SUBJECT: Graduate medical education funding

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Berlanga, Hirschi, Coleman, Davila, Delisi, Glaze, Maxey

0 nays

2 absent — Janek, Rodriguez

WITNESSES: For — Troy Alexander, Texas Academy of Family Physicians; Torry Boucher, Texas Osteopathic Medical Association; Deborah Greene, Texas Medical Association

Against — None

On — James Gukian and Charles Mullins, University of Texas System; David Low, University of Texas Health Science Center Houston; Mike McKinney, Texas Health and Human Services Commission; Kern Weldenthal, University of Texas Southwestern Medical Center

BACKGROUND: Texas hospitals that serve as teaching centers for medical resident physicians incur expenses for resident stipends, benefits, and malpractice insurance; faculty supervision; increased testing and treatment time to allow for instruction and evaluation; and maintaining a diverse staff and patient mix.

To defray these costs, the state allocates additional Medicaid funding to teaching hospitals with graduate medical education (GME) programs. In 1994, approximately 55 Texas teaching hospitals were reimbursed an estimated $40 million for GME costs through payments for services delivered to Medicaid patients. Some 63 percent of that amount came from the federal Medicaid match of state dollars.

Graduate medical education is also funded by appropriations from state general revenue; these funds go directly to medical schools and other residency programs, often located in communities without their own medical schools. In 1995, the Legislature appropriated approximately $138 million for medical schools. An additional $14 million, disbursed through the

Higher Education Coordinating Board, went toward GME programs at teaching hospitals. The estimated average cost of training one post-graduate resident medical student is about $70,000 per year. The state currently funds 1,916 of the total 4,884 resident physicians at a cost of $28.74 million per year.

DIGEST:

HB 1511 would change the way Texas funds graduate medical education. It would require the Texas Department of Health (TDH) to establish an equitable system for allocating available federal Medicaid funds to teaching hospitals. It also would direct the Higher Education Coordinating Board to set up a new state program for funding GME.

Reallocating Medicaid funds

HB 1511 would require TDH to develop procedures and formulas for allocating federal medical assistance funds for graduate medical education. Before adopting or revising such a formula, TDH would have to consult with the coordinating board, which would provide any relevant information. TDH would have to allocate the funds in the most effective and equitable manner, consistent with the needs of the state for GME and the training of medical residents. In determining the needs of the state, the department would give special emphasis to graduate medical education in primary care specialties.

HB 1511 also would implement a new funding formula for GME that would take into account: the number of residents for the fiscal year and the annual cost of training those residents, weighted equivalents that count each full-time resident in primary care as 1.2 residents and each other full-time resident as 1.0 residents, the number of patient days for the hospital attributable to Medicaid patients, and the total number of patient days for the hospital.

To determine a hospital's annual cost for training residents, TDH could use the hospital's most recently submitted Medicaid cost report.

HB 1511 would phase in the new funding structure for GME over a five-year period and would affect hospitals that were eligible for federal medical assistance funds for training residents in the state for the fiscal year ending

August 31, 1995. During the phase-in, hospitals would be guaranteed a declining percentage of the funds they would have received in that fiscal year under the formulas for awarding federal medical assistance funds used in fiscal year 1995. The bill would include a fiscal hold-harmless provision for fiscal 1998 that would keep the formula weights for primary care and all other residents at 1.0. The first year, fiscal 1999, a hospital would receive at least 90 percent of the funds it would have received; in fiscal 2000, not less than 85 percent; in fiscal 2001, not less than 80 percent; and in fiscal 2002, not less than 75 percent.

TDH would be required to pay the funds in monthly installments and make adjustments as necessary to ensure the appropriate annual amount.

Establishing a state funding program

HB 1511 would require the Higher Education Coordinating Board to administer a program for funding GME consistent with the needs of the state, including for primary care specialties. The bill would create a shell account, administered by the board, which would receive and distribute appropriations and other funds for medical schools and other residency programs. The account would be funded by appropriations, gifts, grants, donations, federal funds, and any other funds the board obtained. The money would support appropriate GME programs or activities for which other funds were not otherwise available and foster new or expanded programs or activities to address the state's GME needs. In disbursing funds, the board would consider the costs of supporting faculty instruction of residents, including programs in osteopathic medical education.

The board would appoint an advisory committee to advise it on program development and administration. The committee's functions would include:

- reviewing applications for funding and recommending their approval or disapproval;

- making recommendations on standards and criteria used for consideration and approval of grants or development of formulas for distributing funds; and

- recommending how funds would be allocated among medical schools, teaching hospitals, and other entities eligible to receive funds.

The advisory committee would consist of the top official or designee of the Texas State Board of Medical Examiners, Family Practice Residency Advisory Committee, and Primary Care Residency Advisory Committee.

The board members would further appoint to the advisory committee: one representative of a teaching hospital affiliated with a Texas medical school and one not affiliated with a Texas medical school; one representative of a medical school in the University of Texas System and one not in the University of Texas System; two physicians active in private practice, one of whom would have to be a generalist; one doctor of osteopathic medicine active in private practice; one representative of a managed care provider; two clinical faculty members, one of whom must be a generalist; and two nonvoting members, one a resident and the other a medical student. These advisory committee members would serve staggered three-year terms.

The changes made by the bill would apply only to the distribution of federal medical assistance funds for the support of graduate medical education received on or after the bill's effective date and to any such federal funds received before the effective date that have not been promised, obligated, or otherwise identified for distribution to specific entities before the effective date.

HB 1511 would take immediate effect if finally approved by a two-thirds record vote of the membership in each house.

SUPPORTERS SAY:

HB 1511 would reorganize the way Texas funds graduate medical education in order to respond to significant new developments in paying for health care. In order to maintain high quality health care for all citizens of Texas, the state must ensure adequate numbers of fully capable and qualified medical doctors. This means maintaining special funding for teaching hospitals in Texas, which perform an indispensable role in educating medical students and training residents.

HB 1511 would make sure that money intended for graduate medical education in Texas was not siphoned off by for-profit managed care organizations. As Texas shifts the focus of its Medicaid program from a fee-for-service approach to managed care, the way medical education is funded will change. Because GME funding and patient care funding are currently rolled into one Medicaid reimbursement formula, Medicaid managed-care contracts effectively distribute to private HMOs both public Medicaid funds earmarked for teaching expenses and Medicaid funds related to direct patient care.

Managed care organizations, which will be receiving more and more of the state's Medicaid dollars, are under no obligation to forward the GME component of their funds to teaching hospitals. Teaching hospitals, therefore, need to be protected from the loss of funds implicated by the switch to managed care.

HB 1511 would carve out and protect the Medicaid reimbursement portion of GME funding. The money would be set aside before Medicaid payments were made by the state to HMOs, and the Health and Human Services Commission would be authorized to distribute it to the hospitals. The House Public Health Committee's interim report recommended such a system be created to reimburse teaching hospitals for GME costs and maximize the state's federal Medicaid match.

A wide variety of studies have demonstrated the need to train more primary care physicians and encourage medical students to go into primary care. As the entire health care industry moves inexorably toward managed care, Texas will need more and more primary care physicians. At the same time, a large portion of the state's practicing primary care physicians are nearing the end of their careers and will be retiring just as the HMO boom greatly increases demand for their services. Encouraging new primary care residents, therefore, is of utmost importance to the state.

CSHB 1511 would weight the new funding formula to spur an increase in the training of primary care physicians; hold-harmless provisions would allow the formula to be phased in without placing undue financial stress on teaching hospitals.

CSHB 1511 would coordinate the various funding sources for GME in order to provide much needed cohesion and efficiency to a complicated process and ensure the stability of funding sources even in the fast changing health care industry. Administration of these functions has see-sawed back and forth between the coordinating board and TDH in recent years, and stabilizing authority within the board would end this inconsistency.

Establishing an advisory committee to make policy decisions regarding how and where GME funds could be distributed would ensure proper financial oversight. The composition of the board as proposed by CSHB 1511 would guarantee that the interests of all affected parties were well served.

OPPONENTS SAY:

HB 1511 would not deal sufficiently with the many ambiguities of funding graduate medical education. One important omission is the future relationship between teaching hospitals and HMOs. Currently, hospitals and managed care organizations negotiate contracts for services. Though the costs of dealing with teaching hospitals are inherently somewhat higher, HMOs realize the value of working with the hospitals and make an effort to accommodate their special needs. The extra GME money currently coming to the HMOs through Medicaid helps defray these extra costs. If HB 1511 caused HMOs to lose large sums of money, HMOs could become disinclined to work with those hospitals and send the bulk of their patient caseloads elsewhere.

Further ambiguities could cause problems in the development of future funding formulas. Calculating formulas for distributing GME funds is a subjective process. The actual cost of training a resident is difficult to determine because of the indirect costs associated with clinical instruction. The state needs to figure the actual costs directly associated with post-graduate medical instruction and develop a standard for indirect costs associated with the clinical training of residents.

The future of funding for Medicaid and GME should be comprehensively studied and planned for by those who will be making GME policy in Texas. The GME advisory committee should be directed to undertake a study within a specified time frame on methods for funding GME. The study should include but not be limited to discussion of the all-payer approach,

which would require private insurers to share the burden of medical teaching costs with Medicare and Medicaid.

The U.S. Congress currently is considering creating a medical education trust fund to pay for medical education and help ease the strain on the national Medicare Trust Fund. Testimony from several advocacy groups before the House Subcommittee on Health suggested an all-payer approach to funding GME.

Other approaches to funding GME should be examined as well. Other states have dealt with the issue in a number of ways, and their experiences could be beneficial to Texas. Florida, for example handles GME funding as a component of its Medicaid capitated rates paid to the health plans. Teaching hospitals then capture the GME amount when they bill the health plans.

HB 1511 would improperly weight the formula for distributing GME funds to favor primary care residents. In most large teaching hospitals, primary care residents compose over half of the total resident population. There is no shortage of primary care residents but rather a problem of distribution. Primary care residents are plentiful in urban areas but scarce in outlying areas. HB 1511 would serve as incentive to increase the number of primary care residents, but it would not remedy the inequity of their distribution. Instead, the weights would unduly reward large hospitals for the existing composition of their resident population.

Programs in osteopathic medicine should not receive special consideration in the distribution of funds for GME. There may be special need to emphasize osteopathic medicine now, but such needs change and shift regularly among medical disciplines and should not be addressed in state law. The board would already be directed to consider the needs of the state in distributing GME funds; therefore, this special consideration would be unnecessary.

OTHER OPPONENTS SAY:

The advisory board's membership should better reflect the interests of all parties in the GME process. This could be achieved by including more representation from medical students. They are the ones the advisory committee's actions would primarily affect; they would have every incentive to make sound decisions regarding the distribution of GME funds.

The fiscal expertise of the Legislative Budget Board also should be reflected in the development of GME funding procedures and formulas. HB 1511 should include some provision for LBB input, perhaps by providing an LBB member of the GME advisory committee.

NOTES:

Rider 47 to the Texas Department of Health budget in CSHB 1 would direct the Health and Human Services Commission to remove from hospital Medicaid reimbursement rate methodologies the portion that is related to GME funding and make direct Medicaid payments to hospitals and clinics.