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RURAL HEALTH AND HEALTH REFORM

WORKSHOP

BEFORE THE

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UNITED STATES SENATE

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CONTENTS

APPENDIX I

APPENDIX II

PREPARED STATEMENTS OF WORKSHOP PARTICIPANTS

APPENDIX III

RURAL HEALTH AND HEALTH REFORM

MONDAY, MAY 3, 1993

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 10:30 a.m., in room 485, Russell Senate Office Building, Hon. David Pryor (Chairman of the Committee) presiding.

Present: Senator Pryor.

Also present: Kate Kellenberg, investigator; Bonnie Hogue, professional staff; Mary Berry Gerwin, minority staff director; and Priscilla Hanley, minority professional staff.

[This workshop was co-sponsored by the Senate Rural Health Caucus]

OPENING STATEMENT OF SENATOR DAVID PRYOR, CHAIRMAN

The CHAIRMAN. Good morning, ladies and gentlemen. I started to begin our meeting by saying welcome to this hearing, but this is not a hearing.

We chose a workshop format for our gathering this morning because we wanted to hear from a wider group of individuals, and we have a very splendid group today who have come from all over the country to testify and share their points of view. We will later allow questions from the audience, which, of course, during a formalized hearing we don't normally do.

This is one in a series of workshops and hearings on rural health that the Aging Committee has held in the last several years.

With the proposals now about to come from the White House relating to health care and health care reform, I don't think a workshop like this could be any more timely.

Many of the proposals actually made in these sessions have led to the passage of legislation that has helped rural communities keep their doctors and keep their hospitals open.

For example, the Finance Committee, upon which I also serve, has modified Medicare payment policies almost every year to be more fair to rural doctors and hospitals following the advice received at workshops just such as this.

There will be a full transcript of this hearing, and, by the way, we appreciate very much our friends at C–Span deciding to televise this session.

I regret that I cannot stay with you today. I've also just been informed that Senator Cohen will not be able to attend our workshop,

but I'm certain that he too will be interested in the transcript and his staff is representing him at the meeting this morning.

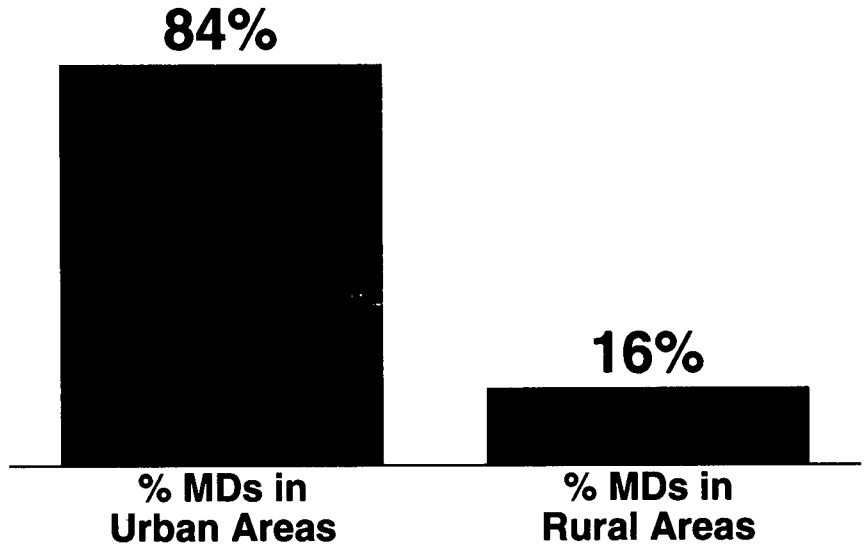
This workshop will focus on proposals that may improve access to medical care in rural communities. By way of introduction to this subject we've prepared some charts that I'll share with you in just a moment.

Recently the city of Little Rock was the site of a National Rural Health Summit sponsored by the Robert Wood Johnson Foundation and the Arkansas Department of Health that brought together more than 100 experts from across the country to talk about rural health care. These experts prepared recommendations for us on how to make health care reform work in rural areas. This morning's session will address these recommendations.

During this afternoon's session we're going to be considering an issue of considerable interest to me and one which has been discussed at the summit in Little Rock, and oftentimes in the Aging Committee. We'll be asking how we graduate more of the primary care doctors we need so desperately in rural America.

Our first chart shows that 84 percent of primary care physicians practice in urban areas. Only 16 percent of these doctors practice in rural areas.

Percent of Primary Care Physicians Practicing in Urban and Rural Areas



Source: Office of Technology Assessment (1988 data)

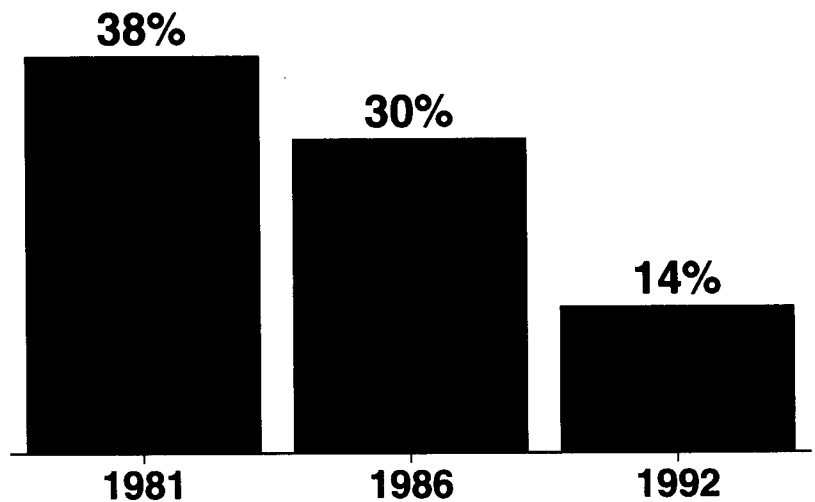
120124A.aging

This massive disparity in the distribution of primary care physicians must be addressed now.

Recently, the Physician Payment Review Commission made a far-reaching recommendation that we revamp all graduate medical education to get more medical school graduates into primary care. We'll be asking this morning whether we really need to go this far at this time.

Let's look at chart two, Jeff, if we could. This is a very revealing chart. The interest of medical school graduates in generalist careers has waned, and so what we're seeing is that in 1981, 38 percent of those graduating from medical school were going into primary—or what we call generalist—careers in medicine. There were 38 percent in 1981; by 1986, the number sharply drops to 30 percent; and by 1992, the number of graduates going into generalist careers in medicine has plummeted to 14 percent.

Interest of Medical School Graduates in Generalist Careers Has Waned



Source: AAMC

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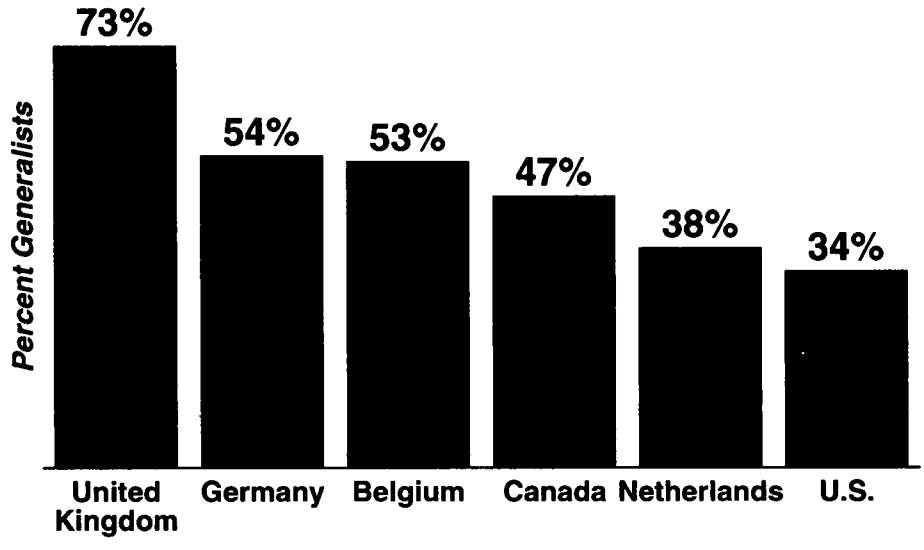
Now this is to me a very, very alarming figure. It is a problem I think too, if we could look at chart three, that most other countries are already solving. And I don't know quite why we're not solving it, but if we would look at the United Kingdom for generalists as a percentage of physicians, 73 percent are generalists. In Germany, 54 percent are generalists; Belgium, 53 percent; Canada, 47 percent; The Netherlands, 38 percent; and, finally, the United States where a mere 34 percent of doctors are generalists.

Generalists as a Percentage of Physicians:



Source: JAMA, 252:373-84.

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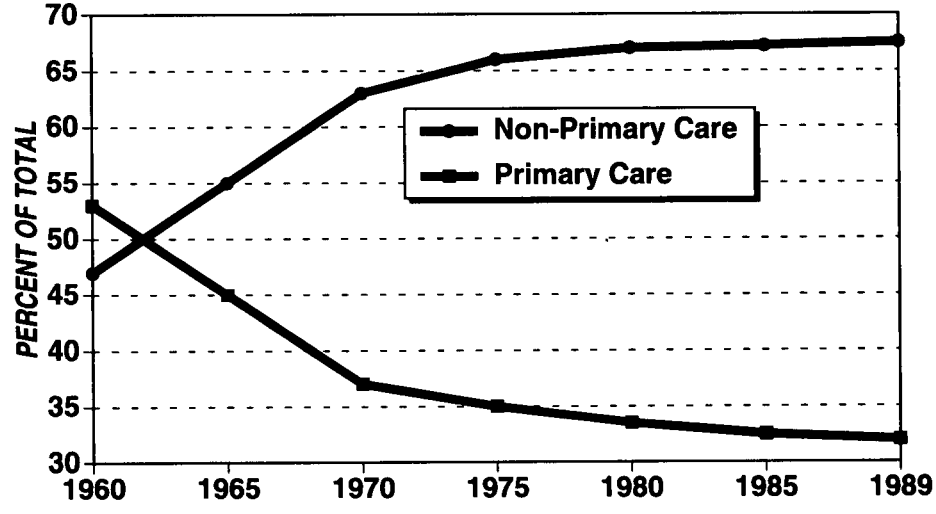
Even if we start to reform graduate medical education now, it's going to take a long time to fix this problem because it has taken a long time to get this bad.

This, by the way, is Jeff Human. He is on loan from the Department of Health and Human Services to the Aging Committee. He has been with us for several months, and, Jeff, I don't know how we got by without you for so long. You've done a great job, and we're going to turn the moderating challenge over to Jeff in a moment.

Looking at our next chart we see that in approximately 1962 the number of primary care physicians and the number of specialists was just about even. Through discussions with Jeff I've learned that a massive amount of new technology began to come to the forefront about that time. We then saw the number of specialists rise dramatically up until 1965 and on up to 1980. If we look at the lower line on this chart we see the percentage of primary care doctors go down just as dramatically as the percentage of specialists rose during that period of time. And now we see a huge difference—the last figure is 1989, I believe, between the percentage of specialist and primary care physicians.

A Steady Decrease in Primary Care M.D.s*
compared to other specialties, 1960-1989



* Refers to family physicians, general internists, and general pediatricians

Source: American Medical Association

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Our last chart shows that a higher percentage of primary care physicians leads to lower health care costs. We see the percentage of physicians in primary care; Great Britain at 70 percent—they only spend 6 percent of their GNP for health care—and you can see in Canada, it's 50 percent of primary care physicians and 9 percent of GNP is spent for health care.

A Higher Percentage of Primary Care Physicians Leads to Lower Health Care Costs

	Percent of Physicians in Primary Care	Health Care as a Percent of GNP
Great Britain	70%	6.0%
Canada	50%	9.0%
United States	34%	11.5%

Source: AMA Physician Survey

120124E.aging

Here we are with 34 percent of our physicians in primary health care and we're spending 11.5—and I imagine it's 12 percent by now—of our GNP on health care. We can see that the more primary care physicians a nation has, the lower percentage of health care as a percent of the Gross National Product expenditure.

One of our presenters this afternoon is Charles Cranford of the University of Arkansas Medical School. Would Charles stand? Charles is representing Dr. Harry Ward, the Chancellor of the University of Arkansas for Medical Sciences. These are people whose advice I have long valued over the years, and I am very glad that Charles could be with us.

Two people who could not be with us today in addition to our friend and colleague, Senator Cohen, are Senators Tom Harkin and Bob Dole, co-chairs of the Senate Rural Health Caucus. They both convey their regrets.

It's a little out of the ordinary, I might just add, generally for there to be hearing or a workshop on a Monday morning like this because so many of our colleagues are traveling and are getting back into town.

Once again, I've asked Jeff Human to moderate the workshop for me. Jeff, as I've said, is on loan to us. I hope we can keep him as long as we possibly can. He conducted a similar workshop for us recently on undergraduate medical education, and I appreciate his expertise and assistance.

Jeff, may I ask you to come up, and open our morning session?

WELCOMING STATEMENT OF JEFF HUMAN, MODERATOR

Mr. HUMAN. Thank you very much, Senator, and welcome again to everybody.

Just to put this in a little bit of perspective, we have a general problem in rural health in this country that goes even beyond the doctor problem.

During the 1980's, 10 percent of all of America's rural hospitals closed, and, with respect to doctors, we found on a per capita basis in the smaller communities we had less than half as many doctors as we did in the urban areas. And it was a problem that also reached into many other areas as well and continues to.

Rural occupations, such as farming and timbering, mining, are the most dangerous occupations in America, and the health hazards to rural farmers and others are very, very high. And this is a problem that also is more than a health problem. Just as surely as the hospitals are closing and the doctors are leaving, well, grocery stores are closing and schools were consolidating and closing, and so on.

So, as a result, we have a general problem in maintaining the viability of rural America, and, in particular, health services and other services, which would make it attractive for people to stay in rural communities and for people to move there.

And that is the context in which we had a rural health summit that was held in Little Rock to consider these issues. For this morning's session I am going to ask Nancy Barrand to bring with her the group of people who provided the leadership for setting up this summit to report back to us the findings of that summit and what's really important to deal with, given that we have a problem

now and we have a new situation confronting us—the possibility of health care reform, which could either help solve these problems or exacerbate them. And so Nancy and her group will be providing their advice to the Committee and to the Senate generally.

Nancy is a Senior Program Officer at the Robert Wood Johnson Foundation, and she's been deeply involved in questions of rural health care for some years. She has also served as a staff person in the U.S. Senate, and for the California General Assembly, and with the Institute for Health Policy Studies at the University of California at San Francisco.

So, Nancy, if you and your group could come forward, we will be glad to let you take over.

STATEMENT OF NANCY BARRAND, ROBERT WOOD JOHNSON FOUNDATION

Ms. BARRAND. Well, thank you. I want to thank Senator Pryor for the opportunity for us to come and talk to you about the meeting that we had in Little Rock to look at health care reform in rural areas.

Too often rural health care tends to be an oversight or an afterthought in our policy process, and our purpose in sponsoring this meeting was to look at rural health care under health care reform scenarios and to give visibility to some of the issues about how health care reform needs to address the problems that we have in rural areas.

I want to start by introducing my colleagues who are here with me today at the table. Starting from the right:

Dan Campion is an associate at the Alpha Center. The Alpha Center is a nonprofit policy institute here in Washington, D.C., and they have a grant from the Foundation to provide technical assistance under the Federal Rural Each-Peach Program. Dan is in charge of that program and the Alpha Center conducted and organized the meeting that we held in Little Rock last month.

Next to Dan is Dr. John Coombs. Dr. John Coombs is the Associate Dean for Regional Affairs and Rural Health at the University of Washington School of Medicine. He was a participant and one of the work group leaders at the meeting, and you'll be hearing from him a little bit later on when we walk through some of the specific recommendations.

Next to John is Dr. Ira Moscovice. Dr. Moscovice is the Professor and Associate Director at the Institute for Health Services Research at the University of Minnesota School of Public Health.

Next to me is David Helms, President of the Alpha Center. Again, the Alpha Center conducted and organized this meeting for us.

Sitting next to me is Charles McGrew who is the Director of the Section of Health Facilities Services and Systems at the Arkansas Department of Health. The Arkansas Department of Health cosponsored and hosted this meeting along with the Foundation. It was Charles who first brought to our attention the need for this meeting to occur. In a minute I'm going to ask Charles to make some opening remarks.

I also want to point out that in the audience we also have Linda Goldsmith, who is the Director of the Office of Rural Health at the

Arkansas Department of Health who was also very much involved with the meeting as well as Don Dickey who is also with the Robert Wood Johnson Foundation.

Let me give you a little bit of overview of the meeting. This was a 2-day meeting that we held in March. The first day was devoted to looking at various health care reform scenarios and how they might play out in rural areas, and you'll hear a little bit later on about some of the assumptions that we made as we looked at what health care reform might include.

We had, as Senator Pryor mentioned, 100 participants who represented researchers, health care providers, and health policy experts from across the country and really represented a diversity of opinion, as well as diversity of experience in rural health care issues.

On the second day of the meeting, we broke the 100 participants into eight working groups, focusing on specific topics of rural health care, and those are listed in the report that we've handed out. The work groups focused on service areas, supply of human resources, and network structure and formation, network financing, and network operations. You're going to hear a lot about rural health care networks and the importance of the formation and operation of these networks to creating the types of linkages that are necessary to provide access to health care in rural areas. Other work groups, focused on public health and State roles; State roles in organizing the service delivery system, as well as what the State role should be in allocating resources.

These eight work groups were asked to identify what they saw as the key issues for implementing health care reform in rural areas and to develop recommendations for how those issues might be addressed. These are the recommendations that we're going to talk to you about today.

I want to mention at the outset that the recommendations that we're going to be talking about do not necessarily in all cases represent the consensus of the 100 participants at the meeting. They do very much represent the tone and the discussion at the meeting and, in some cases, did represent the consensus of the group. But, as you'll see, there was debate and some diversity of opinion about these various recommendations, and I think you'll even see that represented on this panel up here.

I want to leave you with three themes that came up over and over again at this meeting, and you'll hear them again as we go through the report.

The first is that health care reform seems to represent a real opportunity to begin to address some of the issues that we all know persist in rural areas.

Second, however, is that there is some concern that health care reform may only address the financing side and may not address what is the critical issue in rural areas, which is the delivery system. In rural areas, health care reform means delivery system reform, and I can't over emphasize that.

As Senator Pryor was going through the charts, the problems of undersupply of providers, the problems of a lack of infrastructure, are problems that we all know too well exist in rural areas. And

health care reform is seen by rural residents as an opportunity to address some of these issues.

And, finally, the last theme I want to leave you with is the issue of flexibility. It is critical that there be some flexibility in how health care reform is implemented if we are going to address some of the special needs in rural areas.

The solution for how to address access in rural North Carolina may not be the solution for how we address similar problems in rural Montana. So, therefore, there is a need to look at how health care reform is implemented in rural areas and to allow as much flexibility as possible to take into account some of the special considerations in these areas.

With that, I'd like to turn it over to Charles McGrew to add his opening remarks.

STATEMENT OF CHARLES McGREW, ARKANSAS DEPARTMENT OF HEALTH

Mr. MCGREW. Thank you.

I'd like to thank the Foundation and the Alpha Center for the support and all the really hard work that went into making the conference what I think was a real success.

I'd like to get into the recommendations as quickly as possible, but I would like to repeat something I said earlier this morning because in talking to my colleagues around the country who work on rural health care issues at the State and local level on a daily basis and have been trying to come up with some solutions over the last several years to some of the problems that we face, one message that's really clear I think from everyone who is in the business out there is that what rural is not is urban health care in miniature. And I think that that's a message that people in rural America who are working in the system, are concerned about the system, would like to make sure that's clear.

You can take all the problems that you face in an urban environment and then overlay them with the fact—we talked about earlier and it certainly will be discussed here this afternoon—that we have a huge problem with providers. It's going to get worse instead of better, I think, as we get into network formation because it would be pulling some of the primary care physicians from rural areas into those urban networks.

We have massive problems in rural areas with transportation, we have folks that don't make as much money, percentagewise—fewer of those people have health insurance, all kinds of issues that are different when you're dealing in that rural environment.

So that's an issue and a focus that my rural colleagues would really like for you to keep in mind. With that, I'd really like to get into the recommendations so as to allow time for questions at the end.

Ms. BARRAND. We're going to ask David Helms to walk us through the cross-cutting themes from the meeting, and then he will moderate our discussion of the specific recommendations.

STATEMENT OF DAVID HELMS, ALPHA CENTER DIRECTOR

Mr. HELMS. Thank you, Nancy.

This was, I think, a very important opportunity for the rural community to come together. Health care reform was certainly well underway. They saw this as a tremendous opportunity to get their input into the process, and this report, as it has been developed, has been shared with the White House Working Group, and we have briefed the House of Representatives as well. I'll just start by saying that the rural participants see health care reform as a critical opportunity for addressing the fundamental problems in the rural delivery system.

You've already heard this morning about the acute shortage of primary care physicians, you've heard some about the financial problems facing small rural hospitals. Therefore, we see this rural reform as an opportunity to acknowledge that many parts of our country, the rural are underserved, and we're going to need to build a rural infrastructure, and we're going to have to build capacity in rural areas.

Secondly, you've heard that flexibility is very important. One area in rural America is not the same as another area in rural America. They are represented by as much diversity as may be there exist between urban and rural.

So as we think about health care reform, we'll need a range of options so that we can implement the reform and achieve the objectives and meet the very diverse local needs and utilize those tremendous local resources that are out there.

This diversity is going to require that States and communities then have flexibility to fashion systems in response to their unique circumstances. We've also learned from this meeting that the rural participants very much want to have a role and be meaningfully represented in efforts at the State level to ensure that they have a voice in how we implement health care reform.

Rural residents are often characterized by independence and a desire to maintain control over their local institutions, but we've also found that given information and resources, rural residents have the ingenuity and commitment to find solutions to their problems.

The fourth theme was the development of regional health care networks, which would deliver primary care through locally based providers, should be a fundamental strategy for restructuring the rural health care delivery system.

Rural residents are not particularly interested in having the urban-based systems ride out to rural areas and now take some interest in them, so they would like very much to have rural networks based with rural primary care providers, where they exist, as the fundamental building blocks in developing these systems. These systems would help use resources more efficiently and strengthen the practice of medicine in rural areas. Also, priority needs to be given to providing primary and preventive service locally.

The fifth cost-cutting theme is that the development of these networks will require a variety of approaches. You've heard a lot about managed competition, and there may be a few areas where we can really use the concept of managed competition. But I think most of rural America will be needing to adopt the concept of managed cooperation, and this will mean that we will have to find ways to

bring together the rural providers by providing better backup service, on-call service, providing better peer support, using telecommunication linkages—truly building systems that will link and support the rural providers that we do have.

Now dramatic changes are going to be needed if we're going to have an adequate supply of primary care in rural areas. Frankly, health care reform presents a real threat to rural areas. As our urban based systems discover the need and value for more generalist physicians, rural communities fear that they will be the victim of rural primary care physicians being recruited out of rural areas and into urban areas.

So we need to dramatically improve the supply of primary care physicians, and I think we'll have to worry about not having the ones we do have in rural areas moving into the urban systems.

So the health care infrastructure in theme number seven means that the people, the structures, and the systems need to be strengthened to assure access to essential health services. That will mean capital financing for some rural facilities and systems, human resources and even some additional capital resources to build and improve the transportation system. In some instances, we won't be able to take the services to the people. There, we'll have to build a transportation that will move the people to the services.

Clearly, we're going to have to upgrade emergency medical services and improve the telecommunication systems, and we're going to need managers sensitive to the needs of rural areas, to design those systems, and to involve rural residents in their operation.

Additionally, we're going to need some planning at the State and regional level to be sure that we have the adequate resources to build that infrastructure.

And, last, we think States should play a major role in implementing health care reform in rural areas. The States understand the diversity of their various communities, and we think they should be given considerable flexibility as we implement health care reform.

Now we have 13 recommendations, which we're going to share with you. I'm going to ask Ira to begin, and then I'll be calling on Dr. John Coombs to talk about some of the health personnel systems.

But, Ira, why don't you begin by talking about the criteria that we'll need for defining whether competition can work in a given area.

STATEMENT OF IRA MOSCOVICE, UNIVERSITY OF MINNESOTA

Mr. MOSCOVICE. The first two recommendations came out of the service area work group at the Little Rock conference. The first recommendation is define criteria for identifying areas where competition will or will not achieve the desired results.

At the workshop I heard the term geographically challenged to represent these kinds of areas. There was a real feeling that although health care reform offered a tremendous opportunity to help build up the infrastructure that David and Nancy mentioned earlier, there were going to be some areas where it would be very difficult to create a competitive market. And the feeling was that

it would be helpful if we could develop some guidelines, perhaps at the Federal level, that would help identify areas up front that are going to have a hard time developing a competitive market.

The notion was that they would just be guidelines and that determinations would be made at the State level, so that we're not envisioning a national standard.

Some people from New Mexico had already started doing work on that issue, and started identifying areas ranging from frontier and high poverty areas, to low density areas, to small city, to small MSAs, to major metropolitan areas.

The first recommendation suggests that we may be able to identify some areas that require special initiatives under health care reform.

The second recommendation suggests that States should have the responsibility for determining the geographic area served by health insurance purchasing cooperatives. The feeling here was that States really do understand their local markets and their rural areas better than the representatives from the Federal level and that it should be up to the States to make decisions such as whether they want one purchasing cooperative for the whole State, as several people have suggested might be appropriate in States like Wyoming? Or they want four or five areas designated, as seems to be the case, under health care reform at the State level in Washington or seven areas, as has been suggested, in New York State?

The issue is that there are a variety of ways that States might carve up their geographic areas, and that can be best accomplished by policymakers at the State level. This also would help us deal with border problems, which are going to arise under any kind of reform package that involves the development of networks.

Mr. HELMS. John, why don't you talk to us about the three major recommendations regarding health personnel.

STATEMENT OF JOHN COOMBS, M.D., UNIVERSITY OF WASHINGTON

Dr. COOMBS. The next three recommendations, three through five, really tried to shed some light on the direction of health care personnel as it relates to meeting future needs of rural health. The third, to establish national and State health personnel policy goals and to allocate training funds to assure that there would be an adequate supply of primary care providers for the future of rural health.

When we talk about, first of all, some definitions, when we talk about primary care providers, we are certainly talking about family physicians, and general internists, and pediatricians. But we're also talking about the so-called mid-level practitioners, the advanced registered nurse practitioners, the physician assistants, as well as the certified nurse midwives, in addition to both dental and mental health professionals.

So when you hear us say primary providers, we're really talking about that whole group of people.

Clearly, as was demonstrated earlier, we're looking at a significant gap in terms of primary providers for the future. The estimates are that the newly designed system may require as much as

50 percent. Again, maybe even 100 percent, again, what currently exists in terms of primary providers. And so how are we going to do that? And, clearly, it requires that all of the policies that are developed in terms of training and in terms of defining State needs within rural communities be directed in that direction.

I think the critical issues when we look at this though are also the removal of disincentives, and, hopefully, the introduction of incentives to move the work force in the direction of rural America. We're talking about the development, again, of a level playing field in terms of reimbursement. Clearly, there has been disincentives to providers moving into rural communities in the past, and that is something that clearly needs to be addressed for the future—that the goals have to be consistent with the needs of the population within a rural community, and that's not something that given the fragile nature of the infrastructure for health care delivery within rural communities, that has always been the case.

We also felt that in terms of—that the development of support for this, that those who benefit should pay. In the past, the funds, training funds, have largely come from the Federal Government in terms of the direct reimbursement—the Medicare passthroughs, as well as some of the Title VII, et cetera, funds.

We looked at instead the AHPs, as we were calling them then, the Accountable Health Plans. And, clearly, things have changed. We now might call those the health care alliances. We're going to hear of some changes in definitions, but it was the feeling at the conference that a mechanism should be developed, so, again, those who benefitted from the practitioners being there should also contribute to their training.

Along those lines, you haven't heard a lot about academic medical centers and where they should be positioned in terms of health care reform, and, clearly, they have to be part of the system so that the access to training activities and whatnot can be assured for the future.

The fourth recommendation was to re-orient medical education to focus on primary care and to provide clinical experience in rural practices. I heard the other day, for instance, that you can take the boy out of the country but you can't take the country out of the boy unless you send him to medical school. That, I think, calls for the need that we begin to look at rural opportunities, rural track training, if you will, so that during the course of medical school and into graduate medical education that opportunity can be there.

The focus has to be within the schools in terms of the medical schools on primary care training. There has to be shift away from the hospital base into the ambulatory setting also, and that the reimbursement or allocation of training funds must follow that. That was the consensus, I feel, of the people who were together in Little Rock.

As well, there has to be attention paid to the graduate medical education slots as they exist now, which, clearly, there is an abundance of focus specialists within the setting. We saw that earlier from Senator Pryor's charts, the direction since 1960. That's something that clearly needs to be looked at, perhaps, by the regulation of graduate medical education slots as well as still the attention to it in terms of the regional nature of that. We don't need to train

all the focus specialists in one community, for instance, within the United States but that has to be regionally distributed in some fashion.

You know, we talk a lot about primary care, but it's also something where we do need to pay attention to the focus specialties. Clearly, they need to be sensitized to the needs of rural communities and exposure to rural training, both in terms of direct as well as the indirect benefits of that, as well as their role in terms of outreach and some of the things that have been devised within the current system need to be paid attention to.

Finally, in this section on the recommendations, recommendation number 5 took on the issue of the inconsistency between States of scope of practice laws and some of the regulations around mid-level practitioners. It was the consensus of the group, which I facilitated in terms of human resources, that there needs to be Federal guidelines to assure consistency on a State-to-State basis of scope of practice as well as that the basic level of training would in fact lead to entrance level qualifications for mid-level practitioners.

This isn't the case at the present time. Not every State has facilities to train mid-level practitioners, and, consequently, the training which might occur in one State does not necessarily prepare them for entrance level or to be qualified for the scope of practice that might be allowed in another State.

Likewise, there has to be incentives to create movement of these trained people into the needed areas within rural communities. You'll see in the recommendation that it says, "to practice semi-independently." That was a difficult word for, I think, the group to come to. But, clearly, there are areas within the rural America, especially in frontier areas, where the remote placement of mid-levels in relationship to physicians who might also be overseeing or providing continuity for that individual that there needs to be some lead way created within the guidelines in the future.

Mr. HELMS. Thank you, John.

Already you know that health care reform is complicated. We have a Federal Government that we expect will be defining a minimum benefit package and standard benefit package that all Americans would have access to and would be establishing the rules for how the system would operate.

We know we have State governments and we fully expect that States will have a major role to play in operating this system. But now we have purchasing cooperatives, and you need to know that when we met in March, the language was health insurance purchasing cooperatives, and our report continues to use that language but some way to organize the market by pooling together the employees of small firms, public employees, the Medicaid program, et cetera.

We also are talking about building more integrated delivery systems, and at our meeting we were talking about accountable health plans, as it's been described by the Jackson Hull group. But whatever the language that comes out here, I think you need to think about we have States being a player, we have purchasing arrangements, health alliances at work, and we also have delivery systems being structured and developed into more integrated networks.

So we're now going to ask Ira, if he would, to talk about what would an accountable health plan serving a rural region need to be.

Ira.

Mr. MOSCOVICE. What the participants at the work group decided was that these kinds of accountable health plans would agree to make available the full range of services for all people in a designated geographic service area, providing the appropriate level of services, particularly primary care and preventive services, through locally based providers whenever feasible. I believe the key words in the recommendation are full range of services, all people, and locally based providers.

What is it going to mean when we say we're going to provide the full range of services for all people living in rural areas? If you think about a particularly isolated rural area, clearly, the full range of services are not going to be able to be provided at that local level. And this is where networks come in, the development of what are termed vertically integrated networks, where local rural providers are linked with other providers in larger rural areas or in urban based areas.

When we say all people, we're referring to people in rural areas that are very close to urban or metropolitan areas, and also people who are in isolated frontier areas very far away from urban areas. To do that, we will probably need to provide some incentives and structure to give health plans the ability to provide those kinds of services to all rural individuals while maintaining reasonable costs.

And, finally, we feel that locally based providers need to be taken advantage of in terms of their incorporation into the system whenever possible. We believe that under managed competition, health plans will want to take advantage of local providers who are doing a good job out in rural areas and they will become an integral part of any kind of network that's developed.

The focus of control of health care decisionmaking is going to need to remain out in rural areas if any kind of health care reform package is going to be acceptable to the residents of those areas. And that holds whether we develop top down, or urban based, networks that are appropriately linked with rural areas or we develop locally based networks that reach out to urban areas.

In either scenario, we feel it's going to be very important for the decisionmaking for health care to remain in rural America.

Mr. HELMS. We have heard that underserved areas are the hallmark of much of rural America. There is considerable scarcity. We're also very much worried about the fragility of the system that exists in rural areas, and one of our recommendations deals with the vulnerability of rural providers. We'll ask John to tell us a little bit about how we might protect rural providers.

Dr. COOMBS. Our seventh recommendation was given the vulnerability of some rural providers, rules should be established to protect them from unreasonable financial risk.

I think it's clear that as we look at mechanisms for financing the new system, capitation, and putting the provider at risk has been mentioned quite a bit. Rural providers, for the most part, have been pretty much immune from managed care systems. If we look at—perhaps, only 30 percent of providers in rural communities and

most of those are adjacent to metropolitan areas, or, in fact familiar with HMOs or familiar with the managed care mechanisms.

So, clearly, dropping something on them suddenly where they are put at financial risk is something which potentially is fraught with danger of the system collapsing, and David alluded to the fragility of it.

An overabundance of risk then will potentially force their departure. We've heard about the fact that primary care is at a premium, that it's something where there are going to be many, many jobs in urban communities. Many of those are going to be much more secure, much more structured. The potential is there then if, again, we increase the risk, increase the vulnerability of rural communities that we may see those providers who are there escape to go back to a more secure situation where in fact the risk is spread more broadly.

We need to ramp into that in terms of financial risk, we need to utilize mechanisms potentially, such as the area health education centers and our academic medical centers, again, to train rural practitioners who are there about the principles of managed care and how to in fact thrive in that situation.

That was the feeling of, again, our group in Little Rock that this needed to be done.

To ensure that, there's going to need to be an investment, I think, in that infrastructure. And I think that's going to be something that utilizing the mechanisms I mentioned as far as the AICs and the academic medical centers will perhaps allow us to move into that situation.

Mr. HELMS. One of the most hotly debated issues at our Little Rock conference was will we need to provide exclusive franchise arrangements for those provider systems that serve rural areas.

Ira, how did the group come down on that issue?

Mr. MOSCOVICE. The recommendation was that some areas will require exclusive franchising arrangements for alternative health plans, and/or provider network serving rural areas. While these kinds of franchises may be necessary, particularly in more remote or underserved areas, they are not necessarily going to be the vehicle or the dominant model in all rural areas.

Although some people at the conference in Little Rock felt that exclusive franchise arrangements made sense for many rural areas, the vast majority of people there said what we want to do is really not use these franchises as protection for local providers, but use them to help create incentives for special situations so that health plans will go out into an isolated area and develop a full range of services that are accessible.

We see this as being important to protect vulnerable populations that currently are receiving services, such as migrant farm workers. These arrangements would be time limited; they wouldn't necessarily be awarded once and then remain forever, instead there would be a limit on the amount of time that local providers would have an exclusive option on providing services to residents of their region.

The next recommendation suggests the following:

Without the ability to include populations covered under Medicare, Medicaid, and the Federal Employee Health Benefits Pro-

gram, many rural areas will have an inadequate population base to provide sufficient leverage on providers to participate in health plans or other provider arrangements under contract to purchasing cooperatives.

We know that we have hundreds of Medicare dependent hospitals in rural areas, and that in many of these areas we have at last half, if not more, of the population being served under Medicare. The concern is that if the Medicare population is not included up front in the reform package then a large part of the population base in some rural areas will not be covered under health care reform.

Rural providers in those areas might decide to opt out of the system and develop special programs to provide services to exempted payer populations. However, most rural providers may find it hard to opt out of the program because they serve just one population.

If a fee for service option or preferred provider arrangement option is going to be available as an option, providers who opt out of the program would be participating under health care reform either through a fee for service vehicle or a preferred provider arrangement.

Finally, a recommendation for rural providers who decide to opt out of health plans, was to subject them to regulatory oversight on prices and/or capacity. The concern was that we need to make sure that we contain cost in those environments where providers are deciding to opt out of health plans.

We don't want this regulatory oversight to be punitive though because providers—particularly those in frontier isolated areas—may decide that enough is enough and they'll stop practicing and locating in those areas and move on to other rural areas or other urban areas.

Mr. HELMS. Ira has now summarized the recommendations that we have about networks, how those networks are structured with purchasing cooperatives, what about the issue of franchise and opting out.

We said at the outset that States were very important and that they would play key roles in implementing reform, but we have two specific recommendations for things that States will need to do to assure that rural areas have adequate resources.

What were they, Ira?

Mr. MOSCOVICE. The first was that States should oversee the allocation of health care capital to support rural infrastructure development. The reason myself and others are very positive about how health care reform can play out in rural areas is that it is a tremendous opportunity to build up the rural infrastructure that's necessary for appropriate health care delivery. There was a strong feeling at the Little Rock workshop that there's going to have to be a separate capital financing pool that's available to help support the development of rural infrastructure for health care.

This separate pool could include capital from State bonding authorities, from Medicare capital payments, and from the portion of payments made by other insurers to cover provider's capital expenses. The States could best make the decisions in terms of allocating capital.

There was a suggestion that there's also going to be a need to protect new networks up front, particularly those who have assumed risk in any way, shape, or form. We could accomplish that through re-insurance vehicles.

And, finally, there was a strong feeling that to ensure that antitrust laws are not an undue hindrance for rural network development, changes in Federal and/or State statutes and supervision may be needed.

There was a concern that the literal application of antitrust laws may represent a threat to the availability of services in rural areas. Many of the lawyers that I've spoken to—some who were at the conference and others in States that I've visited—feel that antitrust laws are not a major barrier. They should not be a major barrier to the basic thrust of health care reform.

In Minnesota, the State implemented a State action immunity clause with its health care reform package. And up front in the legislative package that was passed, there was a clear statement that providers who would be dealing appropriately with each other in terms of developing integrated service networks would be exempt from the antitrust laws. However, it might be cumbersome to do this State by State. We need to look at Federal antitrust law to see if that could be changed if necessary.

The key issue is insuring that the public interest is met when we look at overcoming any antitrust barriers. States are going to need to clearly articulate what kind of policy they are going to be implementing that is not going to be supporting a competitive environment. And they need to clearly indicate how they are going to monitor and oversee any resulting organization arrangement that develops in such a scenario.

Mr. HELMS. Well, the participants in Little Rock were aware that the President would be introducing legislation calling for a national service program, and they didn't want to miss an opportunity. So our last recommendation would provide rural areas an opportunity to take advantage of that, and John is going to summarize that recommendation.

Dr. COOMBS. I think again this brought us back in terms of formulating this recommendation to the basic principle that we are dealing with a fragile infrastructure and that a service approach to this, a national service program, should be put in place to strengthen that so that the goals of it should be consistent with the other strong themes that we saw going through the conference.

One of those, of course, is that we get back to the basic issue, which is community focus; in other words, as well as local controls and a local control of that system because really what the whole principle of managed competition—the way it is being developed—is that it's a real top-down kind of activity. Instead, we are suggesting that the infrastructure within rural America depends upon that local control and the community focus to assure that the diversity of rural is met in terms of any system which is devised.

The one last thing that I would mention again is the theme that health care within rural America is very, very closely tied to the economic development also of the community. So it's something where when we hear about people saying that we need to centralize, we need to build bigger and faster ambulances and deal with

the issues in that respect, that isn't going to play well in terms of public health; it's not going to play well in terms of prevention; and, it's something that also is going to potentially erode at the economic infrastructure of rural America in which 25 percent of our population currently reside.

Mr. HELMS. We're about to go to your questions, and they've asked me to ask you to go to the microphone and identify yourselves. While you're coming in droves, I know, to ask your questions, I would ask Dan Campion to talk just for a minute about a program that already exists—passed by your Federal Government—called the Essential Access Community Hospital Program, which is about the task of building networks.

Dan, tell us about the EACH program.

Mr. CAMPION. One of the major fundamental themes coming out of the Little Rock conference, as you've just heard, is that regional rural health networks should be a fundamental strategy for restructuring the delivery system. And there is one Federal program that is making a start at the development of networks.

It is called the Essential Access Community Hospital Program, sometimes known as the EACH program. And the EACH program seeks to create networks in rural areas that consists of small rural primary care hospitals. It's a new category of hospital design just for this program, and these small hospitals would have a limited service capacity and be linked to a hub hospital, which would be the essential access hospital. So it's a hub-n-spoke design.

Major elements of the program are grant programs that assist rural areas in developing telecommunication systems, emergency medical systems, kinds of linkages that are needed to create networks. And there is a significant focus on the role of the State in this program. The program actually is considered a Federal-State partnership; States are given resources to create rural health plans under the program, and it's a program that can be viewed in this context of health reform as a model for how we can begin to use Federal incentives and a Federal program to work within the context of State governments doing planning that reach down to the community level and involve local decisionmaking.

So it is an important program to watch. There is a report in your briefing packet about networking for rural health, discussing this program. We're at an important point in the program's development in that within the next few weeks we anticipate that Secretary Shalala will be releasing the implementing regulations for this program.

So it's at a crucial point, and you can be in touch with the Alpha Center in producing more materials describing the seven States that are now in the program and the 30 networks that are being developed.

Mr. HELMS. Thank you, Dan.

We have some time for questions.

PETER REINECKE, STAFF PERSON FOR SENATOR TOM HARKIN

Mr. REINECKE. Peter Reinecke with Senator Tom Harkin who co-chairs the Senate Rural Health Caucus.

One thing that you all didn't talk about, and I was wondering, is whether there was much discussion at the conference on more of a short-term focus and that is the status of a lot of our rural hospitals and other providers.

Senator Harkin has introduced legislation, Senator Dole has introduced legislation as well, that would extend the Medicare-dependent hospital program that provides a little bit extra payment to a lot of our smaller rural hospitals that are dependent on Medicare so heavily.

And the fact that so many of our rural hospitals are really right, as of today, teetering on the edge financially.

I was wondering if there was any discussion about the short-term needs and also potential impact of short-term cost containment measures as part of health care reform on rural providers.

Mr. HELMS. I'm going to ask Ira and John in a second if they have a response to your question. I think in fairness we went off to Little Rock to try to understand what the grand design for health care reform, as we knew it then, might have for rural areas, but we understood your point that the rural health infrastructure was on the brink and was in very fragile state. And that's one of the reasons why you see in these recommendations coming out a need to protect the fragility of the existing system so we'll we have something to build on.

So while I don't think we spent a lot of time dealing with the very immediate issues, I think these recommendations would give support for anything that preserves the existing capacity, so that we'll have capacity to start to build and develop those networks.

But let me ask if either John or Ira would like to comment.

Mr. MOSCOVICE. I couldn't have said it better, but the only thing I would add would be that there's a feeling that we wouldn't necessarily be maintaining the status-quo vis-a-vis rural hospitals. For instance, the EACH program that Dan just described may support the use of capital for rural infrastructure projects.

I agree with David that many of the recommendations support new opportunities and new roles for rural hospitals, as well as maintaining and preserving those hospitals that are able to meet the inpatient needs of rural populations.

Dr. COOMBS. I would just add a couple of comments to those, and I agree with the previous comments.

There was, I think, a fair amount of trepidation in terms of putting together recommendations because of the fragile nature of things. I had mentioned earlier in my remarks about concern that in fact things will look more attractive now in urban areas potentially as networks come together. We know that, for instance, 60 percent—as was reported by The New York Times recently—60 percent of people who are graduating from medical school now and are under the age of 35 are now looking for employed jobs. They are in fact employed physicians, and, consequently, I think we're going to potentially have lots of good jobs which come to bear.

When we talked about short-term fixes though I think that there needs to be even more attention paid to that in the short-term as far as what was mentioned. A recent study that we just completed looked at the margins of rural hospitals, and to our alarm when we broke it down according to if the community was proximate to a

metropolitan area, or if it was isolated, or if the county was growing or not growing, the average on all of those hospitals were negative margins. And, consequently, I think that the effects, some of the ill-effects, of prospective payment over the past 10 years have really put many of the hospitals that are still alive in a very jeopardized kind of position.

So I would strongly support the initiatives you mentioned to address the immediate—now—so that as we look at the ramp up that I expect is going to occur perhaps over the next 3 to 5 years in the big fix that we can maintain what already exists in satisfactory shape.

Mr. HELMS. Okay, other questions?

Yes, sir. If you'll come to the microphone and again identify yourself?

DARRYL LEONG, M.D., NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Dr. LEONG. Okay, my name is Darryl Leong from the National Association of Community Health Centers.

My question has to do with whether these new networks would indeed stabilize the system to prevent unevenness or crises in certain essential service, and I would mention OB services as an example in rural areas where one or two physicians—if one leaves, and the other physician wants to leave and in some areas that have chronic shortage, how that system would assure that there would be some continuity of service? If you're pregnant now, you can be assured that you would deliver your baby at a local community.

The second one is a question for Dr. McGrew——

Mr. HELMS. How about if I take these questions one at a time. We'll come right back to you.

I think your point does illustrate thought and it underscores Nancy's point in the beginning. When we talk about health care reform, we'll often talk about financing and how we're going to change the financing system. When we start talking about rural, we're talking about real problems that exist in the availability of service and how those services are structured.

But maybe I will ask John, if he would, to comment on that.

Dr. COOMBS. Two comments on that. I think one of the things we've seen in the whole HPSA approach and looking at filling underserved areas is that frequently they fill up or at least they get to that critical mass and then suddenly they're no longer HPSA so that the scenario you just mentioned suddenly becomes on which throws the community into a crisis.

Just this past 2 weeks, I have been dealing with an issue in Seward, Alaska, for instance, where three family physicians, all doing OB, one was forced to leave because of problems; the two were left and they said, I'm sorry, we just can't continue to deliver babies. You're going to have to go to Anchorage, and if you've ever driven to Anchorage from Seward, you'll know that that's probably not something that's real exciting when you're two centimeters and about to have a baby.

What do we do about that? I think there are two things that I would suggest:

First of all, we have to have, I think, some local common sense, if that's possible, through organizations like HCVA where when we have a HPSA and it's filled up, we can make a decision that maybe just a little bit more to create a little less jeopardy for that community might be a good idea.

So adjusting what we're talking about in terms of critical need or shortage areas I think becomes important.

The second——

Mr. HELMS. John, there's great interest out here in knowing what a HPSA is—a Health Profession's Shortage Area.

Dr. COOMBS. Health Professional Shortage Area, previously known as HMSA, or Health Manpower Shortage Area and revised terminology. Thank you.

The second comment I think, and it becomes a State issue, is locum tenens. There needs to be some short-term relief of people to come in and to be paid a reasonable wage and some provisions made to in fact—for that to occur.

I know we've seen States that have successfully done that; it's difficult. I know that the University of West Virginia, for instance, has put in a program through their academic medical center and in talking to the Dean there I find that the problem is that they don't have enough capacity. They can't keep up with the need as they arise.

So there has to be, I think, some investment in that kind of system so that when fragile systems are put in jeopardy like you describe that we can have a SWAT team, if you will, come in and rescue it until more long-lasting relief can be found.

Mr. HELMS. Ira also had a comment.

Mr. MOSCOVICE. I think that's where networks can help. We've just finished a study in Minnesota of physicians who have stopped practicing obstetrics. The primary reason they stopped practicing OB was not malpractice concerns. The primary reason was simply the amount of time it took to practice OB and the burden on them. The development of integrated service networks, where you're linking rural providers with other providers outside the area, can facilitate locum tenens arrangements and other kinds of support structures for rural providers.

We also finished a study in Colorado that suggests that most rural primary care physicians in that State are in solo practice and are not linked very well with other providers. We think health care reform and network development can help support OB services in rural areas.

Mr. HELMS. You had a second question?

Mr. LEONG. Yes, the second question has to do with the standard care in a similar issue over Mr. McGrew's opening comments about not being driven by urban standards. And, again, I think that—I've worked in both areas where the standard would be that you'd have to have a crash C-section in 30 minutes in a rural hospital, and, again, that kind of standard would not necessarily be malpractice—again, from a medical standpoint—might drive you away from doing OB.

Dr. COOMBS. Just a comment. I agree and I think this question is asked frequently—are there two standards of care; in other words, is there a standard for urban and a standard for rural?

I've always answered that by saying that I don't think so. I think there's only one standard of care, but there are modifiers to that standard which clearly the geographic barriers and a variety of other things—access to technology—will modify how that is delivered in any given community. That's a tough one though when you start talking about malpractice, and something that needs to be taken into consideration.

Mr. HELMS. Other questions? If not, I'll turn this back to Nancy Barrand for any closing comments.

Do any of you want to ask your questions?

Mr. HAWKINGS. Yes, sir.

DAVID HAWKINGS, THOMPSON NEWSPAPERS

Mr. HAWKINGS. I am David Hawkings with Thompson Newspapers. I know I came in late, but are any of you willing to venture a prediction as to how many of the recommendations from Little Rock will be included?

Mr. HELMS. Oh, I suppose that's my job.

I think that all of them will be given very serious consideration because rural is a very important component of this country, and I think even politically it's going to be hard to sell health care reform to this country without addressing adequately some of the rural infrastructure issues.

We were joined in Little Rock by Secretary Shalala and Carol Rascoe, and they made it very clear—certainly from the Administration's point of view—and as we have met with Members of Congress and did these briefings on the Hill, we understand that rural is a central issue and will have to be addressed. And I think we're beginning to see that, as this concept evolves, as we try to re-organize markets and try to build integrated delivery systems, we're going to have to do some different things in rural. But that doesn't mean that these recommendations won't be understood and taken advantage of, and I can say from our meetings even with the White House task force that there's considerable understanding of these issues.

Mr. CAMPION. I would just add that the implications of these recommendations are not just short-term. There's a lot of long-term work to be done. We're talking about infrastructure development, network development, which will require not only capital investment and personnel policy goals being developed to get the right amount of personnel in rural areas, but also the development of relationships. Networking requires that providers come to know their colleagues who have other specialties and expertise who require rural residents understanding that maybe the local rural hospital has now a different role within a network setting.

So there are a lot of educational relationship components to this so that it's a long-term process to include in the rural system.

Mr. HELMS. The one issue to watch fairly closely, and I probably wouldn't predict that this one might be taken, but that will be this issue of how large the population base is for the purchasing cooperative that affects rural areas and whether or not they permit the Medicare program to be the provider network and the population served by the Medicare program, whether they can be given some

kind of a waiver or exemption and to be brought into that purchasing cooperative in rural areas.

I think that will be a very hot issue. Some believe that that's essential; others not. But you can watch that one closely.

Ms. BARRAND. I think, as you've heard, health care reform is going to be difficult to implement. It may be particularly difficult to implement in rural areas, and these recommendations are really offered as a way to begin to address some of the issues that might play out as we see health care reform being implemented in rural areas.

On behalf of my colleagues here, I'd like to thank you for the opportunity for having us present this meeting and I'll turn it back over to Jeffrey Human.

Mr. HUMAN. Thank you very much. And on behalf of Senator Pryor and Senator Cohen and the rest of the members of the Aging Committee, I'd certainly like to thank all of you for a very illuminating presentation this morning.

Before we break for lunch, I'd like to make just a few announcements:

First of all, since we've got an audience here who's interested in health care, I'd like to let you know about an upcoming event later this week and that is a Senate Aging Committee hearing on preventive health: "An Ounce of Prevention Saves a Pound of Cure," that will be held at 10 a.m. on May 6 in room 562 of the Senate Dirksen Building. This hearing will explore how lifestyle choices about tobacco, alcohol, and nutrition affect the aging process and health care costs. And we will be exploring how Federal policy can reduce those costs.

I'd also like to acknowledge the presence of some of the members of the staff of the Aging Committee who are with us this morning:

On Senator Cohen's staff, the Minority Staff Director, Mary Berry Gerwin, and Priscilla Hanley, who are in the back. If you can raise your hand or stand for just a second. We are real glad to have you with us. We've already said that Senator Cohen regretted that he couldn't be with us.

Kate Kellenberg, of Senator Pryor's staff is with us. Please stand for a moment. Kate is taking over rural health activities for the Committee.

And Bonnie Hogue, who is in the audience, if you can stand for a moment, Bonnie. Bonnie also handles health activities for the Committee.

If there is any way to summarize some of the recommendations of this Committee and what happened at the summit in a little different way, it is around the concepts of equity and self-sufficiency.

When the century began, 60 percent of the people of America lived in rural areas and now that percentage is 25 percent and falling. And I think people in rural areas need to feel that when the Nation designs any new program, that it is designed for them as well as for the people who live in the urban areas.

By the principle of equity, I mean that if we're talking about health care, at a minimum, they should have access to primary care.

In terms of self-sufficiency, I think that people who live in the smaller communities of America feel that if they are to sustain the

populations in rural areas and the services that they need to keep their communities alive and viable, then they need a measure of control over what happens as well. And I think we've come back to that again and again this morning, a request that self-sufficiency in health care would be respected as we design a new system.

And those recommendations that we have heard this morning I think are consistent with those principles of equity and self-sufficiency.

With that, we'll now break until 1:30 when we will be back again.

Thank you.

[Whereupon, at 11:55 a.m., the Committee recessed to reconvene at 1:30 p.m., the same day.]

AFTERNOON SESSION—1:36 P.M.

Mr. HUMAN. On behalf of the Senate Special Committee on Aging, I would like to welcome you folks back to today's workshop on rural health care and health care reform.

This morning we looked at the problems the residents of the Nation's smaller communities currently have in getting necessary health services. We heard a report from a National Rural Health summit recently held in Little Rock on how to address these problems if health care reform is enacted, as President Clinton has proposed.

This afternoon we're going to look at perhaps the single biggest problem facing rural areas: the shortage of primary care physicians and one important way that it can be addressed, by reform of graduate medical education.

Can we reform graduate medical education in such a way as to lead to more primary care physicians and less specialists.

I'm conscious that some of you folks who are watching this on C–Span may need a few definitions to help you follow this as we go along. When we speak of primary care or generalist physicians, we ordinarily mean three kinds of doctors—family physicians, general internists, and general pediatricians.

These are the doctors with the broadest training, the doctors we see at the onset of not feeling well. If our problem is serious, they may refer us to a specialist, but they can provide the bulk of all of the health care that we are going to need, all by themselves.

Now Senator Pryor left us with a chart* this morning that shows that the percentage of doctors who are in primary care, the blue line on the chart there, is only 34 percent and is continuing to decline. The rest of the doctors in America today are represented by the rising red line. They are the specialists.

He also told us that of the primary care doctors who are serving in this country today, 84 percent are located in urban areas and only 16 percent in rural areas. So we're short of primary care doctors to begin with, and we're particularly short in rural areas.

Now there are many ways to address this problem, and we probably have to try a lot of approaches all at once.

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* See p. 3.

Right now, for example, under Medicare we pay rural physicians less than we pay urban physicians, and we pay primary care physicians less than we pay specialists.

Senator Pryor has introduced legislation to give tax breaks to physicians who serve rural areas, as one type of a remedy, and I believe that it will help.

We need also to reform undergraduate medical education, the 4 years that would-be physicians spend in medical schools, so that we place more emphasis on community practice and less in hospital practice. We need to send medical students out into communities to practice who are more comfortable with community practice and are more likely to serve local communities as primary care physicians.

But today we are going to consider the 3 years that usually follow medical school. This is what we call graduate-medical education, and our speaker who is going to introduce this subject, and also make a rather far-reaching proposal for our consideration in the Senate, and in the Nation, is Anne Schwartz.

Anne is a Senior Analyst with the Physician Payment Review Commission. This is an advisory commission to the U.S. Congress that looks at how doctors ought to be paid under Medicare. It is a commission that has made a number of recommendations to the Congress that have been accepted and resulted in better pay for primary care physicians and better pay for rural physicians, even though we still have not achieved the equality that we need to greatly increase the supply of physicians in rural areas.

Anne holds a master's degree and is working toward a doctorate in health policy from Johns Hopkins University. She has worked as a staff member in the U.S. House of Representatives for the Select Committee on Children, Youth, and Families, and she has worked for a Member of the House of Representatives as well.

Her work at the Physician Payment Review Commission has addressed graduate medical education and physician supply, physician payment, and access to care under Medicaid and beneficiary issues as well.

STATEMENT OF ANNE SCHWARTZ, SENIOR ANALYST, PHYSICIAN PAYMENT REVIEW COMMISSION

Ms. SCHWARTZ. Thanks, Jeff.

What I'm going to talk about today are the recommendations of the PPRC made in our March 31st report to Congress on Graduate Medical Education Financing. I also have a very brief disclaimer, which is that when we were designing this policy we did not specifically look at the problems of rural America, although I think that the policy is sufficiently flexible that rural interests can certainly be accommodated.

Let me also say that these recommendations really sketch out a vision of a new system of graduate medical education financing, and there are some places in which our vision may not be blurred but we have some blind spots. There are many details that still need to be filled in, and we're going to be working on that—both at the Commission level and in dialogue with various groups that are interested in our work.

So if you see a glaring omission here, do not fret; let us know, and we would like to figure how to address those omissions.

Let me just say a little bit about the PPRC and what we're doing in the area of GME financing.

Most people know us as the group that brought you the Medicare fee schedule. But in 1990 our mandate was substantially expanded to include a number of other topics, which include physician supply, specialty distribution, and financing of graduate medical education.

So it is in our mandate to look at this issue, and the impetus for the mandate, as we understand it, is a concern by Members of Congress about the rising expenditures for health care, both for the Medicare program and for the Nation, and how both physician supply and specialty distribution influence expenditures; also a realization that for years we've been tinkering with several millions of dollars of public health service moneys by giving grants for family practice, general internal medicine, and general pediatrics, while the Medicare program is currently spending about $5 billion in payments to teaching hospitals which support graduate medical education in one way or another.

So our directive from Congress was to look at the potential of using Medicare money spent on graduate medical education financing as a way to influence broader changes in physician supply and specialty distribution.

We started our work in graduate medical education about 2 years ago, and we did what we always did well, which is read a lot, talk to a lot of people, and figure out the lay of the land before we start making recommendations. And we came up with three working assumptions on which we would base our work.

The first relates to physician supply, and our assumption was that physician supply right now is just about right or will soon exceed that required to meet national health care needs. The Commission's view is that physician supply, if unchecked, if the growth continues to exceed the growth of the population, this growth will undermine other efforts to bring health care costs under control. We don't know particularly why that may be. It may be because physicians will be serving patients whose demands were currently unmet, or whether because physicians are able to continue demand for their services even as prices increase.

But, in any case, the Commission felt that it was not a need to increase supply—if anything there was a need to hold the line where we are.

Our second goal relates to specialty distribution, as Jeff just said, and the Commission assumed that there are too many medical subspecialists—And by medical subspecialists, I mean specialized fields of internal medicine, such as cardiology, gastroenterology, and endocrinology.—And too many specialists in some of the surgical specialties relative to the number of primary care physicians. The availability of graduate medical education financing has been part of the problem in getting us to the specialty distribution that we have now.

And, finally, our third assumption is that because of the concentration of GME financing in the hospitals, many physicians are getting their entire training in the hospital and lack the appro-

priate training experiences that will prepare them for practice in ambulatory settings. This is particularly important now as over the last 10 years we've seen more and more care move out of the hospital while training has pretty much stayed in the pattern that it's been since the beginning of the century.

We've started this work before health system reform seemed like it might be a possibility, but we're very pleased about that development because it presents new opportunities for changes for graduate medical education financing, and it certainly creates an opportunity to coordinate the policies affecting physician training with those affecting physician payment and the organization delivery of health services.

As a bit of a prelude before I get into the policy, let me just give you a feel for how residency training is structured in this country and how it's financed.

First of all, the creation of residency programs is within the hands of the medical profession which accredits residency positions and decides whether a position can open in a particular hospital in whatever field. The financing is provided almost entirely through hospital patient care revenues, but most of this is not explicitly designated as money for graduate medical education financing.

The Medicare program, however, does have an explicit payment for GME financing. In fact, it has two payments:

The first is called the direct payment, and that's the payment made to hospitals to cover what they call direct costs—resident salaries, faculty supervision, and administrative overhead—and those are per-resident payments to hospitals.

The second is the indirect costs, indirect payment, which is an extra additional payment to teaching hospitals to recognize the higher cost of providing care in teaching hospitals. Because that latter factor is not explicitly for training costs but just the fact that teaching hospitals cost more, the Commission has primarily focused on mechanisms that affect the direct cost.

In any case, these two together are about $5 billion annually for the Medicare program. Nobody has a really good handle on what the total cost of graduate medical education is because it's buried in multiple places. It's buried in the fees that are paid to faculty physicians, it's buried in the charges paid to teaching hospitals, it's buried in research grants, but it's probably somewhere between $8 and $12 billion.

That's about as good as we can get.

Looking at this world, what were the goals that the Commission came to as it started its work?

Our first goal would be limit future growth in resident supply. Right now there are about 86,000 residents in training. Enrollment in medical schools has been relatively flat over the past decade while training for residents has grown by about 25 or 30 percent.

Our second goal would be to rationalize the allocation of residency positions to achieve the goals of specialty distribution and potentially to better serve rural areas.

And, third, to make institutions sponsoring training programs more accountable to the Nation's health care needs so that the focus of training should not just be on the needs of a particular

teaching hospital, but on what should be the supply and distribution of physicians more broadly.

We've come up with a five point plan for changes in the financing of graduate medical education under health system reform. It's a mixed public-private model, meaning that there are roles both for the Federal Government and for the private sector. And what I'd like to do is go through each of these five points and give you the highlights of each.

The first point is that there would be a congressionally set limit on the number of residencies to be funded. Right now, as I've said, there is no limit as Medicare will pay for as many positions that could be created. Our goal is that the number of first year positions would be set to equal the number of U.S. medical graduates plus 10 percent, and we see those reductions are being sequenced in over successive classes of first year residents. So you wouldn't have a situation where someone was in their second or third year of training and then suddenly that residency slot didn't exist anymore. We tried to structure a policy that would avoid pulling the rug out of students already in training.

Let me just give you a sense of what this 110 percent limit would mean.

For the class of residents that started last year on July 1, this would have meant 2,500 fewer slots and over time it would lead to reduction of about 11,000 residents. And that's on the base of 86,000 that I mentioned earlier.

One flaw of this policy is that it's based on whatever current medical school enrollment is, so certainly it could be subverted if medical schools continue to increase their enrollments. We have some concern about that, but there are very few policy levers affecting medical school class size. It just might affect what the decision—the limit might be.

Once Congress sets this limit in statute, we see the creation of a Federal commission created for this purpose to determine the distribution of those slots by specialty. We see this body using objective data and input from interested parties, having a research, evaluation, and planning function so over time the decisions could be informed by changes in the health system. So you could think about, well, what is the growth of managed care and organized systems of care? What does that do to the demand of residents and for physicians in different specialties? What is the availability of a new surgical technique or a new diagnostic tool that now allows us to treat or diagnose a condition that we couldn't before? How does that affect the demand for physicians in different specialties?

We have no explicit recommendation on where this commission should be placed within the Federal Government. It could be a congressional commission, it could be within the Department of Health and Human Services, it could be an independent Federal agency, or, alternatively, if as a part of health system reform a national health board is created, it could be a sub-board of that board.

The third point of this model is where the private sector comes in. We see the decisions of which slots to fund being made by the accrediting bodies that exist already within the medical profession. And they would select the slots to be funded based on educational quality.

Let me just give an example of how this might work.

There's 110 percent limit and the Federal commission gets to decide how to divvy up that number of slots among each of the specialties. So say dermatology gets 100 positions that will be funded; this is communicated to the accrediting body that governs dermatology residencies.

Well, say there are 130 dermatology slots out there right now. It would be up to that accrediting body to figure out which 100 of the 130 should be funded and primarily should be based on educational quality but it also could be based on some other considerations that might be specified in the legislation, such as commitment to training underrepresented minorities or perhaps the record of graduates at the program locating in underserved areas—rural or urban.

These accrediting bodies have information to make these decisions. At one point there was some discussion within the Commission about why don't we just have a Federal agency do this and everybody would submit information and we would make a grant?

But it was thought that the residency programs were already having to submit this information on a regular basis anyway about their faculty, their facilities, the volume of services they provide, their patient population. Why not just make this one process? It also creates a less intrusive role for the Federal Government. It keeps the Federal Government out of specifying what the content of training should be. There's clearly a need, however, to ensure some accountability so that the accrediting bodies do their work in a way that's consistent with Federal policy goals.

On to the fourth point, how do you make this stick? And the answer, of course, is money. The fourth point of our policy is that payment for direct costs of graduate medical education would be made from a national financing pool from which all payers, not just Medicare, would contribute a percentage of premiums or payments for medical care.

For example, a 1-percent contribution would add up to about $8 billion, which falls in the range that I mentioned earlier.

A second component of this financing would be an option for the payments not just to be made to hospitals as they are now, but to other bodies as well. For example, the payment could be made to the residency program itself.

This is a key point for encouraging ambulatory training because you have a situation now where the hospital is really the home for all residency programs and this effects the extent to which programs can get students into outpatient training. They are always in a sense cheating off their hospital base. If you give the money to the program, instead you could have the ambulatory site be the home base and then have the hospital training, which is, of course, an integral part of medical training, be a supplement to their home base on the ambulatory side.

We see this as being an option. It could be to the hospital, to the medical school, or to the program, where appropriate. And different things will work in different regions and in different specialties.

And, finally, the third component of our financing recommendation is that there would be a standardized prospective payment for each resident. Right now, as I mentioned earlier, the per resident payments are based on historical costs so you have a situation

where some hospitals are getting paid $11,000 to $15,000 for residents and others are being paid $100,000.

Now that's not the salary for the resident; that reflects a lot of other costs. But it's the view of the Commission that a standardized prospective payment, perhaps with some variation based on geographic area, would be appropriate.

And, finally, the fifth point of our policy is what we call a transitional relief mechanism. Every time that you go out and talk about getting rid of residents, or reducing the number of residents, or taking residents out of the hospitals and putting them on the outpatient side, the hospitals say, well, how are we going to take care of our patients? What are we going to do with—how are we going to take care of people and what are we going to do for professionals? And these are clearly essential service needs that teaching hospitals have, and any policy that's going to have any chance has to be able to accommodate these needs.

We've talked to a number of people around the country in different types of institutions that have had a lot of success with a number of different types of approaches. In some places, it's hiring nonphysician practitioners such as nurse practitioners and PAs to help cover when the residents are moved off the teaching service; in other places, it's requiring more commitment and responsibility on the part of the attending physicians; in other places, it's hiring more staff physicians; in some places, it's reconfiguring or simply closing a few services.

We view the transitional relief mechanism as essentially a grant that would be available to teaching hospitals on a time limited basis, and, hopefully, with preferential consideration for institutions serving the poor. We did one estimate of what this would mean, where would the money come for it, and we found that under the Medicare program, the 110-percent limit would save about a half a billion in Medicare payments, which could then be funneled back to teaching hospitals for these transitional relief grants.

So what are the implications of the recommendations? Well, I see a couple that are both pluses and minuses.

On the plus side, this policy for the first time tries to link the decisions about financing with those determining the supply and mix of residency positions.

On the other hand, there's a potential problem of physicians funded outside the system from other sources of revenue. The Commission is going to look at some different options that might be available because we clearly don't want to have a policy that just creates incentives for people to figure out a way to get around it.

A third implication is the need for complementary policies affecting medical education and practice environment.

Just prior to coming over here this afternoon, I was speaking with a group of medical students and their view was any policy that limits the number of subspecialty residencies will only make those positions more attractive, more competitive and make primary care less desirable. And I think their views reflect the fact that as students, they are being told from the day they step in the door in medical school and maybe even as undergraduates that primary care is not the place to go if you're smart and ambitious.

So clearly there's a need for other policies affecting medical education and the practice environment that sends a message that primary care is intellectually challenging, that it can be financially rewarding, and that we value it as a society.

Work that the Commission is doing in other areas such as broader adoption of the Medicare fee schedule, changes in the resource base practice expense component of the fee schedule, support for the National Health Service Corps, and support for primary care research are all components of improving the undergraduate experience and the practice environment.

And, finally, is the issue of how effective would this policy be given the length of the pipeline? If you think about it, the average 35-year-old physician can expect another 35 years of active practice, and this means it will take a very long time for any policy affecting today's first year residents, to affecting the entire physician population.

One suggestion that has come out is opportunity for specialists to retrain, get better training in primary care, and be re-tooled. And we would use the talent and resources of the physician community that's out there to help us address these problems. One of the things the Commission will be looking at over the next year will be how could you restructure retraining, what would it take for a physician to re-tool, what are the incentives that would be available, and what would be the appropriate levers to encourage such retraining?

And that's our policy, and I'm happy to take any questions on it.

Mr. HUMAN. Anne, I'm going to put off the questions for a little while, and I'd like you to stay up with us because now that we've heard from you, what I'd like to do is bring up the first of three panels that will be responding to your proposal today. And then we'll try to work a little time after each panel to discuss with the audience involved as well.

So if the first panel could come forward, Bob Dickler, Marc Rivo, Bob D'Alessandri, and Charles Cranford.

We're going to start with Bob Dickler as the first response, and when I say response, that's perhaps too narrow a word because these folks have been asked to comment on the PPRC proposal but also to advance any proposals they might have. The idea here this afternoon is to give the Senate Special Committee on Aging members and the Members of the Senate generally advice on whether we have to go as far as the PPRC approach to get more of the primary care physicians that we need in this country or whether there are other approaches that we should be considering as well.

Now Bob Dickler is very well qualified to do this. He is Vice President for Clinic Services at the Association of American Medical Colleges, which means the 126th allopathic medical schools in this country—most of the medical schools in this country. We will talk about 14 more a little bit later on in the program.

Among other things at the Association, he is responsible for the analysis of public policies affecting hospitals and physicians. Mr. Dickler received a master's degree in hospital and health care administration and pursued doctoral studies at the University of Minnesota. He has been chief executive officer of the University of Colorado Hospitals. He has also been at the University of Minnesota,

the assistant vice president of the Health Sciences Center and General Director of the hospital.

So Bob Dickler has a distinguished background that he has brought with him and continues with the Association of American Medical Colleges.

STATEMENT OF BOB DICKLER, VICE PRESIDENT, DIVISION OF CLINICAL SERVICES, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Mr. DICKLER. Thank you. On behalf of the Association of American Medical Colleges, we appreciate this opportunity to comment on not only the PPRC report but the issues of primary care/generalist physicians, and, of course, rural health care.

Before commenting specifically on the PPRC report, I would like to make some general comments. Most of these are contained in our written testimony which I'll try to abstract in my comments rather than reading through it.

As Ms. Schwartz has already noted, the PPRC report does not focus specifically on rural health care issues. It is a vexing problem which all of us have been struggling with for a number of years.

I would like to call your attention to a compendium that the Association put together several years ago on physician supply in rural areas and academic center initiatives. This reviews the efforts—some 250 within 65 academic centers that have been working to increase physician supply and the supply of generalists in rural areas. We're updating that and would be happy to provide copies to any who might like it.

The AAMC has also recognized that this country clearly has an imbalance between generalists and specialists, and, in fact, that problem is growing worse as that chart indicates. Studies by the AAMC have indicated that there has been a declining interest in going into the generalist arena on the part of medical school graduates.

As the national association representing medical schools, the Association recently looked at this problem in detail and developed a policy statement which advocates moving toward a majority of medical school graduates entering the generalists arena as soon as possible, and, hopefully, by the turn of the century.

In that report, we have outlined a number of changes which need to occur, in our estimation, for this imbalance to be corrected. Most of those changes are not in the financing or structure of graduate medical education. As noted by Dr. Human earlier, they are fundamentally intermingled into the whole structure of health care delivery, and we are focusing on the experience in undergraduate medical education, graduate medical education, and things that need to occur in reimbursement and the infrastructure of health care.

A final general comment before going to the PPRC report is to caution all of us to remember that producing more generalists is not synonymous with their practicing in rural America. We need to be cautious because previous efforts in this regard have often demonstrated that while we have been able to some degree to affect the production of manpower in certain specialty and generalist areas,

that has not always led to changes in the distribution of that manpower, which is something that we clearly need to address.

The Prospective Payment Review Commission report on graduate medical education is, in our estimation, superb. It is well-thought-out, it is well-documented, and it presents a stimulating and thoughtful proposal which we believe all facets of medical education need to respond to. It is clear—and we agree with the PPRC on this—that the financing and organization of graduate medical education may need to be changed. However, we are not necessarily in total concurrence with the changes that they have proposed, and we currently have a panel that is looking at some proposals that cover many of the topics related to the PPRC proposal.

So I'm in the unenviable position of not being able to state a clear position on behalf of the Association, but in some ways that may be helpful because it permits me to make some brief comments on some of the discussions that we've had relating to the key proposals that the PPRC has come forth with.

First, looking at financing, the Association is clearly supportive that graduate medical education be supported by all facets of the health care system. An all-payer pool has been historically the means for financing graduate medical education.

The payment mechanism has been explicit in Medicare, it has been explicit in some Medicaid programs, but it has not been explicit in most other payment mechanisms and has been simply through the charges that teaching hospitals were able to set and were therefore able to get an extra amount for that educational activity.

In advocating an all-payer pool and trying to develop one, the AAMC is concerned that a separate pool of the magnitude we're speaking about—even if it dealt only with direct medical education (whatever the range is that you may talk about, my figures differ a little from Anne's because we only talk about the direct medical education component), makes it very vulnerable at the Federal level. And I think we're all concerned that when you designate a sum of money for a singular purpose, and face difficult budgetary and financing issues, those purposes may fall to the side.

So in an attempt to stabilize and enhance the ability to finance graduate medical education, at least some of our membership expresses concern that we may jeopardize it at the same time.

The control system proposed by the PPRC has three facets, as Ms. Schwartz has reviewed: congressional limits on the number of total residents, a national body to allocate those to various specialties, and an allocation within specialties by the accrediting commission on graduate medical education.

We are concerned about congressionally established limits. First, we're not quite certain that these should be set at the Federal level nor are we convinced that we know what level they should be set at—105 percent, 110 percent, etc.

We need to remember that when medical students enter their first year of residency, they are pursuing, in many cases, different tracks than they later choose. Some are pursuing in their first year the residency and specialty they want to go into—including generalist arenas, some are entering it as a transitional year for only a 1-year experience before going on to other types of specialization or

general training, and some are entering without being sure what they want to do.

So when we begin to set limits on that first year slot, it presents some problems.

We also have concerns that we may be intermingling a presumption that a limit on the number of first year residency positions, with a priority for generalists, would rebalance generalists and specialists. I know this is dealt with in the national body proposed by the PPRC, but that's not necessarily correct either.

Finally, there is a question of the International Medical Graduate, the IMG. That is one which many of our communities are dependent upon, both urban and rural. If we are targeting U.S. graduates, we are limiting foreign graduates. We're not speaking for or against this but we need to recognize the implications of this limitation and what source of medical manpower will be most affected.

From an allocation standpoint, the proposal for a body to divide positions among the specialties is one which is very controversial in our deliberations. There are many in our Association who are at the medical schools and teaching hospitals, who are convinced that the changes proposed in health care reform—at least as far as we understand it today and the experience we've seen in California, Minnesota, and other communities—are in fact resulting in a transition to more and more graduates pursuing generalist medicine.

We have seen rises in income levels for first year, post residency training, generalists entering practice; we have seen demands from physicians in practice for opportunities to go into generalist practice. And, as always, one is faced with the issue here of whether in fact we may see market forces being as effective, or more effective, than any singular national planning process.

The final elements of the control structure, the ACGME, is one that there is a historical Association policy on. We do not believe that the accreditation commission should be in the business of manpower allocation in terms of numbers. There are very serious philosophical issues with intermingling monitoring and quality assessment with the allocation of the positions based upon some top-down process.

I cannot sit here and say this could not work. I simply want to make you aware that those are important issues and ones which, in our view, are very limiting. We also would like to comment, in terms of the ACGME, that it needs to be brought to closure in terms of its structure if we're going to go on with this proposal.

There are many other comments I could make on who receives the funding, ambulatory settings, and so on, but in the interest of time, let me end there and respond to any questions that there may be.

Mr. HUMAN. Thanks, Anne. I'd like to next have the other three presentations and then we'll open it up for a broader discussion.

Now let's turn to Marc Rivo. Dr. Marc Rivo is a family doctor who directs the Division of Medicine in the Department of Health and Human Services and also serves as Executive Secretary to the Council on Graduate Medical Education.

All the folks you're hearing from in this first panel are involved in the graduate medical education business to some extent, either providing advice to it or being a direct part of it. And the Council

on Graduate Medical Education has been supplying recommendations in this area for years.

Dr. Rivo, in addition to working full time at the Department of Health and Human Services and providing grants to medical schools for good purposes, such as maintaining departments of family medicine, is also on the medical teaching staff at George Washington and Georgetown Universities. He is an Associate Editor for the American Family of Physicians, the Nation's most widely read medical journal for primary care physicians. He continues to see patients once a week, and is generally an enlightened type of person with the necessary energy to do things at once, and do them well.

STATEMENT OF MARC RIVO, M.D., COUNCIL ON GRADUATE MEDICAL EDUCATION

Dr. RIVO. I am delighted to be here to speak on behalf of the Council on Graduate Medical Education and to bring greetings from the Chair of the Council, Dr. David Satcher, who is the president of Meharry Medical College and was the convener of the process that led to the Council's third report. The Council's third report was released in October 1992. Its title is "Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century."* I'll be speaking from the Council's report in response to the PPRC's report.

In June, the Council will be building upon this report by considering a series of implementation recommendations that could be of use to policymakers and the public in order to implement the key workforce goals.

For those of you who are interested in receiving the report, it is available. We could mail it to you if you would call the COGME at (301) 443–6326.

Overall, the Council on Graduate Medical Education applauds the Physician Payment Review Commission for really an excellent report, an important set of conclusions and recommendations as to how the physician workforce can match the health care needs of this country.

The Council has a number of similar conclusions and recommendations, and I will walk through some of the general thinking that led the Council to its conclusions and point out one or two small differences between what the Council on Graduate Medical Education came up with compared with the Physician Payment Review Commission.

The first conclusion, which I think is now being recognized widely by the public and policymakers, is that the physician workforce does not match up well with health care needs, and that is of particular concern as we try to provide universal health care to all citizens, especially underserved rural communities. Specifically, this country has too few family doctors, general internists, and general pediatricians; conversely, too many non-primary care specialists and subspecialists; its doctors are poorly geographically distributed both in our Nation's inner cities, and particularly in rural areas; we are facing a perplexing oversupply of physicians in this country;

* See appendix.

and that simply training more doctors but not changing the incentives for them to choose to be a family physician or practice in a rural area is not going to solve our problem. In fact, those who are watching may be surprised to know that during the past decade we had 150,000 net physicians enter practice in the United States after completing residency training and, yet, the number of primary care shortage areas actually grew during this period—some of the perplexing problems that we've been facing as we've been trying to get a hold of this system.

Like the PPRC, COGME is concerned about a medical education system that is relatively unresponsive to these needs. Only 15 to 20 percent of all graduates are choosing generalists careers and for every 100 or so students who enter the medical education pipeline, only 1 or 2 become a generalist physician and settle in a rural area where they are needed. And the others go into specialties and areas that are not in such great need. Family physicians are the only specialty to be evenly distributed across all county size, but some medical schools don't even have a required course in family practice.

But it's also important to recognize that medical schools are not alike and that the medical education system is not monolithic, that there are medical schools who are doing an outstanding job of training the kind of doctors that we need.

For example, the University of Minnesota at Duluth, through a special program, produces 50 percent family doctors and 50 percent who practice in rural communities in Minnesota.

Although the allopathic schools do not do quite as good a job—only 15 to 20 percent of their graduates go into primary care careers—our Nation's smaller number of osteopathic schools do a better job of producing generalists; some 40 percent overall of their graduates go into generalist careers. Some osteopathic schools graduate 65 percent or more who enter generalist careers.

We know then that the medical education system can produce generalist physicians; we know from data that the admissions policy is important; that students from rural backgrounds are much more likely to enter a generalist discipline, such as family medicine, and practice in a rural setting; we know that training students in community-based settings works; and we know that even among the allopathic schools the top producers such as East Carolina University and South Illinois, half of their students do complete residency programs and remain generalists.

But many of the schools that are community-oriented and many of the students who are committed to generalists careers will tell you it is like swimming upstream currently given the forces in our health care reimbursement system, in our medical education financing system, to produce the kind of doctors that we need.

And, like the PPRC, the COGME recognized a number of barriers in our system:

First and foremost, the health care reimbursement system must be addressed and changes must be made to encourage and support those who are interested in becoming family doctors or general internists and general pediatricians, and practice in rural communities.

Second, that the medical education financing system currently has many incentives that go to encourage hospital-based training. Yet, if a program wants to train a family doctor in a community setting, the hospital may not get reimbursed for that.

There are also imbalances currently among Federal funding for research, which changes the mix of faculty who are in medical schools. We should as a country, look at a better balance of our research fundings particularly in the new areas that are identified with health care reform—be they population based research, primary care, or clinical research, or health services research.

And, then, finally, accreditation and certification; these are complicated terms, but they have to do with what a program needs in order for it to train someone, let's say, in general internal medicine.

For example, for an internal medicine residency program, they have to have a cardiac catheterization unit in their hospital, they have to have several internal medicine residency programs in their hospital. Obviously, if you are a small rural hospital wanting to train general internists for rural settings, you may have a hard time meeting those guidelines.

And, then, finally and most importantly there are unique barriers for practice in rural communities that must be addressed as well.

Now there is hope that the changes that are being discussed in the health care system may go a long way toward emphasizing primary care and prevention. With health care reform, there will be changes that will make it easier for both the public to get access to care as well as providers who want to be generalist physicians to practice. And students are getting this message. In fact there was a 10-percent increase in the number of students who matched in family practice residencies. Family practice filled more first-year slots than, I believe, since 1984. That's a sign that students are understanding the needs and opportunities in the health care system of tomorrow.

However, at the same time, like the Physician Payment Review Commission, the Council on Graduate Medical Education recognized that fundamental changes in the way we structure medical education are necessary in order to train the kind of doctors that are needed. That would include the setting of a national commission that would help determine the number and mix of residency positions to be funded.

The Council on Graduate Medical Education recommends that half of all residents graduate in generalist careers, and that residency slots should be allocated based on the needs in rural communities and across the Nation. COGME recommends a set of financing strategies that will support programs to expand and enhance training in primary care and some incentives to practice in rural areas; institutional incentives to expand training into the community, such as the Area Health Education Centers (AHEC) program; more funds for primary care research, and other incentives so that institutions can make the kind of changes that need to be done.

And then, finally, the Council did have as one of its goals that all primary care shortage areas should be eliminated and urban-rural imbalances in distributions should be reduced by a series of

targeted strategies that will make it easier for generalist physicians to practice in rural areas.

I'll be happy to discuss this at greater detail if there are any questions.

Mr. HUMAN. Thank you very much, Marc.

I'd like to turn now to Charlie Cranford. Charlie is in a second career now, having been a distinguished member of the Federal establishment for some years. He is a dentist who went on to get an advanced degree at the Lyndon Johnson School of Public Affairs as a master of public affairs. He is a person who currently is an Associate Dean of the College of Medicine of the University of Arkansas for Medical Sciences. He is also Executive Director of the Area Health Education Center Program at the University of Arkansas and Executive Director of the Center for Rural Health at the University of Arkansas.

So if he works all three of those jobs about 8 hours a day, I'd say he's a busy man.

STATEMENT OF DR. CHARLES O. CRANFORD, EXECUTIVE DIRECTOR, CENTER FOR RURAL HEALTH, UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Dr. CRANFORD. Thank you, Jeff. I am pleased to have the opportunity to represent the University of Arkansas for Medical Sciences today and to respond to the PPRC recommendations.

We strongly agree with the concept of the need for more primary care physicians in the health care workforce. The PPRC is to be commended for addressing this issue and developing recommendations for effecting change in the current GME system.

In principle we support the recommendations to determine limits on the total number of residents and the allocation of slots by specialty. Although we support these recommendations, there is reason to question the need for a new Federal level bureaucracy or to ask the ACGME to implement the reforms. These reforms could be implemented through entities like the health purchasing cooperatives in a managed competition model or through some other yet to be identified State entity, perhaps within a global number established at the national level. I think that we have to wait and see how that works.

We strongly support a funding mechanism separate from Medicare to provide incentives and regulations for shifting the emphasis in GME toward primary care. The 1 percent setaside for all payers proposed by PPRC makes great sense for achieving such a shift in that emphasis.

The funds should be allocated to primary care educational programs, using an allocation formula influenced by the achievement of a set of desirable outcomes. Allocations directly to the residency programs themselves would provide a major incentive and would, in our view, enhance ambulatory experiences.

Medicare, the current principle supporter of GME, was not originally conceived as a way of paying for routine day-to-day primary care; rather it was developed to place a safety net under the elderly who require acute and expensive in-hospital care. That by its very nature is predominately specialty oriented.

Medicare is a broad-based inpatient acute health care system, but there are major gaps in its funding of outpatient services. Thus, it makes little sense to us to use Medicare GME funding to encourage increases in primary care physicians who deliver services largely in outpatient settings. We believe the PPRC is on the right track to recommend a different mechanism to help support primary care training programs.

The Medicare GME system emphasizes hospital based residency training, and it's important to protect that educational system although it may be downsized somewhat. The PPRC recommendations to make available transitional relief funds to teaching hospitals that lose residency positions is also desirable and would help maintain the integrity of the surviving parts of the in-hospital educational system.

I will leave it this afternoon to others with whom I share this opportunity to describe more fully the impact of the PPRC recommendations on large university teaching hospitals. I would rather like to use my remaining moments to comment on the development of appropriate primary care training experiences in community-based settings, and, more specifically, following Jeff's invitation, I'd like to describe for you the geographically designed network of family practice residency programs in Arkansas and the outcomes of our system.

We are proud of the community-based model for educating family practice physicians in Arkansas and would like to offer this model for consideration. I'll give you a few highlights now, and there's more in my complete statement if you would read that.

Back several years ago we divided Arkansas into six geographic regions and in each of these regions, we placed a community-based family practice residency program sponsored by UAMS and through its statewide AHEC program.

To date, we've had more than 340 family practice physicians who have received residency training in this model. An overwhelming majority of these family practice physicians have elected to practice in Arkansas, some 75 percent.

Graduates of these programs are in 56 of the State's 75 counties. Since 1989, 45 percent of those remaining in Arkansas to practice have chosen towns of less than 10,000 population. We believe the strategic locations of these residency programs enhance their selection by the University of Arkansas for Medical Sciences graduates and that their locations influence the ultimate choices of medical practice within the State.

And, as more family practice physicians have been produced in this model, a greater number have chosen smaller communities for practice locations. Thus, indicating to us that if we produce more family practice physicians in regionally based centers, more will find their way into practice in smaller communities.

Our central and overreaching strategy of this model is to place the last phase of formal education of the primary care physician in regional centers throughout the State.

The recommendation by the PPRC that all payers, including self-insured employers, contribute 1 percent of their payments to underwrite the cost of graduate medical education, would seem to benefit community-based residency programs such as we have in

Arkansas. With adequate GME support for primary care residency programs, the Arkansas community-based family practice residency model could be expanded and could be complemented by adding residents in general pediatrics, general internal medicine, and perhaps OB.

With sufficient incentives and reform of the health care system, I am confident that the 26 percent of this year's graduating class choosing family practice could be increased, as well as the total choosing all primary care specialties. Twenty-six percent is about twice or more than twice the number in the average medical school in this country.

When considering reform of the GME system, it's important that excellent community programs developed over the last 20 years not be left out of the proposed solutions. PPRC recommendations can make these programs even better. Actually, the PPRC recommendations could provide the assistance needed to help these community programs achieve their greater potential. The best of these community programs should be incorporated into the proposal for health care workforce reform.

Among these community programs are the community health centers, which have become an essential part of health care delivery in our State and with which AHECs have formed educational and service alliances in community settings for the training of primary care residents. Also the National Health Service Corps has been a strong program that—coupled with effective affiliations with academic health centers and administered more as a community health service corps rather than a national health service corps—this program could attain greater achievements.

In concluding, I'd like to say that we have an effective program for producing family practice physicians in our State. We believe the PPRC recommendations can enhance that program, and we welcome the opportunity to participate in this discussion today.

Mr. HUMAN. Thanks very much, Charlie.

Our last speaker in this particular panel is Dr. Robert M. D'Alessandri. .

Bob D'Alessandri is a physician, a graduate of Fordham University and the New York Medical College. He completed his postgraduate training at Metropolitan Hospital in New York and at the University of Florida. He is the Vice President for Health Sciences and Dean of the School of Medicine at West Virginia University. A specialist in infectious diseases and comprehensive medicine, he is a fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

And Bob is increasingly an expert on primary care, above all, because he is committed to providing services to smaller communities in West Virginia and because he works for an organization that is probably as interested in primary care as any in this country. I am speaking, of course, of the West Virginia legislature, which is not shy about making its views known to Bob.

STATEMENT OF ROBERT D'ALESSANDRI, M.D., ASSOCIATION OF ACADEMIC HEALTH CENTERS

Dr. D'ALESSANDRI. That's correct. Thank you, Jeff. Thank you for inviting me here today.

The AAHC represents a broad spectrum of health professions education and has a number of position papers relating to health care reform, and if any of you are interested in those or a list of those, please see me after this discussion. I would be happy to provide those to you.

Mr. HUMAN. Let me just digress for a second because I really should have said that in coming here Bob is representing not West Virginia University per se, but the Association of Academic Medical Centers; that is to say, the teaching hospitals of America.

Dr. D'ALESSANDRI. Academic Health Centers, right. It's a little broader than that, than just the teaching hospitals, but it represents health professions education, nursing, dentistry, pharmacy, and medicine as well.

The problem of increasing the number of primary care providers is one that has concerned my State greatly over the past few years. We have struggled as a medical school with the problem of how to produce more generalist physicians to meet the needs of our State.

We have made some very significant changes in our undergraduate medical education curriculum, both in how and where we teach, which I hope will begin to pay off in our students choosing primary care as their career specialty.

I have reviewed the Physician Payment Review Commission report and have some comments on their recommendations:

Generally, I should say up front I am in agreement with most of the recommendations of the Commission. I believe this issue is much like changing the health care system itself. Producing more generalists will not be the result of any one strategy. It will take a systematic change in all aspects of the health care system to produce more primary care providers.

We must look at graduate medical education in the context of the whole system of education of physicians, not just the residency programs.

When I ask my students why they have chosen a particular specialty over primary care especially rural primary care, I get a number of responses. Many feel primary care is too demanding on their personal life, too many nights on call, not enough backup for vacation or to attend continuing education seminars. Many cite the extremely low pay for primary care providers as compared to specialists.

These are some of the determinants for students in choosing a specialty, and these are the first issues that must be addressed if we are to have an adequate supply of primary care providers. We must begin by changing undergraduate medical education.

Medical students generally enter medical school with a very positive attitude about primary care. At West Virginia University, we are now requiring every student to do an off campus rural care rotation. Some of our students are spending up to 6 months of their education in a rural area with a local primary care provider and soon some will spend 1 year in rural settings.

There are two very important programs that support this educational effort. We have a grant from the Kellogg Foundation to make substantive changes in our curriculum to provide education in rural sites. We have supported this project with on-site faculty,

the development of learning resource centers, computer and video links to our main campus, and more.

The second program involves some 113 agencies, hospitals, behavioral medical centers, private physicians, and primary care clinics that form eight consortia where health profession students can train in a multidisciplinary setting and care can be provided by university faculty.

We're trying to re-instill the concept of service as a reward in our students and show them the value we place on primary care providers. We need to as a Nation raise the value of service and raise the status of primary care providers.

Changing the hospital based setting for residency programs is a good idea, but it comes with a lot of problems. Many residency review committees whose responsibility it is to approve and accredit programs have very strict guidelines about where residents spend their time. The recommendations of the PPRC could help to change the payment mechanisms for residents to a nonhospital based situation, but we must have significant changes from the RRCs as well.

I think it's critical that all payers contribute to the cost of medical education, as the PPRC suggests. I'm also in favor of reducing the overall number of residency slots.

The part of the report that most concerns me, however, is the determination of the allocation of those slots and which slots should be approved for funding. I certainly agree that funded and approved residency should meet and exceed minimum educational standards.

However, funding should not be based solely on meeting those standards. Other factors must play an important role.

In West Virginia, a predominately rural State, our health sciences center has the only training programs in many subspecialty areas. The great majority of practicing subspecialists in West Virginia graduated from these programs.

In general, these programs are small and have the minimum number of residents required for accreditation, about two or three residents per year. It is rare that an ophthalmologist who graduates from a residency program in New York City comes to West Virginia.

West Virginia and many other rural States have tremendous subspecialty needs as well as primary care needs. To base funding solely on educational standards will enable larger urban institutions to make decisions that would disenfranchise small programs in many rural areas.

Regional and rural needs must play an important role in deciding funding for graduate medical education. Otherwise, the very problem you are trying to alleviate would be exacerbated.

There are two other areas that merit attention if we are to increase the number of primary care providers: income and infrastructure.

Health care reform should increase the income of primary care providers making this a more desirable field. In the PPRC report they cite Canada as being successful in changing their physician mix to assignment of residency slots.

I would submit to you that a much more effective strategy was Canada's reforms in physician reimbursement so that a primary

care provider now earns nearly as much as a specialist and the disparity in income has been narrowed considerably.

If we really do value primary care providers, we must pay them more and pay other subspecialists less. Otherwise, we will always see our best and brightest lured to the areas that society pays more, and, hence, values more.

Universal coverage of all Americans will go a long way to encouraging people to both practice primary care and settle in rural areas. The lack of coverage in rural America is a major deterrent to practicing in rural areas.

It is very discouraging to see a patient with an ear infection and prescribe an antibiotic knowing the prescription will not be filled because the family must choose between antibiotics and food.

Finally, I'd like to address the need for an appropriate infrastructure. If there were a better network of programs to support rural primary care providers, we could reduce isolation and increase retention.

At WVU we have developed many programs to support rural providers, programs that can serve as national models. The Medical Access and Referral System, MARS, is a simple 800-number staffed 24 hours a day for specialist consultation and medical information. Users of the system say this is a lifeline for rural physicians and other providers.

Two of our physicians have decided that the phone system wasn't enough. There would be significant improvement by being able to see the patient and the rural physician face to face. Many patients have been needlessly transferred to the more expensive referral hospital because our physicians couldn't tell based solely on described symptoms what the patient's problems were. It was safer to transfer the patient.

So in cooperation with a rural hospital 70 miles away, we developed a pilot program called MDTV, or Mountaineer Doctor Television. Through the use of telephone lines, MDTV establishes a two-way interactive televideo link between a rural hospital and the specialists at WVU. We have used this system to interview and diagnosis patients, read x-rays, send family medicine rounds out weekly to the rural medical staff.

This year we'll add six more rural sites to our network. This program will keep more of the care locally, which will improve the viability of rural hospitals. It will also improve the local quality of care through the provision of interactive continuing education. If you could see this program, you would be as excited as I am about the possibilities that telemedicine brings to rural areas.

This program has been supported through a Federal grant from the Office of Rural Health Policy, and I'd be happy to arrange for a demonstration for the Committee if they'd like one right here in this room. This is tremendous technology that can really improve care in rural areas and increase provider retention.

Another successful program we developed to address retention is the visiting clinician program. This program brings primary care providers into the health sciences center regularly to teach our students in the morning and to be matched in the afternoon with the specialist of their choice to brush up their skills.

These rural doctors are appointed to the clinical faculty and are the doctors to whom we send our students for rural primary care experiences.

I make it a priority to meet regularly with the visiting clinicians. About a year ago, I met with a family doctor from the southern part of our State, Fayette County. He told me that before the program began, he had just about given up his practice. He didn't believe anyone cared about the rural physician. He felt burned out, frustrated, and abandoned.

The program with its exposure to students had helped him recover his enthusiasm for rural medicine. He felt rejuvenated and able to strongly recommend rural medicine to our students.

These are programs that can be implemented nationally at very little cost in a very short time frame and can reduce isolation and improve retention.

Health care reform presents us with many opportunities. We need to make sure that the solutions we develop work for the whole system, both rural and urban.

Thank you very much.

Mr. HUMAN. Thank you very much, Bob.

Okay, we've heard the first. We've heard the proposal of the Physician Payment Review Commission to really dramatically and drastically change the way we run graduate medical education in this country by doing a number of things, including setting a limit on the number of residencies and the number of people in those residencies that we support, by allowing us to allocate through the Federal Government the number of specialties so we can have many more primary care specialties.

They've come up with a way to fund it through taxing the present health care industry at a 1 percent rate to raise the $8 billion that would be necessary to fund it. And the question is do we need to go this far, should we go this far, in order to come up with what we need in the number of primary care specialties?

We've heard a number of responses which stress some of the other things that we can do as well, and before we close this panel, I'd like to open it up to any questions or comments that we may have from the audience.

Would anyone like to say anything or to ask any questions of our panelists while they're still here? We'll continue this discussion in panel two from a different perspective, but we'll continue the discussion of the reform of graduate medical education.

Any questions? [No response.]

We're now going to go into our second panel of response to Anne Schwartz's presentation today. Anne presented recommendations that have been made by the Physician Payment Review Commission to reform graduate medical education.

In our first panel, we heard from the people in the graduate medical education community. And, in our second panel, we're going to hear from the primary care physicians because what is really at the heart of this afternoon's session is trying to figure out how to graduate more of the primary care physicians that rural communities tell us they need—and that even urban communities across the country tell us that they need.

Our first speaker on this panel will be John M. Tudor, M.D. who is President of the American Academy of Family Physicians, which is a 74,000 member organization representing practicing family physicians, family practice residents, medical students, and others.

Dr. Tudor maintains a private solo practice in Salt Lake City, Utah. He earned his medical degree from Harvard University in 1964 and he has a master's degree from Michigan State University in higher education and administration. In addition, he has previously held assistant and associate professorships in the Department of Family and Community Medicine at the University of Arkansas, an associate professorship at the Department of Family and Community Medicine at the University of Utah, and has served as Director of the Family Practice Residency Program at the University of Utah.

I should tell you at the beginning that when we talk about primary care physicians generally, we often are tempted to talk only about family physicians, or osteopathic general physicians as a second category, because these are the physicians who have the broadest possible training and they are more suitable for practice in rural communities because it's the only specialty that can see the adults in the family and the children in the family and can even deliver babies.

So family physicians have a very broad expertise, and for a community that can only afford to support one physician or two physicians, the ideal configuration is often to have a couple of family physicians so that some people think that we really shouldn't be talking so much about the need for more primary care physicians, we should be talking instead about the need for more family physicians and only parenthetically about the need for more internists and more pediatricians. And that is certainly something we hear frequently from the rural communities.

STATEMENT OF JOHN M. TUDOR, M.D., PRESIDENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. TUDOR. Good afternoon. I appreciate the opportunity to participate in today's workshop, and I particularly appreciate those favorable comments.

We have for 20 years been speaking to the need for more family physicians and just the reasons that you gave, and feel that we are on the verge of expanding training programs that would provide that opportunity.

It's the Academy's belief that no matter how one reforms the health care system, correctly the physician geographic and specialty maldistribution is an essential element of reform.

As you may know, the Academy has a proposal for reforming the health care system called "RX for Health," which contains several recommendations for achieving this goal. The importance of universal coverage, preventive services, correction of the payment inequities for family physicians, primary care services, and the support of services in rural communities and certain neighborhoods is all important.

Other presenters have already emphasized the multiple factors of reimbursement in medical school curriculum, faculty makeup, and

the selection criteria for medical students. So I won't go further into that.

We're in substantial agreement with many of the recommendations made by the Physician Payment Review Commission especially that all payers should contribute an equal percentage to the graduate medical education, that direct payment should be rationalized and standardized, that physician specialty distribution should be determined through an explicit delivery of process based on need, and that ambulatory training should be eligible for graduate medical education funding.

In the short-run, we believe that a rational workforce planning process should be delegated to a national commission. Over the longer term, such a commission might not be necessary. It is conceivable that the medical education establishment will become responsive to health plans, which would presumably by their purchasing and payment mechanisms be the most sensitive indicators of workforce needs.

Sunsetting a workforce commission may be worth considering. Two basic strategies have been proposed for achieving the desired specialty distribution: financial incentives through differential weighing of per resident amounts, or, number two, specialty specific quotas on the residency slots eligible for funding, which is the PPRC recommended approach.

It's unclear to us just how prescriptive an allocation of slots by residency needs to be or if it is necessary to federally sanction the process of pruning programs on the basis of quality.

We're concerned about the use of quality as the sole criterion for determining which residency programs will be eligible for funding.

To illustrate, in reducing the number of general surgery residency slots on the basis of quality alone, a number of smaller programs whose graduates might have been more likely to enter rural practice were eliminated because of the size of the hospital or the other resources in the training program. There is now a severe shortage of rural general surgeons.

The Academy supports the use of financial incentives. However, if financial incentives are to be effective the re-weighing or prioritizing must be substantial. PPRC has expressed its beliefs that preferential weighing of generalist residencies is unnecessary because a number of existing slots have gone unfilled.

However, there has been a 13-percent increase in the number of graduating medical students entering family practice training programs this year, suggesting to us that an increase in the number of training slots will be needed in the near future.

I might take this point to correct in the written testimony on page three footnote the use of 19 percent is an error; it's 13 percent. On a personal note, it is obvious that we increased the number of slots this year; we increased the number of fill matches even greater, which increased our percentage of fill as well as our percentage of actual numbers and the quality and the competitiveness of the candidates was much improved.

We interpret this to mean that the students are responsive to the national priorities. In addition, any increased funds derived from re-weighing the formula could be used to increase primary care resident salaries, which has been shown in some settings to be an

effective recruiting tool. Administrators of hospitals are greatly influenced by program funding as to whether a program is to grow or shrink.

The Commission has also expressed it's concern that a re-weighing scheme would be relatively inflexible. However, this specialty maldistribution is so severe, the physician training pipeline is so long, there will be plenty of opportunity for mid-course correction. It's important to start now.

In the final analysis, we do not believe there is sufficient evidence to know which approach, quotas, or financial incentives would be more effective. The experience of other developed countries with quota systems has been impressive. On the other hand, the early experience of New York State system for funding graduate medical education suggests perhaps greater sensitivity to financial incentives than is commonly thought.

We support funding eligibility for consortia consisting of teaching hospitals, medical schools, residency programs, and other institutions of training. Operating under broad national goals, consortia are more likely to be sensitive to local needs and better able to allocate training funds accordingly.

Contrary to the Commission, we believe it is important to utilize the indirect GME payments to influence specialty distribution. The prospect the Payment Assessment Commission has estimated that current indirect formula overpays hospitals for indirect costs of inpatient medical education by approximately $800 million per year. These funds could be better used to support the indirect costs of ambulatory training.

The expansion of eligibility for GME payments to ambulatory training facilities is an essential element of GME reform. Residency programs themselves should be eligible for direct funding. Whether or not nonhospital entities become eligible, there must be full and open accounting of how these payments are used. Indirect GME payments should also be extended to all ambulatory training sites.

Concern has been raised regarding the quality of medical education in ambulatory settings, especially those remote to academic medical centers. We believe that family medicines' long experience with ambulatory training is especially relevant to this question.

In the past few years, many family practice residency programs have developed remote training sites in rural and urban underserved communities. Not only did these sites provide high quality training, but they actually provide training that is in many ways more relevant than that which is provided in traditional inpatient medical center settings.

Of related concern is the cost of ambulatory training, which may be more expensive than inpatient training. The added costs is in part due to the fact that few ambulatory facilities were designed to accommodate medical training. In the future, medical education funding must provide resources necessary to build an ambulatory training infrastructure.

As a final point, it seems clear to us that teaching hospitals have established various inpatient services based more on the availability of cheap resident labor than because there existed a clear community need for these training programs. We do not think it inappropriate for hospitals to reassess the need for their service be-

cause modifications in Medicare GME funding results in a loss of some residency slots.

Furthermore, shifting the emphasis and funding from inpatient to ambulatory services may provide hospitals with an important incentive to establish badly needed community-based health care services.

Once again, I appreciate the opportunity to participate in today's workshop. Please know that the Academy stands ready to work with you in addressing these important issues, and I look forward to your questions.

Mr. HUMAN. Thank you very much.

I would like to introduce now Dr. Robert Luke who is the chairman of the Department of Medicine at the University of Cincinnati Medical School. He is also Chair of the Medical Education Finance Committee of the Association of Professors of Medicine, the national organization of the leaders of Departments of Internal Medicine at U.S. Medical Schools.

Prior to coming to Cincinnati, Dr. Luke was on the faculty of the University of Alabama-Birmingham School of Medicine.

Now when you hear Robert Luke speak, you're probably going to say to yourself, "I didn't know that's the way they talk in Cincinnati." And before you come to that conclusion, you should probably know also that Dr. Luke is also a native of Scotland, and, perhaps, that's the way they talk in Scotland.

He is board certified in both internal medicine and nephrology.

STATEMENT OF ROBERT G. LUKE, M.D., CHAIRMAN, MEDICAL EDUCATION FINANCE COMMITTEE, ASSOCIATION OF PROFESSORS OF MEDICINE

Dr. LUKE. Thank you. On behalf of the Association of Professors of Medicine, I am very grateful to be involved in today's proceedings.

What is an internist? An internist is trained to prevent and care for all medical illnesses in adults both in an ambulatory and hospital setting, and this includes geriatrics.

There's an interesting new combined discipline in primary care called medicine and pediatrics as well. All other subspecialists—I almost hesitate in this context to use the word subspecialists, which has become almost a bad word. We do train all our subspecialists first in 3 years in general internal medicine.

I think it's important to say that we need all the family practitioners, all the general internists, and all the pediatricians we can get, and there's no need whatsoever for any rivalry between the various types of primary caregivers or generalist physicians. This country is going to need all of the ones we can produce. One can argue about the merits in certain situations, but I think that it's very important that we not concentrate on any one of them. We need all of them.

What is the Association of Professors of Medicine? This is the national association of the Chairs of the Departments of Internal Medicine at the 126 U.S. medical schools. Our departments and affiliated programs train most of the general internists and virtually all the subspecialists in the disciplines of internal medicine; that

is, cardiology for the heart, nephrology for the kidney, pulmonology for the lung, and so on.

By many estimates we provide approximately one-quarter of medical student education during the 4 years of medical school. Our divisions of general internal medicine, most departments are divided into divisions related to organ systems, and in many departments of medicine increasing in size are the divisions of general internal medicine.

These are involved in health care outcome research, which measure the cost-effectiveness of the care we give, and this is an extremely important area; in other words, we should be very concerned with measuring the effectiveness of what we do for close to $900 billion in the United States.

We support the major thrust of the COGME and PPRC reports, which we think are excellent. We recognize in departments of medicine our responsibility and are committed to produce more generalists. This may surprise some in this country who have regarded departments of internal medicine as part of the problem rather than part of the solution.

We are determined to educate our medical students and house staff in an ambulatory setting, both in a rural and urban environment. We think the PPRC is correct to separate service and teaching. We think an all-peer system is absolutely essential. Indeed, if the change is upcoming and the delivery of care in this country come about without an all-peer system, we'll have a disaster in the training programs throughout the Nation and in primary care. And if we don't have primary care doctors, we wouldn't be able to do what the country wants the present government to do for health care.

We must change who gets the money for graduate medical education, at least to some extent, and we must make part B Medicare payments recognized—or whatever system replaces Medicare—the cost of training medical students and residents in ambulatory settings. I think you've heard that time and time again this afternoon. It's extremely expensive to educate medical students and residents in an ambulatory setting. It's less cost-efficient in some ways than doing it in a hospital, but we must do it because medicine has moved out of the hospital in many areas, and we're not training properly.

Apart from the issue of wanting more primary care doctors, much of medicine has moved into the ambulatory setting, and it's simply right to train medical students and residents in that setting, and the present system of reimbursement does not recognize the cost of that.

We are going to ensure that all of our future subspecialists continue to be trained in general internal medicine. There's an important pipeline issue for internal medicine, and I hope I won't appear a little partisan for the sake of the internists at this point. I'm trying just to make a general point about numbers:

One-third of all M.D. graduates in this country enter the training programs of internal medicine. Now let me admit immediately that we have probably in the past trained too many subspecialists for many reasons—not all of which lay at our door—but I think that if you're going to resolve the issue of producing more primary care

doctors in this country, internal medicine will have to be part of the solution because of the size and volume of our pipeline.

We have over 100,000 general internists and subspecialists out there. They are the most numerous number of doctors in practice and many of these physicians, as has been mentioned before today, could be retrained, probably quite quickly to do more primary care because it's likely that we're going to need few subspecialists in the future.

So the capacity of our discipline to deliver more generalists we believe is considerable.

We have some things for the PPRC to think about.

We do think a Federal study is necessary as well as a commission to determine where these training positions should go. We do not think that this should in any way postpone action, nor do we mean it to be a mechanism for postponing action. But we don't think you can determine how many cardiologists or ophthalmologists or any of the ologists without some study as to need.

For example, if we came out with a vaccine for AIDS tomorrow, the need for training in infectious disease would be much different. Now it's not very likely we're going to come out tomorrow with a vaccine for AIDS, but there are developments and technology that will require rapid responses in training.

We do favor restriction of training slots based on quality. We think otherwise the process will be extremely politicized at the Federal, State, and local level. We also think it would be better if quality assessment was based on objective data.

It's interesting that no one has challenged the quality of residency training in this country, and I speak as someone who came here from Europe. We hear a lot about the United States having the best medical care in the world; some of that can be questioned, but no one questions the quality of our resident education.

But nobody questions that we are training physicians who are outstanding in their ability to deliver the knowledge of modern science to the bedside, and nothing we do should change that quality. You can be very proud of the quality physicians we are producing. We may be turning out too many cardiologists, but the cardiologists we turn out are outstanding in quality and can compare with any subspecialists training in the world. Indeed, many people come to this country to see how we train residents.

We need to continue to train teachers and investigators for both general medicine, outcomes research, and for the treatment and prevention of major diseases. We can't stop, and not try and prevent the ravaging diseases in this country, and not allow continued research. We need to diminish the number of people going into subspecialties, but it would be a tragedy if we did not continue to meet the needs for training in education.

Finally, today's discussion has avoided the Department of Veterans Affairs (VA). I think it's important that the VA has been and remains an exceedingly important training site and that there's been a win-win relationship in this country between the veterans and the medical schools such that the training of young physicians has enhanced the treatment of our veterans.

There are certain dangers and change in the system at the present time that we need to be very careful about. Unless—and

you've heard this several times—we change the general environment and practice for the generalist, nothing that we do will succeed. We need to pay the generalist back to their normal disciplines, and, although my colleagues wouldn't like this, probably pay the subspecialists less or pay fewer of the subspecialists in any case.

The resource-based relative value scale (RBRVS) has been a big disappointment for most generalists, and that's a fact. There are all sorts of defenses made of it that I think RBRVS hasn't gone far enough. It's not just money. The hassle factors—the 24-hour coverage, the number of different insurance forms physicians have to deal with—must be dealt with in reform if we're to get more generalists.

If we don't fix this, then closing the entry to subspecialists for general internal medicine may indeed drop the number of people available for being trained in generalist medicine.

Finally, in this area there's a danger, and it was mentioned by the PPRC and the AAMC, that indigent care may suffer. It's unlikely that we'll be able to come up with enough money, in my view, to take care of all the people without insurance at the present time. We'll have to probably do it over a few years because of the costs, and we should remember that the academic health service centers take care of a tremendous number of indigent patients in this country. And if we don't consider how to replace the services or residents and to make other arrangements for that, there will be some—particularly urban areas—that may be devastated.

There's a tremendous opportunity for the academic health centers and the medical centers of this country to cooperate with rural practice in terms of putting their internists in rural settings, or rotating the family physicians and internists in rural settings back into the teaching hospitals for some retraining. Certainly internists and family doctors can learn from one another.

So I think there's a tremendous opportunity for cooperation.

Finally, we believe that it's very important that the incentives that are being talked about to increase primary care be coordinated; that is, that medical student stipends are paid, that early screening in medical school for students interested in primary care exist, that resident payments be increased not by the weighing system. Perhaps more imaginative systems should be examined, such as by practice set up costs, all of these linked with payback mechanisms; that is, if you don't go on in primary care, you have to pay it back.

We think also a similar but smaller system will be essential for teachers and investigators with payback mechanisms so that we don't forget that we need to train in general medicine, that we need to do health care research to make sure that the care that we deliver is cost-effective and worthwhile, and that we try and do away with the diseases we're trying to treat by finding their causes.

Thank you very much.

Mr. HUMAN. Thank you very much, Robert, as well.

Our last speaker on this panel is Brian Hyps who is Vice President for Governmental Relations and Counsel for the American Osteopathic Hospital Association, which he joined in 1991. The Asso-

ciation is made up of more than 100 hospitals, the majority of which have teaching programs.

Prior to that, he was a lobbyist for nearly 6 years with the American Pharmaceutical Association, the National Professional Society of Pharmacists.

Mr. Hyps is also a former counsel to the House of Representatives, Veterans Affairs Committee, Subcommittee on Hospitals and Health Care.

And I might just say a word before we get started about osteopaths for those of you who are interested. We tend to lump physicians into two categories—physicians, the allopaths and the osteopaths. We mentioned earlier that there are 126 schools of medicine that are represented by the American Association of Medical Colleges, and, yet, there are 14 more medical schools which are osteopathic medical schools. And they are very substantially similar, in the type of education that they provide, to the allopathic medical schools.

Yet, osteopaths are more likely to go into primary care and are more likely to serve rural areas. Five percent of all of the doctors are osteopaths, but 15 percent of the doctors who serve rural areas are osteopaths. And this also plays out in an interesting way in the urban areas.

In the Washington, D.C. area, for example, I would submit that the biggest difference between an osteopath and an allopath is that for the most part you can get an appointment with an allopath, but you have to have some kind of influence to get in to see an osteopath because there are so few and they're so much in demand.

STATEMENT OF BRIAN HYPS, AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, ASSOCIATION OF OSTEOPATHIC DIRECTORS AND MEDICAL EDUCATORS

Mr. HYPS. Thank you, Jeff. Thank you for the very gracious introduction. Thank you for the invitation to participate today.

In addition to AOHA, our statement is also supported by the Association of Osteopathic Directors and Medical Educators and by Sherry Arnstein, Executive Director of the American Association of Colleges of Osteopathic Medicine.

Osteopathic hospitals and osteopathic medicine have long had a commitment to serving rural areas of the Nation. As you said, although only 5 percent of all physicians are osteopathic physicians, they represent 15 percent in areas that have 10,000 or less people. The figure climbs to 18 percent in rural counties of 2,500 or less.

A review of osteopathic physicians in practice in all 50 States shows a large number of rural communities served by osteopathic physicians.

Let me give you just two of the many examples. One example is from an article from the April 19, 1993, issue of Modern Health Care. In it they talk about hospitals providing rural emergency care. Osteopathic physician, Craig Thompson, is the only physician in Strawberry Point, Iowa. This general family practice physician staffs a Strawberry Point Medical Center which offers ambulatory, emergency, and health education services to the 1,800 families in a four-county area.

His work week ranges from 60 hours to 90 hours. President Bill Clinton cited the Strawberry Point Clinic as a rural health care model for the Nation during a campaign swing in Iowa when he was Governor of Arkansas.

And we have the greatest respect for former Governors of Arkansas, as the example shown in both the President and the chairman of the panel, and the greatest respect for their opinions.

Another example is from the April 1993 issue over The DO published by the American Osteopathic Association. This nationally known story tells us about Dr. Roger T. Pelli and how the six local communities in rural Aroostook County, Maine, voluntarily agreed to pay a tax to send him to osteopathic medical school in exchange for his agreement to come back and practice there.

Eight years from the day of the agreement, Dr. Pelli is faithfully putting in his 15-hour days as a general practice physician practicing in Aroostook County.

Congress stepped in and with the leadership of the Senate Majority Leader and members of this Committee and Caucus, passed the Rural Health Care Provider Recruitment and Education Act, which has become known informally as the Dr. Pelli Bill. As you know, the law provides matching funds to rural communities that try to finance the education of primary care physicians, nurses, nurse midwives, and physician's assistants.

These are just two of the examples of what osteopathic physicians committed to rural communities have meant to these communities. Most of osteopathic physicians in practice in those towns are primary care physicians. A total of 58 percent of all osteopathic physicians practice in primary care.

Although this figure is considerably higher than the percentage of allopathic physicians in primary care, we share the concerns of the allopathic community over the downward trend in interest in primary care among all medical students.

Our greatest fear, however, is that rural communities may not have as many Dr. Thompsons and Dr. Pelli's, and there are not sufficient safeguards added to the proposal of the PPRC made to Congress as it is further developed.

The PPRC proposal would establish a Federal body that would determine the number of residencies per specialty. Accrediting bodies would then determine which residencies would survive and which would have funding canceled based on an undefined determination of the quote, "quality of training."

The proposal does not specify whether the osteopathic accrediting body would remain independent or be combined with the larger allopathic accrediting entity. If the determination of quality is based on the number of full-time teaching faculty, for example, certain academic medical centers may potentially benefit to the detriment of community-hospital based training sites.

This would be true even if the community hospital training program had a much better record of training primary care physicians serving rural areas. Community hospital based training is generally found at osteopathic teaching hospitals. These programs make extensive use of part-time and volunteer educators who are practicing physicians in the community.

These osteopathic training programs offer far more patient contact and exposure to actual primary care practice than do most research based training programs. After years spent in medical school learning theory and scientific application, hands-on practical experience in residency training provides excellent preparation for careers in primary care practice.

We need to safeguard against the unnecessary elimination of quality osteopathic community-based residency training programs that have an excellent record of training, needed primary care physicians for rural and other underserved areas.

The osteopathic community must retain existing fully separate authority over its residency programs. The osteopathic community has been unequaled in its commitment to serving the primary care needs of the rural underserved, and has been helped in doing this through maintaining separate accrediting authority.

We also have concerns about the PPRC proposal for a mandatory central planning approach to allocation of residencies. Osteopathic medicine has been able to keep a higher percentage of primary care physicians serving rural areas and other areas through several factors, including the following:

The availability of primary care practitioners as role models for residents; the required exposure of osteopathic residents to primary care training in the first year of postgraduate training; osteopathic medical college recruitment of persons from rural areas with an interest in returning there, and the location of several osteopathic medical colleges in rural communities.

We think that increased payment incentives for primary care practitioners through RBRVS and weighing of GME payments to favor primary care residents are more effective ways to help increase interest in primary care.

Greater earning capacity for primary care physicians will lead to more residents choosing primary care practice. The continued expansion of managed care plans, which make greater use of primary care physicians may also create market driven incentives for physicians to choose primary care.

Jeff, this concludes my remarks. Thank you for the opportunity to voice the concerns we have in the osteopathic community.

Mr. HUMAN. Thank you very much, Brian.

I'd like to open this up to questions from the audience in just a moment, but before I do that, I'd like to ask a question or two myself.

I think that one of things that there's been a fair amount of consensus on today is that we do somehow need to limit the number of residencies in this country and that it is probably legitimate in some way to try to decide as national policy that we ought to have a higher percentage of these residencies reserved for primary care.

But after that, the consensus then begins to break apart pretty quickly on the issue of how we decide, if we're going to have to close some residencies, which ones we really do close.

On the one hand, we've heard some concern earlier in this panel from John Tudor that if we go strictly on the basis of quality, we may end up closing a lot of heartland residencies. And, certainly, I have seen maps that seem to suggest that a disproportionate

share of all residency programs are located east of the Appalachian Mountains or west of the Rocky Mountains.

And, on the other hand, we've heard from Robert Luke a very spirited defense of the quality of American residencies and a lot of concern that if we go and use any other basis other than quality, then we will threaten the reputation and the real value of American residency programs.

Brian Hyps has introduced the concern of the osteopathic community that they are kind of a minority group within medicine, and if they're a part of this national effort, how will the allopaths who will be in the majority judge the quality of osteopathic residency programs? Can we expect the same kind of sensitivity toward osteopathic residencies that would be directed toward allopathic programs or is this a weakness in this approach?

Anne Schwartz, you've been developing this proposal for a long time. I'm sure these are not all together new issues. I wonder how you folks at PPRC look at this issue.

Ms. SCHWARTZ. Well, I think it's certainly true that this is one area of our proposal which is not as cut and dry as the rest, and, certainly, where the politics lay.

Let me just try and explain it in terms of the decision that the Commission had to make and how we got to the decision that we did make.

When you're faced with the question and you have an excess number of residencies, then the question is how to decide who stays and who goes?

The first thing we thought about was a percentage reduction if you need to lost 10 percent of the residencies and every program lose 10 percent.

Well, the problem with this approach is that it basically grandfathers in the state of affairs, both in terms of geographic distribution and specialty distribution and whatever it is at the time this policy would be enacted. And that's not necessarily where we want to go. There certainly would be arguments that could be made that residency programs should be encouraged to develop new strengths, different strengths, and that we wouldn't always want to be bound to whatever the experience was in 1993, and 1995, or whatever.

So then we looked and decided that quality would be appropriate because there seems to be some concern within the medical profession that there are residency programs that exist that are not quite up to snuff and that it's very difficult to disaccredit these programs. And this seemed like a mechanism—you know, if you're going to have to lose someone, what we want to lose is those of marginal quality.

Clearly, though, there are other factors that come into consideration when you get into some gray areas, and I think that the Commission would certainly be open to other ideas about other factors that should weigh into the decision—not only service to underserved communities, such as rural areas or inner cities, but perhaps outcome measures, such as suggested as a record in producing primary care graduates or a record of graduating underrepresented minorities, all valued public policy goals in which this sufficient refinement in this would certainly help serve.

So I think this is an area where we'll have to develop, and I've heard a lot of good ideas today that we can continue exploring.

Mr. HUMAN. Are there any folks in the audience who would like to ask Anne or any of these panelists any questions at this point?

[No response.]

Dr. LUKE. Could I respond to your previous question?

Mr. HUMAN. Sure.

Dr. LUKE. Most of the programs that we'll close will be subspecialty programs. I do not think we'll be closing many generalist programs. They may be changed in character, there may be local cooperatives between medical schools and regional and community hospitals, which I think would be a very good idea. But it's very difficult to close subspecialty programs in particular without looking at the quality of the product, and I think you're not going to need all subspecialty disciplines in every medical school. And I think, with due respect to some previous testimony here, that training one or two people in a complete specialty area may not necessarily be the best way to train them because you do need a certain number of people in a training program in order to develop a peer group, and the representatives of these committees have made that point.

And I think that because someone trains in, say, Cincinnati, that doesn't mean they can't go and be a subspecialist in rural West Virginia, or rural Indiana, or rural Ohio, for that matter.

So I think that if we're going to close subspecialty programs, which will be the main ones, then I think the quality of the product, of the training of the physician, has to be the first criterion.

Dr. TUDOR. I'd like to be sure no one thinks that we're opposed to quality, but how do you define quality? And some of the abstract concepts proposed by Ivy League schools have to do with how much research you've got, and how many faculty you've got in certain subspecialties, and how many beds for this, or rooms for that. And if we're talking about a product, the quality is the defined product, meeting the criteria that are specified, setting up accreditation standards, which we've worked with the ROC and we compliment the American Osteopathic Association for their accreditation programs that are being developed for 3-year family practice residencies.

That's the criteria of quality we want, not just some academic things that perpetuate the status quo.

Dr. LUKE. Well, we do want to pass the subspecialty boards. At least in that sense, it will be academic.

Mr. HUMAN. Well, we've had a little creative disagreement here for the first time this afternoon, and I think that's really good.

I'd like to ask one more question of Dr. Luke also before we go on to our last panel, and that has to do with a concept that we hear a lot about called "leakage." Earlier I had said that a lot of people think we need to rely more on family physicians than either pediatricians or internists because they're the most broadly trained and most useful in rural areas because of that.

And Dr. Luke had several good answers to that, but I want to ask him about this tendency of general internists to then go on and subspecialize. I've heard that about 70 percent of general internists go on to subspecialize, and, of course, to the extent to which they

do that, they're not available for the general primary care kinds of functions. They're not performing those primary care functions as much as they were in the past.

And I wonder if within internal medicine, there's been any effort to stem this leakage and whether you think if we do go to some kind of a national system, which places a higher value on primary care, some of these folks might be coming back to the practice of general internal medicine.

Dr. LUKE. Well, you asked me a lot of questions there, Jeff, but I don't think there's any question that perhaps 65 percent of people training in internal medicine—different numbers and different programs—have go on to subspecialty training.

The Association of Professors of Medicine is committed to achieving 50–50 training. We do point out that while our training, one can criticize its site and its emphasis perhaps in subspecialists, that it can't change things without a change in the practice environment. These young people are graduating with $50,000, $70,000, $100,000 in debt and are being forced to choose subspecialties sometimes not because they want them, but because they're going to go bankrupt otherwise.

The calculations are quite clear about paying back these debts. Congress has been working with this in terms of the number of years to pay off.

So we are determined to change, and when I talk to my young medical students and residents now, I'm telling them that they should go into primary care. I honestly believe the country needs them, that the circumstances are going to change, and that we will change. I think the departments of internal medicine are trying to change the output. They need the help of the Federal Government and State governments to do so, but I think we really have made a change in our attitude because we believe that it's right.

Mr. HUMAN. Okay, let's move to our last panel—thank you very much panelists for a very interesting discussion.

We've been focusing on the responses to the proposal to restructure graduate medical education from the graduate medical education community and from the primary care physicians community.

And now we're moving to another community—the community of people who represent those with special needs in this country based on geography, folks who represent the rural communities, in particular, are represented by all three groups; and, to some extent, the people who have less of a capacity to afford primary care at the present time.

The first speaker of the last panel is Bruce Behringer. Bruce is currently the Executive Director of the Office of Rural and Community Health in East Tennessee State University in Johnson City, Tennessee. In this capacity, he is responsible for the operation of the Kellogg Foundation's Community Partnerships Program, which is an interdisciplinary effort to train medical, nursing, and public and allied health students in rural areas.

Bruce is also currently the President of the National Rural Health Association, a national organization that is very active in Washington, D.C., as well as in rural communities throughout the

country in trying to establish better health care for rural residents everywhere.

STATEMENT OF BRUCE BEHRINGER, NATIONAL RURAL HEALTH ASSOCIATION, KANSAS CITY, MO

Mr. BEHRINGER. Thank you, Mr. Human, for the opportunity to comment on the Physician Payment Review Commission's annual report, specifically the proposal to restructure the graduate medical education financing system.

The ongoing shortage of health care providers in rural America is a problem which has been faced for years. We understand that 80 percent of all the physicians who practice in rural areas are primary care providers.

Therefore, almost anything that can be done by the Commission to help training in primary care will certainly help rural health in the long-run. It will help to replace the aging cadre of rural providers, a problem which has been faced, I'm quite sure, by each of the members of the Special Committee on Aging, as well as the Senate Rural Caucus, when their constituents come and talk to them about health care issues.

Much of the PPRC report coincides with policy, issues and positions already taken by the National Rural Health Association, and I'd like to point out a few of them.

First, we applaud the growing recognition of the shortage of primary care providers in rural America. A series of reports have begun to discredit the worn out estimation that physicians will diffuse from crowded urban to rural shortage areas. This is known by rural advocates as the "trickle-out" theory of health profession supply.

The problems faced in recruiting and retaining providers in rural areas must be recognized from a comprehensive viewpoint, one which is now being proposed by the series of reports nationally, including the PPRC.

Even with the extensive array of Federal and State health programs targeted to assist high need shortage areas throughout the country, the number of health profession shortage areas nationally has increased since 1980. The total numbers have increased from over 1,900 areas in 1980 to over 2,200 in 1992.

Certain areas of the country remain problematic. For example, two-thirds of the Appalachian counties in the 13 States in the Appalachian Regional Commission area still remain as health profession shortage areas.

The PPRC recommendations certainly go to the roots of one of the solutions of this problem. It calls for a new and more active policy in addressing health professions needs.

Second, although the initial assumption upon which the PPRC report is based may in fact be true, using the argument of an excess of physicians to recommend reduction in Federal investment in health professions production is one which has an ironic precedent.

The Graduate Medical Education National Advisory Council and the RAND commission reports in the early 1980's also cited oversupply and were used as evidence by the Reagan administration to

curb Federal spending for many health professions education programs.

Ironically, the expenditures on graduate medical education continued to increase throughout the 1980's. Unfortunately, though, the only national program which was designed to target the redistribution of primary care providers to severe shortage areas was fiscally dismantled. The National House Service Corps Scholarship Program reduced the scholarship placements from over 1,400 per year in the early 1980's to less than 40 in 1990.

For many rural areas, this was disastrous. History has taught a difficult lesson to rural localities and their elected officials. Beware of the well-meaning attempts to reduce spending that in turn result in further restricting rural recruitment opportunities.

Third, the implications of health care reform through managed competition or some other derivation could potentially bring disaster to an already thin health professions workforce in rural America.

Primary care physicians could become targets for metropolitan recruitment campaigns. The Commission's proposal for non-physician providers to replace residents in teaching hospitals is another. Nurse practitioners, certified nurse midwives, and physician assistants have been a reliable and quality source of health professions who have stayed in rural areas.

Rural shortage areas cannot engage in recruitment wars with the urban institutions which sponsor training programs. This is a no win situation.

Again, although it is clear that this is not the intent of the Commission, its suggestion should be a further warning signal to those who are concerned about access to providers in rural areas.

Finally, we understand the necessity to limit the scope of the Commission's recommendations, but that which the report characterizes as the training pipeline from a pre-professional experience to continuing medical education cannot be ignored in the deliberations of Congress.

Many rural communities end up trying to recruit graduates of the health professions education systems whose most recent rural exposure was a childhood summer camp or a vision from 35,000 feet of altitude while flying across the country.

National Rural Health Association urges Congress to adopt the successes and provide resources to expand a multitude of private and public efforts which have demonstrated track records in this area. Needed is the expansion of the continuum of contact idea which is now being used by the National Health Service Corps and other programs to encourage admissions of students with rural backgrounds, to provide them with rural training experiences, with rural primary care role models, and to assist them in returning to the rural communities.

Our final recommendations are for more targeted expenditures of graduate medical education dollars.

These include, number one, Medicare reimbursement formulas should give a substantial weighing preference to primary care specialties, especially family practice which provide most of the providers in rural communities.

Number two, nonhospital primary care entities should become eligible for direct and indirect Medicare graduate medical education funding.

Number three, primary care training grant programs, including nonphysician providers, should be expanded using proposed GME savings produced by the PPRC revenue plans and reductions in the number of residency positions.

Rural training sites should get preferential funding, including access to capital, which is needed to expand key viable training sites.

Number four, the National Health Service Corps program should be supported and expanded as a distribution system for health professionals.

Number five, the community health centers program provides a vital program and infrastructure development for rural and underserved areas. This program should be supported, expanded, and used increasingly as a site for undergraduate and graduate health professions education.

And, number six, programs that encourage the exposure of students at all levels of primary care practice in rural communities should be supported.

Thank you for the opportunity to speak to the issue, and I hope that as time goes on with the reform movement in the country, that we clearly understand that the reforms being highlighted in the PPRC and the COGME and other such reports are also going to be linked to the financing and service delivery system reforms that are being proposed by the administration.

Mr. HUMAN. Thank you very much, Bruce.

I particularly appreciated the emphasis on undergraduate medical education as well since, as I indicated earlier today, that's another important way in which we can get more doctors trained in the specialities that we need in rural areas. And when we look at the record, we find that there are some undergraduate medical schools that have a distinguished record in graduating students who go on into primary care residencies.

So that has to be an important part of our emphasis as well.

I had the opportunity last year to do the commencement address at Marshall University Medical School in West Virginia, and one of the points that I made there was that I thought we could consider the Marshall University Medical School to be superior to the Harvard University Medical School or the Yale University Medical School because they were doing a better job of graduating the kinds of doctors that this country needs. At Marshall they are graduating students who are going out into primary care residencies and then going out to serve the communities that are unserved or underserved. Many of the other State tax supported universities have been providing the bulk of the primary care physicians in this country and most of those who are serving rural areas. And we need to continue to support them, and we need to continue to keep the emphasis on undergraduate as well as graduate medical education.

Our next speaker, now that I'm done with my little editorial, is Darryl Leong, M.D., M.P.H. Dr. Leong is a board certified pediatrician and a public health professional with State and national leadership experience in health service delivery and health care policy

development with a career objective of making a positive effect in the public's health.

Darryl is currently the Director of Clinical Affairs at the National Association of Community Health Centers here in Washington. He provides policy analysis, advocacy, leadership, and direction on clinical, health professionals, and other issues related to community health centers and primary care.

He develops clinical programs and activities that support the mission of providing comprehensive primary care for the medically underserved.

For those of you who don't now about the Nation's community health centers, there are about 600 of them. They provide day-to-day care to more than 5 million Americans, half of whom are in rural areas, and they provide care at affordable rates, using sliding fee scales, so that the unemployed and people who have no money have to pay very little, if anything, to get their care; whereas, people who are employed are able to get the same kind of quality medical care at these centers by paying a fee that is based on the cost of services to them.

STATEMENT OF DARRYL LEONG, M.D., DIRECTOR OF CLINICAL AFFAIRS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, WASHINGTON, DC

Dr. LEONG. Thank you, Jeff.

First, I'd like to thank the Special Committee on Aging and David Pryor for this actually second workshop they've held on this issue 2 years ago. The first part is attention to the issue of shortage of primary care in rural areas, and, certainly, for the Physician Payment Review Commission for putting this pretty hot issue on the table as we heard today.

Before I start, I want to mention maybe a view of the world which I think was brought to us by a medical director at a recent meeting. He mentioned that he felt that he was like Galileo in that the entire training world in medical education felt that the world revolved around a teaching hospital. And, indeed, his view of the world is that the world should revolve around a teaching community health center or something out in the community, and that's the kind of change that he thinks that we would have to make in terms of the concept of what we're trying to do.

Anyway, the National Association of Community Health Centers is the major national organization representing community-based, migrant, homeless, and community health centers, which are also known as Federally Qualified Health Centers and Rural Health Clinics throughout the United States including Puerto Rico and other territories.

Over 200 of the Nation's 700 health centers are already involved in health professions education for students and residents.

And, perhaps, the most critical issue in the provision of quality health care to all Americans is the availability of primary care practitioners—not just physicians—in medically underserved, rural, and urban areas throughout the United States.

We strongly believe that past and current financing of graduate medical education is directly related to the shortage of primary care practitioners for medically underserved areas and populations.

This hearing has come at an opportune time with a growing national consensus that there is a worsening national shortage of primary care physicians. We agree with others who have recommended moving more graduate and undergraduate medical education out of hospitals into the community, especially rural and inner city communities and increasing the academic prestige and visibility of primary care at all levels of the medical education pipeline.

The other comment I wish to make at this point is that we—community health centers and migrant health centers have been in a chronic shortage of primary care providers for over 25 years. And it's only recently that we've come to recognize that we've been at the end of a pipeline that has been delivering more and more subspecialists and a shrinking pipeline to primary care that we really felt that we had to get into the supply side, at least in terms of advocacy.

We can't overemphasize the importance of developing financing to support teaching and Federally Qualified Health Centers and Rural Health Clinics. We have repeatedly heard from our members that the absence of financing has almost singlehandedly prevented the development of training programs in our health centers.

This has been especially true for rural health centers where training dollars are already scarce. Many and more health centers, including rural health centers, can function as quality training programs in addition to providing needed services. Health centers already involved in teaching have reported both immediate and long-term positive impacts on recruitment and retention.

Migrant, homeless, and community health centers are comprehensive primary care centers located in medically underserved rural and urban areas, and together comprise a high quality service and education system which is capable of providing model ambulatory training sites for primary care.

We have only four more points to make in the rest of this testimony, and I'm just going to summarize them now.

The first point is that the current system of Federally Qualified Health Centers and Rural Health Clinics has a lot to offer in terms of ambulatory community-based education and training.

The second point is that we support the recommendations of the Physician Payment Review Commission on reforming graduate medical education payments.

The third point; positive clarification relating to graduate medical education are needed for the current Federally Qualified Health Centers and Rural Health Centers Program.

And, lastly, that these recommendations should be carried forth as part of an overall health care reform.

In terms of what we can offer, teaching community health centers and other primary care centers for medically underserved populations have a lot to offer as ideal places to recruit students, conduct ambulatory care training, and serve as a major means for recruiting and retaining providers in needed areas.

We are a national system—in fact, it's growing with centers in every State—providing real access to quality health care, not just an insurance card, providing care to over 6.4 million people in over 1,500 sites.

Location.—We are located in federally designated medically under-served areas both rural and urban.

Recruitment and retention for underserved areas.—We foster recruitment and retention of physicians and other health providers by exposing them to careers in primary care and underserved areas by providing yet another reason to work in an underserved area.

Patient diversity.—Over 60 percent of the clients of community migrant health centers are ethnic or racial minorities, and we serve other homeless, migrant, geographically isolated, and poor areas as well.

Health centers are at the front line of patient care in dealing with major problems such as infant mortality, teenage pregnancy, and AIDS.

Comprehensive community health care.—Community health centers provide a unique form of clinic care called Community Health Care with over 27 years of experience.

A quality workforce and team care.—Health centers clinical staffing includes over 3,000 physicians; 9,000 other health professionals, the vast majority of whom have had community health as the ultimate health career working in health care teams.

The unique health care delivery model.—The health center model places consumers in charge of their own health in health care while the practitioner's responsibility for improved health is the entire community, not just those who keep appointments. Each center is a not-for-profit entity owned and operated by the community.

Prevention and public health.—Health centers have eliminated the arbitrary separation between primary care and prevention services, instead providing a comprehensive service of health—not just medical services. Community health centers provide much more than medical services integrating a wide range of social, mental health, substance abuse, nutritional, school health, environmental health, and other services.

Community-based research.—We have the capacity to conduct or participate in new forms of community-based research to bring new-found understanding of problems such as those that underlay youth violence today.

And, finally, administration and finance.—Health centers are administered as nonprofit private corporations that are also statutorily recognized as federally qualified health centers entitled to receive cost base reimbursement under Medicare Part B and Medicaid.

And in terms of supporting Physician Payment Review Commission, we especially support the recommendation that graduate medical education payments be made directly to entities other than hospitals as a means to encourage training and ambulatory care, establishing a direct payment mechanism to ambulatory entities such as Federally Qualified Health Centers and Rural Health Clinics would be a critical first step in the movement of training programs from a hospital-based to community-based settings.

We also agree with the Commission on limiting the total number of residency training slots and with incentives or mandates to also limit the number of subspecialty resident slots.

We also hope that other primary care providers, including dentists, nurse practitioners, certified nurse midwives, and physician's

assistants will be included as part of graduate medical education reform.

In terms of clarifying the Federally Qualified Health Center Program and Rural Health Clinic Program, I'm not going to go into details here, suffice to say that graduate medical education seems to be recognized under this new program, but without sufficient clarification, we're not able to make reimbursement claims for those services.

On the health care reform, we expect changes in graduate medical education reimbursement to be compatible with the positive larger health care reform proposals.

In our written testimony, we have provided samples of model teaching programs already accredited and operating in rural urban areas around the country.

I just want to point a few them that are already operating in partnership with academic health centers, universities, and teaching hospitals:

The Sequoia Community Health Foundation in Fresno, California, provides a unique community-based family medicine resident training program in a rural and urban site, emphasizing training for Latino physicians;

In Patchogue, Long Island, the Blackstone Valley Community Health Center provides a rural urban family medicine training program which includes a metropolitan child health fellowship training program;

In Sioux Falls, South Dakota, the Sioux River Valley Community Health Center provides a model rural family medicine training program;

In the Bronx, New York, the Montifiore Family Health Center has been training primary care physicians for over 15 years;

And in Algonac, Michigan, the Downriver Community Health Services provides a rural osteopathic internal medicine training program;

The Sunset Park Family Health Center in Brooklyn, New York, trains both dental and medical residents;

The Maine Ambulatory Care Coalition in Manchester, Maine, started a new program replacing medical students and residents in rural health centers and is planning to add more;

The West Alabama Health Services in Eutaw, Alabama, provides multiple disciplinary health professional student training, along with the University of Alabama;

And a number of health centers in the Boston area have been working with the community-oriented primary care training program.

In addition, we have heard from these and other health centers stating their desire to do more teaching at the health center but that the largest barrier has been adequate financing.

In closing, we seriously believe that the recognition of graduate medical education payments to ambulatory Federally Qualified Health Centers and Rural Health Clinics could have a significant influence on the shortage of primary care providers in rural and medically underserved areas.

We plan to continue to work in close partnership with health professional institutions on the development and expansion of edu-

cation and training in migrant, homeless, and community health centers and rural health clinics across the country.

Thank you.

Mr. HUMAN. Thank you very much, Darryl.

Our last speaker of the day and our last speaker for this panel as well is Dr. Dena Puskin.

Dr. Puskin has her doctorate in health policy from Johns Hopkins University. She has been with the Prospective Payment Assessment Commission as their rural health expert. She was one of the people who planned the rural health summit, the report from which we heard this morning. She has been an active participant in White House groups helping to plan the health care proposal that the President will be introducing later, and for her regular job she is Acting Director of the Office of Rural Health Policy in the Department of Health and Human Services. And she is the acting executive secretary for the National Advisory Committee on Rural Health.

We've asked Dena this afternoon to come and talk to us about the recommendations of the National Advisory Committee on Rural Health and how they fit in terms of this objective of reforming graduate medical education so that we get more primary care doctors and what are the recommendations they might have toward this same effect?

STATEMENT OF DR. DENA S. PUSKIN, ACTING EXECUTIVE SECRETARY, NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH

Dr. PUSKIN. Thank you, Jeff.

Well, on behalf of the National Advisory Committee on Rural Health, I am pleased to be here this afternoon to discuss the implications of graduate medical education reform for the development of an adequate workforce in rural America. We appreciate the attention the Committee and Caucus are giving to this important issue.

Now what is the National Advisory Committee? Well, the National Advisory Committee on Rural Health advises the Secretary of Health and Human Services on health care issues of importance to rural Americans. The committee was established in 1987 and has produced five annual reports to the Secretary that have been widely distributed. This 18-member committee is chaired by former Governor Robert D. Ray of Iowa, and includes members from both the public and private sectors with expertise in rural health who are physicians, nonphysicians practitioners, nurses, administrators, educators, mental health professionals, and those expert in public health. There's even a lawyer on the committee.

The committee has begun to discuss GME and plans to issue its recommendations in its next report, which is due in December. The committee recognizes the relative importance of Medicare GME dollars, which are now nearly $6 billion compared to Federal grant funding for medical education which is only about $200 million.

It has not yet had an opportunity to review the PPRC's latest recommendations on GME. We expect the committee will thoroughly review these recommendations as a part of its deliberations at its June meeting. Because the committee has not yet drafted rec-

ommendations, I am unable to give you specific recommendations at this time.

However, in its previous reports, the committee has made numerous recommendations on the development of an adequate workforce for rural America. These recommendations provide insights into the direction the committee is likely to take as it considers graduate medical education reform.

Three consistent concerns emerge from the previous recommendations:

First, the need to train health care practitioners for rural practice;

Second, strong support for the use of nonphysician practitioners; that is, physician's assistants, nurse practitioners, and nurse midwives;

And, third, improved payments to practitioners in rural areas to facilitate recruitment and retention.

These concerns will be heightened by the prospects of health care reform, which is likely to rely on increased use of primary care services. As documented in the PPRC report, we do not have enough primary care physicians to fill existing positions.

Expected growth in managed care systems is likely to absorb as many new primary care physicians as can be produced.

Moreover, these physicians will find plentiful opportunities to work in urban managed care settings where hours are more regular and support is more available.

Even if we started today, and all medical school graduates entered primary care specialties, it is estimated that it would take at least 22 years until half the U.S. physician workforce would be in primary care.

Thus, there is need for other solutions. The committee has had a long-standing interest in expanding the supply and scope of practice of primary care nonphysician practitioners to meet this need. There are chronic shortages of these practitioners.

As mentioned in the PPRC report, it is estimated there are four to seven jobs for every nurse, practitioner, and physician assistant that graduates.

Moreover, just as physicians choose urban-based specialty practices, it is believed that increased numbers of nonphysician practitioners also are choosing to specialize in urban settings. Opportunities for nonphysician practitioners to specialize will proliferate when specialty residencies are eliminated.

As Bruce has mentioned and as discussed in the PPRC report, teaching hospitals are likely to use NPPs, or nurse nonphysician practitioners, to replace the residents who provide specialty services. These new opportunities will only strengthen the incentives for nonphysician practitioners to specialize in urban settings, rather than providing primary care services in rural settings.

To forestall the further depletion of practitioners from rural communities, the committee has recommended a series of strategies to improve the training, recruitment, and retention of rural practitioners. Simply training more primary care practitioners—that is, physicians and nonphysician practitioners—will not ensure that rural needs will be met; rather primary care practitioners need to be specifically trained for rural practice.

One way to prepare practitioners for rural practice is to train them in rural areas. Rural practice is sufficiently different from urban practice to warrant the establishment of strong primary care training programs in rural settings.

Model teaching practices need to be established that demonstrate the rewards of rural practice. These practices need to be part of health care networks that link rural primary care practitioners with supporting specialists.

Training should be interdisciplinary; that is, all types of practitioners are trained together so they can effectively work together.

Health profession schools will play a key role in developing these types of programs because they provide the connection between the medical practice site and the educational site.

Development of these programs might entail numerous components. For example, telecommunications linkages would be used for education and consultations between the two sites. The rural preceptors would be paid as faculty of the health profession schools. Both sides would learn from each other as they share the responsibility of training new practitioners.

The liaison between the entities would contribute to increased stability of rural practices and improved retention of rural practitioners.

Rural training programs will help prepare practitioners for rural practice. However, the committee has also recognized that chronic shortages of rural practitioners are due to a wide range of well-documented factors—not the least of which is how and where they are trained.

Lower payments to rural practitioners for the same services, based on historical charges, remain a tremendous disincentive to practitioners to locate in rural areas. Therefore, the committee has consistently recommended that rural practitioners receive equal pay for equal work.

Rural communities have historically depressed economies, with lower wages and more people out of work. Fewer individuals in rural areas have health insurance, and what they do have often provides poorer benefits than in urban areas.

Health care providers in rural communities charge less to make health care more affordable for their patients. Medicare payments to rural providers that are based on historic charges reflect the differential in charges between urban and rural practitioners.

However, knowledge that rural practitioners make less than their urban counterparts is a deterrent to new graduates choosing to practice in rural communities. The lower payment levels to rural practitioners makes it difficult to recruit and retain an adequate workforce in rural areas.

Payments to rural practitioners should be based on the economic cost of rural practice. This means the payment should reflect the price that has to be paid to make rural practice attractive to more health care practitioners.

This price may be considerably higher than historic charges would indicate. Unless payments to rural practitioners are improved, rural practice will continue to be viewed as unattractive by those establishing new practices.

In conclusion, the National Advisory Committee will consider all of these issues, as well as the issues raised by other participants of this workshop, as they develop recommendations to the Secretary on graduate medical education.

I want to thank you again for the opportunity to participate in the workshop. I will be happy to answer any questions.

Mr. HUMAN. Thanks very much, Dena.

And I would like to open the meeting up for any questions anybody does have, but before I do that, I'd like to ask one quick question of Anne Schwartz.

We've been through a whole afternoon and we've heard a lot of reaction and a lot of support for the general concept of what the Commission is proposing to do, from people who might generally be regarded as being in the health policy community, people who look at these issues and think about them on a regular basis.

At the same time, this kind of a proposal is pretty new to the political community, to the Senators and Congressmen and their staffs who have been coming through all day long and listening to these proposals. And we're talking about a very big proposal by congressional standards. We're talking about $8 billion, we're talking about really changing substantially and taking an awful lot of Federal control over a system that's operated pretty much independently for a long time.

I wonder what you think the political prospects are for this proposal to restructure graduate medical education or if you've given this any thought at the Physician Payment Review Commission. What are the prospects for your program in Congress? If we can't accomplish it all, is there any way that we can go half way toward it?

It seems to me to be pretty much an integrated proposal whether it stands or falls, and, yet, maybe I'm misconstruing it; maybe there are ways to go part way there if we can't go all the way.

Ms. SCHWARTZ. Well, first of all, you should know that I bet on Buffalo in the Super Bowl, so take anything I say with a grain of salt. [Laughter.]

I think what has struck me over the course of the afternoon sitting here is how complimentary the comments were about the Commission's work from very different interests who have very different concerns at stake.

So from a personal level and for the Commission, that's very good to hear. I think partly that reflects the fact that we've been working on this over a course of 2 years, and we've heard from a lot of different people and have been able to shift around a little bit in response to what we've heard as very important concerns.

In terms of the prospects in Congress, I think that's really your bailiwick. I think it's true we did develop this as a comprehensive proposal which has a number of pieces that fit together. We initially started out doing a Medicare policy primarily because health system reform wasn't on the agenda.

I think the fact that health system reform may be in the offing makes this work better because there's only so much the Medicare dollars can do alone. So while a Medicare only policy might be simpler to do, I'm really not convinced that it would be very effective.

Mr. HUMAN. Thanks very much.

How about anybody from the audience? Would anybody like to ask any questions of Anne or the panelists?

[No response.]

Well, if not, I'd like to conclude with just a personal comment or two.

I would like to thank Dr. Bob Harmon and John Kelso of the Department of Health and Human Services for allowing me to come over and work on the Aging Committee.

I would like to thank Kay Sterling and other officials of the American Political Science Association for extending me a fellowship, which made it possible.

I would like to thank Senator David Pryor for trusting me to moderate this workshop and an earlier workshop in 1991 on Undergraduate Medical Education.

And I would like to thank one of our panelists, Dena Puskin for doing a terrific job in filling in for me on my job while I'm working here and thus making it possible for me to be here.

Thank you very much, all of you, and I hope you've enjoyed this workshop today and found it useful.

[Whereupon, at 4:30 p.m., the Committee adjourned, to reconvene at the call of the Chair.]

APPENDIX I

HEALTH CARE REFORM IN RURAL AREAS

Summary of an Invitational Conference

March 10-12, 1993

Sponsored by
The Robert Wood Johnson Foundation
and
Arkansas Department of Health

Prepared by
Alpha Center

This report was prepared by the Alpha Center with funds provided by The Robert Wood Johnson Foundation. The writing of this report was a collaborative effort by persons who participated in an invitational conference on *Health Care Reform in Rural Areas* on March 10-12, 1993 in Little Rock, Arkansas. The conference was co-sponsored by The Robert Wood Johnson Foundation and the Arkansas Department of Health.

The views expressed in this report do not constitute the official positions of The Robert Wood Johnson Foundation, the Arkansas Department of Health, or any other government or private organization represented at this conference.

PREFACE

This document summarizes the cross-cutting themes and recommendations developed from an invitational conference on *Health Care Reform in Rural Areas*, sponsored by The Robert Wood Johnson Foundation and the Arkansas Department of Health. The conference was held in Little Rock, Arkansas on March 10-12, 1993. The purpose of the conference was to develop a cogent statement of the major issues which must be considered in developing health care reform for rural areas and to offer recommendations regarding the design and potential impact of such reform for consideration by the Administration and Congress.

The Alpha Center was responsible for conducting the conference and preparing the final report. The 120 persons who attended the conference represented a broad and diverse range of health professions, provider organizations, educators, researchers, and state and federal agencies responsible for the delivery of health services in rural areas.

A background paper was commissioned by the Federal Office of Rural Health Policy to guide the conference deliberations. This paper, *Health Care Reform: Issues for Rural Areas*, was prepared by Jon Christianson and Ira Moscovice of the Rural Health Research Center at the University of Minnesota.

The three major components of the conference -- informational presentations, panel discussions, and workgroups -- were designed to assist participants in shaping policy recommendations. Presentations by Alain Enthoven and Paul Ellwood provided an overview of managed competition and networks in health care reform. Lynn Etheredge and Dan Beauchamp followed with an overview of expenditure caps and global budgets. John Wennberg also discussed the potential roles of population-based health care planning and consumer choice in shaping a reformed health care system.

Conference participants met in the following eight workgroups: Service Areas, Supply of Human Resources, Networks Structure and Formation, Networks: Financing, Networks: Operations, Public Health, State Roles: Service Delivery/Network Formation, State Roles: Resource Allocation. The cross-cutting themes and recommendations in this summary were drawn from the reports developed by these workgroups.

A planning committee guided the development of the conference agenda, invitation list, and summary report. Members of the planning committee included: David S. Abernethy, Staff Director, Subcommittee on Ways and Means; Nancy L. Barrand, Senior Program Officer, The Robert Wood Johnson Foundation; James D. Bernstein, Director, North Carolina Office of Rural Health; Robert DeVries, Program Director, W.K. Kellogg Foundation; Donald F. Dickey, Program Officer, The Robert Wood Johnson Foundation; Linda Goldsmith, Director, Office of Rural Health, Arkansas Department of Health; Jeffrey Human, APSA Legislative Fellow, Senate Special Committee on Aging; Charles McGrew, Director of the Section of Health Facility Services and Systems, Arkansas Department of Health; Ira Moscovice, Ph.D., Professor and Associate Director of the Institute for Health Services Research, University of Minnesota; Dena S. Puskin, Sc.D., Acting Director of the Federal Office of Rural Health Policy; Sally K. Richardson Director, West Virginia, Public Employees Insurance Agency; Steve Rosenberg, President, Rosenberg Associates; Robert T. Van Hook, Rural Health Consultant.

Questions or comments regarding this *Summary* should be directed to W. David Helms or Daniel Campion at the Alpha Center, 1350 Connecticut Avenue, N.W., Suite 1100, Washington, D.C. 20036, (202)296-1818. A limited number of copies of the complete conference report are available from the Alpha Center for those wanting to review the eight workgroup reports and the background paper by Christianson and Moscovice.

INTRODUCTION

This report summarizes the cross-cutting themes and major recommendations which emerged from the conference on *Health Care Reform in Rural Areas*. The themes provide a policy framework for restructuring the rural health system within the context of comprehensive health care reform. The recommendations offer specific guidance to assure that the goals of health care reform can be realized by rural residents and health professionals.

To provide a central focus for the conference, it was necessary to make preliminary assumptions about the structure of health care reform. Based on their understanding of the proposals being considered by the Clinton Administration as it took office in January 1993, the conference planning committee assumed that the eventual health care reform plan would contain elements of both "managed competition" and "global budgeting." In their background paper for the conference, Christianson and Moscovice list eleven assumptions that were used to provide the context for assessing the impact of health care reform on rural areas.[1]

The workgroup recommendations were generated in response to these assumptions about health care reform. For example, workshop participants assumed that the federal government would define a standard set of health benefits, that employers and individuals would share the cost of health insurance, and that subsidies would be provided for the poor. They assumed that most persons, except employees of very large firms, would obtain coverage through "health insurance purchasing cooperatives" (HIPCs) that serve defined geographical areas. HIPCs would contract with private health plans, which would resemble what architects of "managed competition" proposals were calling "accountable health plans" (AHPs). They also assumed that states would have authority to establish and supervise these HIPCs and that, in areas where competition among AHPs would not be feasible, the HIPCs would be permitted to set payment rates for the providers required to deliver the needed services.

While the terminology and design specifications for these new entities may change, the basic concepts of purchasing cooperatives and integrated managed care organizations will likely be central elements of any new national health care reform plan. We urge that those developing specific reform proposals give serious consideration to the cross-cutting themes and recommendations presented in this report.

CROSS-CUTTING THEMES

1. ***Health care reform presents a critical opportunity for addressing fundamental problems in the rural health care delivery system.***

   The rural health care delivery system is burdened by persistent problems that will require comprehensive solutions targeted not only at the financing, but also at the ***delivery*** of health care services. For example, there is an acute shortage of primary care providers in rural areas and many communities find it difficult to recruit and retain physicians and other health professionals. Small rural hospitals are more likely to be financially distressed than their urban counterparts. Rural residents are more likely to be uninsured. Furthermore, rural people must often travel long distances to health services and have more difficulty getting there. Fundamental to addressing such interrelated problems will be the development of the needed infrastructure and capacity for a fully functioning delivery system. Most important, health care reform must seek to increase and strengthen the supply of human resources in rural areas, provide appropriate incentives for network development, channel capital investment/resources where it is needed most, and allow flexible mechanisms for accommodating unique local circumstances.

2. ***Flexibility and a range of options will be necessary for implementing health care reform in rural areas in order to meet diverse local needs and utilize local resources.***

   Health care reform policies must be sensitive to the underlying dynamics and special needs of rural areas. The widely dispersed regions that we call "Rural America" are characterized by major differences in geography, natural resources, economic bases, and demographic compositions. In addition, state-by-state variation in facility regulations, health personnel certification/licensure requirements, and investments in health care training programs contribute to considerable differences in the capacity of local and regional health care systems. Both health care needs and resources can vary substantially from one rural community to another. Because of this tremendous diversity, states and communities will need an array of implementation options that they can use to restructure and strengthen their local health care delivery systems. Allowing for flexibility in the implementation of health care reform mechanisms will be vital to meeting the diverse needs of rural residents and attaining national goals for a reformed health care system.

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[1] The background paper is part of the full conference report, which is available from the Alpha Center.

3. ***The active involvement of rural residents and the meaningful representation of rural communities at the state level will be essential to assure successful implementation of health care reform in rural areas.***

Many rural residents would be displeased with a national reform plan that came to their communities as an outside agenda developed by government leaders in Washington, DC. Physicians, hospital administrators, and other health professionals are integral to the social and economic fabric of rural communities. Many rural residents are also characterized by extreme independence and the desire to maintain control over their local institutions. Given the proper data, information, and an opportunity to consider their various options, however, residents in many rural communities have shown tremendous ingenuity and commitment in finding solutions to their health care delivery and financing problems. Because the extensive change under national health care reform will not come easily for many rural areas, it is critical that federal and state policy makers utilize the creative energy and resources of local communities to reshape the health care system that ultimately must serve their needs. Therefore, actively involving local residents and giving them the opportunity for meaningful participation in the development of regional and state health care policy will be essential to the success of health care reform in rural areas.

4. ***The development of regional health care networks, which deliver primary care through locally-based providers, should be a fundamental strategy for restructuring rural health care delivery systems.***

Rural health networks have the potential for improving access to needed services, utilizing resources more efficiently, and strengthening the practice of medicine in rural areas. Guaranteeing financial access to a standard set of comprehensive health benefits will require providing geographic access to a range of primary, secondary, and tertiary services. Providing primary care and preventive services *locally* should be a priority, because family physicians and other primary care practitioners can meet the majority of health care needs that require a visit to a health care professional, and they generally use less costly equipment and technology. Regional networks would improve access to secondary and tertiary services that can not be provided efficiently by low-volume providers. Agreements among hospitals regarding consultations and patient transfers would assure access to surgical and specialty services provided at referral hospitals and tertiary care centers. The formation of such regional health networks will involve the creation of new organizational relationships, more extensive telecommunications linkages, and improved transportation systems among providers in multiple communities.

5. ***Developing health care networks will require a variety of approaches from "managed competition" to "managed cooperation."***

It is unrealistic to think that a single model for network development can be implemented successfully in all rural areas. A range of implementation options and incentives -- from "managed competition" to "managed cooperation" -- will be needed to create networks that utilize existing resources most efficiently, build additional capacity where necessary, and meet the needs of vulnerable and underserved populations. "Managed competition" may be a useful approach for health care reform in some rural areas, such as those served by rural-based HMOs, having higher population densities, or located adjacent to urban markets. In such cases, competition may provide incentives for the more extensive and even more efficient delivery of services.

Providing incentives for cooperation and collaboration may be more appropriate for other areas, however, especially in sparsely populated areas, or where it has traditionally been difficult to recruit and retain health care personnel. To support practitioners in these rural areas, special efforts should be made to provide adequate back-up services, peer support, telecommunication linkages to hospitals in larger communities, and to arrange clinics with visiting specialists as needed. In many communities, special provider organizations -- including migrant health centers, community health centers, and rural health centers -- have been established to serve vulnerable and underserved populations. The investments made by the national, state, and local governments, as well as community-based organizations, in these types of facilities and organizations have been substantial. A cooperative approach to forming networks and appropriate financial incentives could help strengthen these vital entities.

6. *Dramatic changes will be needed to provide an adequate supply of primary care providers in rural areas.*

Health care reform as currently envisioned depends heavily on increasing the provision of primary care services. However, the supply of health care professionals who can provide these services is currently inadequate, especially in rural areas. Health care reform presents a critical opportunity for addressing this shortage in a systematic fashion. Graduate medical education must be reoriented to focus on primary care, and more primary care training and residency programs should be established in rural areas. Young people from rural areas should be encouraged and adequately prepared to enter the health professions. Barriers to practice must be removed for nurse practitioners, physician assistants, and nurse midwives. Reimbursement policies must be structured to compensate adequately primary care practitioners, both for their training and the time they spend with patients. Finally, additional recruitment and retention efforts are needed to assure that appropriate providers reach underserved areas and are supported once they begin practicing there.

7. *The health care infrastructure – including people, structures, and systems – needs to be strengthened in many rural areas to assure access to essential health care services.*

In many rural communities, the small population size, limited economic base, and a lack of trained personnel and organized systems have contributed to a weak health care infrastructure. Affordable capital financing is needed to renovate facilities and update equipment. Additional capital and human resources are needed particularly for improving transportation systems, upgrading and coordinating emergency medical services, and developing communications systems (e.g., teleradiology and compressed video linkages with referral hospitals). Besides increasing the supply of primary care providers, as noted above, other skilled professionals are needed to assure an adequate supply of managers, communications specialists, emergency medical personnel, and others. This will also require that educational programs are developed to train rural residents to perform these roles.

To guide system change, additional investments will be needed to build regional and state planning capabilities, including a data collection systems, analytic resources, and community education and decision-making structures.

8. *States should play a major role in implementing health care reform in rural areas.*

States will need to play a number of important roles under a national health care reform plan, especially to assure that the needs of rural residents are met. While the federal government should set the overall framework for health care reform, states must build on their traditional roles in health care to implement the plan (e.g., setting operational rules for risk-bearing organizations, regulating provider quality, providing coverage for their own employees, providing for the special needs of vulnerable populations, training health professionals, etc.). States are closer to local communities than the federal government, integrally tied to them through a system of elected officials, county commissioners, local social service agencies, public health departments, and other community leaders. Given sufficient resources and the flexibility to adapt national goals to meet unique local needs, states should be able meet the needs of rural residents by: (1) assuring equitable access to capital, (2) training and promoting the appropriate distribution of health care personnel, (3) assisting communities with network development, (4) setting the geographic boundaries for health insurance purchasing cooperatives (HIPCs), and (5) assuring that vulnerable populations are adequately served.

RECOMMENDATIONS

1. *Define criteria for identifying areas where competition will or will not achieve the desired results.*

Given the fundamental concern that a "managed competition" strategy may not work in "non-competitive" rural health care markets as envisioned for urban and suburban markets, federal and state governments must develop criteria for identifying locations and conditions under which a competitively-based health care reform program is likely, or not likely, to achieve the desired goals. Such criteria could be used for determining distinct populations or geographic areas to be served by HIPCs, accountable health plans (AHPs), and where exclusive franchises might be given to AHPs and/or rural providers. These criteria would also be useful for health care planning and resource allocation purposes. As an illustration, workgroup number one on Health Care Service Areas outlined a five-tier typology of "regions for competition" ranging from "frontier," where competition would not be possible, to "major metropolitan," where full competition would be sustainable.

2. *States should have the responsibility for determining the geographic area served by HIPCs.*

If a managed competition framework is adopted for health care reform, states should be given the responsibility for determining the geographic areas to be served by HIPCs. Given states' interest and responsibility for guiding the allocation of health care resources, such control would be appropriate given the HIPC's function as a principle mechanism for pooling and allocating financial resources. States should be given the latitude to create sub-state regions for HIPC development, taking into account the boundaries of current health care markets, existing provider and network relationships, and the needs of vulnerable populations.

3. ***Establish national and state health personnel policy goals and allocate training funds to assure adequate supply of primary care providers for rural areas.***

   A health care reform program that appropriately places primary care and preventive services as its priority will increase the demand on an already limited supply of primary care providers in rural areas. To ensure an adequate supply of primary care providers, the number of family practice physicians and other primary care practitioners must be increased dramatically. It is imperative to establish national goals for the health professional workforce consistent with the general population needs and to allocate education and training dollars accordingly. In concert with these national goals, states should establish state-specific goals that take into account the needs of AHPs. States should also be given the authority to oversee the allocation of training resources so as to increase the supply of primary care providers serving in rural areas.

4. ***Reorient medical education to focus on primary care and to provide clinical experience in rural practices.***

   Graduate medical education (GME) must be restructured from its current hospital-based focus to include more ambulatory training sites in rural areas. Additional funding should be allocated to rural-based training programs for all levels of primary care professionals, including physicians, nurse practitioners, physician assistants, and certified nurse midwives.

5. ***Provide strong incentives for states to adopt scope-of-practice laws with nationally recognized criteria that enable "midlevel" practitioners (e.g., nurse practitioners, physician assistants, certified nurse midwives) to practice semi-independently at sites remote from physician preceptors.***

   If nurse practitioners, physician assistants, and certified nurse midwives are to be an important resource for improving the supply of practitioners in rural areas, it will be necessary to overcome the current state-by-state variation in certification and licensure requirements. Recognizing national certification standards and adopting appropriate scope-of-practice acts at the state level would remove inappropriate restrictions currently codified in law and improve the mobility of this important supply of personnel.

6. ***To qualify as an AHP serving a rural region, plans must agree to make available the full range of services for all people in the designated geographic service area, providing the appropriate level of services -- especially primary care and preventive services -- through locally-based providers whenever feasible.***

   Explicitly requiring AHPs to make available all of the services prescribed in the anticipated, national "standard benefit package" would increase access to a wider array of health care services for many rural residents. At a minimum, primary care and preventive services should be provided at the local level, with the understanding that in communities which cannot support a general hospital, such as those in sparsely populated areas, higher acuity inpatient services would be available at a regional referral center or an urban-based hospital.

   One way to give priority to local providers would be to allow well-qualified rural practitioners (e.g., those who have completed residency programs and/or those who are board certified) to have the first option for "bidding" on contracts to serve their established markets. It may also be the case that such a priority status would give local providers the opportunity to establish rural-based AHPs or develop rural-based networks that selectively contract with suburban and urban-based providers for specialty care services. Such arrangements could help preserve existing doctor-patient relationships, as well as referral and collegial relationships already established by rural practitioners. In this way rural providers would be given the opportunity to take an active role in reforming and strengthening their community's health care system.

7. ***Given the vulnerability of some rural providers, rules should be established to protect them from unreasonable financial risk.***

   The imposition of "urban" provider risk sharing models that pass significantly higher financial risks to individual providers may force some rural practitioners to go out of business or move to other areas. If these providers leave, it may be difficult to replace them. Many rural solo practitioners and group practices in rural areas still operate outside of managed care systems and are inexperienced in dealing with the dynamics and financial incentives that drive HMO and PPO systems. There is a major concern that such rural providers may not readily adapt to capitated payment systems or those involving substantial performance-based "withhold" systems. Policymakers should be aware of this extremely sensitive issue.

8. ***Some areas will require exclusive franchise arrangements for AHPs and/or provider networks serving rural areas.***

   Where markets are "non-competitive," franchises should be granted whereby certain AHPs and/or providers are given an exclusive option of serving local residents. There are many questions about the ways such exclusive contracts should be structured and awarded. What time limits would be reasonable for giving local providers an exclusive option on serving their region, before opening the area up to outside provider groups? What discretion should local residents/consumers have in the development and monitoring of franchise agreements?

   While franchises may be necessary in more remote, underserved, or vulnerable areas, it is not necessarily the case that this will be the dominant model in all rural areas. Again, a continuum of regulatory and financing options will be needed to accommodate the diverse range of local situations.

9. ***Without the ability to include populations covered under Medicare, Medicaid, and the Federal Employees Health Benefits Program, many rural areas will have an inadequate population base to provide sufficient leverage on providers to participate in AHPs, or other provider arrangements under contract to the HIPC.***

   Major policy decisions center on the issue of whether or not the financing resources for those currently covered under major federal programs (i.e., Medicare, Medicaid, and the Federal Employees Health Benefit Program) would flow into HIPCs and require these individuals to receive their care through the contracted AHPs or other arrangements made by the HIPCs. Because enrollees in these programs often constitute a large percentage of insured persons in rural areas, the prospect of rural providers "escaping" reforms by establishing specialized practices to serve mainly, or exclusively, exempted payer populations is particularly disturbing. If these major payers operate outside of the HIPC/AHP system, the desired competitive approach, where otherwise feasible, may be undermined in some rural areas. Given that such programs represent a significant proportion of provider revenues in rural areas, special attention to the impact of program exemptions and the payment policies of programs that are exempted is warranted.

10. ***Rural providers opting out of AHPs should be subject to regulatory oversight on prices and capacity.***

    As noted above, the question of whether providers would join an AHP must be considered in light of the alternatives available to them for opting out of such systems. Two scenarios would be possible: one is where providers can obtain sufficient income from payers exempted from HIPCs; the other is where providers choose to serve HIPC enrollees, but operate as solo-practitioners. It is generally believed that providers opting out of managed care systems that are under contract to the HIPC would need to be subject to regulatory oversight, such as rate regulation and controls on capital expenditures for plant and equipment, in order to assure compliance with cost containment and quality objectives.

    The stringency of such price and capacity controls could provide strong incentives for AHP participation. Conversely, tight price controls on payments could jeopardize goals for recruitment and retention of rural providers, especially if prospects appear better elsewhere. Therefore, special attention should be given both to payment policies for health insurance programs exempted from the HIPC and to the HIPC's policies for reimbursing providers who serve HIPC beneficiaries, but do not participate in an AHP.

11. ***States should oversee the allocation of health care capital to support rural infrastructure development.***

    Access to capital financing with affordable terms is a critical need facing rural health care providers with limited capital reserves. Older rural hospitals have a difficult time in maintaining and upgrading their plant and equipment, and both rural hospitals and physicians find it difficult to obtain newer and more advanced health care technologies. Rural communities with little or no established base of networked providers or alternative health plans will likely require greater capital investments to upgrade or convert their existing facilities and form network systems.

    States should be given the authority for ensuring the availability of adequate capital resources and for allocating those resources so as to support appropriate levels of health care services in underserved rural areas. States would identify areas needing infusions of new capital and create mechanisms for channeling investment funds to them. Important sources of capital include state bonding authorities, Medicare capital payments, and the portions of payments made by other insurers or health plans to cover providers' capital expenses. Policymakers should be aware of the severe need for capital to build the rural health care infrastructure and how the financial incentives they create under health care reform will be vital to strengthening or weakening the capacity of rural providers to meet local health care needs.

12. ***To ensure that antitrust laws are not an undue hinderance for rural network development, changes in federal and/or state statutes and supervision may be needed.***

    Some believe that antitrust enforcement practices of the Department of Justice and the Federal Trade Commission have discouraged the formation of the kinds of joint ventures and other arrangements vital to network development. Others contend that antitrust rulings should have had little impact on collaborative relationships among hospitals and other providers. The extensive development of new networks that is anticipated, however, may require special attention by both federal and state law makers. One option would be modification of federal antitrust laws. An alternative would be for states to exercise "state action immunity" for arrangements it considers desirable, but which might otherwise be ruled unlawful under federal law. To create such an immunity, a state must both articulate its policy to allow a particular anticompetitive arrangement and adequately monitor and oversee the resulting organization/arrangement.

13. ***Any national service program should place a priority on strengthening the infrastructure for rural health.***

    Rural health care should be given priority under the development of any national service program that would attract college graduates and others into public service. Given that improving rural health care is a major national concern, any such program should seek to strengthen the supply of, not only health care professionals, but also managers, engineers, planners, and others vital to strengthening the rural health care infrastructure.

REFORMING GRADUATE MEDICAL EDUCATION: REPORT OF THE PHYSICIAN PAYMENT REVIEW COMMISSION

The Physician Payment Review Commission has developed a comprehensive policy intended to result in a system of graduate medical education more responsive to societal needs. This policy is designed to limit growth in residencies, shift the balance between subspecialists and generalists, and facilitate training in ambulatory settings (PPRC 1993).

Although the Commission was created in 1986 to advise the U.S. Congress on reform of Medicare's method of paying physicians, its mandate has since been substantially expanded to encompass a broader set of interrelated policies affecting the financing, delivery, and quality of health services. One issue area, to which the Commission has devoted considerable attention over the past two years, concerns physician supply, specialty distribution, and the financing of graduate medical education.

With the national debate on health system reform, these issues have greater resonance. Broader system reform offers the potential for more effective solutions by including all payers in new financing strategies for graduate medical education and by developing different systems of service delivery for uninsured persons who historically have relied on teaching institutions as their usual source of care. This debate also provides an important opportunity that was missing in the past to coordinate supply and training policies with those affecting payment for physicians' services, access to care, and cost containment.

THE CONTEXT FOR CHANGE

The Commission based its initial work concerning graduate medical education and physician supply on three working assumptions:

- The number of physicians exceeds, or will soon exceed, that required to meet national health care needs.
- The nation is training too many medical subspecialists and too many specialists in some surgical fields relative to the number of primary care physicians.
- Many physicians in both primary care and other specialties lack appropriate training experiences to prepare them for practice in ambulatory settings (PPRC 1992).

Current and past federal policies have had limited impact on these problems. The U.S. physician-to-population ratio will continue growing through the year 2020. This unchecked growth in physician supply may undermine other efforts to bring health care costs under control. Another concern is the continuing decline in the proportion of physicians trained in generalist fields, which is already lower in the United States than in other industrialized nations. Spiraling growth in the number of residencies, primarily to meet the service needs of teaching institutions, has frustrated efforts to constrain supply and shift specialty mix. Moreover, despite discussion about the need for more training in ambulatory settings, mechanisms for financing graduate medical education have made it difficult to move training out of the hospital.

Substantial changes in the financing of graduate medical education will be required to reverse these trends and these should be considered a necessary element of broader health system reform. Policies that create weak incentives for change will not succeed in securing the supply and distribution of physicians suited to meet the population's health needs. Bold actions that bring together those making the decisions about the creation of residency slots with those financing training are essential.

RECOMMENDATIONS FOR REFORM

The Commission has envisioned a new system of graduate medical education that limits future growth in supply, rationalizes the allocation of residency positions, and makes entities sponsoring training more accountable to the nation's health care needs. It includes five components:

- a congressionally set limit on the total number of residencies to be funded;
- a federal body that, using both objective data and input from interested parties, would determine the distribution of these slots by specialty;

- decisions by accrediting bodies to select those residency slots to be funded on the basis of educational quality;

- payments for the direct costs of graduate medical education to approved residencies from a national financing pool to which all payers would contribute a percentage of premiums or payments for medical care services; and

- mechanisms to provide transitional financial relief to teaching hospitals that lose residents but still must meet essential service needs.

Each of these elements is described in greater detail below.

Limits on the Number and Mix of Residents to Be Funded

An often-criticized feature of the current GME system is the absence of a link between decisions about financing and those determining the supply and mix of residency positions (Anderson et al. 1990). The number and mix of residents are determined by a complex process involving the decisions of private accrediting bodies, training program directors, administrators of teaching institutions, and state and federal governments. Because this process is fragmented, there is no effort to ensure that the number and mix of residency positions meet national health needs. Instead, the residency approval process has been primarily driven by the service needs of teaching institutions that can develop programs of acceptable quality.

Graduate medical education is largely financed through patient care revenues generated by hospitals. The federal government is the largest explicit financing source for graduate medical education through the Medicare program. Briefly, Medicare recognizes the costs of training under two mechanisms (1) direct medical education payments to hospitals for residents' stipends, faculty salaries, administrative expenses, and institutional overhead; and (2) an indirect medical education adjustment to per case payments. In 1991, Medicare paid approximately $1.5 billion in direct medical education payments and $3.33 billion in indirect adjustments. The Departments of Veterans Affairs and Defense also finance training in institutions operated by these agencies. In addition, federal grants under Title VII of the Public Health Service subsidize training in primary care fields.

Other payers have less explicit mechanisms for financing graduate medical education. Teaching hospital charges to private payers, for example, reflect the direct costs of graduate medical education (e.g., residents' stipends) although these payers do not identify and separately pay for these costs. Since most state Medicaid programs pay hospitals below cost, these programs provide little support for graduate medical education, even when their payment methodologies recognize direct costs. Many states, however, do provide direct support for some residency programs, particularly those in family practice (Barnett and Midtling 1989).

After considering several alternative mechanisms for creating a link between financing and the number and mix of positions, the Commission determined that limits on the total number of residency positions are essential. Moreover, deliberate decisions should be made about the distribution of these positions across specialties. All positions approved as part of an open, deliberative process should be funded for the full length of training.

Paying for a fixed number of residents would be similar to policies of other Western nations. In Britain, for example, the government finances all residency slots and controls the number of training positions by specialty (Maudsley 1988). In Canada, most residency positions are funded by provincial ministries of health with the number of positions funded determined in annual negotiations among medical schools, associations representing physicians, and provincial governments (Ryten 1991).

The experiences in these systems suggest that when GME financing is used to support policy objectives, patterns of training meet those goals. Even though the trend toward specialization in Canada during the 1960s was similar to that in the United States, changes in the financing and control of GME during the 1970s (combined with other health system reforms) have led to markedly different career choices between Canadian and U.S. medical students. About half of Canadian medical graduates become primary care physicians, compared with less than one-fourth of their American peers (Whitcomb 1992).

In this country, a similar policy could be established with three elements: a congressionally determined limit on the total number of residency slots, allocation of these slots across specialties by a federal body established for this purpose, and allocation of slots to individual residency programs by accrediting bodies. These are described below.

Congressionally Determined Limits on Total Number. The U.S. Congress should set in statute a limit on the total number of residencies to be funded and achieve this by sequencing reductions over successive classes of first-year residents. Reductions in the number of first-year positions combined with limits on the number of positions by specialty will limit the number of trainees in every postgraduate year. Sequencing cuts would provide for a transition period and avoid the possibility that residents already in programs will not be able to complete training due to elimination of positions. If implemented in 1992, a policy that limited the number of first-year residents to U.S. graduates plus 10 percent would have required cutting about 2,500 positions. Over time, this policy would reduce the current number of residents by about 11,000 to around 75,000.

Although the Commission has concerns about the number of medical students graduating annually and the long-term impact this will have on the stock of physicians, it does not recommend setting the limit for first-year residents below the number of U.S. medical graduates. Assuming that medical school enrollment does not increase, all graduating students should have the opportunity to complete their training. There should also be an additional number of slots above the number of U.S. graduates so that the United States can fulfill its obligation to train health professionals from abroad. This policy would not discriminate against international medical graduates (IMGs); instead IMGs would compete for residency positions against U.S. graduates just as they now do either through the National Residency Matching Program or by direct application to individual programs.

Allocation of Slots by Specialty. Decisions about the number of residencies per specialty should be made by a federal body created for this purpose. This would permit more deliberative analysis of the appropriate allocation of slots than would be possible if this were set in statute. It would also allow flexibility to resident allocation over time.

This new decisionmaking body would meet regularly in an open forum, using objective data and input from interested parties in its decisionmaking. It should also have research, planning, and evaluation functions and either fund or conduct analyses to inform future decisions. Issues of interest might include the impact of changing practice patterns and shifting demographics on supply and distribution, lessons to be learned from staffing patterns in managed care organizations, and the implications of delivery system changes for the content and length of training in different specialties.

In considering the functions of this decisionmaking body, the Commission looked at several different alternatives for how it should be structured and its relationships to the Congress and the Department of Health and Human Services. It could be a commission that provides advice to the Congress. A promising model is the Defense Base Closure and Realignment Commission. Its recommendations are subject to congressional approval but cannot be amended. If accepted, its recommendations are binding as statute. Alternatively, it could be a commission that advises the Secretary of Health and Human Services. Or decisions could be made by an independent federal agency. This is the model suggested by those advocating creation of a national health board as a key element in system reform; if such a board were created, this body could be one of its subunits.

Accrediting Bodies. Once the decision is made about the number of positions to be funded for each specialty, a second tier of decisions will be required as to which specific positions in these fields should be funded. These decisions should be made on the basis of educational quality by the bodies that accredit graduate training. The goal would be to protect high-quality programs, making necessary cuts in more marginal programs. An example may help illustrate this process. First, the federal body would determine the number of residents to be funded per specialty: for example, 100 residents in Specialty A. This would then be communicated to the residency review committee (RRC) for that specialty (or other accrediting body, as appropriate). If 125 positions were currently available in Specialty A, it would be the responsibility of the RRC for Specialty A to rank programs based on quality measures and then go down that list approving slots until 100 positions were selected. Presumably, the RRC would have the flexibility to fund all positions in the best programs or to spread cuts across all programs.

Making the profession a partner in this process has several advantages. Accrediting bodies, such as the Accreditation Council on Graduate Medical Education and its residency review committees, already have access to information and the expertise needed to evaluate training programs and would be well-positioned to make informed choices about which should be funded. In addition, it would keep the federal government at an arms' length from decisions about the content and quality of training.

Another important advantage of this approach is its implications for antitrust enforcement. The profession has long argued that it cannot limit the number of residencies because this

would be considered a restraint of trade. But this process would be federally sanctioned. Therefore, it is the Commission's understanding that because the federal government would be asking the profession to make these choices, the RRCs and others making them would not be subject to antitrust action. To clarify this relationship and ensure that decisions are made based on policy goals, it may be desirable to draw up a contract that specifies responsibilities and expectations.

Payer Pool

All payers should share the costs of graduate medical education, reflecting the principle that all who benefit from graduate medical education should contribute to its costs. Currently, some payers may escape from supporting GME by avoiding inclusion of teaching hospitals in their networks. This could be exacerbated under some approaches to system reform if plans continue to seek a competitive advantage by directing patients to hospitals that charge less because of the absence of teaching costs.

All payers, including self-insured employers, should contribute a percentage of their payments for medical care to a national pool. For example, a 1 percent set-aside would generate about $8 billion per year to support training. (Although the total cost of graduate medical education has not been estimated, educated guesses range between $5 billion and $9 billion). The funds in this pool would be used to pay for the direct costs of graduate medical education for residency positions approved as part of a process in which policymakers, the medical profession, and other interested parties participate. Because Medicare would contribute to this pool like all other payers, it would no longer make direct medical education payments to hospitals.

Experiences at the state level suggest that where there are explicit and predictable sources of funding for graduate medical education, these have been successfully used to leverage changes. For example, in Buffalo, New York, where hospitals receive explicit GME funds under the state's rate-setting mechanism, member institutions of the Graduate Medical Dental Education Consortium of Buffalo have a written agreement to contribute a share of their GME funds into a common fund for special initiatives such as training more primary care physicians, developing ambulatory training sites, and reaching out to minority students. Rate setting has also enabled the state of New Jersey to set strict caps on the number and mix of residencies funded.

Breaking the link between payment for hospital services and the financing of graduate medical education creates two additional questions: who should receive the payment and what methodology should be used for determining payment amounts. Because local circumstances will determine the effectiveness and desirability of making payments to either the hospital, medical school or training program, payments could be made to any of these entities. Making payments available to programs and medical schools would facilitate training in ambulatory settings. In addition, Medicare's current payment methodology, based on hospital-specific historical costs, should be replaced by a new standardized payment per resident.

Meeting Hospital Service Needs With Fewer Residents

Reducing the number of residents and shifting positions from subspecialty fields to primary care and from inpatient settings to ambulatory sites will be disruptive to teaching hospitals. Because these institutions' reliance on house officers to meet clinical service needs has been a major impediment to changes in resident supply, specialty mix and the site of training, an effective policy should also address these needs. Transitional relief funds should be made available to teaching hospitals that lose residency positions as a part of this process. Preference should be given to those hospitals with a disproportionate share of indigent patients.

Teaching institutions could respond to the loss of residents by eliminating services or by using highly skilled nonphysician practitioners (NPPs) or community physicians. There is a growing literature documenting the favorable experience teaching hospitals have had using nonphysician practitioners on the wards, in critical care and in surgery. Under certain circumstances, nonphysician practitioners may actually be preferable to residents. Some faculty would rather work with nonphysician practitioners, who have a lower turnover rate, greater familiarity with departmental procedures, and more clinical experience than junior residents (Silver and McAtee 1988). Using NPPs may also ensure that residents have richer educational experiences by freeing them from routine tasks that lose their pedagogical value after a certain number of repetitions (Cawley 1992).

There are clinical, financial, and practical reasons that caution against relying too heavily on NPPs as substitutes for residents. Some may require additional training to assume responsibility for complex cases that call for more advanced medical decisionmaking or technical skill. While these concerns may lessen in the future with increasing specialization among advanced practice nurses and physician assistants, additional attending physicians may be needed to assume responsibilities that require medical training.

Another barrier to using more nonphysician practitioners is the view that they are more expensive to hire than residents. First, unlike residents who bring Medicare graduate medical education payments to the institution, hospitals do not always receive an explicit payment for the services of NPPs. Second, nonphysician practitioners command far higher salaries than residents and work many fewer hours. For example, the average national salary for physician assistants ranges from $45,000 to $49,000 compared with the average stipend of about $29,000 to $31,000 for second- and third-year residents (AAPA 1992; AAMC 1991). But, NPPs may cost institutions less than salary figures suggest because they may be more efficient than residents or require less faculty supervision. Finally, it is unclear whether a sufficient number of NPPs will be willing to step into new jobs that might be created by the loss of 11,000 residents (the reduction envisioned under the Commission's proposed limit). Anecdotal reports suggest that demand for NPPs is already outstripping supply. Whether NPPs will be willing to accept jobs created by the loss of residents will depend upon the competitiveness of salaries and the attractiveness of these positions relative to other opportunities.

In addition to giving more responsibility to nonphysician practitioners, a number of teaching hospitals have tried other strategies to ensure service coverage for units previously staffed by residents. At the Medical College of Virginia, for example, a nonteaching service has been developed as one of several curriculum experiments designed to increase resident's training time in ambulatory settings, reduce inpatient clinical service demands, and mitigate stress. Patients are admitted to the nonteaching service if their care has less educational value for residents; many are admitted for special procedures that require minimal stays. Faculty physicians receive backup support from nurse practitioners, subspecialty fellows, and senior residents who are freed from other responsibilities and paid extra for their services (Fallon 1992).

These experiences suggest that teaching hospitals can continue to meet their service needs even when the number of residents or residents' work hours are constrained by external forces. But the transition to new staffing and scheduling arrangements takes time and money. In New York, implementation of resident work hour regulations, coupled with new requirements for continuous supervision of residents and 24-hour availability of intravenous, phlebotomy, and messenger/ transport services, has cost approximately $225 million; this figure represents about a 2 percent increase in total hospital expenditures (NYSGME 1992; Thorpe 1990).

A portion of funds from the payer pool should be made available to institutions that downsize or close residency positions but still have essential service needs that must be met, at least in the short term. The Commission's estimate of the impact of limits on the total number of residents on the Medicare program indicated that, if this policy had been fully implemented in 1992, it would have saved about $483 million in Medicare payments to hospitals (about 10 percent of total payments). Of this, $165 million would have been saved in direct medical education payments and $318 million in indirect adjustments. Making a portion of these funds available to teaching hospitals for several years would provide a cushion during which teaching services could be reconfigured, restaffed or closed.

Transitional relief funds could be channeled by a formula related to the number of residents per occupied bed or by extending payments for the initial complement of an institution's residents (even though some or all of those positions would be eliminated) for a time-limited period. To be effective and equitable, relief should be available only to certain institutions. Payments should be made only to those that actually lose residents, not just those that have positions that were not funded. Hospitals serving the indigent should be given preferential consideration.

In addition, it may be desirable to expand existing federal programs that support nonphysician training to increase the supply of nonphysicians trained to staff tertiary care centers. These include institutional grants, student loans and scholarships, and the National Health Service Corps. Many of these programs lost substantial funding during the early 1980s and have not yet been restored to their previous funding levels.

IMPLICATIONS OF THE COMMISSION'S APPROACH

Federal policies are needed that not only signal preferences but also lead directly to reductions in resident supply, changes in specialty mix, and additional training opportunities in ambulatory settings. A process that restricts the total number of residency positions and links the power of public financing with informed decisionmakers within the medical profession will help achieve these goals.

There are limits, however, to what these proposed reforms in GME financing may accomplish. Goals could be subverted if residencies not approved for funding from the payer pool are financed from other revenue sources. This has already happened in New Jersey where, under the state's all-payer hospital rate-setting authority, the number of residencies was capped at 2,610 in 1986. Since then, 200 additional positions have been created, all financed from faculty practice plans and grants (AGMEC 1991).

Steps could be taken to prevent programs from financing positions beyond the statutorily set limit. Ideally, only positions funded from the payer pool would be accredited. Students would accept unaccredited positions at their own risk as they would be unable to sit for specialty boards. There is no obvious legislative lever, however, to compel accreditors to do this. Financial penalties could be imposed on institutions creating or continuing positions not approved for funding from the pool. Funding could be reduced for every unapproved slot, for example. This would be similar to the approach used in Quebec, where the number of ministry-funded positions has been reduced for each nonministry-funded position created (Ryten 1991). Similarly, the state of New Jersey has plans to reduce payments to hospitals that exceeded state-set caps (Vaun 1992). Other alternatives might include making programs that fund residencies outside the system ineligible for any funding from the pool or making the institutions where these residents train ineligible for Medicare participation.

Moreover, graduate medical education financing is only one of many factors affecting the supply and specialty mix of physicians. Although the availability of training in any field will clearly influence students' career decisions, specialty choice and practice location are also affected by factors such as expectations of income; perceptions about the prestige, intellectual content, and quality of life aspects of particular fields; other educational experiences; and sociodemographic characteristics and personality traits (McCarty 1987).

Thus, achieving policy goals will also require changes in both medical education and the practice environment to complement reforms in graduate medical education financing.

Of concern to many is the need for policies that will make primary care careers more attractive. These include rewards for primary care practice in the form of equitable payment and for primary care academicians in the form of sufficient research funding. Such policies would send a message to medical students that primary care careers are as intellectually challenging, financially rewarding, and important to society as those in subspecialties.

The federal government can clearly effect change in some of these areas. Adoption of a resource-based method for calculating the practice expense component of the Medicare Fee Schedule, for example, will improve payments for primary care physicians. Adoption of the fee schedule by other payers will also enhance income for primary care specialties.

Other changes are less amenable to federal policy, particularly given the limited resources available for new initiatives. Medical educators thus must take it upon themselves to foster student and faculty development in primary care. Promising strategies include preclinical exposure to primary care, family medicine clerkships, preferential admissions policies, and appointment of primary care faculty to key administrative posts.

Finally, changes in GME financing will take many years to affect the national stock of physicians. This is because physicians have unusually long work lives; the average 35-year-old physician can expect to practice almost to the age of 70 (Kletke et al. 1987). The length of time required to change specialty distribution suggests that efforts to retrain physicians already in practice may also be needed to achieve policy goals within a reasonable period.

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APPENDIX II

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Robert G. Petersdorf, M.D., President

COMMENTS ON THE PHYSICIAN PAYMENT REVIEW COMMISSION RECOMMENDATION TO RESTRUCTURE GRADUATE MEDICAL EDUCATION

Presented by
Robert M. Dickler
Vice President
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I am pleased to appear at this workshop to comment on the Physician Payment Review Commission's (PPRC) proposal to reform graduate medical education (GME) and on increasing the supply of generalist physicians, particularly in rural areas. I am Robert M. Dickler, Vice President for Clinical Services at the Association of American Medical Colleges (AAMC). The Association represents all of the nation's 126 medical schools, 92 academic societies, over 350 major teaching hospitals that participate in the Medicare program, and 140,000 men and women in medical training as students and residents.

Many medical schools and teaching hospitals have recognized the need to encourage physician education and training in rural settings. An AAMC compendium, **Academic Initiatives to Address Physician Supply in Rural Areas of the United States**, contains descriptions of 250 initiatives at 65 educational institutions that are addressing the problem of physician supply in rural areas and provides a state-by-state listing of institutions and sites that offer physician training opportunities in rural areas. An updated compendium is expected to be issued in Fall 1993. However, it must be stated that changes in the structure and financing of graduate medical education will not by themselves solve the problem of the current maldistribution of physicians between urban and rural areas. Many factors influence choice of practice location in addition to the site of residency training.

Our present system for graduate medical education and its financing has much to commend it. However, the system needs to change. The Association recognizes the present system has failed to produce the number of generalist physicians that society believes it will need in a reformed health care system. To that end, the AAMC has committed itself to identifying ways to reverse the significant underrepresentation of generalist physicians among practitioners in the United States. A recent Association policy statement calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document identifies and recommends strategies for the Association, schools of medicine, graduate medical education programs and the practice environment to facilitate reaching the goal. It also calls for private sector organizations and governmental bodies joining together in a partnership to eliminate the many barriers that exist to meeting the need for more generalist physicians. Among the recommended strategies at the undergraduate level, medical schools should:

- adopt an institutional commitment to help correct the imbalance between generalist and non-generalist practitioners;
- adjust admission criteria to increase the matriculation of applicants who wish to pursue generalist careers; and
- provide appropriate academic recognition for scholarship, teaching and role modeling among faculty in the generalist specialties.

At the graduate medical education level, the report recommends that:

- residency programs for generalist physicians should be designed explicitly to ensure acquisition of the knowledge, skills and attitudes required for practice; and
- residency programs in the generalist specialties should maintain their current capacity for training residents while efforts to increase the attractiveness of these specialties are implemented.

The report also stresses the importance of changes in the practice environment to encourage more students to enter the generalist specialties. One of the most obvious impediments to increasing the number of generalist physicians is the marked disparity in income expectations resulting from our current system of physician payment. Although the resource-based relative value system (RBRVS) promised to narrow the income gap between generalists and non-generalists, implementation of the new system has thus far not produced the anticipated gains in payments to generalist physicians. The AAMC supports an accelerated transition to the resource-based fee schedule and an expansion of the RBRVS concept to all other third-party payers.

Some changes in the funding and structure of graduate medical education (GME) will almost certainly be required to encourage the shift toward more generalists, stimulate more residency training in non-hospital sites, and provide the resources for other initiatives designed to make generalist training programs more attractive to medical students. Strategies for GME will be crucial in shifting the balance of the physician work force to achieve the goals of health care reform. The AAMC believes that the PPRC report analyzes these issues well and that the commission has formulated its recommendations based on thoughtful and extensive deliberation.

As part of its charge, the AAMC's Advisory Panel on Strategic Positioning for Health Care Reform currently is debating many of the policy issues discussed in the PPRC report to Congress, in particular the need for a stream of revenue separate from patient care funds to support GME, and the need for and the potential role of a central body in establishing work force goals. Although the AAMC debate pertaining to these and other related issues is not complete, I offer the following comments on the PPRC recommendations for changing the structure and financing of GME.

All-payer pool. The AAMC agrees with the PPRC that all public and private health care payers should provide their appropriate share of support for the direct costs of graduate medical education. Society must understand that supporting graduate medical education provides fully-trained physicians to meet its health care needs and must encourage all health care payers and other sources to participate in that support. However, the AAMC also recognizes that it is becoming increasingly difficult to persuade payers to provide sufficient funding for GME.

In a price conscious environment teaching hospitals and other physician training sites will be at a disadvantage because they offer special services, such as medical education, that increase their

costs. Hospitals have traditionally incorporated these costs in their charge or price structures, but as new payment methods-such as capitation and discounting-are adopted, hospitals' ability to pass along or shift these costs to payers who are willing to pay will be severely limited. In addition, ambulatory settings and other practice sites will have even more difficulty absorbing these costs.

Like the PPRC commissioners, many in the academic and policy making communities believe a single national fund should be created to finance GME separately from patient care revenue. A separate fund for the added costs of physician training would enable teaching hospitals and other training sites to compete more readily. A separate pool would provide comprehensive funding compared to the current revenue base for training which may be incomplete and in flux. However, with a national pool, training would depend on a single source of revenue that would be one of many competing priorities in the annual debate over federal spending. The AAMC also recognizes that many complex issues would need to be resolved before establishing such a fund, including the size of the pool, how funds should be raised and distributed, and the composition, governance and staffing of the entity responsible for the fund.

Congressionally-determined limits on the total number of funded residency positions. The AAMC views this recommendation as intermingling two separate but related issues: the overall supply of physicians and the specialty distribution of the physician work force. Limiting the number of first-year residency positions to an aggregate amount will not necessarily ensure that students will choose generalist careers. In addition, there are three different paths through which graduating medical students enter their residencies: students may enter generalist specialties with the intention of practicing generalist medicine; or students may enter a generalist training program with the intention of completing one-year before moving on to another specialty (a transitional year); or students simply may enter a first-year generalist training slot with no specific career choice yet in mind.

The AAMC concurs with the PPRC in acknowledging that all graduating medical students should have the opportunity to complete their initial board residency training program. Current AAMC policy states that funding for GME should be limited to graduates of medical schools approved by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA). The accreditation process of these two bodies assures that the medical or osteopathic school is preparing its graduates to accept the responsibilities of residency training programs conducted in the United States. Additionally, the Association believes that only residents in programs approved by the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association's Committee on Postdoctoral Training should be funded. Accreditation by the ACGME or the AOA ensures that residency training programs are of high quality and that residents receive appropriate and adequate supervision and education so that upon completion of their training they may practice independently.

Federal allocation of residency training slots by specialty. As indicated earlier, the need for and the potential role and structure of a body that would allocate training slots is being debated within the Association. This debate focuses on the need for such a control mechanism if, as many believe, the market forces inherent in managed competition will realign the career choices of graduating medical students toward the generalist specialties. An additional issue the Association is considering is the relationship of a body that controls residency training positions to the potential role of regional, state and/or local bodies in work force planning.

The PPRC analysis of alternative structures for the proposed national body capture very well the nature of our internal discussion. Important issues include the role, composition and staffing of a federal body. An advisory commission, composed of private citizens representing various constituencies, would reflect the public/private partnership of the current system of physician training. The AAMC agrees with the PPRC that one promising model is the Defense Base Closure and Realignment Commission.

Funding of residency slots by accrediting bodies based on educational quality. The AAMC does not support the PPRC recommendation that the bodies that accredit the educational quality of residency training programs should make decisions regarding which specific positions in each specialty should be funded. The AAMC believes that the ACGME and AOA should accredit programs solely on the basis of whether the programs meet the established educational criteria. Program accreditation and health work force planning should be separate activities for two reasons. While the ACGME and its residency review committees (RRCs) have expertise to evaluate graduate training programs, there is no method for ranking program quality above the normative standards that all approved programs must meet.

Alternatively, the PPRC suggests that "the RRC would have the flexibility to...spread cuts across all programs." (p. 70) Given its current composition, organization and structure, the ACGME is not a suitable entity for making funding decisions for specific positions. Substantial reorganization of the ACGME and the RRCs would be necessary.

Transitional Relief. The AAMC supports the PPRC recommendation to make temporary transitional relief funds available to teaching hospitals that lose residency positions as a part of the recommended fundamental changes in the structure and financing of GME. There is no doubt that teaching hospitals' service needs would be affected if the PPRC recommendations were adopted. The commission suggests that teaching hospitals would be expected to respond to the loss of residents by eliminating services or substituting highly skilled nonphysician practitioners or community physicians. Questions regarding how much funding is provided, under what circumstances and the period during which funds are available are serious issues that must be resolved. Some problems may not be solved easily. For example, some hospitals that have major service responsibilities to patient populations who are unable to pay may not be able to attract physicians or other health professionals to offset the loss of resident trainees.

Additional Observations

While the comments above reflect AAMC views on the PPRC major GME recommendations, I also would like to make some observations about some specific points made in the chapter on reforming GME. They include the issues of what entity should receive the payment, encouraging training in ambulatory settings, weighting of direct GME payments by specialty, variation in per resident costs, and the indirect medical education adjustment in the Medicare prospective payment system (PPS).

Who receives the payment. Like the commission, the AAMC is engaged in internal debate over the issue of what entities should be eligible to receive payments for direct GME costs. While increased flexibility in the eligibility for payment probably is desirable, care must be taken to maintain the alignment between costs and payments to sponsors of GME training programs. Some costs, such as residents' and supervising faculties' salaries, are easily transferred among entities. However, infrastructure costs associated with the physician training program, such as maintaining space, administrative systems, and allocated overhead, often cannot be passed along to other entities, but remain at the site. In this regard, the AAMC has concerns about the commission's conclusion to permit payments for GME costs to be made directly to the program. As the commission notes, this option particularly would complicate the already difficult relationships between deans, hospital administrators, and department chairs.

Encouraging training in the ambulatory setting. The AAMC agrees with the commission that the financing structure of GME neither stimulates or fully supports ambulatory training. The Association's Task Force on the Generalist Physician noted that "appropriate training for the generalist physician should include substantial ambulatory care experiences, community-based rotations and other non-hospital activities." Payment systems for hospital services may present impediments to encouraging the development of ambulatory training sites. Mechanisms employed to finance the costs of GME should not create nor perpetuate barriers to shifting training to the ambulatory setting. It is possible some flexibility and modification of payment systems may be necessary to achieve this objective.

Weighting of direct GME payments by specialty. The AAMC is pleased that the commission has concluded that preferential funding for primary care positions (weighting) is an undesirable approach to linking the mix of residents to GME financing. Since 1989, the AAMC has maintained that weighting Medicare hospital payments for GME by specialty will not affect the decisions senior medical students make with respect to specialty choice. There already are many existing unfilled training slots in the generalist specialties. As the PPRC has concluded, weighting would have little impact on the decisions of hospital administrators and residency program directors.

The AAMC also applauds the commission's rejection of the options of paying only for primary care positions or only for the first three years of training. In all instances, residents should be supported in their training at least until they are capable of the independent practice of medicine. The Association believes that this level of competence is attained when resident trainees have completed sufficient training to be eligible to sit for their initial specialty board in their chosen discipline.

Variation in per resident costs. The AAMC believes that the conclusions of the Department of Health and Human Services regarding variation in direct costs per resident, as reported by

the PPRC, are incomplete. In addition to differences in accounting practices, there are legitimate reasons why per resident costs vary among institutions, including how medical centers are organized and how faculty costs have been paid historically. There also is a methodological issue in determining the cost per resident. Two hospitals may have the same costs, yet have a very different mix in terms of the number of residents that they pay for, thus resulting in variation as a result of the denominator.

The PPS indirect medical education (IME) adjustment. The AAMC is pleased the commission refrained from making recommendations to redirect or restructure the IME adjustment because it was not designed to support teaching per se. This adjustment frequently is misunderstood by policy makers and has been recognized increasingly by some as a payment for graduate medical education. Its purpose is much broader. Both the Senate Finance and the House Ways and Means Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, No. 98-23, March 11, 1983 and House Ways and Means Committee Report, No. 98-25, March 4, 1983).

In conclusion, the AAMC commends the commission for a thoughtful analysis of the structure and financing of graduate medical education. The Association recognizes the frustration of government policy makers in assuring the public has access to generalist physician services and concurs that the current system for the training of physicians needs to be reevaluated in the context of health care reform. The nature of graduate medical education is changing. Many factors in the current environment are contributing to changes in how graduate medical education is conducted and how it may be financed in the future. Residency and fellowship education is a system of learning by participation in the care of individual patients and, therefore, includes elements of both education and service. However, as hospitals increasingly are called on to improve efficiency, residency programs are under constant pressure to balance service and education. Additionally, while graduate medical education is organized primarily in hospitals and has been focused mainly on inpatients, its involvement with ambulatory patients is and should be increasing.

Strong residency programs require continuity of effort and stable support. If future generations of Americans are to have appropriate access to well-trained physicians, we must maintain and strengthen our medical education system, including its residency training component.

Mr. Chairman, thank you for the opportunity to testify and I am pleased to answer any of the committee's questions.

Executive Summary

COUNCIL ON GRADUATE MEDICAL EDUCATION

Third Report

Improving Access to Health Care Through Physician Workforce Reform:

Directions for the 21st Century

- Changing the Physician Supply
- Increasing Minority Representation in Medicine
- Reforming Medical Education

October 1992

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration

Table of Contents

Highlights

Findings

The Council's seven major findings identify a series of deficiencies in the current physician supply, medical education financing, and health care reimbursement systems, which hinder health care access. The Council's findings conclude that the Nation has:

- *Too few generalists (i.e., family physicians, general internists, and general pediatricians) and too many nonprimary care specialists and subspecialists.*
- *Access to care problems in inner-city and rural areas that are growing despite substantial increases in the total physician supply.*
- *Too few underrepresented minority physicians.*
- *Shortages in certain nonprimary care medical specialties, including general surgery, adult and child psychiatry, and preventive medicine, and among generalist physicians with additional geriatrics training.*
- *An increasing physician-to-population ratio, which will do little to improve the public's health or increase access and will hinder cost-containment efforts.*
- *A system of undergraduate and graduate education that can be more responsive to these regional and national workforce needs.*
- *No national physician workforce plan or sufficient incentives in medical education financing and health care reimbursement to attain the appropriate specialty mix, racial/ethnic composition, and geographic distribution of physicians.*

Goals

Based on these findings, COGME recommends adoption of the following national physician workforce goals. The United States should:

- *Move toward a system in which 50 percent of physicians practice in the generalist disciplines of family medicine, general internal medicine, and general pediatrics.*
- *Increase to at least 50 percent the percentage of residents who complete a three-year training program in family medicine, general internal medicine, and general pediatrics and enter generalist practices.*
- *Improve physician distribution to eliminate primary medical care shortage areas and urban/rural disparities.*
- *Double the number of entering underrepresented minority medical students from 1,500 to 3,000 by the year 2000, a goal established by the Association of American Medical Colleges.*
- *Increase the number of general surgeons, preventive medicine specialists, adult and child psychiatrists, and general internists and family physicians with additional geriatrics training.*

• *Maintain the osteopathic and allopathic physician-to-population ratio at current levels.*

Recommendations for the Nation

The centerpiece of COGME's recommendations is the establishment of a workforce plan, rational medical education infrastructure, and financing strategy to attain the national physician workforce goals. Recommendations include:

• *Establishing a National Physician Workforce Commission and State Commissions to determine local, regional, and national needs.*

• *Implementing the workforce plan through local, State, or regional academic consortia, which might include one or more medical schools, teaching and community hospitals, health maintenance organizations (HMOs), community health centers, and other educational and teaching institutions or agencies.*

• *Allocating residency positions and graduate medical education (GME) funding based on State and regional workforce needs and national goals for aggregate physician supply, minority recruitment and retention, and specialty distribution.*

• *Encouraging allopathic and osteopathic medical schools to not increase enrollment.*

• *Capping Medicare (and other) funded first-year residency positions at 10 percent more than the number of U.S. allopathic and osteopathic medical graduates.*

• *Providing undergraduate financial incentives, including loan and scholarship programs, to recruit and retain more underrepresented minorities and graduate more generalists.*

• *Providing GME financial incentives, through Medicare and other payers, to train more generalists and fewer nonprimary care specialists and subspecialists.*

• *Increasing incentives for primary care practice and service in inner-city and rural areas, through physician payment reform, reduction of administrative burdens, National Health Service Corps (NHSC) scholarship and loan programs, tort reform, and differential Medicare and Medicaid reimbursement for practice in shortage areas.*

Specific Recommendations for Medical Educators

A physician workforce plan and financing strategy will help our Nation respond to societal needs for more minority and generalist physicians and for access to more primary care services, particularly in underserved inner-city and rural areas. Achieving these national workforce goals will also require the commitment and leadership of our Nation's medical educators. The Council's vision of a medical education system that is responsive to our Nation's health care needs in the 21st century will be reflected in the institution's:

• *Mission statement and strategic plan.*

• *Recruitment, admissions, and retention policies.*

• *Medical education objectives and curricula.*

• *Faculty composition and reward system.*

• *Medical education and teaching environment.*

• *Linkages with a variety of teaching sites.*

Executive Summary

In 1988, when COGME issued its first report to the Secretary of the Department of Health and Human Services (DHHS) and Congress, it expressed concern that physician specialty and geographic maldistribution was growing despite an increasing aggregate supply of physicians. At that time, concerns about access to health care and rising health care costs had not yet been thrust into the national spotlight. Similarly, physician workforce policy was not high on the national agenda.

The historical context of this report is vastly different. Today, the health care system is acknowledged to be in crisis. While health care expenditures exceeded $650 billion in 1990 and are projected to reach $1 trillion in 1995, 37 million Americans remain medically uninsured, and millions more face barriers to basic health care. Furthermore, the Nation's basic health status indicators, which are in some measure influenced by access to health care, lag behind most economically developed countries. There is now recognition that health care reform to ensure all Americans access to basic care is not possible without physician workforce reform.

It is in this context that COGME has been examining physician workforce supply and distribution and its impact on ensuring access to care for all Americans. Over the past two years, the Council has focused on the following seven major questions:

1. Do we have an adequate mix of generalists and specialists to provide the most efficient and the most cost-effective system of quality care for all Americans?

2. What implications do problems of access have for recommendations on physician workforce, supply, and distribution?

3. What is the status of minority representation in medicine and what effect does it have on minority health as well as the health of the public in general?

4. What are the supply needs of specific medical specialties?

5. Do we currently have adequate numbers of total physicians? Will the projected supply of physicians be adequate?

6. Can our medical education system be more responsive to the health care needs of the Nation?

7. What are the factors that have hindered efforts to attain the appropriate composition, specialty mix, and geographic distribution of physicians to ensure access to care for all Americans?

Over the two-year period since its last report, the Council received a broad range of input. This included solicited papers covering supply and demand for physician workforce, barriers to access to physician services, and updated need-based requirements for selected specialties. The Council limited its review of workforce assessments to the following specialties: general/family practice, general internal medicine, general pediatrics, general surgery, obstetrics/gynecology, adult and child psychiatry, preventive medicine, and the area of geriatrics as an added qualification to family practice and internal medicine.

The Council received significant testimony at plenary sessions and before its three subcommittees on Physician Manpower, Medical Education Programs and Financing, and Minority Representation in Medicine. Representatives from major organizations and policy-making bodies, including the major allopathic and osteopathic hospital and medical education organizations and major specialty organizations, have testified on aspects leading to this third report. Major foundations have provided testimony, including the Josiah Macy, Jr. Foundation, the Robert Wood Johnson Foundation, the Pew Charitable Trusts, and the Kellogg Foundation. Representatives of State and local concerns, such as the New York State Council on Graduate Medical Education and the National Conference of State Legislatures, also testified. In addition, COGME has reviewed the latest recommendations from medical educators and policymakers on medical education reform policy.

This third report to Congress and the Secretary of DHHS provides the Council's findings, goals, and recommendations to address these major physician workforce issues of today and the underlying principles that guided its deliberations.

Findings and Goals

Finding No. 1

The Nation has too few generalists and too many specialists.

Goal: The United States should move toward a health care system in which 50 percent of physicians practice in the generalist disciplines of family practice, general internal medicine, and general pediatrics. Consequently, at least 50 percent of residency graduates should complete a three-year training program and enter practice as generalists.

- The growing shortage of practicing generalists (i.e., family physicians, general internists, and general pediatricians) will be greatly aggravated by the growing percentage of medical school graduates who plan to subspecialize. The expansion of managed care and provision of universal access to care will only further increase the demand for generalist physicians.

- Increasing subspecialization in U.S. health care escalates health care costs, results in fragmentation of services, and increases the discrepancy between numbers of rural and urban physicians.

- A rational health care system must be based upon an infrastructure consisting of a majority of generalist physicians trained to provide quality primary care and an appropriate mix of other specialists to meet health care needs. Today, other specialists and subspecialists provide a significant amount of primary care. However, physicians who are trained, practice, and receive continuing education in the generalist disciplines provide more comprehensive and cost-effective care than nonprimary care specialists and subspecialists.

Finding No. 2

Problems of access to medical care persist in rural and inner-city areas despite large increases in the number of physicians nationally.

Goal: All primary medical care shortage areas should be eliminated and disparities between the metropolitan and nonmetropolitan distribution of physicians should be reduced.

- Access to primary care services is especially difficult in rural and inner-city areas. Many factors contribute to the problems of access, including economic and social circumstances of rural and inner-city areas as well as the shortage of minority and generalist physicians.

- Minority physicians and physicians in the three primary care specialties (family practice, general internal medicine, and general pediatrics) are more likely to serve inner-city populations. Family physicians and general surgeons are more likely than other specialties to serve rural populations. The decline in numbers of general surgeons entering rural practice is little recognized and has significant implications for access to trauma services in rural settings and to the fiscal viability of rural hospitals.

- Consequently, more minority and generalist physicians must be educated and educational programs should specifically address skills needed in these settings. This must be accompanied by sufficient incentives to enter and remain in inner-city and rural practice and the development of adequate health care systems in which they can practice.

- Access to one important component of primary medical care, obstetrical services, has been in the national spotlight. Problems are greatest in rural and inner-city areas. Causes include economic and sociocultural factors and the availability of obstetricians, family physicians, and nurse midwives. While the total number of obstetricians continues to increase, the proportion providing obstetrical services decreases dramatically with the number of years in practice.

- Less than 10 percent of obstetricians practice in rural settings. Consequently, family physicians historically provide the majority of rural obstetrical care. In recent years, however, the proportion of family physicians providing obstetrical services has also markedly declined. While rising malpractice claims clearly have contributed to the decreasing provision of obstetrical care, other factors such as unpredictable hours, also seem to have contributed to these decisions.

Finding No. 3

The racial/ethnic composition of the Nation's physicians does not reflect the general population and contributes to access problems for underrepresented minorities.

Goal: The racial/ethnic composition of the physician population should reflect the overall population's diversity. The Nation should adopt the goal of the Association of American Medical Colleges to double the number of first-year entering underrepresented minority medical students from 1,500 to 3,000 by the year 2000.

- Although African Americans, Hispanic Americans, and Native Americans compose 22 percent of the total population and will constitute almost one-fourth of all Americans by the year 2000, they represent only 10 percent of entering medical students, 7 percent of practicing physicians, and 3 percent of medical faculty.

- Increasing the percentage of underrepresented minorities in the medical profession is vital as a means of improving access to care and health status of these vulnerable and underserved populations. Minority physicians tend to practice more in minority/underserved areas, reduce language and cultural barriers to care, and provide much needed community leadership.

- Strategies to increase minority enrollment must emphasize increasing and strengthening the applicant pool, the acceptance rate from within this pool, and the student retention rate. These strategies must take into account disproportionately high rates of poverty, poor health status, poor schools, and a continued lack of access to educational and career opportunities. They must include both traditional short-term efforts and long-term strategies targeting younger students early in the education pipeline.

Finding No. 4

Shortages exist in the specialties of general surgery, adult and child psychiatry, and preventive medicine and among generalist physicians with additional geriatrics training.

Goal: The percentage of physicians trained and certified in the specialty fields of general surgery, adult and child psychiatry, and preventive medicine, and the percentage of family physicians and general internists with additional geriatrics training should be increased.

- The future growth in general surgical services is likely to exceed the growth in the supply of general surgeons. Aging of the U.S. population will increase demand for surgical services, and the number of physicians in general surgery is inadequate to meet a growing need for trauma care services and for surgical care in rural areas. The training curricula for general surgery need to be broad-based to ensure that graduates have sufficient knowledge and skills to manage the wide array of surgical problems that may be seen in rural and inner-city areas.

- The burden of psychiatric illness in both children and adults indicates a need for more psychiatrists and child psychiatrists. However, effective demand for psychiatric care is constrained by limited insurance coverage.

- Continued shortages remain in the field of preventive medicine, which includes specialty areas of public health, general preventive medicine, occupational medicine, and aerospace medicine. These physicians make significant contributions to our Nation's year 2000 health objectives. Although four qualified students apply for each training slot, the greatest barrier to training physicians in preventive medicine is the virtual absence of GME funding.

- Additional emphasis is warranted in the area of geriatrics, given the aging of the population. Family physicians and general internists must be trained to provide comprehensive care for the elderly. Strategies should be developed to train more generalist physicians and support those who are interested in pursuing additional training in geriatrics.

Finding No. 5

Within the framework of the present health care system, the current physician-to-population ratio in the Nation is adequate. Further increases in this ratio will do little to enhance the health of the public or to address the Nation's problems of access to health care. Continued increases in this ratio will, in fact, hinder efforts to contain costs.

Goal: The aggregate allopathic and osteopathic physician-to-population ratio should be maintained at current levels.

- Efforts to solve problems of access to health care by increasing the total physician supply have been largely unsuccessful. A growing physician

oversupply is projected, which will hinder efforts to contain costs.

• Consequently, the number of physicians educated should be reduced. Strategies to improve access to care should, instead, focus on altering the specialty mix, racial/ethnic composition, and geographic distribution of physicians.

Finding No. 6

The Nation's medical education system can be more responsive to public needs for more generalists, underrepresented minority physicians, and physicians for medically underserved rural and inner-city areas.

Goal: Undergraduate and graduate medical education should increase its emphasis upon meeting regional and national physician workforce needs.

• The Nation's system of undergraduate and graduate medical education, taking place in 141 osteopathic and allopathic medical schools and in more than 1,500 institutions and agencies, has responded effectively to many of the Nation's health care needs. During the past 25 years, our Nation's medical education system has responded to public demands to increase the numbers of physicians, advance biomedical research, and develop new medical technology. These responses have resulted in a doubling of the physician supply and the establishment of a biomedical research and medical technology infrastructure that is unsurpassed.

• Today, the medical education system must respond to the Nation's health care and physician workforce needs in the 21st century. These include the need for more minority and generalist physicians, more primary care research, and increased access to primary care, particularly in underserved rural and urban communities. Changes in the institutional mission, goals, admissions policies, curriculum, faculty composition and reward system, and the site for medical education and teaching are necessary to respond to these needs.

Finding No. 7

The absence of a national physician workforce plan combined with financial and other disincentives are barriers to improved access to care.

Goal: In order to improve access to care, a national physician workforce plan, infrastructure, and approach should be established that combines financial and other incentives and disincentives to achieve national physician workforce goals.

• There is no national physician workforce plan for the United States to meet the current and projected future health care needs of the American people. In addition, there is no coordinated financing strategy and integrated medical education system to implement such a plan. Instead, such critical policy issues as the aggregate physician supply and specialty mix are the result of a series of individual decisions made by the 126 allopathic and 15 osteopathic medical schools and nearly 1,500 institutions and agencies that currently sponsor or affiliate with GME training programs.

• The medical education financing and health care reimbursement systems create significant barriers to students who wish to become generalists, physicians who wish to practice in underserved areas, and to the provision of basic primary care and preventive services to all Americans.

Recommendations for the Nation

An adequate supply, mix, and distribution of physicians and other health professionals is needed to ensure basic and essential health care to all citizens. Deficiencies in the Nation's medical education financing and health care reimbursement systems significantly hinder our ability to achieve this fundamental goal. The Council recommends the following measures which, if implemented, would establish a national physician workforce plan and infrastructure to meet the Nation's basic health care needs in the 21st century.

National Physician Workforce Goals

1. The Nation should adopt the following overall national physician workforce goals to ensure the proper supply, mix, and distribution of physicians needed to ensure access to basic and affordable health care for all Americans:

a. The provision of health care in the United States should be based upon a system in which 50 percent of physicians practice in the generalist disciplines of family practice, general internal medicine, and general pediatrics.

b. All primary care shortage areas should be eliminated and disparities between the metropolitan and nonmetropolitan distribution of physicans should be reduced.

c. The racial/ethnic composition of the physician population should reflect the overall population's diversity. The Nation should adopt the Association of American Medical Colleges' goal of increasing the number of first-year entering underrepresented minority students from 1,500 to 3,000 by the year 2000.

d. The percentage of physicians trained and certified in the specialty fields of general surgery, adult and child psychiatry, and preventive medicine should be increased.

e. The percentage of family physicians and general internists who receive additional training in geriatrics should be increased.

f. The aggregate allopathic and osteopathic physician-to-population ratio should be maintained at current levels. Consequently:

- There should be no increase in the aggregate number of first-year enrollments in U.S. medical and osteopathic medical schools. At the same time, medical schools should maintain and expand their commitment to recruiting minority students and training generalists.
- The total number of entry residency positions should be limited to the number of U.S. allopathic and osteopathic medical school graduates plus 10 percent (exceptions should be made for exchange visitor international medical graduates).

Physician Workforce Infrastructure

2. Congress should establish a National Physician Workforce Commission to develop and recommend the necessary policies to attain the national physician workforce goals, project and monitor physician workforce trends, and revise the workforce goals and policies as necessary. This new entity should:

a. Serve in an advisory capacity to the Secretary of DHHS and all appropriate congressional committees with jurisdiction involving undergraduate and graduate medical education.

b. Make recommendations on Federal and other financing of medical education.

c. Have broad representation, including physicians, medical educators, students, residents, and representatives of hospitals, HMOs, community health centers, business, labor, government, third-party payers, and consumers.

d. Have an adequate State and regional physician workforce data base from which to evaluate trends and make recommendations.

e. Have sufficient staff and funding to permit its effective operation.

f. Coordinate its recommendations with the Physician Payment Review Commission and the Prospective Payment Assessment Commission.

g. Replace COGME and assume its charge.

3. States should be encouraged to establish State or regional Physician Workforce Commissions to study physician workforce needs and trends and set workforce goals. The State Commissions should have broad representation of key leaders in medical education, and representatives of profes-

sional communities, hospitals, HMOs, community health centers, business, labor, government, third-party payers, and consumers.

4. The National Commission should be responsive to the workforce needs identified by State Commissions and develop a mechanism to facilitate cooperation and collaboration between itself and the State and regional entities.

5. General principles that should be considered by the National Physician Workforce Commission include the following:

a. The national workforce plan could be implemented through local, State, and regional academic consortia. Each academic consortia might include one or more medical schools, teaching and community hospitals, community health centers, HMOs, and educational institutions from primary school through college.

b. Under this plan, residency positions and GME funding should be allocated based on State and regional workforce needs and national goals for aggregate physician supply, minority recruitment, and specialty distribution.

c. All payers should contribute to GME, including Medicare, Medicaid, private insurers, self-insured employee plans, and HMOs and other managed/coordinated care systems.

d. The funds from the Public Health Service, Health Care Financing Administration, and private sources should be utilized to assist in meeting overall physician workforce goals.

Financing the Physician Workforce Plan

6. A multifaceted incentive/disincentive approach should be used to achieve these workforce goals. The net impact of any financing strategy must, therefore, be to support the following goals:

- To increase the number of underrepresented minorities recruited.
- To increase the number of medical graduates entering generalist medical practice to at least 50 percent and concurrently decrease the percentage who choose subspecialties.
- To increase the number of general surgeons, adult and child psychiatrists, and preventive medicine specialists.
- To increase the number of family physicians and general internists receiving additional training in geriatrics.
- To eliminate primary medical care shortage areas.

Financing strategies must address undergraduate and graduate medical education, as well as the physician practice setting. The following is one approach toward achieving these goals. The Council expects to continue to study additional options as part of its future work.

A. Undergraduate Medical Education

7. Each medical school should establish and attain objectives for the composition and specialty mix of its graduates in support of the above national goals.

8. Financial incentives must be realigned to reward medical schools for recruiting more underrepresented minorities and for graduating more future family physicians, general internists, and general pediatricians. The major revenue sources of undergraduate medical school budgets are Federal and State funds and income generated from faculty practice plans. Federal and State strategies to increase minority representation and the production of generalists must focus on these funding streams.

9. Primary care scholarships and/or low interest rate loans should be established for students who commit themselves to generalist careers. Funding would have to be repaid if the graduate chooses a nonprimary care specialty or subspecialty.

10. Public and private incentives should be increased to assist medical schools in raising the minority applicant pool, selecting more minorities, retaining more minority students, and expanding the number of minority faculty.

a. Funding to the DHHS Centers of Excellence program should be increased to reward medical schools for demonstrated excellence in educating minority medical students.

b. Funding to the DHHS Health Careers Opportunity Programs should be increased, and the program expanded to secondary schools, such as magnet high schools, with expertise in preparing underrepresented minority youngsters for the health professions.

c. A national minority recruitment/counseling/advisory clearinghouse should be established to assist and better prepare potential medical school applicants from underrepresented minority populations.

d. The private sector should be encouraged to support the nationwide replication of programs that have been successful in increasing the minority applicant pool.

e. Active collaboration among major medical groups, such as the American Medical Association, Association of American Medical Colleges, National Medical Association, Association of American Indian Physicians, and the InterAmerican College of Physicians and Surgeons, should be encouraged with the goal of increasing minority recruitment and retention.

11. Government should assist medical schools in developing a critical mass of faculty in the generalist disciplines. This critical mass of strong academic faculty will assist in providing an educational milieu that fosters selection of a primary care specialty.

a. Funding through the National Institutes of Health and the Agency for Health Care Policy and Research should be increased for research in primary care, health services delivery, and patient care outcomes, as well as for the development of research faculty in the primary care disciplines.

b. Title VII grants to assist in the development of Departments of Family Medicine should be maintained and new funding should be made available to assist in strengthening Divisions of General Internal Medicine and Pediatrics.

c. Physician payment reform must continue and should be extended to private payers to correct the imbalance between the income generated by generalist and subspecialist faculty practice plans.

12. Government should assist medical schools in their efforts to increase education in ambulatory and community settings.

a. Title VII grants for predoctoral education should be expanded to assist medical schools in enhancing education in the primary care specialties.

b. Legislation for Area Health Education Centers should be modified and expanded to facilitate community-based primary care education for medical students at every medical school.

B. Graduate Medical Education

13. The number of Medicare and other funded first-year entry residency positions should be capped at 10 percent more than the number of U.S. allopathic and osteopathic medical school graduates.

14. Financing strategies should support the goal that at least 50 percent of medical graduates should complete a three-year residency program and enter generalist practice and that the percentage who choose subspecialties should concurrently decrease. The following is one approach toward these goals:

a. Medicare direct and indirect GME payments should be limited to residency training for initial certification or five years, whichever is less. Residency programs in preventive medicine should also receive Medicare GME payments. There should be exceptions to initial certification limits for training in child psychiatry and geriatrics.

b. Increased direct medical education (DME) payments should be allocated to family practice residency programs.

c. Increased DME payments should be allocated to internal medicine and pediatric residency programs that develop an agreed-upon curriculum that specifically prepares graduates for primary care practice. These increased payments will reimburse programs for the higher costs of training in the primary care setting.

d. Incentive salaries should be made available to residents in family practice, internal medicine, and pediatrics, who sign a contract indicating their intention to complete their three-year program and enter generalist practice, with a year-by-year payback for those who choose to subspecialize.

e. Because residents in allopathic family practice and osteopathic general practice programs are more likely to remain generalist physicians and practice in needy rural areas than other physicians, incentives to increase the number of family practice and osteopathic general practice residents should be a high, short-term priority.

f. Because of the significant decline in internal medicine and pediatric graduates completing three-year residencies and entering generalist careers and the concurrent growth in those choosing to subspecialize, both disciplines are strongly encouraged to review their workforce needs for generalists and subspecialists and to develop curriculum and training opportunities commensurate with those needs.

15. To facilitate the expansion of ambulatory/outpatient GME and to encourage innovative program development and growth, all approved GME programs, including those based in community settings, should be eligible for Medicare direct and indirect GME reimbursement.

16. Changes in the Medicare portion of GME financing should be budget neutral. Savings in direct and indirect GME from capping slots and eliminating payments beyond the initial certifica-

tion or five years (with the previously noted exceptions) should be directed to:

a. Training conducted in primary care ambulatory/community training sites.

b. Innovative programs to train generalist physicians for rural and urban medically underserved areas.

c. Innovative programs to increase minority representation in the physician workforce pool.

17. Financing strategies should support the goal of increasing the percentage of residency graduates in the specialty fields of general surgery, adult and child psychiatry, and preventive medicine, and the percentage of family physicians and general internists with additional geriatrics training. In addition to the previously mentioned approaches:

a. Incentive salaries should be made available to residents who sign a contract indicating their intention to complete their program in the above fields, with a year-by-year payback for those who choose to train and practice in another specialty or subspecialty.

b. Increased direct GME payments should be allocated to general surgery programs that contain an agreed-upon curriculum that specifically prepares graduates for general surgical practice, especially in rural and inner-city areas.

c. Increased direct GME payments should be allocated to adult and child psychiatry programs.

d. Preventive medicine residency training programs should receive Medicare GME reimbursements for the entire three-year period. (Currently, Medicare payments are made only for residents in their clinical training year, which takes place only in the first year.)

18. Primary care residency programs providing substantial training in urban or rural underserved areas or serving a substantial percentage of medically underserved populations should be reimbursed for generalist residents under Medicare DME at a higher rate.

C. Practice Environment

19. The economic incentives to enter generalist fields must be increased and incentives to specialty practice must be reduced by extending physician payment reform to include all third-party payers.

20. Partial loan forgiveness should be provided for residents entering practice as family physicians, general internists, and general pediatricians.

21. Solutions must be found to reduce administrative burdens in medical practice imposed by the third-party payers. These burdens are primary causes of the increasing disillusionment among generalist physicians in practice.

22. Tort reform must be implemented to reduce malpractice barriers to the provision of needed primary care services, such as prenatal care.

23. Major incentives in Medicare and Medicaid reimbursement should be implemented to encourage physicians to provide primary care services to underserved rural and urban populations. These additional payments would assist in offsetting the heavy burden of unreimbursed care provided by physicians in these settings.

24. Federal and State programs, including the NHSC Scholarship and Loan Forgiveness Program, must be maintained, enhanced, and expanded to address the relative undersupply of physicians in rural and inner-city areas. Such programs should be maintained indefinitely in the most severe shortage areas that have little likelihood of attracting physicians.

25. Physicians in shortage areas are overworked, isolated, and frequently overwhelmed by the complex business of medicine. Systems of health care delivery and professional support will enhance the attractiveness of practice in shortage areas.

Specific Recommendations for Medical Educators

The attainment of these workforce goals will require a partnership between government and the medical education system, which comprises medical schools, hospitals, and other educational institutions and agencies. It will require government to establish and implement a national workforce plan with a set of goals, a rational education infrastructure, and a financing mechanism, as previously recommended. It will also require the commitment and leadership of our Nation's medical educators. The following recommendations describe the Council's vision of a medical education system that is responsive to our Nation's physician workforce needs in the 21st century.

Mission Statement and Strategic Plan

26. The institution's mission statement recognizes responsibility and accountability to societal needs for more generalist physicians, more underrepresented minority physicians, more primary care research, and the provision of more primary medical care, particularly to underserved urban and rural communities.

27. The strategic plan contains quantifiable outcome measures for these societal needs, including the percentage of:

a. graduates choosing generalist careers;

b. underrepresented minorities who apply and matriculate;

c. required educational experiences in community and underserved settings; and

d. graduates choosing to practice in underserved rural and urban areas.

Recruitment, Admissions, and Retention Policies

28. The medical school's admissions policy, structure, and function reflect the need to recruit and admit more students who are inclined to select the generalist disciplines of family practice, general internal medicine, and general pediatrics.

29. The medical school's admissions policies, structure, and function reflect the need to recruit and admit more minority students in medical school.

a. The school establishes a minority recruitment/retention section with underrepresented minority participation, or individuals committed to the goals, and minority participation on the admissions committee.

b. Emphasis is placed on the development and support of programs that improve the size and quality of the minority applicant pool by focusing on early intervention. The school participates in forums and networks involving students in high school, elementary school, and primary levels, including kindergarten, to expose minority youngsters to health professions role models, encourage their interests and pursuits in health, and provide networks of mentoring programs to assist and support students inclined toward health careers.

c. The school provides ongoing support to ensure the successful progress of these students through their education.

Faculty Composition

30. The institution's departments and faculty composition are more balanced, with increased representation of generalist physicians, minority physicians, primary care researchers and physicians, and other health care providers from community settings.

31. The institution's system of advancement and tenure rewards faculty with demonstrated excellence in teaching in the same manner it recognizes excellence in biomedical research.

32. The institution involves large numbers of community-based primary care physicians and other providers as preceptors, teachers, and role models for medical students and residents and gives significant academic recognition and adequate reimbursement or other rewards (e.g., locum tenens coverage for continuing medical education for their contribution).

Medical Education Objectives

33. The institution incorporates effective adult education techniques in its curriculum. Self-directed learning and problem-solving directed skills are emphasized throughout the curriculum for students and residents to learn to acquire detailed information and to apply such knowledge effectively.

34. The institution emphasizes effective communication skills to improve the doctor/patient relationship.

35. The institution provides mandatory multicultural awareness/sensitivity sessions for students, residents, and faculty.

Achieving a More Integrated and Balanced Medical Education Curriculum

36. The basic sciences are incorporated within a clinical context throughout the undergraduate curriculum.

37. Undergraduate and graduate training includes social, behavioral, and humanistic aspects of health and health care delivery. Instruction is provided from faculty, researchers, and clinicians in fields such as nursing, psychology, public health, medical sociology, medical education, health services delivery, and bioethics.

38. Undergraduate and graduate training emphasizes the importance of team approaches to health care delivery. They include experience working as a team member with other health care professionals and training in utilizing the skills and expertise of physician assistants, nurse practitioners, nurses, pharmacists, public health professionals, social workers, and other health care professionals and ancillary personnel.

39. Experimental primary care programs and curricula are offered that may help reach the identified goals. Such models emphasize generalist practice and community-based training. The effectiveness and productivity of the fourth year of medical school should be examined.

40. Undergraduate and graduate training contains well-defined curricula, educational objectives, and evaluation methods, including outcome measures, to assess the effectiveness of the education experience.

Expanding the Medical Education Teaching Environment

41. The curricula and clinical rotations provide all students and residents with a balance between hospital-based, subspecialty training and community-based, primary care training. A much greater proportion of medical training is shifted to outpatient and community-based sites where the majority of medical care is provided.

42. The community-based educational experiences are developed and managed with significant community participation and involvement.

43. Academic consortia are developed to link together the various settings in which undergraduate and graduate medical education are provided, including community hospitals, community health centers, HMOs, and public health departments.

Background, Charge, and Principles of COGME

The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends and to recommend appropriate Federal and private sector efforts to address identified needs. The legislation calls for COGME to serve in an advisory capacity to the Secretary of DHHS, the Senate Committees on Labor and Human Resources and Finance, and the House of Representatives Committees on Energy and Commerce and Ways and Means. By statute, the Council terminates on September 30, 1996.

The legislation specifies that the Council is to comprise 17 members. Appointed individuals are to include representatives of practicing primary care physicians, national and specialty physician organizations, international medical graduates, medical student and house staff associations, schools of medicine and osteopathy, public and private teaching hospitals, health insurers, business, and labor. Federal representation includes the Assistant Secretary for Health, DHHS; the Administrator of the Health Care Financing Administration, DHHS; and the Chief Medical Director of the Veterans Administration.

Charge to the Council

Although called the Council on Graduate Medical Education, the charge to COGME is much broader. Title VII of the Public Health Service Act in Section 799(H), as amended by Public Law 99-272, requires that COGME provides advice and makes recommendations to the Secretary and Congress on the following:

1. The supply and distribution of physicians in the United States.

2. Current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties.

3. Issues relating to foreign medical school graduates.

4. Appropriate Federal policies with respect to the matters specified in (1), (2), and (3) above, including policies concerning changes in the financing of undergraduate and graduate medical education programs and changes in the types of medical education training in graduate medical education programs.

5. Appropriate efforts to be carried out by hospitals, schools of medicine, schools of osteopathy, and accrediting bodies with respect to the matters specified in (1), (2), and (3) above, including efforts for changes in undergraduate and graduate medical education programs.

6. Deficiencies in, and needs for improvements in, existing data bases concerning the supply and distribution of, and postgraduate training programs for, physicians in the United States and steps that should be taken to eliminate those deficiencies. The Council is to encourage entities providing GME to conduct activities to voluntarily achieve the recommendations of this Council under (5) above.

Previous Reports

The Council was asked by Congress to issue its first report by July 1, 1988, and subsequent reports every three years. Since its establishment, COGME has submitted the following reports to Congress:

- First Report of the Council, Volume I and Volume II (1988).

- Second Report: The Financial Status of Teaching Hospitals and the Underrepresentation of Minorities in Medicine (1990).

- Addendum to the Second Report: The Financial Status of Veterans Administration Teaching Hospitals (1990).

- Scholar in Residence Report: Reform in Medical Education and Medical Education in the Ambulatory Setting (1991).

Principles of the Council

In making these recommendations to Congress and the Secretary, the Council's deliberations have been guided by the following principles:

- The primary concern of the Council must be the health of the American people. There must be ensured access to quality health care for all. Concern for the well-being of the health professions, medical schools, and teaching hospitals, while im-

portant, must be secondary to the previously mentioned concerns.

• The Council should consider the diverse needs of the various geographic areas and segments of the population, such as rural and inner-city areas and minority and disadvantaged populations.

• A goal of the Council is increased representation of minorities in the health professions. Targeted programs are appropriate and a necessary means of achieving this objective.

• The Council must consider the interrelationship between services provided by physicians and those provided by other health professions.

• Although the Council supports the continuation of successful private sector initiatives, it recognizes that an active Federal and State role has been and will continue to be needed to address the specific problems of distribution, quality, and access to health care.

• The Council should be concerned about effects on total health care costs in the Nation. The Council must consider the financial and programmatic impact of its recommendations on the Federal budget, both short and long term.

• The Council recognizes that health care in the United States is not a closed system; therefore, its deliberations must be guided by an international perspective.

• The Council must consider changes in demographics (e.g., the aging population), disease patterns (e.g., increasing prevalence of the acquired immunodeficiency syndrome [AIDS]), patterns of health care delivery (e.g., increased emphasis on ambulatory care), and the unmet needs for prevention and care.

• The Council believes that a strong system of medical education must be maintained in order to expand medical knowledge and provide access to quality medical care through an adequate supply of appropriately educated physicians.

• American medical education should provide a basis for physicians of the future to be able to deliver continually improving patient care through a better understanding of disease processes and their clinical manifestations. The education system should prepare physicians to appropriately apply new techniques of diagnosis, treatment, and prevention in a compassionate and cost-effective manner.

Issues for Further Exploration

The Council recognizes that there are a number of issues requiring further exploration. Among these are the following:

• The Nation's voluntary system of specialty certification, medical education accreditation, and licensure, which have a significant impact on physician workforce supply and distribution.

• The important role of physician assistants, nurse practitioners, and certified nurse midwives in delivering primary care, when working in collaboration with generalist physicians.

• Representation of women in medicine, particularly in academic roles.

• The State's role, including model initiatives, in addressing workforce data needs, supply, and distribution.

• Other financing and infrastructure approaches that have potential to attain the stated workforce goals.

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Presentation by Dr. Robert D'Alessandri on behalf of the Association of Academic Health Centers to the Senate Special Committee on Aging and the Senate Rural Health Caucus
May 3, 1993

Thank you for inviting me here today. The problem of increasing the number of primary care providers is one that has concerned my state greatly over the past few years. West Virginia has many counties that are classified as Health Professional Shortage Areas and when this fact is combined with issues of transportation, literacy and poverty many people do not get the health care they need.

We have struggled as a medical school with the problem of how to produce more generalist physicians to meet the needs of our state. We have made some significant changes in our undergraduate medical education curriculum, both in how and where we teach, which I hope will begin to pay off in more of our students choosing primary care as their career specialty and in particular more of them choosing to practice in a rural underserved area.

I have reviewed the Physician Payment Review Commission Report and have some comments on their recommendations. Generally, I should say up front, I am in agreement with most of the recommendations of the Commission.

I believe this issue is much like changing the health care system itself. Producing more generalists will not be the result of any one strategy...changing the numbers of residency slots in and of itself will not mean more primary care providers. It will take a systematic change in all aspects of the health care system to produce more primary care providers.

We must look at Graduate Medical Education in the context of the whole system of education of physicians, not just the residency period. We cannot control supply, or the maldistribution of physicians, by choosing to look at only one element.

When I ask my students why they have chosen a particular specialty over a primary care specialty, especially a rural primary care specialty, I get a number of responses. Many feel primary care is too demanding on their personal life--too many nights on call, not enough back up for vacations, or to attend continuing medical education seminars. Many cite the extremely low pay for primary care providers as compared to the specialists. There are comments about the glamour and excitement as well as the prestige of specialty care, over the sometimes tedious work of primary care. There is the chance in specialty medicine to become an expert on one segment of the body instead of having to learn a little about a multitude of problems. Sometimes there are references to the fact that specialists are "better doctors" than primary care providers, an attitude they have no doubt picked up from some of their professors, I'm sorry to say.

These are some of the determinants for the students in choosing a specialty and these are the first issues that must be attacked if we are to have an adequate supply of primary care providers.

We must begin by changing undergraduate medical education. Medical students generally enter medical school with a very positive attitude about primary care. After all, for most students their role model has been their family physician, that is who they want to be like when they graduate. The system of undergraduate medical education can oftentimes dissuade them of that decision. We need to change that, and many of us are trying.

At West Virginia University we are now requiring every student to do an off campus rural primary care rotation. Some of our students are spending up to six months of their education in a rural area with a local primary care provider and soon, some will spend one year in rural settings. We have tried to set up these experiences to be multidisciplinary in nature so the medical students train with nursing, dental and pharmacy students.

We have two very important programs that support this educational effort. We have, along with the other West Virginia medical schools, a $6 million grant from the Kellogg Foundation to make substantive changes in our curriculum to provide education in rural sites.

Three sites in rural primary care clinics have been set up as mini health sciences centers where medical, dental, nursing, pharmacy and physical therapy students learn from local providers. We have supported this project with on-site faculty, the development of learning resource centers, computer and video links to our main campus, and more. It has been a tremendous process of change and accommodation both by the rural sites and by the schools.

The second program to provide for rural medical education was actually developed by our Governor using the Kellogg model. He wanted more than the sites supported by Kellogg. So he, and the legislature, allocated money to develop Rural Health Initiative sites. Over one hundred and thirteen agencies, hospitals, behavioral medical centers, private physicians and primary care clinics got together to form eight consortia where students can train and care can be provided by university faculty.

We are trying to reinstill the concept of service as a reward in our students, and show them the value we place on our primary care providers. We need to, as a nation, raise the value of service and raise the status of primary care providers.

While they are students we have the luxury of training them in a variety of settings. That is not true for residents. Two major factors restrict the settings for resident education. Since hospitals pay resident salaries and educational expenses, it is hard to justify

residents spending a great deal of time outside the hospital setting. Also, many Residency Review Committees, whose responsibility it is to approve and accredit programs, have very strict guidelines about where residents spend their time. The recommendations of the PPRC could help the first issue with changing the payment mechanisms for residents to a non hospital based situation, but without significant changes from the RRC's as well I don't believe much will change. The proposals being discussed by the White House for network development may be well timed to the development of consortia for care giving as well as educational training but there are still some questions in my mind about how this will all actually work.

I think it is critical that all payers contribute to the cost of medical education as the PPRC suggests. I am also in favor of reducing the overall number of residency slots. The part of the report that most concerns me however is the determination of the allocation of those slots and which slots should be approved for funding. I certainly agree that funded and approved residencies should meet and exceed minimum educational standards. However, funding should not be based solely on meeting those standards. Other factors should play an important role once those standards have been met.

In West Virginia, a predominantly rural state, our health sciences center has the only subspecialty training programs in ophthalmology, otolaryngology, orthopedics, obstetrics-gynecology, dermatology and others. The great majority of practicing subspecialists in West Virginia graduated from these programs. In general these programs are small and have the minimal number of residents required by the Residency Review Committees for accreditation, about two or three residents per year. It is rare that an ophthalmologist who graduates from a residency program in New York City comes to West Virginia.

West Virginia and many other rural states have tremendous subspecialty needs as well as primary care needs. To base funding solely on educational standards would enable larger institutions who generally control the RRC's and other formal structures in medical education to make decisions that would disenfranchise small programs in many rural states. Regional and rural needs must play an important role in deciding funding for graduate medical education. If educational criteria were to become the sole deciding factor, the requirements would increase beyond a reasonable level, allowing only the most affluent programs to survive. Community hospital experiences would be eliminated, subspecialty training would be limited to large urban tertiary and quaternary care centers, and graduates of these

programs would tend to practice in and around these centers. The very problem you are trying to alleviate would be exacerbated.

The last section I would like to address is the environment after the completion of graduate medical education and the effect that has on the choice of primary care as a specialty. There are two areas that merit attention if we are to increase the number of primary care providers; income and infrastructure. Health care reform will hopefully do something to increase the income of primary care providers, making this a more desirable field. Resource Based Relative Value Scales have had that as their goal, but as we have seen some reduction in the income of specialists we have seen relatively little increase in the income of primary care providers. In the PPRC report they cite Canada as being successful in changing their physician mix through assignment of residency slots. I would submit to you that a much more effective strategy was Canada's reforms in physician reimbursement so that a primary care provider now earns nearly as much as a specialist and the disparity in income has been narrowed considerably. If we really do value primary care providers we must pay them more, and pay other specialists less. Otherwise, we will always see our best and brightest lured to the areas that society pays more, and hence values more.

Universal coverage of all Americans will go a long way to encouraging people to both practice primary care and settle in rural areas. The lack of coverage in rural America is a major deterrent to practicing in rural areas. It is very discouraging to see a patient with an ear infection and prescribe an antibiotic knowing the prescription will not be filled because the family must choose between antibiotics and food.

Finally, I would like to address the need for an appropriate infrastructure. If there was a better network of programs to support primary care providers we could reduce isolation and increase retention of providers in rural areas. At West Virginia University we have developed many programs to support rural providers, programs that can serve as national models for rural areas. About five years ago the WVU Medical School started the Medical Access and Referral System-MARS. A simple 800 number staffed 24 hours a day provides specialist consultation and medical information for West Virginia physicians, physician assistants, midwives and nurse practitioners. We have just expanded it to serve dentists and pharmacists as well. We receive over 1500 calls a month on this system. Users of the system say that this is a lifeline for the rural physician and practitioner that allows them to provide better patient care.

Well, two of our physicians decided that the phone system was nice but it wasn't enough. The system would be significantly improved by being able to see the patient and the rural physician face to face. Many patients had to be needlessly transferred to the more expensive referral hospital because our physicians couldn't tell, based solely on described symptoms, what the problems were. It was safer to transfer the patient.

So in cooperation with a rural community hospital 70 miles away, we developed a pilot program called MDTV, or Mountaineer Doctor Television. Through the use of telephone lines, MDTV establishes a two-way interactive tele-video link between a rural hospital and the specialists at WVU. We have used this system to interview and diagnose patients, read X-rays, and send family medicine grand rounds out weekly to the rural medical staff. This year we will add six more rural sites to our network. This program will keep more of the care locally, which will improve the viability of rural hospitals. It will also improve the local quality of care through the provision of interactive continuing medical education. If you could see this program, you would be as excited as I am about the possibilities that telemedicine brings to rural areas. This program has been supported by a federal grant through the Office of Rural Health Policy and I would be glad to arrange a demonstration for the committee here in this room should you so desire. This is a tremendous technology that can really improve care in rural areas and increase provider retention.

Another successful program we developed to address the issue of isolation is the Visiting Clinician Program. This program brings family medicine or other primary care physicians into the Health Sciences Center regularly to teach our students in the morning and to be matched in the afternoon with a specialist of their choice to brush up skills in their chosen area. These rural doctors receive a stipend for their teaching and are appointed to the clinical faculty at the University. They are the doctors to whom we send our students for rural primary care experiences.

Rural administrators work with us on securing faculty appointments for doctors they are trying to recruit and these doctors

feel less isolated. We literally have not been able to keep up with the demand from rural providers to participate in this program.

I make it a priority to meet regularly with the Visiting Clinicians in the program. About a year after it started I met with a family doctor from Fayette County in the southern part of the state. He told me that before the program began he had just about given up his practice. He didn't believe anyone cared about the rural physician, he felt burned out and frustrated. This program, with its exposure to students had helped him recover his enthusiasm for rural medicine. He felt rejuvenated and able to strongly recommend rural medicine to our students.

Yet another program we have started at the urging of rural health providers is a locum tenens program. We try to provide faculty members or residents to take the place of rural providers. These rural providers need a few days off for a CME conference, are ill or in need of a vacation. Our residents pick up some extra money, see how a rural practice works and the local provider pays a fraction of what a commercial service would cost and gets away for a few days. Again the demand is greater than our ability to meet it, but we continue to try.

These are programs that can be implemented nationally at very little cost in a short timeframe and can reduce isolation and improve retention.

Health care reform presents us with many opportunities. We need to make sure that the solutions we come up with work for the whole system. Thank you for your attention.

REFORMING GME TO STRENGTHEN PRIMARY CARE

Charles O. Cranford, D.D.S.
Associate Dean, College of Medicine
Executive Director, Area Health Education Centers Program
University of Arkansas for Medical Sciences

I am pleased to have the opportunity to respond on behalf of the University of Arkansas for Medical Sciences to the PPRC recommendations.

We strongly agree with the concept of the need for more primary care physicians in the health care work force. The PPRC is to be commended for addressing this issue and developing recommendations for effecting change in the current GME system.

In principle, we support the recommendations to determine limits on the total number of residents and the allocation of slots by specialty. Although supporting these recommendations, there is reason to question the need for a new federal level bureaucracy or to ask ACGME to implement the reforms. Rather, the reforms could be implemented through entities such as HPPCs in a Managed Competition model or through some other yet to be identified state entity, perhaps within a global number established at the national level.

We strongly support a funding mechanism separate from Medicare to provide incentives and regulations for shifting the emphasis in GME toward primary care. The 1% set aside from all payers proposed by the PPRC makes great sense for achieving such a shift in emphasis. The funds should be allocated to primary care educational programs using allocation formulae influenced by the achievement of a set of desirable outcomes.

Medicare, the current principal supporter of GME, was not originally conceived as a way of paying for routine day to day primary care. Rather, it was developed to place a safety net under the elderly who require acute expensive in-hospital care, that by its very nature is predominantly specialty oriented. Medicare is a wonderful inpatient health care system, but there are major gaps in its funding of outpatient services. Moreover, in the overall patient mix seeking outpatient care at any given time, Medicare patients are in the minority. Thus it makes little sense to use Medicare GME funding to encourage increases in primary care physicians who deliver service largely in outpatient settings. The PPRC is on the right track to recommend a different mechanism to help support primary care training programs.

The Medicare GME system emphasizes hospital-based residency training and it is important to protect that educational system although it may be downsized somewhat. The PPRC recommendations to make available transitional relief funds to teaching hospitals that lose residency positions is desirable and will help maintain the integrity of the surviving parts of the in-hospital educational system.

I will leave it to the others with whom I share this opportunity this afternoon to describe more fully the impact of the PPRC recommendations on large university teaching hospitals. I would rather like to direct my comments to the development of appropriate primary care training experiences in community-based settings; and more specifically, I would like to describe for you the geographically designed network of family practice residency programs in Arkansas and the outcomes of such a system. I will also address the anticipated impact of the PPRC recommendations on that training model.

Arkansas has been divided into six geographic regions and each region has a community-based, family practice residency program sponsored by the UAMS statewide AHEC Program.

To date, more than 340 family practice physicians have received residency training in the Arkansas community-based model. An overwhelming majority of these family practice physicians have elected to practice in Arkansas (75%). Graduates of these programs are in 56 of the state's 75 counties. Since 1989, 45% of those remaining in Arkansas to practice have located in towns of less than 10,000 population. The strategic locations of Arkansas family practice residency programs enhance their selection by the University of Arkansas for Medical Sciences College of Medicine graduates, and these locations influence the ultimate choices of medical practice locations within the state. As more family practice physicians have been produced in Arkansas, a greater number have chosen smaller communities for their practice location, thus indicating that if we produce more family practice physicians more will find their way into practice in smaller communities.

Our central and overarching strategy is to place the last phase of formal education of the family practice physician in regional centers throughout the state. The program strategy is based on the belief that the most effective way to increase the supply and quality of primary care physicians in Arkansas is to increase the number and quality of primary care residency positions in key locations within the state. Even as others were downsizing residency programs in recent years, UAMS was increasing the number of positions in family practice in community-based settings.

The earliest contact with medical students are aimed at recruiting them into family practice and hopefully, into an Arkansas family practice residency program. We believe that the results of undergraduate experiences are diminished if we cannot deliver a family practice residency opportunity in the region of the state in which the resident physician ultimately plans to locate.

An important factor in the development of our community-based family practice residency program network is the mission of UAMS. It is first and foremost a school to supply the needs of Arkansas. One of the arguments that served academic health centers very well when seeking federal funds for construction or expansion of health professions schools was to describe the school as a national resource. Certainly it is very evident that graduates cross state lines with ease and frequency; however, viewing one's institution primarily as a national resource does not today seem to be the most appropriate mission to serve the needs within one's state or region.

The regionally based family practice residency programs in Arkansas have demonstrated that they are excellent sites for the training of primary care physicians. In such locations many Medicaid eligible and other underserved individuals receive health care services. These community-based family practice residency programs are viewed as major providers of Medicaid services and health care for the medically indigent. Although they deliver less than 10% of the Medicaid services delivered statewide, they are the most accessible Medicaid provider for many.

A large percentage of the primary care physicians who graduate from these programs locate practices in small towns within their respective regions. During the family practice residency program in community settings, residents frequently develop a support system that will keep him or her in the region upon graduation. The residency program assumes a responsibility for helping to develop the support system to nurture graduate physicians once they have entered practice. We know where our graduates are, and we keep in contact.

Arkansas has an 18 year history of successfully sponsoring a network of family practice residency programs based in community hospitals with significant support from state appropriations. The state appropriations have been sufficient to shield the community hospitals from loss of the programs during periods of fiscal constraints. Arkansas has developed an exemplary program and the continuing growth of the Arkansas Family Practice Residency Programs is a positive indication that we have a very viable system. I believe it is a model that should be considered by other states as a means of alleviating the shortage of primary care physicians.

The recommendation by the PPRC that all payers, including the self-insured employers, contribute 1% of their payments to underwrite the cost of graduate medical education would seem to benefit community-based residency programs such as we have in Arkansas. With adequate GME support for primary care residency programs, the Arkansas community-based family practice residency programs could be expanded and could be complemented by adding residents in general pediatrics, general internal medicine and perhaps OB/Gyn. With sufficient incentives and reform of the health care system, I am confident that the 26% of this year's graduating class choosing family practice can be increased, as well as the total choosing all primary care specialties.

When considering reform of the GME system, it is important that the excellent community programs developed over the past twenty years not be left out of the proposed solutions. The PPRC recommendations can make these programs even better. Actually the PPRC recommendations could provide the assistance needed to

help these community programs achieve their greater potential. We have learned a lot in our experiences with community-based programs. The best of these community programs should be incorporated into the proposal for health care work force reform.

Among those community programs are:

1. The AHEC Program which has enabled UAMS to develop an effective community-based model network for educating most of its family practice residents.

2. The Community Health Centers which have become an essential part of health care delivery in our state and with which AHECs have formed educational and service alliances in community settings for the training of primary care residents.

3. The National Health Service Corps which has the potential to provide a mechanism for recruiting significant numbers of medical students into primary care. Coupled with effective affiliations with academic health centers and administered more as a "community health service corps" than as a national health service corps, this important program can reach new achievements that are consistent with the needed health care work force reform.

In Arkansas a network of high quality community-based family practice residency programs has been developed to serve the entire state. They are all fully accredited by ACGME and they have an excellent recruitment record. This year 85% of our positions were filled on match day compared with 77.3% nationwide. Moreover, we are confident that all positions will be filled when the year starts July 1.

Arkansas has an effective system in place for producing the family practice physicians needed in the state. Financial assistance such as that proposed by the PPRC would enlarge and strengthen these programs. Combining that support with other incentives that would increase the number of medical school graduates choosing primary care specialties is what is now needed to make additional significant progress toward gaining a more appropriate balance between primary care and the other medical specialties.

STATEMENT of the American Academy of Family Physicians

to the
Senate Special Committee on Aging
and the
Senate Rural Health Caucus

presented by
John M. Tudor, Jr., M.D., President

Good afternoon. I am John M. Tudor, Jr., M.D., President of the American Academy of Family Physicians. It is my privilege to participate in today's workshop and respond to the Physician Payment Review Commission's thoughtful proposals to reform graduate medical education.

Allow me to begin be stating the Academy's firm belief that the geographic and specialty maldistribution of the American physician workforce is a key factor in this country's health care cost and access problems. Furthermore, the sheer magnitude of this issue places it squarely within the larger context of health system reform. No matter how one envisions a reformed health care system, correcting the physician maldistribution will be an essential element of the reform effort. As you may know, the Academy has developed a comprehensive proposal for reforming the health care system, *Rx for Health: the Family Physicians' Access Plan*. Contained within the proposal, are several recommendations for achieving the joint goals of fifty percent of physicians in the generalist specialties and half of generalist physicians in family medicine.

As noted by PPRC, there are many factors influencing the specialty training choices of medical students. These factors include medical school admission criteria, medical school curricula, the residency training characteristics, practice environment, and physician income. We believe that all of these factors will have to be corrected before there will be a major shift in the physician distribution. Ironically, the perception that any one change will not have a significant impact has been used to argue against making any change. Clearly, major policy changes must start somewhere.

We find ourselves in substantial concurrence with the general direction of PPRC's recommendations, especially in the following areas.

- All payers should contribute an uniform proportion of outlays for GME. The health care workforce is a public good, and, therefore, should be supported through a broad funding process.

- The determination of the direct GME per resident amount should be rationalized and standardized.

- The distribution of physician specialties should be determined through an explicit deliberative process based on an assessment of societal need.

- Expanded ambulatory training should be supported by extending eligibility for GME funding to non-hospital entities.

A more detailed discussion of a number of the important issues raised by PPRC appears below.

Setting Specialty Distribution Goals

The Commission's consideration of physician workforce issues proceeds under the assumption that too many sub-specialists are being trained relative to the number of generalist physicians. However,the Commission has refrained from stipulating a specific specialty mix. While we respect the Commission's belief that there is an inadequate analytic base on which to specify a goal, it is not apparent that the most appropriate mix of physicians can ever be known with absolute certainty. Meanwhile, the evidence of a specialty maldistribution is incontrovertible. We find the high proportion of generalist physicians in managed care systems and in other developed countries to be compelling evidence. We fear the Commission's reluctance to state even a tentative goal may undermine the persuasiveness of the Commission's recommendations in this area.

Achieving an Appropriate Specialty Distribution

The current mix of physician specialists is exactly what one might expect from an examination of the financial incentives in current federal policy. Specifically, funding of biomedical research by the National Institutes for Health, Medicare graduate medical education support, and Medicare's traditional over-reimbursement of procedural services have powerfully influenced the specialty distribution of the physician workforce. We anticipate that changing the specialty mix of the physician workforce will require massive shifts in these federal policies. It is unrealistic to expect Congress to adopt changes of this magnitude without a clearly defined goal and without an appreciation of just how far medical education needs to move in order to reach the goal even within a timeframe measured in units as long as decades.

As noted in the Commission's Annual Report to Congress, several different mechanisms have been proposed for achieving the desired distribution of physicians by specialty. Typically, proposals either advocate financial incentives through differential weighting of per resident amounts, or establishing specialty specific quotas on the residency slots that are eligible for funding.

A rational workforce planning process would reasonably include (1) an assessment of the current status of the health care workforce, (2) an assessment of the workforce needs of society, (3) the establishment of workforce goals based on society's health care needs, (4) the development of strategies for achieving workforce goals. In the short run, these functions should be organizationally fixed in a national commission. Requiring further consideration is how a workforce commission would consider regional needs in terms of both specialty and geographic distribution. The main disadvantage of any regulatory approach is that it may become unresponsive to societal needs and create its own market distortions. However, over the longer term, such a workforce commission might not even be necessary. Under the incentives of a reformed health care system, it is conceivable that the medical education establishment will become responsive to health plans, which would, presumably, be the most sensitive indicators of workforce needs. Sunsetting a workforce commission may be worth considering.

In considering PPRC's workforce commission approach it is unclear just how prescriptive an allocation of slots by residency needs to be or if it necessary to federally sanction the process of pruning programs on the basis of quality. We are concerned about the use of quality as the sole criterion for determining the specific residency programs that will be eligible for funding. As noted by PPRC, the number of general surgery residency slots was successfully reduced on the basis of quality. However, in the process, a number of smaller programs whose graduates might have been more likely to enter rural practice were eliminated. There is now a severe shortage of rural general surgeons.

Where they exist, we support funding eligibility for consortia consisting of teaching hospitals, medical schools, residency programs, and other training institutions. Operating under broad national goals, consortia are likely to be more sensitive to local needs and better able to allocate training funds accordingly.

The Academy supports the use of financial incentives to influence the specialty distribution of residency training slots. If financial incentives are to be effective, we believe there must be a substantial reweighting of per resident amounts in favor of those specialties in short supply. Limiting funding to the first three years of residency training or to only those specialties in short supply are essentially reweighting schemes. PPRC has expressed its belief that preferential weighting of generalist residencies is unnecessary because a number of existing slots have gone unfilled. However, there has been a substantial increase in the interest of graduating medical students in family practice training this year, which suggests to us that an increase in the number of training slots will be needed in the near future.[1] In addition, the increased funds derived from preferential weighting could be used to increase primary care resident salaries, which has been shown to be an effective recruiting tool.

The Commission has restricted its consideration of Medicare GME support to the direct costs of training. We believe it appropriate and important to consider the powerful influence that the massive indirect GME payments have on the specialty distribution of residency slots. Furthermore, the Prospective Payment Assessment Commission has estimated that the current indirect formula overpays hospitals for the indirect costs of inpatient medical education by approximately $800 million per year. These funds could be better used to support the indirect costs of ambulatory training.

The Commission has also expressed its concern that a reweighting scheme would be relatively inflexible in regard to changing needs. We think this a minor concern. The specialty maldistribution is so severe and the physician training pipeline is so long that the rate of shift in the specialty distribution will be glacial, at best. There will be plenty of opportunity for mid-course correction.

We do not believe there is sufficient evidence to know if one approach would be more effective or more appropriate than the other. The experience of other developed countries with quota systems has been impressive. On the other hand, the early experience of New York State's new system for funding graduate medical education suggests greater sensitivity to financial incentives than is commonly thought.

Ambulatory Training

The Commission clearly recognizes the discontinuity between the dominant site of medical training (inpatient) and the increasingly ambulatory nature of medical care delivery. The funding sources for medical education dictate that it mostly occur in inpatient settings. Until the incentives in medical education funding change, there is no reason to believe that the dominance of inpatient training will change. While family practice training has bucked this trend and requires ambulatory training for all residents, most family practice training programs are constantly having to negotiate a dizzying maze of small funding sources in their never-ending struggle for financial viability.

We support an expansion in eligibility to receive payment for both direct and indirect medical education costs to all hospital and non-hospital entities with approved medical residency training programs. Residency programs should be eligible for direct funding. Furthermore, direct GME payments should be limited to residents in the first three years of postgraduate training and substantially weighted in favor of the generalist specialties. Whether or not non-hospital entities become eligible for direct GME payments, there must a full and open accounting of how these payments are used.

Medicare support for the indirect costs of GME should be extended to qualified non-inpatient services provided in all sites affiliated with approved medical residency programs in the generalist specialties. Qualified services should be those non-inpatient services provided by medical residents in the initial three

[1]The number of 1993 senior medical students selecting family practice residency training increased 13 percent over 1992.

years of postgraduate training in the fields of family medicine, general internal medicine, and general pediatrics. Indirect GME support would be added to payment amounts determined under part B for non-inpatient services. These changes could occur in a budget neutral manner.

Concern has been raised regarding the alleged difficulty in ensuring the quality of medical education in ambulatory settings, especially those remote to academic medical centers. We believe that family medicine's long experience with ambulatory training should inform the deliberations on this issue. In the past few years many family practice residency programs have developed remote training sites in rural and urban underserved communities. Our experience suggests that such sites not only provide high quality training but actually provide training that is in many ways more relevant than that which is provided in traditional inpatient settings. Of related concern is the cost of ambulatory training, which may be more expensive than inpatient training. The added cost is in part due to the fact that few ambulatory facilities were designed to accommodate medical training. In the future, medical education funding must provide the resources necessary to build an ambulatory training infrastructure.

Inpatient Service Needs

The relevance of the specialty maldistribution to health system reform is illustrated by the reliance of some hospitals and populations on international medical graduates. The disproportionate loads of un- and under-insured patients has led a number of hospitals to rely on relatively cheap resident labor to meet their service requirements. We recognize that withdrawing the funding for these residency slots is difficult to consider without establishing an alternative means of providing for the care of indigent populations. It may be that such changes can only be considered in the context of universal health insurance coverage, which, by eliminating uncompensated care, could provide hospitals with the funds to secure the physician and non-physician personnel needed to substitute for the services currently being provided by residents.

Furthermore, there can be little doubt that hospitals have been encouraged to establish various inpatient services by the availability of relatively inexpensive resident labor. Community need for specific health care services may not have played as important a role in establishing these services as it would have absent Medicare's GME largess. The loss of residency slots due to modifications in Medicare GME funding may force some hospitals to reassess the appropriateness of their services in relation to actual community needs. The policy challenge will be to direct funding cuts where service capabilities are in excess of need.

Once again, I appreciate the opportunity to participate in today's workshop. Please know that the Academy stands ready to work with you in addressing these important issues. I look forward to your questions.

Association of Professors of Medicine

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Statement

of the

Association of Professors of Medicine

to the

Physician Payment Review Commission

December 9, 1992

Executive Summary

Recognizing that the United States needs to produce more generalists, APM adopted a resolution earlier this year stating that 50 percent of the graduates of internal medicine residencies should enter the practice of general internal medicine.

Having taken the first step by passing the 50 percent resolution, APM charged its Medical Education Finance Committee with developing recommendations for restructuring GME support in order to improve physician specialty distribution.

Last month, the APM Board of Directors endorsed a GME reform initiative developed by the committee. This initiative -- which includes many of the recommendations recently made by COGME -- is built on the following eight principles:

I Medicare GME funds should be redistributed to finance training in the ambulatory setting.

II An adjustment to Medicare Part B payments should be added to providers outside the inpatient setting for the indirect costs of GME.

III The development of local, state, and regional medical education consortia should be encouraged.

IV All payers should contribute to GME, including Medicare; Medicaid; private insurers; self-insured employee plans; and managed care arrangements, such as HMOs.

V All providers of medical education should be required to adopt a uniform system of accounting for educational costs. All recipients of medical education funding should be required to be accountable for use of all such funding.

VI A mechanism should be developed -- through the accreditation process, the certification process, or the reimbursement system -- for limiting the number of residency and fellowship positions in all specialties.

VII Explicit funding for training in family medicine, general internal medicine, and general pediatrics should be identified. A portion of this funding should be given directly to the medical school, residency training program, or department chair.

VIII The economic incentives to enter generalist fields must be increased.

Although restructuring GME support will improve physician specialty distribution, it is only part of the solution. In order to produce more generalist physicians, the U.S. health care delivery system must address a number of important issues that are not linked to the GME financing system. These include medical student debt; the comparative income structure for generalists, specialists, and subspecialists; quality of life and prestige concerns; and the need for active role models.

In working to develop a health delivery system that is cost-effective, accessible, and provides the best medical services in the world, APM wants to ensure that the excellence identified with the current system of medical education in this country continues, even as the method for financing the system changes.

Introduction

On behalf of the Association of Professors of Medicine (APM) -- which is the national organization of the chairs of departments of internal medicine at the 126 U.S. medical schools -- thank you for this opportunity to testify before the Physician Payment Review Commission (PPRC). I am James P. Nolan, M.D., President-Elect of APM and Chair of the Department of Medicine at the State University of New York (SUNY) at Buffalo School of Medicine.

APM has been asked to comment on a series of policy options PPRC is considering for restructuring financial support for graduate medical education (GME). My testimony will address this request by commenting on PPRC's draft policy options paper, "Financing Graduate Medical Education: Options for Reform," as well as by describing a series of recommendations for restructuring GME financing endorsed last month by the APM Board of Directors. APM's GME financing reform proposals -- which are similar to many recommendations recently made by the Council on Graduate Medical Education (COGME) -- were developed through the work of the association's Medical Education Finance Committee, which is chaired by Robert G. Luke, M.D., Chair of the Department of Internal Medicine at the University of Cincinnati Medical Center.

APM maintains that the following physician workforce and medical education issues have a significant negative impact on the U.S. health care delivery system:

- The under-production of generalists, which APM defines as family physicians, general internists, and general pediatricians.
- The lack of adequate medical training in the ambulatory setting.
- The lack of an adequate physician supply in rural and inner-city America.
- The lack of under-represented minorities who apply to, matriculate through, and graduate from U.S. medical schools.

APM's Efforts To Address Physician Workforce Issues

Recognizing that the United States needs to produce more generalists, APM adopted a resolution earlier this year stating that 50 percent of the graduates of internal medicine residencies should enter the practice of general internal medicine. The Federated Council of Internal Medicine (FCIM) -- which consists of APM, the American Board of Internal Medicine (ABIM), the American College of Physicians (ACP), the Association of Program Directors in Internal Medicine (APDIM), the American Society of Internal Medicine (ASIM), and the Society of General Internal Medicine (SGIM) -- has also backed this goal.

Last year, APM initiated a major study of the internal medicine residency curriculum. This study resulted in the development of three models that will be implemented at various training sites in the near future. The first model, which I am working to implement at SUNY-Buffalo School of Medicine, would change the current three-year internal medicine residency so that 50 percent of resident time would be spent in ambulatory care locations. The second model would add a flexible fourth year to the existing three-year program of residency designed to enhance training for general internists. And the third model would utilize a portion (three- to 12-months) during the fourth year of medical school for early residency training.

Besides adopting the 50 percent goal and implementing curriculum reform models, APM is in the early stages of developing a model for determining the proper ratio of general internists to internal medicine subspecialists both in practice and in academia. The association is also examining the projected need for clinical investigators and physician scientists. In addition, APM is working to increase the number of under-represented minorities who attend and graduate from U.S. medical schools.

In many cases, APM's efforts in these areas -- reaching the 50 percent goal, adopting curriculum reform, measuring the ratio of generalists to subspecialists, examining the need for clinical investigators and physician scientists, and increasing the number of under-represented minority physicians -- are assisted by other organizations,

many of which testify today. For example, representatives from SGIM and APDIM serve on the APM Curriculum and Medical Education Finance Committees.

It is also critical that the issue of restructuring financial support for GME be viewed as part of the overall reform of the U.S. health care delivery system. As James Todd, M.D., Executive Vice President of the American Medical Association (AMA) states, "A health care system as massive as ours cannot be changed without changing how physicians are educated at all levels. Indeed, a Flexner-like study for the 1990s would be useful, not because medical education is bad, but because it needs to be different."

The United States Produces Too Few Generalists

There are strong and growing indications that the United States produces too few generalist physicians and too many specialists and subspecialists. Data also indicate that these trends make it more difficult for the health delivery system to provide cost-effective primary medical care to much of the population. Compounding this situation is recent data from a survey of graduating medical students by the Association of American Medical Colleges (AAMC): less than 15 percent of the 1992 medical school graduates expressed an interest in generalist careers, a 15 percent decline from 10 years ago. It is estimated that around 30 percent of U.S. physicians are practicing generalists, compared with 70 percent in Great Britain and 50 percent in Canada. Over the past three decades, the proportion of generalists has decreased from more than 40 percent of the nation's total physician supply.

Based on recent fill rates in the National Resident Matching Program (NRMP), the decline in practicing generalist physicians may continue for years to come. Since 1986, there has been a 26 percent drop in the number of U.S. medical school graduates choosing categorical internal medicine programs through the NRMP. However, the actual drop in generalism is much worse than the match data reflect, because approximately two-thirds of the residents in internal medicine choose to enter a subspecialty. As pointed out in PPRC's draft paper, although the 1992 NRMP shows a slight increase in the overall number of residency positions filled in family medicine, general internal medicine, and pediatrics, the rates are still lower than they were in 1986. If the primary care freefall continues, the number of U.S. generalists may dip below 25 percent by the turn of the century. Also, an increasing percentage of first-year internal medicine residency positions are filled by international medical graduates (IMGs). In 1990, IMGs constituted 21 percent of these positions, an increase of more than 125 percent since 1986.

Within internal medicine, the balance between generalists and subspecialists is approximately 35 percent to 65 percent; there appears to be an increase in subspecialization among recent residency program graduates, based on responses to

the AAMC Graduation Questionnaire. Since 1985, the number of cardiology and gastroenterology residents has doubled, while general internal medicine trainees have grown by a modest three percent. Between 1985 and 1990, the ranks of practicing physicians identifying themselves as general internists has grown by 10 percent, while the number calling themselves cardiologists and gastroenterologists went up by 19 and 26 percent.

Some evidence indicates that internal medicine subspecialists perform a level of primary care services as part of their subspecialty practice; these data require further examination in order to understand this situation better. Even if moderate to substantial primary medical care is being provided by subspecialists, considerations about the costs of such care may mitigate its impact on the assessment of workforce needs.

Finally, rapid changes in the health care delivery system -- through its increasing dependence on the managed care approach -- will require the production of more generalists. Most managed care arrangements, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), use generalists to provide preventive and primary services as well as make referrals for other services along the system's continuum of care. The American Medical Care and Review Association surveyed 91 HMOs in 1989 and found that 79 percent relied on generalists as gatekeepers or team leaders.

Several studies have shown that a delivery system based on managed care will require fewer physicians overall, but demand more generalists and fewer specialists. A recent article in American Medical News states: "Studies indicate that group and staff-model HMOs use only about 120 physicians per 100,000 population." The American Medical Association (AMA) estimates that by the year 2000 there will be 241.5 physicians per 100,000.

Issues Within The Medical Education System

Systemic issues exist within the academic medical enterprise that should also be reviewed as part of a comprehensive evaluation of the need to train more generalists. One such issue is the need to increase training in the ambulatory setting. There are financial and structural barriers that deter expanded medical training outside the traditional inpatient setting. These barriers include the link between current Medicare GME reimbursement and inpatient clinical service, best evidenced by the use of the intern and resident to bed ratio in calculating the indirect medical education (IME) adjustment; the generally lower reimbursement for services provided in the outpatient setting; current regulations requiring a hospital to be responsible for "substantially all" the training costs in the ambulatory setting in order to receive GME reimbursement for costs from this site;

a lack of recovery mechanism for indirect costs associated with medical education outside the hospital; the continued reliance on residents to fulfill service needs at most major academic hospitals; a scarcity of teaching faculty in the ambulatory setting; and the difficulties in providing teaching space in outpatient clinical practices, especially in physician office settings.

In a similar manner, if GME providers developed a more uniform method of accounting for GME costs, it would improve the climate for training more generalists. The wide variability in the practices of teaching hospitals in accounting for GME costs places limitations on the implementation of wide-ranging solutions to workforce problems. For example, one hospital may include a large portion of its teaching faculties' salaries and other costs in the calculation for direct medical education (DME) reimbursement, while at another hospital these costs may be the sole responsibility of one of the clinical departments. This situation has led to a wide variability in per resident costs at our nation's teaching hospitals as well as confusion among policymakers.

In addition, the majority of internal medicine residents are trained in teaching hospitals located in large metropolitan areas, with a high percentage of these sites being in core inner-city locations. Studies indicate that academic medical center hospitals provide more than 10 percent uncompensated care, whereas non-teaching hospitals provide less than six percent (as a percent of total patient care revenues). As long as a continued large number of inner-city residents lack health insurance, house-officers on inpatient wards will continue to provide a great deal of the care to indigent patients as well as encounter such patients as the majority of their teaching cases.

Important Factors Contributing To Student Specialty Choice

Many other issues contribute to the shortage of generalists and surplus of specialists. Although the full impact is unclear, evidence has shown a link between medical student debt and potential specialty selection. "Medical students may deny their debt as an influencing factor, but their decision to practice a specialty can be made several years later when the size of the debt weighed against the likely low income of a primary care physician tips the scale toward specialization," explains former Surgeon General C. Everett Koop, M.D. In 1991, nearly 80 percent of medical school graduates were indebted, with a mean educational debt of more than $50,000, according to AAMC data.

Meanwhile, AMA data indicate an imbalance in the comparative income structure for generalists, specialists, and subspecialists. For example, the average anesthesiologist in the United States earned $207,400 in 1990, the average radiologist made $219,400, and the average surgeon made $236,400. At the same time, the average generalist physician earned $120,600, with one-fourth of all generalists making less than $70,000.

APM feels strongly that restructuring GME support is only part of the solution. In order to produce more generalists, the health care system must address the imbalance in the comparative income structure for physicians.

Quality of life and prestige issues also help push medical students from generalism to specialization. For example, most generalists work long hours and are more adversely affected by continued administrative interference in the medical profession. Americans also tend to consider specialists more knowledgeable than generalists. This has led to a public perception that generalists provide less competent care than specialists as well as added to the negative atmosphere for generalists at medical schools across the nation.

There is also strong evidence that positive role models influence the specialty choice of medical students. Therefore, generalist faculty -- the source of primary care role models -- start with a disadvantage in their efforts to influence a student's specialty choice. Steven Schroeder, M.D., President of the Robert Wood Johnson (RWJ) Foundation, adds that "the medical students' exposure to internal medicine, as seen through the prism of the inpatient medical clerkship, is incomplete. Students who are given the chance to observe internal medicine as it is practiced outside the hospital setting think more highly of the specialty and are more apt to choose it." Many students perceive generalist residencies as more stressful, less satisfying, and less competitive.

APM's GME Financing Reform Initiative

As a result of the overwhelming federal budget deficit, it is doubtful that new federal funds will be available to support increased training opportunities for generalists. Therefore, while recognizing that GME financing consists of many payment streams, APM has focused much of its attention on restructuring the current methods of and sources for financing GME -- specifically, the Medicare program's DME payments, which provided $1.5 billion in 1991.

Having taken the first step by passing the 50 percent resolution, APM charged its Medical Education Finance Committee with developing a new policy initiative on GME support to improve physician specialty distribution. Last month, the committee submitted a GME reform initiative to the APM Board of Directors. This initiative, which was endorsed by the board of directors, is built on the following eight principles:

- Medicare GME funds should be redistributed to finance training in the ambulatory setting.

  To facilitate greater ambulatory training, APM supports a number of options, many of which are outlined in PPRC's draft report. For example, time spent by residents in ambulatory care activities both on and off hospital premises could be

included in calculating the number of full-time equivalents (FTEs) for the purposes of DME and IME. APM agrees with the paper that this "would effectively remove the financial disincentive to training residents off hospital premises."

The association would also support placing conditions on Medicare payments to HMOs. As the paper notes, calculation of the average allowable per capita cost (AAPCC) that is currently paid to HMOs with risk contracts includes both DME and IME payments. And, since HMOs with Medicare risk contracts are not required to use teaching hospitals, they effectively can receive GME funding without accompanying assurance that these funds will be used to support training.

In terms of more substantial changes in Medicare financing, APM would support increasing clinical income from Part B to support ambulatory training. The paper outlines several ways to do this. In fact, one of these options provides a transition to the second principle upon which APM's GME financing reform initiative is built.

II An adjustment to Medicare Part B payments should be added to providers outside the inpatient setting for the indirect costs of GME.

As PPRC's draft paper points out, the goal of creating an add-on would be to allow physicians in non-hospital settings to use these extra revenues to support training in sites other than the hospital. APM has concluded that support for the direct and indirect costs of GME outside the inpatient setting is critical in order to increase training in the non-hospital setting.

Under this policy, programs that train residents in the ambulatory setting would apply for an add-on to the fees paid for physician services provided in those settings. This add-on should cover direct medical education expenses – such as professional effort, cost of classroom space, cost of additional equipment and supplies, and designated overhead costs – as well as indirect expenses created by the presence of a teaching program. For this option to work, it is important to establish criteria that all ambulatory training settings would meet in order to qualify for an add-on to physician services in those settings. Such criteria could include direct affiliation with medical schools and established training programs, certification of the program by the Accrediting Council for Graduate Medical Education (ACGME), and a curriculum devoted to producing generalist physicians.

A second substantial change in Medicare financing to increase training in

ambulatory settings would be to make direct payments to entities other than hospitals. APM supports one option outlined in the paper: maintaining Part A financing of GME, but permitting payment for DME costs to entities other than hospitals.

This option provides a transition to the third principle upon which APM's GME financing reform initiative is built.

III The development of local, state, and regional medical education consortia should be encouraged.

Each academic consortium could include one or more medical schools, teaching and community hospitals, community health centers, HMOs, nursing homes, and educational institutions from primary schools through college. Under the plan outlined in the COGME report, residency positions and GME funding would be allocated based on state and regional workforce needs and national goals for aggregate physician supply, the recruitment of under-represented minorities, and specialty distribution.

APM asserts that the key to this principle, as well as the key to restructuring the financing of GME, is a comprehensive determination of the demand for physician services -- by specialty in local communities, states, regional areas, and the entire country. By determining area-specific workforce needs, the federal government can be more effective in distributing GME support.

Many organizations, commissions, and groups have joined APM by advocating that 50 percent of all U.S. physicians be generalists. However, the 50 percent goal needs to be examined within the context of local, state, regional, and national needs for generalists. Until need is determined, efforts to redistribute GME funds may be misdirected. Therefore, APM urges the commission to advocate in next year's report a comprehensive study of area-specific health workforce needs.

For nearly 20 years, the National Study of Internal Medicine Manpower (NaSIMM) has provided an annual census and characterization of internists and subspecialists in training. Today, NaSIMM focuses on the many significant factors that impact physician training in internal medicine. The study has found that these include stipend funding, location and amount of training in ambulatory settings, number of hours worked, size and character of the faculty, content of the curriculum, placement of residents, utilization of computer technology, and the impact of organizational factors on training programs. Under its current leadership, NaSIMM is expected to expand beyond census and characterization

of internists in training. If this occurs, the study would begin to focus on the organization and structure of internal medicine training. As such, NaSIMM would be an excellent tool for assessing health workforce needs across the country.

As an example of the benefits of the consortium approach, I would like to take this opportunity to note some of what the Graduate Medical and Dental Education Consortium of Buffalo (GMDECB) has accomplished. GMDECB includes eight teaching hospitals, one dental school, and one medical school. It was formed nearly 10 years ago to develop an integrated patient care and medical education system. Since it was created, the consortium has promoted inter-institutional cooperation and sharing, strengthened academic programs in graduate medical and dental education, and pooled educational resources. As a result of this cooperation, GMDECB has accomplished the following:

- Provided centralized, coordinated management of all ACGME-approved GME programs in Western New York.
- Developed a standardized application form for all programs.
- Centralized personnel and health records for each trainee.
- Implemented a computerized system with central coordination for resident and medical student credentialing.
- Provided common salary and fringe benefits for trainees paid from a single organization.
- Developed a one-week comprehensive core curriculum that is required for all first-year graduate students (PGY-1s); this curriculum is conducted prior to the beginning of the training program.
- Reduced unnecessary administrative duplication across the hospital system and clinical departments.

IV All payers should contribute to GME, including Medicare; Medicaid; private insurers; self-insured employee plans; and managed care arrangements, such as HMOs.

COGME includes this principle as one of its 43 recommendations. PPRC's draft paper also includes this option, stating, "A more fundamental change in the financing and control of residency training would be to require all payers to contribute to a special [GME] fund that would be either local, state, or national in scope. Payments would be made from this fund to support residencies that meet policy goals related to supply, specialty mix, and site of training."

APM would support a number of uses for the special GME fund, including the following:

1. Funds could be awarded by the federal government either through grants to states or on an institution-specific basis for generalist training. For institutions to qualify, programs would have to meet production criteria. A phase-in period, mixing current DME funds with taxes, could be used to assess how well programs produce generalists. Limits on the number of training slots could be established.

2. Funds could be used for loan forgiveness programs. Trainees would be required to sign a contract to practice in a generalist field for five years after completion of residency. In return, principal and interest of loans taken specifically for medical education would be paid during service period. A threshold for loan forgiveness would be established. Failure to fulfill service obligation would result in penalty of 150 percent of amount paid by government. IME would continue as presently structured.

3. Funds could be used to allow physicians who are practicing in a generalist field and in a designated geographic area or setting to deduct from their income taxes the principal and interest on qualified medical education loans for five years. Qualified sites could be urban ambulatory clinics or hospitals, Department of Veterans Affairs (VA) hospitals and clinics, prisons, rural community practices, Indian Health Service facilities, Area Health Education Centers. Penalties would be established for violating agreements.

PPRC's draft paper discusses the GME financing system in rate-setting states such as Maryland, New Jersey, and New York. Although each state has difficulties with its rate-setting system, these difficulties are generally not a result of including the direct costs of GME in the rates.

However, this kind of rate-setting system does not naturally lend itself to meeting any predetermined physician workforce needs. As such, APM favors an all-payer approach that is tied more closely to policy goals. While PPRC's paper correctly points out that this type of arrangement could become highly politicized, APM maintains that such difficult decision-making is needed to address the physician workforce imbalances.

V <u>All providers of medical education should be required to adopt a uniform system of accounting for educational costs. All recipients of medical education funding should be required to be accountable for use of all such funding.</u>

Earlier in my testimony, I stated APM's belief that the lack of a standard definition of the components of direct GME costs has led to a wide variability in what is currently included in such costs by hospitals. For example, one GME provider may include a greater amount of faculty time and effort in determining direct GME costs than another GME provider. If this situation is not addressed, APM believes it may mitigate the effectiveness of system-wide GME reform. While not disputing that all allowable GME costs should be recovered, the association believes that if GME providers used a uniform method of accounting for GME costs, it would be easier and more effective to make other changes to the reimbursement system.

In addition, APM maintains that there is a greater need for accountability by providers for GME costs reimbursed through Medicare. For example, the association believes that reimbursements for faculty supervision of residents should be linked to the ultimate source of compensation for such faculty (the hospital, medical school department, faculty practice plan, or any combination of the three). Unfortunately, the present system only allows for reimbursement to one source, causing confusion in many settings.

VI A mechanism should be developed -- through the accreditation process, the certification process, or the reimbursement system -- for limiting the number of residency and fellowship positions in all specialties.

APM recognizes that a reduction in the number of subspecialty training positions is necessary in order to reach the association's 50 percent goal. This presents a difficult problem for APM members, since departments of internal medicine depend on subspecialists to provide a significant amount of the department's clinical income as well as contribute to the institution's biomedical research efforts.

APM believes that the accreditation and certification processes could be used to limit the numbers of subspecialists in training. The association would support increasing the requirements for certifying subspecialists or extending the length of training time. In addition, APM would support empowering residency review committees (RRCs) and ACGME to discredit programs based on an assessment of overall educational quality. To do this, however, it would be necessary to lift certain restrictions imposed by the Federal Trade Commission (FTC).

COGME recommends capping the number of Medicare and other funded first-year residency positions at 10 percent more than the number of U.S. allopathic and osteopathic medical school graduates. COGME also recommends limiting

DME and IME payments to residency training for initial certification or five years, whichever is less. Unfortunately, as I said earlier in my testimony, no one has collected the data that would be needed to make this assessment. As a result, APM supports a comprehensive study of health workforce needs in local communities, states, regional areas, and the entire country. Again, NaSIMM would be an excellent tool for collecting this data.

Under scenarios outlined in APM's fifth (V) GME reform principle, the pooling of funds from all payers could be tied to a certain number of residency and fellowship positions. As was the case with that principle, the association maintains that an area-specific assessment of physician workforce needs is critical to its sixth (VI) GME reform principle.

VII Explicit funding for training in family medicine, general internal medicine, and general pediatrics should be identified. A portion of this funding should be given directly to the medical school, residency training program, or department chair.

APM recommends providing new funds under Title VII to strengthen divisions of general internal medicine at U.S. medical schools. In addition, the association maintains that funding through NIH and the Agency for Health Care Policy and Research (AHCPR) should be increased for research in primary care, health services delivery, and patient care outcomes, as well as for the development of research faculty in primary care disciplines.

COGME makes these recommendations in its report.

VIII The economic incentives to enter generalist fields must be increased.

APM supports providing loan forgiveness or tax deductions to residents who enter practice as family physicians, general internists, or general pediatricians. Earlier in my testimony, I discussed ways for implementing such programs (Principle IV). In addition, the association recommends that federal and state programs, such as the National Health Services Corps (NHSC) scholarship and loan forgiveness programs, be maintained, enhanced, and expanded to address the undersupply of physicians in rural and inner-city America.

COGME makes this recommendation in its report.

In reviewing the eight principles that form the basis of APM's GME reform initiative, I commented on most of the options presented in PPRC's draft paper. I would like to take a few minutes to discuss APM's opposition to applying differential weights for residency positions in calculating DME payments. The reasons for the association's opposition to weighting, which are well documented in the draft paper, are as follows:

- o It is unlikely that weighting will prove an effective means of increasing the proportion of residents in generalist training.
- o Some clinical departments may be forced to make up for the loss of DME payments through clinical income.
- o Weighting sends the message that Medicare does not value training in many important fields.

Conclusion

APM appreciates this opportunity to present the GME reform initiative endorsed last month by the association's board of directors. APM is pleased that much of what it is recommending is discussed in PPRC's draft report and recommended in COGME's third report, Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century. Clearly, many health care players -- such as physicians, hospitals, academic medical centers, and federal commissions -- are beginning to come together on how to restructure financial support for GME in order to address the physician workforce issues facing this country.

As we come together, however, we must keep in mind that restructuring GME financing is only part of the solution. In order to produce more generalist physicians, the health delivery system must address a number of important issues that are not linked to the GME financing system. APM believes that changes in GME support alone will have a limited effect. In particular, the association maintains that imbalance in the comparative income structure for generalists, specialists, and subspecialists must be addressed.

In closing, I would like to say that APM is excited by the prospect of working with President-elect Bill Clinton, his transition team, and the people he selects as his health policy advisors. Based on public opinion polls and election results, the country seems ready to face the important issue of reforming the health delivery system. The day after Governor Clinton was elected president, his campaign staff indicated that health reform would be part of the agenda for his first 100 days in office.

Groups like the ones that have provided testimony for today's hearing must be part of the reform effort. Collectively, our members understand each part of the complex health delivery system. By putting our valuable knowledge to use, President-Elect Clinton, Congress, and federal health policymakers can develop a delivery system that is cost-effective, accessible, and provides the best medical services in the world. However, APM's main charge in this effort must be to ensure that the excellence identified with the current system of medical education in this country continues, even as the method for financing the system changes.

Again, thank you for the opportunity to testify. I would be pleased to answer your questions about APM, the association's GME reform initiative, or my testimony.

Association of Professors of Medicine

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March 2, 1993

Paul Ginsburg, Ph.D.
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Physician Payment Review Commission
2120 L Street, N.W.
Suite 510
Washington, DC 20037

Dear Dr. Ginsburg:

On behalf of the Association of Professors of Medicine -- which is the national organization of the chairs of the departments of internal medicine at the 126 U.S. medical schools -- thank you for this opportunity to comment on the Physician Payment Review Commission's (PPRC's) 1993 Annual Report to Congress.

Although APM is interested in the entire report, I will limit my comments to Chapter 6, "Training Physicians to Meet the Nation's Needs." APM is limiting its comments to one chapter in order to provide PPRC with very specific observations about restructuring federal support for graduate medical education (GME) in order to produce more generalist physicians.

In its testimony to PPRC on December 9, 1992, APM argued that restructuring GME in order to produce more generalist physicians must be closely linked with reforming the nation's health care system. With this as a foundation, APM maintains that the current GME system has little connection to the health care needs of our nation or the workforce requirements of the current delivery system (say nothing of the potential needs of a reformed delivery system).

Since most studies indicate that the delivery system will not be fully reformed until the end of the century, APM asserts that an effort to assess the physician workforce needs of this country should be undertaken as soon as possible. By providing much needed data on physician workforce needs -- both regionally and by specialty -- such an effort would be invaluable to efforts to reform the health care system.

The scope of Chapter 6 is very similar to APM's testimony and the association generally supports PPRC's six recommendations. While there is no need to restate APM's testimony, I would like to take this opportunity to make specific comments about Chapter 6.

- "The Commission considered...providing preferential funding for primary care positions (referred to as weighing)...After careful consideration, the commission rejected these approaches as undesirable for several reasons." (Page 21, lines 1 through 6.)

  APM agrees with the commission that weighing will have little or no effect on limiting specialty positions.

- "[T]he commission determined that limits on the total number of residency positions are essential. Moreover, deliberate decisions should be made about the distribution of these positions across specialties. All positions that are approved as part of an open, deliberative process should be funded for the full length of training." (Page 23, lines 3-6.)

  APM agrees with the commission that a determination of the total number of residency positions is essential to reforming the system and that these positions should be funded for their entire length of training.

- "The commission recommends that Congress set in statute a limit on the total number of residencies to be funded and achieve this number by sequencing reductions over successive classes of first-year residents...a policy that limited the number of first-year residents to U.S. graduates plus 10 percent would have required cutting about 2500 positions." (Page 24, lines 12-14, and 17-19.)

  APM agrees that Congress should set in statute a limit on the total number of residencies to be funded, and that this should be tied to funding of specific residencies based on workforce needs.

- "Moreover, an additional number of slots above the number of U.S. graduates should exist so that the United States can fulfill its obligation in training health professions from abroad." (Pages 25 and 26, lines 16-1.)

In providing residency positions to international medical graduates (IMGs), U.S. medical schools must seek trainees who can improve the overall quality of the program's GME training and be consistent with defined workforce policy goals. IMGs should not be granted residency positions solely to fulfill clinical service needs. Both of these factors are best determined by national assessment of specialty and geographic needs. This should also be a factor in assessing a program's quality, as mentioned later in the report.

- "Decisions about the number of residencies per specialty should be made by a federal body created for this purpose. This would permit more deliberative and detailed analysis of the appropriate allocation of slots than would be possible if these were set in statute. It would also allow for continuous adjustment of resident allocation over time." (Page 26, lines 5-9.)

  APM agrees that a new federal body should be created to make decisions on the number of residencies per specialty. Further, the association maintains that generalist fields should be initially shielded from any cuts based on an allocation of total residency cuts. However, APM adds that this total number of residency slots must be based on a national assessment of physician needs.

- "The commission would, however, caution against funding a comprehensive national workforce study. This is because the policy question has changed since GMENAC from how many physicians does the nation need to how many can it afford. Moreover, waiting on the results of such an effort would substantially slow progress towards achieving policy goals." (Page 27, lines 5-9.)

  APM strongly disagrees with the commission's caution against a comprehensive national workforce assessment. Unless such a study is undertaken, all decisions related to physician workforce will be based on empirical evidence rather than comprehensive data. Further, APM believes that while a determination of aggregate numbers of physicians is no longer prudent, an assessment of the **type and geographic distribution** of physicians is essential to linking GME to policy goals.

  APM agrees that the answer to this question must be reconciled with how many physicians the country can afford, but that this should not obfuscate the need for a determination of workforce needs. Finally, any delay in implementing GME reform caused by conducting the national workforce assessment would be outweighed by the benefits of the results of this assessment since such a study would provide data that help improve the health delivery system greatly.

- "Once the decision is made about the number of positions to be funded by specialty, a second tier of decisions will be required as to which specific positions in these fields should be funded. The commission recommends that these decisions be made by the bodies that accredit graduate training on the basis on educational quality." (Page 29, lines 2 through 5.)

  APM strongly agrees that decisions regarding specific residency positions to be funded be based on an assessment of educational quality and that these decisions be made by private sector accreditation bodies such as the residency review committees (RRC). Not only are these organizations well-positioned to make such assessments, but the policy speaks to any concerns about the micro-management of medical education by the federal government.

- "It is the commission's view that the costs of graduate medical education should be shared by all payers. This reflects the principle that all who benefit from GME should contribute to its costs...The Commission recommends that all payers...contribute a percentage of their payments for medical care to a public [GME] pool." (Page 32, lines 2 and 3 and 10 and 11.)

APM strongly agrees that everyone who benefits from GME should contribute to its costs. The creation of an all payer system is beneficial from both considerations of equity as well as ensuring a consistent source of funding for GME. It would also help sever the link between hospital clinical service and medical education.

- "A related question that the commission did not resolve is whether the Departments of Veterans' Affairs and Defense should contribute to the payer pool or continue to fund residencies within their agency budgets." (Page 34, lines 3-5.)

APM believes that the Department of Veterans Affairs (VA) and its medical centers should continue to be an integral part of GME training, and that this relationship should continue through the current affiliation agreements between VA and academic medical centers. The Commission should consider the creation of VA specific training programs in such areas as ambulatory education, geriatrics, and rehabilitation medicine since it could make the best use of VA's patient population and health care professionals.

- "Breaking the link between payment for hospital services and the financing of graduate medical education creates two additional questions: who should receive the payment and what methodology should be used for determining payment amounts....The commission struggled with the issue of who should be eligible to receive payment for graduate medical education. It considered several alternatives: making payments to teaching hospitals, medical schools, consortia of medical schools and teaching hospitals, or directly to residency programs." (Page 34, lines 8-16.)

APM supports uncoupling hospital service and GME, as well as the need for an identification of the true costs of graduate physician training -- regardless of the loci of GME funding. APM agrees with PPRC that there are strengths and weaknesses to each of the alternatives the commission outlines in the report. In its testimony, APM supported the development of medical education consortia. In the final analysis, APM maintains that this approach would provide the most equitable way for distributing GME funds.

However, this approach would need to be refined based on situations unique to local communities and regional areas. In addition, it may be feasible to develop a combined approach with some funds being available to residency training programs directly in order to support initiative such as faculty development for generalists residencies and data collection. If the present system is to be retained (e.g., payments to hospitals through the Part A system), APM strongly urges that a uniform method of accounting for GME costs and a greater degree of accountability for the use of such funds be developed.

In addition, the APM reiterates its support for the creation of a Part B add-on to help finance training in physician offices. While the PPRC's concerns over program quality are legitimate, exposing residents to more typical practice settings during their training is an important factor in helping to increase the production of generalist physicians. Criteria for program quality could be addressed through the profession, and could include a requirement for size and of practice and scope of operations.

- "Although payments from the payer pool could be determined using Medicare's current methodology, the commission recommends development of a new standardized payment

per resident....Medicare payments vary substantially across hospitals as a function of accounting practices, payments to supervisory physicians, and historical cost inefficiencies. This method effectively penalizes efficient hospitals and those that did not report all potential direct costs in the 1984 and 1985 base year." (Page 38, lines 3-9.)

APM agrees that all providers of medical education be required to adopt a uniform system of accounting for educational costs as well as be accountable for use of all such funding. If GME providers developed a more consistent approach to documenting GME costs, it would improve the climate for training more generalists.

- "Reducing the number of residents and shifting positions both from subspecialty fields to primary care and from inpatient settings to ambulatory sites will be disruptive to teaching hospitals...The Commission recommends making available transitional relief funds to teaching hospitals that lose residency positions as part of this process." (Page 38, lines 16-18, and page 39 lines 2 through 5.)

  APM strongly supports efforts to provide transitional relief to teaching hospitals, because such relief would mitigate the impact on care of patients in affected teaching hospitals and such funds would help lessen the disruptiveness of reducing the number of residents and shifting positions.

In closing, although restructuring GME support will improve physician specialty distribution, it is only part of the solution. The commission's recommendations have to make explicitly clear the necessity of making concomitant changes in a number of important issues that are not linked to the GME financing system if the goals of GME financing reform are to succeed. This situation is particularly crucial within internal medicine given the forces that have led to increased subspecialization by graduates of residency training programs.

Thus, issues such as medical student debt; the comparative income structure for generalists, specialists, and subspecialists; quality of life and prestige concerns; and the need for active role models have to go hand-in-hand with the changes in GME financing. At this time, most generalists are disappointed by the resource-based relative value scale (RBRVS), which was intended to address the comparative income scale for physicians.

APM appreciates this opportunity to comment on PPRC's 1993 Annual Report to Congress. If you have any questions about APM's remarks or wish to discuss them, please call me at (202) 857-1158.

Sincerely,

Jim Terwilliger
Executive Director

STATEMENT

of the

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

to the

U.S. SENATE SPECIAL COMMITTEE ON AGING

and

SENATE RURAL HEALTH CAUCUS

on

THE PHYSICIAN PAYMENT REVIEW COMMISSION PROPOSAL TO RESTRUCTURE GRADUATE MEDICAL EDUCATION

and

RECOMMENDATIONS TO INCREASE THE SUPPLY OF PRIMARY CARE PHYSICIANS

May 3, 1993

These are just two of the examples of what osteopathic physicians committed to rural communities have meant to these communities.

Most of the osteopathic physicians in practice in those towns are primary care physicians. A total of 58 percent of all osteopathic physicians practice in primary care. Although this figure is considerably higher than the percentage of allopathic physicians in primary care, we share the concerns of the allopathic community over the downward trend in interest in primary care among all medical students.

Our greatest fear, however, is that rural communities may not have many more Dr. Thompson's and Dr. Pelli's if there are not sufficient safeguards added to the proposal of the Physician Payment Review Commission (PPRC) made to Congress this year to revise graduate medical education. PPRC is proposing a dramatic change in the way graduate medical education funds would be provided. We're afraid that without safeguards, the proposal could wipe out many osteopathic training slots that are today filled by students planning primary care practices in rural areas.

The Commission calls for a mandatory central planning approach that may cut the total number of residencies in the nation by 11,000. Many of these slots which could be cut may well be existing primary care residencies.

The PPRC proposal would establish a federal body that would determine the number of residencies per specialty. Accrediting bodies would then determine which residencies would survive and which would be cancelled based on an undefined determination of the "quality" of training. The proposal does not specify whether the osteopathic accrediting body would remain independent or be combined with the larger allopathic accrediting entity. If the determination of "quality" is based on the number of full-time teaching faculty or some similar costly determinant, academic medical centers will benefit to the detriment of community-hospital based training sites. This would be true even if the community hospital training program had a much better record of training primary care physicians serving rural areas.

Community-hospital based training is generally found at osteopathic teaching hospitals. These programs make extensive use of part-time and volunteer educators who are practicing physicians in the community. These osteopathic training programs offer far more patient contact and exposure to actual primary care practice than do most research-based, medical center training programs. After years spent in medical school learning theory and scientific application, hands on practical experience in residency training provides excellent preparation for careers in primary care practice.

The PPRC proposal would potentially offer federal and private funds for the conversion of part of the research-based programs to offer some increased presence of primary care training at these centers. However, we feel this should not be done at the expense of eliminating existing primary care residencies in community hospital teaching settings.

Thank you Mr Chairman. My name is Brian Hyps, Vice President for Government Relations and Counsel for the American Osteopathic Hospital Association (AOHA). In addition to AOHA, this statement is also supported by the Association of Osteopathic Directors and Medical Educators and by Sherry Arnstein, Executive Director of the American Association of Colleges of Osteopathic Medicine. Osteopathic hospitals and osteopathic medicine have long had a commitment to serving rural areas of the nation. Although the 33,500 osteopathic physicians represent only five percent of all physicians, they make up 15 percent of all physicians practicing in communities with less than 10,000 people. The figure climbs to 18 percent in rural counties with less than 2,500 population.

We've included a list of the towns served by osteopathic physicians in Arkansas, Mr. Chairman, and as you know, many of these are rural towns that often have difficulty attracting needed physicians.

A review of osteopathic physicians in practice in all 50 states also shows a large number of rural communities served by osteopathic physicians. Let me give you just two of many examples.

One example is from an article from the April 19, 1993 issue of Modern Healthcare. In it they talk about hospitals providing rural emergency care. Craig Thompson, Doctor of Osteopathy, is the only physician in Strawberry Point, Iowa. He staffs the Strawberry Point Medical Center which offers ambulatory, emergency and health education services to the 1,800 families in a four-county area. This modern rural facility includes a landing pad for helicopters. President Bill Clinton cited the Strawberry Point Clinic as a rural healthcare model for the nation during a campaign swing in Iowa when he was Governor of Arkansas.

Another example is from the April 1993 issue of The DO published by the American Osteopathic Association (AOA). The nationally known story tells of Doctor Roger T. Pelli and how the six local communities in rural Aroostook County, Maine voluntarily agreed to pay a tax to send him to osteopathic medical school in exchange for his agreement to come back and practice there. Eight years from the day of the agreement, Dr. Pelli is faithfully putting in his 15-hour days as a physician practicing in Aroostook County. "I love it up here," Dr. Pelli is quoted as saying. "This place has everything I want."

Congress stepped in and with the leadership of the Senate Majority Leader and members of this panel, passed the Rural Health Care Provider Recruitment and Education Act which has become known informally as the Dr. Pelli Bill. As you know, the law provides matching funds to rural communities that try to finance the education of primary care physicians, nurses, nurse midwives and physician's assistants.

We need to safeguard against the unnecessary elimination of quality osteopathic community-based residency training programs that have an excellent record of training needed primary care physicians for rural and other underserved areas. The osteopathic community must retain existing fully separate authority over its residency programs. The osteopathic community has been unequalled in its commitment to serving the primary care needs of the rural underserved -- it has been helped in doing this through maintaining separate accrediting authority.

We also have concerns about a mandatory central planning approach to allocation of residencies. Osteopathic medicine has been able to keep a higher percentage of primary care physicians serving rural areas through several factors including the following:

Availability of primary care practitioners as role models for residents.

Required exposure of osteopathic residents to primary care training in the first year of post-graduate training.

Osteopathic medical college recruitment of persons from rural areas with an interest in returning there.

The location of several osteopathic medical colleges in rural communities.

Increased payment incentives for primary care practitioners through the Resource Based Relative Value Scale (RBRVS) and weighting of GME payments to favor primary care residents are more effective ways to help increase interest in primary care. Greater earnings capacity for primary care physicians would lead to more residents choosing primary care practice. The continued expansion of managed care plans which make greater use of primary care physicians may also create market-driven incentives for more physicians to choose primary care.

But the most important point for me to make today is that there be no elimination of the existing community-based, osteopathic teaching hospital residency programs that train higher numbers of qualified rural primary care practitioners as a part of any effort to encourage academic medical centers to increase primary care training.

Mr. Chairman, this concludes my remarks. Thank you for the opportunity to voice the concerns we have in the osteopathic community.

Communities in Arkansas Served by Osteopathic Physicians

Arkadelphia, Ashdown, Batesville, Beebe, Bella Vista, Belle Vista, Bentonville, Bull Shoals, Camden, Conway, El Dorado, England, Fayetteville, Flippin, Forrest City, Fort Smith, Gravette, Greenwood, Hampton, Harrison, Heber Springs, Helena, Hiwasse, Hope, Hot Springs, Hot Springs National Park, Hot Springs Village, Jacksonville, Jonesboro, Judsonia, Lake Village, Lakeview, Little Rock, Marianna, Marshall, Monticello, Mountain Home, Mountain View, North Little Rock, Paris, Pine Bluff, Rogers, Siloam Springs, Springdale, Stamps, Star City, Stuttgart, Van Buren, Vilonia, Waldron, Warren and White Hall.

National Rural Health Association

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STATEMENT FOR THE

UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING AND RURAL HEALTH CAUCUS

May 3, 1993

Presented by
Bruce Behringer, M.P.H.

President, Board of Directors
National Rural Health Association
Kansas City, Missouri

Executive Director
Office of Rural and Community Health
East Tennessee State University
Johnson City, Tennessee

Thank you for the opportunity to comment on the Physician Payment Review Commission's Annual 1993 Report, specifically on its proposed restructuring of Graduate Medical Education financing. The National Rural Health Association is very concerned about the on-going shortage of health care providers in rural America and applauds the PPRC in analyzing health professions financing issues which influence this problem.

80% of all physicians in rural practice are primary care providers, and in the face of long term trend of decreasing selection by US medical school graduates of primary care training as indicated in the Commission's report, the next crisis of replacing our aging cadre of providers is upon us. Each of the members of the Committee and Caucus can cite examples of rural communities in their states which are struggling to find new providers and to sustain their fragile rural health systems.

Much of the PPRC report coincides with the policy issues and positions taken by the National Rural Health Association.

First, we applaud the recognition of the Commission of the shortage of primary care providers in rural areas. The report discredits the warn-out estimation that physicians will diffuse from crowded urban to rural shortage areas, known by rural advocates as the "trickle-out" theory of health professions supply. The problems faced in recruiting and retaining providers in rural areas must be recognized from a comprehensive viewpoint, one which goes well beyond professional production estimates and anticipated physician behavior in situations of oversupply in metropolitan areas.

Even with the extensive array of Federal and State programs targeted to assist high need shortage areas throughout the country, the number of Health Professions Shortage Areas nationally has increased since 1980. The total numbers have increased from 1,921 in 1980 to 2,189 in 1992. Certain areas of the country remain problematic. For example, in the Appalachian counties of thirteen states, data indicates that two-thirds of the counties still remain designated shortage areas. Clearly, the solution to the issue requires a more extensive plan and the PPRC recommendations goes to one of the roots of the solution.

Second, although the initial assumption upon which the PPRC Report is based may in fact be true, using the argument of an excess of physicians to recommend reduction of Federal investment in health professions production is one which has an ironic precedent. The Graduate Medical Education National Advisory Council and RAND Corporation reports in the early 1980s also cited oversupply and were used as evidence by the Reagan Administration to curb Federal spending for many health professions education programs.

Ironically, the expenditures on graduate medical education continued to increase through the 1980s. Unfortunately though, the only national program which was designed to target the redistribution of primary care providers to severe shortage areas was fiscally dismantled. The National Health Service Corps Scholarship Program reduced its scholarship placements from over 1,400 per year in the early 1980s to less than 40 in 1990. For many rural areas this was disastrous. History has taught a difficult lesson to rural localities and their elected officials: beware of well-meaning attempts to reduce spending that in turn result in further restricting rural recruitment opportunities.

Third, the implications of health care reform, through managed competition or some derivation thereof, could potentially bring disaster to an already thin health professions workforce in rural America. Rural primary care physicians could become targets of metropolitan recruitment campaigns. The Commission's proposed expanded use of non-physician providers to replace residents in teaching hospitals is another. Nurse practitioners and certified nurse midwives have been a reliable quality source of health professionals who have stayed in rural areas. Rural shortage areas can not engage in recruitment wars with institutions which sponsor training programs: this is a no-win situation. Again, although it is clear that this is not the intent of the Commission, its suggestion should be a further warning signal to those who are concerned about access to providers in rural areas.

Finally, we understand the necessity to limit the scope of the Commission's recommendations, but that which the Report characterizes as the "training pipeline from preprofessional experiences to continuing medical education" can not be ignored in the deliberations by Congress. Many rural communities end up trying to recruit graduates of our health professions education system whose most recent exposure to rural America was childhood summer camp or a vision from 35,000 feet in altitude while flying across the country.

National Rural Health Association urges Congress to adopt the successes and provide resources to expand a multitude of private and public efforts which have demonstrated track records in this area. Needed is the expansion of the "Continuum of Contact" idea now being used by the National Health Services Corps. We must organize our efforts to encourage admissions of students with rural backgrounds, provide them with rural training experiences in rural hospitals and primary care practices by rural primary care role models and assist them in returning to their rural roots. Redirecting the GME savings projected through implementation of the PPRC recommendations should be targeted to expand programs like:

* Kentucky's Professional Education Preparation Program;
* Jefferson Medical College's Physician Shortage Area Program;
* American Medical Student Association's Health Promotion/Disease Prevention Program;
* Minnesota's Rural Physician Associate Program;
* Spokane's Rural Residency Training Track;
* the thirty-five Area Health Education Centers' programs in established rural training sites; and
* the Kellogg Foundation's Community Partnership Programs in East Tennessee, West Virginia, Hawaii, West Texas and Michigan.

The National Rural Health Association applauds consideration of reforms in Graduate Medical Education Financing. We agree that GME expenditures should become more targeted to meet the acknowledged health professions shortages in many rural and inner-city areas. Specifically, NRHA recommends:

1. Medicare's reimbursement formula should give substantial weighing preferences to primary care specialties, especially family practice, which provide most of the providers in rural communities.

2. Non-hospital primary care entities should become eligible for direct and indirect Medicare GME funding.

3. Primary care training grant programs (including needed non-physician providers) should be expanded, using proposed GME savings produced by PPRC revenue plans and reductions in the number of residency positions. Rural training sites should get preferential funding including access to capital which is needed to expand key viable training sites.

4. The National Health Service Corps (NHSC) should be supported and expanded.

5. The Community Health Center Program provides vital program and infrastructure development for rural and underserved areas. This program should be supported, expanded and used increasingly as a site for undergraduate and graduate health professions education.

6. Programs that encourage the exposure of students at all levels to primary care practice in rural communities should be supported.

The efficacy of the changes proposed by the Commission in redirecting Graduate Medical Education financing will help address rural shortage issues. However, rural advocates would be remiss if the related issues being discussed as part of the broader health care reform debate were not mentioned. Stabilizing the finances of rural hospital and provider systems through eliminating urban-rural payment differentials is imperative. These act as disincentives in the recruitment process, reduce practice cash flow and limit access to capital needed for program, equipment and facility development. Taken together, reforms in health professions training and equitable financing of services could result in the strong dose of medicine that rural areas throughout the country need to survive.

Testimony by the
National Association of Community Health Centers
Senate Special Committee on Aging
May 3, 1993
The Honorable David Pryor, Chairman

My name is Darryl Leong and I serve as the Director of Clinical Affairs for the National Association of Community Health Centers. I am a board certified pediatrician and public health professional with local, state, and national experience in primary care and public health.

The National Association of Community Health Centers is the major national organization representing community-based migrant, homeless, and community health centers, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC), throughout the United States including Puerto Rico and other territories. Over 200 of the nation's 700 health centers are already involved in health professions education for students and residents.

Perhaps the most critical issue in the provision of quality health care to all Americans is the availability of primary care practitioners in medically underserved rural and urban areas throughout the United States. We commend this panel for its second hearing on the need for primary care providers for rural and other medically underserved areas.

The National Association of Community Health Centers strongly believes that past and current financing of graduate medical education is directly related to a shortage of primary care practitioners for medically underserved areas and populations. This hearing has come an opportune time with a growing national consensus that there is a worsening national shortage of primary care physicians.

Federally Qualified Health Centers and Rural Health Clinics are currently recognized under both Medicare and Medicaid statutes as a unique type of ambulatory care provider designated to receive reasonable cost reimbursement.

Here is a summary of our recommendations:

1. **What We Can Offer.** Teaching community health centers and other primary care centers for medically underserved populations provide ideal places to recruit students, conduct ambulatory primary care training, and be a major means for recruiting and retaining providers in needy areas.

2. **Supporting the Physician Payment Review Commission Recommendations on Reforming Graduate Medical Education Payments.** We support all of the recommendations contained in the 1993 annual report of the Physician Payment Review Commission.

   We especially support the recommendation that graduate medical education payments be made directly to entities other than hospitals as a means to encourage training in ambulatory sites. Migrant, homeless, and community health centers are comprehensive primary care centers located in medically underserved rural and urban areas and together comprise a high quality service system which is ready and willing to serve as major ambulatory training sites for primary care.

   Establishing a direct payment mechanism to ambulatory entities such as FQHCs and RHCs would be a critical first step in the movement of training programs from hospital-based to community-based settings.

   We also agree with the commission on limiting the total number of residency training slots but with incentives or mandates to also limit the number of subspecialty resident slots.

3. **Clarification of Graduate Medical Education Reimbursement Policy for Federally Qualified Health Centers and Rural Health Clinics.** Although Federally Qualified Health Centers and Rural Health Clinics are already recognized by Medicare and Medicaid for graduate medical education reimbursement, clarifying policies are needed.

4. **Health Care Reform.** We expect that changes in graduate medical education reimbursement for Federally Qualified Health Centers and Rural Health Clinics to be compatible with and a part of the larger health care reform proposals.

We cannot overemphasize the importance of developing financing to support teaching in Federally Qualified Health Centers and Rural Health Clinics. We have repeatedly heard from our members that the absence of financing has almost singlehandedly prevented the development of training programs in our health centers. This has been especially true for rural health centers and clinics where training dollars are already scarce.

Federally Qualified Health Centers and Rural Health Clinics have a great deal to offer to the new education and training systems that will feature ambulatory education and training:

1. **National System.** A growing national system of community-based primary care centers in every state and major city, providing real access to care (not just an insurance card), providing care to 6.4 million people in over 1,500 sites.

2. **Location.** Location in federally designated medically underserved areas, both rural and urban.

3. **Recruitment and Retention for Underserved Areas.** Federally Qualified Health Centers and Rural Health Clinics foster recruitment and retention of physicians by exposing them to careers in primary care and underserved areas and by providing yet another reason to work in an underserved area.

4. **Patient Diversity.** Over 60% of clients are ethnic or racial minorities. Serve migrant, homeless, geographically isolated, poor, as well. Health centers are at the front line of patient care in dealing with major problems such as infant mortality and AIDS.

5. **Experts in Community Health.** Community health centers provide a unique of clinical care: community health care with over 27 years of experience.

6. **Quality Work Force.** Health centers' clinical staffing includes over 3,000 physicians, 9,000 other health professionals, the vast majority of whom have made community health as the ultimate health career.

7. **Unique Health Care Delivery Model.** Places consumers in charge of their own health and health care where the practitioner's responsibility for improved health is an entire community, not just those who keep appointments. Each center is a not-for-profit entity owned and operated by the community.

8. **Prevention and Public Health.** Health centers have eliminated the arbitrary separation between primary care and prevention services, instead providing a comprehensive set of HEALTH, not MEDICAL services.

9. **Comprehensive Primary Care Services.** Community health centers provide much more than medical services, integrating a wide range of social, mental health, substance abuse, nutritional, school health, environmental health and other services.

10. **Community-Based Research.** Ability to conduct or participate in new forms of community-based research to bring newfound understanding of problems such as those that underly youth violence today.

11. **Administration and Finance: RHC/FQHCs.** Health centers are administered as non-profit private corporations that are also statutorily recognized as Federally Qualified Health Centers entitled to receive cost-based reimbursement under Medicare and Medicaid.

We are confident that many health centers can function as quality training programs in addition to providing needed services. Health centers already involved in teaching have reported both immediate and long-term positive impacts on recruitment and retention.

Here is just a sample of model teaching programs already operating in rural and urban areas in partnership with academic health centers, universities, and teaching hospitals:

Family Medicine

Sequoia Community Health Foundation, Fresno, California. Rural and urban family medicine.

Blackstone Valley Community Health Center, Pawtucket, Rhode Island. Rural/urban family medicine, including a maternal and child health fellowship training program.

Family Health and Social Services, Worcester, Massachusetts. Rural family medicine.

Sea Mar Community Health Centers, Seattle, Washington. Urban family medicine.

Salt Lake City Community Health Centers, Salt Lake City, Utah. Urban family medicine.

Cordelia Martin Health Center, Toledo, Ohio. Urban family medicine.

Sioux River Valley Community Health, Sioux Falls, South Dakota. Rural family medicine.

Montefiore Family Health Center, Bronx, New York. Urban family medicine.

Internal Medicine

Claretian Medical Center, New City Health Center, Near North Health Services Corporation, and Erie Family Health Center, Chicago, Illinois. Urban internal medicine.

Downriver Community Services, Algonac, Michigan. Rural osteopathic internal medicine.

Cleveland Neighborhood Health Services, Cleveland, Ohio. Urban internal medicine.

Pediatrics

Waianae Coast Comprehensive Health Services, Waianae, Hawaii. Rural pediatric medicine training.

Anthony Jordan Health Corporation, Rochester, New York. Urban pediatric medicine.

Oak Orchard Community Health Center, Brockport, New York. Rural pediatric medicine.

Dentistry

Sunset Park Family Health Center, Brooklyn, New York, which trains both dental and medical residents.

Mixed Models

West Alabama Health Services, Eutaw, Alabama. Multidisciplinary health professional student training program with the University of Alabama.

Primary Health Care, Des Moines, Iowa. Trains both residents and students at the health center.

Maine Ambulatory Care Coalition, Manchester, Maine. Medical student placement program in rural health centers and is planning to add residents.

Preventive Medicine

Neponset Community Health Center, Geiger-Gibson Health Center, East Boston Neighborhood Health Services, Boston, Massachusetts. Community-oriented primary care program.

Mariposa Community Health Center, Nogales, Arizona. Rural preventive medicine.

Geriatric Medicine

Over 60 Health Center, Berkeley, California.

In addition, we have heard from these and other health centers stating their desire to do more teaching at the health center but that the largest barrier has been inadequate financing.

In closing, we seriously believe that the recognition of graduate medical education payments to ambulatory Federally Qualified Health Centers and Rural Health Clinics could have a significant influence on the shortage of primary health care providers for rural and medically underserved areas. We plan to continue to work in close partnership with health professions institutions on the development and expansion of education and training in migrant, homeless, and community health centers and rural health clinics across this country.

National Association of Community Health Centers
General and Specific Comments to

Physician Payment Review Commission
"Financing Graduate Medical Education: Options for Reform"

The National Association of Community Health Centers strongly believes that past and current financing of graduate medical education is directly related to a shortage of primary care practitioners for medically underserved areas and populations. The Commission's work has come an opportune time with a national consensus that there is a worsening national shortage of primary care physicians.

The major theme for our comments is a focus on financing for ambulatory graduate medical education. While most reports have recommended a shift from hospital-based to community-based training, the actual sites for this community-based training have not been well defined, especially in terms of financing their *operational* and *developmental* costs.

In our general comments, we will attempt to explain the policy rationale for recognizing teaching health centers (as part of the Federally Qualified Health Centers/Rural Health Clinics program) as ideal ambulatory training sites and begin the discussion of options for their financing. However, note that this is not a complete discussion of the programmatic and financing options for teaching health centers. Rather, we would like the Commission to be more aware of the existence of current reimbursement mechanisms for recognizing teaching costs in Federally Qualified Health Centers and Rural Health Clinics.

Our comments are organized into four sections:

1. **Rationale for Supporting Teaching Health Centers**
2. **Why Teaching Health Centers Should Receive Special Consideration for Graduate Medical Education Reimbursement**
3. **Financing Teaching Health Centers**
4. **Specific Comments**

I. Rationale for Supporting Teaching Health Centers

Currently about 30 of the 500 community health centers located throughout the United States are major teaching centers. Another 200 are involved in teaching. A new plan by the National Association of Community Health Centers calls for the creation of 200 "Teaching Health Centers" over the next five years. These will be centers where young physicians and other primary care professionals can learn about community health care in ambulatory settings in both rural and urban areas rather than only in urban hospital settings.

Teaching health centers have a great deal to offer to the new education and training systems that will feature ambulatory education and training:

1. **National System.** A growing national system of community-based primary care centers in every state and major city, providing real access to care (not just an insurance card), providing care to 6.4 million people in over 1,500 sites.

2. **Location.** Location in federally designated medically underserved areas, both rural and urban.

3. **Recruitment and Retention for Underserved Areas.** Federally Qualified Health Centers and Rural Health Clinics foster recruitment and retention of physicians by exposing them to careers in primary care and underserved areas and by providing yet another reason to work in an underserved area.

4. **Patient Diversity.** Over 60% of clients are ethnic or racial minorities. Serve migrant, homeless, geographically isolated, poor, as well. Health centers are at the front line of patient care in dealing with major problems such as infant mortality and AIDS.

5. **Experts in Community Health.** Community health centers provide a unique of clinical care: community health care with over 27 years of experience.

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10. **Community-Based Research.** Ability to conduct or participate in new forms of community-based research to bring newfound understanding of problems such as those underly youth violence today.

11. **Administration and Finance: RHC/FQHCs.** Health centers are administered as non-profit private corporations that are also statutorily recognized as Federally Qualified Health Centers entitled to receive cost-based reimbursement under Medicare and Medicaid.

A full summary of the Teaching Health Center concept is found in the attached paper entitled: Why Teaching Community Health Centers? A Concept Paper by Darryl Leong, M.D., M.P.H., Director of the Department of Clinical Affairs of the National Association of Community Health Centers.

II. Why Teaching Health Centers Should Receive Special Consideration for Graduate Medical Education Reimbursement

A. **Teaching Health Centers are the Ambulatory Equivalents of Teaching Hospitals.** Under the current system, the costs of graduate medical education are recognized only for teaching hospitals under two mechanisms: direct medical education payments and indirect medical education adjustments. Training in community health centers achieves several objectives which currently need to be addressed including the need for more training in the ambulatory care setting, training in primary care, prevention and community health, addressing recruitment and retention of health professionals in underserved areas, etc.

The teaching health center is the ambulatory equivalent of a teaching hospital. Training occurs in both the teaching hospital and the teaching health center settings. Since ambulatory training is a core part of the training experience, it should be reimbursed. Teaching hospitals receive direct and indirect payments for teaching. Teaching health centers should also receive also receive direct and indirect reimbursement.

B. **Teaching Health Centers are positioned well to receive direct medical education (DME) payments** for graduate medical education activities through the FQHC/RHC cost-based methodology which easily recognizes teaching costs are an allowable cost.

C. **Teaching Health Centers Should Have Payment Adjustments Similar to Teaching Hospitals.** Teaching Hospitals have indirect adjustments to their prospective rates for their relatively higher costs thought to be associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized service available only in teaching hospitals.

In addition, hospital indirect adjustments are based on geographic wage levels, the indirect costs of training in a service environment, and the fact that teaching hospitals provide care to a disproportionate share of poor and sick patients.

Of the four adjustments to the prospective payment system for hospitals, two apply to Teaching Health Centers. They are:

1. Indirect Teaching Adjustments. Teaching Hospitals are recognized for their relatively higher costs associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized service available only in teaching hospitals.

   Teaching health centers also have higher costs associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require services available only in teaching health centers. These indirect costs of Teaching Health Centers should be recognized.

2. Disproportionate Share Adjustments. Teaching Hospitals are recognized for providing care to a disproportionate share of low income patients.

   Teaching Health Centers also see a disproportionate share of low income, Medicaid, and uninsured patients. These indirect costs of Teaching Health Centers should be recognized.

Chart #1 graphically represents the parallel between hospital indirect teaching adjustments and Federally Qualified Health Centers indirect teaching adjustments.

D. **Sources of Funds for Teaching.** Hospitals currently have multiple sources of funds for teaching. The predominate source is patient revenues from Medicare GME (78.7%), however additional sources include state appropriations, city appropriations, medical school/university sources, physician fee revenue and NIH to name a few. Chart #2 graphically represents the sources of funds that currently exist for hospitals.

Although Teaching Health Centers represents a training model which helps to achieve several policy objectives cited, none of these funding sources are currently available to them. In addition to reforms in graduate medical education, other sources of funds should be made available to teaching health centers.

III. Financing Teaching Health Centers

A. **Introduction.**

We acknowledge the variety of financing options to promote primary/ambulatory training in non-hospital settings that the report reflects. We are suggesting an additional financing option reflecting the "teaching health centers" concept presented here–one which builds upon the Federally Qualified Health Center and Certified Rural Health Clinic programs that are presently found in both Medicare and Medicaid statute.

Medicare and Medicaid statute designate certain primary care providers who meet federal statutory eligibility requirements (there are different requirement for FQHC and RHC) as special providers under Medicare and Medicaid. There is a bundle of covered, ambulatory services prescribed in statute and covered services are to be reimbursed on a reasonable cost basis (all inclusive rate per visit) for both Medicare and Medicaid following Medicare's (Part A) reasonable cost principles. It should also be noted that FQHCs and RHCs have been given the same statutory rate appeal rights to the PRRB as Part A providers.

All in all, the policy option that we are presenting for consideration is that "teaching health centers," like teaching hospitals, have some statutory foundation in both Medicare Part A and Part B. One could build upon this foundation for the financing of GME in ambulatory settings, i.e. FQHCs and RHCs.

B. **Direct Medical Education (DME)**

Recognition of direct medical education costs as an allowable cost in the FQHC/RHC reimbursement methodology (some Hill staff believe this may be the case now given the fact that FQHC/RHC reasonable cost methodology is based upon Medicare reasonable cost principles found in 42 CFR Part 413) would be a relatively straight forward way to finance DME in FQHCs and RHCs. One problem is that there is presently a cap on the rate per visit (with an urban rural differential) in Medicare FQHC regulations and in the RHC statute. This cap approach would have to be modified to reflect the costs of teaching; perhaps it could be treated as a pass through or eliminated for teaching health centers until we know more about the costs of teaching in these free-standing ambulatory centers. The fact that these DME costs would flow through a cost reporting system would provide HCFA, and therefore national policy makers, with a solid date base on the costs of teaching in ambulatory settings in order to further refine policy development; thus resolving a problem identified in the draft.

C. **Indirect Medical Education**

Teaching Health Centers would experience additional indirect costs for the training of residents similar to those pointed out in the draft report; additionally, health centers now experience additional costs given their patient mix, intensity and comprehensiveness of ambulatory care services. Existing factors such as the Medicare FQHC regulatory productivity screen of 4200/MD and the cap on the rate per visit, which does not reflect the increased ancillary costs inherent in teaching settings, would need to be adjusted for teaching health centers.

A methodological approach to determining an IME payment to teaching health centers would need to be developed reflecting these and other considerations, but the vehicle for making the "add-on" payment exists given the FQHC/RHC reimbursement system. A further embellishment of the option of making direct payments to entities other than hospitals in Part A, would be to fully recognize teaching FQHCs and RHCs in Part A; payments could then be made either in the form of a reimbursement "add-on" or a grant. Because the costs of developing teaching health centers is such a crucial element to making this initiative workable, perhaps the capital for development could be financed through a grant payment, while the ongoing maintenance of the teaching costs could be financed through an "add-on" IME reimbursement payment.

D. **Inclusion of Medicaid and Considerations for the Uninsured.**

For most health centers Medicaid represents a much larger patient base than does Medicare and, of course, health centers have a high proportion of uninsured patients. Therefore, DME Medicare payments would not alone significantly impact on covering teaching costs. One option worth consideration would be to recognize DME in both FQHC/RHC Medicare and Medicaid (some states do this now), with the DME costs being fully supported (i.e., 100% federal match) at the federal level to relieve the states from the financial pressure. An option for IME would be to develop an "add-on" methodology which not only reflected indirect teaching costs mentioned above, but also the proportion of Medicaid and uninsured patients or visits which the FQHC/RHC serves. This would result in assuring that the methodology covered much, if not most of the teaching costs.

STATEMENT OF

DENA S. PUSKIN, Sc.D.

ACTING EXECUTIVE SECRETARY

NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH

Mr. Chairman and Members of the Committee and Caucus:

On behalf of the National Advisory Committee on Rural Health, I am pleased to be here this afternoon to discuss the implications of graduate medical education (GME) reform for the development of an adequate health care workforce in rural America. We appreciate the attention you are giving to this important issue.

National Advisory Committee on Rural Health

The National Advisory Committee on Rural Health (NACRH) advises the Secretary of Health and Human Services on health care issues of importance to rural Americans. The Committee was established in 1987 and has produced five annual reports to the Secretary that have been widely distributed. This 18-member committee is chaired by former Governor Robert D. Ray of Iowa and includes members from both the public and private sectors with a broad range of experience in rural health -- physicians, nonphysician practitioners, nurses, administrators, educators, mental health and public health professionals, and even a lawyer.

The Committee has begun to discuss GME and plans to issue recommendations to the Secretary in its next report (due December 1993). The Committee recognizes the relative importance of Medicare GME dollars (nearly $6 billion) compared to federal grant funding for medical education (about $200 million). It has not yet had the opportunity to review the new recommendations on GME made by the Physician Payment Review Commission (PPRC). We expect that the Committee will thoroughly review the recommendations as a part of its deliberations in June. Because the Committee has not drafted its recommendations on GME, I am unable to give you specific recommendations at this time.

Previous Recommendations

In its previous reports to the Secretary, the Committee has made numerous recommendations to develop an adequate workforce in rural areas. These recommendations provide insights into the direction the Committee is likely to take as its considers graduate medical education. Three consistent concerns emerge from their recommendations:

- the need to train health care practitioners for rural practice;
- strong support for the use of nonphysician practitioners (NPPs -- physician assistants, nurse practitioners, and nurse-midwives); and
- improved payments to practitioners in rural areas to facilitate recruitment and retention.

Increased Demand for Primary Care Practitioners

These concerns will be heightened by the prospects of health care reform, which is likely to rely on increased use of primary care services. As documented in the PPRC report, we do not have enough primary care physicians to fill existing positions. Expected growth in managed care systems is likely to absorb as many new primary care physicians as can be produced. Moreover, these physicians will find plentiful opportunities to work in urban managed care settings, where hours are more regular and support is more available.

Even if we started today and all medical school graduates entered primary care specialties, it would take 22 years until half the U.S. physician workforce would be in primary care. Thus there is a need for other solutions.

The Committee has had a long-standing interest in expanding the supply and scope of practice of primary care NPPs to meet this need. There are chronic shortages of these practitioners. As mentioned in the PPRC report, it is estimated that there are four to seven jobs for every nurse practitioner and physician assistant graduate.

Moreover, just as physicians choose urban-based, specialty practices, it is believed that increased numbers of NPPs also are choosing to specialize in urban settings. Opportunities for NPPs to specialize will proliferate when specialty residencies are eliminated. As discussed in the PPRC report, teaching hospitals are likely to use NPPs to replace the residents who provided specialty services. These new opportunities will only

strengthen the incentives on NPPs to specialize in urban settings rather than providing primary care services in rural settings.

Strategies to Train Practitioners for Rural Practice

To forestall the further depletion of practitioners from rural communities, the Committee has recommended a series of strategies to improve the training, recruitment, and retention of rural practitioners. Simply training more primary care practitioners -- physicians and NPPs -- will not ensure that rural needs will be met. Rather, primary care practitioners need to be specifically trained for rural practice.

One way to prepare practitioners for rural practice is to train them in rural areas. Rural practice is sufficiently different from urban practice to warrant the establishment of strong primary care training programs in rural settings. Model teaching practices need to be established that demonstrate the rewards of rural practice. These practices need to be part of health care networks that link rural primary care practitioners with supporting specialists. Training should be interdisciplinary; that is, all types of practitioners are trained together so they can effectively work together.

Health professions schools will play a key role in developing these types of programs because they provide the connection between the medical practice site and the educational site. Development of these programs might entail numerous components. For example, telecommunications linkages would be used for education and consultations between the two sites. The rural preceptors would be paid as faculty of the health professions schools. Both sides would learn from each other as they share the responsibility of training new practitioners. The liaison between the two entities would contribute to increased stability of rural practices and improved retention of rural practitioners.

Payments to Rural Practitioners

Rural training programs will help prepare practitioners for rural practice. However, the Committee also has recognized that chronic shortages of rural practitioners are due to a wide range of well-documented factors, not the least of which is how and where they are trained. Lower payments to rural practitioners for the same services, based on historical charges, remain a tremendous disincentive to practitioners to locate in rural areas.

Therefore, the Committee has consistently recommended that rural practitioners receive equal pay for equal work.

Rural communities have had historically depressed economies, with lower wages and more people out of work. Fewer individuals in rural areas have health insurance, and what they do have often provides poorer benefits than in urban areas. Health care providers in rural communities charge less to make health care more affordable for their patients. Medicare payments to rural providers that are based on historical charges reflect the differential in charges between urban and rural practitioners. However, knowledge that rural practitioners make less than their urban counterparts is a deterrent to new graduates to choosing a rural practice. The lower payment levels to rural practitioners make it difficult to recruit and retain an adequate workforce in rural areas.

Payments to rural practitioners should be based on the economic costs of rural practice. This means the payments should reflect the price that has to be paid to make rural practice attractive to more health care practitioners. This price may be considerably higher than historic charges would indicate. Unless payments to rural practitioners are improved, rural practice will continue to be viewed as unattractive by those establishing new practices.

Conclusion

The National Advisory Committee will consider all these issues, as well as the issues raised by other participants of this workshop, as they develop recommendations to the Secretary on GME. Thank you again for the opportunity to participate in this workshop. I am happy to answer any questions you may have.

APPENDIX III

Networking for Rural Health

The Essential Access Community Hospital Program

A Report from the Technical Resource Center
on Alternative Rural Hospital Models

by
Daniel M. Campion
Debra J. Lipson
Robert M. Elliott

ALPHA CENTER
Washington, DC

March 1993

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Acknowledgements

As the debate over health care reform exposes the fragility of the rural health care infrastructure, the development of regional health care networks is emerging as an important strategy for strengthening and restructuring health care delivery systems in rural areas. The Essential Access Community Hospital (EACH) Program is the only federal program designed specifically to assist states and local communities in forming hospital-based rural networks. With grant support from The Robert Wood Johnson Foundation, Alpha Center is pleased to be serving as a Technical Resource Center for this unique federal-state partnership. We especially appreciate the vision and guidance provided by Nancy Barrand and Donald Dickey of the Foundation's program office during this first year of operation.

A major focus of the Technical Resource Center has been to provide a forum for the sharing of ideas and information among the seven states that have received grant funding under the EACH Program. As discussed in the state profiles section of this report, the following officials who are responsible for implementing the program in their respective states, are pioneers in the area of rural network development: Ernesto Iglesias (CA), Lindy Nelson (CO), Richard Morrissey (KS), Paul FitzPatrick (NY), James Bernstein (NC), Bernie Osberg (SD), and Mary Huntley (WV).

On the national level, officials at the Health Care Financing Administration are responsible for managing and developing regulations for the EACH Program. We thank Mary Kenesson, Michael Hupfer, Thomas Hoyer, George Morey, Wayne Smith, and Sheldon Weisgrau for their willingness to enter into a constructive federal-state dialogue about this important new initiative. We also appreciate the work of George Wright and Suzanne Felt of Mathematica Policy Research, Inc., who are heading up HCFA's evaluation of the EACH Program. They have willingly shared with us not only their insights about the program, but also the maps displayed in the state profiles section of this report.

Much of this report is based on the proceedings of a technical assistance workshop conducted by Alpha Center in January 1993. We are grateful to the following presenters and panelists from that meeting (other than those already listed above) who have contributed greatly to our collective wisdom about the EACH Program and rural network development: David Abernethy, Nicholas Benson, Victor Cocowitch, Ellen Cooper, Barbara Hatfield, Robert McDaneld, Steve McDowell, Paul McGinnis, Ira Moscovice, Neil Motenko, Dian Pecora, Janet Reich, Sally Richardson, Steve Rosenberg, Karen Travers, Robert Van Hook, and John Wendling. We also thank Debra Lipson and Robert Elliott for their excellent work in preparing this report.

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Table of Contents

Introduction

Viable alternatives to the traditional acute care hospital for delivering essential health care services in rural communities are critically needed. In sparsely populated areas, smaller hospitals often find it difficult to meet both state licensure regulations and the federal Medicare program's conditions of participation. These facilities need greater regulatory and financial flexibility in order to cut back on the provision of costly acute inpatient care services, which require specially trained personnel and expensive equipment, and to focus on the provision of primary care, emergency care, and lower-acuity inpatient care services. Because not all services can be provided locally, regional networks are needed to better assure access to higher levels of care provided at full-service hospitals in larger communities.

The Alpha Center has established a Technical Resource Center on Alternative Rural Hospital Models under a grant from The Robert Wood Johnson Foundation. In its first year of operation, the Center's primary focus has been to assist the seven states participating in the federal Essential Access Community Hospital (EACH) Program. The EACH Program is a joint federal-state effort to assure the availability of primary care, emergency services, and limited acute inpatient services in rural areas where it is no longer feasible to maintain full-service hospitals. The Health Care Financing Administration's Office of Research and Demonstrations manages the EACH Program which includes the following seven states: California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia.

HCFA has awarded over $17 million in grants to both states and facilities participating in the EACH Program. The funds support state efforts to develop rural health plans and designate facilities as either EACHs or Rural Primary Care Hospitals (PCHs). Grants made to facilities cover their costs to convert to EACHs and PCHs and form "rural health networks."

Federal and state officials asked The Robert Wood Johnson Foundation to support the development of the Technical Resource Center. This public-private collaboration represents a special opportunity for the Foundation to provide technical support for the grantees of a federal program. The Foundation has undertaken this unique partnership because of its strong commitment to support alternative models for strengthening the health care delivery system in rural areas.

The primary objectives of the Technical Resource Center are: first, to facilitate interaction and communication among project directors of the EACH Program and provide a forum for the exchange of information and ideas between state grantees; and second, to provide technical assistance on the organization of rural health networks and the development of EACH and PCH facilities. In developing the Technical Resource Center's workplan, the state project directors and hospital association officials from the seven states were asked to identify and rank their major technical assistance needs. The key needs identified through this process include:

- guidance in interpreting HCFA's program rules,
- avoiding violations of antitrust law,
- developing emergency medical services plans and protocols,
- assuring quality of care in PCH facilities,
- developing sound financing strategies,
- defining admissions criteria for PCH's,
- linking facilities through telecommunications,
- using effective community education strategies.

The Alpha Center conducted a workshop for federal and state officials responsible for implementing the EACH Program on January 14-15, 1993 in Baltimore, Maryland. The meeting included four major sessions on key technical assistance topics: Organizing Regional Emergency

Medical Systems, Antitrust Issues for Rural Health Networks, Options for Financing Alternative Rural Hospitals, and Community Education and Decision-Making. The workshop also provided opportunities for the states to report on their efforts to implement the program and for HCFA officials to address specific questions posed by the states in advance of the meeting.

This report on the Essential Access Community Hospital Program has six parts. The first article provides an overview of the EACH Program, including a description of the facility criteria for EACHs and PCHs and a discussion of some of the program's major implementation challenges. The next four articles summarize the four major sessions from the January workshop on organizing emergency medical services, antitrust, financing, and community education and decision-making processes. The final section provides a profile of the EACH Program in each of the seven participating states.

For further information about the EACH Program or the Technical Resource Center on Alternative Rural Hospital Models please contact the Alpha Center at 1350 Connecticut Avenue, N.W. Suite 1100, Washington, DC 20036.

EACH Program Overview: States Launch Networks While Seeking to Amend Law

The Essential Access Community Hospital Program (EACH) is a unique federal-state partnership to assure the availability of primary care, emergency services, and limited acute inpatient services in rural areas, where it is no longer feasible to maintain a full-service hospital. The program creates a new category of limited-service, or "down-sized," rural hospital under Medicare rules called the Rural Primary Care Hospital (PCH), which must establish a network relationship with a larger, supporting EACH facility. Congress established the EACH Program as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and the Health Care Financing Administration's (HCFA) Office of Research and Demonstrations oversees the initiative. Currently, the program is limited to seven states, which have received federal grant funds to develop rural health plans and designate facilities as either EACHs or PCHs. Since October 1991, HCFA has awarded about $3.8 million in start-up funds to California, Colorado, Kansas, New York, North Carolina, South Dakota and West Virginia. It has also awarded about $13.3 million to 75 hospitals within those states to cover the costs of converting their facilities and improving communications and transportation systems as needed to form networks.[1]

The EACH Program has released an enormous amount of creative energy focused on the development of regional networks.

The EACH Program has released an enormous amount of creative energy focused on the development of regional networks that link health care providers in remote areas with those in more densely populated communities. Low-volume rural hospitals see the program as a way to shed unnecessary beds, strengthen the provision of primary care services, and receive cost-based reimbursement for Medicare patients. States are using the opportunity to review their hospital licensure laws, identify vulnerable facilities, and assist rural residents in the process of reconfiguring their health care systems. State hospital associations have been integral to the EACH Program as well, opening up new channels of communication between the hospital industry, state regulators, and local hospital boards. Local and regional philanthropies, such as the Kansas Health Foundation, have promoted the formation of EACH/PCH networks by supporting technical advisory groups, community forums and other special activities. The seven states have also used a variety of approaches in developing their rural health plans, which must be submitted to HCFA, reflecting their varying investments in maintaining a health planning infrastructure. Given the wide variation in geography, demographics, and available resources, the states are now using their early lessons from the EACH Program to develop other network models, which include community health centers and other non-hospital providers, to meet unique local needs.

Although states received their first grant funds over eighteen months ago, full implementation of the EACH Program has been delayed due to a lack of final federal regulations. HCFA issued draft regulations for the program in October 1991, with the goal of publishing final rules by the following summer. The Department of Health and Human Services just recently cleared its version of the final rules, however, and is now awaiting approval from the Office of Management and Budget before publishing them in the *Federal Register*. Meanwhile, a debate continues over both statutory and regulatory aspects of the program. For example, some believe that OBRA 1989 is too specific regarding criteria for the PCH facility allowing little flexibility regarding the design of this limited-service hospital, which is the linchpin of the EACH Program. The states have major concerns over the program's criteria for admitting patients to PCH facilities and for limiting the length of stay to no more than 72 hours. HCFA officials received a great deal of

input about draft regulations during a two-month public comment period, but have said that their final regulations will probably look quite similar to the earlier version. In response, the states are supporting a slate of amendments to the federal statute that are currently in a bill before Congress. Ironically, if they become law, these amendments may further delay HCFA's ability to release the final regulations and begin paying facilities as EACHs and PCHs for treating Medicare patients.

This article provides an overview of the statutory requirements for Essential Access Community Hospitals and Rural Primary Care Hospitals. It discusses some of the major problems with the EACH Program as perceived by the participating states and facilities and how HCFA is seeking to address these problems through the regulations. Later articles in this report focus on specific implementation issues and describe the breadth of activities being conducted by states under the EACH Program.

Facility Criteria for PCHs and EACHs

The EACH Program is based on the concepts of regionalization and network formation and utilizes a hub-and-spoke design to link small and large facilities that have varying service capacities. Rural Primary Care Hospitals form the outer points of the network and are linked by referral agreements, communication systems and emergency transportation services to larger Essential Access Community Hospitals, which serve as network hubs.

In becoming a PCH, a licensed hospital chooses to limit its scope of inpatient services in exchange for less restrictive licensure requirements and cost-based reimbursement under Medicare. It must agree to maintain no more than six inpatient beds for acute care services and provide only temporary inpatient care for periods of 72 hours or less (unless a longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions) to patients who require stabilization before being discharged or transferred to another hospital. A physician, physician's assistant (PA) or nurse practitioner (NP) must be available to provide routine diagnostic services and to dispense drugs and biologicals, and inpatient care provided by the PA or NP must be subject to the oversight of a physician. The PCH facility must also "make available" 24-hour emergency care, however, the facility is not required to keep staff at the facility if beds are unoccupied. This means, for example, that medical personnel could be on-call, rather than on-site, during the night if the facility has an inpatient census of zero. In the first year of operation, Medicare payments for PCH inpatient services will be based on the reasonable costs for the facility determined on a per diem basis. For later cost reporting periods, payment will be the first-year per diem rate, updated to reflect increases in rural hospital operating costs. For outpatient services, the facility may elect either of two payment methods: a cost-based facility service fee with reasonable charges for professional services billed separately, or an all-inclusive rate combining both the professional and facility service components. See Appendix I for additional facility requirements for PCHs.

An EACH facility must have at least 75 inpatient beds and agree to provide emergency and medical backup service to the PCHs in its network. The EACH must be located more than 35 miles from any hospital that is either designated as an EACH, classified as a regional referral center, or located in an urban area but meets the criteria for classification as a regional referral center; or meets other geographic criteria imposed by the state and approved by the Secretary of the Department of Health and Human Services (DHHS). It must accept patients transferred from PCHs and agree to receive data from and transmit data to PCHs. Under Part A of Medicare, the EACH will be reimbursed as a "sole community hospital" (SCH) for which payments are based more heavily on hospital-specific costs than under the Prospective Payment System. See Appendix II for a more detailed description of the facility requirements for EACHs.

Role of the State

State governments play a central role in the EACH Program. To be eligible for the program states must have developed or be developing a rural health care plan in consultation with the

state hospital association and must designate (or be in the process of designating) rural nonprofit hospitals within the state as EACHs and PCHs. In addition to the federal requirements, the state may impose additional eligibility criteria for EACHs. Before HCFA designates EACHs and PCHs, the state must approve the facilities' applications for designation and show that their plans for forming a network are consistent with the state's rural health care plan. States selected to participate in the program receive grant funds that may be used to carry out the program and to improve communications and emergency transportation systems.

"Without a base in the Medicare program, change in rural health care delivery is a moot point. We believe the EACH concept is an alternative of value."

The law currently limits the EACH Program to no more than seven states. In September 1991, after reviewing 21 applications, HCFA awarded grants to California, Colorado, Kansas, New York, North Carolina, South Dakota and West Virginia. It classified the states as either "Type A" or "Type B". Five type A states (California, Kansas, North Carolina, South Dakota, and West Virginia) were those that had already identified specific networks and wanted to implement their programs immediately. Two Type B states (Colorado and New York) were those that sought additional time to identify specific facilities for their networks.

OBRA 1989 also permits the Secretary to award grants to facilities of up to $200,000 to support their conversion to EACHs and PCHs. In 1991, HCFA made funds available to facilities in the Type A states. In September 1992, grants were awarded to facilities in the Type B states, as well as to facilities in both new and established networks in Type A states. Supplemental grants were also awarded to each of the seven states in this second round. HCFA awarded all of the grant funds—$9.8 million—available under the EACH Program in fiscal year 1991, but only $7.4 million of the additional $9.8 authorized for fiscal year 1992. Congress authorized no funds for the program in fiscal year 1993.

HCFA Releases Draft Regulations

In January 1990, shortly after passage of OBRA 1989, rural health experts gathered to discuss the EACH Program at a national invitational meeting on alternative rural health care delivery models sponsored by the Federal Office of Rural Health Policy. Participants were particularly sensitive to the potential difficulties of balancing federal needs for a uniform policy and basic standards with an array of unique local circumstances.[2] They noted that considerable challenges would be posed by the diversity between states regarding licensure/certification requirements, planning capacities, and varying levels of experience in addressing rural health needs. There was also a general consensus that the program must be "flexible" if it is to succeed, such as allowing states to use different criteria for designating EACHs and PCHs, or permitting experimentation with various approaches to limiting the scope of services at PCH facilities. They noted that further clarification was needed regarding the law's statement that PCH facilities could participate in Medicare's Swing Bed program, which allows licensed acute care beds to be used as skilled nursing beds, in rural hospitals where patients could not otherwise be discharged due to a shortage of nursing home beds in the area. They also questioned how flexible HCFA would be in granting waivers, especially regarding the 6-bed and 72-hour length-of-stay limits for PCHs.

HCFA utilized its waiver authority under OBRA 1989 to address many of these concerns when it published its draft regulations, or "proposed rules," for the EACH Program in October 1991. Congress gave the Secretary of DHHS two types of waiver authority. One is to designate as PCHs hospitals that have more than six beds or keep people more than 72 hours. The other is an authority to waive other requirements of the Medicare statute, except those relating to EACHs and PCHs, in order to make the program work. In January 1993, at Alpha Center's workshop for federal and state officials responsible for the EACH Program, Thomas Hoyer, Director of HCFA's Division of Provider Services Coverage Policy, who is responsible for creating the regulations, explained that the swing bed portion of

the OBRA 1989 statute is inconsistent with its PCH provisions. According to Hoyer, "The waiver authority was designed to allow us to correct such problems. It was not designed to allow us to change the EACH/PCH program." Rather than have individual hospitals ask the Secretary for waivers because they need more than six beds or regularly keep some patients more than 72 hours, HCFA chose to address the issue on a national basis by writing a regulation that says a PCH facility can have up to 12 beds if it is a swing bed hospital. This regulation, which is expected to be part of the final rule, would allow a PCH that was certified for the swing bed program prior to conversion to hold patients longer than 72 hours, if appropriate, by switching their bed status from "acute care" to "nursing care." No more than 10 patients, however, could occupy these nursing care/swing beds at any time, leaving at least two available for acute care patients. HCFA officials created this 10-patient limit on swing beds in their proposed regulations in light of the limited staffing and resource capacity of most hospitals that might elect to become PCHs. In accordance with Medicare rules, the swing-bed length-of-stay is not capped.

States Propose Amendments

Beginning in January 1992, the project directors of the seven states participating in the EACH Program began a consensus-building process to focus on changes to the program that would facilitate implementation. In a letter detailing "critical issues" for the EACH Program that they sent to HCFA officials in April, 1992 the project directors wrote, "while none of the seven states believe that the EACH is an end product of rural health delivery restructuring, it is currently the only alternative recognized in law. Without a base in the Medicare program, change in rural health care delivery is a moot point. We believe the EACH concept is an alternative of value...and will assist policy-makers, regulators and change-makers in the long process of refocusing rural health delivery."

The states have developed a set of proposed amendments to the federal law that they believe would improve and expand the program. These amendments are now being considered by Congress as part of HR-21. The amendments would allow urban hospitals to be designated as EACHs and exclude them from the requirement that they be located a minimum of 35 miles from other EACH facilities. Bi-state rural networks would be allowed where the grantee state believed that the most appropriate partner for either an EACH or a PCH was located across the border in another state. An important change regarding Medicare payments would allow PCH facilities to be reimbursed based on their actual costs, rather than on the basis of the "lower of costs or charges" as stipulated in HCFA's draft regulations. HCFA would also be authorized to designate up to nine EACH states expanding the current program by two.

If passed, however, several of the proposed amendments would impose additional constraints as well as freedoms in attempting to redress what the states' perceive to be OBRA 1989's most onerous requirements. For example, the amendments would change the current limit on inpatient lengths of stay at PCHs to an average 72 hour length of stay. Under current law, if HCFA officials detected that the 72-hour limit was breached, they would cite the deficiency and ask the PCH for a plan of correction. The PCH would then have an opportunity to correct the deficiency and avoid termination, according to the same procedure as is used for hospitals with deficiencies. Under the proposed amendment, however, HCFA would be given the authority to simply cancel the facility's Medicare agreement if it had an average length of stay over 72-hours.

The states also believe that requiring a physician to certify that a PCH admission is for "temporary and immediate care," as stipulated under the proposed rule, would be too restrictive. Under their proposed amendments, physicians would be required to certify that PCH services "may reasonably be expected to be completed within 72 hours, or that a decision to transfer the patient may reasonably be expected to be reached within 72 hours." In practice however, this level of specificity may actually be more

restrictive than the regulation now envisioned by HCFA. According to Hoyer, HCFA's current enforcement process would be "relatively merciful in cases where some folks ended up staying longer." Similarly, the current law allows PCHs to deliver any hospital services that takes 72 hours or less, including surgery. On the other hand, HR-21 would permit only surgical procedures that can be done in an ambulatory surgery center.

While these changes may turn out to be less desirable than the states originally thought, one provision of HR-21 could delay the release of final regulations even further. HR-21 would permit PCHs to provide swing bed services up to the hospital's licensed acute-care bed capacity at the time of conversion to a PCH, minus the number of inpatient beds (up to six) retained by the PCH.

States and local communities participating in the EACH Program are exploring the development of more expanded networking models.

Under Medicare's general swing bed program, where hospital beds may be used for nursing home patients, there is a presumption that hospitals are well-staffed 24 hours a day. That is, however, not true of PCHs. Hoyer explained that if HR-21 passes, PCHs with swing beds may be required to comply with HCFA's regulations for nursing homes. Putting the current 10-patient swing bed limit for PCHs into proper context, Hoyer noted that because of nursing home reform in 1987, "nursing home requirements are probably more burdensome in a rural area than hospital requirements, so if you are looking at an area with no manpower, nursing home beds are not necessarily the easy answer."

Summary

The EACH Program is the only federal program that creates a new category of limited service hospital facility under Medicare—the Rural Primary Care Hospital. The legislation that created the program, OBRA 1989, stipulated very specific criteria for the PCH, giving the Health Care Financing Administration little latitude in drafting regulations for the program. HCFA has chosen to use its available waiver authority to establish the EACH/PCH initiative as a national program with a single set of implementation rules, rather than to encourage waivers on a facility-by-facility or even a state-by state basis. HCFA's final rules for the EACH Program were cleared by the Secretary of DHHS in December 1992 but now await final approval by the Office of Management and Budget. How quickly OMB will choose to act on the rules is uncertain, especially given the Clinton Administration's fast-track effort to create a broader health reform policy agenda.

Congress may be the next player to mold the program it created three years ago. Amendments crafted with input from the seven states participating in the EACH Program, are moving forward as part of HR-21, a legislative vehicle carrying several higher priority measures that were vetoed by President Bush last fall. Some of these amendments would give states and local facilities the kind of flexibility they feel they need to establish viable rural health networks, but others would require HCFA to go back to the regulatory drawing board and delay the release of "final" rules even longer.

While the lack of final regulations has delayed implementation of the EACH Program, this federal-state partnership has broken important new ground in the development of rural health policy. The EACH Program provides an intergovernmental framework for creating hospital-based rural health networks, or systems of care, that can better assure access to emergency care, primary care, and limited inpatient care services in rural areas. While they await the release of final federal rules, states and local communities participating in the EACH Program are addressing a host of complex implementation issues and exploring the development of more expanded networking models.

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[1]Ten hospitals subsequently withdrew from the program or are on administrative hold.

[2]Alpha Center. *Alternative Models for Delivering Essential Health Care Services in Rural Areas: Summary Report of an Invitational Workshop held January 16-17, 1990,* sponsored by the Federal Office of Rural Health Policy, January 1991, p.vii.

EMS: The Missing Link in Rural Health Networks

A California rural health network has used EACH/PCH resources to buy two ambulances. The state of West Virginia has used EACH Program funds to improve emergency medical services (EMS) system components, such as equipment, communication linkages and training. But these examples are the exception, rather the rule, according to early reports. "EMS remains the missing link in most rural health networks," said Janet Reich, an EMS Consultant from Arizona and author of a book called *Success and Failure of Rural EMS Systems*. All EACH/PCH grantees will have to deal with EMS system improvements at some point, but it is better to deal with them *before* a crisis happens warned the panelists in the session on "Organizing Regional Emergency Medical Systems."

Organizing EMS systems is, "about as grassroots as you can get."

Sooner or later, EMS issues rise to the top of EACH/PCH grantee concerns for several reasons. First, federal program rules specifically mention the development and support of emergency transportation systems as one of the purposes for which grant funds can be spent. Second, EMS is a critical part of the rural health safety net; if a rural hospital closes or the sole doctor retires, frontier and rural areas have only EMS to turn to for basic health care. Third, national trends are increasing the demand for EMS in rural areas—more elderly people, growing public expectations, earlier hospital discharges, need for more transfers to tertiary care hospitals, and higher risk for certain types of injuries. Perhaps most important, however, are the profound concerns of rural citizens for maintaining EMS services. At the meeting in January, Robert McDaneld, Administrator of the Kansas Board of Emergency Medical Services in Topeka, recalled meeting with a group of 30 people in the small community of Lakin, Kansas during the planning stages of the EACH Program. Their primary concern, he said, was access to health care. "The focus was not specifically on keeping the hospital open. It was on being able to get emergency treatment, and on being able to have primary services," he said.

While most people think of EMS as ambulance transportation, a comprehensive EMS system includes much more. Barak Wolff, session moderator and Chief of Primary Care and Emergency Medical Services for the New Mexico Department of Health, defined an EMS system as, "a coordinated system of centralized access to a comprehensive range of emergency care." It starts with emergency access (e.g. CBs, 911 lines) and dispatch capabilities, trained first responders, rescue squads and ambulance services. But it also includes communication with physicians during transport, hospital emergency departments, transfers to specialty care facilities, and overall medical direction and quality assurance.

Even before considering the organizational challenges associated with EMS system development, the structural problems facing rural EMS systems can seem overwhelming. For example, volunteers are hard to recruit and must be provided with high quality training. Often, there are outdated or weak communications infrastructures, so upfront investments are needed in equipment and technology. Major sources of financing for emergency services are often inadequate, especially since ambulances and hospital emergency rooms must serve everyone, including those who cannot pay. And it can be particularly difficult to recruit and retain qualified health care professionals to staff the system. Many rural areas lack qualified physicians who have the time and interest to supply vitally important medical direction.

While the panelists did not offer any "magic bullets" to solve these problems, they highlighted some strategies that have contributed to successful rural EMS systems development. First, they underscored the importance of careful planning, before a real crisis develops, by all potential play-

72-182 95 – 7

ers in the system. Organizing EMS systems is, "about as grassroots as you can get," Wolff said. Janet Reich also emphasized how important it is to consider "who to invite to the party." They urged EACH Programs to involve all the organizations that currently or are expected to participate in each stage of the process: from dispatch and pre-hospital care, to hospital emergency treatment of patients, to medical transportation of a patient from one facility to another. There are virtually no parts of the country where all EMS system components are handled by only one organization.

One set of players includes all of the ambulance services operating in the region, both those that are staffed by paid, professional paramedics and those staffed by lay volunteers, as well as fire and police departments. Since there is a wide range of organizations providing emergency services and many types of EMS personnel that vary from state to state, planning across state borders can be particularly difficult. There are approximately 35 different levels of pre-hospital personnel in the country recognized in some states but not in others. A second set of players is the emergency department personnel in the EACH and the PCHs. Ms. Reich asserted that the federal law requirement for EACH hospitals to provide backup emergency services "will demand new approaches for how hospitals interact with the pre-hospital care providers. Strict lines delineating the roles of the pre-hospital and hospital care providers will have to change...[because] pre-hospital care personnel will be called on to perform functions which are beyond their current scope of practice." For example, some hospitals may need to change their staffing configuration, or allow R.N.s to provide advanced life support and initial diagnosis prior to the arrival of the physician, or permit paramedics and EMTs to provide care in emergency rooms to ensure a smooth transition from one level of care to another. State officials may need to enact new state legislation or provide waivers to allow providers to take on these new roles.

The provision of emergency back-up by EACH hospitals "will demand new approaches for how hospitals interact with the pre-hospital care providers... pre-hospital care personnel will be called on to perform functions which are beyond their current scope of practice."

Several panelists recommended that explicit agreements be written, which clarify relationships between each hospital and each ambulance service. Such agreements assure that each party understands its role in the system and its relationship to each other. In some cases, the agreements will need to incorporate fairly explicit medical protocols, so that physicians and other stakeholders can define what level of care can be provided by whom. Tertiary hospitals must also get involved to support the EACH/PCH emergency transfer process.

The third set of players are the political leaders who have legal responsibility for the EMS system. In most parts of the country, that means a county board of commissioners. Because they tend to fight for resources for their constituents rather than for the entire county, Bobbie Hatfield, R.N., an EMS consultant in West Virginia and former state legislator, recommended removing direct oversight responsibility from this body and vesting it in an emergency medical advisory board, made up of public safety, pre-hospital, medical and nursing personnel. However, local politicians as well as local businesses and other community leaders should still be involved in systems development.

Ms. Hatfield discussed the importance of dealing with cultural issues unique to each rural area. "You cannot understand how to develop a program by sitting in meetings with people, asking what their problems are. You have to let them develop their own program." She recounted a story about her involvement in developing a local paramedic training program. "Somebody in the higher echelons [of state government] in West Virginia decided that the [paramedics] were

going to wear pink smocks to go into the hospitals to do their clinical training. As a result, the whole class quit...you do not put loggers and miners in pink smocks." State officials can help the most, she said, by removing bureaucratic barriers.

Another panelist, Dr. Nicholas Benson, Medical Director for the North Carolina Office of EMS, and current President-Elect of the National Association of EMS Physicians, stressed the importance of medical direction in an EMS system. He talked about two types: 1) on-line or real-time medical direction, i.e. the actual giving of orders or giving of permission to do certain interventions, and, 2) physician oversight of all aspects involving patient care of a pre-hospital system. "Medical direction ensures that there is a patient advocate, that the patient will get the best care possible," he said. At the same time, he warned that many areas of the country face "a crisis of medical direction. There is a lack of physicians who are qualified...who are interested...[or] who are educated in emergency medicine."

To recruit well-qualified physicians, he strongly advocated for the addition of funds to an EMS budget to adequately compensate a medical director. Yes, it costs more, but in return he said, "You get contractual accountability so that you can pin down the medical director to what your expectations are, and what he or she needs to deliver." He also suggested using nurses to relieve some of the burden from medical directors; they can help physicians with some day-to-day administrative tasks and in some cases deliver on-line medical direction.

His recommendations served to remind the audience about how difficult it can be to secure sufficient funds to establish a high-quality EMS system. While EACH/PCH funds provide welcome financial supplements to a few communities, they are only a drop in the bucket. Most communities have less resources to work with, not more.

But there are reasons for optimism. First, some states have enacted legislation which targets dedicated revenues to support local EMS providers. Second, McDaneld urged participants to think creatively about which services to maintain in distressed rural areas. While rural communities and their hospitals may not be able to provide specialty medical services, they may still be able to offer good basic primary care and emergency services. To do so, however, requires communities to develop appropriate expectations about what can be performed within their own community. He concluded, "Until we are able to do that, [networks] are not going to be successful either in rural Kansas or nationally."

Antitrust Facts and Fears: Skidding on Ice?

After hearing two legal experts discuss antitrust issues surrounding rural network development, one is tempted to recall the words of Franklin D. Roosevelt: "The only thing we have to fear is fear itself." Although their presentations noted certain situations that merited caution, they contended that EACH/PCH grantees' fears concerning possible violations of antitrust laws were largely misplaced.

The EACH Program's attempt to foster the development of rural health networks justifies a certain amount of antitrust apprehension. Such networks may involve arrangements between hospitals to apportion services, consolidate operations, and perhaps even close some facilities entirely. While these types of actions may result in lower health care costs and improvements in quality, they may also be challenged by the Federal Trade Commission and the U.S. Department of Justice, as both agencies have increased their oversight of antitrust activity in the health care field during the last 10 years.

Networks become more suspect if the joint venture is undertaken by competitors to disguise anti-competitive conduct.

Thus, grantees came to the EACH/PCH workshop on "Antitrust Issues for Rural Health Networks" desperately seeking a better understanding of the legal rules of the road. What can facilities do legally in terms of collaboration and networking activities? If they cannot do something prohibited by antitrust laws, what does it mean for state governments to provide "state action immunity" to permit certain mergers or collaboration to occur?

Neil Motenko, a partner in the law firm of Nutter, McClennen and Fish in Boston, who specializes in antitrust litigation and counseling, explained that antitrust law has few hard and fast principles or regulations. Instead, much of it has evolved through case law and judicial decisions in state and federal courts. Because of this, Motenko compared fears of antitrust suits to "being on a plane that is skidding around on the ice as it taxis up the runway." He conceded, "There are serious issues to be considered," but added, "there is a lot that you can do."

Essentially, antitrust law prohibits certain types of: a) agreements or "conspiracies" to restrain trade, for example, through price-fixing or allocating markets among certain competitors; b) conduct by monopolists or those attempting to monopolize particular markets; c) price discrimination; and, d) exclusive or preclusive dealing. Antitrust law also governs the structure of mergers and joint ventures—and potentially the networks in the EACH Program—so as to promote competition. Prohibited joint ventures include agreements among separate entities that restrain trade and those that consolidate entities in a way that would invoke the merger law (Section 7 of the Clayton Act).

In general, antitrust enforcement has been favorable toward joint ventures in the health care arena because they can be pro-competitive. They can produce efficiencies by reducing transaction costs, consolidating research and development, or pooling resources, all of which can allow organizations to compete more effectively. Networks that help to introduce new products or allow entities to buy or share services and equipment that they could not have done on their own are likewise viewed as pro-competitive. When networks serve to integrate facilities or services, or improve access and quality of care as in the EACH Program, the result can be seen as generally promoting efficiency and competition.

The key test in these examples concerns the effect on competition; if a bona fide joint venture promotes competition, then courts are more likely to rule in favor of the arrangement. Those that improve health care and lower health care costs are generally allowable under the antitrust laws. Motenko also advised that, "if you integrate and

share risk in order to provide more efficient health care services, you have a legitimate joint venture." The mere appearance of merging operations may not be sufficient absent meaningful integration and risk-sharing. He also said that "if providers are not talking about price, [there is] a lot more room to maneuver."

The major issue in networks and joint ventures concerns the players; if competitors are involved, there are more antitrust issues than if a single hospital develops its own network. Networks become more suspect if the joint venture is undertaken by competitors to disguise anti-competitive conduct. Antitrust questions may also be raised if the network "aggregates power" in the relevant product or geographic market to such an extent that it can easily raise prices or exclude competitors or otherwise create market distortions. But what constitutes the relevant geographic market in a rural area? And with the scarcity of providers in rural areas, can any joint venture truly be said to increase competition? While few suits have been brought against providers in rural areas, a recent opinion in a case involving a hospital in Ukiah, California treated the geographic market as relatively large. Since bigger geographic areas are likely to contain more competitors, there is less opportunity for adverse competitive effects. But other decisions have viewed the geographic market more narrowly.

"The lack of clear guidelines and conflicting federal court decisions creates a "chilling effect" on network formation, particularly since small rural hospitals lack the resources to challenge antitrust suits."

Many people remain concerned that the lack of clear guidelines and conflicting federal court decisions creates a "chilling effect" on network formation, particularly since small rural hospitals lack the resources to challenge antitrust suits. However, Motenko believed that, "there is misplaced fear about antitrust laws in the context of networks and joint ventures." He advised those with any doubts to seek guidance from legal counsel, from publications prepared by the American Bar Association's Antitrust Section Health Care Committee (of which Motenko is Vice Chairman), and by consulting with their state Attorneys General offices, the FTC or Department of Justice—"on a no-names basis."

Those who feared that their rural health care networks could violate federal or state antitrust laws were intrigued by Ellen Cooper's presentation on "state action immunity." Cooper is the Chief of the Antitrust Division of the Maryland Attorney General's Office, and chair of the Multi-state Antitrust Task Force's Health Care Working Group of the National Association of Attorneys General. She explained that this doctrine, which dates back to a 1943 Supreme Court decision in *Parker v. Brown*, exempts state actions from antitrust law. Thus, state entities and state employees acting pursuant to a clear authorization from the state are protected. Furthermore, a 1980 Supreme Court decision clarified that the state action doctrine also immunizes private entities from antitrust liability if the state has: 1) clearly articulated a policy to displace competition with regulation; and 2) the state actively supervises the anti-competitive conduct.

State policy, expressed by the state legislation or the state's highest court, is clearest when it pertains to a particular, rather than general class of activity. She warned however, that other expressions of state policy, such as decisions of licensing boards, are not necessarily covered by the state immunity doctrine. And the need for state supervision has come to mean "that the state has to exercise ultimate control over the challenged anti-competitive activity. The mere presence of some state activity or some state monitoring is not sufficient. State officials...must have and exercise power to review particular anti-competitive acts of private parties and disapprove those that fail to accord with state policy."

Cooper advised state officials that wanted to enact legislation to incorporate language protecting all of the parties involved. This would include not just the state and the state officials or municipalities or counties involved, but the private par-

ties, private hospitals and medical staff that may also be implicated. She emphasized that the legislation should, "set out the state's intent to increase access by replacing competition in rural health care areas with a system of regulation, to have the legislation delegate authority to a state agency to establish regulations, and to provide for staffing and funding of some kind of oversight of the rural health care scheme. Then—and this is extremely important—the state must actually review the network's activities on an ongoing basis to make sure that state policy is being executed properly."

Until such laws are passed, however, Motenko suggested that EACH/PCH networks consider the strength of the arguments they can make to support the "rule of reason" test, which is used by judges to examine the effects of a particular activity on competition. In order to have a violation of the rule of reason, there has to be a substantial adverse effect on competition that is not outweighed by pro-competitive benefits. For example, if EACH/PCH networks constitute legitimate joint ventures that allocate services in a way that promotes quality of care or access to health care, the arrangement, "could be viewed as a reasonable restraint ancillary to a legitimate joint venture," he said. In other words, the networks could be sacrificing some types of competition in order to enhance other benefits in a competitive marketplace.

Since it remains largely true that competition is more difficult to achieve in isolated markets, some still argue that explicit exemptions from antitrust laws should be made for rural networks. Under a managed competition approach, for example, there may need to be an explicit acknowledgement that competition cannot occur in rural areas. W. David Helms, President of the Alpha Center, believed that a federal law may be necessary to encourage certain arrangements that could be perceived as anti-competitive. "State action is wonderful," he concluded, "but the ultimate protection would be federal legislation that gives rural networks an explicit exemption from the antitrust laws."

Throwing the Dice? Risks and Realities in Rural Health Network Financing

For the past year or so, Dian Pecora, administrator for Southern Humboldt Community Hospital District in North California, has been trying to figure out whether it is financially worthwhile for her hospital to become a Rural Primary Care Hospital (PCH). The process she said, "has been extremely fluid [because] information has been conflicting and confusing. Rural hospitals have been asked to make choices about financing and licensure status before they knew the final rules." Because of this uncertainty, Pecora and many other rural hospital administrators may come to view the decision to become a PCH as a gamble. It remains unclear which set of financing strategies will be most favorable for their facilities. Should they retain risk-based DRG payments for inpatient services? How should they bill for outpatient services—separately or through a blended rate? Is it better to provide long-term care services through a skilled nursing facility or home health care or some mix of the two? To help make sense out of the confusion and reduce the degree of risk-taking, three panelists at the workshop session on "Options for Financing Alternative Rural Models" presented findings from PCH financial feasibility studies. In each case, they tried to determine whether cost-based reimbursement would be more advantageous than risk assumption under Medicare's prospective payment system (PPS). They also offered some thoughts on factors other than reimbursement methods that contribute to a successful financial strategy for rural hospitals.

Steve Rosenberg, a California-based health care consultant and the workshop's moderator, explained the basic financial options for PCHs. Rural hospitals that become PCHs can be expected to provide three sets of services, each of which is paid according to a different set of reimbursement rules:

- **Limited inpatient services.** The PCH program limits hospitals to no more than six inpatient beds, and restricts length-of-stay to 72 hours. If a hospital becomes a PCH, it will be reimbursed on the basis of reasonable costs. If it does not seek PCH certification, the hospital will continue to be reimbursed under Medicare Part A (prospective payment using DRGs) rules.
- **Outpatient services.** The PCH program allows facilities to choose between: a) a cost-based facility service fee with reasonable charges for professional services billed separately; or b) a cost-based blended or all-inclusive rate that combines both the professional and facility services.
- **Long term care.** PCHs can provide skilled nursing services in a distinct-part skilled nursing facility, and/or in a swing bed, and/or as home health services, each with different Medicare and state Medicaid reimbursement systems.

The offer of an alternative reimbursement mechanism to the Medicare prospective payment system (PPS) has been welcome news to many small rural hospitals. Many of them had been financially harmed by PPS, so a cost-based reimbursement system looked as if it might be a financial blessing— even if they had to downsize to qualify for it. The blended Part B rate was also viewed as one that could help rural communities build systems and networks between inpatient and outpatient services.

But certain rural hospitals may not find it to their advantage to abandon the PPS system just yet. Federal legislation that changed PPS rules in OBRA 1989 is beginning to improve the financial picture for many rural hospitals. It began to phase out the urban-rural rate differential, establishing a single national rate which will be in effect by 1994. In addition, the recently adopted PPS system for capital costs tends to favor rural hospitals that have older facilities. In fact, one of the studies featured in the workshop confirmed that risk-based reimbursement could be more beneficial if certain changes were made in hospital operations.

Pecora, who administers a potential PCH in California, described both the process and substance of those changes for her facility. The near closure of the hospital in 1986 prompted the hospital to explore a number of alternatives. They tried to develop networks with other hospitals and clinics in nearby counties and began to study their operations with the help of the state's Alternative Rural Hospital Models program. In the process, they learned that the hospital's average length-of-stay (ALOS) was fairly high for Medicare patients. They revitalized the utilization review committee, whose efforts were instrumental in increasing the number of patients admitted for short-term outpatient observation, which is eligible for Medicare Part B reimbursement. The hospital also added a new distinct-part skilled nursing facility (DP-SNF). These initiatives helped to reduce ALOS and, as a result, Pecora discovered that the advantages of cost-based reimbursement were reduced.

"...a successful financial strategy is dependent on the allocation of joint costs between inpatient, outpatient, and long-term care services...not solely on whether a PCH is reimbursed on a cost or risk basis."

Contrasting these findings were those of a study performed by John Wendling, managing partner of Wendling, Noe, Nelson and Johnson, a certified public accounting firm in Kansas. The study's purpose was to determine how a select group of rural hospitals, some of which were historically Medicare-dependent and very small, would fare as a PCH. The study retrospectively reviewed medical records to assess where patients would have been cared for—in the PCH, in an EACH, in a swing bed, etc. Hospital managers were then asked how they would have staffed the hospital under those conditions. Based on their responses, the study compared the financial impact of cost-based reimbursement to the hospitals' previous experience under PPS.

Generally, the Kansas study found that for facilities with smaller volume, cost-based reimbursement was preferable to risk. But the advantage was not strong; while six of the nine hospitals in the study would have improved their financial status as a PCH receiving cost-based reimbursement for facility costs, only one of the nine would have had a positive bottom line if Medicare payments were limited to the "lower of costs or charges," as stipulated in the EACH Program's draft regulations.

The third study was the only one to examine the impact of a "blended" rate of facility and professional service costs on a hospital's bottom line. It was performed by Karen Travers, President of Travers Associates, a consulting firm in Augusta, Maine, for a hospital in Webster Springs, West Virginia. In that state, hospitals must perform a community needs assessment before receiving state certification as a PCH. The needs assessment disclosed that the community needed additional primary care providers, expanded home health services, and significant improvements in both the emergency response system and mental health care. It also found that the hospital was overstaffed, given its average daily census.

Based on the results of the needs assessment, West Virginia rules also require potential PCHs to undertake a financial feasibility study of the reorganized rural health system. The community designed the PCH as the hub of an integrated system combining limited hospital services, primary care, home health care, and emergency medical services. Travers' financial projections found that the hospital's conversion to a PCH would likely result in a precipitous drop in its proportion of Medicare days—from 78% to 9% of all patient days. Since the community wanted to maintain current health care personnel and reduce net loss of jobs, they planned to shift hospital-based staff to other positions. Some public health personnel and functions were even brought into the hospital to complete the service continuum.

After projecting costs and estimating revenues under various reimbursement options, her analysis found: 1) acute care services would continue to generate a net loss, 2) primary care would generate surpluses using the methodology for

Rural Health Clinic (RHC) cost-based reimbursement; and 3) home health services would be budget-neutral. The bottom line was positive overall, largely because the RHC rate represents an all-inclusive blend of Medicare Part B professional fees and allowable facility costs. The blended rate is high—again, as long as Medicare payments are not limited to the lower of costs or charges.

The findings from all three studies suggest that a successful financial strategy is dependent on the allocation between inpatient, outpatient, and long-term care services and not solely on whether a PCH is reimbursed on a cost or risk basis. Their results indicate substantial benefits may be possible by beefing up primary care services and billing for them using a blended rate of facility costs and professional services, which are paid on the basis of reasonable costs. It also appears that, in some situations, distinct-part SNFs may be more advantageous than swing beds. Rosenberg speculated that "PCHs with multiple service centers over which to spread fixed costs, an integrated Part B rate, and a distinct-part SNF, may not need cost-based reimbursement for inpatient services, especially as DRGs move to a single national rate after 1994."

While many hospitals are still unsure about the financial implications of the EACH Program, the studies stressed the importance of performing financial analyses and ongoing efforts to reorganize or improve the management of existing services. Rosenberg believed that the process of making a rural hospital financially viable is "three-quarters management." Pecora's financial studies have also shown her that "the most important part of the process has been the work that is done to develop, implement, and put systems of patient care together for rural communities." Financial analyses and system reforms, they concluded, replace the high-stakes risk usually associated with network formation with a stronger sense of reality.

From Hospital to Health System: Making Progress through Process

There's a joke that goes: How many psychiatrists does it take to change a light bulb? Only one, but the bulb has to want to change. So too, it seems with changes in the way rural hospitals or health care providers deliver services. Networks, augmented primary care, or any other significant changes in rural health services do not happen overnight. And they will not occur just because federal or state policies dictate them. Rural communities must adopt these goals as their own, and take part in a process to reach them or they will never be achieved, according to panelists in the session on "Community Education and Decision Making."

Robert Van Hook, a rural health consultant and former director of the National Rural Health Association, opened the session by presenting an overall framework, which he and Victor Cocowitch developed, that portrays all of the inputs and outputs of rural health systems change.

The process begins with the catalysts for change: external incentives and pressures, new information, leaders or change agents, and the methods and structure for considering alternative options. These catalysts plant the seeds of change that are then fertilized by community debate, organizational development, and technical assistance. When it works, the interaction between all of these elements results in improvements in the way rural communities use and organizations deliver health services. When it fails, communities and organizations risk further deterioration.

It is difficult to gain community involvement, panelists stressed. For one thing, apathy abounds. "One in five families moves every year. People do not solve problems locally anymore. They move away from them," said Paul McGinnis, Project Director for the Mountain States Health Corporation and a private consultant specializing in strategic planning. Another problem he encounters is the tendency of, "communities to blame outsiders. They say, 'It's the fault of federal reimbursement policies, it's the fault of state licensure and regulatory requirements, it's the fault of greedy doctors who don't want to come here to practice.'"

"Without appropriate community education and decision-making processes, federal or state efforts to develop regional health networks in rural areas are destined to fail."

Then why even bother with community education and community decision-making processes? Because without them, federal or state efforts to develop regional health networks in rural areas are destined to fail, McGinnis asserted. Everyone may agree on the need for better access to health care, but unless everyone also agrees on how best to achieve it, the goal will much harder to attain. For example, few communities can understand the benefits of downsizing a beloved hospital without knowing what will replace the services that are lost. Decisions that require people to travel further to receive health care are hard to implement without community consent.

In order to gain their participation, McGinnis advised state-level officials to help local people see that, "We are not fixing blame, we are fixing problems," and added, "people will only become involved in public policy decisions when they can see the results of their participation." Though it takes more time and effort, he said, gaining the support of businesses, educators, clergy and other community leaders is absolutely essential. Their input ensures that changes in hospital services will enhance health services overall and benefit or at least not harm the local economy.

McGinnis offered a few basic guidelines for state-level officials to follow in order to make it easier for community members to become and stay involved:

- Provide all of the information that is relevant in language they can understand, and then trust them to make good decisions.

- Make sure that all of the people who have power and influence to actually implement decisions are sitting at the table.
- Ensure that the decision-making process precedes changes, rather than the other way around.
- Help communities implement their decisions by intervening with federal agencies where necessary.

State-level officials must also carefully consider how and where to enter a community to help it begin to change, according to Victor Cocowitch, a management and strategic planning consultant who specializes in working with rural hospitals. Offering technical assistance to rural communities is, "like throwing a few stones into the middle of the pond and watching the ripples go on for three or four years," he observed. "You have to sort out how those reverberating circles are going to work together."

Cocowitch primarily enters communities through hospital boards of directors. In his practice, he finds that hospitals pursue systems change according to three different models:

- *Developmental change*, improves that which already exists.
- *Transitional change*, uses strategic planning to create a new model over a period of time.
- *Transformational change*, which is often prompted by severe crises, facilitates the fundamental change that rural hospitals must undertake in order to adapt to a rapidly changing environment.

At the beginning, Cocowitch often observes that, "People have this belief that they do not have a health care system in their community unless it has two stories of brick and an emergency room and a hospital sign." But if he can get hospital CEOs and trustees to confront the magnitude of the changes they must make to survive in the new health care environment, they quickly see that they cannot do it alone and begin to appreciate how important it is to bring others into the process. At that point, the ripples of concern that have spread to the community and to physicians can be merged with those of the hospital. And in so doing, hospital officials may realize, for example, that it is not just possible but necessary to move the public health department inside its walls or work with physicians to form a PPO or capitated system.

Steve McDowell learned the basic principles of community education and decision-making from one of the founders and most successful practitioners of rural health systems development. Several years ago, he asked Jim Bernstein, Director of the North Carolina Office of Rural Health and Resource Development, how to develop rural health systems. McDowell recalls him saying, "You need four things to affect change: data, an outside facilitator, money, and leadership." Since then, McDowell, a former Director of the Kansas Office of Rural Health and currently the Director of the Integrated Community Health Development Project for the Kansas Health Foundation, has been putting those words of advice into practice. Through the project, the Foundation provides support for data collection and analysis, outside facilitation and financial assistance, although it cannot supply local leadership.

Developing such leadership is one of the most important functions of community needs assessment, education and decision-making, McDowell said. When done correctly, these methods not only develop community leaders, but help them reach consensus about an appropriate scope of services and a structure for the delivery of those services. The real sign of success, he said, is when "people know exactly what those words mean."

McDowell too finds the hardest part of the process is getting rural communities to change their perception of the hospital as the beginning and end of a health care system. Unfortunately, the EACH Program requirements don't help; they assume that hospitals are at the center of decision making and restrict the health network requirements to the hospital.

Getting people to understand that a health care system means more than just a hospital is half the battle, he said. It helps to perform a community health assessment on a complete scope of services, from public health and home health

services to hospital and nursing homes. It also helps to provide information about current utilization patterns and financial performance, so people begin to understand what's working and what's not. And when the community group is ready to examine various alternatives, it is especially important to provide rural-specific options. "Rural is not small urban. You cannot downsize an urban model and make it work," McDowell said.

While it is important to offer as much technical assistance and information to local communities as possible, the state government's role in initiating change at the local level is more encompassing, according to Paul FitzPatrick, Director of New York State's Office of Rural Health. State officials must also work to create a positive climate for change in rural health delivery systems by educating other state-level policymakers, including state legislators, state provider associations, and state executive agencies about how they can help.

In New York, a State Rural Health Council was formed for this purpose. It has been instrumental in persuading state policymakers to approve $50,000 grants to local communities to help them develop rural health networks or systems. In addition to these financial incentives, the state has set up a framework to ensure that state-level and local-level "conversations for change," as FitzPatrick called the two processes, are complimentary. The framework is expressed in a set of rural health development guidelines which permit local flexibility, while still assuring some basic accountability to state policymakers.

Lindy Nelson, Director of Rural and Primary Health Policy and Planning for the Colorado Department of Health, stressed that meaningful opportunities for involvement are as important at the state level as they are at the local level. In Colorado, for instance, a state task force was set up to help plan the EACH Program. Task force members were given responsibility for developing criteria, drafting regulations, and approving the applications of hospitals that wanted to be designated as EACHs or PCHs. This not only involved them personally, but gave them incentive to get input on the structure of rural health networks from other people in each of the communities they represented.

At what point should state program officials involve the community in the development of networks? When should they transfer major responsibility for network development to the local level? The sooner the better, panelists agreed. While most of the states participating in the EACH Program were unable to involve every affected community in the process of change before submitting their federal application, panelists made it clear that it is never too late. The product is the process, they said. Delaying the community's involvement will only make it more difficult to change the light bulb.

Profiles of State EACH Programs

This section of the report discusses the Essential Access Community Hospital (EACH) Program as it is being developed in the seven states that have received grant funding from the Health Care Financing Administration. The information is based on progress reports that were presented by the states at a recent workshop conducted by the Alpha Center for federal and state officials responsible for implementing the EACH Program. Maps identifying the rural health networks under development in each state were prepared by Mathematica Policy Research, Inc. and updated by the Alpha Center. The following symbols are used to designate various types of facilities or networks.

- **E** = Essential Access Community Hospital (EACH) Grantee
- **P** = Rural Primary Care Hospital (PCH) Grantee
- **M** = Member Hospital, not an EACH or PCH Grantee
- * = State Program Network, not receiving federal funds

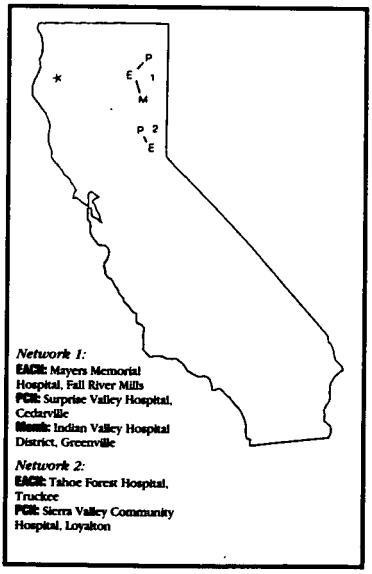
California

California's recent involvement in shaping the health care delivery system in rural areas dates back to 1978, when the state legislature established criteria to identify small, rural hospitals for planning purposes. A decade later, the legislature passed Assembly Bill No. 2148 which directed the Office of Statewide Health Planning and Development (OSHPD) to review acute care operating and building code regulations; to assume responsibility for granting waivers or exceptions to regulations that were determined to be excessively burdensome to rural hospitals; and to research existing alternative rural hospital models and develop a new model for California.

Under this authority, OSHPD appointed a technical advisory committee which was charged with the development of the Alternative Rural Hospital Model (ARHM) Program. In some ways a precursor to the federal EACH Program, the state's application to the federal government was a direct outgrowth of its work on the ARHM program. Indeed, the two programs have become closely linked; participation in the ARHM program is an eligibility requirement for PCH designation in California.

The ARHM program provides exceptions from certain state hospital certification and licensure requirements for hospitals in rural or remote areas of the state, whose financial viability has been jeopardized by these rules. The program adopted a limited service hospital model by allowing ARHM hospitals to drop inpatient surgical services. All ARHM facilities must offer five basic core services: standby emergency medical services; basic medical holding/stabilization capacity; basic ambulatory care for outpatient services; basic laboratory services; and basic radiology services. Beyond that, ARHM rules allow facilities to select their own scope of services using a "building block approach." Facilities have the option of adding additional service modules such as ambulatory surgical services, obstetric services, and expanded radiology services.

Individuals involved in the planning process for the state's EACH application believe that the federal program introduced an important new requirement for limited service facilities—networking and local integration of services. California currently has two networks (and one network that was initially rejected by HCFA for technical reasons, which is now under appeal). The two networks were developed with substantial input from EMS personnel, the public health department, primary care groups, and private practice groups. While several facilities in other areas have expressed interest in the concept of networks, they are waiting to see the Health Care Financing Administration's final regulations for the EACH Program before seeking PCH designation. In the meantime, however, the fact that all PCHs are also designated ARHM facilities suggests that the ARHM process may become an incremental step in the hospital downsizing process in California.



Network 1:
EACH: Mayers Memorial Hospital, Fall River Mills
PCH: Surprise Valley Hospital, Cedarville
Hosp: Indian Valley Hospital District, Greenville

Network 2:
EACH: Tahoe Forest Hospital, Truckee
PCH: Sierra Valley Community Hospital, Loyalton

Colorado

Over the past several years, the problem of assuring access to health care in Colorado's rural and frontier areas has become more pronounced due to hospital financial pressures and a dwindling supply of rural physicians. Such factors led the state to experiment with a number of innovative rural health delivery models that in turn, spurred the state's interest in participating in the federal EACH Program.

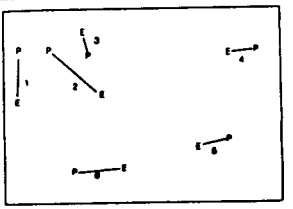
For example, in 1979, Colorado established a new class of health facility, called the "Community Clinic Emergency Center" (CCEC), which integrates ambulatory primary care with limited inpatient services. The CCEC can be considered a prototype to the rural primary care hospital (PCH), because it too, may have a maximum of only six beds in which patients can stay for no more than 72 hours. Most CCECs cannot be designated as PCHs, however, because they have never been licensed as hospitals, which is a requirement for receiving Medicare certification.

Another model program is the Silverheels Health Center in mountainous and isolated Park County. After a nine-bed county hospital closed, energetic local leaders opened this primary care/emergency care center, that is staffed by non-physician providers and integrates public health services. A third program—the Rural Healthcare Initiative—is sponsored by The Colorado Trust, a state-based foundation. This program has supported the development of local, regional health care systems by awarding grants to groups of rural health care centers, rather than individual facilities.

In order to build on these programs, the Colorado Department of Health decided to apply for participation in the EACH Program as a "Type B" state because more time was needed to design a statewide approach for developing rural health networks. State officials have pursued a strategy that ensures the networks are designed to meet the needs of local communities. It has approved funds for six self-identified networks to hire their own consultants who can perform local needs assessment and other planning activities. The networks must also establish advisory and oversight boards comprised of representatives from local social service agencies, public health departments, schools, and local government bodies.

The state health department has also sought to involve local representatives in the design of the state's overall strategy. State officials created a task force which includes interested individuals, hospital administrators, and state personnel. The task force is charged with establishing state criteria for PCHs, EACHs, and networks, reviewing all facility grant applications, and making recommendations to HCFA for designation.

Currently, Colorado officials are trying to determine how to implement the 72 hour maximum length of stay for PCHs. Substantial distances between the EACHs and PCHs makes this a potential problem for some facilities. Lindy Nelson, Director of Rural and Primary Health Policy and Planning in Colorado, remarked, "The thought of having to send somebody 70 or 100 miles down the road when they could actually be taken care of within their own community is something that our hospitals are struggling with."



Network 1:
EACH: St. Marys Hospital, Grand Junction
PCH: Rangely District Hospital, Rangely

Network 2:
EACH: Valley View Hospital, Glenwood Springs
PCH: Pioneers Hospital, Meeker

Network 3:
EACH: Routt Memorial, Steamboat Springs
PCH: Kremmling Memorial, Kremmling

Network 4:
EACH: Sterling RMC, Sterling
PCH: Haxtun Hospital, Haxtun

Network 5:
EACH: Arkansas Valley RMC, La Junta
PCH: Weisbrod Memorial, Eads

Network 6:
EACH: San Luis Valley RMC, Alamosa
PCH: St. Joseph Hospital, Del Norte

Kansas

The EACH Program in Kansas, which consists of 10 networks, is the largest among the seven state grantees. Currently, there are eight EACH hospitals, two supporting hospitals, fourteen PCH facilities, and nineteen member hospitals included in the program. Eight of the 10 networks have received federal funding while the remaining two did not qualify for the federal grant. Those two include one that crosses state lines and is based on a supporting hospital in Oklahoma, and another that depends on an urban supporting hospital.

The Kansas Hospital Association and private foundations have been instrumental in supporting the development of several rural health initiatives in Kansas including the EACH Program. In 1985, The Robert Wood Johnson Foundation awarded a grant to the Kansas Hospital Association to analyze the potential for providing nontraditional health and human services in small rural hospitals. Additionally, the Kansas Health Foundation (formerly known as the Wesley Foundation) has funded a special Primary Care Bridging Program that supports residency training in rural communities. Perhaps the greatest impact on the state's EACH Program came from a 1990 Kansas Health Foundation grant that jointly funded the Kansas Hospital Association, the Department of Health and Environment, and the Emergency Medical Services Board to analyze the potential for EACH/PCH networks in Kansas and to prepare an application for a HCFA grant.

Kansas has created a three-pronged approach to developing their networks. The first involves community education. Kansas program officials found that the initial process of designating networks failed to educate the affected communities adequately about the EACH Program. Consequently, network participants find themselves in communities that have no knowledge of the program, and have heard some negative publicity surrounding the proposed regulations and standards. Kansas officials believe it is important to ensure that residents in these communities understand the EACH Program and its goals. Program staff are working with each hospital in the program to conduct an objective appraisal of community and provider perceptions and, based on that appraisal, develop a plan for community education.

The second area of the network development process focuses on the Emergency Medical Services (EMS) plan. EMS systems must be capable of providing care to patients with urgent medical problems and ensure that the services of a physician or midlevel provider are available within a reasonable length of time. The PCH will be responsible for providing an initial diagnostic evaluation, a limited range of definitive treatments, necessary resuscitation and stabilization, and for initiating transport to the EACH or other back-up hospital for services not offered at the PCH.

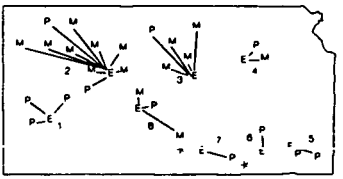
The final area of the network development process examines physician relationships and referral protocols. The purpose of this process is to devise ways for physicians within a network to relate to each other and decide how medical staffs at EACHs and PCHs will interact on a regular and formalized basis.

Because of the varying situations of the individual networks, Kansas decided not to impose a state-wide approach or a single type of consulting procedure to the process of network development. Instead, they have issued a request for proposals for consultants to work with the networks on the three major planning tasks. The objective is for each network to select its own consultant in order to develop a process that it feels will best fit its needs.

A unique feature about the Kansas program is the inclusion of facilities that are neither EACHs nor PCHs. Kansas refers to these networks as "member facilities." Many hospitals were interest-

ed in participating in a network, but were not eligible to become PCHs or were not willing to enter into the designation process. Kansas saw no logical reason to exclude these hospitals from taking part in a mutually supportive networking process and have included them from the beginning.

Additionally, Kansas views the EACH Program and other alternative service delivery models has being on a continuum with options available to rural communities. They have discussed three levels of potential network systems: first, the EACH/PCH network as defined and conceived in the federal program; second, a network which is based on the EACH/PCH concept, but without the federal rules and guidelines; and third, an integrated service model network which includes a broader set of services in a network system concept that goes beyond hospitals envisioned in the EACH Program.



Network 1:
EACH: St. Catherine Hospital, Garden City
PCH: Kearney County Hospital, Lakin
PCH: Lane County Hospital, Dighton
PCH: Wichita County Hospital, Leoti

Network 2:
EACH: Hays Medical Center, Hays
PCH: Grissell Memorial, Ranson
PCH: Rawlins County Hospital, Atwood
Mem: Plainville Rural Hospital, Plainville
Mem: Decatur County Hospital, Oberlin
Mem: Graham County Hospital, Hill City
Mem: Trego County Hospital, Wakeeney
Mem: Northwest Kansas Regional Medical Center, Goodland
Mem: Citizens Medical Center, Colby
Mem: Sheridan County Hospital, Hoxie

Network 3:
EACH: Asbury-Salina RMC, Salina
PCH: Jewell County Hospital, Mankaro
Mem: Republic County Hospital, Bellville
Mem: Mitchell County Hospital, Beloit
Mem: Lincoln County Hospital, Lincoln
Mem: Ottawa County Hospital, Minneapolis

Network 4:
EACH: Memorial Hospital Association, Manhattan
PCH: Dechairo Hospital, Westmoreland
Mem: Wamego City Hospital, Wamego

Network 5:
EACH: Central Kansas Med Center, Great Bend
PCH: Labette County Med Center, Parsons
PCH: Baxter Memorial Hospital, Baxter Springs

Network 6:
EACH: Mercy Hospital, Independence
PCH: Wilson County Hospital, Neodesha

Network 7:
EACH: William Newton Memorial, Winfield
PCH: Cedar Vale Community, Cedar Vale

Network 8:
EACH: Ellinwood District Hospital, Ellinwood
PCH: Oswego City Hospital, Oswego
Mem: Clara Barton Hospital, Hoisington
Mem: St. Francis Regional Medical Center

New York

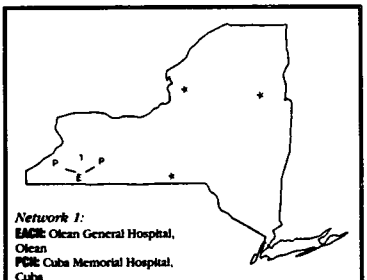
New York State was actively involved in the development of rural health networks even before the EACH Program. Since 1982, the state has provided network planning grants to over twenty projects under its Rural Health Network Demonstration Program. The state asked the Health Care Financing Administration to accept four of these networks under the EACH Program, but only one of the sites has been awarded EACH/PCH grant funding. The other three applications were not accepted for technical reasons.

In June 1992, the New York State Department of Health, in cooperation with the New York State Rural Health Council, drafted a set of *Proposed Rural Health Network Guidelines and Requirements* to assist with the state's rural health network initiative. The document presents guidelines for two different alternative facility models, one of which is a "primary care hospital." The other model envisions an upgraded diagnostic and treatment center that would enable community health centers to add capacity to serve urgent and limited emergency medical care needs.

The proposed guidelines are intended to serve several purposes in rural health network development. First, they outline the current policy directions being promoted by the Rural Health Council and the Department of Health. Second, they define the process and establish requirements for rural health network development that will allow rural communities throughout New York to avail themselves of the fiscal benefits and regulatory flexibility of this initiative. Third, the document provides a framework for identifying and assessing other new approaches to organizing and financing rural health services. Finally, the network guidelines provide an overall structure for state support of network delivery approaches.

In addition to these guidelines, the Department of Health and the Rural Health Council have developed three strategies to enhance the effectiveness of the proposed EACH/PCH networks in New York. First, all four networks have developed operational plans that describe the networks' mission, goals, organizational structure, operating principles, service area, and functions and ability to conform with selected service delivery model. Currently, these operational plans are being evaluated for conformity with New York's proposed rural health network guidelines and requirements.

The second strategy is the development of a legislative proposal to be incorporated into the next set of changes in New York's hospital reimbursement methodology. The proposed legislation defines networks, alternative service facilities, including upgraded ambulatory care centers and primary care hospitals, and core full-service hospitals (including EACHs). It also establishes a three-part grant program for promoting the development of networks: a planning grant to provide up to $50,000 a year for up to two



Network 1:
EACH: Olean General Hospital, Olean
PCH: Cuba Memorial Hospital, Cuba
PCH: Salamanca Hospital District Authority, Salamanca

years to allow communities and providers to develop a network operational plan; a start-up grant of up to $500,000 to support infrastructure costs associated with implementing the network; and an administrative grant of $100,000 to $200,000 per year for up to three years to provide operational support for the administration of the network. The legislation would also establish a permanent reimbursement stream for key network providers once they have become fully operational. Annual rate enhancements would be provided to the core full- service hospital to cover its additional costs for supporting the network, and to upgraded care centers for the additional costs of providing emergency services. Finally, the legislation would allow a facility that converts to a primary care hospital to maintain its historical revenue stream under the current hospital reimbursement system. It is estimated that on average this package would amount to $5.75 million annually.

The third strategy is the creation of a rural health provider panel to assist in establishing admissions criteria, developing an exceptions process, and reassessing the currently proposed criteria and standards for primary care hospitals.

North Carolina

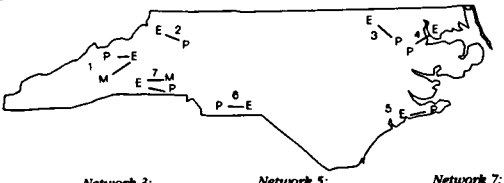
The approach to the EACH Program in North Carolina is consistent with many years of work in the development of rural health resources. It combines support to communities to ensure their active involvement in decision-making with a comprehensive range of technical assistance to facilities and community leaders.

When it becomes clear that their hospital can no longer survive in its current form, state program officials believe that community members must be involved in decisions regarding the preferred type of service delivery model. At the same time, they understand that information and technical assistance can help these communities make informed choices and implement changes most appropriate to their area.

Consequently, North Carolina's Program provides many types of technical assistance to EACH and PCH facilities to support their conversion efforts and strengthen their networks. The Office of Rural Health and Resource Development (ORHRD) spends a great deal of time on basic organizational development with both hospitals and communities, which includes strategic planning sessions with the hospitals' board of directors and board of trustees, as well as development of public relations strategies for overcoming problems often associated with the transition to PCH hospitals. ORHRD staff also assess management strengths and weaknesses and are in the process of developing training programs for all of the EACH and PCH facilities.

Reimbursement is another area in which ORHRD staff spend a great deal of effort. For example, one of its specialists helps hospitals analyze financing options, such as the relative advantages of Rural Health Clinic versus Federally Qualified Health Clinics (FQHC) reimbursement for outpatient services. They also work with private physician practices, particularly where they are having trouble surviving and their retention is key to staffing the PCHs. Therefore, ORHRD is devoting more time in reimbursement and billing procedures to help those struggling practices.

Finally, North Carolina officials provide assistance to the networks in health professional recruitment, fundraising, and specific program development. Over the course of the past year they have helped to find 10 to 12 physicians for EACH and PCH hospitals in the state. They have also conducted two fundraising drives with PCH facilities, which raised $65,000 and $250,000 to support conversions. They have also helped to set up long-term care units in hospitals and are currently in the process of developing Medicaid case management programs for the elderly.



Network 1:
EACH: Spruce Pine Hospital, Spruce Pine
PCH: Burnsville Hospital, Burnsville
Mem: Memorial Mission Hospital, Asheville

Network 2:
EACH: Watauga Hospital, Boone
PCH: Blowing Rock Hospital, Blowing Rock

Network 3:
EACH: Halifax Memorial Hospital, Roanoke Rapids
PCH: Our Community Hospital, Scotland Neck

Network 4:
EACH: Chowan Hospital, Edenton
PCH: Bertie Memorial Hospital, Windsor

Network 5:
EACH: Carteret General Hospital, Morehead City
PCH: Sea Level Hospital, Sealevel

Network 6:
EACH: Richmond Memorial Hospital, Rockingham
PCH: Anson County Hospital, Wadesboro

Network 7:
EACH: Rutherford Hospital, Rutherfordton
PCH: Crawley Memorial, Boiling Springs
Mem: Cleveland Memorial Hospital, Shelby

South Dakota

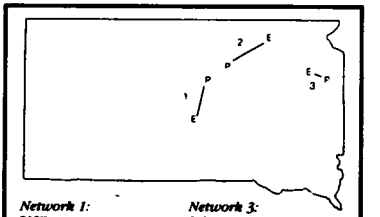
A major goal of the South Dakota EACH Program is to preserve and improve access to a set of basic or essential health services in rural areas of the state. These services have been defined as primary care (which includes preventive health services), acute care (which includes emergency room services), ambulance services, and nursing care. To accomplish this goal, South Dakota has developed several strategies.

The first step involves a basic determination regarding which rural hospitals are either "at-risk" or "access-critical." The former includes hospitals that face a high probability of closing in the next year as well as those in which continued operation over a two to five year period is in question. "Access-critical" rural hospitals are those that provide access to essential health services (emergency, primary, acute, and nursing care) in a service area where few, if any, other providers of such essential services exist. By identifying hospitals that fit into these two categories, South Dakota has been able to structure the type and level of technical assistance needed to help stabilize their operations.

Since it is difficult to accurately predict which hospitals are likely to close, South Dakota officials have developed a system to assess the relative risk of closure. They have identified characteristics of hospitals that have closed, developed standards to measure degrees of risk, and applied these standards to each hospital to determine its degree of risk. Through the risk-identification process, and provision of technical assistance, three hospitals that were at greatest risk of closing are still operating. They are in the process of converting to PCHs and are establishing networks with EACHs.

South Dakota's second strategy focuses on providing technical assistance to designated EACHs and PCHs as well as activities designed to foster the development of health care networks. One area involves resolving critical health professional shortages in rural areas. For example, they have begun to study the feasibility of sharing personnel among network facilities. Although the study is not yet complete, one EACH has already started a locum tenens program which brokers professional services on a temporary basis. Other technical assistance areas include improving the delivery of emergency medical services within networks, establishing telecommunication linkages between EACHs and PCHs and examining financial reimbursement issues for PCHs.

Additionally, South Dakota offers two services to assist communities with financing health projects and community-based planning efforts. The first is the "Health Project List," which is a roster of projects that have been approved by the Department of Health, in accordance with criteria and standards of the state's Primary Care Plan. Those on the list are eligible to receive funding from the Governor's Office of Economic Development and its Community Development Block Grant Program.



Network 1:
EACH: St. Mary's Healthcare, Pierre
PCH: Gettysburg Memorial, Gettysburg

Network 2:
EACH: St. Luke's Midland Regional Medical Center, Aberdeen
PCH: Holy Infant Hospital, Hoven

Network 3:
EACH: Prairie Lakes Health Care Center, Watertown
PCH: Deuel County Memorial Hospital, Clear Lake

The second is the "Charting a Healthy Future" program which helps communities give local residents a voice in configuring a health care delivery system that meets their needs more effectively. This program fits well with one of the state EACH Program's highest priorities of getting broader community participation in the process of network development. As Bernard Osberg, Branch Manager of the South Dakota Office of Rural Health explained, "we need to spend more time working with folks in the community to inform them about the purpose and the goals of the program." The Charting a Healthy Future process not only educates the community but helps residents become involved in decisions affecting community health care services.

West Virginia

The West Virginia EACH Program has already made great headway. Its networks are conducting thorough community needs assessments, carrying out financial analyses, and purchasing sorely needed equipment for providing emergency medical services.

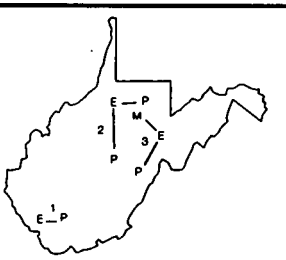
These early achievements are due in large part to a strong and committed leadership. A solid partnership has been formed between the state Office of Community and Rural Health Services and the West Virginia Hospital Association, which fosters open communication between the two organizations and allows frequent discussions about program goals and directions. Furthermore, the state's EACH Advisory Council has been operational since 1990 and continues to be instrumental in directing program policy.

The Council has developed a two-step process for network designation. Upon receiving preliminary designation, a network must conduct a community needs assessment according to state specifications, conduct a financial feasibility study, and submit a budget to the state before applying for final designation. Throughout this process, the state periodically brings together the grantees to provide advice, clarify state requirements, and allow the grantees to share their experiences with one another. Finally, a public hearing is held in the network's area before the commissioner of public health makes the final designation.

Improvements in emergency medical services constitute a central component of West Virginia's EACH Program. The state has installed a microwave tower in mountainous Webster County in order to enhance direct communication between ambulance personnel, the PCH, and a regional emergency medical command center. The use of this technology allows the emergency medical command center to direct an emergency case to the most appropriate care facility and, most importantly, bypass the PCH when treatment is recommended in a higher-level facility. Currently, the state's microwave communications network covers 40 percent of the state's population.

In addition to the EACH/PCH model, West Virginia officials are interested in promoting other network models for areas with different combinations of providers. "We are looking for state resources, foundation resources, grants, etc., because there are hospitals and primary care centers that are ready to implement other models," said Mary Huntley, Director of the Office of Community and Rural Health Services.

To further their efforts, the state has initiated a study to determine which models can work in three areas of the state: one with a primary care center, two physicians, and a local health department, but no hospital; one with two competing hospitals and a primary care center; and one with a tertiary care center that currently has an affiliation with three rural hospitals. The study is to be completed by early March.



Network 1:
EACH: Logan General Hospital, Logan
PCH: Guyan Valley Hospital, Logan

Network 2:
EACH: United Hospital Center, Clarksburg
PCH: Grafton City Hospital, Grafton
PCH: Webster County Memorial, Webster Springs

Network 3:
EACH: Davis Memorial Hospital, Elkins
PCH: Pocahontas Memorial Hospital, Marlinton
PCH: Broaddus Hospital, Philippi

Appendix I
Rural Primary Care Hospital (PCH) Facility Requirements

Criteria for the Designation of Facilities

- Be located in a rural area (an area outside a metropolitan statistical area) or in an urban county whose geographic area is substantially larger than the average area for urban counties and whose hospital service area is similar to the service area of hospitals located in rural areas (OBRA-90).
- Comply with Medicare hospital conditions of participation at the time it applies.
- Participate in the network's communication and data-sharing system.
- May have been closed for not more than one year prior to the application date for PCH designation (OBRA-90).

Service Criteria[1]

- "Make available" 24-hour emergency care.
- Agree to cease providing inpatient care, except as specified below:
  - Not more than 6 inpatient beds
  - Temporary inpatient care for periods of 72 hours or less (unless a longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions) provided to patients who require stabilization before being discharged or transferred to another hospital
- May maintain swing beds.
- Have a physician, physician's assistant or nurse practitioner available to provide services, provide routine diagnostic services (including clinical lab services), and dispense drugs and biologicals in compliance with state and federal law.

Linkages and Referral Relationship Criteria[2]

- Enter into agreements with the EACH for the referral and transfer of patients.
- Agree to participate in the network's communications system including electronic sharing of patient data, telemetry, and medical records if the network operates such a system.

Personnel/Staffing Criteria

- Meets staffing requirements of other rural hospitals, except as described below.
- Need not meet standards for hours or days of operation, as long as it meets requirement to provide 24-hour emergency care.
- Furnish the services of a dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.
- May allow a physician's assistant or nurse practitioner to provide required inpatient care subject to oversight by a physician.

Medicare Reimbursement

- Inpatient PCH services to be covered under Medicare Part A and defined the same as inpatient services delivered in any other hospital. Payment will be made only if a physician certifies that services had to be furnished immediately on a temporary, inpatient basis, as described below:
  - For the first 12-month cost reporting period: a per diem payment to be made based on the reasonable costs of the facility

SOURCE: OBRA-1989, except as noted, as summarized by Suzanne Felt and George Wright in *Diversity in State's Early Implementation of EACH Program*, Mathematica Policy Research, Inc., July 27, 1992.

[1]The Secretary has authority to waive the 6-bed, 72-hour service limits.

[2]Applies to PCHs that are members of a rural health network. The Secretary is required to give preference to facilities participating in a rural health network, but may designate not more than 15 PCHs outside grantee states that would not meet rural health network requirements as defined in the law.

- Later periods: payments to be the per-diem payment amount for the preceding 12-month cost reporting period, increased by the PPS update factor for rural hospitals
- On or after January 1, 1993: a prospective payment system to be used for inpatient PCH services

- Outpatient PCH services to be covered under Medicare Part B, for services defined as hospital outpatient services, as described below:
  - Before 1993, facilities may elect either of two payment methods:
    (1) a cost-based facility service fee with reasonable charges for professional services billed separately, or
    (2) an all-inclusive rate combining both the professional and facility service components.
  - By January 1, 1993, a prospective pay ment system for outpatient PCH services is to be developed

Appendix II
Essential Access Community Hospital (EACH) Facility Requirements

Criteria for the Designation of Facilities

- Be located in a rural area (an area outside a metropolitan statistical area).
- Be located more than 35 miles from any hospital that is designated as an EACH, classified as a rural referral center, or located in an urban area but meets the criteria for classification as a regional referral center; or meet other geographic criteria imposed by the state and approved by the Secretary of Health and Human Services.
- Have at least 75 inpatient beds, or be located more than 35 miles form any other hospital (the Secretary may waive these restrictions).
- Agree to provide emergency and medical back-up services to PCHs in its rural health network and staff privileges to PCH physicians.
- Accept patients transferred from PCHs.
- Agree to receive data from and transmit data to PCHs.
- Meet any other requirements imposed by the state with the approval of the Secretary.

Medicare Reimbursement

- Hospitals designated as EACHs by the Secretary will be treated as "sole community hospitals" for payment purposes.
- If the Secretary determines that an EACH incurs increases in reasonable costs during a cost reporting period and will incur increases in subsequent periods because it became a member of a rural health network, the hospital's target payment amount will be increased to account for the increased costs.

SOURCE: OBRA-1989, as summarized by Suzanne Felt and George Wright in *Diversity in State's Early Implementation of EACH Program*, Mathematica Policy Research, Inc., July 27, 1992.

Clarification of Medicare and Medicaid Support for Health Professions Training at Rural Health Clinics and Federally Qualified Health Centers

Located in underserved areas, rural health clinics (RHCs)[1] and federally qualified health centers (FQHCs) offer comprehensive primary care to millions of patients. RHCs and FQHCs make potentially strong health professions training sites because of the comprehensiveness of their care, the standards that apply to their certification, and the quality of their clinical staff. Encouraging training at these sites is extremely important because of the serious recruitment difficulties they face (these difficulties have been exacerbated by the decline in funding support for the National Health Service Corps). Experts believe that increasing Medicare and Medicaid support for health professions training programs carried out at RHCs and FQHCs might significantly help both recruitment and retention as well as add to the quality of primary care training.

Many FQHCs and RHCs currently participate in approved health professions training programs, and some receive Medicare and /or Medicaid reimbursement for these activities.[2] However, HCFA policy regarding RHC/FQHC reimbursement for costs associated with health professions training is not clearly set forth. As a result, health professions programs may be making far less active use of these providers than they might, and a critical opportunity to attract and retain rural and urban primary care professionals is being lost.

Given the broad definition of allowable cost for providers reimbursed on a cost basis under Medicare and Medicaid, HCFA could use its authority to lend far greater policy and financial support to health professions training at rural health clinics and federally qualified health centers. The reasonable cost of training physicians, dentists, nurses, nurse midwives, licensed professional midwives, nurse practitioners, physician assistants, podiatrists, clinical psychologists, clinical social workers and other allied health professionals could be expressly recognized and built into FQHC and RHC reimbursement rates.

Current law regarding Medicare and Medicaid payments for training at FQHCs and RHCs

The following analysis provides an overview of current law pertaining to RHC and FQHC reimbursement.

- Coverage of both RHC and FQHC services is established at §§1832(a)(2)(D) and 1905(a)(2)(B) and (C) of the Social Security Act. Payment for care and services furnished by RHCs and FQHCs is to be made in accordance with Medicare's reasonable cost principles, which apply to both Medicare and Medicaid reimbursement. §§1833(a)(2)(D) and 1902(a)(13)(E).

- In the case of Medicare, the §1833 reasonable cost payment requirements (as defined at §1861(v)) govern payment for those services offered by RHCs and FQHCs that fall within the "core" definition of FQHC and RHC services. These are physician, physician assistant, nurse practitioner, clinical psychologist, and clinical social work services. §1861(aa)(1). In the case of Medicaid, the §1833 cost principles govern both the "core" services set forth at §1861(aa)(1) as well as all other ambulatory services furnished by RHCs and FQHCs which are covered under a state's Medicaid plan. §1905(a)(2)(B) and (C). Thus, the services of health professionals such as dentists and therapists, if included in the state's Medicaid plan, must be reimbursed on a reasonable cost basis when furnished by an FQHC or RHC.

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[1] Rural health clinics include both PHS-funded clinics (such as migrant health centers) and office-based private physician practices employing mid-level health professionals. Thus, both publicly supported and private practices qualify for RHC reimbursement statute. This means, of course, that initiatives aimed at RHCs carry the added attraction of reaching physicians in both public and private practice.

[2] See the attached study prepared by staff at the Bureau of Health Professions.

• I can find nothing in the statute appears to prohibit inclusion of teaching costs in FQHCs' and RHCs' reasonable cost rates. Indeed, as the accompanying paper shows, teaching costs already are recognized to some degree under both programs. Nor does there appear to be any provision in the statute which would limit recognition of reasonable teaching costs to hospitals only. Moreover, because payments to RHCs and FQHCs are governed by cost principles normally applicable only to providers, the Secretary has the discretion (if not the duty) to recognize their teaching costs as reimbursable, even though FQHCs and RHCs are not Part A "providers" under §1861(v) but are instead Part B "suppliers".

• Currently there are no rules governing Medicare and Medicaid reimbursement for health professions training at FQHCs and RHCs.[3] Regulations implementing the §§1833 and 1861(v) cost principles are found at 42 CFR §413. These regulations contain only very general cost principles for health professions training costs, as well as specific principles governing hospital training programs authorized under §1886(h) of the Act. The rules do not otherwise set forth principles governing payment of training costs incurred by other entities paid on a reasonable cost basis under the Act.

Thus, there is no clarity regarding:

(a) the classes of health professionals whose training costs can be supported;

(b) the types of costs that can be taken into account; and

(c) how the reasonableness of training costs is to be determined and reimbursed.

(d) how to compensate for other indirect losses from training programs (e.g., lost revenues from other sources because of lower productivity).

Payment Principles for Health Professions Training Costs Incurred by RHCs and FQHCs

In order to bring clarity and consistency to treatment of RHC and FQHC teaching costs and to encourage these entities to become part of an approved teaching program, HCFA should develop standards setting forth the circumstances under which the programs can be paid, the reimbursement principles that are to be applied, and the training programs that qualify for payment. Given the high proportion of RHC and FQHC activities are either Medicare or Medicaid reimbursable, clear standards could significantly improve their ability to develop such programs and would have a negligible impact on the budget (since special payment rules would apply only to providers who are part of an approved training programs, this would necessarily limit the number of clinics qualifying as teaching sites). As noted, Medicare already pays at least some centers, and at least several sate Medicaid programs also recognize their costs.

In developing new payment standards HCFA would have to consider several issues:

• Classes of health professionals covered: To assure that training achieves maximum recruitment and retention results, HCFA should expand the types of health professionals who

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[3] Note tat the Bureau paper alludes to teaching rules under development. I have no idea who is developing these rules or what the look like. An ominous sign, however, is that according to the Bureau paper, the rules would use the same productivity standards as rules governing payment to non-teaching sites.

practice at RHCs and FQHCs beyond physicians. RHC and FQHC coverage of physician assistant, nurse practitioner, clinical psychology and social work makes training of these professionals at these sites possible. Many clinics are a community's sole dental provider, so dental training is a strong possibility.

• Productivity standards and administrative costs: Payment principles should recognize the lower productivity levels that can be expected in a training program, as well as the higher intensity of patient care that can from training. The current productivity standard of 4200 encounters per year must be relaxed, and other methodological caps that reduce the adaptation of these sties to training must be identified and revised.

• Participation in an approved training program: payment for training must of course be conditioned on participation in an approved training program, but payments should be made directly to these entitles as part of their FQHC and RHC reimbursement [4] and not passed through a hospital.

• Indirect costs: There probably would have to be some additional adjustment taking into account lost productivity that cost teaching centers other revenues.

• FQHC and RHC payment caps: Current HCFA rules cap FQHC payment levels. Undoubtedly, these caps will need to be adjusted once the higher costs incurred by teaching programs are estimated (none of this was taken into account when the 1992 caps were set, to the best of my knowledge). The RHC cap problem is more difficult, since it is set by statute. We might try some Congressional history clarifying that when the statutory cap was set, it applied to non-teaching sites only and did not take teaching sites into account. This might be enough to give HCFA the authority to set new upper payment limits for teaching programs. alternatively, HCFA might have the discretion to deal with the problem by treating teaching costs as a pass-through not subject to the caps.

[4] This of course means that you will be in essence rasing the current RHC and FQHC upper payment limits in the case of entitles that are training sites.

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