AN ARIZONA POLICY PRIMER

Graduate Medical Education

ARIZONA HEALTH FUTURES

JANUARY 2003

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Policy Primers: *a non-partisan guide to a better understanding of key terms and issues in the Arizona health policy landscape.*

What is Graduate Medical Education?

Graduate Medical Education (GME) is the second phase of a physician's training and takes place after medical school. Upon graduation, a physician receives either a Doctor of (Allopathic) Medicine (MD) degree or a Doctor of Osteopathy (DO) degree. Physicians with degrees, however, can't practice medicine until they complete at least one year of residency, pass a three-part licensing exam, and receive a license from a state board of medical examiners. Physicians who choose to go on to specialize must spend an additional 3 to 8 years in a specialty residency.

St. Luke's Health Initiatives
A Catalyst for Community Health

Who Pays for **Graduate Medical Education?**

Funding for residencies – or GME programs – in non-federal teaching hospitals comes from two primary sources in addition to the hospitals themselves:

1. MEDICARE. About $7 billion nationally; $56 million in Arizona alone. This comes in two parts:

Direct Medical Education (DME). Costs directly related to medical education, such as salaries for residents and teaching staff, etc.

Indirect Medical Education (IME). For the increased costs of having a teaching program in the hospital, such as more diagnostic tests ordered by trainees, etc.

2. MEDICAID. Funds appropriated from state Medicaid budgets, which contain both state and federal dollars. Most states (43) participate to the tune of about $2.3 billion annually.

MEDICAID/MEDICARE FUNDING OF GRADUATE MEDICAL EDUCATION IN ARIZONA

SOURCES OF FUNDING	AMOUNT
Medicare – Indirect Medical Education (IME) payments *	$ 42 million +
Medicare – Direct Medical Education (DME) payments *	$ 14 million +
AHCCCS – **	
State	$ 6 million
Federal	$ 12 million
TOTAL	**$ 74 million +**

** Arizona Council for Graduate Medical Education, State of the State, January, 2000. Medicare IME and DME Payments 1998 provided by Blue Cross/Blue Shield of Arizona. (The Medicare figures are for 1996 as reported by 1998 and will have increased somewhat. More recent figures are available in individual hospital Medicare cost reports.)*

*** AHCCCS Payments 2002, AHCCCS.*

Arizona's Medicaid Program – the Arizona Health Care Cost Containment System (AHCCCS) – allocates about $18 million annually for direct GME payments ($6 million state, $12 million federal).

Teaching hospitals subsidize GME programs through revenue from services, grants and other sources. Private insurers do not provide direct support for GME programs, although they respond that they support GME through higher payments made when their beneficiaries use teaching hospitals for specialized care.

Arizona contributes roughly $6 million from the AHCCCS budget with a federal Medicaid match of $12 million – a return of $2 on every dollar invested by the state. The programs garner another $56 million in federal dollars for Medicare IME and DME funding. Overall, the state contributes 8 percent or less of the payments made to hospitals for GME programs.

Arizona Teaching Hospitals and **AHCCCS Payments for GME**

AHCCCS began contributing to the cost of GME for residents working in Arizona hospitals in 1993. Initially, a small portion of each AHCCCS payment made to a teaching hospital was designated to support the program. Legislation enacted in 1997 changed the approach from one of small additional AHCCCS payments for each hospital stay to one where AHCCCS aggregates GME into one large pool. Rather than paying for GME with each bill, hospitals serving AHCCCS patients and meeting the criteria for approved GME programs receive two lump sum payments each fiscal year. This change allows direct monitoring of the flow of monies for GME and increases accountability.

Fourteen teaching hospitals currently receive AHCCCS payments. (Other teaching hospitals in the state do not receive AHCCCS GME payments because they do not serve AHCCCS patients.) One half of the GME payments go to two programs serving AHCCCS patients: Maricopa Medical Center ($6 million) and Phoenix Children's Hospital ($3.5 million). Another $7 million goes almost equally to three other institutions: Good Samaritan Regional Medical Center, St. Joseph's Hospital-Phoenix, and the University Medical Center. A total of about $2 million is distributed between 9 small programs.

- AHCCCS GME payments should support training only in accredited programs that serve AHCCCS patients.
- Funding for medical education should flow to the entity that incurs the costs of the educational program. In turn, that entity may appropriately support other entities and individuals that provide educational experiences as a component of the GME program.
- Changes to GME funding approaches should be gradual. Transitions should be designed to avoid funding shifts that are disruptive or destructive to the system, the trainees and the institutions. Changes should occur in a manner that provides continuity for existing educational cohorts, that recognizes the multi-year character of ongoing training programs, and that encourages innovation in training programs.
- Eligibility for GME payment should be open to all educational and health care services entities with nationally accredited programs. Accrediting and regulatory bodies should facilitate the accreditation of innovative and community based educational programs.
- Arizona's teaching institutions should be responsive to the demands and needs of the populations served and the evolving health care market. They should produce health professionals who possess the necessary knowledge, skills, and competencies for tomorrow's health care system.
- Quality control of education programs should continue to be assured by the teaching institutions themselves according to the standards of national private accreditation bodies.

AzCGME Recommendations for the Future of GME in Arizona

- **MONITOR ARIZONA RESIDENT SUPPLY** It is important to collect reliable and timely demographic information on the supply of physicians and residents in Arizona to aid in developing responsible policies on GME. Arizona-specific data from the American Medical Association's annual FREIDA (Fellowship and Residency Electronic Interactive Database Access) survey should be published for the state by the Arizona Medical Association.

  Continued monitoring of the extent and location of primary care training in Arizona is desirable. Stakeholders and supporters of GME should provide funding to conduct and disseminate information on such health manpower studies.

- **MONITOR ARIZONA PHYSICIAN SUPPLY** A minimum data set should be identified and included in both the Board of Medical Examiners and Board of Osteopathic Examiners annual/semi-annual licensure renewal process. The State should ensure that the level of funding permits inclusion of the minimum data set in electronic licensure processes under development by the Boards. The respective Boards should publish annual reports on physician supply.

- **CONTINUE A GME FORUM** A continuing forum at which GME programs can meet to discuss and consider issues and threats to GME is needed. The forum should advocate for and advance understanding of GME in Arizona. It should include both allopathic and osteopathic GME programs.

- **CONTINUE TO ADVANCE UNDERSTANDING OF GME AT THE ARIZONA LEGISLATURE** Since GME and related health care services represent a necessary and reasonable state investment in the quality of Arizona medicine, it is necessary that the Arizona State Legislature be kept aware of and informed about the role GME plays in the delivery of health services in Arizona. It is important that the need for continued public and private support for the funding of GME be made clear by GME stakeholders and supporters.

- **CONTINUE AHCCCS FUNDING OF DIRECT GRADUATE MEDICAL EDUCATION** Continued AHCCCS funding of GME is essential to the survival of strong GME programs in Arizona. One-half of the physicians completing the majority of their GME experience in Arizona remain part of the Arizona physician supply. GME stakeholders and supporters at all levels should work to ensure ongoing funding for GME as part of the AHCCCS program.

FURTHER SOURCES FOR INFORMATION ON GME

1. Council on Graduate Medical Education (Congressionally authorized): www.COGME.gov

2. Health Resources Services Administration, Bureau of Health Professions: www.hrsa.gov

3. Medicare Payment Advisory Commission: www.medpac.gov

4. American Academy of Medical Colleges: www.aamc.org

Legal And Financial Issues Might Arise Residents expect that they will complete the programs at the same hospitals where they began their residencies. It is unclear what legal impact closing GME programs would have on the hospitals or the residents. Residencies are filled through a national placement process. Residents forced to look for new residencies after an Arizona program closed conceivably might not find an available slot that would allow them to complete their training, raising legal issues for the hospitals.

Physician Supply Could Be Adversely Affected For the last decade, over 50 percent of physicians doing a majority of their residencies in Arizona have stayed to establish a practice in the state. At the same time, roughly one-half of all new practices begun in the state each year are started by physicians who complete their GME outside the state (Arizona Council on Graduate Medical Education, Jan. 2000). According to the federal Health Resources Services Administration, in 1998 Arizona had 176 physicians per 100,000 population, while the national average was 198 per 100,000. Arizona's rapid population growth over the last decade – and its expected continued growth – suggests a continuing need to import physicians to meet demand. Anything that decreases the number of physicians completing their GME programs in the state could be expected to contribute to fewer physicians establishing a practice in Arizona.

Health Care For Those In Greatest Need Could Be Adversely Affected – Costs Could Rise Arizona teaching hospitals receiving AHCCCS support serve poor, needy and elderly clients. Residents practice in all areas of a hospital and may potentially be called upon to serve any patient. If residents were not present, it is not unreasonable to assume hospitals would have to hire additional physicians, nurses and other personnel to meet patient needs – and at a considerably higher cost than subsidies for residents. The availability of new personnel would most likely present a problem, since in addition to already having to import physicians, Arizona and the nation are currently facing a nursing shortage that is only expected to worsen.

GME and Public Policy

The public policy underlying AHCCCS support of GME is that GME programs provide benefit to Arizona citizens through the care received from residents participating in the programs, and represent a public good. There is no federal or state requirement that the legislature fund a GME pool, only that AHCCCS payments to hospitals be "reasonable and adequate payment rates." There are no specific requirements of the hospitals and programs other than procedural ones, and there are no additional statements as to how GME should serve the interests of the state.

Should there be specific requirements for GME support in Arizona? Should the state further specify the parameters of the "public good?"

GME history and reform is a complex – even arcane – subject. At the risk of over-simplification, here is a short distillation of the core issues that set the context for a discussion of GME and health policy in Arizona:

Medical Education as a Public Good In an era of managed competition and managed care, medicine is just another business. Modern day economists have little patience with teaching, research and cross subsidies for safety net services, yet most people expect health providers to be "charitable" and act on behalf of the public good. If hospitals use GME funds for "cheap labor" to cover costs with dubious ties to medical education, they are accused of self-aggrandizement. If hospitals don't provide indigent care, they are accused of neglecting their charitable mission. When it comes to GME, teaching hospitals are damned if they do, and damned if they don't.

The policy issue is what role the nation expects its academic medical centers and teaching hospitals to play in establishing a health safety net, and to what degree. It is fundamentally an ethical, not an economic, issue.

Paying for GME Most observers agree that the present means of financing GME primarily through Medicare direct and indirect payments is fraught with problems. Where they disagree is what to do about it.

> **SOME,** like academic medical centers, favor an "all-payer" system that would place a surcharge on private insurance premiums in addition to Medicare and Medicaid funding. Everyone should pay their fair share of medical education costs. **OTHERS** buy the tax financing argument, but think it should come from general funds and made to compete with other claims on public funds in an annual appropriation process.

SOME argue that a surcharge on premiums is just another tax hike, and a regressive one at that. **OTHERS** argue that there is little justification for public support of GME because physicians are among the highest paid of all professionals, and there are more qualified applicants for medical schools than spaces to accommodate them. They favor letting market forces sort out the winners and losers.

Despite their differences, few advocate eliminating the federal financing of GME. The issue is how much – if any – of the cost should be funded through Medicare, and how much should be funded through other public means.

The Structure of GME GME payments, based as they are on the number of residents and the "unfathomable logic" of Medicare costs reports, can vary widely between regions and institutions.

SOME believe that tying direct medical education payments to residents in hospital-based settings skews the distribution to specialty-based, tertiary care settings in urban areas and doesn't address primary care needs in rural and ambulatory settings. **OTHERS** agree that the payment system could be refined to support more training in ambulatory settings, but payments still need to be tied to specific residencies because of advances in medicine that require more specialized training and community expectations for a highly skilled physician workforce.

SOME believe that the way to reduce unwarranted variability in GME payments is to attach GME "vouchers" to medical students upon graduation and let programs compete for them based on their interests and market forces of supply and demand. **OTHERS** say vouchers are unnecessary because training programs already compete for residents, and that the vagaries of market forces would make it difficult for academic and teaching institutions to plan GME needs from year to year and make the long-term capital investments in facilities and personnel necessary to provide specialized training.

SOME believe that subsidies for teaching hospitals should be funded independently of the number of resident positions because of their broader social mission in teaching, research and service, and that this subsidy should be spread across all payers, not just Medicare. **OTHERS** don't see a justifiable distinction between the social mission of physicians and other professionals like engineers, and that the result would be more professions seeking public subsidies. Better to eliminate subsidies and let the market decide.

The States **And GME***

Arizona, like many other states, is between a rock and a hard place when it comes to paying for GME:

- **MASSIVE BUDGET DEFICITS,** coupled with rising health care costs. The impact of increased emergency room use, EMTALA regulations, workforce shortages, liability insurance, court-mandated services and other factors impacting costs and the delivery of services are well known.
- **INCREASING MEDICAID ENROLLMENTS.** The demand for services is increasing at the same time public resources are declining.
- **REDUCED MEDICARE PAYMENTS.** The 1997 Balanced Budget Act reduced Medicare indirect medical education payments for GME and capped residency slots at 1996 levels.

Because Medicare is the dominant provider of GME payments, states are limited in how they can approach changes in GME. It is in the use of state Medicaid GME funds that differences start to emerge.

- Some states simply include Medicaid GME payments in capitation rates to managed care organizations. This potentially diminishes the flow of those funds to teaching hospitals because health plans do not always direct GME funds that are imbedded in capitation rates to those institutions.
- Some states "carve out" GME payments from state-set Medicaid managed care rates and make GME payments directly to teaching institutions. Arizona is an example.
- Some states that carve out GME Medicaid payments distribute those funds as "carrots" to encourage the implementation of specific health policies, such as more residents in targeted shortage areas, more minority representation among residents, more primary care specialists, etc.

**More information on GME in the states can be found in Graduate Medical Education Financing Reform Efforts, National Governors Association, 1999. http://www.nga.org*

- Of those states that carve out GME Medicaid payments from general capitation rates, some specify in advance what health workforce policies the state intends to promote, make those policies explicit and widely known, and then hold GME payment recipients accountable for applying the funds in the intended manner. In some cases these funds are augmented with payments from other sources, and may support the education of groups like nurse practitioners, pharmacists and others in addition to physicians.

Based on Arizona's distribution of AHCCCS (Medicaid) GME payments to teaching hospitals, there would appear to be some rationale for the uneven distribution of GME funds among institutions, but the underlying policy behind the distribution – if there is one – is not explicitly stated.

One view is that the rationale is left unstated because Arizona does not have a coherent and explicit state health policy.

The Return on the GME Investment

HEALTH CARE FOR THOSE IN NEED

GME supports the training of hundreds of physician residents in critical health care settings who provide services to the elderly, the poor and those in need. Without that support, the provision of those services would be less effective and ultimately more costly for everyone. The direct daily care benefits to the citizens of the state appear as significant in 2003 as they were 10 years ago when AHCCCS GME payments were initiated.

FINANCIAL LEVERAGE

Arizona's AHCCCS investment of $6 million for teaching hospital GME programs receives an immediate yearly return of $2 for every $1 the state invests. If one adds Medicare payments that come to Arizona because of its GME programs, the return is 11 to 1.

AN INVESTMENT IN PEOPLE AND THE FUTURE

Public support in Arizona for GME is an investment in developing an adequate supply of physicians in a growing state to insure the provision of quality health care in the future. In addition to working in Arizona hospitals, clinics and other settings, GME residents are some of the people the new academic and research initiatives will be recruiting to staff the bioscience initiatives planned for Arizona. To the extent that the state diminishes its pool of medical residents, it potentially diminishes the ability to respond to new health and science initiatives.

The Arizona Council For **Graduate Medical Education (AzCGME)**

There is currently no group in Arizona that provides the full scope of information necessary to assess GME policies. From 1990 to 2000, The Arizona Council for Graduate Medical Education (AzCGME), a voluntary collaborative supported by the Flinn Foundation, provided research and analysis of GME issues and made recommendations on GME policy changes. It involved all allopathic and osteopathic medical schools and universities, teaching hospitals and consortia, and medical and hospital associations involved with GME in the state. The Council ceased to exist in January 2000.

Two documents from the Council's closing report are presented here to inform future deliberations on GME public policy in Arizona:

AzCGME Guiding Principles on GME Payment

- GME and related health care services represent a necessary and reasonable state investment in the quality of Arizona medicine; they further public purposes and merit continuing public support. Since all Arizona residents potentially benefit from medical education activities, the public should help finance these activities through the state's AHCCCS program.
- All health care purchasers, including public, private (including self-insured) and individual purchasers should help finance graduate medical education.
- Implementation and administration of any GME financing mechanism should be simple and cost efficient.
- AHCCCS payments for health professions education should be made with an accountability in the use of the funds, so those making payments can identify what is being purchased with public dollars. Each institution receiving AHCCCS GME funds should establish a methodology for accounting for the direct medical education (DME) monies received.

AHCCCS Payment for Graduate Medical Education in Arizona Teaching Hospitals

HOSPITALS WITH GME PROGRAMS	NUMBER OF RESIDENTS IN PROGRAMS*	AHCCCS TOTAL GME PAYMENT FFY 2002
Good Samaritan Regional Medical Center	119 [1]	$2,079,809.61
Kino Community Hospital (part of UA program)	15 [2]	$322,473.92
Maricopa County Medical Center	196 [1]	$6,183,096.74
Mesa General Hospital	23 [3]	$29,117.67
Phoenix Baptist Hospital	21 [2]	$134,131.81
Phoenix Children's Hospital**	30 [1]	$3,488,590.00
Phoenix General Hospital – Deer Valley	12 [3]	$13,666.95
Scottsdale Memorial Hospital – Shea	32 [1]	$41,655.33
Scottsdale Memorial Hospital – Osborn	15 [1]	$150,465.47
St. Joseph's Hospital – Phoenix	127 [1]	$2,587,199.90
Tucson Medical Center	43 [1]	$574,349.16
University Medical Center	229 [2]	$2,892,562.53
Walter Boswell Memorial Hospital	1 [1]	$2,827.00
Tempe St. Luke's	11 [3]	$85,053.86
TOTALS	**874 +/-**	**$18,585,000.00**

** There are different interpretations of the number of residents involved in each program, since residents rotate to various hospitals for clinical experiences. During the time a resident is at a hospital's program, they may be counted as "residing" there. The numbers provided are based on the following:*

1. *Number of residents based on Arizona Council on Graduate Medical Education Council review of Medicare cost report audited data from 1996 and agreed to in 1999 (when final reports became available) by all hospitals. Numbers may have changed slightly since that time, but there is no other hospital agreed-upon count available. While number of residents have remained relatively stable, the population has increased.*
2. *Survey by Phoenix Area Medical Education Consortium, Fall 2002.*
3. *Arizona Osteopathic Medical Association, Fall 2002.*

*** The disparity between PCH's ratio of residents/AHCCCS GME payments and those of other hospitals is well known in Arizona health care and political circles. The subject generates more heat than light, and cannot be explored further here.*

For each of the 874 residents in GME programs in Arizona, the state contributes approximately $7,000 while the federal government contributes roughly $78,000, for a total of $85,000 per resident. A average cost of $75,000 – $90,000 or more per resident is consistent with national norms.

What If **AHCCCS No Longer Funded GME?**

Arizona Would Lose Matching Funds A total of $32 million in direct support to GME programs is used to fund staff, residents and operating costs for the programs. The $6 million in state dollars and $12 million in federal match from AHCCCS provide $18 million of that direct support. If AHCCCS were to discontinue its contribution toward GME in Arizona, the federal Medicaid match would also end. Arizona GME programs would receive only Medicare DME payments of $14 million a year to run the programs, less than half of what they currently receive. Federal Medicare direct and indirect GME payments would be the only major source of outside funding and would total $56 million – an average of $64,000 per resident versus the $85,000 available with continued AHCCCS funding. If GME programs were to close as a result of losing state/federal Medicaid dollars, their Medicare GME funds would go away as well.

Hospitals Would Have To Increase Their GME Subsidies The direct costs of GME programs are relatively fixed, as are the number of residents trained each year. Since the teaching hospitals already subsidize the programs, decreases in direct funding would mean a need for greater subsidization from within the hospital. If AHCCCS funding was curtailed from one budget year to the next, the hospitals receiving the largest payments would have to replace $16 million in payments in a matter of months to ensure survival of their programs. Given rising health care costs and the limited ability of hospitals to shift costs to other payers, it is questionable how many teaching hospitals would choose, or be able, to continue GME programs. The "ripple" effect could be significant.

Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on vulnerable populations and building the capacity of communities to help themselves.

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St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve the health of all Arizonans, especially those in need.

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