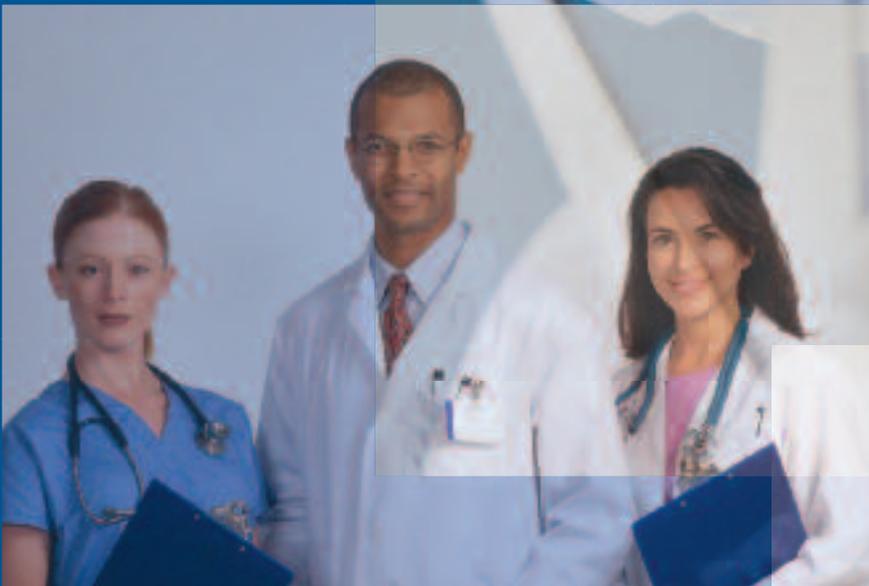


ANNUAL REPORT

on Graduate Medical Education in Florida



Submitted By The Graduate Medical Education Committee

In Response to the Provisions of Section 381.0403 (9), Florida Statutes

January 2008

The opinions expressed in this report are those of the Graduate Education Committee and do not necessarily reflect the opinions of the Florida Department of Health or its staff. The agency assumes no responsibility for any statements made in this report.

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PREFACE

Pursuant to Section 381.0403 (9), *Florida Statutes (F.S.)*, the Graduate Medical Education (GME) Committee, an 11-member workgroup appointed by the Governor, is responsible for preparing an annual report on the graduate medical education in Florida. This annual report is provided to the Governor, to the President of the Senate, and to the Speaker of the House of Representatives on January 15 of each year. The statute requires that the report must address the following:

- (a) The role of residents and medical faculty in the provision of health care;
- (b) The relationship of graduate medical education to the state's physician workforce;
- (c) The costs of training medical residents for hospitals, medical schools, and teaching hospitals, including all hospital medical affiliations and practice plans at all of the medical schools and municipalities;
- (d) The availability and adequacy of all sources of revenue to support graduate medical education and recommend alternative sources of funding for graduate medical education; and
- (e) The use of state and federally appropriated funds for graduate medical education by hospitals receiving such funds.



ACKNOWLEDGMENTS

The Department of Health would like to sincerely thank the Graduate Medical Education Committee and representatives who give so generously of their time and talents to ensure the continued success of graduate medical education in Florida. The Graduate Medical Education Committee members or their designees are:

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INTRODUCTION TO GRADUATE MEDICAL EDUCATION

WHAT IS GRADUATE MEDICAL EDUCATION?

Graduate Medical Education (GME) is the period of training following graduation from a medical school when physicians refine clinical skills and hands-on expertise necessary to practice in a specific medical field (surgery, dermatology, family practice, etc.). GME or “residency” programs for allopathic and osteopathic physicians include internships, residency training and fellowships, and can range from three to six years or more in length of time. The length of time from medical school through completion of a residency program is the “medical education pipeline.”

WHY IS GRADUATE MEDICAL EDUCATION IMPORTANT?

- GME training has a direct impact on the quality and adequacy of the state’s physician specialty and sub-specialty workforce and the geographic distribution of physicians. The support and expansion of residency programs in critical need areas could mean more specialists practicing in Florida.
- Residents are more likely to practice in the state where they completed their graduate medical education training than where they went to medical school. Quality and prestigious programs will attract the best students, who will stay as practicing physicians.
- Residents in graduate medical education programs act as “Safety Nets” to care for indigent, uninsured and underserved patients in the state.
- Physicians in Florida are the driving force to address access to care issues in the health care industry. Supporting residency programs helps ensure the continuation of the medical education pipeline and Florida’s ability to train and retain the caliber of medical doctors the state’s citizens and visitors deserve.

Florida continues to have top-ranked GME programs nationally, however, access to these programs for medical students is limited. Florida currently ranks 44th nationally in the number of residency positions per 100,000 population, 41st nationally in the number of medical school students per 100,000 population, and 16th in total physician per 100,000 population (American Association of Medical Colleges, 2006). Data is currently being collected on the geographic distribution and specialty mix of physicians to help policymakers determine areas of shortage and critical need.

There are 309 allopathic and osteopathic residency programs with more than 3,200 resident physicians in training in Florida (Accreditation Council of Graduate Medical Education and American Osteopathic Association, 2006).

Florida needs to add close to 3,000 new GME positions to meet the national average. Meeting that average is an important health access issue for a state that:

- Has the largest and fastest growing percentage of citizens over 65, who typically have their health care needs increase as age increases;
- Ranks 5th in the number of citizens who are uninsured;

- Has one of the oldest physician workforces in the nation, with 25 percent of physicians over the age of 65;
- Depends on physicians educated and trained in other states and countries because there are only a small number of residency positions available in Florida; and
- Has been impacted by medical malpractice and liability issues.

GRADUATE MEDICAL EDUCATION CAPACITY

Expanding residency positions is a key component of an increased physician workforce and access to care, however, several factors influence the ability to create new programs and residency positions within existing programs. Expansion depends upon:

- Availability of qualified faculty to supervise and teach;
- Ability to increase or reinvigorate incentives for physicians to remain in the state to practice through loan reimbursements, loan repayments and other programs, particularly in medically underserved areas;
- Commitments from hospitals to sponsor programs, which is influenced by the availability of federal and state funds; and
- Caps on the number of resident positions supported in programs. Under the Balanced Budget Act, any new residency positions in existing programs would have to find alternative sources of funding. Any new program would fall under the criteria defined in the Balanced Budget Act, and could be a viable option in Florida, particularly for smaller, rural hospitals that have not supported programs in the past.

GRADUATE MEDICAL EDUCATION FUNDING

Funding for GME programs comes from several sources. The specific costs identified that are related to medical education vary among individual residency programs. The largest source of funding for graduate medical education is the federal Medicare Program, which reimburses teaching hospitals for both the direct cost of operating the programs (Direct Medical Education or DME costs) and indirect costs (Indirect Medical Education costs or IME, often considered a surrogate for medically indigent care). Florida's Medicaid Program also provides funding to graduate medical education, although it is not as clearly defined as it is in the Medicare Program. As identified by the Council for Education Policy, Research and Improvement (CEPRI), Florida needs to find additional funds to improve and support GME (CEPRI, 2004).



RELATIONSHIP OF GRADUATE MEDICAL EDUCATION TO THE STATE'S PHYSICIAN WORKFORCE

THE IMPACT OF GRADUATE MEDICAL EDUCATION ON FLORIDA'S PHYSICIAN WORKFORCE

Recognizing the role residency programs play in providing health care to a largely underserved, underinsured community, and how physicians completing their residency training flow into the state, is a starting point in evaluating the state's physician workforce needs. Health care planners need to go one step further and evaluate the overall physician workforce in terms of geographic location and specialty mix. Understanding Florida's current physician workforce will help identify areas of growth and emphasize the role GME plays in fulfilling the need for physicians, specifically in critical specialty and primary care areas. Key workforce indicators include:

- Location of a physician's residency program is a better predictor of where the physician will practice than the location of his or her medical school. Nationally, approximately 55 percent of physicians ultimately practice in the state where they completed their residency training, with 68 percent of primary care physicians participating in the Community Hospital Education Program remaining in Florida after completing their residencies (American Association of Medical Colleges, 2005 and Community Hospital Education Program Destination Report, 2007) .
- Maintaining the quality of residency programs and developing expanded capacity of residency programs are explicit strategies that address the potential for an adequate physician workforce. These strategies can work in collaboration with expanding medical school enrollment.
- Assuring the most qualified physicians-in-training are rendering care by attracting top medical school graduates to Florida's quality residency programs.
- Having an inadequate number of residency positions in the state can result in a negative impact on access to health care, particularly for Florida's most vulnerable citizens.
- Serving Florida's citizens by having residency programs providing critical access to care, particularly primary care, and supplementing specialty care across the state. Relying on the net importation of doctors from other states and countries if Florida does not have an adequate number of residency programs to keep up with population growth and with numbers of medical school graduates.

PHYSICIAN WORKFORCE PROJECT AND GRADUATE MEDICAL EDUCATION

Landmark legislation passed in 2007 allows the Florida Department of Health (Department) and physician workforce stakeholders to focus on identifying and analyzing data that will directly contribute to shaping policy aimed at Florida's physician workforce. Chapter 2007-172, Laws of Florida, authorizes the Department to collect mandatory data on the geographic distribution and specialty mix of Florida's physicians as part of the Physician Licensure Renewal process. Questions on key specialty areas identified by the legislature, developed by a team of physician workforce stakeholders and the Department, were included as part of the renewal requirements. The Department is establishing an Ad Hoc Committee to address data analysis and policy recommendations on Florida's health practitioner workforce, and will be implementing administrative rulemaking to expand the capacity of the survey to collect pertinent information.

The Department will work with the Physician Workforce Ad Hoc Committee to develop a strategic plan that will assess the entire medical education pipeline, and will submit recommendations to state agencies and policymakers on physician workforce development. This long-term plan will use data from the physician workforce survey and analysis by Department staff and the Ad Hoc Committee. Understanding where, and in what specialty areas physicians practice, creates the baseline for each element of the strategic plan. Graduate Medical Education will focus on creating or expanding capacity in certain areas, like obstetrics or pediatrics, or in sub-specialties like neurosurgery. It also allows policymakers and educators to ask secondary questions aimed at recruitment and retention in certain specialty or sub-specialty areas.

ROLE OF RESIDENTS AND MEDICAL FACULTY IN THE PROVISION OF HEALTH CARE

GME is the process of comprehensive specialty training a medical school graduate undertakes to develop and refine skills. Residents work under the direct supervision of medical faculty, who provide guidance, training, and oversight, serving as role models to young physicians. Medical faculty provide the vital link between access to quality care and balancing the demands of educating and training residents. Physicians that assume this role are often juggling demands of patient care, teaching, research and policy and budgetary issues related to the programs they administer.

The American Association of Medical Colleges (AAMC) notes the importance of medical faculty vitality as essential to the sustained health of medical colleges, teaching hospitals and the overall infrastructure (AAMC, 2005). The AAMC supports increased salaries based on the contribution of faculty, medical faculty's capability, responsibility to the system and overall support of the community. AAMC 2005 data indicate that Florida has 2,949 full-time, allopathic medical school faculty for the 4 allopathic schools (AAMC, 2005). The American Association of Colleges of Osteopathic Medicine reports that there are 101 full-time osteopathic faculty in Florida.



THE ECONOMIC IMPACT OF GRADUATE MEDICAL EDUCATION

THE COSTS OF TRAINING MEDICAL RESIDENTS

Training medical residents involves education, research, and the provision and documentation of patient care. Traditionally, two categories of GME costs are reported: direct medical education (DME); and indirect medical education (IME). These costs are adjusted annually and are usually determined as the cost per resident. Direct costs vary widely by program and cannot be systematically tracked across programs, even for the six statutory teaching hospitals in Florida. The reported direct costs of teaching hospitals include resident costs, faculty cost attributions, and overhead costs, and vary greatly by the size of the program, as well as by geographic location. Some of the cost differential is due to a hospital's size in comparison to the size of its residency programs. Some hospitals share the resident costs with other facilities that participate in the residents' training, however, only a portion of the costs may be claimed. These costs, as reported in 1999, but not audited by a common reproducible methodology, ranged from \$39,554 to \$141,107 per resident physician.

Indirect costs can be even more variable as they more closely relate to a hospital's case mix. Patients in teaching hospitals tend to have more complex conditions that may require advanced testing and costly treatments not directly related to the direct costs of medical education, but rather the programs and case mix of the hospital. Teaching hospitals also usually have higher staff-to-patient ratios, conduct more research and have the additional task of educating young physicians, which may mean longer diagnostic exams, greater surgery times, or even longer inpatient hospitalization if not adjusted for acuity of care and risk. Calculating these factors into indirect costs is specific to each facility without a rigorously defined terminology and methodology and, in the same 1999 cost study, the numbers ranged from \$65,000 to \$154,000 per resident physician.

REVENUE SOURCES AND THE USE OF STATE AND FEDERALLY APPROPRIATED FUNDS

The two major sources of funding for graduate medical education are the federal Medicare program, which provides direct graduate medical education subsidies and indirect medical education adjustments, and Medicaid, which is a federal-state partnership.

The Medicare program uses a reimbursement formula based on hospital costs per resident, multiplied by the number of residents. The Direct Graduate Medical Education subsidy covers some salary and benefits for residents and faculty members, and teaching and overhead costs. The Indirect Medical Education payments are additional funds to cover higher inpatient care and are based on adjustments made to the Diagnosis-Related Groups (DRG) for which hospitals bill. It is difficult to assess Medicare payments made to Florida hospitals, however, the most recent available data indicate that, for only the six statutory teaching hospitals, direct graduate medical education and indirect medical education funding ranged from \$25,000 to \$125,000 per resident physician per year (AAMC, 2005). Most teaching hospitals have greater charity care costs and see a larger number of Medicaid patients than do non-teaching hospitals. Medicare DME and IME adjustments are only made for Medicare patients, so teaching hospitals with low Medicare volume receive very little GME reimbursement as compared to teaching hospitals with higher Medicare volumes.

Medicaid is currently the only other source of graduate medical education funding in Florida. While there is no statutory requirement that the state support graduate medical education through Medicaid payments, Florida includes graduate medical education costs in its base per diems as well as part of the Upper Payment Limit (UPL) program and usually as part of the Disproportionate Share (DSH) program. This funding relies heavily on intergovernmental fund transfers from local governments to match with federal dollars, which offsets general revenue in other parts of the state budget. These programs, approved by the Legislature and the federal government, allow for cost-based reimbursements derived from cost reports completed by hospitals. The DSH program has a ceiling for the total amount of inpatient and outpatient services for which reimbursement will be provided, and there are other county specific caps on reimbursements for specific procedures. The DSH program allows the public the benefit of a hold-harmless payment, or a “Safety Net” payment, but without specific graduate medical education accountability.

Reimbursement under the UPL program cannot exceed the cost of services provided to Medicaid and uninsured persons. Hospitals are usually reimbursed under Medicaid at a rate, which is calculated to be approximately 65 percent of their costs. This payment is based on the previous year's cost report. The payment relies on the Medicaid costs divided by the number of Medicaid days to calculate the rate. The Community Hospital Education Program hospitals and statutory teaching hospitals are eligible to be exempt from the lower rate; these hospitals are paid approximately 95 percent of their costs.

The Legislature approved the Florida Medicaid Reform Waiver in December 2005, and began enrollment in Broward and Duval Counties in September 2006. The reform includes key elements such as new options and choices for Medicaid eligible individuals, different financing, outreach efforts and the Low Income Pool (LIP). The Medicaid Reform Waiver, Low Income Pool, was established to ensure continued government support for the provision of health care services to Medicaid and underinsured populations. Under Medicaid Reform, the UPL program becomes the Lower Income Pool. Funding for LIP over the 5-year waiver period is \$1 billion per year for a total of \$5 billion. The LIP Council was created, per statute, to advise the Agency for Health Care Administration, the Governor and the Legislature on funding methodologies and the allocation of LIP funds.

The LIP Reimbursement and Funding Methodology was submitted to the Centers for Medicare and Medicaid Services in June 2006, defining the allocation and monitoring of funds. The allocation of funds is contingent upon local tax support for non-federal share and LIP funds will be distributed to hospitals serving a significant portion of Florida's Medicaid, underinsured and uninsured populations. These hospitals include “Safety Net” hospitals, pediatric hospitals, primary care hospitals, rural hospitals, and trauma hospitals. While the LIP Council discusses the funding of Community Hospital Education Program hospitals, and while there are plans to add additional categories for the allocation of funds, at this time the Community Hospital Education Program hospitals are still exempt from caps under UPL and remain outside LIP, with no impact to their current funding (Florida Medicaid Reform, 2006).

ALTERNATIVE SOURCES OF FUNDING

- Veterans Administration funding to the state's veterans medical centers in Miami, Tampa, Gainesville, and Bay Pines.
- The National Health Service Corps, as part of the Health Resources and Services Administration, offers individual assistance for residents and physicians in underserved or designated shortage areas after the completion of their training and hence, is not a direct contributor to defray the direct costs of graduate medical education in Florida's resident physician training programs. In fact, this program principally repays medical school tuition loans through a program of debt forgiveness.
- The Area Health Education Centers also support programs through the medical schools in Florida and in specific program activities the centers sponsor.
- Children's hospitals, which frequently have limited Medicare participation, have access to other designated funding streams through DSH funding that provides support for direct and indirect costs, although at a lower rate than the average per-resident Medicare payment.

Florida medical schools receive no specific funding for graduate medical education to support the internal costs incurred by sponsoring programs, such as faculty support for the time and effort spent in teaching resident physicians in the education portion of their training programs or additional support expenses, such as travel, books, journals, and administration. Medical schools may receive some support from teaching hospitals for faculty services not directly related to the graduate medical education programs. There are other contractual agreements that individual, but not all medical schools may participate in to help absorb or share these costs.

RECOMMENDED FUNDING SOURCES FOR GRADUATE MEDIAL EDUCATION INCLUDE:

- Supporting GME Stakeholders in asking the Legislature to fund a percentage of each new residency position;
- Exploring a "carve out" or amount calculated as representing DME and IME adjustments within Medicaid fee-for-service payments. In other states, formulas have been created to use this money as a support for existing GME programs, for primary care programs, and as grants for innovative proposals related to GME;
- Exploring the renewed funding to Florida's existing "Innovations" program defined in section 381.0403 (4), Florida Statutes;
- Exploring concepts like Utah's detailed demonstration project to address Medicare monies earned, yet unclaimed by teaching hospitals, and awarding them these funds;
- Tapping into managed care organizations in the form of capitated payment rates. Since graduate medical education costs are included in inpatient rates, the value of these could be "carved out" of managed care premiums and paid to teaching hospitals and medical schools for the allocated direct costs of programs. There are other incentives for this type of managed care carve out, one of which allows teaching hospitals to become competitive with non-teaching hospitals, because their costs for graduate medical education are now being paid for through this incentive. Utah, through carve out, has increased its state's federal match by \$5 million.

RECOMMENDATIONS

The Graduate Medical Education Committee has supported the continuous improvement of graduate medical education programs in the state, assuring quality and fiscal support for expanding existing programs, or creating new programs.

THE GME COMMITTEE'S RECOMMENDATIONS ARE:

1. Explore stable and recurring funding for Florida's residency programs.
2. Conduct a cost survey of residency programs to understand the economic impact and contributions these programs make at the local and state level.
3. Creation of a strategic plan to address the growth and funding of graduate medical education. This plan will include, but not be limited to:
 - Funding issues based on the real costs of graduate medical education;
 - Specifying positions and recommendations based on physician workforce data findings; and
 - Documenting the accountability and contribution of GME programs related to the care of citizens in Florida, the biomedical industry, research, translational studies and other areas or impact.



