

Issue Paper



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FACING THE MICHIGAN LEGISLATURE

GRADUATE MEDICAL EDUCATION: SOURCES OF FUNDING AND HISTORIC APPROPRIATIONS

by

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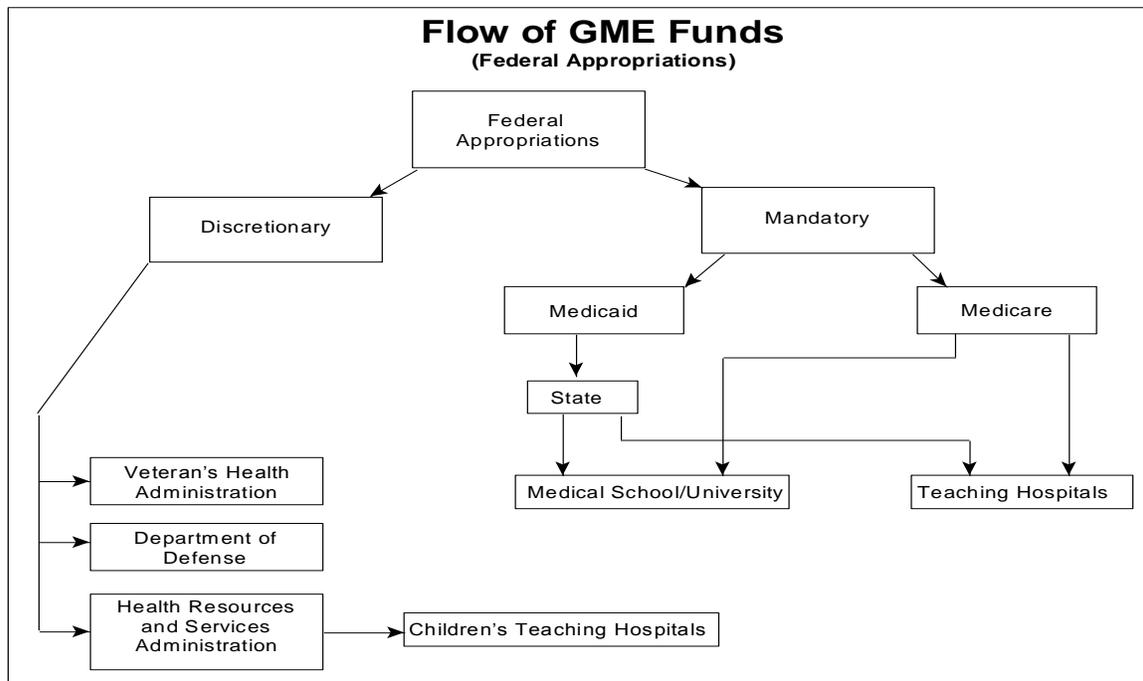
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INTRODUCTION

Although the concept of graduate medical education (GME) through the use of residencies and internships has existed, in some form, since 1840, it was not until the administration of President Lyndon B. Johnson that the Federal government became involved in financing medical programs at teaching hospitals across the United States. With the enactment of Titles XVIII and XIX of the Social Security Act in 1965, creating the Medicare and Medicaid programs, the mechanisms for funding graduate medical education on a Federal level were established. Originally, GME funding was provided to help augment the supply of consistently well trained physicians in order to respond to the increased pressure on existing health care resources caused by the creation of these two programs¹. Medicare and Medicaid fund GME programs slightly differently. Medicare funding flows directly from Federal appropriations to the teaching hospitals and residency training programs that are providing eligible services, while Medicaid funding for GME flows through the state budget process before being disbursed to teaching hospitals.

Graduate medical education funding flows to various medical schools and teaching hospitals through several different paths. Figure 1, below, shows the flow of federally appropriated funds. Federal funds are considered to be either discretionary or mandatory. Discretionary appropriations are the smaller of the two categories and consist of annual allocations that set the total level of funding and are governed by annual appropriations acts. Conversely, mandatory appropriations, also known as "entitlements", set eligibility criteria and funding is then provided to all who meet the criteria, regardless of total annual cost. Mandatory spending is controlled by laws other than the annual appropriation act. The most well known examples of mandatory appropriations are Medicaid and Medicare, which will be discussed further in subsequent sections of this paper.

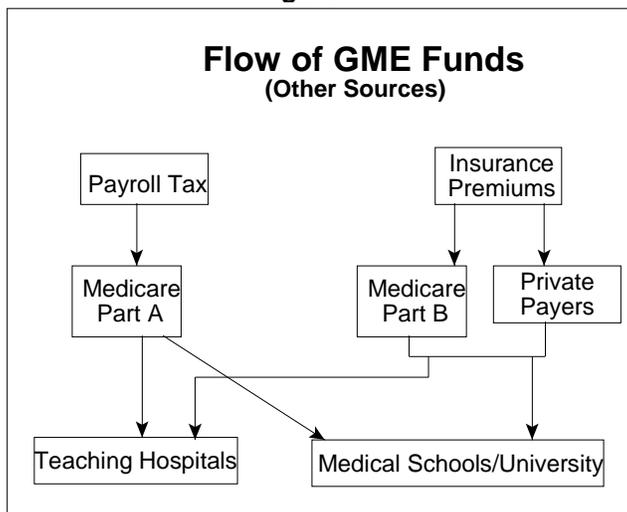
Figure 1



In addition to Federal appropriations, GME funding sources include payroll taxes and insurance premiums. Often, teaching hospitals have higher costs than nonteaching hospitals. This factor is reflected in the higher rates paid to teaching hospitals by private insurers. Figure 2 shows the flow

of funds from non-Medicaid and non-Medicare sources, including the implicit GME payments made by private payers. In addition to the sources shown in [Figures 1](#) and [2](#), some teaching hospitals and medical schools are supported by private grants and donations. Since private funding of GME is based less on costs associated with running a residency program, and more on unquantifiable factors, this paper does not include a discussion of the impact of private funding on residency programs. However, it would be an oversight to ignore the existence of such grants and gifts completely.

Figure 2



This paper provides a breakdown of the different funding mechanisms through which GME money reaches teaching hospitals within the State of Michigan. The first two sections of the paper discuss the funding streams over which the State has little discretion, mainly Medicare and other non-Medicaid GME funding. The remainder of the paper discusses how the State distributes General Fund/General Purpose (GF/GP) money along with Federal Medicaid matching funds to hospitals in Michigan, as the State has more discretion in the distribution of funds to in-State hospitals than it does with money that comes from the Federal government and private payers. The final portion of the paper discusses recent historic funding for GME. This portion is broken down into five subsections covering fiscal year (FY) 2011-12 through FY 2015-16.

MEDICARE

Between 1965 and 1984, Medicare funding for GME was paid strictly on a cost basis. As hospitals added residents and teaching staff, they automatically received an increase in GME funding from the predecessor to the Centers for Medicare & Medicaid Services, the Health Care Financing Administration. This resulted in a retrospective program that allowed the creation and growth of medical education training programs that were not constrained by Federal policy². Beginning in 1985, Medicare payments for GME were broken down into payments for direct graduate medical education (DGME) and indirect graduate medical education (IGME). Direct graduate medical education payments are used to reimburse costs directly resulting from the teaching program, such as the benefits and stipends of both residents and faculty, as well as some overhead costs. Indirect graduate medical education is the more controversial of the two funding streams as it attempts to quantify the costs that a teaching hospital incurs, but cannot be directly attributed to the presence of residents. Some examples of IGME costs are additional diagnostic tests that are ordered either because residents need training in a particular area, or because residents lack experience to correctly diagnose patients without additional confirmation³.

Beginning in 1985, DGME payments were calculated by multiplying three variables: a hospital's weighted resident count, a per-resident amount (PRA), and the hospital's Medicare day ratio. In order to be counted as 1.0 full-time equivalent (FTE) resident in the weighted resident count, a resident must be in his or her initial residency period and spend all of his or her time working in a full-time residency slot at the teaching hospital or a qualified nonhospital site⁴. Residents who spend only a portion of their time working in a full-time residency slot at the teaching hospital are counted as a partial FTE. Additionally, residents who are past their initial residency period are counted as 0.5 FTE. The weighted number of full-time equivalent residents is averaged over the most recent three-year period to create this variable. The per-resident amount is a dollar amount that is calculated by dividing the hospital's allowable 1984 GME costs by the number of residents at the hospital in 1984. This dollar amount is then adjusted for inflation and geographic differences. In 2000, the minimum PRA was raised from 70% to 85% of the national average by Medicare, Medicaid, and the State Children's Health Insurance Program Benefits Improvement and Protection Act⁵. The final variable, the hospital's Medicare day ratio, is calculated by dividing the hospital's number of Medicare inpatient days by the total number of inpatient days⁶.

Indirect graduate medical education payments are an adjustment to the fixed diagnosis-related group payment hospitals receive for each Medicare discharge. The IGME adjustment is a formula that is calculated by using a hospital's ratio of residents to beds (also known as the IRB), as well as a multiplier set by Congress⁷. Effectively, the current multiplier of 1.35 would result in a 5.5% increase in the IGME payment for every 10% increase in the IRB. This is much lower than the 11.59% adjustment factor mandated by Congress at the inception of the adjustment factor in 1983. In response to fears that the Medicare Trust Fund would be depleted within the near future, the Clinton administration and Congress enacted the Balanced Budget Act of 1997. The Act's provisions resulted in a reduction to the IGME adjustment.

In addition to reducing the IGME adjustment factor, the Balanced Budget Act of 1997 placed a cap on the number of residency slots available, limiting slots to the unweighted number of residents on the hospital's most recent cost report before December 31, 1996. Section 407 of the Balanced Budget Refinement Act of 1999 increased the resident cap for rural hospitals to 130% of the hospital's resident count as of December 31, 1996⁸. Subsequent laws have not changed the cumulative cap, but have attempted to move existing residency slots from hospitals with unfulfilled slots. The Patient Protection and Affordable Care Act of 2010, commonly known as the ACA, reduced training slots in hospitals that had 65% of their positions unfulfilled. Of these excess slots, 70% were allocated to teaching hospitals in states with low resident-to-population ratios, while the remaining 30% went to teaching hospitals located in the top 10 with primary care shortages and rural areas⁹.

The ACA also addressed the problem of what happened when a teaching hospital closed. Previously, the slots were not redistributed and were considered "lost". Section 5506 of the ACA retroactively redistributed slots from hospitals that closed between March 23, 2008, and August 3, 2010. Subsequent redistribution of slots from future teaching hospital closures would require the receiving hospital to meet specific criteria, with preference given to hospitals located in or near the same core based statistical area as the hospital that closed¹⁰. For new residency training programs established between January 1, 1995, and October 1, 2012, the unweighted residency cap for the hospital is adjusted based on the sum of the highest number of FTE residents in any program during the program's third year of existence and the highest number of FTE residents in each type of program during the minimum length of time to obtain board eligibility for that program. In the case of residency programs established after October 1, 2012, the residency cap is adjusted based on the sum of the highest number of FTE residents in any program year during the fifth year of the program's existence¹¹. There are some slight variations to these rules depending on

whether the residents are spending only a portion of their year at the training program, whether the hospital is a rural hospital, or whether the hospital had allopathic or osteopathic residents before December 31, 1996.

Table 1, below, shows a breakdown of Medicare funds received by hospital systems, based on affiliations in existence at that time, for hospital fiscal years ending between September 30, 2013, and June 30, 2014. For a breakdown of Medicare funds received by hospital, please see Table A located in the Appendix.

Table 1

MEDICARE GME FUNDING BY SYSTEM^a	
System	Total Medicare GME
Allegiance	\$1,948,512
Beaumont	19,099,129
Borgess	4,779,132
Bronson	4,235,585
Detroit Medical Center	28,785,908
Henry Ford	42,517,518
McLaren	20,702,742
Lakeland	1,629,800
Trinity	25,815,796
MidMichigan	1,574,102
Munson	948,245
Oakwood	14,225,372
St. John Providence	26,535,782
Sparrow	7,132,633
Spectrum	7,217,633
Saint Marys	1,707,838
Unaffiliated	61,543,068
Statewide Total	\$270,398,795
^a Data are from hospital cost reports for fiscal years ending between 9/30/13 and 6/30/14.	

Source: Michigan Health and Hospital Association

OTHER SOURCES OF FUNDING

There are three smaller payers of GME funds in addition to Medicare and Medicaid. As of 2012, the U.S. Department of Defense funds approximately 3,000 residency positions spread among the four branches of the military. The number of residency slots that will be offered for a given year are decided in advance by a joint committee of military leaders, known as the Health Professions Education Requirement Board. Factors that determine the number of slots offered are the needs of the military as well as the discretionary appropriation to the Department of Defense to cover expenses. After the number of training slots are approved, medical students submit applications to, and are assigned to residency training programs by the Joint Service Graduate Medical Education Selection Board¹².

The second discretionary appropriation for GME goes to the U.S. Department of Veterans Affairs (VA), which supports 10% of all residency positions. The VA is prohibited by policy from sponsoring training programs, but works through affiliation agreements with medical schools to provide residents who rotate through Veteran's Health Administration facilities. Since the VA cannot bill Medicare for services provided, all GME funding comes from its yearly appropriation. Unlike Medicare, DGME payments are based on current costs rather than the formula discussed in the previous section, while IGME funding is a pre-set amount based on the number of residents per facility¹³.

Additionally, the Children's Hospital Teaching Fund was authorized by the Health Research and Quality Act of 1999 to fund residency programs at pediatric hospitals¹⁴. Children's hospitals graduate medical education (CHGME) payments are made to only freestanding children's hospitals. General teaching hospitals with a pediatric residency, or children's hospitals that are part of a larger hospital system, are supported through the Medicare and Medicaid streams discussed elsewhere in this paper. Unlike Medicare, funding for CHGME is determined by annual discretionary appropriations. Furthermore, DGME payments are statutorily required to make up one-third of the appropriation, while IGME payments make up the remaining two-thirds of the total appropriation. Children's hospitals graduate medical education payments are calculated using the Medicare formulae. The payments a specific children's hospital would receive under the Medicare funding stream are then taken as a percentage of the total funds for all children's hospital payments. This percentage is applied to the yearly appropriation for CHGME to determine the specific children's hospital's actual payment¹⁵. In FY 2012-13, the Children's Hospital of Michigan was the only pediatric hospital in Michigan receiving support from the Children's Hospital Teaching Fund, with a total of \$11,027,475¹⁶.

The Health Resources and Services Administration also funds the Teaching Health Center (THC) GME program. The THC was created by the ACA as a five-year initiative to expand the number of residents in community-based settings. The Teaching Health Center funding is not formula-based, but rather allocates \$150,000 per full-time resident per year. Two Michigan entities began receiving funding through the THC GME program in FY 2012-13. Over the life of the initiative, the Detroit Wayne County Health Authority has received \$17,852,016, while Hamilton Community Health Network, Inc. of Flint has received \$2,250,336 to support residencies in such areas as family medicine, internal medicine, pediatrics, psychiatry, geriatrics, and obstetrics/gynecology¹⁷. The Medicare Access and CHIP Reauthorization Act of 2015 effectively extended the program past its September 30, 2015, end date by making the original appropriation of \$230,000,000 available until spent¹⁸.

MEDICAID

Under Federal law, states are allowed to appropriate funds to support GME programs, which are then eligible for Federal Medicaid matching funds. While Medicaid is a mandatory appropriation on the Federal level, the State does have the ability to set the level of GF/GP funding it wishes to use to pull down Federal matching funds for Medicaid GME. Michigan does not differentiate between DGME and IGME payments, but rather created two different pools from which money is allocated. In order for a hospital to receive funds from either of these pools, the Michigan Department of Health and Human Services (DHHS) requires that the hospital have a national Medicare accredited medical education program. One of these pools is the Primary Care Pool, which allocates funds only for residents who are training to become primary care physicians¹⁹. In FY 2014-15, this pool accounted for 14.3% of all Medicaid GME funds appropriated. The other pool is the GME Funds Pool, which reimburses hospitals for costs stemming from both primary care residents and those pursuing specialties. This pool includes a small fund for dental and

podiatry residencies. In FY 2014-15, this pool accounted for 85.7% of appropriated GME funds. Table B in the Appendix at the end of the paper shows the breakdown of how funds from both pools were distributed as well as the total GME Medicaid payments for each hospital.

Michigan's Primary Care Pool

In FY 2014-15, the Primary Care Pool distributed \$21,269,600 to fund primary care residencies around the State. The formula that the DHHS uses to calculate individual hospital payments is based on the FTE residents as shown in a hospital's filed cost reports, total hospital outpatient charges, Title V (Children's Special Health Care Services) outpatient charges, and Title XIX (Medicaid) outpatient charges.

The formula for calculating the individual hospital payment is:

$$\text{Pool Size} \times (\text{Adjusted FTEs} / \text{Sum of Adjusted FTEs}) = \text{Individual Hospital Payment}$$

The adjusted FTEs are equal to the total number of a hospital's FTE residents, multiplied by a ratio of the hospital's Title V and Title XIX outpatient charges to the hospital total outpatient charges.

Michigan's Graduate Medical Educate Funds Pool

The GME Funds Pool is the larger of the two with a gross appropriation of \$127,109,100 in FY 2014-15. In addition to distributing money for primary care residencies, funds from this pool are used for residents pursuing specialties²⁰. As with the Primary Care Pool, the GME Fund Pool uses a formula that includes the total number of FTE residents at a hospital, but also looks at the Medicaid case mix (patient acuity), the Title V and Title XIX days, and the total hospital days²¹.

The formula for calculating the distribution of individual hospital payments is:

$$\text{Pool Size} \times (\text{Adjusted FTEs} / \text{Sum of Adjusted FTEs}) = \text{Individual Hospital Payment}$$

In this pool, the adjusted FTEs are calculated by multiplying the total number of FTEs by the hospital's case mix and by a ratio of the hospital's Title V and Title XIX days to the hospital's total days.

The GME Funds Pool includes approximately \$300,000 to \$400,000 annually that is used to make payments for dental and podiatric residencies. Payments for these residencies are calculated by multiplying the hospital's updated dental podiatric FTEs by the average dental and podiatric FTE payment. The average payment is based on hospital cost reports filed during the 1995 calendar year, while each hospital must update its dental and podiatric FTE count annually.

RECENT FUNDING HISTORY IN MICHIGAN

FY 2011-12

The Executive budget recommendation for FY 2011-12 proposed an appropriation level for GME of \$34,163,600 GF/GP (\$100,896,500 Gross), a 40% decrease in funding from the FY 2010-11 level of \$56,939,800 GF/GP (\$168,954,800 Gross). While the House concurred with the reduction, the Senate created a placeholder for all GME funding. When the Conference Committee met, an overall funding level of \$52,232,400 GF/GP (\$154,259,900 Gross) was agreed upon, with \$5,800,000 GF/GP (\$17,129,400 Gross) designated as one-time funding. When both ongoing funding and one-time funding are included, the net impact on GME funding was an 8.7% reduction in payments from the previous fiscal year.

A new boilerplate section, Section 1846, was included to set up a workgroup on GME funding. The workgroup would attempt to identify shortages in specific specialties and geographic areas, research ways in which other states addressed practitioner shortages through the use of GME payments, and recommend specific policy changes. Additionally, this section included intent language that GME funding for FY 2012-13 potentially be based on the report.

Public Act 89 of 2012 included supplemental appropriations of \$3,000,000 GF/GP (\$8,860,000 Gross) for graduate medical education. This brought the FY 2011-12 overall appropriation for GME to \$55,232,400 GF/GP (\$163,119,900 Gross).

FY 2012-13

In his Executive budget recommendation, Governor Snyder removed one-time funding for GME, including the supplemental funds from the previous budget year, leaving a total appropriation of \$46,432,400 GF/GP (\$137,130,500 Gross). The House restored all of the one-time funding, as well as provided a small increase over the original FY 2011-12 appropriation²². The Senate chose to create a \$100 placeholder in order to keep the issue open. The Conference Committee agreement between the two chambers restored funding to the postsupplemental FY 2011-12 level, and designated a portion of the funds as one-time. The final agreement was to fund graduate medical education at \$54,746,800 GF/GP (\$162,888,300 Gross), with \$1,450,000 GF/GP (\$4,314,200 Gross) reflected as one-time funding. Overall, this was a \$231,600 decrease in the Gross funding level from the previous fiscal year.

In the boilerplate portion of the budget bill, Section 1846 was rewritten to direct the Department of Community Health (now within the DHHS) to research the effectiveness of GME funding, specifically to identify physician shortages by practice and geographic area, and consider ways to reduce shortages through policy changes. This report was to be presented to the Legislature by April 1 of that fiscal year.

FY 2013-14

The Executive budget recommendation for FY 2013-14 removed one-time funding equal to \$1,450,000 GF/GP (\$4,314,200 Gross) for graduate medical education. The House included a partial restoration of this funding, bringing the level of one-time GME appropriations back up to \$555,000 GF/GP (\$1,656,800 Gross). The Senate rejected the reduction in funding, and the Conference Committee concurred. This kept the appropriation equal to the FY 2012-13 level of \$54,860,800 GF/GP (\$162,888,300 Gross).

The Department of Community Health (DCH) budget for FY 2013-14 retained the FY 2012-13 language in Section 1846 and included a new boilerplate section, Section 1870, which directed the Department to create a consortium with medical-school-affiliated faculty practice physician groups to develop a plan to create primary care GME programs. This section also directed the Department to pursue a Federal waiver to implement a program similar to the Utah Medicare GME demonstration project²³.

FY 2014-15

In his initial budget recommendation for FY 2014-15, Governor Snyder removed all of the one-time funding for GME, along with the Federal match, which had been included in the FY 2013-14 budget. The House included a partial restoration of the funding at the level of \$54,680,500 GF/GP. This would have pulled down \$106,795,500 in Federal matching funds, bringing the program to a Gross funding level of \$161,476,000. The Senate proposed, and the Conference Committee concurred with, a full restoration of GME funding to equal what had been in the budgets for both FY 2012-13 and FY 2013-14.

In addition to the \$162,888,300 Gross in appropriated funds, the Conference Committee concurred with the Senate proposal to appropriate \$500,000 GF/GP to create a GME consortium to be known as MiDocs. These funds were to be used to develop freestanding residency training programs, legally create the consortium, prepare a report on progress, and obtain Accreditation Council for Graduate Medical Education (ACGME) accreditation. Boilerplate Section 1870 was rewritten to specify the membership of the consortium as well as require that MiDocs be responsible for obtaining continuing accreditation from the ACGME, financial accountability, clinical quality, clinical compliance, and submission of an annual report detailing per-resident costs for medical training and clinical quality measures.

The FY 2014-15 DCH budget also contained a rewrite of boilerplate Section 1846 to reflect the goals associated with the distribution of graduate medical education funds. (This language also was included in the FY 2015-16 budget.) Specifically, GME funds are to encourage the training of physicians in specialties that meet the future needs of residents of Michigan, and train physicians in ambulatory sites and rural locations, as well as other settings.

In February 2015, Governor Snyder signed Executive Order (E.O.) 2015-5 to implement various expenditure reductions for the fiscal year. The E.O. included an 8.9% reduction to graduate medical education funding. This reduced total funding to \$51,131,300 GF/GP (\$148,378,700 Gross). Total GME funding by hospital system is shown in Table 2 below. A breakdown of GME funding by hospital can be found in Table B in the Appendix.

Table 2

FY 2014-15 MEDICAID GME FUNDING BY SYSTEM^a			
System	GME Funds Pool	Primary Care Pool	Total GME
Ascension	\$10,605,882	\$2,659,848	\$13,265,730
Beaumont	6,874,576	2,143,636	9,018,212
Bronson	2,734,331	393,464	3,127,795
DMC	36,766,326	6,460,764	43,227,090
Henry Ford	14,980,018	1,385,480	16,365,498
LifePoint	238,916	66,608	305,524
McLaren	3,888,296	1,287,116	5,175,412
MidMichigan	180,364	116,076	296,440
Munson	135,478	76,228	211,706
Sparrow	2,830,761	605,740	3,436,501
Spectrum	6,067,147	736,244	6,803,391
Trinity	3,378,448	1,149,392	4,527,840
Unaffiliated	38,428,557	4,189,004	42,617,561
Statewide Total	\$127,109,100	\$21,269,600	\$148,378,700

^a These totals reflect E.O. 2015-5.

Source: Michigan Department of Community Health

FY 2015-16

The Governor's budget recommendation for FY 2015-16 reflected a departure from the approach taken in previous years toward GME funding. Rather than supporting the program with GF/GP dollars, the Executive budget proposed increasing the hospital Quality Assurance Assessment

Program, or QAAP, to support the program. A QAAP is a tax on a class of medical providers, which is then used to supplant GF/GP dollars as the non-Federal share of Medicaid funding. The remaining revenue is used to increase reimbursement rates for services to Medicaid recipients. Using this approach generates Federal matching funds, which allows the provider group to receive more revenue in Medicaid reimbursement than it paid in taxes²⁴. Rather than using a QAAP increase to raise provider rates, as a whole, the FY 2015-16 Executive budget proposed using \$56,131,300 of the QAAP increase to offset the GF/GP dollars used to fund GME. This would have resulted in a widespread tax being used to support specialized pools. The House concurred with the Governor's proposal to use the QAAP to offset the GF/GP funding of GME. However, the Senate and the Conference Committee rejected the proposal and continued to fund GME at the same level as the initial appropriations for FY 2014-15: \$162,888,300 Gross and \$56,033,600 GF/GP.

The initial FY 2015-16 budget included two new boilerplate sections concerning GME as well as a revision of an existing section. The first new section, Section 1805, requires hospitals receiving GME funds from the State to submit fully completed quality data to a qualifying national nonprofit organization with extensive experience in collecting and reporting hospital quality data on a public website. This section spells out the requirements for the national nonprofit organization receiving the data. This section also includes a penalty holding a hospital's fourth-quarter GME payments until submission of the required data. The second new section also deals with data collection regarding residency training programs. Section 1812 requires two reports covering costs associated with residency training programs, postresidency retention rates, and the marginal cost of adding additional residency slots by hospital. Upon submission of the data to the Department, a workgroup will be created to develop metrics for the future distribution of GME funds. This section includes the same penalty as in Section 1805. As discussed above, in FY 2014-15, Section 1870 created the MiDocs GME consortium and appropriated \$500,000 to legally create the consortium, obtain ACGME accreditation, develop new residency programs, and prepare a report on per-resident costs for medical training and clinical quality measures. The FY 2015-16 budget maintained the language, but created a work project allocation from FY 2014-15 in order to allow the Department to continue spending the \$500,000 appropriated in the previous budget.

CONCLUSION

As the baby boomer population continues to age, a common refrain heard in the media is that the country is facing a physician shortage. This fear seems to be contradicted by the fact that more students are entering medical school now than at any point in recent history²⁵. While part of this can be accounted for by the shift from studies of general practice medicine to studies of specialized medicine, resident caps play a large role in explaining the remainder of the discrepancy. It can be difficult to obtain a complete picture of the state of graduate medical education in Michigan as a result of the numerous, fragmented funding streams that provide support. The schism between Federal and State funding often limits the availability of information. This paper has attempted to provide a unified overview of the sources and recipients of GME funding. It is clear that, since FY 2011-12, the funding of graduate medical education has been a point of contention between the Executive Office and the Legislature. As the State continues to face other budgetary pressures, GME funding will continue to be an issue, due to the fact that the State portion is funded entirely with GF/GP dollars. The Senate Fiscal Agency will be following future developments related to the program, in particular the progress of any legislative or budgetary adjustments.

ENDNOTES

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- ¹ Cymet, T., Chow, R.D. (2011), "The funding of graduate medical education in the American healthcare system". *Medical Science Educator*, 21(4): 367-374.
- ² Rich, C., Liebow, M., Srinivasan, M., Parish, D., Wolliscroft, J., Fein, O., Blaser, R. (2002), "Medicare financing of graduate medical education: Intractable problems, elusive solutions". *General Internal Medicine*, 17(4): 283-292. doi: 10.1046/j.1525-1497.2002.10804.x
- ³ Cymet, T., Chow, R.D. (2011), "The funding of graduate medical education in the American healthcare system". *Medical Science Educator*, 21(4): 367-374.
- ⁴ The initial residency period is the minimum amount of time required to obtain board eligibility or five years, whichever is shorter.
- ⁵ Public Law 106-554
- ⁶ Wynn BO, Guarino C, Morse L, Cho M. (2006), "Alternative ways of financing graduate medical education".
- ⁷ The formula for calculating the IGME Medicare payment is $\text{Payment} = \text{Multiplier} \times [(1 + \text{IRB})^{0.405} - 1]$ If the adjustment factor were to equal 3.2%, it can be interpreted as saying that for every 10% increase in the resident-to-bed ratio a hospital's Medicare payments would increase by 3.2%.
- ⁸ Association of American Medical Colleges. "Medicare Resident Limits ("Caps")".
- ⁹ Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. "Graduate Medical Education That Meets the Nation's Health Needs". Washington (DC): *National Academies Press* (US); 9-30-2014. 3, GME Financing.
- ¹⁰ Centers for Medicare & Medicaid Services. "Direct Graduate Medical Education (DGME)".
- ¹¹ 42 CFR 413.79- Direct GME Payments: Determination of the Weighted Number of FTE Residents.
- ¹² Durning SJ, Artino AR, Dong T, Cruess DF, Gilliland WR, DeZee KJ, Saguil A, Waechter DM, McManigle JE. "The Long-Term Career Outcome Study (LTCOS): What have we learned from 40 years of military medical education and where should we go?" *Military Medicine*. 2012;177(9S):81–86. [PubMed]
- ¹³ Chang BK. "VA funding of graduate medical education"; Paper presented at Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) GME Summit; Seattle, WA. 3-23-2012.
- ¹⁴ Rich, Eugene C et al. "Medicare Financing of Graduate Medical Education: Intractable Problems, Elusive Solutions". *Journal of General Internal Medicine* 17.4. (2002): 283–292. *PMC*. Web. 8-12-2015.
- ¹⁵ Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. "Graduate Medical Education That Meets the Nation's Health Needs". Washington (DC): *National Academies Press* (US); 9-30-2014. 3, GME Financing.
- ¹⁶ Children's Hospital Association. Summary of CHGME payments to freestanding children's hospitals- 2013.
- ¹⁷ Data found using the HRSA Data Warehouse for Awarded Grants.
- ¹⁸ Public Law No: 114-10 Sec. 221(b)
- ¹⁹ Primary care physicians are those practicing in the areas of general internal medicine, general pediatrics, family practice, and obstetrics/gynecology.
- ²⁰ Specialties cover a wide array of medical areas, but are often classified along four main axes: surgical or internal medicine, age range of the patient, diagnostic or therapeutic, and organ-based or technique-based.
- ²¹ By looking at the Medicaid case mix, DCH is able to measure the severity of a specific hospital's Medicaid population.
- ²² The House appropriation was \$52,521,400 GF/GP (\$155,118,900 Gross).
- ²³ The Utah Medicare GME demonstration project applied only to Medicare GME payments and allowed the state to make its payments to the training program rather than to the teaching hospitals. These payments were to be rewards for outcomes that addressed the workforce concerns of Utah. Beginning in January 2003, the Federal government paid all funds to a statewide council for five years. These funds were then distributed through a formula that reflected actual documented costs, rather than estimates of case mix and adjusted FTE counts.
- ²⁴ For more information on the QAAP, please see "A Summary of Quality Assurance Assessment Programs" by David Fosdick. This Senate Fiscal Agency State Notes article can be found at <http://www.senate.michigan.gov/sfa/Publications/Notes/2007Notes/NotesJulAug07df.pdf>
- ²⁵ According to the Association of American Medical Colleges, the enrollment in American medical schools has grown by 23.4% since 2006.

APPENDIX

Table A

MEDICARE GME FUNDING BY HOSPITAL ^a		
Hospital Name	FY End	Total Medicare GME
Allegiance Health	6/30/2014	\$1,948,512
Beaumont Hospital - Grosse Pointe	12/31/2013	1,404,947
Beaumont Hospital - Royal Oak	12/31/2013	16,456,150
Beaumont Hospital - Troy	12/31/2013	1,238,032
Borgess Medical Center	6/30/2014	4,779,132
Botsford Hospital	12/31/2013	8,576,728
Bronson Methodist Hospital	12/31/2013	4,235,585
Community Health Center of Branch County	12/31/2013	250,806
Covenant Medical Center Inc.	6/30/2014	3,156,598
Crittenton Hospital Medical Center	12/31/2013	2,955,572
Detroit Receiving Hospital	12/31/2013	5,521,336
DMC Huron Valley - Sinai Hospital	10/31/2013	2,048,595
Doctors Hospital of Michigan	12/31/2013	1,037,914
Garden City Hospital	9/30/2013	4,822,883
Genesys Regional Medical Center	6/30/2014	7,987,197
Harper/Hutzel Hospital	12/31/2013	12,002,291
Henry Ford - Macomb Hospital	12/31/2013	7,324,188
Henry Ford Hospital	12/31/2013	31,972,774
Henry Ford Wyandotte Hospital	12/31/2013	3,220,556
Hillsdale Community Health Center	6/30/2014	182,264
Hurley Medical Center	6/30/2014	5,281,275
Karmanos Cancer Center	4/30/2014	674,385
Lakeland Medical Center, St. Joseph	9/30/2013	1,629,800
McLaren - Bay Regional	9/30/2013	461,207
McLaren - Flint	9/30/2013	6,048,889
McLaren - Greater Lansing	9/30/2013	4,262,843
McLaren - Macomb	9/30/2013	3,862,614
McLaren - Oakland	9/30/2013	5,392,804
Mercy Health Hackley Campus	6/30/2014	148,321
Mercy Health Mercy Campus	6/30/2013	890,701
Metro Health Hospital	6/30/2014	2,510,571
MidMichigan Medical Center - Midland	6/30/2014	1,574,102
Munson Medical Center	6/30/2014	948,245
Oakwood Hospital - Dearborn	12/31/2013	7,610,040
Oakwood Hospital - Southshore	12/31/2013	3,508,846
Oakwood Hospital - Taylor	12/31/2013	1,489,846
Oakwood Hospital - Wayne	12/31/2013	1,616,640

MEDICARE GME FUNDING BY HOSPITAL^a		
Hospital Name	FY End	Total Medicare GME
ProMedica Monroe Regional Hospital	6/30/2014	\$280,784
Providence Hospital & Medical Centers	6/30/2014	7,882,759
Saint Joseph Mercy Health System	6/30/2014	5,684,718
Saint Joseph Mercy Livingston Hospital	6/30/2014	1,729,772
Saint Mary's Health Care	6/30/2014	2,688,014
Sinai-Grace Hospital	12/31/2013	9,213,686
Southeast MI Surgical Hospital	12/31/2013	224,218
Sparrow Carson Hospital	12/31/2013	14,377
Sparrow Hospital & Health System	12/31/2013	7,132,633
Spectrum Health - Butterworth Campus	6/30/2014	7,217,633
St. John Hospital & Medical Center	6/30/2014	9,913,044
St. John Macomb - Oakland Hospital	6/30/2014	8,727,617
St. John River District Hospital	6/30/2014	12,362
St. Joseph Mercy/Oakland	6/30/2014	7,986,044
St. Mary Mercy Hospital	6/30/2014	6,688,226
St. Mary's of Michigan	6/30/2014	1,707,838
University of Michigan Hospitals & Health Centers	6/30/2014	23,436,678
UP Health System - Marquette	6/30/2014	825,203
Statewide Total		\$270,398,795

^a Data are from hospital cost reports for fiscal years ending between 9/30/13 and 6/30/14.

Source: Michigan Health and Hospital Association

Table B

FY 2014-15 MEDICAID GME FUNDING BY HOSPITAL^a			
Hospital	GME Funds Pool	Primary Care Pool	Total GME
Barbara Ann Karmanos Cancer Hospital	\$1,475,869	\$99,368	\$1,575,237
Beaumont Hospital Grosse Pointe	106,691	78,872	185,563
Borgess Hospital	1,353,509	248,416	1,601,925
Botsford Hospital	1,513,292	457,832	1,971,124
Bronson Methodist Hospital	2,734,331	393,464	3,127,795
Carson City Osteopathic Hospital	5,101	0	5,101
Children's Hospital of Michigan	15,942,762	3,284,684	19,227,446
Community Health Center of Branch County	47,774	40,952	88,726
Covenant Medical Center, Inc.	915,608	163,148	1,078,756
Crittenton Hospital	159,668	161,084	320,752
Detroit Receiving Hospital	6,876,857	977,016	7,853,873
Doctor's Hospital of Michigan	56,294	206,100	262,394
Edward W. Sparrow Hospital	2,825,660	605,740	3,431,400
Garden City Hospital	600,599	310,764	911,363
Genesys Regional Medical Center	1,154,097	448,136	1,602,233
Harper University Hospital	8,705,521	1,239,896	9,945,417

FY 2014-15 MEDICAID GME FUNDING BY HOSPITAL ^a			
Hospital	GME Funds Pool	Primary Care Pool	Total GME
Henry Ford Hospital	\$13,727,400	\$1,024,008	\$14,751,408
Henry Ford Macomb Hospital	777,944	288,560	1,066,504
Henry Ford West Bloomfield Hospital	20,686	3,268	23,954
Henry Ford Wyandotte Hospital	318,171	69,644	387,815
Hillsdale Community Health Center	19,167	0	19,167
Hurley Medical Center	3,139,497	1,539,012	4,678,509
Huron Valley - Sinai Hospital	177,388	48,624	226,012
Kingswood Psychiatric Hospital	135,817	0	135,817
Lakeland Hospital - St. Joseph	324,947	123,608	448,555
Marquette General Hospital	238,916	66,608	305,524
McLaren - Greater Lansing	920,565	259,784	1,180,349
McLaren Bay Region	88,399	53,776	142,175
McLaren Flint	906,301	316,656	1,222,957
McLaren Oakland	1,080,188	343,456	1,423,644
Mercy Health Partners - Hackley Campus	88,191	120,144	208,335
Mercy Health Partners - Mercy Campus	138,042	75,148	213,190
Metro Health Hospital	772,562	280,708	1,053,270
MidMichigan Medical Center - Midland	180,364	116,076	296,440
Mount Clemens Regional Medical Center	892,843	313,444	1,206,287
Munson Medical Center	135,478	76,228	211,706
Oakwood Annapolis Hospital	227,379	283,336	510,715
Oakwood Heritage Hospital	277,332	37,040	314,372
Oakwood Hospital and Medical Center	1,710,048	601,988	2,312,036
Oakwood Southshore Medical Center	257,396	102,108	359,504
Providence Hospital	1,329,949	336,524	1,666,473
Rehabilitation Institute	163,661	4,896	168,557
Sinai-Grace Hospital	4,900,137	905,648	5,805,785
Spectrum Health	6,067,147	736,244	6,803,391
Southeast Michigan Surgical Hospital	19,289	0	19,289
St. John Hospital and Medical Center	4,976,196	1,092,028	6,068,224
St. John Macomb - Oakland Hospital - Macomb	1,466,324	395,612	1,861,936
St. John River District Hospital	3,718	6,380	10,098
St. Joseph Mercy Hospital - Ann Arbor	717,613	178,860	896,473
St. Joseph Mercy Livingston Hospital	116,288	109,656	225,944
St. Joseph Mercy Oakland	790,680	208,420	999,100
St. Mary Mercy Hospital	424,099	134,644	558,743
St. Mary's Health Care (Grand Rapids)	1,103,535	322,520	1,426,055
St. Mary's of Michigan Medical Center	322,089	132,752	454,841
University of Michigan Health System	30,897,283	1,264,260	32,161,543
William Beaumont Hospital - Royal Oak	2,692,532	515,352	3,207,884
William Beaumont Hospital - Troy	89,906	67,108	157,014
Statewide Total	\$127,109,100	\$21,269,600	\$148,378,700

^a These totals reflect the passage of E.O. 2015-5.

Source: Michigan Department of Community Health