

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 2009

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 graduate medical education in Florida. On January 15 of each year the Governor, the President of the Senate and the Speaker of the House of Representatives receives this annual report. 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.

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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 the clinical skills 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?

Graduate Medical Education is important because:

- 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, prestigious programs will attract the best students, who will stay as practicing physicians.
- Residents act as “Safety Nets” to care for indigent, uninsured and underserved patients in the state.
- 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.
- Strategic planning for the expanded capacity of GME programs is crucial to Florida meeting its healthcare needs. The Department of Health (DOH), GME Committee and Physician Workforce stakeholders are following trends that include gender differences by specialty mix and location, age of physicians by specialty, and projected changes in scopes of practice by specialty and location. These data indicate:
 - Female physicians are more likely to practice in populous counties;
 - Physicians who attend medical school in Florida are more likely to do their residency in Florida; and
 - There is a relationship between the location of medical schools attended (in-state vs. out-of-state) and whether or not they are in a solo practice.

Graduate Medical Education in Florida

Florida continues to have top-ranked GME programs nationally; however, access to these programs for medical students is limited. Florida currently ranks (American Association of Medical Colleges, 2007):

- Forty-third nationally in the number of ACGME-accredited residency positions per 100,000 population;
- Seventh in active physicians who graduated from a medical or osteopathic school in the state and completed GME in the state, who are active in the state;

- Thirty-sixth nationally in the number of medical school students enrolled per 100,000 population; and
- Twentieth in total physicians per 100,000 population

There are 318 allopathic and osteopathic internship and residency programs, with more than 3,100 resident physicians in training in Florida (Accreditation Council of Graduate Medical Education and American Osteopathic Association, 2007).

Florida needs to add close to 3,000 new GME positions to meet the national average. Having an adequate number of residency programs 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;
- Ranks 4th in active physicians age 60 or older (AAMC, 2007), with 25 percent of physicians over the age of 65;
- Depends on physicians educated and trained in other states and countries, which makes up approximately two-thirds of the currently active physicians¹ because there are only a small number of residency positions available in Florida; and
- Has been impacted by medical malpractice, liability and reimbursement issues.

Graduate Medical Education Capacity

Expanding residency positions is a key component of 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 Balance Budget Act, any new residency positions in those 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 graduate medical education 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 these 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.

¹ Florida Department of Health. November 2008. *2008 Florida Physician Workforce Annual Report*.

Relationship of Graduate Medical Education to the State's Physician Workforce

The Impact of Graduate Medical Education on Florida's Physician Workforce

Active Florida Physicians

Information on active, licensed Florida physicians used in this report is primarily from the Department of Health's Division of Medical Quality Assurance (MQA) Physician Practitioner Profile coupled with 2008 Physician Workforce Survey data. The Practitioner Profile database includes information on a physician's education, qualifications, practice specialty and background. The 2008 Physician Workforce Survey was a series of questions incorporated into the 2008 Physician Licensure Renewal that assessed the geographic distribution and specialty mix of active licensed physicians in the State. These data are important in the evaluation of the current workforce and in planning for residency programs as a strategic method to address shortage areas.

Based on the 21,610 Florida allopathic and osteopathic physicians who responded to the 2008 Physician Workforce Survey (excluding those without a valid Florida license and those who indicated that they do not currently practice in Florida), 31% are 56 or older and over 64% are older than 46 years of age (see Figure 1). Sixty-seven percent of Florida physicians are white (Figure 2) and 77% are male (Figure 3).

Figure 1. Distribution of Physicians by Age

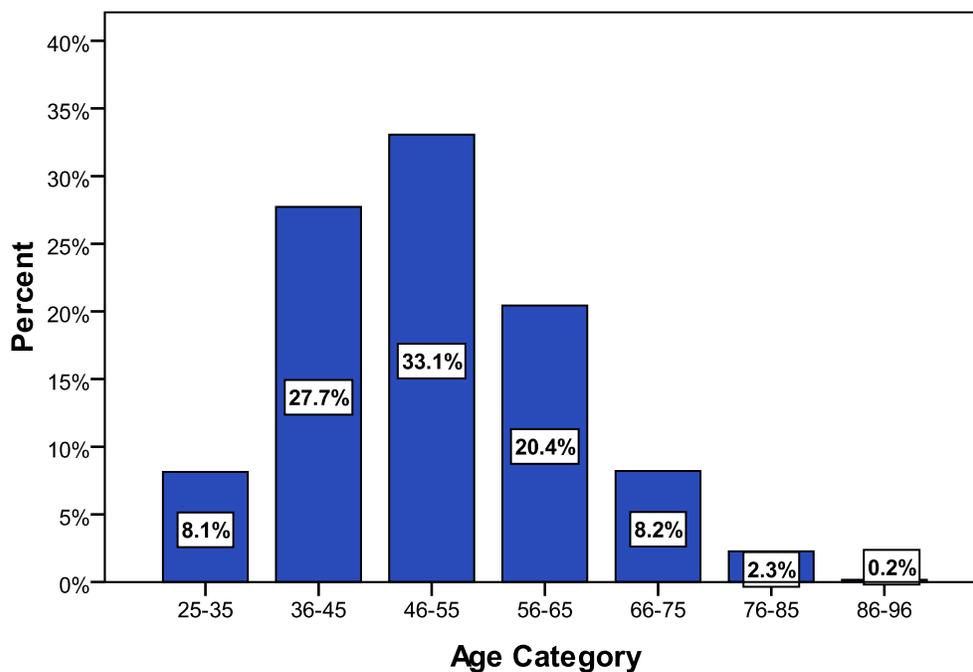


Figure 2. Distribution of Physicians by Race

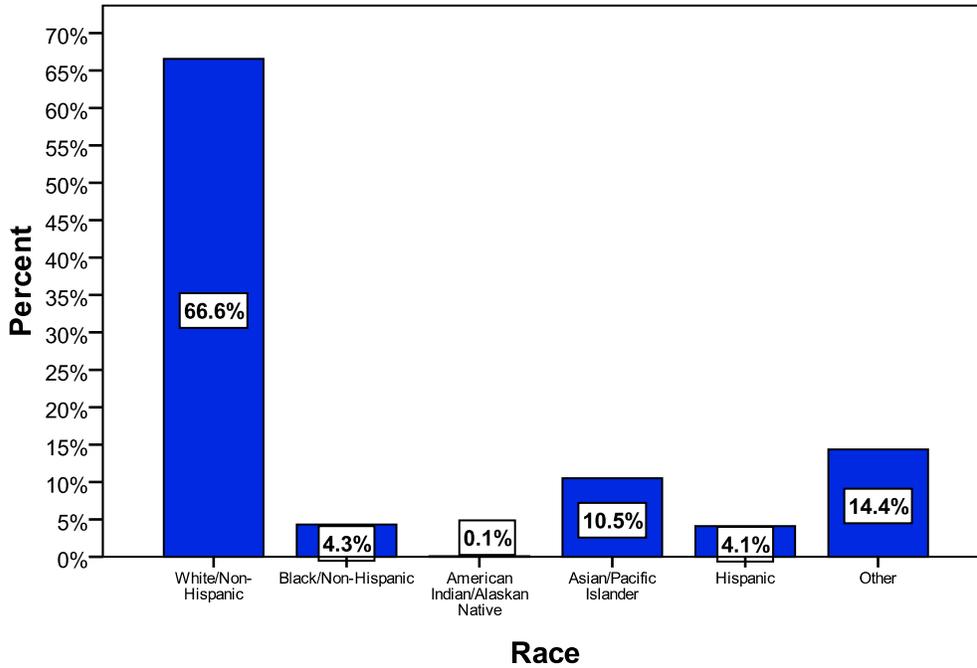
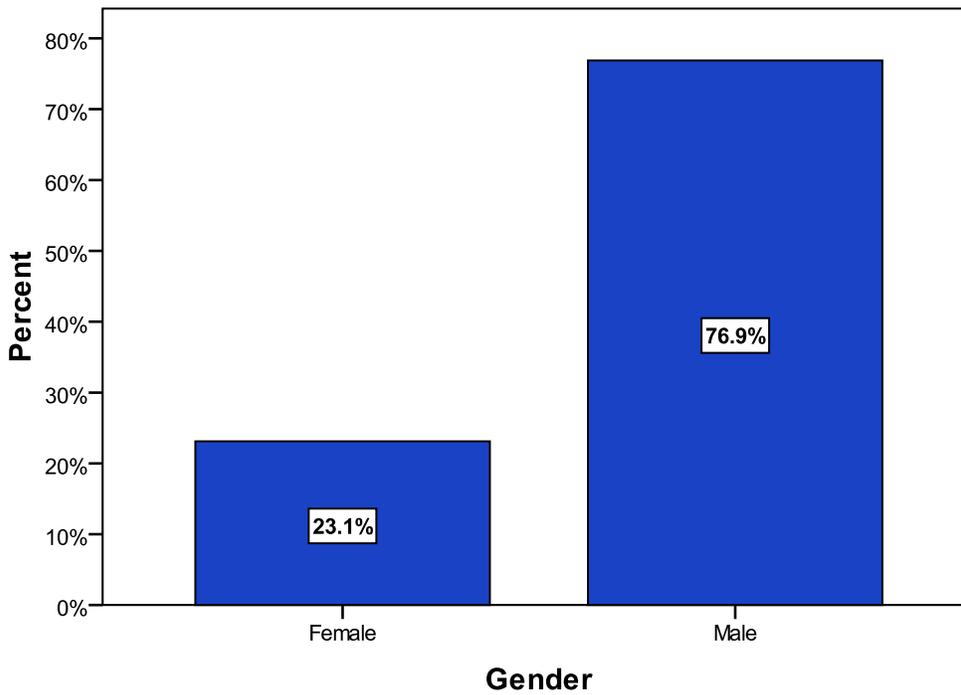
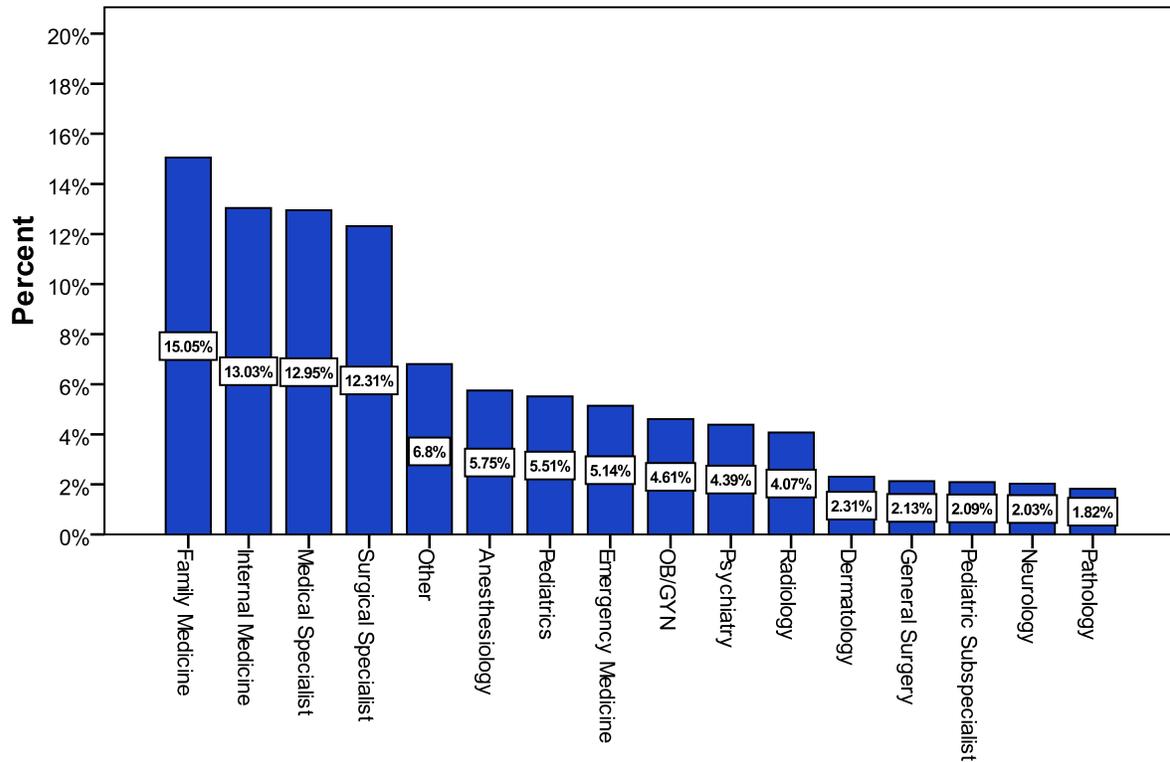


Figure 3. Distribution of Physicians by Gender



The top specialties indicated using the survey data were Family Medicine, Internal Medicine and Pediatrics (Figure 4).

Figure 4. Distribution of Physician Specialty



Using the Physician Workforce Survey and the Practitioner Profile data, the Department of Health and GME stakeholders can begin to evaluate the impact on Florida’s physician workforce and strategically plan ways to meet those identified needs. This mechanism includes not only the current numbers of physicians practicing, but also includes assessing the scopes of practice per specialty and projected changes in practice over time. For example, the GME stakeholders have anecdotally predicted a shortfall of Obstetricians in the state due to a number of indicators. The 2008 Physician Workforce Survey data indicates that of only 554 of obstetricians who deliver babies, over 14% of the survey respondents indicated that they would discontinue providing obstetric care in the next two year (see Figure 5).² Once the data mature, the Department will be able to project these numbers forward and indicate per 100,000 population

² The 554 physicians are based on those who indicated that they deliver babies. There are 833 physicians who indicated that they do not deliver babies. However, since physicians who provide obstetric services only are directed to response to the question, it can be argued that there are 1,387 obstetricians in the state.

the demand and supply of obstetricians. Based on the survey, there are 7.6 obstetricians per 100,000 populations in Florida.³

Figure 5. Are you planning to discontinue doing obstetric care for any reason, including retirement, in the next two years?

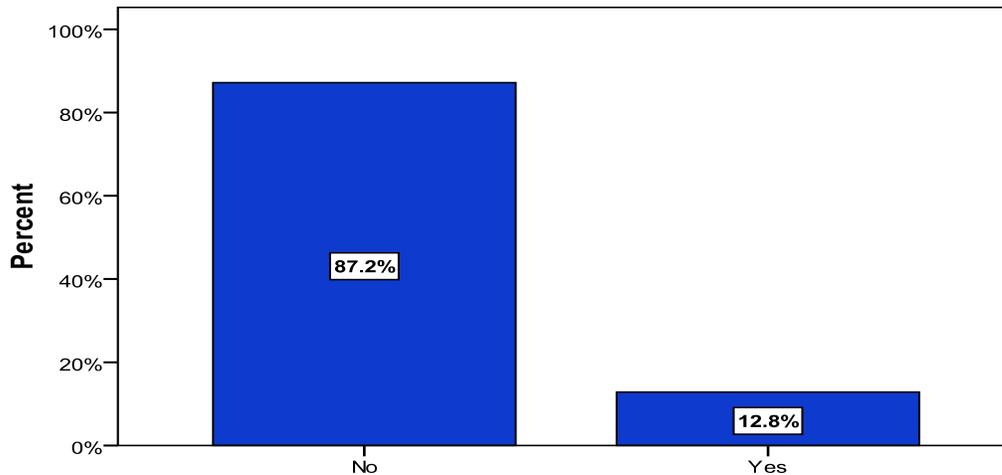
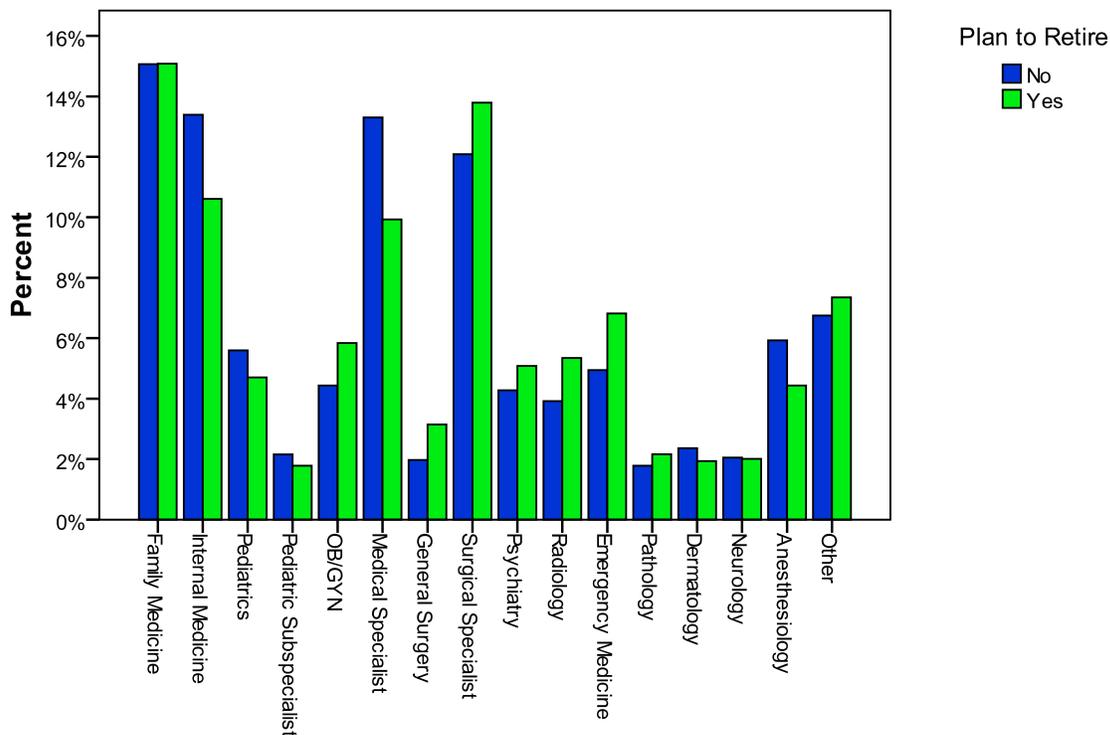


Figure 6 shows the percentage of physicians planning to retire, relocate, or significantly reduce the scope of their practice by all specialties. The figure shows that of those planning to reduce the scope of their practice (12.9%), family medicine (15.1%), surgical specialist (13.8%), internal medicine (10.6%), and medical specialist (9.9%) make up the top four specialties. When the percentages are broken out within each specialty, 19.1% of those in general surgery indicated that they are planning to reduce the scope of practice, followed by 16.9% in emergency medicine, 16.85 in radiology, 16.3% in OB/GYN, 15.2% in pathology, 14.9% in psychiatry, and 14.4% in surgical specialist (data not shown).

³ The survey included half of the currently active, licensed allopathic physicians and all osteopathic physicians. The numbers per 100,000 are projected to increase upon including all allopathic physicians, which will be available after 2009 Physician Workforce Survey report is released..

Figure 6. Do you plan to retire, relocate outside of the State of Florida, or significantly reduce the scope of your practice within the next five years?



The survey data, over time, will allow the Department to model and report on these changes by specialties and use additional questions and resources to help determine the cause of changes in scopes of practice, for example, in terms of retirement versus reimbursement or policy issues. This information will shape policy and funding decisions aimed at addressing the state’s physician workforce and healthcare needs focused on defined shortage areas. This includes the expansion and added capacity of Florida’s residency programs based on specialty shortages and may include additional incentives or innovative programs to attract interest in these areas, particularly primary care specialties like Family Practice, Obstetrics and neurology.

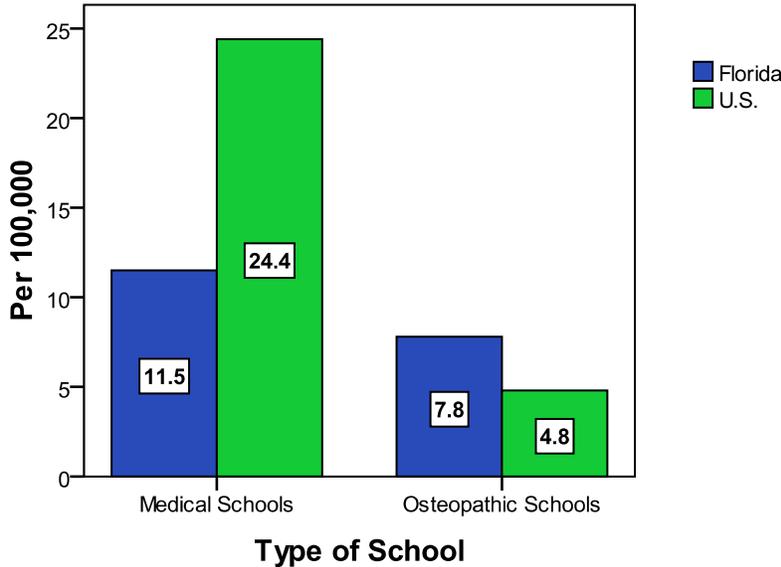
Florida Medical Schools and Residency Programs

The composition of Active, Licensed Florida physicians evaluated in the 2008 survey indicates that:

- Twenty-six percent (5,538) completed a Florida residency;
- Eighty-three percent (18,031) completed U.S. residency, with missing cases (2,956) included;
- Almost 3% (623) completed a residency in another country;
- Sixteen percent (3,404) went to a medical school in Florida;

- Eighty-two percent (17,659) went to either an out-of-state medical school or out-of-country medical school.

Figure 7. Students Enrolled in Medical or Osteopathic Schools for the 2007-2008 Academic Year Per 100,000 Population



In 2007-2008, Florida had 2,082 students enrolled in medical schools, while 1,403 students enrolled in osteopathic schools. Overall, Florida ranks 36th in total students enrolled in medical or osteopathic schools at 19.3 per 100,000 populations. While the number of medical students in medical schools was far below the national average, the number of students in osteopathic schools was approximately twice the rate of the U.S. at 7.8 compared to 4.8 for U.S (see Figure 7).⁴

In 2007-2008, Florida had 318 allopathic and osteopathic internship and residency programs, with more than 3,100 resident physicians in training in Florida. Florida residency programs are as diverse as physician specialties, but the Accreditation Council for Graduate Medical Education reports that the largest numbers of residents on duty in an allopathic program are:

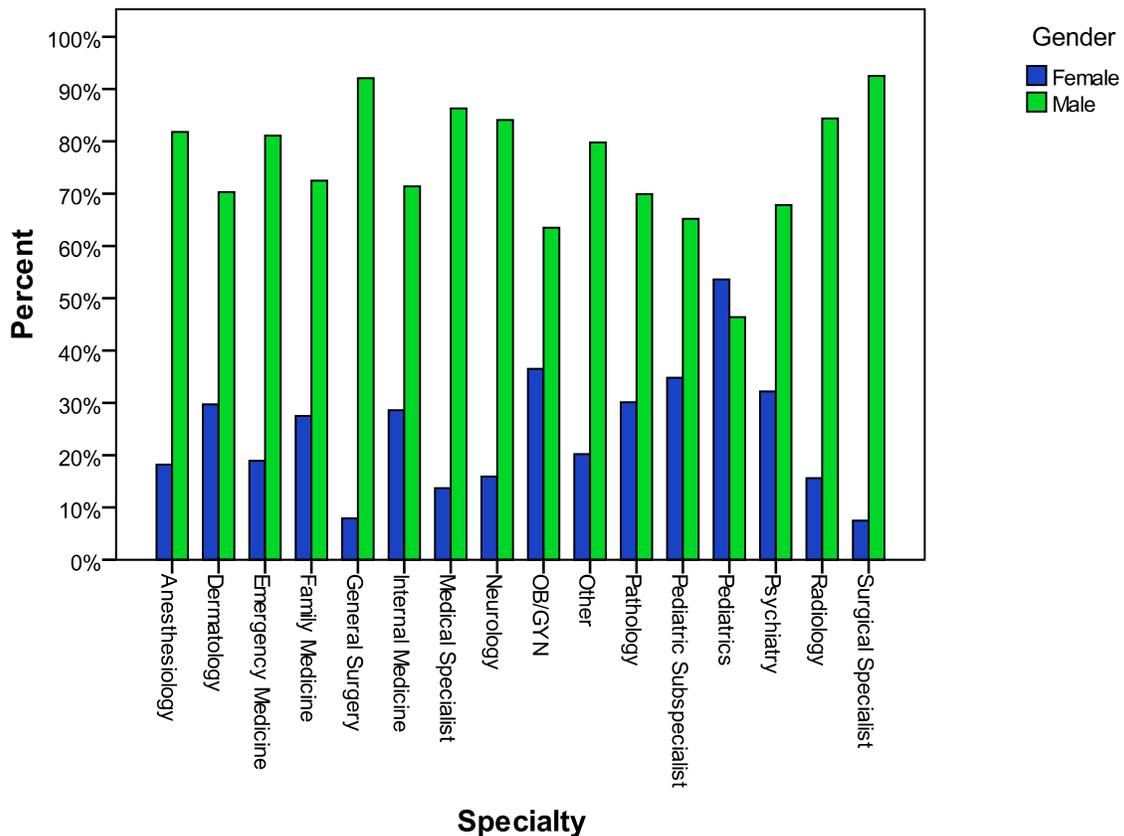
- Internal Medicine-456 residents on duty;
- Pediatrics-328 residents on duty ;
- Family Medicine- 321 residents on duty;
- Anesthesiology-214 residents on duty;
- Radiology-158 residents on duty;
- Obstetrics/Gynecology-147

Medical school application and enrollment trends are important for several reasons, particularly for the impact to the medical education pipeline. The Medical College Admission Test Scores, gender and age characteristics, and the location of the applicant’s undergraduate degree all assist policymakers and stakeholders in understanding the needs and strengths of Florida’s medical education system, including areas of pre-medical education. For example, as the gender of medical students shifts from largely male to female, what impact will this have on the

⁴ Source: July 1, 2006 Population Estimates, U.S. Census Bureau. Students enrolled in Medical school were obtained from the 2008 AAMC State Physician Workforce Data Book.

physician workforce in 7-10 years? What impact will shifts in gender or age have on residency programs in the state, particularly by specialty? As figure 8 shows, male physicians are dominant in almost all specialties. For example, male physicians were the overwhelming majority in medical specialist (86.3%), general surgery (92.1%), surgical specialist (92.5%), and radiology (84.4%). Male physicians were also the majority in family medicine (72.5%), internal medicine (71.4%), pediatric sub specialist (65.2%), OB/GYN (63.5%), and anesthesiology (81.8%). Physicians in pediatrics were the only ones that had the majority (53.6%).

Figure 8. Distribution of Specialty by Gender



Residency programs have additional sources of data to trend and analyze, aiding policymakers and stakeholders in making determinations about funding and structuring of programs in the state. The American Association of Medical Colleges surveys graduating medical students to determine what specialty areas they are interested in and in what locations around the country. This data, along with the National Residency Match Program data, can assist in understanding if Florida medical students are interested in residency programs in Florida. Coupled with the Physician Workforce Survey, state policymakers can focus resources to provide additional incentives or support for programs that strengthen access to healthcare in the state, particularly for vulnerable areas and populations.

Recognizing the role residency programs play in providing health care to a largely underserved, under-insured community is important. Health care planners and state policymakers need to evaluate the overall medical education pipeline in terms of geographic location and specialty mix to assure that access to care is a priority and that the expanded capacity of new programs is deliberate and focused based on fulfilling the need for physicians in critical specialty and primary care areas. Key indicators to consider for future planning include:

- Location of the 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.
- Maintaining the quality of residency programs and developing expanded capacity of residency programs are explicit strategies that address the potential for adequate physician workforce. These strategies can work in collaboration with expanding medical school enrollment.
- Assuring the most qualified physicians-in-training rendering care by attracting top medical school graduates to Florida's quality residency programs.
- The caliber of residency training also attracts physicians as faculty and mentors to the state, with the benefit of supporting research and biomedical technology.
- 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 is the alternative if Florida does not have an adequate number of residency programs to keep up with population growth in the state and with numbers of Florida medical school graduates.

Role of Residents and Medical Faculty in the Provision of Health Care

Graduate medical education 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 faculties 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 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, and medical faculty's capability, responsibility to the system and overall support of the community. AAMC 2205 data indicate that Florida has 2,949 full-time, allopathic medical school faculties for the four allopathic schools (AAMC, 2005). The American Association of Colleges of Osteopathic Medicine reports that there are 101 full-time osteopathic faculties 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 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 they vary greatly by the size of the program, as well as by geographic location. Some of the cost differential is due to the hospital's size in comparison to the size of their residency programs; and some hospitals share the resident costs with other facilities that participate in the residents' training, and 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 the costs more closely relate to a hospital's case mix. Patients in teaching hospitals tend to have more complex patient 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 and they 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 cost 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 (DGME) 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, and since Medicare DME and IME adjustments are only made for Medicare patients, teaching hospitals with low Medicare volume receive very little GME reimbursement as compared to teaching hospitals with higher Medicare volumes.

The Community Hospital Education Program (CHEP) is a statewide graduate medical education program supporting primary care residents and interns. The program provides health care access at the local level and ensures the continued supply of highly trained primary care physicians for Floridians. Current general revenue funding is \$14.5 million to the DOH. \$75,000 is statutorily directed to administration of the program and DOH transfers \$14,425,000 to AHCA to be deposited in the Medicaid Upper Payment Limit (UPL) Program. Utilizing the UPL program creates additional funding for the residency programs by allowing the sponsoring hospitals to receive an increased payment on each Medicaid claim. Current funding impacts:

- Approximately 65% of CHEP residents stay in Florida to practice or continue education. National retention rate is only 55%.
- CHEP serves over 61 primary care residency programs with over 1,400 residents and interns.
- Among the primary care residencies are emergency medicine, family practice, internal medicine, pediatrics, psychiatry, obstetrics/gynecology, and combined pediatrics and internal medicine.

CHEP funding is the only source of funding for Florida residency programs in the state other than Medicare support to hospitals. 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 CHEP 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 Florida Medicaid Reform legislation 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 allocation of LIP funds.

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 CHEP hospitals and while there are plans to add additional categories for the allocation of funds, at this time the CHEP hospitals are still exempt from caps under UPL and remain outside LIP, with no impact to their current funding (Florida Medicaid Reform, 2007).

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 though the medical schools in Florida and in specific program activities the centers sponsor.
- Children's hospitals, which frequently have limited Medicare participation, primarily related to chronic renal disease and certain other chronic diseases, such as cystic fibrosis, 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, 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 medical 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 may be another option. 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, 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:**
 - a. funding issues based on the real costs of graduate medical education,**
 - b. specific positions and recommendations based on physician workforce data findings; and**
 - c. the accountability and contribution of GME programs to the care of citizens in Florida, the biomedical industry, research, translational studies and other areas or impact.**