant Secretary for Health,
 716-G U.S. Department of Health and Human Services

 Herbert T. Abelson, M.D., Chairman, Department of Pediatrics, The
 University of Chicago Children's Hospital

 Larry J. Shapiro, M.D., Chairman, Department of Pediatrics, University of
 California, San Francisco



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Statement

**Lawrence A. McAndrews
President and CEO, National Association of Children's Hospitals**

**RECOMMENDATIONS FOR FEDERAL GME SUPPORT
FOR CHILDREN'S TEACHING HOSPITALS
WITH THEIR OWN MEDICARE PROVIDER NUMBER**

**Presented to the U.S. Department of Health and Human Services'
Initiative on the Future of Academic Health Centers**

August 27, 1997

The National Association of Children's Hospitals (N.A.C.H.) is pleased to have the opportunity to submit testimony to Secretary Shalala's initiative "to update relevant Federal policy that can ensure the academic health centers' capacity to achieve their public goods missions in a new, evolving health care system."

The purpose of our testimony is to bring to the Department's attention the critical need for commensurate federal GME funding, including interim measures if needed, for one subset of teaching hospitals -- children's teaching hospitals that use their own Medicare provider number in billing for Medicare reimbursement. They do not share a provider number with a larger adult hospital or system.

N.A.C.H.'s Membership and Purposes

N.A.C.H. is a national association devoted to addressing the public policy challenges to the missions of our nation's children's hospitals. It represents over 100 institutions, including free-standing acute care children's hospitals, children's specialty and rehabilitation hospitals, and children's hospitals that are part of larger institutions. They have missions of service to the children of their communities, including clinical care, education, research, and advocacy -- all devoted to the unique health care needs of children, regardless of their medical or economic condition.

N.A.C.H. is affiliated with the National Association of Children's Hospitals and Related Institutions (NACHRI).

N.A.C.H. joins with the American Association of Medical Colleges and others in supporting a "shared responsibility" approach to financing graduate medical education (GME). It has consistently supported a policy that all entities that pay for hospital and health-related services should assume their share of GME financing. Both the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) agree. The federal Council on Graduate Medical Education (COGME) has recommended all-payer funding as well.

Children's Teaching Hospitals with Their Own Medicare Provider Number

Children's teaching hospitals with their own Medicare provider number include fewer than 60 hospitals nationwide -- about 45 acute care children's hospitals and 13 children's specialty and rehabilitation hospitals. Although they represent less than one percent of all hospitals, these children's teaching hospitals make a significant contribution to graduate medical education.

They train over five percent of all residents in the country, 25 percent of pediatricians, and over half of all pediatric subspecialists. In most cases, they are major, academic teaching hospitals, with agreements with accredited schools of medicine and residency programs that are, on average, the same size as major teaching hospital programs nationwide. In fact, their teaching intensity, measured using a ratio of residents to beds, is almost twice the national average for all teaching hospitals.

Children's teaching hospitals with their own Medicare provider number share the same missions of patient care without regard to medical or economic need, education, and research as other major, academic teaching hospitals, and they face the same pressures from a financial environment that is increasingly price competitive. There is, however, one notable difference. These children's hospitals face the competitive pressures of the market place without the buffer of Medicare support for GME.

The Need for Federal GME Support for Children's Teaching Hospitals with Their Own Medicare Provider Number

Because children's hospitals see very few Medicare patients -- children with end stage renal disease -- children's teaching hospitals with their own provider number receive very little Medicare GME support. Using data from the Hospital Cost Report Information System (HCRIS) updated to 1996, The Lewin Group, an independent health care policy and research consulting firm, found that these children's teaching hospitals received an average of just \$230 per resident in Medicare GME support compared to an average of \$77,370 per

resident for teaching hospitals overall. Indeed, non-children's teaching hospitals received an average of \$81,863 per resident in combined direct and indirect medical education payments under Medicare.

Graduate medical education is largely financed through patient care revenues. The federal government, through Medicare, is the largest explicit financing source of GME. Indeed, Medicare has become the bulwark of financing for graduate medical education as other health care purchasers are becoming increasingly unwilling to pay teaching hospitals to account for these costs. These other purchasers include Medicaid, which is generally experiencing a substantial decline in support for GME with the demise of fee-for-service reimbursement and the shift to managed care.

Their rapidly growing inability to cover GME costs, combined with their responsibilities for care of low income patients and specialty care, is taking a toll on children's hospitals. In 1995, the average total margin for the acute care children's hospitals with their own provider number -- the difference between total revenues and total expenses -- was 2.37 percent, compared with average total margins for all hospitals and major teaching hospitals, according to ProPAC, of 5.6 percent and 3.7 percent respectively. The children's hospitals' average total margins were even lower than the 3.6 percent average of disproportionate share hospitals in large urban areas, demonstrating the value of Medicare's payment adjustments, including GME.

Proposals for GME Reform

Like other hospitals, children's hospitals are adapting to a market driven health care system. However, reducing costs and managing care efficiently alone cannot erase the competitive disadvantage brought about by added responsibilities of education, research, and specialized and low-income patient care.

The children's teaching hospitals with their own provider number, which do not benefit from the current federal commitment to GME financing through Medicare, represent about half of the nation's major pediatric academic medical centers. It is their combined missions that enable them to serve as regional referral centers and sources for innovation in children's health care, benefitting all children. Their ability to sustain these missions depends on an approach to federal GME financing which can recognize their needs.

Two innovative approaches to fund the costs of medical education, which could address this goal, did emerge in the 104th Congress. First, with the leadership of the Ways and Means Committee, H.R. 2491, the Balanced Budget Act of 1995, would have created a Teaching Hospital and Graduate Medical

Education Trust Fund consisting of five separate and distinct accounts. Three of the five accounts would have been funded by appropriated general revenues, and the Medicare program would have contributed funds to the two other accounts. The Ways and Means Committee explicitly recognized that the use of general revenue funds would provide an opportunity to address the GME costs of children's hospitals and directed that they be considered in mechanisms for trust fund allocations.

Second, another approach to broader-based financing of GME was taken in S. 1870, the Medical Education Trust Fund Act of 1996, introduced by Senator Daniel Patrick Moynihan, who has reintroduced this proposal as S.21, the Medical Education Trust Fund Act of 1997 in the 105th Congress. The bill would establish an all-payer trust fund for graduate medical education, establishing five accounts, including accounts for teaching hospitals and one for medical schools. Companion legislation has been introduced in the House.

However, instead of acting on such proposals this year, Congress has enacted as part of the Balanced Budget Act the creation of a new Medicare Payment Advisory Commission, which is charged, in part, with an assessment of alternative GME financing mechanisms, including for children's hospitals. This commission is directed to report recommendations for Congress' consideration within two years.

N.A.C.H. Recommendations

N.A.C.H. strongly supports the creation of a trust fund for graduate medical education and the establishment of broader-based financing mechanisms which can encompass children's hospitals.

However, until such time as an appropriate GME trust fund with broader-based financing is established, it is imperative that children's teaching hospitals with their own Medicare provider number receive, at least on an interim basis, commensurate federal GME support.

In particular, N.A.C.H. urges the Department to identify a mechanism for sustainable GME financing for children's teaching hospitals with their own provider number and to develop recommendations for implementation of such financing as part of the President's FY 1999 budget request to Congress. Such support would be a major step toward leveling the increasingly tilted playing field for these important centers of pediatric graduate medical education.

Thank you for the opportunity to present our recommendations. I would be pleased to try to answer any questions you may have.

**LEGISLATION TO PROVIDE GRADUATE MEDICAL EDUCATION PAYMENTS
TO CHILDREN'S HOSPITALS**

Section _____. To create a new Section 1893 of the Social Security Act to read as follows:

SECTION 1893.

(a) **PAYMENTS TO FUND GRADUATE MEDICAL EDUCATION PROGRAMS AT CHILDREN'S HOSPITALS-** The Secretary shall make payment under this Section to each Children's Hospital (as defined in Section 1886(d)(1)(B)(iii)) for hospital cost reporting periods ending during fiscal year 1998, and each subsequent fiscal year through 2002 for the direct and indirect expenses associated with operating approved medical residency training programs. For purposes of this legislation, the definitions contained in Section 1886(h)(5) shall apply.

(b) **AMOUNT OF PAYMENT-**

(1) **DIRECT MEDICAL EDUCATION PAYMENT-** Subject to subsection (e) below, the amount payable to each Children's Hospital under this Section for direct expenses related to approved medical residency training programs for each year shall be the product of:

(A) The per resident rate as determined in subparagraph (b)(2) below;

(B) The weighted average number of full-time equivalent residents in the hospital's approved medical residency training programs for the cost reporting period as determined in accordance with Section 1886(h)(4); and

(C) .25.

(2) The per resident rate for each hospital shall be determined as follows:

(A) For cost reporting periods ending during fiscal year 1998, it shall be equal to the average amount recognized as reasonable under Medicare cost reimbursement principles for the direct graduate medical education costs of the hospital for each full-time equivalent resident enrolled in an approved medical residency training program for the hospital cost reporting period ending during fiscal year 1995 as updated by the percentage increase in the consumer price index during the 36-month period beginning at the mid-point of the hospital's cost reporting period which ends during fiscal year 1995;

(B) For subsequent cost reporting periods, it is equal to the per resident rate for the previous cost reporting period updated, through the mid-point of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period, ending at that mid-point, with appropriate adjustment to reflect previous over or underestimations under this paragraph for the projected percentage change in the consumer price index.

(3) Payments under this subsection (b)(1) are in lieu of any payments under Title XVIII for direct graduate medical education expenses, but shall not be substituted for or shall not be construed to effect any payments currently being made to Children's Hospitals for direct graduate medical education under Title XVIII.

(4) **INDIRECT MEDICAL EDUCATION PAYMENTS-** Subject to subsection (e) below, the amount payable to each Children's Hospital for each year for the indirect costs associated with an approved medical residency training program shall be:

(A) The product of the number of full-time equivalent residents enrolled in an approved medical residency training program and providing services in an inpatient or outpatient area of the hospital, and the indirect medical education amount as determined in Subparagraph (B).

(B) The indirect medical education amount shall be:

(i) For fiscal year 1998, \$58,000; and

(ii) For fiscal years 1999 through 2002, the subsequent year's amount updated by the percentage change in the consumer price index for the previous 12-month period.

(c) **TIMING OF PAYMENTS-**

(1) The Secretary shall estimate, prior to the start of each Children's Hospital's fiscal year, the amount of direct and indirect payments to be made under this Section and shall remit, as interim payments, such amount to each hospital in 26 equal installments. After the close of each fiscal year, each Children's Hospital shall report to the Secretary such information as is necessary to determine final payment pursuant to subsection (b). The Secretary shall then determine the final payment due and shall recoup or pay any over or underpayments made on an interim basis.

(2) Final determination of the amount due under subsection (b) shall be subject to review pursuant to Section 1878.

(d) DIRECT SPENDING-

(1) IN GENERAL- For carrying out this section, there shall be appropriated, out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

(A) For fiscal year 1998,

(i) For purposes of making direct medical education payments, \$79,000,000; and

(ii) For purposes of making indirect medical education payments, \$249,000,000.

(B) For fiscal year 1999 and each subsequent fiscal year through 2002 (i) for purposes of making direct and indirect medical education payments, the amount determined under this subsection (d) for such purpose for the previous year, updated to reflect the percentage change of the consumer price index for the previous 12 months.

(e) ENTITLEMENT STATUS-

(1) IN GENERAL- Effective on and after October 1, 1997, the requirement established in subsection (a) for the Secretary to make a payment under this section

(A) is an entitlement for a Children's Hospital on behalf of individuals served by such hospital but is not an entitlement for any such individual; and

(B) represents the obligation of the Federal Government, subject to paragraph (2), to make a payment under subsection (a) to the Children's Hospital in the amount determined for the hospital under subsection (b).

(2) **CAPPED ENTITLEMENT-** The entitlement established in paragraph (1) is subject to the extent of the amount appropriated in subsection (d) for the fiscal year.

(3) **PRO RATA REDUCTIONS UNDER CAP AMOUNT-** If the Secretary determines that the budget authority provided in subsection (d) for a fiscal year is insufficient to provide the total of all amounts due under subsection (b) for the year, the Secretary shall reduce each amount determined under subsection (b) for the year on a pro rata basis to the extent necessary for the payments under this section to be provided in an aggregate amount equal to the budget authority available under subsection (d) for the year.

(4) **CARRYOVER OF UNOBLIGATED FUNDS-** Any amounts appropriated under subsection (d) for a fiscal year that remain unobligated at the end of such fiscal year shall remain available for obligation for payments under this section in subsequent fiscal years.

**GME Payments to Children's
Teaching Hospitals With Separate
Provider Numbers:
Analysis and Findings**

Spring 1997



Outline

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

Political Backdrop

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



Purpose of Lewin Analysis

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

Constraints/Caveats

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

Executive Summary

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

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

Data

◆ Hospital Cost Report Information System (HCRIS) Files*

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

◆ Hospitals not in HCRIS

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

*The HCRIS files are widely used for analytical research.

Data, continued

Teaching Hospitals

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

* Children's teaching hospitals with separate provider numbers

** Estimate from HCRIS

Methodology

DME Equation

*DME = Medicare share of inpatient days * Residents * "Allowed Amt"*¹

IME Equation

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

- Medicare share of inpatient days
- DRG payments

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

Methodology, continued

◆ DME

➤ allowed amount

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

➤ Medicare patient day share

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

Methodology, continued

◆ IME

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

Lewin's Cost Estimates

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

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

DME Payments

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

IME Payments

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

* Children's teaching hospitals with separate provider numbers

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

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

◆ Assumptions:

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

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

* Children's teaching hospitals with separate provider numbers

DME Costs vs. Payments

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

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

* Children's teaching hospitals with separate provider numbers

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

Adjusted IME Payments: Simulated for Children's Hospitals

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

◆ Assumption:

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

◆ IME payments per resident are about the same

* Children's teaching hospitals with separate provider numbers

Summary

◆ Status quo

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

◆ These policy changes would

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

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

ALABAMA

Children's Hospital of Alabama
Birmingham
CEO: Jim Dearth, M.D.

ARKANSAS

Arkansas Children's Hospital
Little Rock
President: Jonathan Bates, M.D.

CALIFORNIA

Children's Hospital Oakland
President: Antonie Paap, J.D.

Childrens Hospital Los Angeles
President: William Noce

Lucile Salter Packard Children's Hospital
Palo Alto
Exec. VP: Christopher Dawes

Children's Hospital of Orange County
Orange
President: Thomas Jones

Children's Hospital and Health Center
San Diego
President: Blair Sadler, J.D.

Valley Children's Hospital
Fresno
President: J.D. Northway, M.D.

COLORADO

The Children's Hospital
Denver
President: Lua Blankenship

National Jewish Center
Denver

CONNECTICUT

Connecticut Children's Medical Center
Hartford
President: Larry Gold

DELAWARE

Alfred I. DuPont Institute
Wilmington
Administrator: Thomas Ferry

DISTRICT OF COLUMBIA

Children's National Medical Center
President: Edwin Zechman

FLORIDA

All Children's Hospital
St. Petersburg
President: Dennis Sexton

Miami Children's Hospital
President: William McDonald

GEORGIA

Egleston Children Health Care System at Emory
Atlanta
President: Alan Gayer

HAWAII

Kapiolani Women's and Children's Medical
Center, Honolulu
President: Frances Hallonquist

ILLINOIS

Children's Memorial Hospital
Chicago
President: Jan Jennings

LaRabida Children's Hospital and Research
Center, Chicago
Director: Paula Jaudes, M.D.

LOUISIANA

Children's Hospital
New Orleans
President: Steven Worley

MARYLAND

Kennedy Krieger Children's Hospital
Baltimore

President: Gary Goldstein, M.D.

MASSACHUSETTS

Children's Hospital
Boston

President: David Weiner

MICHIGAN

Children's Hospital of Michigan
Detroit

Sr. Vice President: Thomas Rozek

MINNEAPOLIS

Children's Health Care
Minneapolis and St. Paul
President: Brock Nelson

Gillette Children's Specialty Healthcare
St. Paul

President: Margaret Perryman

MISSOURI

Cardinal Glennon Children's Hospital
St. Louis

President: Douglas Reis

St. Louis Children's Hospital

President: Ted Frey

The Children's Mercy Hospital
Kansas City

President: Randall O'Donnell, Ph.D.

NEBRASKA

Boys Town National Research Hospital
Omaha

Director: Patrick Brookhouser, M.D.

Children's Hospital
Omaha

President: Gary Perkins

NEW JERSEY

Children's Specialized Hospital
Mountainside

President: Richard Ahlfeld

NEW MEXICO

Carrie Tingley Hospital
Albuquerque

Medical Director: James Drennan, M.D.

NEW YORK

Blythedale Children's Hospital
Valhalla

President: Robert Stone

Children's Hospital of Buffalo

OHIO

Children's Hospital
Columbus

Acting Pres.: Thomas Hansen, M.D.

Children's Hospital Medical Center of Akron
President: William Considine

Children's Hospital Medical Center
Cincinnati

President: James Anderson, J.D.

Children's Medical Center of Northwest Ohio
Toledo

Exec. Director: Jan McBride

Rainbow Babies and Children's Hospital
Cleveland

Sr. Vice President: Gail Larson

The Children's Medical Center
Dayton

President: Laurence Harkness

Tod Children's Hospital
Youngstown

Administrator: Kris Hoce

OKLAHOMA

Children's Medical Center
Tulsa

President: Gerard Rothlein

PENNSYLVANIA

Children's Hospital of Pittsburgh
President: Paul Kramer

St. Christopher's Hospital for Children
Philadelphia
President: Calvin Bland

The Children's Hospital of Philadelphia
President: Edmond Notebaert, J.D.

PUERTO RICO

University Pediatric Hospital
San Juan

SOUTH CAROLINA

The Children's Hospital, Medical University
of South Carolina, Charleston
Director: Carol Dobos, Ph.D.

TEXAS

Children's Medical Center of Dallas
President: George Farr

Cook Children's Medical Center
Fort Worth
President: Russell Tolman

Driscoll Children's Hospital
Corpus Christi
President: J.E. Stibbards, Ph.D.

Santa Rosa Children's Hospital
San Antonio
Medical Director: Richard Wayne, M.D.

Texas Children's Hospital
Houston
Exec. Director: Mark Wallace

UTAH

Primary Children's Medical Center
Salt Lake City
President: Joseph Horton

VIRGINIA

Children's Hospital of the King's Daughters
Norfolk
President: Robert Bonar

WASHINGTON

Children's Hospital and Medical Center
Seattle
President: Treuman Katz

Mary Bridge Children's Health Center
Tacoma

WISCONSIN

Children's Hospital of Wisconsin
Milwaukee
President: Jon Vice

GRADUATE MEDICAL EDUCATION AND CHILDREN'S HOSPITALS

- **Number of hospitals and distribution of resident FTE.**

	CHILDREN'S TEACHING HOSPITALS	OTHER TEACHING HOSPITALS
NUMBER OF HOSPITALS	57	1,004
RESIDENT FTE	4,623	74,851
RESIDENT FTE PER HOSPITAL	74.8	74.6
RESIDENT FTE PER BED	0.38	0.19

- **Total and operating margins by hospital type (1995 HCRIS)**

	CHILDREN'S TEACHING HOSPITALS	OTHER TEACHING HOSPITALS
TOTAL MARGIN	7.9%	4.7%
OPERATING MARGIN	-6.3%	-3.4%

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

SUMMARY

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

BACKGROUND

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

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

POLICY OPTIONS

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

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

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

Option 2: Eliminate IME reimbursement from the Kerrey proposal.

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

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

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

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

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

PROBLEMS WITH THE KERREY PROPOSAL

Senator Kerrey has introduced a proposal to provide freestanding children's hospitals with funding for their graduate medical education (GME) costs. This proposal uses general appropriation funds to distribute GME funds based upon a formula that is similar to the Medicare formula currently used. 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.

There are several problems with the Kerrey proposal as currently drafted. These include:

- **Making the government entirely responsible for the cost of direct medical education (DME).** Currently, the government only assumes the percentage of the DME costs associated with providing care to Medicare patients. Under the Kerrey proposal, children's hospitals would 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. As currently drafted, the Federal government would be required 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.
- **Providing indirect medical education (IME) reimbursement that does not account for additional costs associated with training.** 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. Teaching hospitals receive indirect medical education payments to account for these costs. Under the Kerrey proposal, children's hospitals would receive a per resident amount that would not consider the additional costs associated with training physicians. As currently drafted, the Federal government would be required to provide approximately \$70,000 per resident for IME costs alone. This is as much as we presently provide to other teaching hospitals for both their direct and indirect medical education costs.
- **Administering the cap on GME payments to these hospitals will be difficult.** The Kerrey proposal requires the Secretary to limit the expenditures under this proposal to the amount specified in statute; if the appropriation is insufficient to provide the payments due to the children's hospitals, she must reduce the amounts disbursed. As the proposal is currently drafted, it is clear that the Secretary will be forced to reduce the payments to the hospitals. The formulas provide the children's hospitals with approximately \$215 million for DME and \$244 million for IME, for a total of \$459 million in GME payments. However, the Kerrey proposal caps GME payments at \$285 million per year. This would place the Department in the position of having to reduce the funds provided on a retrospective basis which would be extremely difficult if not impossible.

CHILDREN'S HOSPITALS

After the children's hospital folks present their argument for funding, we should:

1. Ask them to expand upon their numbers.

Their total margins are very high. Why is it that they need the extra financial support?

They will talk about greater case mix intensity and greater cost per patient because of supervision and equipment needs, but that has nothing to do with GME.

2. Discuss the flaws in the Kerrey proposal.

See your cheat sheet.

Also, does this create any incentives or equity issues for children's hospitals that are in larger systems (not freestanding) and would not benefit from this proposal?

3. Determine their bottom line.

Would they accept a grant program?

How much money do they actually need?

add kids gme

**PRESIDENT CLINTON AND VICE PRESIDENT GORE:
EXPANDING HEALTH INSURANCE COVERAGE, IMPROVING HEALTH CARE
QUALITY, AND SAFEGUARDING THE PUBLIC HEALTH**

**I. REFORMING THE INSURANCE MARKET / ASSURING PATIENT
PROTECTIONS**

Enacted the Family and Medical Leave Act (Public Law 103-3). The Family & Medical Leave Act enables workers to take up to 12 weeks unpaid leave to care for a new baby or ailing family member without jeopardizing their job. Millions of workers have already benefited from FMLA since its enactment. In June 1996, President Clinton proposed expanding FMLA to allow workers to take up to 24 unpaid hours off each year for school and early childhood education activities, routine family medical care, and caring for an elderly relative.

Enacted the landmark Kennedy-Kassenbaum legislation that ensures individuals continued access to health insurance (Public Law 104-191). The Kennedy-Kassenbaum (Health Insurance Portability and Accountability Act) legislation prevents individuals from being denied coverage because they have a preexisting medical condition. It requires insurance companies to sell coverage to small employer groups and to individuals who lose group coverage without regard to their health risk status. It also prohibits discrimination in enrollment and premiums against employees and their dependents based on health status. Finally, it requires insurers to renew the policies they sell to groups and individuals.

Enacted legislation requiring mental health parity for annual and lifetime insurance limits (Public Law 104-204). To help eliminate discrimination against individuals with mental illnesses, the President enacted legislation containing provisions prohibiting health plans from establishing separate lifetime and annual limits for mental health coverage.

Enacted legislation establishing protections for mothers and their newborns and women recovering from mastectomies (Public Laws 104-204 and 105-277). Some health plans have refused to pay for anything more than a 24-hour hospital stay, and some have recommended releasing mothers as few as 8 hours after delivery. The President signed into law common sense legislation that requires health plans to allow new mothers to remain in the hospital for at least 48 hours following most normal deliveries and 96 hours after a Cesarean section. The President also enacted legislation that would ban drive-through mastectomies, allowing women to stay in the hospital at least 48 hours following a mastectomy.

Enacted legislation to eliminate duplicative and wasteful administrative requirements of the health care system (Public Law 104-191). The Health Insurance Portability and Accountability Act (HIPAA) provided the Administration with the authority to develop a single set of national standards for all health care providers and health plans that engage in electronic administrative and financial transactions to promote more cost-effective electronic claims processing and coordination of benefits. This implementation of this law will eliminate administratively burdensome, duplicative, and wasteful billing requirements for health care providers and insurers.

Issued landmark Federal regulations protecting the privacy of electronic medical records.

In the absence of Congressional action, under authority provided by PL 104-191, the Administration released a new regulation protecting the privacy of electronic medical records held by health plans, health care clearinghouses, and health care providers. This rule limits the use and release of private health information without consent; restricts the disclosure of protected health information to the minimum amount of information necessary; established new requirements for disclosure of information to researchers and others seeking access to health records; informs consumers about their right to access their health records and to know who else has accessed them; and establishes new administrative and criminal sanctions for the improper use or disclosure of private information.

Enacted legislation prohibiting discriminatory underwriting practices by insurers through the use of genetic information (Public Law 104-191). Applies to insured and self insured but not individual market and prevents group health insurers from using genetic information to deny individuals health insurance benefits.

Established and endorsed the recommendations of the historic Quality Commission. In 1996, the President created a non-partisan, broad-based Commission on quality and charged them with developing a patients' bill of rights as their first order of business. In October of 1997, the President accepted the Commission's recommendation that all health plans should provide strong patient protections, including guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections; and access to a fair, unbiased and timely internal and independent external appeals process. The work of the Commission lay the foundation for subsequent administrative and legislative initiatives to improve patient protections and quality improvement.

Issued executive memorandum requiring that the 85 million Americans in Federal health plans receive critical patient protections. In the absence of Congressional action, President Clinton directed HHS, OPM, DOL, DOD, and DVA to ensure that their employees and beneficiaries had the important new benefits and rights that are guaranteed to health care consumers in the Administration's proposed Patients Bill of Rights, including choice of providers and plans, access to emergency services, participation in treatment decisions, confidentiality of health information and a fair complaint and appeals process. Medicare, Medicaid, S-CHIP, the Indian Health Service, FEHBP plans, the Veterans Administration facilities, and the Military Health System are responding by ensuring that all protections that can be extended under current law be provided.

Issued executive order preventing genetic discrimination in Federal hiring and promotion actions. In February of 2000, President Clinton signed an executive order prohibiting every civilian Federal Department and agency from using genetic information in any hiring or promotion action. This historic action prevents critical information from genetic tests used to help predict, prevent, and treat diseases being used against them by their employer. Since 1997, the Administration has called for legislation that will guarantee that Americans who are self-employed or otherwise buy health insurance themselves will not lose or be denied that health insurance because of genetic information.

Called for the passage of a strong, enforceable, Patients' Bill of Rights without further delay. President Clinton has endorsed the Norwood-Dingell Patients' Bill of Rights, which passed the House with overwhelming bipartisan support. This legislation, endorsed by over 200 health care advocacy groups, is the only proposal that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful. The legislation includes: guaranteed access to needed health care specialists; access to emergency room services when and where the need arises; continuity of care protections; access to a fair, unbiased and timely internal and independent external appeals process; and an enforcement mechanism that ensures recourse for patients who have been harmed as a result of health plan's actions.

Called for legislation to protect the private genetic information of all Americans. President Clinton has endorsed the Genetic Nondiscrimination in Health Insurance & Employment Act of 1999. This bill would extend the protections for genetic information included in the President's executive order preventing discrimination on the basis of genetic information by Federal employers to the private sector. HIPAA prevents group health insurers from using genetic information to deny individuals health insurance benefits. The Daschle-Slaughter legislation finishes the job begun by HIPAA and ensures that genetic information used to help predict, prevent, and treat diseases will not also be used to discriminate against Americans seeking employment, promotion, or health insurance.

II. EXPANDING COVERAGE

Enacted single largest investment in children's health care since 1965 (Public Law 105-33). The Balanced Budget Act included \$48 billion for the State Children's Health Insurance Program – the single largest investment in health care for children since the enactment of Medicaid in 1965. This new program, together with Medicaid, will provide meaningful health care coverage for up to five million previously uninsured children – including prescription drugs, vision, hearing, and mental health services. Within three years of enactment, all 50 states have implemented S-CHIP programs, and over 2 million children have been covered. In addition, the number of states covering children up to 200 percent of poverty increased by more than 7 fold – to 30 states – during that time.

Enacted landmark legislation providing new health insurance opportunities for working people with disabilities (Public Law 106-70). The Jeffords-Kennedy Work Incentives Improvement Act creates important new health insurance options provided to people with disabilities. This landmark new legislation creates two new options for states to offer the Medicaid buy-in for workers with disabilities and provides \$150 million in grants to encourage states to take this option; establishes a new Medicaid buy-in demonstration to help people with whose disability is not yet so severe that they cannot work; extends Medicare coverage for an additional 4 and a half years for people in the disability insurance system who return to work; and enhances employment-related services for individuals with disabilities.

Enacted new legislation to help young people leaving foster care (Public Law 106-169).

Today, when young people emancipate from foster care, they face numerous health risks, but too often lose their health insurance. The new law grants states the option for these young people to remain eligible for Medicaid up to age 21. HHS issued guidance to all State Medicaid Directors encouraging them to take up this option.

Enacted new legislation to provide Medicaid coverage to certain uninsured women with breast and cervical cancer. President Clinton enacted a new Medicaid option to provide needed insurance coverage to the thousands of uninsured women with breast and cervical cancer detected by Federally supported screening programs. This new proposal will help eliminate the current and frequently overwhelming financial barriers to treatment for these women. The Vice President and the First Lady, national leaders in the prevention, diagnosis, and treatment of breast cancer, strongly advocated for this initiative, which has been endorsed by the National Breast Cancer Coalition and other cancer groups.

Approved waivers expanding health insurance coverage for Americans. The Clinton Administration has approved 17 state-wide Medicaid waivers linking public health financing with private health plans, providing an estimated 1.4 million low income Americans with critical health insurance coverage for the first time.

Issued Executive Directives to target and enroll uninsured children and launched the national Insure Kids Now Campaign. The President issued two executive directives to enhance current efforts to identify and enroll uninsured children in Medicaid and S-CHIP; one requiring Federal agencies to implement over 150 new actions to enroll eligible but uninsured children, and one directing Cabinet Secretaries to develop strategies to integrate children's health insurance outreach into schools. These Executive Memoranda cut across jurisdiction and traditional agency inflexibility by directing Federal agencies to work together to design collaborative initiatives that build on state innovations. The Insure Kids Now Campaign was designed to build on Administration actions to further promote outreach and enrollment. This bipartisan, public-private education and information campaign includes: the "1-877-KIDS NOW" Hotline, a toll free number to provide information about Medicaid and CHIP to families in all 50 states; running PSAs on national television and radio about Insure Kids Now; printing the toll free number on common products; and reaching out to enlist every school in the country in a children's health outreach campaign.

Issued new guidance to ensure that Medicaid applications are properly processed. In order to address concerns that families who left TANF but who remained eligible for Medicaid or Transitional Medicaid benefits may have inadvertently lost coverage to which they were still entitled, the Administration released clarifying guidance stating that states must review their Medicaid records since 1996 and identify individuals who have been terminated improperly from Medicaid in order to automatically reinstate their Medicaid coverage while their eligibility is redetermined. The guidance also clarifies that states must have systems and processes in place that explore and exhaust all possible avenues of eligibility.

Issued new guidance to assure families that the receipt of Medicaid, CHIP, or other benefits will not affect immigration status. The Administration unveiled new regulations assuring families that enrollment in Medicaid or S-CHIP and the receipt of other benefits, such as school lunch and child care services, will not affect their immigration status. The new regulation, effective immediately, clarifies a widespread misconception that has deterred eligible populations from enrolling in these programs and undermined the public health. Federal agencies also sent guidance to their field offices, and program grantees to educate the public about this new policy.

Proposed \$110 billion in FY 2001 budget to extend coverage to over 5 million currently uninsured Americans and provide more affordable coverage to millions more. This initiative would help cover parents of S-CHIP children, 19 and 20 year olds, 55 to 65 year olds, workers in between jobs, and small businesses and their employees. It addresses the nation's multi-faceted coverage challenges by building on and complementing current private and public programs. Specifically, the initiative would:

- **Provide a new, affordable health insurance option for families.** This proposal invests \$76 billion over 10 years to provide health insurance to the uninsured families. S-CHIP would be expanded to provide higher Federal matching payments for expanding health insurance to parents of children eligible for or enrolled in Medicaid and S-CHIP. FamilyCare: provides higher Federal matching payments for expanding coverage to parents; increases S-CHIP allotments and makes them permanent to ensure adequate funding for parents and their children; enrolls parents in the same program as their children; covers lower income parents first; and requires all states to cover at least all poor parents by 2006, providing the same coverage their children have today.
- **Accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP.** The President's budget, which will invest \$5.5 billion over the next five years in this initiative, will: (1) promote school-based outreach by allowing states to use information on school lunch applications to find uninsured children and to automatically enroll children in the school lunch program in Medicaid and SCHIP while their applications are formally processed; (2) allow additional sites such as child care referral centers to enroll children while their applications are formally processed; (3) require states to synchronize Medicaid and SCHIP eligibility processes.
- **Expand health insurance options for Americans facing unique barriers to coverage.** Some vulnerable groups of Americans often lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. This proposal: expands state options to insure children aged 19 and 20 through Medicaid and FamilyCare; establishing a Medicare buy-in option and making it more affordable through a tax credit equal to 25 percent of their insurance premiums; providing a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs; improving access to affordable insurance through tax incentives to establish voluntary purchasing coalitions for workers in small businesses; and extending transitional Medicaid for people leaving welfare for work as well as restoring state options to insure legal immigrants.

- **Strengthen programs that provide health care directly to the uninsured.** This historic new grant program invests \$1 billion over 5 years to support community providers of services to the uninsured. These grants will allow providers to deliver the full range of primary care services to the uninsured, rather than treating only the most emergent problems. Currently, many uninsured individuals do not have access to primary care, mental health, and substance abuse services. Funds will be used to preserve access to critical tertiary care services while holding providers accountable for health outcomes.

III. ELIMINATING TAX INEQUITIES IN HEALTH CARE

Enacted legislation to eliminate the discriminatory tax treatment of the self-employed (Public Laws 104-191 and 105-33). HIPAA law increased the tax deduction from 30 percent to 80 percent for the approximately 10 million Americans who are self-employed. The President also signed into law a provision to phase it in to 100 percent in the BBA.

Enacted legislation to provide consumer protections and tax incentives for private long-term care insurance (Public Law 104-191). The HIPAA legislation took steps to make long-term care more affordable by guaranteeing that employer sponsored long-term care insurance receives the same tax treatment as health insurance; implemented new consumer protections to assure that any tax favored product meets basic consumer and quality standards.

Proposed a new 25 percent tax credit for COBRA premiums. COBRA allows workers in firms with greater than 20 employees to pay a full premium (102 percent of the average cost of group health insurance) to buy into their employers' health plan for up to 18 months after leaving their job. This proposal would provide a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs.

IV. STRENGTHENING AND MODERNIZING MEDICARE

Enacted Medicare reforms that extended solvency, provided new preventive benefits, and added new plan choices (Public Laws 105-33 and PL 103-66). The Balanced Budget Act of 1997 contained major new Medicare reforms including:

- **Payment and structural reforms that extend the life of the Medicare Trust Fund until 2025.** When the President came into office, Medicare was projected to become insolvent in 1999. The President's 1993 economic package included policy and structural changes that extended the life of the Medicare Trust Fund by at least three years, and the Balanced Budget Act extended the life of the Trust Fund by an additional 10 years. The Administration's [fraud] stewardship of Medicare has resulted in the longest Medicare Trust Fund solvency in a quarter century, extending the life of the Medicare Trust Fund by a total of 26 years and offering premiums that are nearly 20 percent lower today than projected in 1993.

- **New structural reforms to modernize the program.** The BBA included a series of structural reforms which modernize the program, bringing it in line with the private sector and preparing it for the baby boom generation. These reforms: increased the number of health plan options; improved Medicare managed care payment methodology and informed beneficiary choice; implemented a prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments; and adopted private-sector oriented purchasing.
- **New preventive benefits.** The BBA also: waived cost-sharing for mammography services and provided annual screening mammograms for beneficiaries age 40 and older to help detect breast cancer; established a diabetes self-management benefit; ensured Medicare coverage of colorectal screening and cervical cancer screening (early detection of cancer can result in less costly treatment, enhanced quality of life, and, in some cases, greater likelihood of cure); ensured coverage of bone mass measurement tests to help women detect osteoporosis, and increased reimbursement rates for certain immunizations to protect seniors from pneumonia, influenza, and hepatitis.

Enacted legislation and took administrative action to fight fraud and waste in Medicare (Public Law 104-191). Since 1993, the Clinton Administration has assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 410% saving more than \$50 billion in health care claims. In addition, HIPAA law created a new stable source of funding to fight fraud and abuse that is coordinated by the HHS Office of the Inspector General and the Department of Justice. Since its passage, nearly \$1.6 billion in fraud and abuse savings has been returned to the Medicare Trust Fund.

Enacted legislation to help remedy the reimbursement concerns of health care providers (Public Law 106-113). The Administration advocated strongly for the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, which addresses flawed policy and excessive payment reductions resulting from the Balanced Budget Act of 1997. This legislation invests over X billion over Y years to moderate the impact of the BBA by placing a moratorium on therapy caps; increasing payments for very sick patients in nursing homes; restoring funding to teaching hospitals; and easing the transition to the new prospective payment system for hospital outpatients.

Enacted legislation to limit beneficiary hospital outpatient cost-sharing (Public Law ____). The Clinton Administration advocated for the reduction of the Medicare beneficiary coinsurance for hospital outpatient department services from its current approximately 50 percent of costs to 20 percent over a number of years, limiting the amount of coinsurance that a beneficiary pays for outpatient care to the Part A deductible (\$776 in 2000).

Enacted legislation to extend Medicare coverage of immunosuppressive drugs (Public Law 106-113). President Clinton enacted the BBRA which extended Medicare coverage for the prescription drugs that help prevent rejection of transplants for 42 months. The President's FY 2001 budget includes a proposal to extend coverage of these drugs for another 6 months, for a total of 48 months of coverage.

Issued an Executive Memorandum directing Medicare to reimburse providers for the cost of routine patient care associated with participation in clinical trials. The President issued an Executive Memorandum directing the Medicare program to revise its payment policy and immediately begin to explicitly reimburse providers for the cost of routine patient care associated with participation in clinical trials. HHS was directed to take additional action to promote the participation of Medicare beneficiaries in clinical trials for all diseases, including: activities to increase beneficiary awareness of the new coverage option; actions to ensure that the information gained from important clinical trials is used to inform coverage decisions by properly structuring the trial; and reviewing the feasibility and advisability of other actions to promote research on issues of importance to Medicare beneficiaries.

Proposed new, comprehensive plan to strengthen and modernize Medicare for the 21st century. This historic initiative would:

- **Make Medicare more competitive and efficient.** The President's plan adds price competition and successful private-sector management tools to Medicare. These policies manage cost growth and allow flexibility to adopt innovative private practices to improve quality and efficiency.
- **Modernize Medicare's benefits, including a long overdue prescription drug benefit.** The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine by establishing a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries and proposal eliminates all cost sharing for all preventive benefits in Medicare. The benefit also provides financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. In addition, the President's FY 2001 budget also includes financing for protections against the cost of catastrophic drug expenses.
- **Strengthening Medicare's financing for the 21st century.** The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Without new financing, excessive and unsupportable provider payment cuts or beneficiary cost sharing increases would be needed. The President proposes to dedicate \$299 billion over 10 years from the non-Social Security surplus to the Medicare Trust Fund, improving its financing and reducing debt.

V. PROTECTING MEDICAID AND IMPROVING LONG TERM CARE

Vetoed Republican proposals to block grant Medicaid, which threatened insurance coverage for millions of low income people and nursing home residents. The President protected the Medicaid guarantee for children, elderly, pregnant women, and people with disabilities. The President vetoed the Republican proposal to block grant the Medicaid program, and protected the guarantee of meaningful health care coverage or benefits to 37 million beneficiaries.

Enacted new actions to modernize the Medicaid program (Public Law 105-33). The Balanced Budget Act of 1997 (BBA) included several provisions to modernize the Medicaid program and increase state flexibility, including:

- **New steps to increase provider payment flexibility.** The BBA repealed the Boren Amendment and the cost-based reimbursement requirement for Federally qualified health centers and rural health clinics, providing states with greater discretion in establishing their provider payment rates. It also eliminated the burdensome administrative standards for payment to obstetricians and pediatricians, freeing providers from completing up to 300 pages of paperwork before being able to be reimbursed for their services.
- **New flexibility for Medicaid managed care programs.** The BBA allowed states to implement managed care programs without Federal waivers if beneficiaries have a choice of plans. States are permitted to enroll Medicaid beneficiaries in a health plan for up to six months and to guarantee Medicaid eligibility during this enrollment period. It also established Federal guidelines for new state-based quality improvement programs to ensure that managed care providers maintain reasonable access to quality health care.
- **Simplifies state options to expand eligibility and design community based long term care programs.** States able to manage costs below their per capita limits can expand coverage to any group of people with incomes below 150 percent of the Federal poverty level without a waiver. States can also scale back their coverage expansions to the minimum required by law if they wish. In addition, states can now provide home and community based services to elderly and disabled Medicaid enrollees below 150 percent of the poverty level without a Federal waiver.

Enacted legislation that extends the availability of the \$500 million fund for children's health outreach (Public Law 106-113). The welfare reform law put aside a \$500 million fund for states to use for the costs of simplifying their eligibility systems and conducting outreach. To date, only about 10 percent of this fund has been spent, and for nearly 30 states, the funding sunsets this year. The Balanced Budget Refinement Act eliminates the sunset and extends the availability of this fund until it is expended.

Launching a comprehensive nursing home quality initiative. The Clinton Administration has made ensuring the health and safety of nursing home residents a top priority and has issued the toughest nursing home regulations in the history of the Medicare and Medicaid programs, including increased monitoring of nursing homes to ensure that they are in compliance; requiring states to crack down on nursing homes that repeatedly violate health and safety requirements; and changing the inspection process to increase the focus on preventing bedsores, malnutrition and resident abuse. The Administration also established the Nursing Home Compare website, which provides prospective consumers facility specific information on nursing homes. Finally, the Administration recently instructed states to impose immediate sanctions, such as fines, against nursing homes any time that a nursing home is found to have caused harm to a resident on consecutive surveys, in order to put additional pressure on nursing homes to meet all health and safety standards. In addition, the implementation of provisions in the BBRA will invest over \$2.7 billion over 5 years in these critical providers, a \$500 million increase in reimbursement in 2000 alone.

Enacted legislation allowing the Federal government to serve as a model employer by offering quality private long-term care insurance to Federal employees. The Office of Personnel Management (OPM) will use its market leverage and set a national example by offering non-subsidized, quality private long-term care insurance to all federal employees, retirees, and their families at group rates. This proposal will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.

Approved state waivers to help seniors and individuals with disabilities to stay in their communities. The Clinton Administration has approved over 200 home and community based waivers nationwide, helping hundreds of thousands of people receive the critical health care services they need to function at home rather than requiring them to enter nursing homes in order to receive care.

Proposed new assistance for individuals with long term care needs and their caregivers. In 1999 and 2000, President Clinton's budgets included an historic long term care initiative. The President's 2001 budget included a \$3,000 tax credit for people with long-term care needs or their caregivers -- tripling the credit over last year's proposal and increasing the total investment in long-term care to \$28 billion over 10 years. This credit is the centerpiece of the President's historic long-term care initiative. The initiative tackles the complex problem of long-term care that affects millions of elderly, people with disabilities and families who care people in need. In addition, the initiative will:

- **Establish a commitment to provide services to assist family caregivers of older persons.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's patients can delay institutionalization for up to a year. This nationwide program would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to utilize a visible, reliable network to provide: quality respite care and other support services; critical information about community-based long-term services that best meet a families' needs; and counseling and support.

- **Improve equity in Medicaid eligibility for people in home- and community-based care settings.** This proposal would enable states to provide services to nursing-home qualified beneficiaries at 300 percent of the Supplemental Security Income (SSI) limit (about \$15,000) without requiring a complicated and frequently time-consuming Federal waiver. This proposal contributes towards this goal of giving people with long-term care needs the choice of remaining in their homes and communities.
- **Encourage partnerships between low-income housing for the elderly and Medicaid.** This proposal would provide \$100 million in competitive grants to qualified low-income elderly housing projects (Section 202 projects) to convert some or all units into assisted living, so long as Medicaid home and community-based services and services for non-Medicaid residents are readily available. As people living in these housing facilities age, their need for long-term care services rises, often leaving them with no choice but to move to a nursing home. This proposal would allow such people to “age in place” by funding the conversion of their units or the buildings that they live in into assisted living facilities. Only sites that bring Medicaid home and community-based services into their assisted living facilities would qualify for grants, to ensure that low-income elderly have access to this opportunity.

VI. PUBLIC HEALTH

Enacted historic comprehensive FDA reform that expedited the review and approval of new drug products (Public Law 105-115). The President signed into law the 1997 FDA Modernization Act that includes important measures to modernize and streamline the regulation of biological products; increase patient access to experimental drugs and medical devices; and accelerate review of important new medications. This reform builds on the administrative initiatives implemented under the Vice President’s reinventing government effort which have led U.S. drug approvals to be as fast or faster than any other industrialized nation. Average drug approval times have dropped since the beginning of the Administration from almost three years to just over one year.

Enacted unprecedented investments in biomedical research. Funding for NIH has increased by \$7.3 billion since 1993 – an increase of 73 percent. In 1997, the President made a commitment to increase the NIH budget 50 percent over the next 5 years. Since that time, the NIH budget has increased by over \$4.3 billion, for an all-time high of \$18 billion. Last year, NIH received \$2.3 billion, a 15 percent increase over FY 1999 funding levels, to build on the President’s commitment to biomedical research. With the \$1 billion increase proposed by the President in the FY 2001 budget, the Administration will be one year ahead of schedule in reaching the 50 percent goal. As a result, NIH now supports the highest levels of research ever on nearly all types of disease and health conditions, making new breakthroughs possible in vaccine development and use and the treatment of chronic and acute disease.

Enacted historic investments in reproductive health. Since the Clinton-Gore Administration took office, funding for domestic family planning services has increased by 58 percent. During his Administration, President Clinton has taken a number of steps to provide safe and effective family planning services to women, including launching a National Task Force on Violence Against Health Care Providers to coordinate the investigation of violence against women’s health care clinics nationwide. In addition, President Clinton has reversed the ban on the

importation of RU-486 and threatened to veto a provision that would have prevented the FDA from using government funds to test, develop or approve drugs that may induce medical abortion; defeated Republican proposals to require minors to obtain parental consent prior to receiving any Title X family planning services and make it illegal to transport a minor across State lines for the purpose of avoiding parental consent or notification laws; and upheld his veto of a bill banning certain late-term abortions without an appropriate exception to protect the life and health of women.

Enacted new investments in mental health prevention and treatment. Since the beginning of the Clinton Administration, funding for mental health services has increased by 65 percent for a total of \$631 million in FY 2000. In addition, the President's FY 2001 budget includes a new investment of \$100 million for mental health services, an increase of 16 percent over last year's funding level and a 90 percent increase since 1993. This includes a \$60 million increase for the Mental Health Block Grant, which provides integral support to States for services for people with severe mental illnesses and \$30 million for new Targeted Capacity Expansion grants to assist those with mental illnesses that the Mental Health Block Grant is not authorized to serve.

Enacted funding increases for AIDS research, prevention, housing, and treatment. President Clinton has worked hard to invigorate America's response to HIV and AIDS, providing new national leadership, greater resources and a closer working relationship with affected communities. During their Administration, funding for AIDS research has increased by over 89 percent at NIH, while funding for HIV prevention increased 47 percent. Funding for the Ryan White CARE Act has increased by over 338 percent. In 1996, for the first time in the history of the AIDS epidemic, the number of Americans diagnosed with AIDS declined. And between 1996 and 1997, HIV/AIDS mortality declined 42 percent, falling from the leading cause of death among 25-44 year olds in 1995 to the fifth leading cause of death in that age group. There has also been a sharp decline in new AIDS cases in infants and children.

Enacted new investments to protect the country from bioterrorist attacks. The Department of Defense has trained over 15,000 firemen and other first responders in 52 cities to respond to bioterrorist and chemical weapons attacks. By the end of 2001, local response systems will be operational in 52 cities. In addition, the Federal Emergency Management Agency will spend \$12 million to help States conduct training exercises and other activities to improve the ability of fire departments and other agencies providing emergency services to respond to a terrorist attack. HHS funding to improve the nation's response to the threat of bioterrorism has increased by 50 percent between FY 1999, the first year of HHS' bioterrorism initiative, and FY 2000. Since FY 1996, when HHS first received funding for broader consequence management of terrorist attacks, HHS funding has increased by more than 5,000 percent.

Issued a new regulation to ensure that consumers understand important information on over the counter drug labels. The President recently unveiled a historic new FDA regulation that, for the first time, requires over-the-counter drug products to use a new product label with larger print and clearer language, making it easier for consumers to understand product warnings and comply with dosage guidance. The new regulation provides Americans with essential information about their medications in a user friendly way and takes a critical first step towards

preventing the tens of thousands of unnecessary hospitalizations caused by misuse of over-the-counter medications each year.

Issued regulation that drug companies provide adequate testing for children. President Clinton directed an important Food and Drug Administration regulation requiring manufacturers to do studies on pediatric populations for new prescription drugs – and those currently on the market – to ensure that prescription drugs have been adequately tested for the unique needs of children.

Launched new effort to promote mental health and eliminate stigma. The Clinton Administration, under the leadership of the Vice President and Mrs. Gore, held the first White House Conference on Mental Health. At this conference, the Administration: released the landmark Surgeon General's report on mental health; took new action to ensure that the Federal Employees Health Benefits Plan (FEHBP) – the nation's largest private insurer - implements full mental health and substance abuse parity; launching national school safety training program for teachers and education personnel with the goal of reaching every school across the country; and launched a \$7.3 million landmark study to determine the nature of mental illness and treatment nationwide and to help guide strategies and policy for the next century.

Launched new effort to increase childhood immunizations. Concerned that too few children were receiving much-needed vaccinations, in 1993 the President launched a major childhood immunization effort to increase the number of children who were being immunized. Since 1993, childhood immunization rates have reached all-time highs, with 90 percent or more of America's toddlers receiving critical vaccines for children by age 2. Vaccination levels are nearly the same for preschool children of all racial and ethnic groups, narrowing a gap estimated to be as wide as 26 percentage points a generation ago. In addition, funding for childhood immunization has more than doubled since FY 1993. The FY 2001 budget includes \$1 billion to promote childhood immunizations.

Launched new effort to prevent teen smoking. President Clinton has imposed strict measures to keep cigarettes out of the hands of our children by restricting youth-targeted advertising. The FDA has also made 18 the minimum age to purchase tobacco products nationwide, requiring photo I.D.s for anyone under the age of 27.

Launched new effort to eliminate racial health disparities. President Clinton launched a new initiative that sets a national goal of eliminating by the year 2010, longstanding disparities in health status that affect racial and ethnic minority groups by setting high national health goals for all Americans, ending a practice of separate, lower goals for racial and ethnic minorities. Initiatives include: a major outreach campaign to send critical treatment and prevention messages to all Americans, with a special focus on reaching racial and ethnic minorities; invested over \$400 million to develop new approaches and to build on existing successes to address racial and ethnic health disparities; proposed a total of \$150 million over five years for grants to up to 30 communities, chosen through a competitive grant process; invested \$250 million investment over five years that would strengthen public health programs that have a proven record of effectively targeting these problems; and launched a major new foundation / public sector collaboration to address disparities.

Launched new public-private effort to ensure that children with emotional and behavioral conditions are appropriately diagnosed, treated, and monitored. The Administration launched an unprecedented public-private effort to ensure that children with emotional and behavioral conditions are appropriately diagnosed, treated, monitored, and managed by qualified health care professionals, parents, and educators. Federal actions include: (1) the release of a new, easy to understand fact sheet about treatment of children with emotional and behavioral conditions for parents; (2) a \$5 million funding commitment by the National Institute of Mental Health (NIMH) to conduct additional research on the impact of psychotropic medication on children under the age of seven; (3) the initiation of a process at FDA to improve pediatric labeling information for young children; and (4) a national conference on Treatment of Children with Behavioral and Mental Disorders to take place this fall.

Launched new initiative to fight childhood asthma. First Lady Hillary Rodham Clinton unveiled a new Administration initiative to fight childhood asthma through a comprehensive national strategy that includes new efforts to: (1) implement school based programs that teach children how to effectively manage their asthma; (2) invest in research to determine environmental causes of asthma and to develop new strategies to reduce children's exposure to asthma triggers; (3) provide funds to states and providers to help them implement effective disease management strategies that will insure we lower hospitalizations, emergency room visits and deaths from asthma; and (4) conduct a new public information campaign to reduce exposure to asthma triggers and dust mites.

Launched new efforts to protect volunteers participating in clinical trials. President Clinton announced that HHS is taking new steps to strengthen Federal oversight and increase the accountability of researchers conducting clinical trials with human subjects in order to protect the safety of individuals participating in all clinical trials, including: (1) issuing new guidelines stating that investigators must obtain new informed consent from participants after any unexpected death or serious adverse health event related to their clinical trial that may affect their willingness to participate; (2) issue new guidelines stating that Institutional Review Boards are expected to conduct an annual audit of safety protocols to ensure that informed consent has been obtained and is being maintained appropriately; (3) begin a systematic evaluation of the informed consent process to ensure that it safeguards the rights of trial participants; (4) proposing new civil monetary penalties of up to \$250,000 per individual and \$1 million per institution to promote compliance with current regulations; (5) expanding human safety training requirements for researchers; and (6) initial steps to address financial conflict of interest issues.

Launched new efforts to increase organ donation nationwide. President Clinton launched the National Organ and Tissue Donation Initiative in December 1997. During 1998, HHS issued a new regulation requiring hospitals to notify organ procurement organizations (OPOs) of all deaths and imminent deaths in order to ensure that opportunities for donation are not overlooked. As a result, organ donation increased 5.6 percent, resulting in the donation of an additional 17,000 organs to individuals in desperate need – the first substantial increase since 1995. HHS continues to work with health care organizations, faith organizations, educational organizations, state partners, and donor and recipient groups to educate the public about the importance of organ donation. In addition, the Federal government is educating its employees about donation,

in order to serve as a model for other employers. With assistance from the Office of Personnel Management, HHS has provided donation materials to over 100 Federal agencies for employees, including donation messages on pay stubs and full-page donation ads in the federal health plan catalog for the past two years.

Proposed new initiative to prevent medical errors and improve patient safety. In order to address recent reports that over half of adverse medical events are due to preventable medical errors, causing 98,000 deaths a year and costing as much as \$29 billion annually, the Administration called for: a new Center for Patient Safety; the development of a regulation requiring each of the over 6,000 hospitals participating in Medicare to have in place error reduction programs; new actions to improve the safety of medications, blood products, and medical devices; a mandatory reporting system in the 500 military hospitals and clinics serving over 8 million patients; and a nationwide state-based system of mandatory and voluntary error reporting, to be phased in over time. These initiatives will help create an environment and a system in which providers, consumers, and private and public purchasers work to achieve the goal set by the Institute of Medicine (IOM) to cut preventable medical errors by 50 percent over five years.

Proposed new protections for consumers purchasing prescription drugs over the internet. The President included a new proposal in his FY 2001 budget to: establish new Federal requirements for all Internet pharmacies to ensure that they comply with state and Federal laws; create new civil penalties for the illegal sale of pharmaceuticals; give Federal agencies new authority to swiftly gather the information needed to prosecute offenders; expand Federal enforcement efforts; and launch a new public education campaign about the potential dangers of buying prescription drugs online.