

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 2010

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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 does not assume 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 15th 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.

Acknowledgments

The Department of Health would like to 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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Executive Summary

This past year there has been national and state attention on healthcare issues, healthcare coverage and access to care. With the national policy focused on healthcare reform, Florida legislators Senator Bill Nelson and Representative Kathy Castor championed provisions within reform legislation that supports the growth of Graduate Medical Education (GME) as a logical and practical means to improve access to physicians and medical care. Allowing for additional positions for GME will allow for expanded care for indigent and underserved populations and could expand residency rotations into underserved areas of the state. This federal legislation is indicative of the importance of graduate medical education and its impact on the delivery of medical care nationally and in Florida.

In Florida attention to GME continued to gather momentum as groups like the Healthcare Practitioner Workforce Ad Hoc Committee, the Council of Florida Medical School Deans, The Florida Board of Governors and the Veterans Administration came together to focus on Florida's physician workforce and residency programs. These leadership groups are hoping to improve the overall physician workforce, focusing on areas of specialty and geographic need. The consensus of many of these groups, including the GME Committee, is that the best results for long term impact to the physician workforce is the expansion and added capacity of GME programs and positions. The Association of American Medical Colleges ranked Florida 43rd nationally in numbers of residents per 100,000 population, ahead of states like South Dakota, Wyoming and Alaska. GME stakeholders have increasingly pushed for additional residency positions in the state, but almost 2700 would be needed to pull Florida up to the national average per population. Florida currently has 346 residency programs and over 3,500 residency positions.

This situation is made much more complex by the methods of

funding for GME, both federally through Medicare, and as state funding as part of the Medicaid program. Medicare funding supports GME by reimbursing hospitals for both the direct and indirect costs of graduate medical education on a per Medicare patient basis. Medicaid recognizes GME costs in the calculation of Medicaid per diem rates as well as through discretionary funding under Medicaid's Disproportionate Share program. These funding streams are necessary to support the high level of residency programs offered in the state. Florida is also unique in that it has statutorily mandated direct GME funding through the Community Hospital Education Program. This program was created to support primary care residency programs and access to care for communities. It is funded through a general appropriation by the legislature each year, which is then put into the Medicaid program to draw down additional federal funding and dispersed to hospitals with participating programs, rather than to the residency program directly as was the initial intent of the legislation. Stakeholders and policymakers have explored changes to the CHEP funding as a means to improve accountability and to ensure compliance and transparency of the program.

The GME Committee recommends that it is a critical time to find additional funding for the strategic growth of residency positions and programs in Florida. This funding should include the ability for existing programs to innovatively expand capacity or the ability to create the opportunities to support resident work outside of the traditional hospital setting. Working in community clinics or underserved sites allows the resident the opportunity to further expand and refine clinical skills and expertise, while being exposed to working environments that may later become permanent placements, an opportunity that many community sites desperately need. This report attempts to succinctly address the main areas that impact graduate medical education, including the importance of GME in the provision of healthcare, the relationship between GME and the state's physician workforce, the costs associated with training a medical resident and the availability of funding for GME.

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Residency programs provide access to medical professionals for persons who are indigent, uninsured or underserved, and provide a significant contribution to the maintenance of their health and their care during illness. Residency programs also positively affect the quality, the specialty or sub-specialty mix of the physician workforce, and the geographic distribution of physician specialists in Florida. More importantly, residency programs are substantial contributors and determinants of the supply and diversity of the specialist physician workforce practicing in Florida. These applicants may ultimately remain in the state to establish practice and to contribute to their respective communities.

The mission of the Graduate Medical Education Committee is to enhance the accessibility, quality, and safety of medical care for all Floridians by maintaining, improving, and expanding graduate medical education training opportunities for physicians and training them in Florida upon graduation. The GME Committee promotes this mission by continuing its focus on funding issues, on establishing a quality database, and by educating stakeholders and policymakers regarding the need for strong residency programs in Florida's communities.

Introduction to Graduate Medical Education

What is 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.

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 result more primary care practitioners and specialists practicing in Florida.
- Medical 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.
- Medical residents act as "Safety Nets" to care for indigent, uninsured and underserved patients in the state.
- Supporting residency programs helps ensure Florida's ability to train and retain the caliber of medical doctors the state's citizens and visitors deserve.
- Ongoing strategic planning for the expanded capacity of GME programs is crucial to Florida meeting its healthcare needs and analyzing existing data can help policymakers plan for the strategic growth of residency programs. The Department of Health (DOH), GME Committee and Physician Workforce stakeholders are following trends that include gender differences, specialty mix and location of practice, age of physicians and projected changes in scopes of practice by specialty and location of practice. These data indicate:
 - Among the practicing physicians in Florida who responded to the survey (2008 and 2009):
 - Age: Only 5% were in the 24-35 age category, while more than 35% were 56 years or older.
 - Gender: 77% (n=29,078) were male.
 - Race: White (n=23,856, 65%), Hispanic (n=5,503, 15%),

Asians/Pacific Islander (n=4,091, 11%), Black (n=1,637, 4.5%), American Indian (n=42, .1%) and Other (n=1,613, 4.4%).

- Specialty Areas: Among the currently practicing physicians in Florida, the top five specialties were: Family Medicine (14.6%), Medical Specialist (14.2%), Surgical Specialist (13.4%), Internal Medicine (12.8%), and Anesthesiology (6.2%).
- Thirteen point two percent of the physicians from the 2009 survey indicated that they plan to retire in the next 5 years.

Graduate Medical Education in Florida

The Physician Workforce Initiative in Florida has continued its momentum since 2006, attempting to assess and develop the state's physician workforce. One of the major strategies discussed as part of the physician workforce development has stakeholders and policymakers focuses on graduate medical education. The recognition of a robust GME program as the central support to both the state's undergraduate medical education programs and to the continued practice of physicians in the state upon completion of a program has inspired stakeholders and policymakers to explore options to support and expand programs in Florida. Legislation has been enacted to support GME activities. These initiatives, however, have not been funded. These include the Florida's Health Service Corps, the Florida Minority Medical Education Program, and the Medical Education Reimbursement and Loan Repayment Programs. The Department of Health also is working with a leadership group including the Veterans Administration, Senator Durell Peaden, the Council of Florida Medical School Deans, and the National Florida Congressional Delegation in support of further state and national legislation that would promote leveraging funds for GME. The Department is in support of "Florida Cares", a program aimed at assessing physician competence and designing educational strategies for reentry into practice as well as interest in assessing retired physicians, particularly veterans, to retrain in order to practice. The Department is working with this leadership group and the Boards of Medicine and Osteopathic Medicine to determine if

there would be ways to facilitate the use of a limited license to practice in areas of critical need, allowing greater access to care for Floridians.

The Department also stands ready in support of the effort of the medical schools and the Veterans Administration to coordinate activities related to an effort to bring in Department of Health and Human Services stimulus dollars to Florida. There is in draft a joint proposal for the medical schools to provide GME opportunities to residents in underserved areas. Upon adoption of this proposal the Department will coordinate with contracted providers—the Area Health Education Center Network, the Federally Qualified Health Centers, the Department of Health clinics and others—to provide service to communities and opportunities for new physicians.

The Board of Governors of the State University System of Florida has also worked with the chair of the GME Committee and the State Surgeon General in support of GME programs in Florida. When the Board approved the two new medical schools in 2006, it recognized that medical schools were one component of a system of medical training, and the expansion of residency programs was a top priority for the state. In September 2009, the Board of Governors released its own report on GME Medical Residency Programs: A Report of the Board of Governors. The report contained information on the national and statewide numbers of GME and identified issues that could become recommendations on future board actions. The report included the following recommendations in brief:

1. Florida needs a multi-agency state and federal strategy to increase residency positions.
2. The medical schools at University of Central Florida and Florida International University need to report on their progress in establishing new residencies.
3. Further research needs to be done on physician workforce and

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existing Florida residency programs.

4. More information could be gathered regarding the extent to which financial incentives play a role in specialty selection and how to strategically plan for the growth of specifically needed residency programs to ensure that new positions will be filled.
5. The Community Hospital Education Program needs to be reviewed. Florida's only program dedicated to GME funding, the CHEP program has seen the fiscal ebb and flow of legislative funding. More importantly, what was at one time a transparent flow of CHEP funding to GME programs for the funding of medical resident education has become more opaque due to the commingling of those funds with other hospital reimbursements for purposes of being able to draw down greater numbers of federal dollars through Medicaid matching. For educational programs there has been a loss of transparency and accountability for the dollars intended for GME program destinations. Stakeholders would benefit from reviewing whether current policies and procedures are providing the best return on investment given Florida's current healthcare challenges.

A big benefit to GME in the past few years has been the total collaboration and collegiality of a multitude of stakeholders, all willing to come together to address the issues and create opportunities in Florida. The State Surgeon General and the Department have been able to work productively with legislators, other governmental agencies, the Council of Florida Medical School Deans and nongovernmental agencies. This has included conference calls with a leadership team, and most recently, the State Surgeon General was able to travel to Washington, D.C. with members of the leadership team and the Florida Board of Governors to offer the Department's support of national legislation that improves GME in Florida. Proposed legislation would expand GME positions and opportunities in Florida through the redistribution of unused residency positions and allowing time spent off site (out of hospital) to count toward Direct and Indirect Graduate Medical Education payments if

the hospital is incurring the costs of the resident during this time. The federal legislation also would explicitly include payments for the cost of GME activities, which occur outside the hospital as legitimate Medicaid payments. This item is of particular importance to the GME community, as congress has directed the Lewin Group to conduct a study that focuses in part on Medicaid GME payments. This study is addressed later in this Report, but it is important to note that among the number of activities in GME this past year, a new state appropriation was enacted for the express purpose of supporting innovative GME positions and programs under Medicaid.

Senate Appropriations Bill 2600 line 189 (Appendix A) allowed for the award of \$2 million dollars from the Medical Care Trust Fund and the Grants and Donations Trust Fund to be provided as payments to hospitals participating in graduate medical education initiatives, specifically to consortia engaged in developing new GME positions and programs. The Department has assisted the Agency for Healthcare Administration (AHCA) in drafting language for the requests for proposals for the new appropriation, and will continue to work in consultation with AHCA to award funding. In addition, the Department will coordinate with the Community Hospital Education Council to ensure that the council has reviewed all programs and positions and reported findings to the Executive Office of the Governor, the Chair of the Senate Policy and Steering Committee on Ways and Means and the Chair of the House Full Appropriations Council on General Government and Health Care. The hope of the GME committee and physician workforce stakeholders is that these funds will stimulate opportunities to innovatively fund GME in the state and create incentives for programs to expand and create new GME positions related to critical workforce needs

Florida is in an interesting situation relative to undergraduate and graduate medical education. The Association of American Medical Colleges (AAMC) 2009 State Physician Workforce Data Book ranks Florida 7th nationally in the retention of physicians who completed both

their undergraduate medical education and graduate medical education in the state (77.9%). When evaluated for only those active physicians that completed a GME program, Florida ranks 4th nationally (59%). Of concern though, is the additional statistic that Florida also ranks 31st nationally in having more undergraduate medical education slots than GME positions. For the 2007-2008 year, before the two new medical schools had their first full enrollments, Florida had 3,626 UME positions and 3,381 GME positions (AAMC, 2009) The AAMC also ranks Florida 43rd for having only 17.9 residents per 100,000 versus 35.7 residents nationally.

While Florida continues to have top-ranked GME programs nationally; policymakers, GME stakeholders and physician workforce planners have recognized on a national and state level, more attention needs to be paid to the strategic development of GME positions and programs. Florida has over 3,600 allopathic and osteopathic residency programs (including 370 positions dedicated to serving veterans and active military personnel). There are 346 allopathic and osteopathic training programs (Accreditation Council of Graduate Medical Education and American Osteopathic Association, 2009). Florida has over 1,700 slots in primary care (as defined per section 381.0403, Florida Statutes as family practice, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, emergency medicine and osteopathic internship), plus 190 general surgery and 25 geriatric medicine trainees (which are also included in the definition of primary care under federal legislation).

The State will almost have to double the number of resident positions to meet the national average ratio per 100,000 population as well as keep pace with the new and expanded medical school enrollment of medical schools in Florida. 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 fifth in the number of citizens who are uninsured;
- Ranks eighth in active physicians age 60 or older (AAMC, 2009), with 25 percent of physicians over the age of 65;
- Ranks third in the number of active physicians who are international medical graduates (AAMC, 2009), creating a dependency on physicians educated and trained in other states and countries; 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 are influenced by the availability of federal and state funds; and
- Federal reimbursement caps on the number of resident positions supported in programs. Under the Balanced Budget Act, any new residency positions in those existing programs must 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

There are many challenges for funding graduate medical education

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programs because of federal limitations instituted in the late 1990s as part of the Balanced Budget Act and because Medicaid funding for GME is not stable. Residency positions in Florida are paid for in part by Medicare, including Direct Graduate Medical Education and Indirect Graduate Medical Education payments. Medicaid also supports GME through per diem rates, which recognizes GME costs as well as through discretionary funding through the Medicaid Disproportionate Share program; both of which support GME programs and positions in hospitals. The only other source of funding that is intended to support primary care residency programs under section 381.0403; Florida Statutes is the Community Hospital Education Program. Though the funding for this program is an annual general appropriation, the amount of funding is transferred into the Medicaid program to draw down additional funding and is paid to the hospital rather than directly to the program as it once was. This past year there was an additional appropriation made, again into the Medicaid pool, to support the growth of new residency program and positions for \$2 million. To date, the funding has not been released, and the impact is undetermined.

In addition to Medicare and Medicaid funding, the statutory teaching hospitals and safety net hospitals with GME programs indicate they contributed in excess of \$250 million for the education of training of medical residents in 2008. The average cost to train a medical resident for one year is generally reported to be around \$200,000 according to the most recent cost reports for Florida's Safety Net teaching hospitals and reporting by the Association of American Medical Colleges which was set in 1984 by the hospital and updated for inflation yearly (AAMC, 2009). This includes the hospital's direct costs of resident and faculty salary and benefits and the indirect costs of overhead; this does not include the costs associated with and particular to the sponsoring medical school.

Hospitals are reimbursed for a portion of these costs based upon the number of residents they had in 1997, at which time funding was and remains frozen. Federal reimbursement under Medicare averages

\$80,000 per resident per year. GME costs embedded in Medicaid per diem and Medicaid GME Disproportionate Share payments account for another \$29,000 in reimbursement per resident. The un-reimbursed cost to a sponsoring hospital for each resident present prior to 1997 is \$91,000, while the un-reimbursed cost of residents added after 1997 is \$171,000 per resident. The state's six safety net teaching hospitals have added over 280 allopathic residents since 1997

As capitated managed care grows in Florida, direct GME-related payments will be forfeited. Over \$28 million in GME-related payments are embedded in the teaching hospitals' fee-for-service per diem payments; these costs are also embedded in the HMO capitated payments. Often times Medicaid HMOs are not willing to pay teaching hospitals their per diem rates. The same is true for faculty physicians who are paid a supplemental amount—the difference being that the supplemental physician payments are not included in the calculation of Medicaid HMO rates.

Support for GME makes good economic sense. Data provided by the American Academy of Family Physicians demonstrates the annual economic impact for each family physician is over \$940,000 (2009). GME funding sources should be stable over time, because the investment in programs is significant and getting new programs and positions accredited takes time, typically 2-3 years for established teaching hospitals. Year by year appropriations statewide may not offer sponsoring programs the security needed to recruit residents to Florida. Without the ability to recruit the top medical school graduates into residency programs, the programs reputation and standing could suffer. Since a physician is more likely to practice nearer residency location than medical school location, the long term impact to the state's physician workforce becomes apparent. There should be options developed for recurring funding to support programs or positions directly, thus supporting the overall state's physician workforce and access to care.

The GME Committee, the Department of Health and the Physician

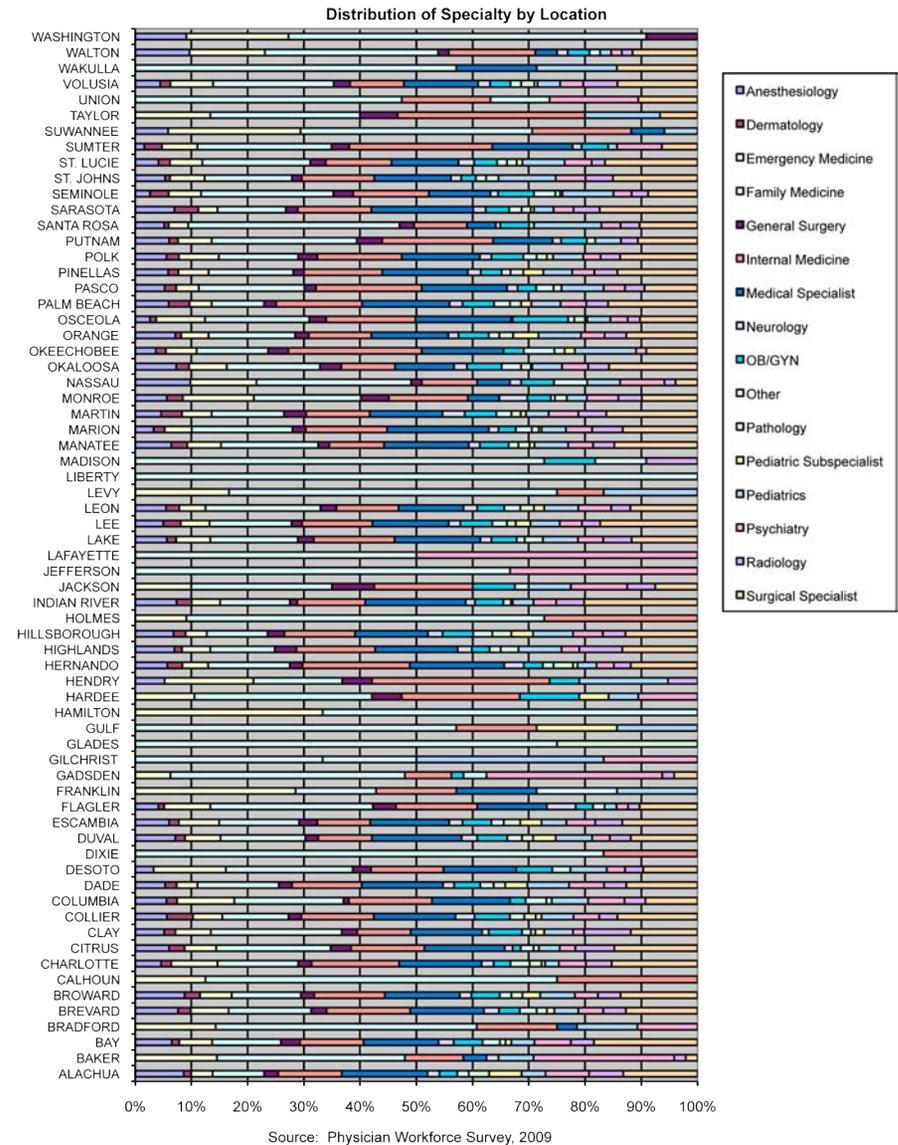
Workforce Ad Hoc Committee support the focus on funding for GME as a critical factor in Florida's physician workforce development and continued ability to provide quality care. Support for the strategic expansion of residency capacity in the state will help meet healthcare needs, and could include the funding of positions and programs and funding for innovations in training for community and ambulatory settings. Concepts in funding including:

- Incentives that would encourage residents to practice in identified areas of specialty or geographic need
- Collaborative work with in-state and, where possible, out-of-state consortia that would encourage cost-sharing and educational support of new and expanded residency programs; and
- The support for the ongoing and critical work of stakeholders in Florida dedicated to meeting the state's healthcare needs, but also contributing to a successful federal partnership that would support and target the needs of graduate medical education.

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

As identified by the Healthcare Practitioner Ad Hoc Committee, the Graduate Medical Education Committee, the Board of Governors, the Council of Florida Medical School Deans, the Department of Health and other governmental and nongovernmental stakeholders, the role of GME to the state's workforce is influential and critical to the overall development of a robust and appropriate specialty mix. The expansion



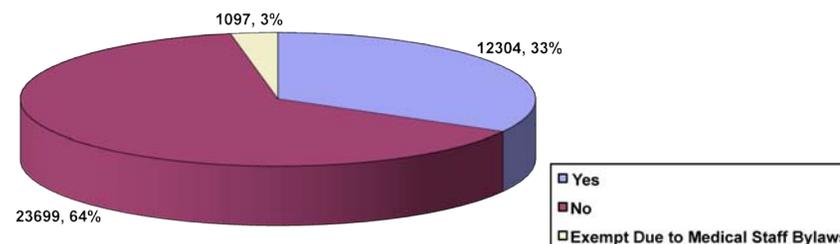
of GME efforts is one of the top priorities of the Healthcare Practitioner Ad Hoc Committee in its recommendations to the State Surgeon General, the Governor and the Legislature. Recommendations center on

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the ability to fund innovative training mechanisms that encourage the maintenance, growth and expansion of programs as well as encourage the development of consortia with DOH Clinics, Federally Qualified Health Centers, Veterans' Administration Clinics and other entities to encourage rotations and resident experiences outside of a hospital setting. The Healthcare Practitioner Ad Hoc Committee also supports the strategic development of GME in Florida to encourage growth in areas of specialty and geographic need.

The importance of planning in GME starts with an understanding of what Florida's current, active physician workforce looks like. Data taken from the 2008 and 2009 combined Physician Workforce Surveys represents all active physicians in Florida completing the survey (99%) who indicated they practice in the state at some time during the year and have an active, valid practice address. The following statistics are from survey results and include over 56,000 responding physicians, 91% are allopathic physicians (MDs) and 9% are osteopathic physicians.

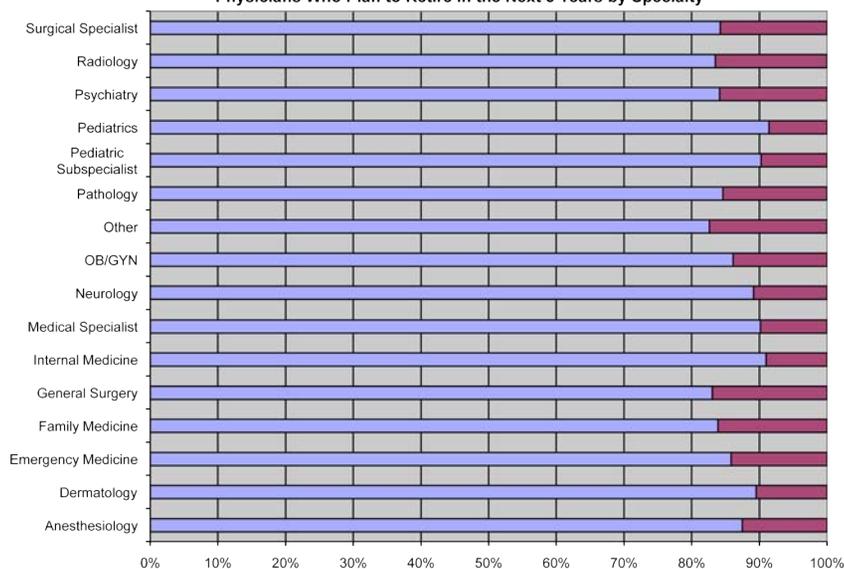
Physicians Who Take Emergency Call or Work Clinically in a Hospital Emergency Department



Source: Physician Workforce Survey (2008 & 2009)

- Only 74% indicated that they practice at any time during the year in Florida
- Of survey respondents, 77% or respondents are male, 65% are white and over 36% were older than 55 years of age.
- Over 13% of respondents planned to retire in the next 5 years.
- Ranking of primary specialty area as indicated by provider includes:
 - Family medicine 14.5%
 - Medical Specialist 14%
 - Surgical Specialist 13%
 - Internal Medicine 12.5%
 - Anesthesiology 6%
 - Pediatrics 5.8%
 - Emergency Medicine 5%
 - Psychiatry 4.7%
 - Radiology 4.7%
 - OB/GYN 4.7%
- Among those indicating OB/GYN was their primary specialty, only 49% said they deliver babies.
- Of those delivering babies, 12% said they would discontinue care in the next two years.

Physicians Who Plan to Retire in the Next 5 Years by Specialty



Source: Physician Workforce Survey, 2009

The Physician Workforce Survey data is also an important source of

information for planning the expansion and growth of Graduate Medical Education programs because policymakers and stakeholders can start to look at trend data related to changes in practice, emergency department coverage and primary care coverage.

Florida Medical Schools and Residency Programs

A critical factor in the medical education pipeline in Florida is ensuring that there is an adequate number of first year residency, or PGY1 positions for medical school students graduating from Florida's medical schools. Florida is at the precipice of having more graduating medical students than first year positions (Council of Florida Medical School Deans, 2009). This issue is compounded by the fact that many medical students are seeking residency programs in specialty areas other than in primary care. GME and physician workforce stakeholders, including the Council of Florida Medical School Deans and the Florida Board of Governors, are watching trends and exploring opportunities to ensure that GME growth is steady and strategically planned to meet both the medical students, the medical institutions and the state's needs.

The composition of Active, Licensed Florida physicians evaluated in the 2008 and 2009 Physician Workforce Surveys and documented in the 2009 Physician Workforce Annual Report indicate that:

- Twenty-six percent completed a Florida residency;
- Eighty-three percent completed U.S. residency, with missing cases included;
- Almost 3% completed a residency in another country;
- Thirty-five point two percent are International Medical Graduates
- Sixteen percent went to a medical school in Florida;
- Eighty-two percent went to either an out-of-state medical school or out-of-country medical school.

The 2009 AAMC data shows that Florida had 2,195 students enrolled in allopathic medical schools, and 1,557 students enrolled in osteopathic

schools. Overall, Florida ranks 36th in total students enrolled in medical or osteopathic schools at 20.5 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.

In 2008-2009, Florida has 3,285 residents and fellows on duty in Accreditation Council for Graduate Medical Education (allopathic) positions with an additional 315 osteopathic positions. These positions include 370 residents dedicated to serving veterans and active military personnel. There are 346 allopathic and osteopathic training programs (Accreditation Council of Graduate Medical Education and American Osteopathic Association, 2009). Florida has over 1,700 slots in primary care (as defined per section 381.0403, Florida Statutes as family practice, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, emergency medicine and osteopathic internship), plus 190 general surgery and 25 geriatric medicine trainees. Florida ranks 10th in the U.S. in terms of the number of sponsoring institutions, and 9th in terms of the total number of programs (Board of Governors, 2009), but Florida ranks 43rd nationally in the number of residency positions per 100,000 population, above states like South Dakota, Nevada, and Mississippi. The conventional wisdom is that Florida needs another 2,700 residencies to meet the national average.

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

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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, the period from high school math and sciences through residency, 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 are 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.
- The state will have to accept the net import of doctors from other states and countries should policymakers fail to address the short

supply of residency programs compared to population growth and in-state production of new doctors.

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. The vast majority of this care takes place in large teaching hospitals which serve as "safety nets" to many indigent and underserved patients who otherwise might not receive help. Resident training, including the supervision component, is an important part of assuring access to care by residents and in training future medical doctors to render appropriate and quality care. 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 notes the importance of medical faculty vitality as essential to the sustained health of medical colleges, teaching hospitals and the overall infrastructure (AAMC, 2007). 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 2007 data indicate that Florida has 2,949 full-time, allopathic medical school faculty members for the four allopathic schools (AAMC, 2005). The American Association of Colleges of Osteopathic Medicine reports that there are 101 full-time osteopathic faculty members in Florida.

As Florida has the eighth oldest physician workforce nationally (AAMC, 2009), so to does age present a concern in recruiting and

retaining faculty members to Florida's medical schools. Faculty member satisfaction and influence is a profound variable in both training and recruiting students to practice in the state and faculty influence is a contributor to the specialty choice of medical students and residents. As medical school enrollment increases in Florida, so to does the demand for quality faculty members. This will be an important issue to both the overall quality of undergraduate and graduate medical education and an impact to the provision of health care 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 audited costs, as reported by the Statutory Teaching Hospitals 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. For instance, IME costs at Florida's statutory teaching hospitals in the 2008 cost reports 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. For Florida's 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.

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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 \$13.75 million to the Agency for Health Care Administration. \$75,000 is statutorily directed to administration of the program and DOH transfers the remainder to the Agency for Health Care Administration to be deposited in the Medicaid Low Income Pool (LIP) Program. Utilizing the LIP 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 direct source of funding for Florida residency programs in the state other than Medicare and Medicaid support to hospitals. The discussion surrounding CHEP payments involves the loss of transparency and accountability that the program once had when payments were made directly to the residency program rather than being paid to the hospital as part of the Medicaid disbursement. While many program directors understand and value the importance of drawing down additional federal dollars, and made comment to the Lewin Group in response to a federal evaluation of GME Medicaid payments that eliminating discretionary Medicaid funding for GME would decimate the ability of the teaching hospitals to provide quality residency programs (Lewin Report, 2009), the CHEP funding is unique. CHEP funding has had a stable history and with that history there could be an opportunity

to target the enhancement or growth for specific innovations in residency programs in the state.

While there is no other 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 LIP program and part of the Medicaid Disproportionate Share (DSH) program. This funding relies heavily on intergovernmental fund transfers from local governments to match with federal dollars, which offset 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, GME costs are included and therefore embedded in a teaching hospital's per diem rates. 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. The Department continues monitors participation in CHEP programs; however, there are no longer penalties or rewards for decreases or increases in CHEP participation. Under Medicaid, a hospital must only meet the minimum CHEP requirements to receive enhanced Medicaid reimbursement.

LIP Reimbursement and Funding Methodology was submitted to the Centers for Medicare and Medicaid Services (CMS) 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, children's hospitals, primary care hospitals, rural hospitals, and trauma center hospitals. The LIP Council recognizes the value of CHEP hospitals and has consistently recommended that CHEP hospitals receive the full benefit of rate rebasing, which has assured greater reimbursement for GME costs (Florida Medicaid Reform, 2007).

On May 23, 2007, CMS proposed new regulations related to the costs associated with GME programs to qualified providers. The change in the regulation would have eliminated all federal payments to state Medicaid programs for the costs of DGME and IME because they would no longer have been considered authorized medical assistance expenditures. It would have also removed Medicare DGME payments from the calculation of Medicaid Upper Payment Limits for both teaching and non-teaching private, state government operated and non-state government operated facilities. As mentioned earlier, Congress delayed implementing the new regulation and asked for an independent impact study, conducted by the Lewin Group (Appendix C).

Florida has cooperated fully with the study, working with the Agency for Health Care Administration, the Department of Health and with GME Stakeholders, including the Statutory Teaching Hospitals. The Lewin Group conducted interviews and collected data on Medicaid payments, and also allowed Florida the opportunity to submit an impact statement on how the elimination of the federal share of state Medicaid GME payments would essentially decimate the infrastructure to resident training in Florida and thus, impact access to health care to many Floridians.

The Secretary of the Department of Health and Human Services has had concerns that are common for states, and have been discussed by Florida stakeholders related to the lack of payment transparency and ability to track GME payments to specific GME expenditures, this in part because GME funding is embedded in reimbursement mechanisms that cannot be uniquely tracked. For instance, it is impossible to track the GME costs embedded in a per diem Medicaid rate with the GME costs associated with providing care to specific patient. In addition, payments not related to improving services or access for Medicaid beneficiaries has been cited as a concern, as well as lack of evidence that Medicaid GME payments benefit training programs. Apparent to Florida GME

stakeholders is the benefit that these payments absolutely have on patient care and residency training; these payments have allowed hospitals to maintain and expand residency programs and positions.

The GME Committee, the Statutory Teaching Hospitals, the Council of Florida Medical School Deans, the Healthcare Practitioner Ad Hoc Committee and many other governmental and non governmental stakeholders are actively tracking the Lewin Group Study and actions by the federal government. It is certain that through collaboration and continued communication the state will be able to provide additional information and options on a national level to try to protect GME in Florida and access to care for Floridians.

Alternative Sources of Funding

Continued and growing GME funding is an important factor in ensuring the ongoing success of state residency programs and the quality access to care for those in need. While federal sources of funding through Medicare and Medicaid have identifiable issues, there are other alternative sources that support GME in Florida.

- Veterans Administration funding to the state's veterans medical centers in Miami, Tampa, Gainesville, and Bay Pines. There are over 370 residency positions dedicated to the VA, and the VA has emerged at the forefront of exploring opportunities to further residency training and the retraining of retired physicians to support the physician workforce in Florida. Working with the VA has become an important collaborative effort and option to share costs and resources while meeting healthcare and professional needs in the state.
- 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

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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 (AHEC) also support the rotation of residents through underserved and rural areas, often exposing residents to a new opportunity to practice outside of the traditional hospital setting. The AHEC Network in Florida also utilizes resources to recruit underserved and minority populations into the medical field and works to recruit and retain physicians in rural and underserved areas. .
- 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 a distinct federally funded children's hospital GME program as well as Medicaid DSH funding that provides support for direct and indirect costs, although at a lower rate than the average per-resident Medicare payment.
- Statutory Teaching hospitals and safety net hospitals with GME programs report contributions in excess of \$250 million for the education and training of medical residents in 2008.
- State appropriations have allowed for additional funding to build consortia that could offer a variety of training opportunities and cost/resource sharing between members. It is an important and innovative strategy in meeting Florida's needs.
- 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 or to otherwise fund GME in furtherance of Florida's Physician Workforce needs;
- 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 recurring 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;
- Working with managed care organizations regarding 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.
- Exploring seed funding from the state to build consortia that would support innovative training in settings out of the hospital.

Recommendations

1. Florida should develop an ongoing state and federal multi-agency strategy to increase residency positions in the state.
2. Florida should strive for an initial goal of increasing the number of residency positions in the state to bring Florida to the national average of residents per population.
3. Florida should continue to develop its collection and analysis of physician workforce information. Such information should serve as the basis for recommendations for specific graduate medical education needs in the state.
4. Current and new funding sources should be examined and explored to ensure accountability, transparency and maximization of funding for graduate medical education in Florida based on physician workforce information.
5. Florida's only program dedicated specifically to graduate medical education funding, particularly in primary care specialty areas, the Community Hospital Education Program, should be reviewed to determine whether current policies and procedures are providing the best return on investment, given Florida's current healthcare challenges
6. Florida should support state, federal and/or local partnerships; collaborations and consortia; and community partnerships in the development of graduate medical education in the state.
7. Florida should consider the possibility of gathering more information regarding specialty selection and the extent to which financial incentives impact such selection. Strategically plan and address state policy to foster the growth of needed residency programs and to ensure that positions in needed specialties might be filled.

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Appendices

Appendix A **Senate Bill 2600, 09-10**

189 SPECIAL CATEGORIES
 REGULAR DISPROPORTIONATE SHARE
 FROM GENERAL REVENUE FUND 750,000
 FROM GRANTS AND DONATIONS TRUST
 FUND 110,256,074
 FROM MEDICAL CARE TRUST FUND 135,564,503

From the funds in Specific Appropriation 189, \$900,400 from the Grants and Donations Trust Fund and \$1,099,600 from the Medical Care Trust Fund are provided for payments to hospitals participating in graduate medical education initiatives, specifically consortiums engaged in developing new graduate medical education positions and programs. Consortiums shall consist of a combination of statutory teaching hospitals, statutory rural hospitals, hospitals with existing accredited graduate medical education positions, medical schools, Department of Health clinics, federally qualified health centers, and where possible, the Department of Veterans' Affairs clinics. Ideally, each consortium will have at least five residents per training year. Each consortium must include primary care providers and at least one hospital, and consortium residents shall rotate between participating primary care sites and hospitals. On or before September 1, 2009, consortiums will apply to the agency for funding with the objective of initiating new medical resident programs and five initial resident positions by July 2010. On or before October 1, 2009, the agency in consultation with the Department of Health shall at a minimum fund two consortiums, one of which shall be designed to serve a rural area. All consortium-initiated residency programs and positions shall be reviewed by the Community Hospital

Education Council, which shall report all findings to the Executive Office of the Governor, the chair of the Senate Policy and Steering Committee on Ways and Means, and the chair of the House Full Appropriations Council on General Government and Health Care.

Appendix B **381.0403 The Community Hospital Education Act.--**

(1) SHORT TITLE.--This section shall be known and cited as "The Community Hospital Education Act."

(2) LEGISLATIVE INTENT.--

(a) It is the intent of the Legislature that health care services for the citizens of this state be upgraded and that a program for continuing these services be maintained through a plan for community medical education. The program is intended to provide additional outpatient and inpatient services, a continuing supply of highly trained physicians, and graduate medical education.

(b) The Legislature further acknowledges the critical need for increased numbers of primary care physicians to provide the necessary current and projected health and medical services. In order to meet both present and anticipated needs, the Legislature supports an expansion in the number of family practice residency positions. The Legislature intends that the funding for graduate education in family practice be maintained and that funding for all primary care specialties be provided at a minimum of \$10,000 per resident per year. Should funding for this act remain constant or be reduced, it is intended that all programs funded by this act be maintained or reduced proportionately.

(3) PROGRAM FOR COMMUNITY HOSPITAL EDUCATION;
 STATE AND LOCAL PLANNING.--

(a) There is established under the Department of Health a program for statewide graduate medical education. It is intended that continuing graduate medical education programs for interns and residents be established on a statewide basis. The program shall provide financial support for primary care specialty interns and residents based on policies recommended and approved by the Community Hospital Education Council, herein established, and the Department of Health. Only those programs with at least three residents or interns in each year of the training program are qualified to apply for financial support. Programs with fewer than three residents or interns per training year are qualified to apply for financial support, but only if the appropriate accrediting entity for the particular specialty has approved the program for fewer positions. Programs added after fiscal year 1997-1998 shall have 5 years to attain the requisite number of residents or interns. When feasible and to the extent allowed through the General Appropriations Act, state funds shall be used to generate federal matching funds under Medicaid, or other federal programs, and the resulting combined state and federal funds shall be allocated to participating hospitals for the support of graduate medical education. The department may spend up to \$75,000 of the state appropriation for administrative costs associated with the production of the annual report as specified in subsection (9), and for administration of the program.

(b) For the purposes of this section, primary care specialties include emergency medicine, family practice, internal medicine, pediatrics, psychiatry, obstetrics/gynecology, and combined pediatrics and internal medicine, and other primary care specialties as may be included by the council and Department of Health.

(c) Medical institutions throughout the state may apply to the Community Hospital Education Council for grants-in-aid for financial support of their approved programs. Recommendations for funding of approved programs shall be forwarded to the Department of Health.

(d) The program shall provide a plan for community clinical teaching and training with the cooperation of the medical profession, hospitals, and clinics. The plan shall also include formal teaching opportunities for intern and resident training. In addition, the plan shall establish an off-campus medical faculty with university faculty review to be located throughout the state in local communities.

(4) PROGRAM FOR GRADUATE MEDICAL EDUCATION INNOVATIONS.--

(a) There is established under the Department of Health a program for fostering graduate medical education innovations. Funds appropriated annually by the Legislature for this purpose shall be distributed to participating hospitals or consortia of participating hospitals and Florida medical schools or to a Florida medical school for the direct costs of providing graduate medical education in community-based clinical settings on a competitive grant or formula basis to achieve state health care workforce policy objectives, including, but not limited to:

1. Increasing the number of residents in primary care and other high demand specialties or fellowships;
2. Enhancing retention of primary care physicians in Florida practice;
3. Promoting practice in medically underserved areas of the state;
4. Encouraging racial and ethnic diversity within the state's physician workforce; and
5. Encouraging increased production of geriatricians.

(b) Participating hospitals or consortia of participating hospitals and

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Florida medical schools or a Florida medical school providing graduate medical education in community-based clinical settings may apply to the Community Hospital Education Council for funding under this innovations program, except when such innovations directly compete with services or programs provided by participating hospitals or consortia of participating hospitals, or by both hospitals and consortia. Innovations program funding shall provide funding based on policies recommended and approved by the Community Hospital Education Council and the Department of Health.

(c) Participating hospitals or consortia of participating hospitals and Florida medical schools or Florida medical schools awarded an innovations grant shall provide the Community Hospital Education Council and Department of Health with an annual report on their project.

(5) FAMILY PRACTICE RESIDENCIES.--In addition to the programs established in subsection (3), the Community Hospital Education Council and the Department of Health shall establish an ongoing statewide program of family practice residencies. The administration of this program shall be in the manner described in this section.

(6) COUNCIL AND DIRECTOR.--

(a) There is established the Community Hospital Education Council, hereinafter referred to as the council, which shall consist of 11 members, as follows:

1. Seven members must be program directors of accredited graduate medical education programs or practicing physicians who have faculty appointments in accredited graduate medical education programs. Six of these members must be board certified or board eligible in family practice, internal medicine, pediatrics, emergency medicine, obstetrics-gynecology, and psychiatry, respectively, and licensed pursuant to

chapter 458. No more than one of these members may be appointed from any one specialty. One member must be licensed pursuant to chapter 459.

2. One member must be a representative of the administration of a hospital with an approved community hospital medical education program;

3. One member must be the dean of a medical school in this state; and

4. Two members must be consumer representatives.

All of the members shall be appointed by the Governor for terms of 4 years each.

(b) Council membership shall cease when a member's representative status no longer exists. Members of similar representative status shall be appointed to replace retiring or resigning members of the council.

(c) The secretary of the Department of Health shall designate an administrator to serve as staff director. The council shall elect a chair from among its membership. Such other personnel as may be necessary to carry out the program shall be employed as authorized by the Department of Health.

(7) DEPARTMENT OF HEALTH; STANDARDS.--

(a) The Department of Health, with recommendations from the council, shall establish standards and policies for the use and expenditure of graduate medical education funds appropriated pursuant to subsection (8) for a program of community hospital education. The Department of Health shall establish requirements for hospitals to be qualified for participation in the program which shall include, but not be limited to:

1. Submission of an educational plan and a training schedule.
2. A determination by the council to ascertain that each portion of the program of the hospital provides a high degree of academic excellence and is accredited by the Accreditation Council for Graduate Medical Education of the American Medical Association or is accredited by the American Osteopathic Association.
3. Supervision of the educational program of the hospital by a physician who is not the hospital administrator.

(b) The Department of Health shall periodically review the educational program provided by a participating hospital to assure that the program includes a reasonable amount of both formal and practical training and that the formal sessions are presented as scheduled in the plan submitted by each hospital.

(c) In years that funds are transferred to the Agency for Health Care Administration, the Department of Health shall certify to the Agency for Health Care Administration on a quarterly basis the number of primary care specialty residents and interns at each of the participating hospitals for which the Community Hospital Education Council and the department recommends funding.

(8) MATCHING FUNDS.--State funds shall be used to match funds from any local governmental or hospital source. The state shall provide up to 50 percent of the funds, and the community hospital medical education program shall provide the remainder. However, except for fixed capital outlay, the provisions of this subsection shall not apply to any program authorized under the provisions of subsection (5) for the first 3 years after such program is in operation.

(9) ANNUAL REPORT ON GRADUATE MEDICAL EDUCATION;

COMMITTEE.--The Executive Office of the Governor, the Department of Health, and the Agency for Health Care Administration shall collaborate to establish a committee that shall produce an annual report on graduate medical education. The committee shall be comprised of 11 members: five members shall be deans of the medical schools or their designees; the Governor shall appoint two members, one of whom must be a representative of the Florida Medical Association who has supervised or currently supervises residents or interns and one of whom must be a representative of the Florida Hospital Association; the Secretary of Health Care Administration shall appoint two members, one of whom must be a representative of a statutory teaching hospital and one of whom must be a physician who has supervised or is currently supervising residents or interns; and the Secretary of Health shall appoint two members, one of whom must be a representative of a statutory family practice teaching hospital and one of whom must be a physician who has supervised or is currently supervising residents or interns. With the exception of the deans, members shall serve 4-year terms. In order to stagger the terms, the Governor's appointees shall serve initial terms of 4 years, the Secretary of Health's appointees shall serve initial terms of 3 years, and the Secretary of Health Care Administration's appointees shall serve initial terms of 2 years. A member's term shall be deemed terminated when the member's representative status no longer exists. Once the committee is appointed, it shall elect a chair to serve for a 1-year term. The report shall be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15 annually. Committee members shall serve without compensation. The report shall 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, teaching hospitals, including all hospital-medical affiliations, practice plans at all of the medical schools,

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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. (e) The use of state and federal appropriated funds for graduate medical education by hospitals receiving such funds.

(10) RULEMAKING.--The department has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this section.

History.--s. 1, ch. 71-311; ss. 1-4, ch. 72-137; s. 1, ch. 74-135; s. 1, ch. 74-358; s. 1, ch. 76-63; s. 1, ch. 82-46; s. 45, ch. 82-241; s. 2, ch. 83-265; s. 6, ch. 84-94; s. 2, ch. 88-291; ss. 1, 2, 3, ch. 91-129; s. 50, ch. 91-297; s. 5, ch. 91-429; s. 25, ch. 92-173; s. 658, ch. 95-148; s. 29, ch. 99-5; s. 27, ch. 2000-163; s. 2, ch. 2001-222.

Note.--Former s. 381.503.

Appendix C **Lewin Group**

Mandated Report to Congress
Independent Study and Report
Contract no: HHSM-500-2005-00024I

Proposed Interview Questions for Regulations Under Review

Graduate Medical Education **Interview and Data Questions**

I. Background

The proposed rule asserts that costs and payments associated with GME programs are not authorized medical assistance expenditures, thereby

eliminating all federal payments for Direct Graduate Medical Education (DME) and Indirect Graduate Medical Education (IME). In addition, the Medicare Direct GME payments would be removed from the Medicaid Upper Payment Limit (UPL) calculations.

II. Interview Questions

Questions 1 through 8 request information about State program administration, payment methods, and policy issues pertaining to Medicaid GME. Responses to these questions will provide a foundation for understanding the current structure of the State's GME program and how it is financed to better assess the impact that implementation of this regulation could have on the State in this area.

1. Which agencies and departments are responsible for administering the Medicaid GME program in your State? What are their respective roles and responsibilities?
2. Which types of providers and/or other organizations are eligible to receive GME payments in your State and what specific criteria are used to determine eligibility for Medicaid GME payments?
3. Are payments specifically designated as Medicaid GME identified within the States Medicaid reimbursement methodology?
4. How are Medicaid GME payments determined in your State, and on what basis (per-diem, per-case, other) are they distributed? To what extent are methods similar to Medicare used?
5. Does your State place explicit limits on Medicaid GME payments to eligible providers? If yes, how is the maximum limit for GME payments determined?
6. Does your State currently link Medicaid GME payments to State

work force or other policy goals (such as addressing shortages of primary care physicians, or shortages of health care providers in medically underserved communities)? If yes, please elaborate.

7. Has your states Medicaid GME program ever been cited as problematic by CMS, GAO, OIG or other federal organizations? If yes, what modifications to the program were made to bring it into compliance?
8. Has your State considered or implemented any strategies designed to address CMS issues of concern regarding Medicaid GME payments? If yes, please elaborate on strategies and their anticipated impacts.

Additional information to be collected — Questions 9 through 14 will help with the determination of the overall impact of the proposed regulation, including potential data sources, as well as identifying possible alternative methods of addressing the problems that the proposed regulation seeks to address.

Currently the general instructions regarding Medicaid State Plan requirements for payment methods for all Medicaid services are provided at § 447.201. We propose to add a new § 447.201(c) to indicate that GME cannot be included as part of any payment methodology in the Medicaid State Plan.

We propose also to modify § 447.257 and 447.304 to address that FFP is no longer available for any reimbursement that includes or specifically pays for GME.

We propose to modify § 447.272(b)(1) and 447.321(b)(1) to indicate that the term “Medicare payment principles” must exclude any Medicare payments associated with direct GME when calculating

the Medicaid UPL.

We propose to modify § 438.6(c)(5) by removing paragraph (v) that addresses the coordination of GME payments under the State plan with capitated rates paid to a Medicaid MCO.

We propose to modify § 438.60 to provide that the limit on payment to other providers would not include an exception related to GME payments made to providers outside the capitation rate and under the Medicaid State Plan.

9. What are the current methods of allocating Medicaid GME payments to eligible providers in your State?
 - a. Fee-for-service (per case, per resident, other)
 - b. Managed Care (bundled payment, separate payment, other)
 - c. Both fee-for-service and Managed Care
 - d. Other-please specify
10. To what extent is your State able to clearly identify all Medicaid GME payments to eligible providers under FFS and managed care payment systems?
11. Do you anticipate that any new and significant administrative costs will be incurred by your State Medicaid agency and/or other State entities in complying with federal requirements as a result of this proposed rule? If yes, please describe the nature of these costs and estimate their key impacts on State agencies.
12. Has your State performed an independent analysis of the financial impact of the proposed Medicaid GME rule, including any analyses conducted at Representative Waxman’s request? If yes, please share with us:
 - a. Data sources used to perform the financial impact analysis

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- b. Analytic methods, time periods, and impact assumptions used to develop the analysis
 - c. Any analysis results, including those shared with any federal agencies or other interested organizations
13. As you know, the proposed CMS rule would eliminate the federal share of State Medicaid GME payments.
- a. How much Medicaid GME funding has your State received through federal matching payments during the most recent State Fiscal Year for which this information is available?
 - b. Do you believe that your State would consider addressing lost federal matching payments from other State revenue sources? If yes, to what extent and from which State sources of revenue?
 - c. How would your State's likely response impact State Medicaid GME payments to eligible providers and other organizations?
14. The proposed CMS rule would also remove federal Medicare DME payments from the calculation of your State's Medicaid UPLs.
- a. Would this component of the proposed rule, if enacted, have a significant financial impact on your State Medicaid program? If so, in what ways?
 - b. Would it likely have a significant impact on hospital Medicaid payment rates? If yes, which provider types would likely be most impacted (State, city/county, or private providers)?
15. Are all Medicaid GME payments currently captured in your State's MMIS?
- a. Yes, both total DME and IME payments are captured
 - b. DME only
 - c. IME only
 - d. Other
16. Are there any Medicaid GME payments to eligible providers that are currently processed outside of the MMIS in your State? If yes:
- a. What provider types are involved and what is the magnitude of these payments for the most recently available fiscal year?
 - b. What method, if any, is used for claiming federal matching dollars for Medicaid GME payments processed outside of the MMIS?
 - c. What strategies are in place to ensure the fiscal integrity of the Medicaid GME payments that are processed outside of the MMIS in your State?

III. Data Requests

1. List of eligible providers and Medicaid GME payments by provider type
2. Aggregated and hospital-specific payments under fee-for-service and managed care
3. Aggregated and total Medicaid GME payments, by component, to non-teaching hospital providers
4. Aggregated and facility group specific Medicaid UPLs
5. Medicare DME payments to teaching hospitals in total and by facility group for the most recent State Fiscal Year

Questions 15 and 16 focus on data sources and the transparency, completeness, and accuracy of data for capturing State Medicaid GME payments.

15. Are all Medicaid GME payments currently captured in your State's MMIS?
- a. Yes, both total DME and IME payments are captured
 - b. DME only
 - c. IME only

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