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May 21, 2003 Joint Committee on Finance Paper #390

MA Payments for Graduate Medical Education (DHFS -- Health Care Financing -- Payments, Services, and Eligibility)

[LFB 2003-05 Budget Summary: Page 216, #6]

CURRENT LAW

Medical assistance (MA) currently reimburses hospitals for graduate medical education (GME) costs under the hospital reimbursement formula. A hospital's base payment rate is adjusted to reflect the additional costs hospitals incur because they operate GME programs. This adjustment is reflected in each claim a hospital submits for services it provides to an MA recipient. Direct GME costs are costs of salaries and fringe benefits for residents and interns. Adjustments for indirect costs are based on the Medicare indirect GME payment formula, which adjusts each hospital's base rate based on the hospital's ratio of residents to its available beds.

In 2001-02, 33 hospitals received GME adjustments totaling approximately $9.7 million (all funds) for direct costs and approximately $18.2 million (all funds) for indirect costs.

Medical schools provide undergraduate medical education. Wisconsin has two medical schools, the Medical College of Wisconsin and University of Wisconsin Medical School. Once students complete their undergraduate medical education, students must participate in a residency program, known as graduate medical education, before they can be licensed to practice medicine. GME programs are generally operated and funded by hospitals. The length of a student's residency can range from three to seven years, depending on the student's specialty.

GOVERNOR

Reduce MA benefits funding by $28,592,000 (-$11,890,000 GPR and -$16,702,000 FED) in 2003-04 and ($28,588,600 (-$11,890,000 GPR and -$16,698,600 FED) in 2004-05 to reflect

cost savings that would result from eliminating MA payments to hospitals for the hospitals' direct and indirect GME costs.

DISCUSSION POINTS

1. The attachment to this paper identifies the total MA GME payments DHFS made to each hospital in 2001-02.

2. Funding for GME under MA is one part of an overall funding system for GME programs. Medicare payments for GME represent a larger share of funding for GME programs than the funding provided under MA. Based on audited cost reports on file with DHFS as of March 21, 2003, hospitals report Medicare GME payments totaling approximately $90.3 million for fiscal years ending in 1999. This funding does not include a federal grant of approximately $8.5 million provided to Children's Hospital in Milwaukee County for GME-related costs. According to the Council on Graduate Medical Education (COGME), private third-party payers have traditionally paid more to teaching hospitals than other hospitals to support GME-related costs. However, this practice have been eroding with the growth of managed care.

3. The administration indicates that its rationale for eliminating MA payments for GME is that funding reductions in MA are necessary to offset rising MA costs in MA and to reduce GPR spending. The administration indicates that these reductions are appropriate because GME payments do not directly benefit MA patients and that GME payments for indirect costs may compensate hospitals in excess of their actual medical education costs.

4. In a letter dated March 17, 2003, to the Co-Chairs of the Joint Committee on Finance, the DOA Secretary requested a modification to the bill to better reflect the Governor's intent to restore GME payments in the future. This request would restore the Department's authority to make GME payments, beginning in the 2005-07 biennium, by requiring DHFS to seek an amendment to the state's MA plan to restore GME payments beginning July 1, 2005. If the Committee approved the administration's revised request, it would create a general fund commitment for the 2005-07 biennium for which no base funding would be provided.

5. It has been argued that if GME payments under MA are eliminated, hospitals could reduce the number or residency slots the fund. Because hospitals have already made commitments to existing residents, it is likely that any reductions in residency slots would be reduced for first-year residents, beginning next year.

6. It is not clear that hospitals would reduce residency slots if MA GME payments were reduced or eliminated, for several reasons. First, some have argued, including the administration, that teaching hospitals have sufficient revenue to support residency programs without MA funding for GME costs. In 2001, the four hospitals that received the largest share of MA GME payments reported net income totaling $75.2 million.

It is difficult to assess a hospitals' ability to absorb a reduction in revenue without affecting

the number of residency slots, since hospitals rarely operate in isolation of one another or in isolation from other health care service providers. Most hospitals are part of larger health care networks, which complicates any assessment of any hospitals' ability to absorb funding reductions. For example, Sinai Samaritan in the City of Milwaukee, one of the four major teaching hospitals, reports net losses in the millions each year, including losses of more than $17 million in 2001. However Sinai Samaritan is owned by the Aurora health care network, which owns a variety of hospitals across the state, many of which regularly generate net income. Other hospitals, which may report net income, may use that income to support other health care services such as nursing homes, home health services, or clinic-based services, which operate at losses each year.

7. Second, if hospitals reduced the size of their residency programs, these hospitals would receive less in Medicare GME payments, since payments under Medicare are based on the size of a hospital's teaching program. As indicated previously, Medicare GME payments for hospitals' fiscal year ending in 1999 totaled approximately $90.0 million.

8. Third, hospitals may not reduce the size of their residency programs if the hospitals determine that maintaining residency programs is in the hospitals' interest, since reducing residency slots could harm hospitals' ability to recruit future physicians. This argument is based on the premise that the number of a state's residency programs has a correlation to size and the make-up of a state's physician workforce.

9. A study reported by the National Conference of State Legislatures (NCSL), found that approximately 35% of physicians currently practicing in Wisconsin completed their GME here. In other words, 65% of physicians practicing here, completed their GME somewhere else. Nationally, approximately 41% of physicians are practicing in the state where they completed their GME. This NCSL study was conducted by the Institute for Primary Care and Workforce Analysis with support from the Health Resources and Services Administration and based on an analysis of data available from the American Medical Association's 1999 physician masterfile.

10. It is not clear that where a physician completes his or her residency has a strong correlation to where he or she practices medicine, since other factors may affect this decision. These factors appear to relate to differences in population size and density, number and size of medical schools and GME programs, and median household income, according to the NCSL report. More recently, managed care penetration and malpractice insurance rates also seem to influence the number of physicians in practice and in training among states. For these reasons, it is difficult to determine what the impact of a reduction in residency slots would be on the size of the future physician workforce in Wisconsin.

11. Nonetheless, a reduction in GME could reduce revenue to hospitals, which could weaken a hospital's financial position. Alternatively, hospitals could shift additional GME costs to other third-party payers in the form of increased rates paid by commercial health plans.

12. The Committee could restore funding for payments related to direct GME costs by increasing funding in the bill by $9.7 million (approximately $4.0 million GPR and $5.7 million

FED) annually. These are costs directly related to hospitals' costs to operate GME programs, such as salary and fringe benefit costs for residents.

13. This alternative would retain the Governor's proposal to eliminate MA payments for indirect GME costs. These are the additional costs that teaching hospitals experience as a result of operating GME programs. These costs include serving more severe, higher cost patients, more diagnostic testing and the additional time associated with using patient care to train physicians. These indirect costs are difficult to quantify, but widely recognized as costs incurred by teaching hospitals.

14. Funding for indirect GME costs tends to be vulnerable to budget reductions because funding for these costs are not directly related to hospitals' costs or patient care. Additionally, there has been ongoing concern at the national level that Medicare payments for indirect GME costs may over-compensate hospitals for indirect GME costs. The 1997 Balanced Budget Act reduced funding for indirect GME payments to hospitals under Medicare over a four-year period due to these concerns. However, in subsequent legislation, Congress modified those reductions to minimize the impact of a variety of funding reductions contained in the legislation that affected hospitals. The current formula for calculating payments for indirect GME costs under MA is the same formula used under Medicare.

15. Most states provide some financial support for direct GME costs, but 16 do not support indirect GME costs.

ALTERNATIVES

1. Adopt the Governor's recommendations to eliminate funding for direct and indirect GME payments.

2. Modify the bill to require DHFS to seek a state plan amendment, effective July 1, 2005, which would restore the Department's authority to provide payments for both direct and indirect GME costs in the 2005-07 biennium.

3. Increase funding in the bill by $4,033,700 GPR and $5,666,300 FED in 2003-04 and $4,037,900 GPR and $5,662,100 FED in 2004-05 to restore funding for MA payments for direct GME costs only.

Alternative 3	GPR	FED	TOTAL
2003-05 FUNDING (Change to Bill)	$8,071,600	$11,328,400	$19,400,000

4. Delete provision.

Alternative 4	**GPR**	**FED**	**TOTAL**
2003-05 FUNDING (Change to Bill)	$23,780,000	$33,400,600	$57,180,600

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Attachment

ATTACHMENT

MA Graduate Medical Education Payments, by Hospital
2001-02 Fiscal Year

Hospital Name	City	Direct Medical Education	Indirect Medical Education	Total Graduate Medical Education Reimbursement
Children's of Wisconsin	Milwaukee	$1,980,246	$3,811,736	$5,791,982
Froedtert	Milwaukee	1,771,936	3,645,083	5,417,019
University of Wisconsin	Madison	1,314,176	3,494,521	4,808,697
Sinai Samaritan	Milwaukee	2,000,696	2,502,495	4,503,191
St. Luke's	Milwaukee	328,033	589,617	917,650
St. Mary's	Milwaukee	371,907	504,111	876,018
St. Joseph's	Milwaukee	240,870	500,070	740,940
Milwaukee County Mental Health	Milwaukee	333,651	404,651	738,303
St. Mary's	Madison	236,940	410,679	647,619
Meriter	Madison	224,916	394,529	619,445
St. Michael	Milwaukee	121,174	459,360	580,535
Gunderson Lutheran Medical Center	La Crosse	123,875	363,063	486,938
St. Joseph's	Marshfield	173,419	201,788	375,206
St. Mary's	Racine	58,420	111,659	170,078
Columbia	Milwaukee	60,599	107,779	168,377
Wausau	Wausau	52,179	113,293	165,472
Franciscan Skemp Medical Center	La Crosse	49,670	86,765	136,435
Mercy	Janesville	41,741	80,762	122,503
Luther	Eau Claire	23,881	93,322	117,202
Sacred Heart	Eau Claire	27,083	79,140	106,223
St. Elizabeth's	Appleton	11,661	88,375	100,036
Waukesha Memorial	Waukesha	18,597	54,977	73,574
Appleton Medical Center	Appleton	16,983	36,137	53,121
Bellin Psychiatric Hospital	Green Bay	37,741	0	37,741
St. Luke's	Racine	6,904	30,277	37,181
Bellin	Green Bay	23,349	139	23,488
Hess Memorial	Mauston	4,749	13,701	18,450
St. Vincent	Green Bay	7,468	1,609	9,077
St. Francis	Milwaukee	1,578	2,161	3,740
Mercy Medical	Oshkosh	2,291	0	2,291
West Allis Memorial	West Allis	0	1,440	1,440
Milwaukee Psychiatric	Wauwatosa	0	1,250	1,250
St. Agnes	Fond du Lac	652	0	652
Totals		$9,667,385	$18,184,490	$27,851,875