The Florida Senate

Interim Project Report 2000-10 *August 1999*

Committee on Budget Senator Locke Burt, Chairman

STUDY OF METHODS TO ENSURE THE AVAILABILITY OF GRADUATE MEDICAL EDUCATION OPPORTUNITIES

SUMMARY

This is the second year of a two-year study of selected medical education issues with an emphasis on physician training.

Last year's study: 1) described the differences between undergraduate and graduate medical education, 2) described changes in Federal funding policies for graduate medical education as required by the 1997 Balanced Budget Act (BBA), and 3) identified additional work to be done to assess the current and future funding situation.

A major recommendation from the 1998 study called for the establishment of a task force to study federal and state funding policies for graduate medical education and to develop pertinent cost information. Proviso language included in the 1999 General Appropriations Act reflected this recommendation.

A 12-member GME task force was established and held its first meeting on August 10, 1999. The task force discussed the objectives of the proviso, heard overviews of the various funding issues, and established a work plan. Three working subcommittees were. The task force will submit its report with recommendations on or before November 1, 1999.

This year's Senate study: 1) identifies the various funding streams that support graduate medical education, 2) identifies the 1997 BBA provisions that affect graduate medical education, 3) identifies data, that at a minimum, should be prepared by the academic health centers and hospitals prior to implementation of new state initiatives, 4) identifies physician workforce considerations, 5) identifies policy questions that need to be addressed by the State prior to implementation of new funding initiatives, 6) identifies models that have been implemented in some states.

For more than 30 years Graduate Medical Education has been primarily funded by the Federal Government through a variety of patient care reimbursement procedures. The effects of the 1997 Balanced Budget Act and the move to a more competitive managed health care market have impacted the way the medical schools and hospitals support the training of future physicians and health care professionals.

Congress appears to be unable, in the near future, to make funding policy changes for graduate medical education beyond the Medicare reforms included in the 1997 BBA. This is causing many states to develop their own funding initiatives. Major policy questions are:1) Who should pay?, 2) Who should be eligible for funding?, 3) What professions should be covered?, 4) How should payment levels be set?, 5) Should funding be linked to performance?, 6) How should funding be administered?, 7) Who should advise the process, 8) Should there be a Medicaid Plan Amendment or waiver? 9) To what extent should states take over what has historically been a Federally-funded program?

A major recommendation is that the colleges of medicine and hospitals should identify all fund sources that support graduate medical education and document the financial impact of the 1997 BBA by fund source and the impacts of managed care on their operations prior to enactment of new funding initiatives at the State level.

Staff will continue to work with the GME Task Force.

This study is related to Senate Interim Project 2000-09: Evaluate Reimbursement Rate Policies for Teaching and Specialty Hospitals and Senate Interim Project 2000-44: Medicaid Disproportionate Share Funding Replacement. In addition, the House Health Care Services Committee has an interim project entitled: A Medicaid Waiver for Graduate Medical Education.

BACKGROUND

Last Year's Study:

Interim project 98-60: Study of Medical Education in the State of Florida, was undertaken last year because of a variety of funding issues raised by the colleges of medicine and the teaching hospitals related to: 1) managed health care, 2) Federal budget reductions occurring as a result of the 1997 Balanced Budget Act, and 3) the State's role and financial commitment to fund undergraduate and graduate medical education. In addition, there was considerable discussion related to expanding the FSU/UP Program in Medical Sciences(PIMS) from one to two years, creating PIMS programs at other universities, and also establishing a new medical school at Florida State University.

Last year's study described the differences between undergraduate medical education (4 years of medical school) and graduate medical education (typically 3-7 years of residency specialty training). The study also described changes in Federal funding policies that affect the medical schools and the hospitals that train medical interns and residents. Finally, it identified additional work that needed to be done in order to more fully assess the current and future funding situation. The FSU/Board of Regents study of medical education was completed after this study, and therefore, not addressed.

Two concepts that emerged as a result of staff research last year were: 1) the financing of medical education is complex and 2) medical education is inextricably linked to the practice of medicine.

This is the result of multiple revenue streams, cross-subsidation of revenues, and multiple missions undertaken by the faculty and medical residents in the medical education enterprise that occurs simultaneously in the medical schools, the hospitals and the outpatient clinics. These missions include: teaching, service, research, and patient care.

This Year's Study:

A major recommendation from the 1998 Senate interim study was that: "A task force should be convened subsequent to the 1999 Legislative Session for the purpose of assessing the impact of current Federal and State studies, new or emerging Federal policies, as well as addressing the need to develop more current and complete cost information." This recommendation resulted in the following proviso language included in the State University System budget for the 1999-00 fiscal year:

> "From the funds in Specific Appropriation 191, a study shall be conducted regarding methods to ensure the availability of graduate medical education opportunities in Florida. The study shall be conducted by a 12 member committee. The Governor, Chancellor of the State University System, Secretary of the Department of Health and Director of the Agency for Health Care Administration shall appoint two members to the committee in addition to the Deans of the four medical schools. The study shall address, at a minimum: 1) the role of residents and medical faculty in the provision of health care; 2) the relationship of graduate medical education to the state's physician workforce; 3) the costs of training medical residents for hospitals, medical schools, teaching hospitals including all hospital/medical affiliations, practice plans at all of the medical schools, and municipalities; 4) the availability and adequacy of all sources of revenue to support graduate medical education; and recommended alternative sources of funding for graduate medical education. A report of the study findings and recommendations shall be submitted to the Governor, President of the Senate and Speaker of the House of Representatives November 1, 1999.

The first meeting of the task force was held in Tallahassee on August 10, 1999. The task force discussed the objectives of the proviso language, heard overviews of the various funding issues, and established a work plan. Three subcommittees were established: 1) institutional finance officers subcommittee - for the purpose of quantifying the issues, 2) public/societal goods subcommittee - for the purpose of articulating the outputs and outcomes derived from expenditures for graduate medical education, and 3) drafting subcommittee - for statutory language or other substantive proposals as needed.

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Funding for Graduate Medical Education:

Purchasers of health care services are the primary participants in the funding of graduate medical education. This is accomplished by different payment mechanisms which are: 1) Explicit formula-driven payments from the Medicare entitlement program that recognize Medicare patients' share of the direct and indirect costs of medical education expenditures and the costs incurred for the disproportionate number of indigent patients served by teaching hospitals,

2) payments from the Medicaid program through fee-for-service reimbursements and disproportionate share funding, and 3) payments by private insurance companies. Complex hospital reimbursement funding formulas for Medicare and Medicaid have made it difficult to clearly identify the costs and payments associated with graduate medical education in the past.

Table I reflects the various funding sources for graduate medical education that have been identified at this time. An "X" is placed in columns to reflect that funding is provided but the amount is unknown at this time. Note: GME DSH means Graduate Medical Education Disproportionate Share, VA and DOD mean Veterans Affairs and Department of Defense.

-Table I-

GME Funding Sources-Florida

Fund Source	State Funding	Non-State Funding
State General Revenue		
Community Hospital	$ 8.5M	
GME DSH	$11.9M	
Academic Health Ctrs	X	
Shands Contract	$ 9.8M	
State Trust Funds		
GME Matching Funds	$13.9M	
Medicaid DSH	X	
Medicaid Per Diem	X	
Non-State Funding		
Medicare DME		X
Medicare IME		X
Managed Care		X
Medicare DSH		X
Self Pay/Other/Commercial Ins.		X
Contracts/Grants/Donations		X
VA & DOD		X

Quoting Tim Henderson with the National Conference of State Legislatures, "state Medicaid agencies, as well as teaching hospitals, have been given little impetus to overcome the complex challenges of isolating and documenting the actual costs of graduate medical education. Medicaid (and Medicare) historically have tied GME payments to patient care costs, and hospital accounting systems have done little to quantify most reimbursable teaching expenses. Thus there has been little incentive to develop better approaches to separating out and measuring GME costs. States should explicitly define, document and reimburse the direct and indirect costs of graduate training. Often lacking their own cost data and reimbursement philosophy, Medicaid agencies, with little fanfare, commonly have followed Medicare methodology in making GME fee-for-service (FFS) payments to teaching hospitals. As states move to managed care, Medicaid should continue funding GME and, in doing so, must decide whether or not to leave payments in managed care organization's (MCO) premiums.

The 1997 Balanced Budget Act (BBA):

Medicare is the single largest payer for graduate medical education programs. Medicaid is the second largest and, at present, the Federal Government does not provide explicit policies or guidelines directed at expenditures for graduate medical education. The 1997 Balanced Budget Act included a multitude of reductions in Medicare funding for hospitals and physician reimbursements. Congressional testimony at the time indicates that the intent was to slow the rate of growth for the Medicare Program. The Act mandated reductions in Federal spending of approximately $250 billion across the country; to be phased-in over the 1998-2002 period. It has been reported that the effect of the BBA has been a substantial reduction in assistance to the teaching centers for graduate medical education and other medical programs.

1997 BBA GME funding impacts are:

1) Reductions in the reimbursement formula for Direct Graduate Medical Education (DME).
2) Reductions in the prospective payment formula for Indirect Medical Education (IME).
3) A freeze in the number of full-time-equivalent (FTE) residents at the 1996 level.
4) A new formula, beginning January 1, 1999, for Medicare Part B physician reimbursements that increases funding for primary care physicians and reduces funding for specialist physicians.
5) Beginning in 1998, 1% per year reductions for disproportionate share (DSH) payments.
6) Under the Medicare + Choice Program, a 5-year phase-out of direct and indirect costs of graduate medical education costs previously included in Medicare managed care capitation rates paid to managed care plans. Simultaneously, Medicare will phase-in direct and indirect medical education payments to teaching hospitals for services provided to managed care patients.

Numerous studies reflect the need for academic medical centers and hospitals across the country to document the relation of their financial problems, the impact of the 1997 BBA, and the price discounts hospitals have been granting private payers in response tocompetition pressures. The Graduate Medical Education Task Force will be developing the data to reflect these financial

impacts for the medical schools, teaching hospitals, and community hospitals.

Hospital Operating Margins:

"Prospective Payment System (P.P.S.) Inpatient Margins" are the result of a comparison of Medicare payments for P.P.S. operating and capital to the total Medicare allowable operating and capital costs. The "Total Hospital Operating Margin" is associated with all hospital operations, including all patient care and income from investments and philanthropy. Historically, teaching hospitals have had high P.P.S. inpatient margins and low total margins. Because the total margin reflects revenues and costs from all sources, it is considered the best available measure of overall hospital financial success.(Medicare Payments with an Education Label, American Association of American Medical Colleges)

Physician Workforce:

The growth of managed care has magnified the need to train more generalist physicians and providers of primary care. Nationally, specialists outside of the field of primary care (family practice, general internal medicine, and general pediatrics), constitute approximately 70 percent of the physician workforce. Recent studies predict a national surplus of approximately 150,000 specialists by the year 2000 even though an estimated two thirds of the new physicians entering practice each year are specialist physicians. Nationally, workforce experts and policy makers have called for a policy of training at least 50 percent of the resident physicians in primary care. To do so, the Bureau of Health Professions of the U.S. Public Health Service recently estimated that the annual production of generalists must increase by 2,500 with a corresponding annual reduction of specialists by 7,000. Policy makers question whether this is attainable.

In 1996, there were 7,800 accredited GME programs at approximately 1,200 sites in the U.S. supporting the training of 98,000 physician residents. The Veteran's Administration is the largest single provider of training sites with approximately 130 VA Centers. The VA funds about 9 percent of the annual number of residency positions. Approximately 90 percent of GME programs are affiliated with a medical school. Annually, there are 17,800 U.S. medical school graduates for an approximate 25,000 first year residency positions. This difference is filled with international medical school graduates.

METHODOLOGY

There are hundreds of studies, articles and speeches that have been written in the past few years that address major funding policy issues for the Medicare and Medicaid programs as well as the effects of managed health care reforms and the 1997 Balanced Budget Act. Staff have reviewed 25 of the more current and pertinent studies and reports for this study.

In addition, Senator Sullivan and staff of the Education Budget Subcommittee and the Health and Human Services Subcommittee traveled to Washington to attend a series of meetings with individuals and associations to better understand the federal perspectives related to the funding of graduate medical education and potential Federal initiatives.

A data request has been developed requiring:

1) for each of the colleges of medicine- annual direct and full cost by fund source per undergraduate medical student; projected out year BBA impact,

2) for each of the colleges of medicine- annual direct and full cost by fund source for each medical resident; projected out year BBA impact,

3) for each of the community and teaching hospitals- annual cost per resident and source of funding; projected out year BBA impact,

4) for each of the teaching hospitals- the total revenue streams for the total hospital operations,

5) for each hospital- the Prospective Payment System(P.P.S.) operating margins and the total operating margins; projected out year BBA impact,

6) for each college of medicine- the 1998-99 expenditures by program activity(Ph.D. Graduate Instruction, M.D. Instruction, Graduate Medical Education Instruction, Other Instruction, Research, Public Service, Clinical Activity, Administration, and Facilities and Support),

7) for each faculty practice plan- beginning with 1996-97 and for a 5-year period, identification of the source of funds(self pay/other, Medicare, Medicaid, managed care, commercial insurance).

Senator Sullivan and staff attended the first meeting of the Graduate Medical Education Task Force on August 10, 1999. Staff will attend all future meetings. The task force report with recommendations will be submitted by November 1, 1999 as required in proviso language.

FINDINGS

The first phase of medical education begins with four years of medical school and ends with the awarding of the M.D. degree for an allopathic physician or D.O. degree for an osteopathic physician. The second phase, referred to as Graduate Medical Education(GME) begins upon completion of medical school when allopathic and osteopathic physicians enter residency training. GME is comprised of multi-year residency programs that typically range from three to seven years and occurs in hospitals and other clinical sites.

The rapid movement of the nation's health care system to managed care, increased competition, funding changes in the Medicare and Medicaid entitlement programs, and the shortage of physicians and other health professionals in rural and inner city communities are forcing a reassessment of how and where health professionals should be trained, the number and type to be trained , and how the training should be financed.

Physician Training is a "Public Good":

Quoting from the report, State Strategies for Financing Graduate Medical Education, published by the United Hospital Fund of New York, "the economic term 'public good' refers to a good or service that benefits the public at large and will not be produced at the appropriate level in the private market because of the difficulty in pricing it. The education of physicians serves the community at large, including the future patients of the future physicians and health care facilities, which need well-trained physicians. However, while the community at large benefits, there is no way to charge each of the future beneficiaries. It has been reported that training physicians can add 20% to 40% to the costs at a teaching hospital. It is also unlikely that insurers and managed care organizations in the competitive marketplace will voluntarily pay higher rates to cover their share of training future physicians. In addition, teaching hospitals treat a disproportionate number of uninsured patients, therefore, even if all insurers and purchasers paid a share of their own subscribers or enrollees, there would still be a funding gap at most hospitals".

Medical research and care for the indigent are two important "public goods" that Medicare has traditionally sought to support through graduate medical education and disproportionate share subsidies in markets where managed care dominates. Some policy analysts believe that if Medicare stops paying for public goods, senior citizens and other constituents could lose access to teaching hospitals and hospitals in their urban and rural communities.

"Most states and the Federal government have accepted the principle that GME is a public good worthy of public support, however, there is little consensus on how to operationalize this concept. There is no consensus on what constitutes reasonable costs of training physicians and how much of these costs are covered by patient fees negotiated between the payers/purchasers of care and training sites. The medical education system has not been particularly responsive to meeting community needs, such as increasing the supply of primary care physicians. This combined with the lack of consensus on reasonable costs, may reduce the willingness of elected officials to provide public dollars for GME."(Salsberg, State Strategies for Financing GME)

The Center for Health Workforce Studies, of the University at Albany, has identified the following physician workforce goals for consideration:

1. Mix of specialties consistent with State needs.
   - Increasing Primary Care Physicians
2. Distribution of physicians consistent with the population
   - More physicians in under-served rural and urban areas
3. Workforce prepared for tomorrow's health care needs
   - More ambulatory care and managed care
   - Multi-disciplinary workforce
4. A workforce reflective of the State's population
   - Racially and ethnically diverse
5. Public accountability
   - Return on State investment
   - In-state retention
6. Preservation of Academic Health Centers

Also identified are key questions related to potential new State funding for Graduate Medical Education:

1. Who pays for Graduate Medical Education?
2. Who should be eligible for funds?
3. What professions should be covered?
4. How to set payment levels?
5. Should funding be linked to performance?
6. How should funding be administered?
7. Who should advise the process?
8. Should there be a Medicaid Plan Amendment or Waiver?

It is reported that the Federal Government is divided

over how and at what level GME and care for indigent patients should be supported in a market-oriented health care system. The current conversations in Congress related to tax reductions, expansion of Medicare benefits to cover outpatient prescription drugs, and mandatory budget caps make it very unlikely that there will be substantial federal initiatives for GME funding reform this year. In addition; despite intense lobbying from the colleges of medicine, hospitals and medical associations; Congress does not seem inclined to enact large-scale reversals of payment cuts included in the 1997 Balanced Budget Act. It is anticipated that Congress may appropriate some level of funding for next year to reduce the level of planned funding reductions.

State policies and funding for GME are being discussed in states across the country. A number of innovative models have been developed. These are reflected in Exhibits I.- X.

Model initiatives contain the following elements:

1) A "carve out" of the direct and indirect costs of graduate medical education from the managed care rates paid to managed care organizations (MCO's) by Medicaid. This carve out is either paid directly to medical schools, teaching hospitals or placed into a fund for subsequent distribution to teaching programs.
2) A "carve out" of the direct and indirect medical education costs from the Medicaid fee-for-service payments and allocation directly to medical schools, hospitals, or into a central fund for subsequent allocation.
3) Establishment of a GME trust fund that pools Medicaid funds with other state-funded GME appropriations and possibly Medicare dollars. This approach provides for more public scrutiny, focuses attention on how the funds are used, and facilitates a link with state identified workforce needs.
4) Linking funding to certain expected outcomes. For example, the State may want to establish a goal of training 50% of the residents in primary care by a certain date or to provide incentives for physicians to practice in undeserved areas.
5) Provider-specific taxes to support graduate medical education.
6) Increased State General Revenue appropriations.

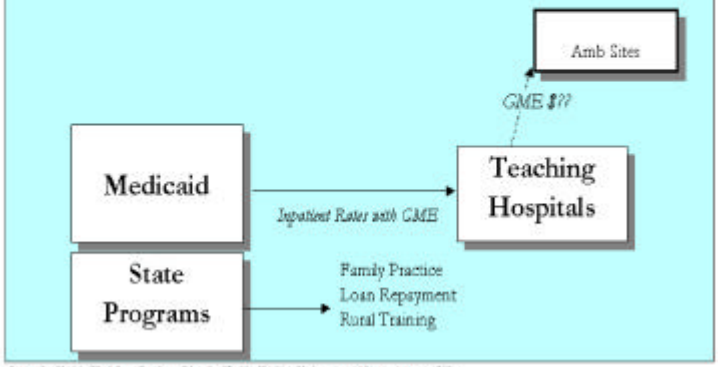
Currently, the Federal Government is the primary funding source for graduate medical education.

Major policy questions for the State relate to: If, when, and to what extent the State should begin to relieve the funding pressures caused as a result of Federal budget policy changes.

RECOMMENDATIONS

1. Prior to enactment of any new funding proposals at the State level, both the colleges of medicine and the hospitals should document all sources of funding that support graduate medical education and reflect the financial impact of the 1997 BBA by fund source, as well as managed care.
2. The colleges of medicine should develop commonly- defined methods for determining the per FTE costs for undergraduate and graduate medical education. The source of funding should also be identified and projected out year costs should be prepared.
3. The Hospitals should develop commonly-defined costs per medical resident. The source of funding should also be identified and projected out year costs should be prepared.
4. The hospitals and academic health centers should identify the price discounts given to private payers in response to competition.
5. Each of the hospitals should provide historical and projected information on their P.P.S. Inpatient and Total Operating Margins.
6. Each hospital, or site that provides residency training, should provide a history of the total headcount and FTE resident counts by type.
7. The Graduate Medical Education (GME) Task Force should prepare a 5-year historical and out year projected plan that reflects the anticipated number of residents to be trained by type. The plan should include comparable information for other states that reflects the number of residency FTE's per 100,000 population.
8. The GME Task Force should provide an inventory and description of all incentive programs funded by the state or other source to encourage physician manpower goals. This would include, but not be limited to:1) physicians practicing in inderserved areas of the state and 2) encouragement toward the goal of increasing primary care physicians.

Exh. I- TRADITIONAL STATE GME FINANCING MODEL



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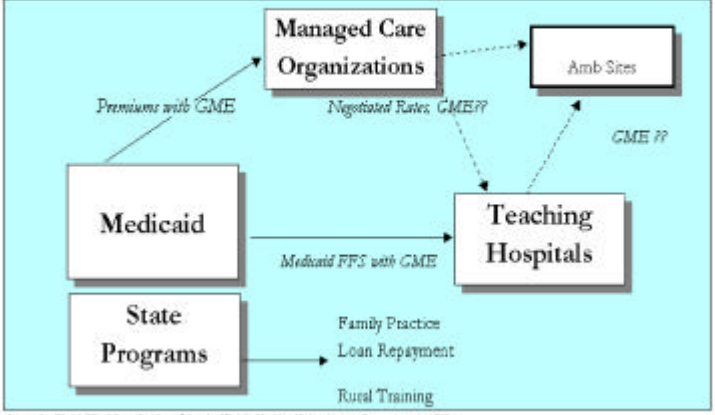
Exh II.- IMPACT OF THE EXPANSION OF MEDICAID MANAGED CARE



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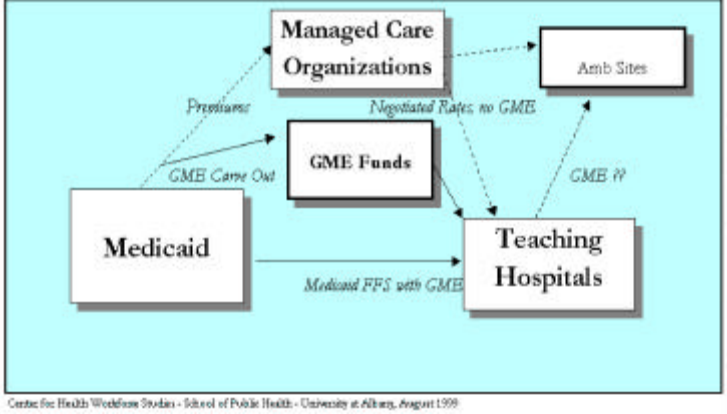
Exh III. - THE MEDICAID MANAGED CARE GME CARVE OUT THE BASIC MODEL



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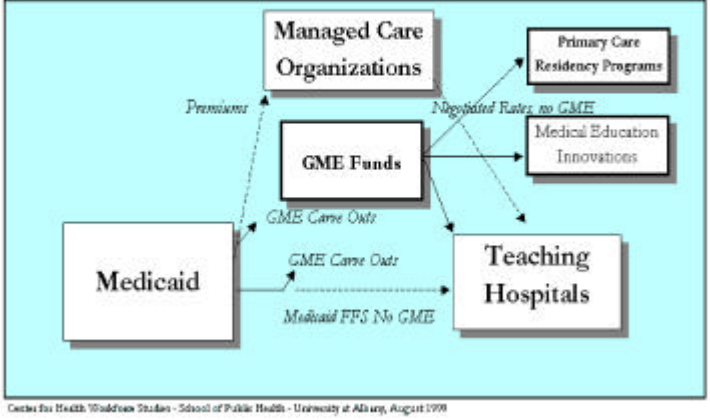
Exh. IV - State GME Financing Model 1: Michigan



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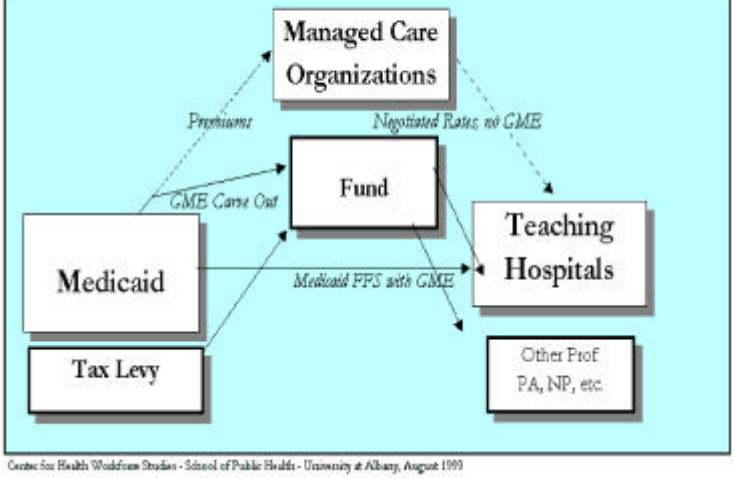
Exh. V. - State GME Financing Model 2: Minnesota



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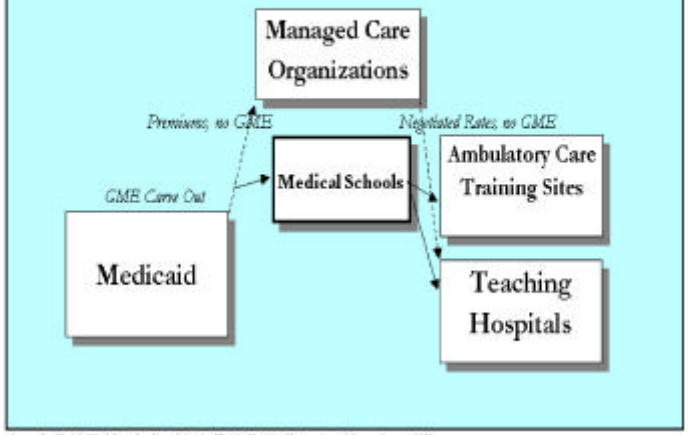
Exh. VI. - State GME Financing Model 3: Tennessee



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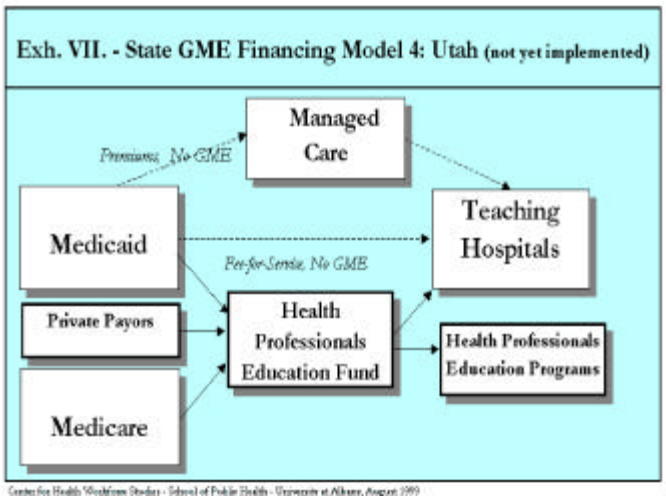

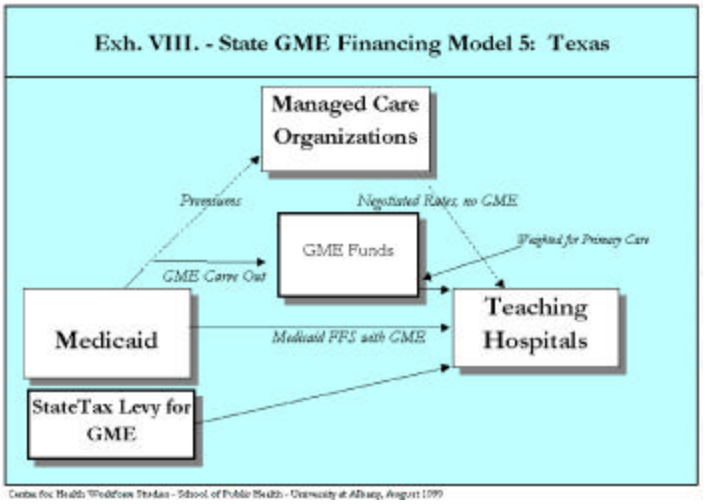

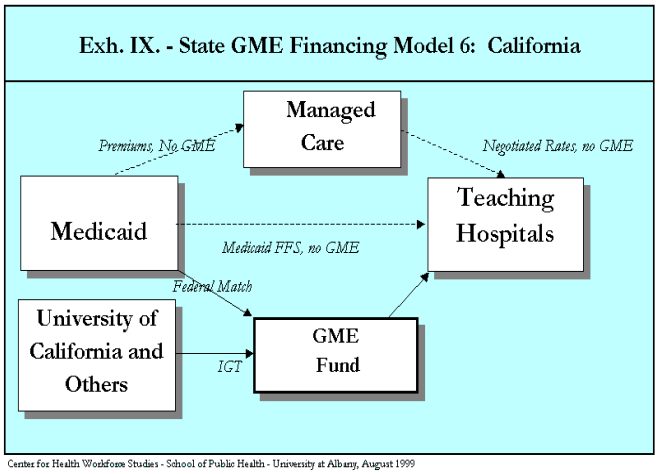

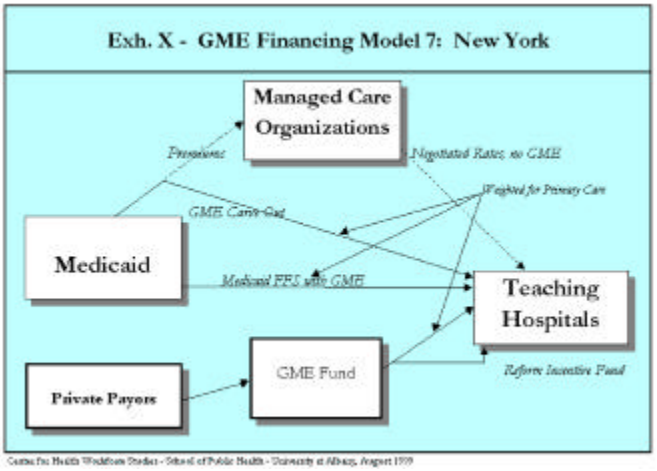

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
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Committee on Budget, Subcommittee on Health and Human Services
Committee on Fiscal Policy

MEMBER OVERSIGHT
Senators Donald C. Sullivan and Betty Holzendorf