GME Central

NEW YORK'S DIRECT LINE TO GRADUATE MEDICAL EDUCATION NEWS

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Governor's Proposed Budget Threatens Hospitals' Stability and Their Key Role in Defense Against Terrorism

Nearly $600 Million in Cuts Proposed for 2003–04 Fiscal Year

New York Governor George Pataki proposed an Executive Budget for State fiscal year (SFY) 2003–04 that, through a combination of a gross receipts tax and new Medicaid cuts, would cause $596 million in hospital losses in SFY 2003–04 and $682 million in losses in SFY 2004–05 statewide. This proposal comes as hospitals are being asked to add a new role to their traditional health care responsibilities—as a key component of the front-line defense against nuclear, biological, and chemical events. And so far, hospitals have undertaken this role without an infusion of significant funds from either the Federal or State government to offset the added costs of this new responsibility.

While the gross receipts tax proposed in the Budget is across the board, the proposed Medicaid cuts would be applied to hospitals differently, depending upon the hospital's share of Medicaid patients and the extent to which the hospital was directly affected by the specific provisions in the

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Resident Working Hours Update

ACGME Standards Effective July 2003

At its February 2003 Board meeting, the Accreditation Council for Graduate Medical Education (ACGME) adopted common program requirements that establish duty hour standards for all ACGME-accredited programs, effective July 2003. In general, the ACGME standards are similar to the New York State regulations, with several key differences. GNYHA has taken particular interest in this issue as New York continues to be the only state in the country that has State-mandated resident working hours limitations. In particular, GNYHA had commented on the ACGME's proposed standards with regard to how those standards would affect New York teaching hospitals and residency programs and attempts to ensure

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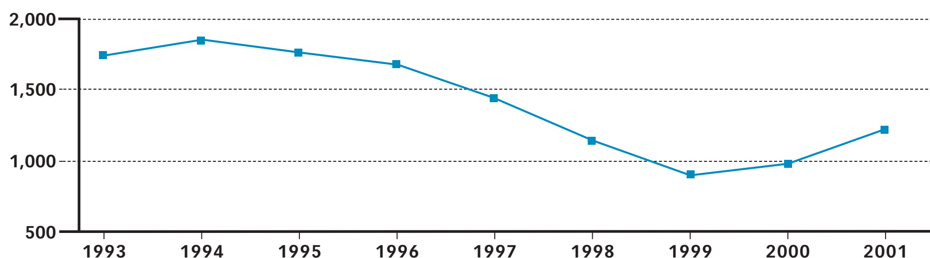
CHWS Survey Reports Strong Job Market for New Physicians in New York

The Center for Health Workforce Studies (CHWS), SUNY Albany recently released its report summarizing responses to its annual survey of all physicians completing a residency or fellowship training program in New York. This "exit survey" has been developed by CHWS in consultation with teaching hospitals throughout the State. In 2002, approximately 70% of the graduates of training programs in New York completed the survey. The purpose of the survey is to track demand for physicians graduating from New York programs in general and across specialties.

Among the key findings from the survey report are:

- Despite the rich physician supply in the State, the opportunities for New York graduates in 2002 continue to be strong, and, in fact, the job market has improved each year that the survey has been conducted.
- Not surprisingly, international medical graduates (IMGs) with temporary visas have much more difficulty in the job market than either U.S. medical school graduates or IMGs with permanent citizenship status.
- Demand for non-primary care physicians continues to be stronger than for primary care physicians, who are nearly twice as likely to report "difficulty finding a satisfactory practice position" (44% vs. 23%).
- Physicians graduating from programs in anesthesiology (see table at left), pain management, gastroenterology, child and adolescent psychiatry, cardiology, radiology, dermatology, and urology experienced the strongest demand.
- Physicians graduating from programs in plastic surgery, pathology, thoracic surgery, general pediatrics, pediatric subspecialties, and ophthalmology experienced the weakest demand. ■

Trends in Number of Graduates of Allopathic Anesthesiology-General GME Programs in the United States, 1993–2001



Source: JAMA Medical Education Editions, 1994–2002.

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compliance with the State regulations.

Of particular concern to GNYHA was an ACGME requirement that had been proposed in June 2002, stating that "a 10-hour time period for rest and personal activities must be provided between all daily duty periods, and following in-house call." The New York regulations mandate that a resident be provided with a minimum of eight hours off between all working assignments. GNYHA had heard from its members that this more restrictive requirement in the ACGME standard had the potential to compromise efforts to comply with the New York regulations, and had communicated that concern to the ACGME. GNYHA was particularly concerned with the effect that this 10-hour nonworking requirement would have on "night float" systems, which have been identified as a key strategy to ensure compliance with the State regulations.

After some discussion with regard to GNYHA's comments and similar concerns it had heard from other organizations regarding the 10-hour nonworking requirement, the ACGME decided to alter this requirement to say, "[A]dequate time for rest and personal activities must be provided. This should consist of a 10-hour time-off period provided between all-duty periods and after in-house call." For those New York residency programs that have built their compliance efforts around ensuring a minimum of eight hours off between assignments, this change is potentially significant. In the language of the ACGME, "must" is a term used to indicate that something is required, mandatory, or done without fail. In contrast, "should" is a term used to designate requirements that are so important that their absence needs to be justified. What the above change in language is expected to mean to all teaching institutions and residency programs is that if a particular residency program is able

The ACGME will incorporate monitoring of compliance with its duty hours standards, effective July 2003.

Governor's Proposed Budget, continued from page 1

Executive Budget. The cuts include a permanent elimination of trend factor increases, limiting the case payment rate to the "group average" for all diagnosis-related groups (DRGs), eliminating a length of stay (LOS) offset to a negative volume adjustment, cuts in per diem rates and freezing of specialty clinic rates, and eliminating certain part-time clinics (see table).

The Governor's proposal would also cut indirect medical education (IME) payments though two separate cuts. The first cut would potentially mix the data sources for the resident count and bed count used in the calculation of IME by using the lower of the 1990 or rate-year resident count together with the 1990 bed count, which is generally higher than the rate-year bed count. This proposal would essentially make the intern and resident-to-bed ratio, which is the methodological underpinning of the IME payment system that determines "teaching intensity," a fiction. The second IME cut would lower the adjustment from the current 7.7% used in the Medicaid IME calculation to 5.5%.

Based on a thorough GNYHA analysis, the average New York hospital loss caused by the Medicaid inpatient cuts will be 9% of baseline Medicaid inpatient revenues. Due to the mix of Medicaid

Hospital Cuts in the Proposed 2003–04 NYS Executive Budget

PROPOSED CUTS	$ IN MILLIONS			
	STATE SAVINGS		PROVIDER LOSS	
	FY 2003–04	FY 2004–05	FY 2003–04	FY 2004–05
Re-establish 0.7% hospital assessment	$190.2	$171.3	$190.2	$171.3
Medicaid cuts				
Eliminate trend factor (2.4%)	14.4	16.4	110.8	126.2
Limit case payment to group average	7.8	8.4	60.0	64.6
Cut IME payments	15.7	23.1	120.8	177.7
Eliminate LOS offset to volume adjustment	4.6	5.3	35.4	40.8
Cut per diem rates by 5%, except AIDS	4.0	6.0	30.8	46.2
Freeze specialty clinic rates, except AIDS	1.0	2.0	7.7	15.4
Eliminate "unnecessary" part-time clinics	5.2	5.2	40.0	40.0
Total	$52.7	$66.4	$405.4	$510.8
Grand total	**$242.9**	**$237.7**	**$595.6**	**$682.1**

to adequately justify a somewhat shorter working assignment separation—such as eight hours—to the relevant residency review committee, then the residency program will not automatically receive a citation from the ACGME on that basis alone.

ACGME Monitoring of the Duty Hours Standards

The ACGME will incorporate monitoring of compliance with its duty hours standards, effective July 2003, as part of its overall accreditation reviews. The duty hours compliance monitoring will be incorporated into the ACGME's usual survey process, through notification to the surveyed residency programs at least 90 days prior to the site visit. Following notification, the residency program is required to complete the ACGME program information form (PIF), and submit it to the ACGME at least 14 days prior to the site visit. Within the PIF, the residency program is expected to address how it has come into compliance with the ACGME duty hours standards. If a residency program is unable to meet a certain requirement (such as the 10-hour nonworking period requirement), the residency program should submit a PIF Addendum, explaining the reasons why it is unable to meet that requirement. Both the PIF and the PIF Addendum are available on the ACGME Web site, at **www.acgme.org**.

The ACGME will be surveying all residents in a program two months prior to the site visit to assess the program's compliance efforts with the duty hours standards. The ACGME site visitor will then have these results in hand when visiting the program.

NYS Continuing Annual Compliance Surveys

As of October 2002, IPRO had visited all teaching hospitals in the State at least once for the purpose of assessing compliance with the New York regulations regarding working hours and working conditions, and the organization is currently conducting its second set of annual compliance visits to teaching hospitals across the State. According to the New York State Department of Health (DOH), every teaching hospital will be visited again, and the survey teams will focus particular attention on those residency programs that were found to be out of compliance during the first year of compliance reviews or during a complaint investigation. The IPRO survey team will also interview residents within additional

services downstate, NYC hospitals would, in the aggregate, experience a 10% drop in Medicaid revenues. For individual hospitals, the losses would range from 2% to nearly half (48%) of the hospital's baseline Medicaid revenue. In the aggregate, when added to current hospital operating losses of $337 million in 2001, the Governor's budget would cause hospital losses around the State to increase to $1 billion. As *GME Central* went to press, it appeared that both houses of the Legislature were prepared to reject the Governor's proposed cuts.

Health Care Reform Act

While the Governor proposed renewing the Health Care Reform Act of 2000 (HCRA), with funding levels for indigent care and graduate medical education remaining the same, it is noteworthy that the proposal included a diversion of funds from the Community Health Care Conversion Demonstration Project (CHCCDP) to displace what are technically cuts in those pools. That is, a total of $350 million in CHCCDP funds intended to support hospital conversion to a system of mandatory Medicaid managed care through primary care development, managed care readiness, and worker retraining would instead be used to offset these HCRA cuts.

Other HCRA cuts include a reduction of the eligibility income cap for the Family Health Plus program from 150% of the Federal poverty level to 133%, new co-payments and prior authorization requirements included in the Elderly Pharmaceutical Insurance Coverage program, and $135 million in other miscellaneous pool cuts. ■

programs, such as psychiatry or rehabilitation medicine, on which they did not always focus during the first year, in order to ensure that those residents are not being overworked to compensate for ensuring other compliance efforts.

As *GME Central* went to press, DOH and IPRO staff were in the midst of reviewing two documents associated with the regulations and survey process. DOH will be releasing a report regarding the first year of the contract that will include aggregate data on hospital compliance and provide more detailed information across specialties. No hospital-specific information, however, will be included in the report. In addition, a comprehensive question-and-answer document is being prepared in response to the many questions that DOH staff and the survey team have been asked regarding the resident working hours regulations and the survey process since the IPRO contract began. That document was developed in addition to the brief question-and-answer document that DOH prepared and distributed several years ago, and a brochure describing the regulations that DOH and IPRO prepared and provided to hospitals for distribution to residency trainees. ■

IN THE SPOTLIGHT

GNYHA Ventures, Inc., Forms Alliance with InSiteOne

This past November, GNYHA Ventures, Inc., announced a strategic alliance with InSiteOne, Inc., a company that provides a unique archiving service in the radiology arena. Through this partnership, GNYHA member institutions will have access to InSiteOne's array of cost-effective medical image storage, archiving, and distribution technology services. InSiteOne has developed a Web-enabled archiving solution that is designed to integrate with any digital imaging modality, hospital network, or Picture Archiving and Communication System (PACS). InSiteOne's solution optimizes the storage and archiving of medical images for health care facilities that are making the transition to filmless digital imaging.

Health care institutions are increasingly faced with the need to upgrade their radiological infrastructure, increase efficiency, and lower costs. InSiteOne's archiving solution enables hospitals to utilize digital imaging technologies on a per study basis while significantly reducing the need for upfront capital expenditures, storage space, maintenance costs, technical upgrades, and staffing support. InSiteOne also offers on-site storage and long-term off-site storage, allowing health care institutions to meet the requirements for the Health Insurance Portability and Accountability Act of 1996, as well as support their business continuity efforts. InSiteOne provides health care institutions with a unique, cost-effective service that delivers short-term and long-term access to digital medical images, enabling institutions to improve operational efficiencies and provide better service to patients and referring physicians.

For additional information about InSiteOne's archiving solutions, please contact Gayle White at GNYHA Ventures, Inc., at (212) 506-5479. ■

Physician Exchange Visitor Program and Waiver Process Update

Several changes have been made recently to the Exchange Visitor Program (EVP) as it applies to physicians beginning and graduating from residency programs. The EVP is the program administered by the U.S. Department of State that allows a foreign national to enter the United States on a J-1 training visa to participate in an educational program. In the case of foreign nationals who seek to undergo medical training or conduct medical research, the Educational Commission for Foreign Medical Graduates (ECFMG) administers the program and acts as the J-1 visa sponsor for the physician.

Changes Affecting Physicians Who Are Beginning a Training Program

In February 2002, the ECFMG issued a notice indicating that the Department of State had informed the organization that sponsorship of foreign nationals for training in programs not accredited by the Accreditation Council for Graduate Medical Education (ACGME) would be permitted only through June 30, 2003, unless a recommendation for an acceptable modification of this policy was forwarded to the Department of State. This program limitation had the potential to significantly hamper the recruitment efforts of a number of training programs (referred to by the parties involved as "non-standard programs") in major teaching hospitals in New York and across the country. For this reason, GNYHA had been in continual communication with the ECFMG expressing its members' concern with potential new restrictions on the program.

Following extended discussions with the academic medicine community and the Department of State, the ECFMG recently forwarded an acceptable recommendation to the Department of State. The ECFMG will continue to sponsor J-1 physicians for participation in training programs if any one (or more) of the following conditions applies:

1. The program is accredited by the ACGME.
2. The appropriate specialty board of the American Board of Medical Specialties (ABMS) offers a certificate in the specialty.
3. The appropriate specialty board of ABMS recognizes the program, as evidenced by a letter of support, and additional requirements are met.

For this third category of program, the training program's sponsoring institution must be in good standing with the ACGME and must submit additional required documentation, including a detailed program description and a statement from the applicant's home country, indicating a need for the specific specialty training included in the program. To date, a majority of the 24 ABMS boards, including the American Boards of Internal Medicine, Pediatrics, OB/GYN, and Surgery, have indicated either their general support for certain areas of specialty training or their willingness to review particular training programs and provide letters of support on behalf of applicant physicians. The ECFMG anticipates receiving additional responses, and will be posting information regarding the process for each Board on its Web site, **www.ecfmg.org**.

Changes Affecting Physicians Who Are Seeking a Waiver

One key feature of the Exchange Visitor Program and the J-1 visa is that foreign nationals who enter the United States on this visa are subject to a two-year home residence requirement following the expiration of the visa. In the case of residency trainees, following completion of a training program, physicians are required to return to their home country if they do not receive ECFMG sponsorship for additional training (for example, subspecialty) or receive a waiver of this return-home requirement. The total period of sponsorship by the ECFMG is generally limited to seven years.

The waiver of the return-home requirement is accomplished by means of a request made to the Department of State by an interested government agency (IGA). In the past, numerous Federal agencies, including the U.S. Department of Housing and Urban Development (HUD), have acted as IGAs and have made requests for these waivers as a means of ensuring adequate health care services in underserved areas. These waivers result in the physician being granted an H-1B temporary worker visa under the condition that the physician work for a minimum of three years in a federally designated health professional shortage area (HPSA), medically underserved area (MUA), or in a Veterans Administration facility. In 1996, HUD stopped participating in the program as an IGA for J-1 physicians seeking to remain in this country. The U.S Department of Agriculture also recently stopped submitting requests for waivers.

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In December 2002, HHS published an interim final rule, with opportunity for comment, indicating that effective immediately, the agency will formally act as an IGA and request waivers for physicians on J-1 visas to receive an H-1B visa so long as the physician agrees to provide primary care services in a designated primary care HPSA or MUA, and for psychiatrists to provide care in a mental health HPSA.

Although there is increasing evidence that various specialty-trained physicians are needed, Federal agencies are currently prohibited from acting as IGAs on behalf of physicians to provide other than primary care or psychiatric services. Greater New York Hospital Association commented on the final rule, expressing its members' support for the HHS decision to formally act as an IGA and requesting that the agency seek a change in the prohibition on also granting waivers for physicians delivering non–primary care and non–mental health services.

In November 2002, President George W. Bush signed into law an expansion of the program allowing any State Department of Health to act as an IGA for the purpose of sponsoring waivers for J-1 physicians who are seeking to remain in this country. The program, which had been referred to as the "Conrad 20 Waiver" program after Senator Kent Conrad, the original sponsor of the bill in 1994, now permits states to increase their annual waiver applications from 20 to 30. As with the HHS program, the physician who are seeking the waiver from the return-home requirement must agree to work full-time in an HPSA or MUA for at least three years on an H-1B temporary worker visa. Unlike the Federal agencies acting as IGAs, the states may sponsor non–primary care physicians for these waivers. In New York, priority has been given to physicians who are providing primary care services, although the State does consider other applications as well. ■

State COGME Hears Presentation on Limited Permits for Residents

The New York State Council on Graduate Medical Education (COGME) held a plenary session on December 16, 2002, at which Council members heard a presentation by Thomas J. Monahan, Executive Secretary of the New York State Board for Medicine, on a proposal to require New York residency trainees to obtain a limited permit from the State Education Department prior to completing the first year of postgraduate training.

This additional requirement would help to ensure that residents are credentialed through a standardized system.

According to Mr. Monahan, this additional requirement would help to ensure that residents are credentialed through a standardized system and would be more clearly subject to the professional disciplinary process. Following Mr. Monahan's remarks, Council members discussed the need for this additional credential and noted that the State Office of Professional Medical Conduct already has jurisdiction over these individuals. COGME members also indicated that they would consider establishing a workgroup to review the issue and make a recommendation to the State Education Department. ■

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ABOUT GNYHA

Greater New York Hospital Association is a trade association that represents 200 not-for-profit hospitals and continuing care facilities, both voluntary and public, in the New York metropolitan area.