SUBJECT: Allocation of federal funds for border graduate medical education

COMMITTEE: Border and International Affairs — favorable, without amendment

VOTE: 6 ayes — Chavez, Griggs, Alonzo, Merritt, J. Moreno, Vo

0 nays

1 absent — Castro

WITNESSES: For — Don Gilbert, Valley Baptist Health System; James G. Springfield; (*Registered, but did not testify:* Michael Crowe, El Paso County Hospital District; James O. "Jim" Manley, on behalf of El Paso County Judge Dolores Briones; David Sibley, City of Harlingen)

Against — None

On — Eduardo Sanchez, Department of State Health Services

BACKGROUND: Most of the state's health-related institutions partner with teaching hospitals to provide residency training, also called Graduate Medical Education (GME), which physicians must complete after medical school to obtain state licensure and specialty certification. The programs contain significant costs, including the cost of residents' stipends and benefits, salaries and benefits of faculty who supervise residents, program administrative staff, and facility overhead costs. Medicare pays for the largest portion of the costs of these programs at most teaching hospitals. Texas pays for a portion of the cost of GME by: 1) making Medicaid payments to teaching hospitals, pulling down additional federal funds; 2) through direct allocations to health related institutions as part of their state budget, and 3) through trusteed funds allocated by the Texas Higher Education Coordinating Board to individual primary care residency programs.

Under chapter 32 of the Human Resources Code, the Health and Human Services Commission is required to allocate Medicaid federal funds in the manner that most effectively and equitably achieves the purposes for which they are received and which is consistent with the needs of the state and takes into account other funds available to support GME. Other

sources of revenue for these programs come from local government funds, clinical practice plans, patient care revenues, local hospital district taxes, hospital reserves, private grants, donations, and Disproportionate Share Hospital funds.

In 1997, the federal Balanced Budget Act capped the number of residency training slots that would be paid for under Medicare at 1996 levels. The state Medicaid program adopted the same caps. Federal Medicare payments are more generous than state Medicaid payments because Medicare recognizes both the direct and indirect costs of GME, while Medicaid recognizes only direct costs.

DIGEST:

HB 2420 would require the Texas Health and Human Services Commission to establish a separate allocation formula for federal funds used to support resident physician training in an accredited primary care residency program at certain teaching hospitals. The formula would recognize the direct and indirect medical expenditures of the program to the same extent that those expenditures were recognized under the Medicare program. The formula could not place a limit on the number of physician training slots.

The bill would apply only to a program sponsored by or affiliated with a public university in Texas that included training at:

- a federally qualified health center; and
- a hospital within 20 miles of the Texas-Mexico border that served patients residing in a rural area.

(The only program that currently meets these criteria is Valley Baptist Hospital in Harlingen.)

The bill would specify that if a waiver or authorization from a federal agency were necessary to implement the bill's provisions, the agency would have to request the waiver or authorization and could delay implementing those provisions until the waiver or authorization was received.

The bill would take effect September 1, 2005.

SUPPORTERS SAY:

HB 2420 would help address the physician shortage along the border by creating a priority reimbursement formula for graduate medical education in the region. This change would save the GME program at Valley Baptist Hospital in Harlingen, which could soon collapse if it does not receive additional funding, and would encourage the creation of more programs along the border. Because the location of residency training is the most important factor in determining where a physician's first practice will be located, supporting programs in the border region is crucial to addressing the critical physician shortage in the area.

The Texas-Mexico border region is one of the most medically underserved regions in the United States. The region suffers from inadequate infrastructure, a shortage of physicians and other medical personnel, low levels of health insurance, and a variety of other socioeconomic, environmental, and cultural factors that affect the health of border residents. Federal programs that transplant physicians to needy areas have not been effective in increasing the long-term number of physicians, as these physicians typically leave when their required service is over. Instead, research has consistently shown that the location of residency training is the single most important determinant in a physician's first practice location, with the majority of graduating residents setting up practices within 75 miles of their residency training site. One of the most effective ways of increasing the number of physicians in the border region would be to increase the number of residents training there. HB 2420 would encourage the growth of current and new programs by providing them with greater reimbursement for their costs under the Medicaid program.

HB 2420 would improve the reimbursement formula under Medicaid for teaching hospitals along the border by removing the artificial cap on the number of residency training positions funded under Medicaid and providing that the allowable GME costs in Medicaid mirrored the allowable costs under the Medicare program. While the state has no authority to change the caps imposed by the Medicare program for Medicare funding of GME, the state could lift the limits imposed on Medicaid that have prevented certain hospitals, like Valley Baptist, from receiving reimbursement for residency training slots that were created after the cap was imposed. Because this program does not receive any Medicare funding, allowing both direct and indirect costs to be paid through Medicaid funds would help to bring this program closer to funding parity with other programs around the state. By encouraging the

growth and sustainability of residency training sites at Valley Baptist and other hospitals in that part of the state where physicians are most needed, HB 2420 would begin to address the border's critical health care needs.

The bill would not hurt other GME programs across the state. The amount redistributed from each program would be small. Moreover, a rider included in the proposed state budget would allow public teaching hospitals to use their funds as a state match, which could draw down as much as $124 million in federal funds, and $220 million is currently pending consideration in Article 11 of the budget. HB 2420 would ensure that an appropriate portion of those and future funds be directed to border GME programs to promote their growth and sustainability.

OPPONENTS SAY:

No GME program in the state receives adequate funding, and, although improving health care in the border region is important, changing the funding allocation formula could impair the ability of other programs in the state to continue functioning. In fiscal 2004-05, funding to Texas Higher Education Coordinating Board for GME was reduced by 37 percent and Medicaid funding was eliminated - a loss of $127 million in state and federal matching funds. In August 2004, Medicaid GME partially was restored with $3 million in unclaimed lottery prizes, which drew down about $4 million in federal matching funds. All GME programs in the state are suffering from this loss and can ill afford to lose any more funding at this time. It is not clear that additional funding will be available in this biennium. The rider mechanism for providing more funding is unworkable, as a few hospitals likely would be asked to provide the matching funds for all hospitals without a guarantee that they would receive that money back.

NOTES:

The companion bill, SB 1500 by Lucio, passed the Senate by 29-2 (Ogden, Nelson) on May 3 and has been referred to the House Public Health Committee.