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ABSTRACT

This report addresses financial problems faced by the four medical schools belonging to the State University of New York (SUNY) which operate their own teaching hospitals and conduct graduate medical education (GME) programs. These hospitals necessarily have higher costs than do nonteaching hospitals. Prior to 1997, the higher costs were absorbed by all payers in the state. Subsequently, changes in federal and state legislation, deregulation of rates, and changes in Medicare, led to reduced reimbursement to hospitals, incentives to reduce the number of residents, and to shift funds from specialty to primary care programs. The study addressed two questions for the period January 1, 1995 to February 28, 1999: (1) whether the three teaching hospitals had adequately planned for the reductions in funding; and (2) whether they had reduced the number of residents in their GME programs and increased the percentage of residents who were in primary care programs. The study concluded that for a variety of reasons, SUNY had not planned for reduced funding, nor had it reduced the number of residents or shifted residents from specialty to primary care programs. Two appendixes list the major contributors to the report and the comments of SUNY officials. (RH)

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State of New York
Office of the State Comptroller
Division of Management Audit and State Financial Services

STATE UNIVERSITY OF NEW YORK

STAFF STUDY: GRADUATE MEDICAL EDUCATION

REPORT 98-D-10

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 98-D-10

Mr. Robert King
Chancellor
State University of New York
State University Plaza
Albany, New York 12246

Dear Chancellor King:

The following is our report addressing graduate medical education at the State University of New York.

We conducted this study pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

May 11, 2000

Executive Summary

State University of New York
Staff Study: Graduate Medical Education

Scope of Study

After medical school, physicians train for at least three years in graduate medical education (GME) residency programs at teaching hospitals. Four of the 13 medical schools in New York State are part of the State University of New York (SUNY): the Health Science Centers at Brooklyn, Stony Brook and Syracuse, each of which operates its own teaching hospital, and the University Center at Buffalo. During the 1997-98 academic year, 2,503 residents participated in GME programs at the four schools.

Because of the more complex types of services performed at teaching hospitals, their costs tend to be higher than the costs of non-teaching hospitals. Prior to 1997, these higher costs were absorbed by all the payors in New York State, as part of the State's system of regulated hospital reimbursement rates. However, rates paid by certain commercial insurers were deregulated by the New York Health Care Reform Act (HCRA) of 1996, and each hospital in New York began to negotiate its own rates with certain commercial insurers.

HCRA provided about $544 million a year for GME programs through charges assessed against commercial insurers. These funds, along with any GME reimbursement obtained through negotiated rates, were expected to total approximately half of the amount paid by commercial insurers for GME programs through the statewide reimbursement rates. About 10 percent of the GME funds provided by HCRA were incentives that encouraged teaching hospitals to reduce the number of residents and to shift a portion of GME training from specialty to primary care programs. The 1997 Federal Balanced Budget Act, which became effective in October 1998, also reduced Medicare payments funding GME programs and provided incentives for hospitals to reduce the number of residents and to shift some residents from medical specialties to primary care. During 1997, $129.2 million (19.1 percent) of the net patient revenue received by SUNY's three teaching hospitals related to GME programs.

HCRA expired on December 31, 1999. However, in December 1999 the Legislature passed the New York Health Care Reform Act of 2000, which further reduced the level of GME program funding available to New York's teaching hospitals. One month earlier, in November 1999, the Federal government restored some of the Medicare cuts to teaching hospitals made in the 1997 Balanced Budget Act. However, overall, there is less funding available to support GME programs than there was under

HCRA. Our study, which covered the period of January 1, 1995 through February 28, 1999, addressed the following questions.

- Have the three SUNY teaching hospitals adequately planned for the reductions in State and Federal funding of GME programs?
- Have the three SUNY teaching hospitals reduced the number of residents in their GME programs and increased the percentage of residents who are trained in primary care programs?

Study Observations and Conclusions

The three SUNY schools with teaching hospitals did not reduce their number of residents or shift residents from specialties to primary care programs. Nevertheless, SUNY has not planned how GME programs will continue to be funded at current levels given State and Federal GME funding reductions.

According to SUNY officials, the main reason for not reducing the number of residents at Brooklyn, Stony Brook and Syracuse is that it would probably cost more to employ alternative personnel. For example, at Stony Brook, a resident's salary averages about $43,000 a year, compared to about $95,000 for physician assistants and $59,000 for nurse practitioners. The officials also noted that residents provide teaching and medical skills that cannot be replaced. The officials told us, that since HCRA was set to expire at the end of 1999, they adopted a "wait and see" stance regarding future GME funding and would not reduce GME programs unless it became absolutely necessary. (See pp. 6-9)

Under HCRA and the Balanced Budget Act, additional funds were available for hospitals that shifted residents from specialties to primary care programs. SUNY officials have been reluctant to make such a shift, because they believe the types of care provided by their resident specialists are needed by their communities. They believe that, if the mix of specialist and primary care residents were analyzed on a regional basis, rather than on a hospital-by-hospital basis, it would be found that SUNY's specialists are needed for an appropriate mix. (See pp. 9-11)

It appears that SUNY's philosophical and programmatic position prevented them from developing plans, contingency or otherwise, to address reduced funding for GME programs.

Comments of SUNY Officials

SUNY officials acknowledge that the issues we identify in this report warrant further study and will receive full consideration. Officials of the Health Service Centers at Brooklyn, Stonybrook and Syracuse disagree with certain of our conclusions and descriptions of their planning and accomplishments with respect to the issue of reduced GME funding.

Contents

Introduction

Background

Physicians begin their training at four-year medical schools. Upon completing medical school, new physicians continue their training by participating for at least three years in residency programs, generally referred to as graduate medical education (GME), which are administered by teaching hospitals. GME programs are designed around the type of medicine a physician will practice upon program completion. These programs range from the generalized primary care practices such as family medicine and general pediatrics to more specialized health care practices such as cardiology and anesthesiology.

New York State is one of the primary training grounds for physicians in the United States. Although New York's population represents just 7 percent of the country as a whole, it trains 15 percent of the nation's doctors at 13 medical schools and 116 teaching hospitals across the State. According to the State Department of Health, half of the medical residents trained in New York leave the State after completing their training. Four of New York's 13 medical schools are within the State University of New York (SUNY). Three of these schools (the Health Science Centers at Brooklyn, Stony Brook and Syracuse) operate their own teaching hospitals, while the fourth school (the University Center at Buffalo) does not operate its own teaching hospital. All four medical schools are affiliated with non-SUNY hospitals in their communities. In addition to educating health care professionals, SUNY's medical schools and their hospitals conduct medical research, and deliver health care services to hundreds of thousands of residents within their regions each year. SUNY System Administration's Health Sciences and Hospitals Office provides overall leadership and support services to the four SUNY medical schools.

The following table shows the number of residents participating in GME programs at the four SUNY medical schools during the 1997-98 academic year:

	Syracuse	Stony Brook	Brooklyn	Buffalo
Residents in Program	416	454	866	767
Residents at SUNY Hospital	241	334	144	NA
Residents at Affiliated Hospitals	175	120	722	767

NA - Not Applicable

The costs at teaching hospitals tend to be higher than the costs at non-teaching hospitals. According to health care providers, these higher costs result from the complex conditions of the patients cared for in teaching hospitals, the participation of additional health professionals and students in the delivery of care, the development and deployment of new diagnostic and therapeutic technologies, and the concurrent clinical research activities that are conducted at teaching hospitals. Also, health care representatives estimate that indirect costs contribute as much as 60 percent of the total cost of teaching hospital GME programs.

Prior to 1997, the costs of the teaching hospitals were absorbed by all payors in New York State through statewide reimbursement rates established by the State Department of Health for each type of service provided by the hospitals in the State. The rates established by the Department allowed a total of about $1.7 billion a year in funding for GME programs. Of this $1.7 billion, approximately $791 million came from Medicaid GME program funds. The remainder of the $1.7 billion (about $909 million) was paid by commercial insurers. An additional $1.2 billion came from Medicare payments, bringing a total of about $3 billion per year that New York teaching hospitals received from both Federal and State sources for GME programs prior to 1997.

However, beginning in 1997, hospital reimbursement rates paid by certain commercial payors were deregulated by the New York Health Care Reform Act (HCRA) of 1996. As a result of HCRA, each hospital began to negotiate its own reimbursement rates with all commercial insurance companies. (Managed care companies were already allowed to negotiate their rates with hospitals prior to HCRA.) It was hoped that the resulting competition among hospitals would contain rising health care costs, improve the quality of the care provided, and provide additional access to health care. To help teaching hospitals cover some of their higher costs, HCRA provided for a guaranteed level of hospital reimbursement for some of the costs of GME programs through the creation of a Professional Education Pool. This Pool was expected to receive $544 million in annual funding through charges assessed against commercial insurance companies. These funds, along with any GME reimbursement obtained by individual teaching hospitals through their negotiated rates, were expected to total approximately half of the funding previously provided by commercial insurers through the statewide reimbursement rates.

Therefore, under HCRA, less funding was available to New York's teaching hospitals to support their GME programs.

HCRA also provided incentives to encourage teaching hospitals to reduce the total number of residents trained and to shift a portion of GME training from specialty to primary care programs. These incentives were intended to help contain medical costs and promote better quality health care, as according to a number of reports within the health care industry, the nation is training far more physicians than are needed, which contributes to rising health care costs, and is training too many physicians as specialists and too few as primary care physicians. (For example, in a 1995 report to the United States Department of Health and Human Services, the Council on Graduate Medical Education recommended that the nation reduce the total number of specialists trained, allow a modest increase in the number of primary care physicians, and improve the training provided to primary care physicians.) Specifically, under HCRA, as part of the Professional Education Pool, $54 million a year was provided to teaching hospitals that met certain targets, such as reducing the number of graduate medical education programs or positions, increasing the number of primary care resident positions, and increasing the number of minority resident positions.

Teaching hospitals also faced reductions in Federal funding, as the 1997 Federal Balanced Budget Act, which became effective in October 1998, reduced Medicare payments, including GME program funding, nationally over a five-year period. The Balanced Budget Act also provided incentive payments to teaching hospitals that voluntarily reduced the total number of resident positions or shifted some of these positions from medical specialties to primary care. In addition, if hospitals in New York State participated in the New York Medicare Graduate Medical Education Demonstration Project (Medicare Demonstration Project) and reduced the size of their residency programs by a certain amount, they received funds to cover some of the costs of replacing the residents with other medical staff.

As is shown in the following table, during 1997, about 19.1 percent of the net patient revenue received by SUNY's three teaching hospitals was related to GME programs:

Revenue Type	Brooklyn	Stony Brook	Syracuse	Total
GME Revenue (in millions)	$30.6	$55.7	$42.9	$129.2
Net Patient Revenue (in millions)	$142.2	$294.3	$239.8	$676.3
GME Revenue as a Percentage of Net Patient Revenue	21.5%	18.9%	17.9%	19.1%

The total amount of GME revenue received by the three hospitals, in 1997 ($129.2 million, including Federal revenue), the first year HCRA was in effect, was about 5 percent less than the total amount received in 1996 ($133.7 million).

HCRA was set to expire on December 31, 1999. In December 1999, the Legislature passed the New York Health Care Reform Act of 2000. Included in this three and a half year plan are additional annual reductions estimated at $50 million to GME program funding levels specified under HCRA. (The portion of the GME program funding in the Medicaid rates was not changed.) One month earlier, it was reported that the Federal government restored to teaching hospitals nationwide some of the Medicare cuts made in the 1997 Balanced Budget Act. However, despite the restoration of some of the Medicare GME program funding, the net effect of these two pieces of legislation still provides less GME program funding for SUNY's teaching hospitals than was previously available.

In addition, in 1998-99, the three SUNY hospitals experienced a shortfall of $77 million and SUNY officials have acknowledged that the hospital shortfalls will continue under current conditions. These declining hospital revenues, combined with further GME program funding reductions included in the Health Care Reform Act of 2000, accentuate the need for SUNY to develop a strategic plan that addresses the impact of these funding reductions on the hospitals' GME programs and their overall mission of medical education and quality health care.

Scope, Objectives and Methodology of Study

The objectives of our study were to determine whether the three SUNY hospitals (1) adequately planned for reductions in State and Federal funding of GME programs, (2) reduced the number of residents in these programs, and (3) increased the percentage of residents who are trained in primary care programs. The period covered by our study was January 1,

1995 through February 28, 1999. To accomplish our objectives, we interviewed officials from SUNY's GME programs and hospitals, SUNY System Administration, and the State Department of Health. We also reviewed relevant SUNY records and reports, as well as literature relating to the health care industry. In addition, we contacted officials from other teaching hospitals in the State and from other state universities with academic health science centers to find out how they have reacted to changes in the GME environment.

Decisions regarding GME programs are made at the hospital level. Since the University Center at Buffalo does not operate a hospital and instead fulfills its teaching mission through affiliations with local private hospitals, it was not included in the scope of our study.

Response of SUNY Officials to Study

A draft copy of this report was provided to SUNY officials for their review and comment. Their comments have been considered in the preparation of this report and are included as Appendix B.

Within 90 days after final release of this report, we request the Chancellor of the State University of New York to report to the Governor, the State Comptroller and the leaders of the Legislature and fiscal committees, advising what steps were taken to respond to the issues raised in this study.

Results of Study

Planning for Reductions in Funding of GME Programs

The three SUNY medical schools began to react to the anticipated reductions in GME funding as early as 1995. For example, in July 1995, Syracuse created a task force to address the anticipated reduction in funding, and in 1997, Stony Brook and Brooklyn sought advice from the SUNY Albany School of Public Health. By 1998, all three medical schools had identified the following options:

- enter the Medicare Demonstration Project, which would require that the number of residents be reduced by about 20 percent or more over a five-year period,
- reduce the number of residents by a more moderate amount, or
- maintain the current number of residents.

Officials at the three medical schools concluded that the best and most cost-effective option was to maintain the current number of residents at the three SUNY hospitals. The officials said that this option would best enable them to provide excellence in education and comprehensive medical care for the community. (As is noted later in this report, the number of residents at each of the three SUNY teaching hospitals declined in 1997; however, this decline reflected the ordinary year-to-year variation in the number of residents in each program, and was not part of a long-term plan to reduce the number of residents at these hospitals.)

According to officials at Brooklyn, Stony Brook and Syracuse, the most significant reason for deciding to maintain the current number of residents was that it would probably cost more to employ alternative personnel at the teaching hospitals. Depending on the case mix, patient volume, and scope of practice, residents might be replaced by nurse practitioners, physician assistants or staff physicians, each of whom would, on average, be paid more than a resident. For example, according to Syracuse officials, a resident often works up to 80 hours per week for an average annual salary of about $38,000. In contrast, a physician assistant or nurse practitioner works a 40-hour week (receiving overtime pay for additional hours of work) at an average annual salary of $58,000 for physician assistants and $49,300 for nurse practitioners. At Stony Brook, the contrast is even greater, where, according to officials, residents earn an average of about $43,000 a year, while physician assistants earn an average of about $95,000 year and nurse practitioners earn an average of about $59,000 a year.

Brooklyn officials also pointed out that, in addition to caring for patients, residents also teach medical students and junior residents. Therefore, if residents were replaced by other medical personnel, the teaching that had been done by the residents who were replaced would have to be done instead by faculty members at a higher cost.

The officials also told us that, because residents have greater in-depth knowledge of their field than alternative personnel, they could not be replaced by alternative personnel without sacrificing the quality of the medical care provided by the hospital. As a result, they believed that the use of alternative personnel often was not a viable option.

Syracuse officials also noted that a resident program in one medical specialty is often dependent on a resident program in another specialty. Therefore, the reduction of residents in one specialty may significantly hamper another specialty, which, in turn, may result in a domino effect through several specialties. The officials said they did not want to risk losing accreditation for their programs because they trimmed the size of their resident staffs.

SUNY officials also noted that so long as any revenue was received for GME, it represented additional funding that the hospitals would not receive if the residents were replaced by alternative personnel. Consequently, for this and the other reasons that were given, the officials at Brooklyn, Stony Brook and Syracuse believed they did not have sufficient financial incentives to reduce the number of residents in their teaching hospitals.

SUNY officials acknowledge that changes were necessary to meet the challenges presented by HCRA and the Balanced Budget Act. However, because HCRA was set to expire at the end of 1999, they told us that they took a "wait and see" stance regarding future GME funding. They said that they did not want to reduce their GME programs unless and until they absolutely had to.

Therefore, the officials at the three schools with teaching hospitals decided not to reduce the number of residents in the SUNY hospitals because they believed this was the most cost-effective means of providing services to their communities and sustaining the academic integrity of their programs. However, the officials did not address the issue of how their GME programs were to continue to be funded at the current levels when the amount of funding available for GME programs declined. We therefore conclude that SUNY officials did not adequately plan for reduced GME funding at Brooklyn, Stony Brook and Syracuse.

(In response to our report, officials of the Health Science Centers at Stony Brook and Syracuse generally disagree with our conclusions that planning for reduced GME funding was not adequate. Health Science Center at Stony Brook officials state that they had carefully reviewed the HCRA incentive program and the demonstration project and embarked upon a modest downsizing plan that would have the most benefit for the institution. Health Science Center at Syracuse officials point out that they had secured $1.2 million of the $56 million incentive pool available to over 120 eligible Medical Schools and have modified their OB/GYN program to have an extensive primary care experience. Syracuse officials acknowledge that they have not concluded that these actions will completely solve the problem, but they contended that these are significant steps in an ongoing program to address the resident funding dilemma.

Stony Brook Health Science Center officials add that our report does not reveal the complexity of GME. For example, officials report that 25 percent of Stony Brook's GME is supported from outside SUNY, primary care positions are the hardest to fill because these are not popular with medical school graduates, and Stony Brook's roughly 91 first year residency program positions is less than 85 percent of the number of graduates in its relatively small medical school.

Health Science Center at Brooklyn officials state that our study implies that it is desirable to reduce the number of residents in teaching hospitals, especially in non-primary care disciplines. They also stated that our study suggests that hospitals should give priority to accessing the incentive pool over broader, financial considerations and, more importantly, over their ability to maintain and improve the quality of patient care and medical education. In addition, Brooklyn officials report that their rotation of residents through several hospitals insures a broad educational experience, but sharply limits the ability to limit the number of residents.)

Auditors' Comments: Our study questions pertaining to whether the hospitals adequately planned for reduced GME funding and whether they reduced residents and increased the percentage of residents trained in primary care are solely intended to determine whether and to what extent the SUNY hospitals substantially accomplished steps consistent with the intent and fiscal specifications of the 1996 Health Care Reform Act and the 1997 Federal Balanced Budget Act. Our study does not represent or imply any Office of the State Comptroller positions with respect to this legislation. We believe our report accurately answers our study questions, while factually presenting justifications and explanations provided by hospital officials during our field work. We acknowledge the additional clarifications and comments provided by these officials in response to this report. We assume that the Health Science Center at Syracuse obtained

the $1.2 million from the incentive pool after the period covered by our study.

Meeting the Targets Established by HCRA

Under HCRA, each year additional funding was provided to teaching hospitals that met the following targets:

- A hospital receives additional funding if it reduces the number of resident positions assigned to medical specialties by between 2 and 6 percent for a specified base period. Funding begins when the number of specialist positions are reduced by 2 percent and increases until the reduction reaches 6 percent. **(Downsizing Target)**

- A hospital receives additional funding if at least 30 percent of its residents are assigned to certain primary care programs (internal medicine, family practice, pediatrics, combined internal medicine/pediatrics, or obstetrics/gynecology). **(Designated Priority Program Target)**

- A hospital receives additional funding if its resident staff reflects a 20-percent minority participation. **(Minority Target)**

- A hospital receives additional funding if at least 95 percent of its residents are assigned to accredited programs. **(Quality Target)**

The percentages used in calculating the targets were based on totals established in a base year. A total of $54 million in additional funding was available each year. The pool of available funds was shared among the hospitals that met the targets on a regional basis, and the amount of funding provided to each hospital was based on formulas established by HCRA.

We reviewed the extent to which these targets were met in 1997 by the three SUNY teaching hospitals at Brooklyn, Stony Brook and Syracuse. As is summarized in the following table, we found that some of the targets were met while other targets were not met:

School	Downsizing Target	Priority Program Target	Minority Target	Quality Target
Brooklyn	*X*			*X*
Stony Brook	*X*			*X*
Syracuse			NA	*X*

X - Target was met
NA - Not applicable

Since our study focused on efforts to reduce the total number of resident positions and efforts to shift resident positions from specialty to primary care programs, we asked officials at the three SUNY hospitals about their efforts in these two areas.

Brooklyn met one of its Downsizing Targets for 1997 by reducing the number of resident positions in its teaching hospital by 6.6 percent. As a result, Brooklyn's teaching hospital received about $528,000 in additional funding. Although Brooklyn increased the number of residents in designated primary care programs by 6.4 percent, it did not meet the Designated Priority Program Target, because less than 30 percent of its residents (9.7 percent) were assigned to these programs.

(In response to our study, Brooklyn officials reiterated that the training experience requirements of residents and the quality of patient care demand Brooklyn residents be rotated through several independently-operated, but affiliated, training hospitals. This rotation requirement sharply limits Brooklyn's ability to modify the number of residents on the payroll.)

Stony Brook met one of its Downsizing Targets for 1997 by reducing the number of resident positions in its teaching hospital by 5.1 percent. As a result, Stony Brook's teaching hospital received about $3 million in additional funding. Although Stony Brook increased the number of residents in designated primary care programs by 2 percent, it did not meet the Designated Priority Program Target, because less than 30 percent of its residents (23.3 percent) were assigned to these programs.

(In response to our study, Stony Brook officials pointed out that Stony Brook did qualify for the downsizing incentive payment and that changes in resident numbers in the first year of a program take three or more years to have their full effect.)

Syracuse officials told us that they made a conscious decision not to meet the targets established by HCRA, because they believed they would not be

able to meet their educational and patient care goals if they reduced the total number of resident positions and the number of specialty resident positions to the extent required by the targets. Syracuse officials reported that, for 1997, they reduced the number of resident positions in the teaching hospital by just 1 percent, and only 2 percent of these residents were assigned to designated primary care programs.

(In response to our study, Syracuse officials pointed out that they received additional funding for residency adjustments that they made where practical.)

GME program officials at each of the three SUNY teaching hospitals told us that they were reluctant to reduce the number of resident positions in specialties because the services provided by these specialists are needed by their communities. They said that, because their hospitals provide a more advanced level of care than all of the other hospitals in their communities, their hospitals necessarily employ a higher percentage of speciality residents than the other hospitals. They further pointed out that, if each of the regions served by their hospitals were viewed as a whole, it would be seen that the desired balance of primary care residencies is achieved within each region. Accordingly, it would not be desirable to change the mix of residents on a hospital-specific basis; instead, they said, the mix should be considered on a regional basis.

The officials also noted that reducing the number of residents in one speciality could affect the accreditation of other programs, because the accreditation of a residency program in one medical speciality may be dependent on the adequacy of a different residency program in another speciality. In addition, the SUNY officials, as well as officials at Albany Medical Center, New York University Hospital, and the University of Massachusetts Medical School, told us that market forces generally play a greater role in determining the size and composition of resident staffing than legislative directives. For example, officials at Albany Medical Center told us that they reduced the number of residents at the Center to the lowest levels necessary to maintain accreditation because the number of patients treated by the residents has declined.

Issues To Be Considered

1. How can the GME programs at Brooklyn, Stony Brook and Syracuse continue to be operated at the current levels as the amount of funding available for GME programs significantly declines?

2. What actions could SUNY officials take to reduce the cost of their GME programs that would balance their agendas for education and quality care?

3. Should SUNY officials work with officials from other teaching hospitals in New York State to develop a proposal for viewing New York's hospitals on a regional basis for GME funding purposes?

4. How will market demand and competition among GME programs Statewide affect the SUNY teaching hospitals?

(SUNY officials acknowledge that these issues are complex and warrant further study. They indicate the issues will receive their full attention.)

Major Contributors to This Report

Jerry Barber
Bill Nealon
Karen Bogucki
Peter Schmidt
Wayne Bolton
Marticia Madory

STATE UNIVERSITY OF NEW YORK

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April 10, 2000

Mr. Jerry Barber
Audit Director
Office of the State Comptroller
The State Office Building
Albany, New York 12236

Dear Mr. Barber:

In accordance with Section 170 of the Executive Law, we are enclosing the comments of State University of New York Health Science Centers at Brooklyn, Stony Brook and Syracuse and SUNY System Administration regarding the draft Staff Study: Graduate Medical Education, State University of New York (98-D-10).

Sincerely,

Richard P. Miller, Jr.
Vice Chancellor and
Chief Operating Officer

Enclosure

Appendix B

State University of New York
Staff Study: Graduate Medical Education
98-D-10

General Comments

Health Science Center at Brooklyn

SUNY Downstate appreciates the in-depth inquiry performed by OSC with respect to the effects of funding changes for Graduate Medical Education (GME) at the SUNY teaching hospitals. The study asked two questions: Have the hospitals adequately planned for funding reductions, and have they reduced the number of residents in their GME programs and increased the percentage of residents in primary care programs.

SUNY Downstate believes that OSC's first question is neutral, while its second question is not. The second question implies that a reduction in the number of residents in SUNY teaching hospitals, especially in non-primary care disciplines, is desirable. OSC bases this assumption on overall reductions in Federal and State GME funding and the inclusion of a $54 million residency reduction incentive pool in the New York Health Care Reform Act (HCRA) of 1996. By accepting this premise, OSC's study suggests that hospitals should give priority to accessing this incentive pool over (a) other, broader, financial considerations, and (b), more importantly, over their ability to maintain and improve the quality of patient care and medical education.

SUNY Downstate continues to believe that high quality medical education and patient care are its first obligations. It is SUNY Downstate's responsibility to deliver these services on a sound financial basis. As OSC's study acknowledges, SUNY Downstate has presented ample evidence that widespread reductions in its residency programs would hurt, not help, University Hospital's balance sheet. Furthermore, as told to OSC's study team, but minimally acknowledged in OSC's report, the training experience offered by Downstate's residency programs -- and the quality of care provided to hospital patients now and in the future – demand that residents be rotated through several independently-operated, but affiliated, training hospitals.

This rotation through several hospitals insures a broad educational experience but sharply limits the ability of Downstate's State-owned University Hospital to modify the number of residents it carries on its own payroll. This was explained to the OSC study team.

Health Science Center at Stony Brook

The first sentence in the section, Study Observations and Conclusions, is not correct, nor is it consistent with the data and the table on page nine of the draft regarding Stony Brook. Stony Brook carefully reviewed the HCRA incentive program and the HCFA downsizing demonstration project and embarked on a modest downsizing plan that would have the most benefit for the institution. Stony Brook, in fact, did qualify for the downsizing incentive payment. The results reported in the Staff Study do not recognize the fact that changes in resident numbers in the first year of a program take three or more years to have their full effect.

The decision to not subscribe to the HCFA downsizing project was based on financial analyses that showed a significant disadvantage of being in the project. It should be noted that of the hospitals in New York State which did subscribe, very few have stayed in despite the considerable cost of getting out. Stony Brook's decision to not join was a correct one, and it considered important factors not addressed in the Study. All downsizing incentives have been structured in a "one size fits all" manner. The fact is that each hospital relates to its GME programs differently from other hospitals. Stony Brook's situation is different from other hospitals including SUNY hospitals in that we have a fairly large number of individual programs but each being relatively small in size.

Also, more than 25% of our total GME effort is supported from outside the SUNY system. The Staff Study does not reveal a real understanding of the complexity of the GME. Despite the interest in some quarters of increasing primary care training, for instance, those programs are the hardest to fill because primary care is not popular with the majority of medical school graduates.

The most important difference between Stony Brook and other teaching hospitals is the fact that our first year programs have roughly 91 positions, which is less than 85% of the number of graduates in our relatively small medical school class. GME programs across the State and the country are training too many residents averaging 140% first year positions per medical school graduate, but Stony Brook is not contributing to the excess in any way. Discussions of downsizing at the federal level have generally suggested a number of first year positions at 110% of the number of U.S. graduates. Stony Brook is well below that target.

Health Science Center at Syracuse

While we commend the Comptroller's Office for their accurate description of the complex situation at hand, we respectfully disagree with the conclusion that we are not prepared to react to funding reductions.

As opposed to enacting a "wait and see" policy, we have been continuously monitoring the situation at hand, and making adjustments where practical. As a result of our efforts, we have secured $1.2 million of the $56 million incentive pool that the Comptroller's Office points to in their report. In consideration of the fact that there are over 120 Medical Schools eligible for a portion of the $56 million pool, we believe that we have earned more than our fair share of that amount.

The means by which we earned the incentive was by meeting 3 (of 7) criteria.

- We reduced the number of residents, overall.
- We increased the number of residents in primary care.
- We modified our programs to emphasize primary care. As an example, we now require all residents in the OB/GYN program to have an extensive primary care experience.

While we have not concluded that these actions will completely resolve this complex problem, we do contend that they are significant steps in an ongoing program to address the resident funding dilemma.

Issues to be Considered (Page 10)

(OSC) 1. How can the GME programs at Brooklyn, Stony Brook and Syracuse continue to be operated at the current levels as the amount of funding available for GME programs significantly declines?

(OSC) 2. What actions could SUNY officials take to reduce the cost of their GME programs that would balance their agendas for education and quality care?

(OSC) 3. Should SUNY officials work with officials from other teaching hospitals in New York State to develop a proposal for viewing New York's hospitals on a regional basis for GME funding purposes?

(OSC) 4. How will market demand and competition among GME programs Statewide affect the SUNY teaching hospitals?

(SUNY) 1-4. We acknowledge that these complex issues warrant further study and they will receive our full consideration.

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