REPORTS OF COUNCIL ON MEDICAL EDUCATION

The following reports, 1-2, were presented by James L. Borland, Jr., MD, Chair:

1. PRESERVING MEDICAID FUNDING OF GRADUATE MEDICAL EDUCATION

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Since the Medicaid program started in the 1960s, states have contributed to the funding of graduate medical education (GME). After Medicare, Medicaid has been the largest explicit payor for GME, providing $2.3-2.4 billion in 1998. While Medicare has a statutory requirement to support GME, Medicaid programs do not. Most state Medicaid programs, however, currently do provide funding for GME. A survey by the National Conference of State Legislatures in early 1999 showed that 45 states and the District of Columbia made some level of GME payments under Medicaid programs (see Appendix). The states that did not pay for GME were Alaska, Idaho, Illinois, Montana, and South Dakota. This report describes the status of GME funding by Medicaid, describes the forces that are acting to jeopardize funding for the future, and recommends future American Medical Association actions.

GME PAYMENT UNDER MEDICAID FEE-FOR-SERVICE

In 1999, 43 states and the District of Columbia were making payments under Medicaid fee for service. Of these, 24 states and the District of Columbia reimbursed both direct graduate medical education and indirect medical education costs. Most of the states (35) that paid for GME under fee for service distributed payments through hospitals' per case or per diem rate.

GME PAYMENT UNDER MEDICAID MANAGED CARE

In 1999, 15 states and the District of Columbia made Medicaid GME payments to teaching hospitals or other teaching programs under their Medicaid managed care programs. Another 17 states included GME payments in their capitated payment rates to Medicaid managed care organizations. All but three of these 17 assumed, but did not require, that the GME portion of their total payments would be distributed to teaching hospitals.

In 27 states, Medicaid GME payments under capitated managed care are made solely to teaching hospitals. In two states, the payments go solely to medical schools. Although resident physicians are the predominant group eligible to be counted for GME payments, eight states and the District of Columbia required or allowed nurses and other health professions students to have their training subsidized, or the Medicaid agency made no distinction among health professions in funding training.

VULNERABILITY OF MEDICAID FUNDING FOR GRADUATE MEDICAL EDUCATION

Medicaid funding of GME may be influenced by a number of factors. The first is changing state priorities. In the late 1990s, 10 states (Georgia, Maryland, Michigan, New Jersey, New Mexico, Oklahoma, Tennessee, Texas, Washington, and West Virginia) were linking some or all Medicaid GME payments to health care workforce goals. Eight of the 10 states were using the GME payments to encourage training in certain specialties (usually primary care disciplines) and three were using the payments to encourage training in certain locations (ambulatory or rural settings). The presence of such priorities can affect the numbers of residency positions available in given specialties.

One example illustrates how changes in a state Medicaid program can have profound effects on funding for graduate medical education. Before its creation of a Medicaid managed care system, the Tennessee Medicaid program paid for GME using a formula similar to Medicare. In its transition to a Medicaid managed care system, the state proposed to discontinue GME payments under Medicaid. While bridge funding was provided to a number of the state's teaching hospitals, this funding proved to be unstable. The TennCare system restored funding for GME, but with clear expectations that the funding be tied to workforce goals. Tennessee allocated all GME payments under Medicaid to the states' four medical schools, based primarily on the number of primary care residents being trained. Funds flow through the medical schools to the sites where residents are being trained. The goal of TennCare was to have 50% of aggregate residency positions in the primary care specialties and, as a result, the number and kinds of GME positions offered in the state changed.

Medicaid funding for GME also is vulnerable to state financial exigency. In the spring of 2002, the Nebraska Health and Human Services System announced cuts in Medicaid GME funding as one response to shortfalls in state revenue. The result could have been up to $4.5 million in reductions to the state's teaching programs from Medicaid. This would have meant losses in federal matching funds as well, bringing the total loss to over $12 million. The funding cut would have resulted in lost residency positions or even the elimination of entire programs. A hearing on the proposed cuts was held in July 2002, and testimony, in person or in writing, was presented by the Nebraska Medical Association and the Association of American Medical Colleges, among other groups. In August 2002, the state legislature agreed to preserve $3 million of the state funding for graduate medical education, and state and hospitals leaders are looking for ways to make up the $1.5 million difference in order to receive full federal matching funds.

The 2003 work plan of the Department of Health and Human Services Office of Inspector General (OIG) Projects for the Centers for Medicare and Medicaid Services (CMS) includes a review of Medicaid GME payments. The work plan includes an examination of "Medicaid graduate medical education payment programs, the coordination of these payments with Medicare graduate medical education payments, and the existence and effectiveness of CMS safeguards and controls over the payment process." It will be important for our AMA to monitor this OIG effort to ensure that funding is not negatively affected.

Cuts in state funding for graduate medical education through Medicaid can have significant negative effects on the teaching and service missions of academic medical centers. Residency programs may be reduced in size or eliminated and faculty positions also may be cut as a result of funding decreases. This, in turn, can affect the types of services provided by the academic medical center and reduce the access to care for underserved populations.

EXISTING AMA POLICY

The AMA has policy in support of all payor funding for graduate medical education (Policy H-305.935, AMA Policy Database). In the absence of an all payor system, the AMA supports Medicare funding of GME at a level that would permit maintenance of the education, research, and charity care missions of teaching hospitals (Policy H-305.936). There is no current policy that explicitly addresses Medicaid funding of graduate medical education.

SUMMARY AND RECOMMENDATION

The current financial problems being experienced by many states may threaten GME funding from Medicaid programs or may cause funding priorities to shift. Medicaid funding for GME is critical for the continued viability of many graduate medical education programs and, consequently, for the service mission of academic medical centers.

Therefore, the Council on Medical Education recommends that the following recommendations be adopted and that the remainder of this report be filed.

1. That our American Medical Association support the continued funding of graduate medical education by Medicaid programs.

2. That our AMA continue to monitor the status of funding for graduate medical education by state Medicaid programs and report back to the House of Delegates at the 2004 Interim Meeting.

3. That our AMA offer support to state and county medical societies and other groups that are working to sustain state funding for graduate medical education under Medicaid.

4. That our AMA work with state and county medical societies to advocate for the direct distribution of Medicaid graduate medical education payments to teaching hospitals and/or medical schools and not to third party payors.

(References pertaining to Report 1 of the Council on Medical Education are available from the Medical Education Group.)

APPENDIX - GRADUATE MEDICAL EDUCATION PAYMENTS BY MEDICAID PROGRAMS[a]

State	GME Payments Under FFS (Y/N)[b]	GME Payments Under Managed Care (Y/N)[c]	Total GME Payments ($ in Millions)[d]
Alabama	N	Y	10.0
Alaska	N	N	0.0
Arizona	Y	Y	17.8
Arkansas	Y	N	5.7
California	Y	N	129.1
Colorado	Y	Y	8.0
Connecticut	Y	Y	7.5
Delaware	Y	Y	1.3
Florida	Y	Y	15.2
Georgia	Y	N	70.0
Hawaii	Y	Y	2.7
Idaho	N	N	0.0
Illinois	N	N	0.0
Indiana	Y	Y	15.0
Iowa	Y	Y	43.8
Kansas	Y	Y	9.6
Kentucky	Y	Y	62.1
Louisiana	Y	N	50.0
Maine	Y	N	2.4
Maryland	Y	Y	54.8
Massachusetts	Y	N	25.0
Michigan	Y	Y	191.0
Minnesota	Y	Y	58.0
Mississippi	Y	Y	15.6
Missouri	Y	Y	26.7
Montana	N	N	0.0
Nebraska	Y	Y	5.0
Nevada	Y	N	8.4
New Hampshire	Y	N	2.1
New Jersey	Y	Y	43.4
New Mexico	Y	Y	4.4
New York	Y	Y	812.0
North Carolina	Y	N	102.5
North Dakota	Y	N	0.9
Ohio	Y	Y	144.6
Oklahoma	Y	Y	15.7
Oregon	Y	Y	8.6
Pennsylvania	Y	Y	66.6
Rhode Island	Y	Y	5.1
South Carolina	Y	Y	57.8
South Dakota	N	N	0.0
Tennessee	N	Y	46.3
Texas	Y	N	40.0
Utah	Y	Y	5.0
Vermont	Y	N	0.6
Virginia	Y	Y	16.1
Washington	Y	Y	63.5
West Virginia	Y	Y	2.7
Wisconsin	Y	Y	37.0
Wyoming	Y	N	0.1

[a] - Adapted from Henderson T. Medicaid's role in financing graduate medical education. *Health Affairs* 2000; 19(1):221-229.
[b] - Includes payments under Medicaid fee for service for direct and/or indirect costs of GME.
[c] - Includes explicit and implicit GME payments. Implicit payments are where GME payments are included in MCO rates.
[d] - Total dollar amounts of GME payments in FY1998.

2. STRATEGIES TO ADDRESS MEDICAL SCHOOL TUITION INCREASES

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

Resolution 312 (I-01), "Mid-year and Retroactive Tuition Increases," which was submitted by the Medical Student Section and adopted as amended, asked that:

> Our American Medical Association work with the Association of American Medical Colleges to discourage assessment of mid-year and retroactive increases in medical school tuition and fees;
>
> Our AMA encourage state and county medical societies to develop policy and lobby state legislatures to help minimize medical school tuition increases in public or officially-designated state medical schools;
>
> Medical schools provide entering students with an estimate of their future tuition costs and fees, possibly based on past history of the schools tuition; and
>
> Our AMA report back to the House of Delegates at the 2002 Interim Meeting on its progress in limiting mid-year and retroactive tuition increases.

This resolution was stimulated by a retroactive tuition increase in the State University of New York (SUNY) system during 2001-2002. The specific circumstances that led to a tuition increase being implemented after classes began were related to New York State regulations. However, budget problems in other states could lead to similar outcomes and, even without mid-year increases, medical school tuition continues to rise at most medical schools. The situation in New York and at other US medical schools raises two broad issues that require attention. The first is the uncertainty of planning for the costs of medical education when tuition can rise at any time during the four years of training. The second is the need for ways to offset the costs of tuition so as to limit, as much as possible, the debt medical students incur and carry after graduation.

Based on the resolution, a letter was sent to the Association of American Medical Colleges (AAMC) asking for the organization's collaboration in limiting mid-year and retroactive tuition increases. Medical schools also were informed about the substance of the resolution. Medical schools now are jointly surveyed by the AMA and the AAMC about their tuition, the mechanisms they are using to limit or offset tuition (for example, fundraising activities to raise money for scholarship support), and about their debt counseling.

BACKGROUND TO THE SUNY TUITION INCREASES

Local circumstances can result in unexpected tuition increases. In 2000-2001, the tuition for students at the public State University of New York (SUNY) system, which includes the medical schools at Stony Brook, Downstate Medical Center (Brooklyn), Upstate Medical Center (Syracuse), and Buffalo, was $10,840. This had not increased since 1995. For the 2001-2002 academic year, medical students in the SUNY system received a tuition increase of $2000 after the close of the fall semester. This was because tuition at SUNY cannot be set until a state budget has been passed, and the budget was not finalized until after the school year had begun.

In April of 2002, another $2000 tuition increase was approved by the Board of Trustees for the SUNY medical schools in 2002-2003 and tuition increases for other professional schools also were approved. The tuition increase for the SUNY medical schools was reported to be in response to declining state aid and the desire to hire additional faculty members. The Chancellor at SUNY plans to raise tuition $2000 per year until 2004-2005. If approved by the Board of Trustees, these increases would result in a tuition of $18,840 for in-state SUNY medical students (a 74% increase from 2000-2001). Members of the Medical Student Section have taken a leadership role in opposing the tuition increases, unfortunately with no success to date. In addition, the AMA prepared a letter to state medical societies asking for assistance in monitoring and addressing such unplanned tuition increases.

DEBT LEVELS AND MEDICAL SCHOOL TUITION

The average educational debt of indebted US medical students graduating in 2002 was $103,855. This includes debts incurred during premedical education and during medical school. Total educational debt rose 9.7% from 2000 to 2002. Of 2002 graduates, only 16.5% had no educational debt on leaving medical school and 17.9% had more than $150,000 in debt. Debt levels vary by type of medical school. Graduates of public medical schools in 2001 had an average debt of $86,630, while private medical school graduates had an average debt of $118,546.

The difference in debt levels between public and private medical school graduates can, in part, be accounted for by differences in tuition levels. The table below illustrates the average and range of tuition and fees for first-year students in 2001-2002 who were residents of the state in which the school is located. Non-state residents paid an average of $28,128 at public schools in 2001-2002 (range $11,065 - $61,771).

Table - Tuition and Fees (2001-2002) for State Residents

Ownership	Average Tuition/Fees	Range
Public Schools*	$12,487	$4183 - $23,681
Private Schools	$29,375	$9033 - $38,305

* - Excludes the Uniformed Services University of the Health Sciences, which does not charge tuition but requires a period of military service after graduation.

Tuition continues to rise at most public and private medical schools. Between 2000-2001 and 2001-2002, average tuition and fees at public medical schools increased 6.8% and at private medical schools increased 4.7%.

In only a minority of cases is tuition set by the medical school. During 1999-2000, tuition at 41 medical schools (33%) was determined by the medical school or health science center administration. In 58 schools (47%), tuition was set at the level of the medical school's parent university and its Board of Trustees. The state legislature or other state authority had the final responsibility for setting tuition at 25 schools (20%).

AVAILABILITY OF INFORMATION ABOUT THE COSTS OF TUITION

It is rare for a student to know, upon entry to medical school, how much tuition he/she will be required to pay throughout the four years. In 2001-2002, only seven of the 125 US medical schools had a policy that tuition is set for the four years at the time a student enters medical school. Given the fact that tuition levels often are not determined by the medical school and that tuition increases can occur in response to unpredictable financial pressures, it is difficult to provide information to students about their four-year tuition obligations.

Medical schools should, however, communicate with students as early and often as possible about the costs of medical school and about the debt that they can accumulate. AMA policy supports medical schools informing prospective students and their advisors of the costs of attending medical school (Policy H-305.995, AMA Policy Database) and of schools' available financial aid resources (Policy H-305.966). In 2001-2002, 112 medical schools reported that they offered a formal counseling program on debt management to their medical students with debt. Typically, sessions are offered in the first (97 schools) and fourth (107 schools) years. Only 45 schools offered debt management counseling in the second year and 46 in the third year. This pattern may not be optimal. Students early in their education may be too overwhelmed with the transition to medical school to consider the issues of borrowing and debt accumulation. The Council believes that appropriate counseling, including options to reduce the accumulation of debt, should be available throughout medical school and into residency training.

WAYS TO OFFSET THE COST OF TUITION

Tuition and fees average about 4% of total medical school revenue. While a small percentage of total revenue, tuition is an important source of unrestricted funding for medical school operations, especially related to the educational program. Unless replacement funds are found, it is difficult for medical schools to cap or reduce tuition. The major other sources of unrestricted funding for medical schools are state dollars and gifts/endowment. State funding, unavailable to most private schools, is steady or declining at many public schools. Many medical schools are seeking to increase the funding they receive from philanthropy. In order to raise money for scholarships and other needs, the majority of medical schools or their parent universities (87 institutions) currently are involved in a fundraising campaign.

One important way to reduce the cost of medical school to students is through scholarships. In 2001-2002, an average of 44% of students were receiving some scholarship support from medical school or university funds, but the range was large across institutions (3% to 100%). Eighty (of the 125 schools) reported that the percent of students receiving scholarships from school/university sources had increased as compared to five years ago. The percent receiving scholarships had remained the same in 30 schools and decreased in 15.

Other options to offset the costs of tuition are programs that offer scholarships or loan repayment funding in exchange for service. Military scholarships are one such option. In addition, federal and state programs exist which define service as practice in an underserved area. Such programs (such as the National Health Service Corps and similar state programs) are directed to physicians intending to practice in specific (typically generalist) specialties. The number of individuals these programs can accommodate is limited, however, and the specialty requirements do not meet the needs of all medical students. Recently, the federal government has been expanding loan repayment programs for physicians and others interested in research. For example, extramural loan repayment programs exist for clinical researchers, researchers in pediatrics, researchers interested in health disparities, and researchers from disadvantaged backgrounds. There also are programs for researchers who will be based at the National Institutes of Health.

CONCLUSIONS

The mid-year tuition increase in the SUNY system that stimulated this resolution is symptomatic of a series of problems related to medical school financing. In difficult financial times, medical schools may not have sufficient revenue from unrestricted sources to maintain their operations. Therefore schools, their parent universities, or state governments may impose tuition increases to generate the needed income. AMA policy encourages the development of a stable funding source specifically dedicated to support the education of medical students (Policy H-305.946). The existence of such funds could allow medical schools to set tuition at a predefined level that would not change during the course of a student's medical education.

While it may be difficult to secure stable funding to support the entire educational program, there should be more attention given to ways to offset tuition-dependence. Many medical schools already are involved in fundraising activities. This should be encouraged. AMA policy supports solicitation of contributions from alumni and private foundations (Policy H-305.973). However, recent graduates with high debt levels will not be able to contribute to support future students, at least in the short term.

The Council believes that federal funding should be expanded to allow support for physicians preparing for careers in areas of need. For example, in addition to funding MD/PhD programs, the federal government should be encouraged to support MD/MPH students who will address public health issues. Opportunities to exchange service for debt repayment or scholarship support should also be broadened to encompass students with varying specialty and career interests, such as research or academic medicine.

RECOMMENDATIONS

While the issue of medical student debt will not be totally resolved until medical education funding is stabilized, there are actions that can be taken to mitigate the effects of high tuition levels. The Council on Medical Education, therefore, recommends that the following be adopted and that the remainder of this report be filed:

1. That our American Medical Association oppose the imposition of mid-year and retroactive tuition increases at both public and private medical schools.

2. That our AMA monitor proposals for medical school tuition increases and continue to work with the Medical Student Section and other student groups, along with state and county medical societies, national medical specialty societies, and the Association of American Medical Colleges, to address the serious issue of rising tuition and medical student debt and to oppose any mid-year or retroactive tuition increases.

3. That our AMA encourage medical schools to alert students of the probability of escalation of tuition costs and provide entering students with an estimate of tuition costs for the four years.

4. That our AMA encourage federal and state agencies to review and expand options for financial aid (scholarship and loan repayment programs) for medical students, resident physicians, and young physicians by developing programs that address areas of existing and emerging national and local need.

5. That our AMA continue to encourage medical schools to provide yearly financial planning/debt management counseling to medical students and the institutions that sponsor residency training to make available similar services for resident physicians.

6. That our AMA encourage and work with medical schools to broaden their fundraising activities directed at obtaining revenue for medical student scholarships or for capping/decreasing tuition.

7. That our AMA continue to work for a stable funding mechanism for undergraduate medical education.

8. That progress in limiting medical school tuition and in developing mechanisms to reduce student debt be monitored and reported to the House of Delegates at regular intervals, beginning with the 2004 Annual Meeting.

9. That our AMA help develop specific strategies to address the problem of mid-year and retroactive tuition increases, and report back at the 2003 Interim Meeting.

(References pertaining to Report 2 of the Council on Medical Education are available from the Medical Education Group.)