FUNDING PRIMARY CARE RESIDENCY TRAINING

Helping to Assure Adequate Physician Supply

A Report of the
Primary Care
Residency
Commission

February 24,1992

EXECUTIVE SUMMARY

The Primary Care Residency Commission was created by the 115th Session of the Maine Legislature to "develop mechanisms for funding a greater number and improved quality of primary care residency slots throughout the State." The 25 member Commission met from September,1991 to February, 1992 to investigate methods of raising funds for primary care physician training programs that would not involve an appropriation from the State's general fund.

In its deliberations, the Commission examined such issues as primary care physician supply and its relationship to residency training, financing of primary care residency programs, Medicare reimbursement policies for medical education, Maine hospital finance regulation as it affects teaching hospitals, funding initiatives in other states, and Maine medical school and physician loan policies.

The resulting recommendations reflect the Commission's efforts to locate funding to support Maine's primary care residencies in two ways. The first was to expand the number of residency slots in the state, both to increase the number of primary care physicians produced as well as to improve the on-call schedules in residencies, the latter being carefully looked at by potential residency applicants. The second funding priority focused on improving the quality of the residencies' curricula, making the residency programs more attractive to potential applicants while producing better trained physicians for practice in a rural state. The recommendations include the following:

To expand the residencies:

- Develop legislative language in the Maine Health Care Finance Commission (MHCFC) statute which would exclude Medicare payments for expanded primary care physician training from the ordinary calculations made by the Commission to determine hospital revenue limits.

- Place oversight responsibility for residency expansions with the Advisory Committee for Medical Education, based in the Finance Authority of Maine. The Committee would advise the MHCFC directly on the appropriateness of such expansions in accordance with a plan for primary care development in Maine, the MHCFC would make final approval.

To facilitate curricular development:

- Recommend to the Advisory Committee on Medical Education that it work toward creating an appropriation of $100,000 over the next four years in its medical education budget for curricular development activities in the primary care residencies.

REPORT OF THE PRIMARY CARE RESIDENCY COMMISSION

Introduction

Although there are reports of an oversupply of physicians in the United states, there are too few primary care physicians practicing (defined as the physician a patient contacts for continuous general medical care). This is particularly true in rural areas such as Maine. The problem is compounded by the fact that nationally most of the new physicians trained are in specialties, while the number of medical students choosing post-graduate primary care residencies is declining.

National physician manpower studies have shown that physicians are most likely to locate their practices in areas where they completed their residencies. In order to maintain a good flow of physicians into Maine communities, it is important to have a healthy system of primary care residency training programs. In recent years, however, Maine's residencies have had trouble competing for the ever-shrinking pool of primary care residency applicants. Without an infusion of funding to improve the quality and attractiveness of these residencies, some officials fear that several might close, reducing even further the availability of needed primary care physicians in Maine communities.

Legislative Authorization

The Primary Care Residency Commission was established pursuant to Chapter 545, P.L. 1991, "to develop mechanisms for funding a greater number and improved quality of primary care residency slots throughout the State." The need for such a Commission arose from work in support of LD 999, An Act to Establish the Maine Primary Care Residency Training Assistance Program, which originally proposed an appropriation of $2 million to provide partial support for residencies in Maine which produce family practice, pediatric, internal medicine, and obstetrical/gynecological physicians. When it became clear that the general fund appropriation was unrealistic, due to significant state revenue

shortfalls, LD 999 was revised to establish the Primary Care Residency Commission in order to develop alternative funding mechanisms for needed residency support. A grant of $15,000 to support the work of the Commission was obtained from The Betterment Fund, a Maine-based foundation which funds health, education, and conservation projects in Maine. The Legislative Council formally authorized the Commission to accept the grant on August 22, 1991.

Commission members numbered 25, with legislative members appointed by the President of the Senate and the Speaker of the House; the rest were convened by the Legislative Council as prescribed in statute. The members represented a wide range of medical education organizations, insurers, physician professional societies, hospitals, rural health advocates, and departmental officials . The Commission was directed to report its findings to the Joint Committee on Human Resources by November 1, 1992.

Commission Deliberations

At its first meeting, the Commission agreed to accelerate its deliberations and report by February 14, 1992, in response to the urgency expressed by some Commission members who argued that Maine's primary care residencies were in jeopardy if additional funding were not located soon. The Commission met monthly from September, 1991 to February, 1992 to develop the recommendations which appear in this report.

To educate itself regarding primary care residency issues, the Commission reviewed articles, reports, and data addressing the following topics:

- Primary care physician supply and distribution nationally and in Maine
- Public policy initiatives affecting primary care physician supply
- The relationship between residency programs and primary care physician supply
- The financing of family practice residency training
- Medicare reimbursement policies for graduate medical education
- Direct and indirect medical education cost figures for Maine's teaching hospitals
- Funding initiatives supporting residency training in other states

- Hospital regulation and its impact on residency development and expansion
- Medical school and physician loan policies and practices in Maine
- Factors which influence a medical student's choice of a residency

Major speakers appearing before the Commission were Daniel K. Onion, MD, Director of the Maine-Dartmouth Family Practice Residency, Augusta/Waterville, reviewing the funding dilemmas faced by primary care residencies and the highly competitive market for residents that Maine faces; Anthony Marple, Vice-President for Finance at Kennebec Valley Medical Center, addressing the fundamentals of residency funding in Maine; and Robert Clarke, Executive Director of the Maine Health Care Finance Commission (MHCFC), discussing the MHCFC regulations as they relate to teaching hospitals. Both Dr. Onion and Mr. Clarke were members of the Primary Care Residency Commission.

Summary of Findings

Maine has six active family practice residencies in Portland, Lewiston, Augusta, Waterville, and Bangor which graduate nearly 30 family practitioners per year. In addition there are pediatric, internal medicine, and obstetrical residencies based at Maine Medical Center in Portland, graduating a total of 18 physicians a year. Family practice residencies involve three years of training with substantial time spent both in the hospital and in model family practice clinics. Pediatrics involves three years of training, internal medicine three years, and obstetrics/gynecology four years. Many of the graduates from these three residency programs will go on to practice primary care like family practitioners; national studies estimate that 31% of internal medicine and 61% of pediatric residents plan careers in primary care.

Primary care residency training programs are major sources of practicing physicians for Maine communities, since physicians are most likely to practice in the areas where they completed their residencies. Residencies also serve a physician retention function by providing continuing education to practicing physicians in Maine communities. Residency programs are, therefore, are an important piece of the access to health care puzzle. The Maine family practice residencies tracked their graduates in 1990 and found that, collectively, over 50%

of their graduates were practicing in Maine, with 58% of those practicing in towns of 10,000 or less.

Maine primary care residencies are, however, facing significant problems. Nationally, fewer medical students are choosing primary care residencies, increasing competition among residencies for a decreasing pool of applicants. In the recent years, three of the Maine family practice residencies did not fill their available first year slots and some had to recruit foreign medical graduates to fill the vacancies. Candidates look very critically at the on-call requirements and the curricular components of residencies when they make their choice of residency location. To become more competitive, Maine residencies actually have to add resident positions in order to reduce the residents' on-call requirements, even though in past years some Maine residencies did not fill all their slots. In addition, Maine residencies need to add new, sometimes expensive, elements to their curricula (such as gerontology, occupational medicine, and rural rotations) both to increase the attractiveness of their program and to better prepare physicians for delivering care to underserved populations.

Costs for training residents in Maine approximate $90,000 per resident per year. Maine's teaching hospitals have been reluctant to support the cost of expanding or improving primary care residencies because of the investment required and because primary care residencies differ from procedure-oriented specialty residencies in that they are largely outpatient in nature and may not generate a sufficient level of revenue to offset this added investment.

In order to maintain the viability of primary care residencies and thereby address their primary care manpower problems, other states have contributed general funds to residency programs. In fact, of the 42 states which contain family practice training programs, only Maine and Idaho do not provide state funding for residencies. Maine's current budget problems have precluded a general fund appropriation. Of necessity, the Primary Care Residency Commission looked elsewhere for funding.

The Commission spent a considerable time learning about the Medicare reimbursement system for graduate medical education, as Medicare is a major funding source for primary care residencies. Medicare funds teaching hospitals

for medical education through a reimbursement per resident system, derived through a complex formula using 1985 as a base year for medical education costs and then trending the costs forward (including an inflation adjustment) every year thereafter. Direct and indirect medical education costs are calculated in the formula. Direct costs include salaries, fringe benefits and malpractice insurance for both residents and faculty, as well as mortgage costs. Indirect costs include extra lab tests, increased potential liability, increased charity care caseload, and other extra hospital expenses which come with sponsorship of residencies. It is important to note that if a primary care resident does a rotation in an off-site ambulatory setting (such as a rural health center), the hospital does not receive Medicare reimbursement for that resident for that time period.

Because the Medicare direct and indirect cost formulas vary so widely among Maine's teaching hospitals, hospitals receive from 66% to 97% of the $90,000 average cost for educating a resident from Medicare (excluding Maine Medical Center, whose indirect cost reimbursement is more generous due to its sponsorship of multiple residencies, leading to a high resident to bed ratio). The balance is supplied by hospital revenues (fees for service charged to patients or other third party payors).

It is clear from these figures that Medicare pays a large proportion of residency costs and that the establishment of new residency positions would result in an increase in Medicare payments. Under Maine's hospital payment system, however, the Maine Health Care Finance Commission is required by law to pass on the benefits of additional payments from the Medicare program in the form of lower charges to Maine's private payors.[1]

The Maine Health Care Finance Commission establishes annually a limit on the amount that each hospital may charge for all of its patient care services. This gross patient service revenue limit must be sufficient to allow the hospital to collect income equal to its reasonable financial requirements. The Commission is directed by law to determine each hospital's financial requirements by adjusting

1 Similarly, the Maine Health Care Finance Commission is required by law to protect Maine hospitals from decreases in payments from the Medicare program by passing the impact of such decreases in the form of higher charges to Maine's private payors.

its budgeted operating expenses for an earlier period, known as the base year, in order to accommodate the impact of a number of factors including inflation, changes in volume and case mix, capital costs and the implementation of projects approved under the Certificate of Need program. For teaching hospitals, medical education costs were also figured into the base year financial requirements and subsequently into each succeeding year's financial requirements.

There are no special procedures within Maine's hospital financing statute to specifically address changes in the costs of medical education. Any hospital could, however, seek to have the impact of such changes recognized through a "special exceptions" provision, which is intended to provide increases or decreases in a hospital's financial requirements for reasonable changes in expenses for which no adequate adjustment is otherwise provided. No Maine hospital has as yet approached the MHCFC to adjust its overall financial requirements because of increased medical education costs.

Hospital regulatory commissions in five other states were contacted by Robert Clarke, Executive Director of the MHCFC, to determine how they dealt with reimbursement for graduate medical education. The states included New York, New Jersey, Maryland, Massachusetts, and Connecticut. As with the MHCFC, none of the other state regulatory commissions had any special policies or adjustments for medical education costs; such costs were included in the base year budget calculations for the teaching hospital, as with all other costs, and trended forward.

However, as the MHCFC delved further into the issue of medical education funding in hospitals, it determined that expanded Medicare reimbursement to teaching hospitals for expansions in their residencies could be treated the same as certain grants that hospitals receive. Grants to hospitals for new activities or projects are not offset against a hospital's financial requirements and therefore do not have the effect of reducing a hospital's authorized limit on patient care charges. The MHCFC indicated, however, that new language in the MHCFC statute would still probably be required to allow the MHCFC to treat additional payments from the Medicare program for new residency positions in the same manner (SEE APPENDIX 1 FOR SUGGESTED LANGUAGE).

Having identified a mechanism for funding additional primary care residency slots, the Commission turned its attention to the second part of its charge: developing funding to improve the quality of primary care residencies throughout the State. Specifically, residency directors identified the need for funding which would enable them to expand their curricula, such as adding a gerontology component, developing rural practice rotations, creating an occupational medicine curriculum, or increasing residents' mental health care skills. Including such elements in residency curricula not only prepares physicians better for practice in Maine but also makes residencies more interesting and attractive to future applicants.

Sometimes residencies can obtain federal grants for curricular development activities but the funding is limited and episodic, making it difficult to maintain these new activities over time. The Commission estimated that an annual pool of $100,000 would be required for curriculum development, for which the residencies would apply through a request-for-proposal process, the funds being granted through some oversight body.

Several mechanisms for raising $100,000 per year were considered, including an assessment on all hospitals (who benefit from the production of primary care physicians by the teaching hospitals), a tax on all hospital patient visits, an insurance tax, expansion of the Hospital Development Account to include funding for training, and other special taxes or fees. None were deemed politically feasible nor practical. Several Commission members questioned whether some of the State funding going into other medical education channels could be directed into residency curriculum development.

Approximately $1.6 million of State general funds and loan repayment funds currently support the Postgraduate Health Professions Program, which includes contracts for medical, dental, veterinary, and optometry school seats for Maine students in out-of-state schools, as well as physician loan repayment programs. Severe budget cutbacks have led to an erosion of the general fund contribution to the Program over the past few years, requiring diversion of funding from other programs into the Program to fulfill contact obligations. The Program is administered by the Finance Authority of Maine (FAME) which

consults with its Advisory Committee on Medical Education regarding program goals. The Advisory Committee, under direction from the Legislature, recently submitted a report outlining major program changes aimed at increasing the numbers of primary care physicians through an integrated approach to medical education and to the recruitment and retention of physicians.

A suggestion was made by Primary Care Residency Commission members who were also members of the Advisory Committee on Medical Education, that the Postgraduate Health Professions Program be charged with integrating residency training issues more directly into this new program approach. These joint committee members stressed that the Advisory Committee is statutorially charged with developing recommendations for residency training as well as medical school training. After much discussion about the realities of funding in the Postgraduate Health Professions Program, the Commission agreed to recommend that, in future years, as the current contract and loan obligations are paid for, the Advisory Committee for Medical Education develop a mechanism for funding residency curricular development which could be gradually phased into its overall budget plan. In addition, the Commission suggested that the CEO distribute such funds in consultation with the Advisory Committee and according to specific criteria developed in rulemaking, requiring no further approval process within FAME.

While discussing these ideas for funding residency expansion and improvements in curriculum, the Commission expressed concern that some oversight function should be created to review residency program requests in both areas. The original legislation seeking general funds for residency programs, LD 999, had created a new 12 member Primary Care Residency Committee within FAME to make recommendations to the Authority regarding allocation of the general funds to the residency programs. The Chief Executive Officer (CEO) of FAME was to call the Committee together only if funds became available.

The Commission decided instead to place review responsibility for residency expansions with the present FAME committee - the Advisory Committee on Medical Education. Since this Committee is presently engaged in creating a new plan for medical education, physician recruitment, and physician

retention, all with a particular focus on primary care in underserved areas, it seemed reasonable for the Advisory Committee to weave residency expansion and development into its comprehensive medical education plan. However, the Commission is suggesting that the Advisory Committee would now give advice to two State agencies: to the MHCFC regarding the appropriateness of proposed residency expansions with their concomitant increases in Medicare reimbursement and to FAME regarding funding of curricular development activities in residencies. An added benefit to using the present FAME advisory structure is that the Commission will contribute to the streamlining of State government by avoiding creation of a new advisory body.

Having placed this new planning and fiscal review responsibility with Advisory Committee for Medical Education, the Commission decided to review the membership structure of this Committee. Current membership is loosely defined in statute to include "representatives from those health care agencies and associations, public and private, whose activities are relevant to the objectives of the plan..." as determined by the FAME CEO. Most Commission members felt that the present Committee should be expanded to include more representatives interested in residency training and funding and medical care access issues. Much discussion followed regarding specification of Committee membership more directly in statute and suggested legislative language was drafted (SEE APPENDIX 2 FOR SUGGESTED LANGUAGE). Because this approach seemed beyond the charge of the Commission, the Commission agreed instead to recommend, rather than prescribe, to FAME that the Advisory Committee on Medical Education be restructured to include such additional members as a MHCFC representative, insurers, and consumer representatives from medically underserved areas or groups. The Commission also suggested that the FAME CEO develop an appropriate liaison mechanism between the Advisory Committee on Medical Education and its Maine Education Assistance Commission, to increase the health professions education expertise of this educational advisory body which is placed above the Advisory Committee for Medical Education in the FAME authority structure.

Summary of Recommendations

1. To facilitate expansion of primary care residencies, develop legislative language in the Maine Health Care Finance Commission (MHCFC) statute which would exclude Medicare payments for primary care physician training from the ordinary calculations made by the Commission to determine hospital revenue limits.

2. Place oversight responsibility for residency expansions with the Advisory Committee for Medical Education, based in the Finance Authority of Maine (FAME). The Advisory Committee would advise the MHCFC directly regarding the appropriateness of proposed expansions as part of its responsibility to develop a medical education plan for the State.

3. Repeal the recently enacted provision for establishment of a Primary Care Residency Committee to be based in FAME, since the Advisory Committee for Medical Education will assume the responsibilities intended for the proposed Residency Committee.

4. Recommend to the CEO of FAME that membership on the Advisory Committee for Medical Education be expanded to include professional associations, hospital associations, health center associations, insurance representatives, medical school and residency representatives, the Executive Director of the MHCFC, and three members of the general public who represent medically underserved areas or populations.

5. To facilitate curricular development in primary care residencies, recommend to the Advisory Committee on Medical Education that, in future years, as the current contract obligations are paid for, it develop a mechanism for funding curricular development in primary care residencies which could be gradually phased into its overall budget plan. Recommend that the CEO of FAME distribute curricular funds in consultation with the Advisory Committee on Medical Education and according to specific criteria developed in rulemaking, requiring no further approval process within FAME.

APPENDICES

APPENDIX 1

AN ACT TO ENCOURAGE EXPANSION OF CERTAIN RESIDENCY PROGRAMS RELATED TO PRIMARY CARE PHYSICIANS

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 5 M.R.S.A. §12004-I, sub-§29-A, as enacted by P.L. 1991, c. 545, §1, is repealed.

Sec. 2. 10 M.R.S.A. c. 110, sub-c. X, as enacted by P.L. 1991, c. 545, §2, is repealed.

Sec. 3. 20-A M.R.S.A. §11806, sub-§2, ¶H is enacted to read:

H. The projected number and location of resident spaces needed in family practice, internal medicine, pediatrics, and obstetrics and gynecology residency programs.

Sec. 4. 20-A M.R.S.A. §11807, sub-§1, as amended by P.L. 1989, c. 698, §23, is further amended to read:

1. Committee. The Advisory Committee on Medical Education shall assist the chief executive officer in developing the plan and shall advise the Maine Health Care Finance Commission concerning the approval of additional primary care resident spaces in accordance with Title 22, section 396-R.

Sec. 5. 20-A M.R.S.A. §11809 is enacted to read:

11809. Curriculum improvements.

The authority may allocate a portion of the fund established in section 11808 for the purpose of supporting improvements in the curriculum of primary care residency programs offered in this State. In accordance with criteria established by rules adopted in accordance with section 11810, the chief executive officer may disburse funds allocated under this section to hospitals that provide primary care residency programs, in the amounts necessary to make improvements in the curricula offered in those programs.

Sec. 6. 22 M.R.S.A. §396-E, sub-§1, ¶C, as amended by P.L. 1991, c. 545, §3, is further amended to read:

C. ~~Excepts as provided in section 396-I, gifts~~ Gifts and grants from federal, state and local governmental agencies are considered available resources.

Sec. 7. 22 M.R.S.A. §396-E, sub-§1, ¶I, as enacted by P.L. 1991, c. 545, §4, is repealed.

Sec. 8. 22 M.R.S.A. §396-F, sub-§3, as enacted by P.L. 1983, c. 579, §10, is amended to read:

3. Differentials. The commission shall provide for revenue deductions ~~which~~ that reflect differentials established and approved pursuant to section 396-G. In calculating revenue deductions to reflect differentials under the Medicare program, the Commission shall exclude from its determination any amounts that the commission finds have been paid by the Medicare program for the following activities, to the extent that the activities have been approved under section 396-R, unless any costs of the activities have been added to a hospital's financial requirements:

(A) any expansion of a family practice residency program after June 30, 1992; and

(B) providing spaces in a residency program in internal medicine, pediatrics, or obstetrics and gynecology, in any given year, for a number of first year residents greater than the number of first year residents in those programs at the same hospital prior to June 30, 1992.

Sec. 9. 22 M.R.S.A. §396-R is enacted to read:

396-R. Approval of primary care resident spaces.

The Commission shall approve the addition of a primary care resident space by a hospital if the Commission finds that the additional space is consistent with the plan developed by the Finance Authority of Maine under Title 20-A, section 11806 or, in the absence of any such plan, with the orderly development of primary care training and recruitment programs in the State.

STATEMENT OF FACT

In order to promote training of additional primary care physicians, this bill would exclude certain Medicare payments for primary care physician training from the ordinary calculations made by the Health Care Finance Commission to determine hospital revenue limits. This special regulatory treatment would apply only to residency spaces explicitly approved by the Commission with the advice of FAME's Advisory Committee on Medical Education. It authorizes FAME to apply some available medical education funds to improve the curriculum in primary care residency programs. The bill also repeals recently enacted provisions for administering a program for which funds are not available.

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APPENDIX 2

PROPOSED LANGUAGE FOR SPECIFICATION OF THE ADVISORY COMMITTEE ON MEDICAL EDUCATION

Title 20-A, Section 11807 Advisory Committee in Medical Education

1. Committee. The Advisory Committee on Medical Education shall assist the executive director in developing the plan.

2. Members. The Advisory Committee shall consist of the following seventeen members:

A. Seven members appointed by the executive director from the major statewide association representing allopathic physicians, the major statewide organization representing osteopathic physicians, the major statewide organization representing family physicians, the major statewide organization representing hospitals, the major statewide organization representing community health centers, the State's largest nonprofit health insurance company, an association of commercial health insurance companies doing business in the state;

B. Three ex-officio members appointed by the executive director from a college of osteopathic medicine in the state, a director of a family practice residency in the State, and a director of medical education at a major teaching hospital sponsoring other residency programs;

C. Two at-large members appointed by the executive director;

D. The Commissioner of Human Services or the commissioner's designee;

E. The Executive Director of the Maine Health Care Finance Commission or the executive director's designee; and

F. Three members of the general public who come from regions or constituencies generally lacking reasonable access to medical care, one to be appointed by the Governor, one by the President of the Senate and one by the Speaker of the House of Representatives.

3. Terms of Office. Each appointed member shall serve a term of three years; except that, of those first appointed, four members appointed under subsection 2, paragraph A, two members appointed under subsection 2, paragraph B and one member appointed under subsection 2, paragraph C shall serve for terms of two years and three members appointed under subsection 2, paragraph A, one member appointed under subsection 2, paragraph B and one member appointed under subsection 2, paragraph C shall serve for terms of one year.