Jim Pitts
Chairman

Sylvester Turner
Vice-Chair

TEXAS HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS

AGENDA

SUBCOMMITTEE ON ARTICLE II
CHAIRMAN
JOHN ZERWAS

SUBCOMMITTEE ON ARTICLE III
CHAIRMAN
JOHN OTTO

FRIDAY, FEBRUARY 22, 2013
7:30 A.M.
CAPITOL EXTENSION E1.030

I. CALL TO ORDER

II. CHAIRMAN'S OPENING REMARKS

III. GRADUATE MEDICAL EDUCATION

- Demetrio Hernandez, Analyst - Legislative Budget Board
- Stacey Silverman, Deputy Assistant Commissioner for Workforce, Academic Affairs and Research - Texas Higher Education Coordinating Board
- Kenneth I. Shine, M.D., Executive Vice Chancellor for Health Affairs - The University of Texas System
- Nancy W. Dickey, M.D., President Emeritus, Texas A&M Health Science Center and Professor of Medicine, Texas A&M Health Science Center College of Medicine
- Roland Goertz, MD, MBA, CEO Waco Family Health Center, Chair, Family Medicine Advisory Committee of the Texas Higher Education Coordinating Board

IV. FUNDING DISPARITIES BETWEEN NURSING AND PHARMACY PROGRAMS

- Sarah Keyton, Higher Education Team Manager - Legislative Budget
- Michael Mueller, Interim Associate Vice Chancellor for Finance - University of North Texas System

V. PROFESSIONAL NURSING SHORTAGE REDUCTION PROGRAM

- Greg Owens, Analyst - Legislative Budget Board
- Paulette Burns, PhD, RN, Dean and Professor, Harris College of Nursing and Health Sciences - Texas Christian University
- Alexia Green RN, Ph.D., Co-Leader of Texas TEAM - Advancing Health through Nursing

VI. THECB HEALTH PROFESSIONS GRANT PROGRAMS

- Greg Owens, Analyst - Legislative Budget Board
- Stacey Silverman, Deputy Assistant Commissioner for Workforce, Academic Affairs and Research - Texas Higher Education Coordinating Board
- Rodney Young, MD - Texas Medical Association, Council on Medical Education

VII. PUBLIC TESTIMONY AND ADJOURNMENT

OVERVIEW OF HIGHER EDUCATION GRADUATE MEDICAL EDUCATION FUNDING

Legislative Budget Board Staff

Presented to the House Committee on Appropriations Subcommittee on Education

February 22, 2013

Higher Education Graduate Medical Education Funding

- The 79th Legislature, 2005, established the Graduate Medical Education (GME) Formula beginning in the 2006-07 biennium. The Legislature directed the institutions to use these funds to increase the total number of residency slots in Texas and to support faculty costs relating to GME.

- The 80th Legislature, 2007, transferred $3 million to the Health Related Institution's GME Formula from the Texas Higher Education Coordinating Board's Graduate Medical Education strategy. The strategy's remaining funding was intended for independent primary care residency programs.

Health Related Institution (HRI) GME Formula Funding

2006-07 Appropriations		2008-09 Appropriations		2010-11 Appropriations Including Formula ARRA		2012-13 Appropriations		2014-15 Appropriations in House Bill 1, As Introduced	
Formula General Revenue	Annual Rate	Formula General Revenue	Annual Rate	Formula General Revenue	Annual Rate	Formula General Revenue	Annual Rate	Formula General Revenue	Annual Rate
$ 25.0	$ 2,403	$ 62.8	$ 5,634	$ 79.1	$ 6,653	$ 56.9	$ 4,682	$ 60.0	$ 4,682

- Amounts in table above are shown in millions.
- 2010-11 GME Formula appropriations consist of $63.1 million in General Revenue funds and $16.0 million in ARRA funds.

An Update on Graduate Medical Education in Texas

Stacey Silverman, Ph.D.
Deputy Assistant Commissioner
Universities and Health-Related Institutions
Workforce, Academic Affairs and Research Division

Presentation to the
House Appropriations Committee
Subcommittee on Education
February 22, 2013

An assessment of GME opportunity in the agency's five year strategic master plan

In 2011, the 82nd Texas Legislature, Regular Session passed House Bill 2908 (HB 2908), which directed the Texas Higher Education Coordinating Board (THECB) to include in the agency's five-year strategic master plan, an assessment of the **adequacy of opportunities for graduates of medical schools in the state to enter graduate medical education** in the state.

Texas Higher Education Coordinating Board

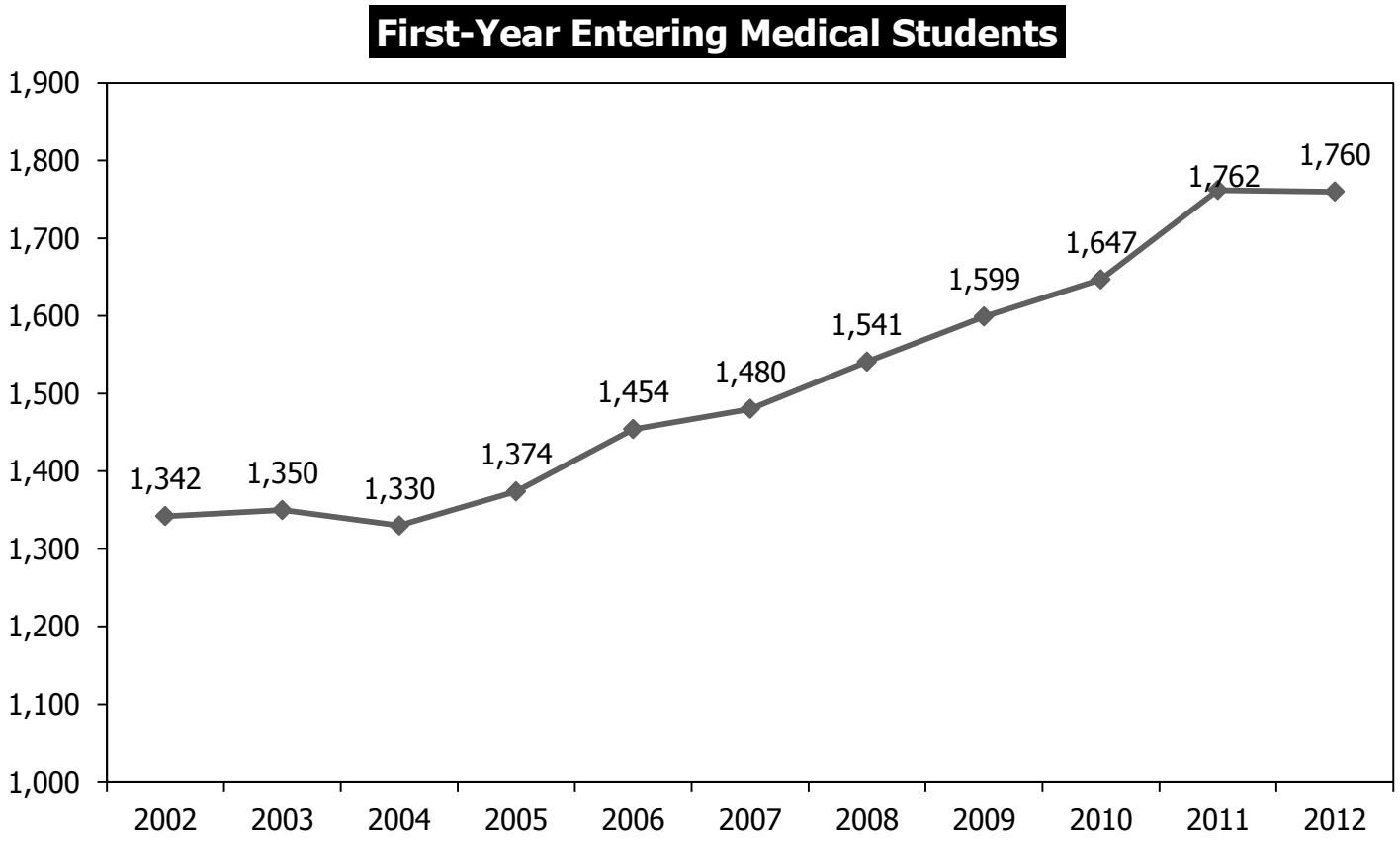
2012 GME Report

The Coordinating Board prepared a report and included its findings in the *2012 Coordinating Board Strategic Plan, 2013 through 2017*. The Board approved the 2012 GME Report at its April 2012 Board meeting.

The Report presents information required by HB 2908 and offers several conclusions and five recommendations.

Texas Higher Education Coordinating Board

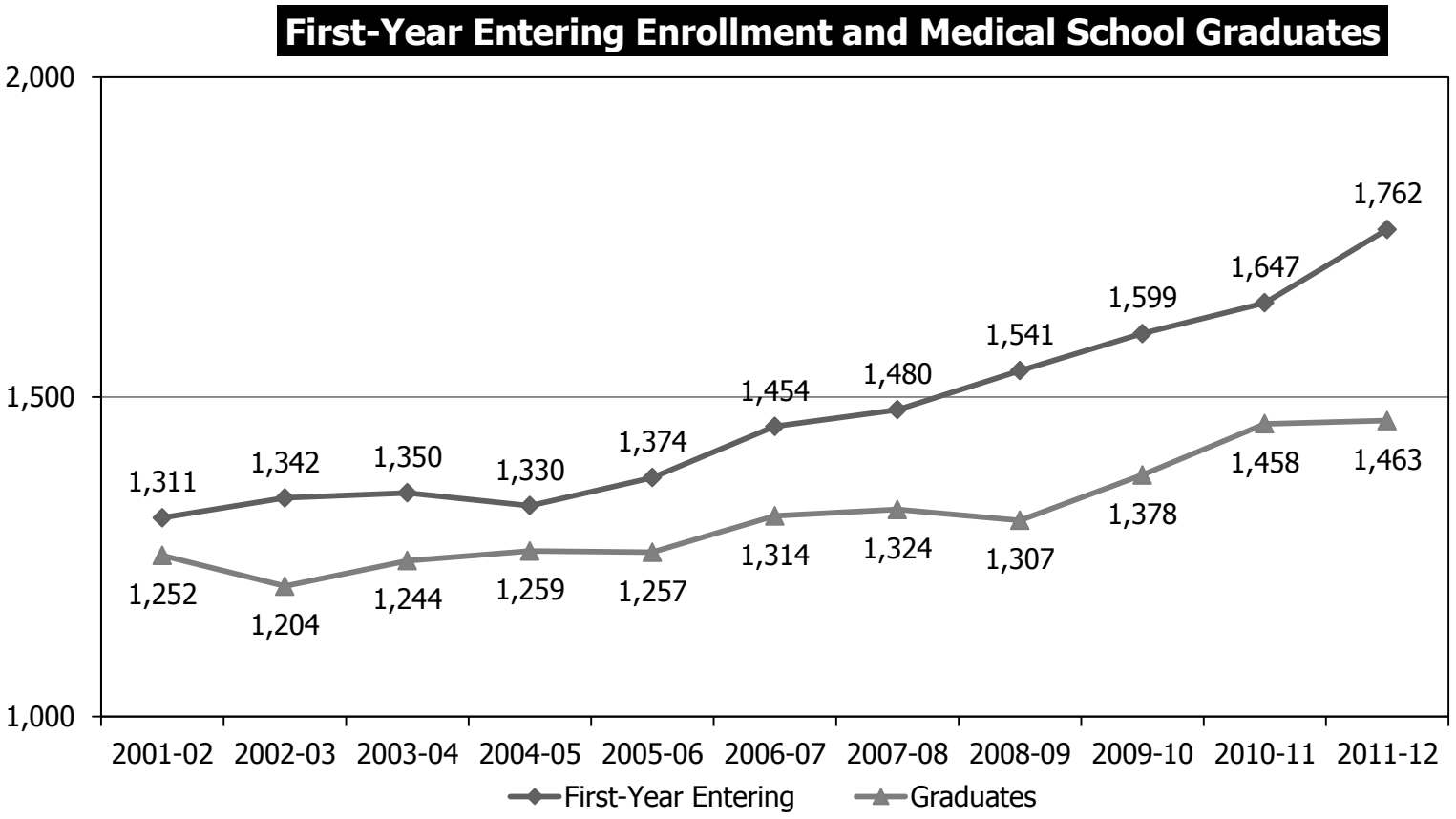
Texas increased its medical school enrollments 31 percent from fall 2002 to fall 2012, from 1,342 to 1,760, responding to the national call by the Association of American Medical Colleges to increase medical school enrollments by 30 percent.



Source: Coordinating Board, certified data.

Texas Higher Education Coordinating Board

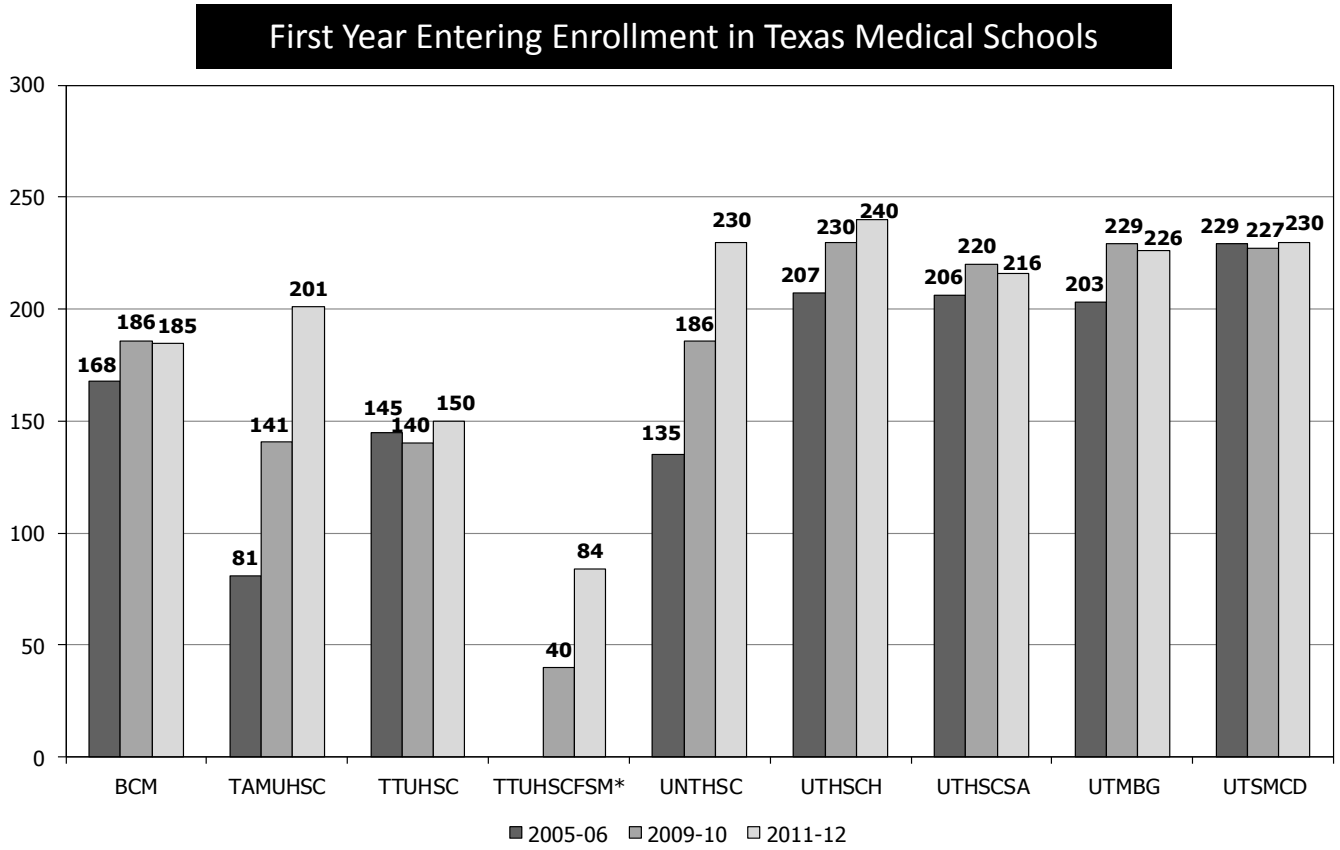
The increases in the entering medical students enrollments are beginning to show up in the number of medical students graduating.



Source: Coordinating Board.

Texas Higher Education Coordinating Board

The fall 2011 classes that have increased medical school enrollments will begin to graduate students in 2015.



*TTUHSCFSM inaugural class matriculated in 2009.

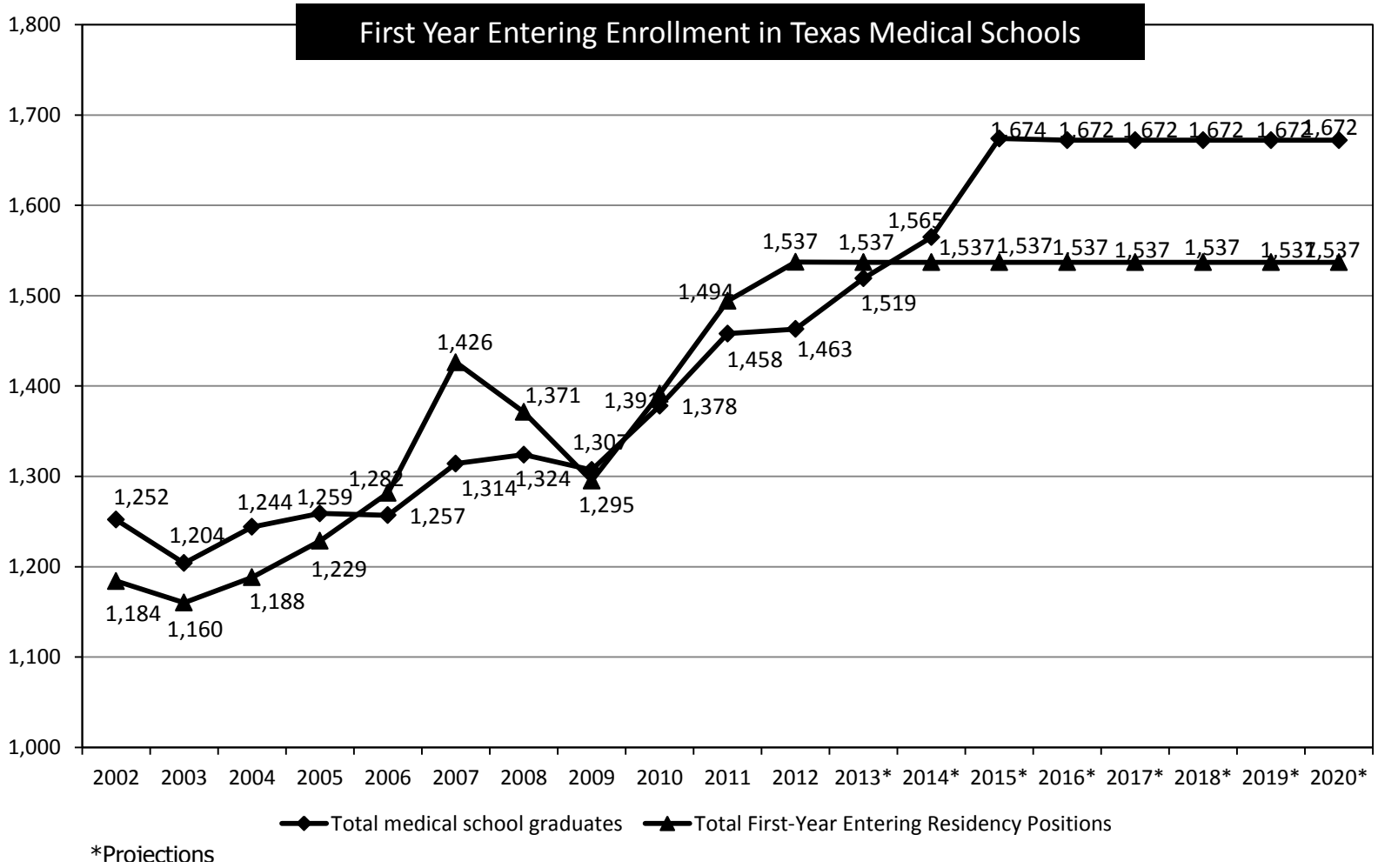
Source: Coordinating Board.

Texas Higher Education Coordinating Board

In 2011, Texas had more than 550 residency programs, offering a total of 6,788 residency positions. Only 22 percent (1,494) of these positions were first-year entering residents. Residency programs require three to eight years of training; thus, each year can only be a maximum of roughly one-third of the total residency positions.

Texas Total Number of Residency Programs and Number of Residency Programs with Entering First-Year Residents			
	Total Residency Programs	Programs w/Entering First-Year Residents	Percent
Public Medical Schools	370	123	33%
Public Health-Related -without medical school (UTMD Anderson and UTHSC-Tyler)	28	2	7%
Private Medical Schools	86	17	20%
Independent Residency Programs	70	23	33%
Total	554	165	30%

Without increases in the number of first-year residency positions, beginning in 2014, an estimated 28 graduates of Texas medical schools will not have an opportunity to enter a Texas residency program. This number increases to 137 in 2015.



Texas Higher Education Coordinating Board

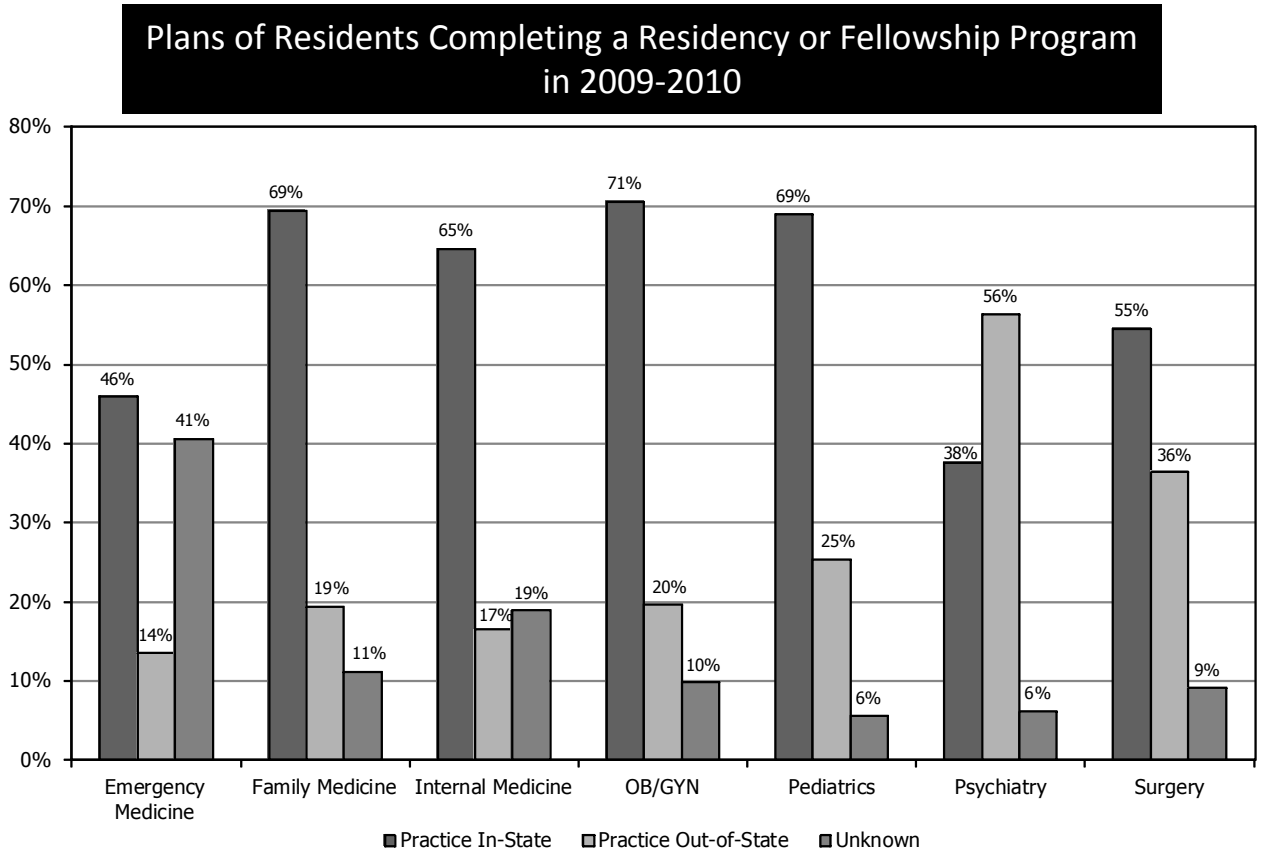
By 2016, an estimated 137 medical school graduates **will have to leave the state** for their first year of residency training due to a lack of residency positions.

The state's investment in their education of $168,000 per graduate, or $23 million annually **will not benefit the state**. The cost of adding additional first-year entering residency positions would reduce the loss of medical school graduates to other states.

While some of the graduates who enter residency training in other states may eventually return to Texas, others will not.

Texas Higher Education Coordinating Board

Resident physicians provide low-cost care to needy populations and tend to remain in the state in which they complete their residency training.



Source: American Medical Association.
*Percents are of those entering practice. Practice state was unreported for 106 residents. Some percentages may not equal to 100 percent due to rounding.

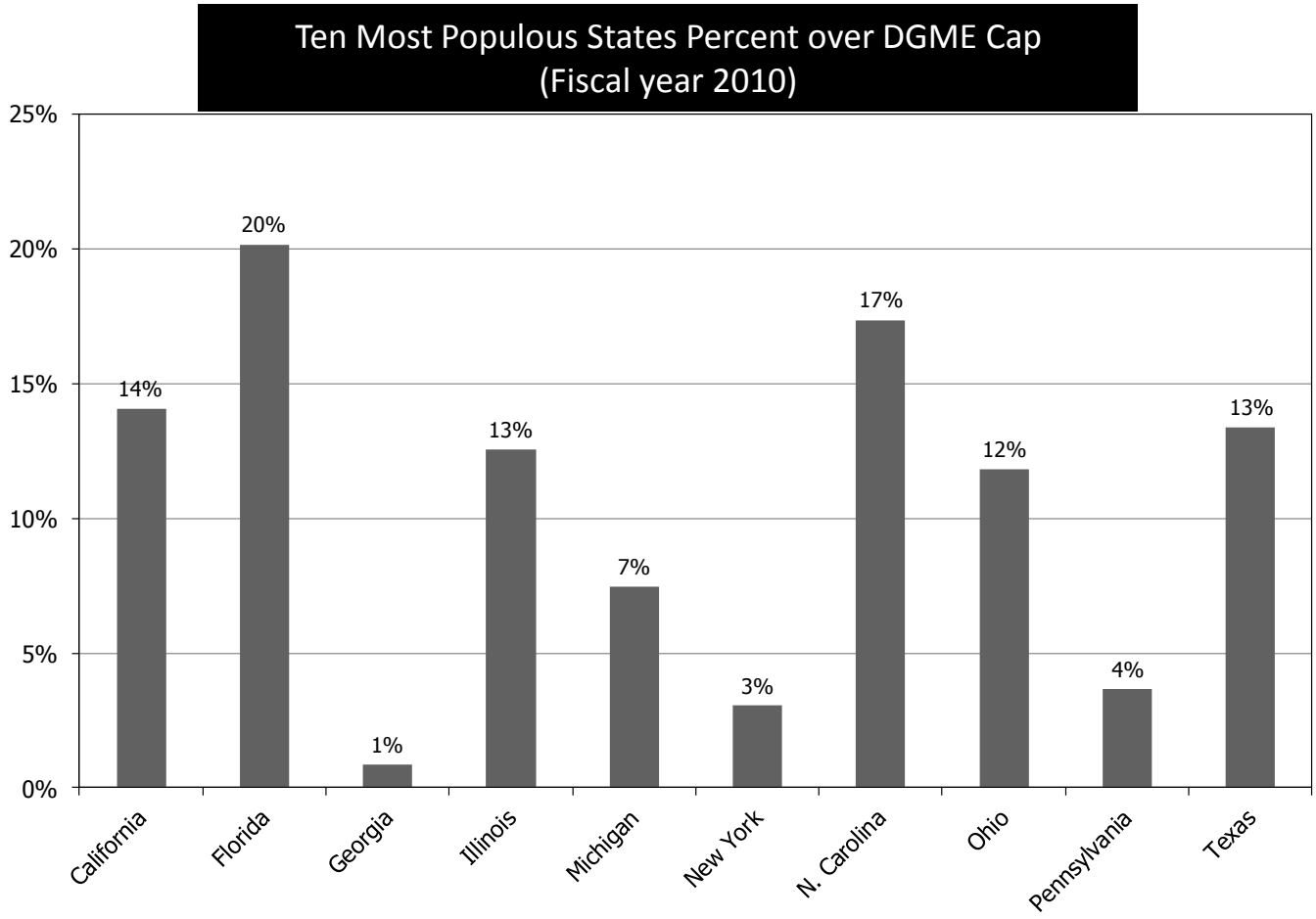
Texas Higher Education Coordinating Board

Residency programs are lengthy and expensive, with conservative estimates of $150,000 to educate a resident physician for a year.

Texas provides minimal funding support for residency training affiliated with health-related institutions through a formula allocation of $4,400 per resident, which equates to just 3 percent of the estimated cost of residency education.

An additional amount of $3,800 per resident is provided to family medicine residents through a trusteed fund administered by the THECB. These funds combined with the formula allocation cover approximately five percent of the estimated cost of these residency programs.

The largest explicit funding support for residency programs is provided through the federal Centers for Medicare and Medicaid Services, which historically has paid its share of total costs. However, federal funding for residency training is capped at 1996 levels for the direct support of graduate medical education.



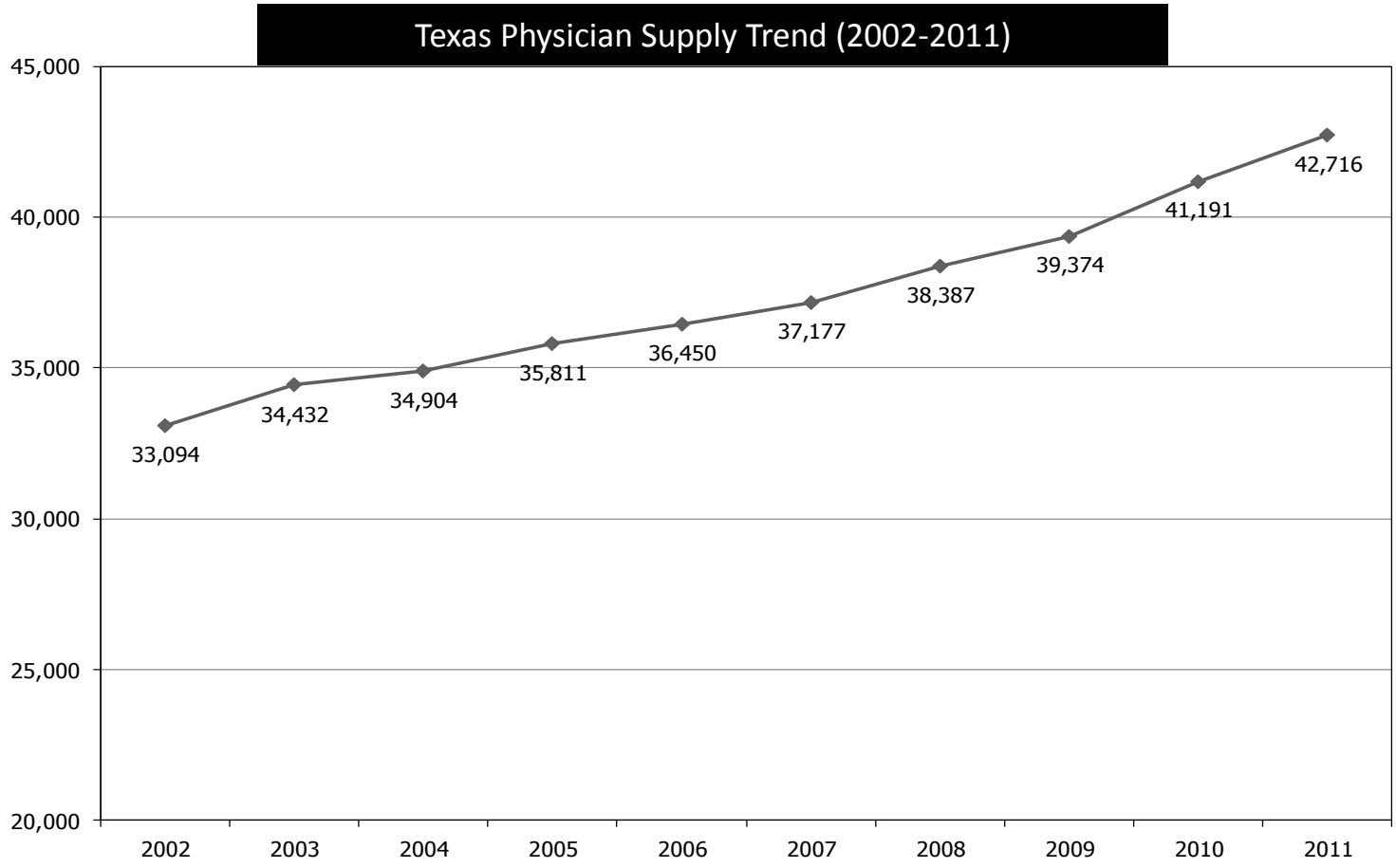
Source: Association of American Medical Colleges.

Texas Higher Education Coordinating Board

The cap only supports a third of the costs of 4,056 of the 4,598 actual positions in Texas, leaving the residency programs to cover the cost of two-thirds of the 4,056 positions and the full cost of 542 positions. Texas is currently over its Medicare cap by 13 percent.

The residency programs have to support the full cost of the education of the 542 federally unfunded residency positions at an estimated cost of $81.3 million ($150,000 x 542). Some of the cost is supported through increased patient care services provided by the residents, while under the direct supervision of faculty.

Texas is a net importer of physicians; however, the growth in the Texas general population has kept the physician to 100,000 population ratio stagnant.



Source: Texas Medical Association.

Texas Higher Education Coordinating Board

If Texas were to reach the current national average of physicians per 100,000 population ratios for the 15 medical specialties that admit first-year residents, significant increases to the number of residents would be required, beginning in 2014.

If an additional 1,048 residents could be trained beginning in 2014, it would take the state 10 years to reach the current national average of physicians for just these specialties.

If the state were to pick up the 10 percent cost of training these additional resident physicians, over the 10 year period, the state would need an additional $15.7 million beginning in 2014. By 2017, this amount would increase to support 4,192 residents, bringing the cost up to an estimated $62.8 million annually.

2012 GME Report Recommendations:

Recommendation: The State should mandate that at least one additional first-year residency position be added for each new medical student enrolled, beginning in 2014.

Recommendation: In order to achieve a 1.1 to 1 ratio of Texas first-year entering positions to medical school graduates, the Texas Legislature should provide an additional $11.7 million ($15,000 x 779) in funding to support 10 percent of the cost for new first-year entering residency training positions beginning in the 2014-2015 biennium, if funding is available. This would support the addition of 220 first-year entering residency positions that would be needed beginning in 2014, and allow the residents to continue training, and add 339 first-year entering residents in 2015. However, this funding would have to be maintained.

Recommendations:

Recommendation: Health-related institutions and hospitals should prioritize establishing more first-year residency positions and maintain the positions through the subsequent years of residency training that will be needed to accommodate the growing number of medical school graduates.

Recommendation: The Texas Congressional delegation should be encouraged to support Congressional action to reconsider the current Medicare caps, which would allow states with increased populations to receive support for the expansion of residency training.

Recommendation: The Legislature should seek alternative funding sources, which may include industry, hospitals, and health-care plans to increase graduate medical education opportunities in Texas.

Contact Information:

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Texas Higher Education Coordinating Board

Background

From 2003 to 2012, academic health centers have increased the number of total residency slots by 27%. Because of financial pressures the rate of growth has slowed in the last five years.[1] From 2003 to 2012 the number of 1st year GME slots statewide has increased 33%, but those increases have slowed in the last five years to 12%.[2]

The Texas Higher Education Coordinating Board has estimated the annual cost to train a resident at $150,000. Only two-thirds of GME slots in Texas are supported by Medicare GME funds. A survey of hospitals in northeast and south Texas indicate for such slots supported by GME, between $75,000 and $130,000 in direct and indirect Medicate GME is provided per covered resident per year. Hospitals which have never had a residency program do not have a Medicare GME cap imposed, which means they would be eligible to establish a residency program and generate Medicare GME funding to support these residents.

Of the nearly 1,600 1st year GME slots that academic health institutions were authorized to offer this year, almost 100 of these approved slots were unfilled. A portion of these 100 slots are unfilled solely because there is no source of funding to cover resident stipend and benefits.

Proposal

Expanding an existing or establishing a new residency program requires a significant investment in resources and is a long term commitment. Funding for new residency slots would need to be consistent and ongoing.

1. Provide $65,000 per resident for stipend, benefit and other direct resident costs to fill currently approved but unfilled 1st year residency slots. These slots could be filled by the second year of the next biennium and funding would be continued for three years of the residency and be ongoing similar to funding for medical students.

2. Provide $65,000 per resident for stipend, benefit and other direct resident costs to expand 1st year slots in existing programs and new programs at hospitals already at their Medicare cap for GME positions. The earliest these programs could fill new 1st year positions is the second year of the next biennium, but most additional slots would be available in Fiscal Year 2016. Funding would be continued for three years of the residency similar to funding for medical students.

3. Provide one-time $150,000 planning grants for hospitals which have never had residency programs and therefore are not subject to the Medicare GME cap. Once these hospitals offer 1st year GME slots, they could apply for up to $35,000 in funding per resident.

4. Restore GME Formula funding level at least to the $6,653 level provided for the 2010-11 biennium—this would cover about 40% of the estimated cost of faculty to supervise residents.

5. Restoration of other GME program cuts.

[1] Based on historical data from THECB.
[2] Based on THECB data from February 2013.

ESTIMATED COSTS OF GME EXPANSION

	$150,000	15 grants						
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
	$2,250,000							
	$65,000	new slots						
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
1st year	50	125	200	280	280	280	280	280
2nd year		50	125	200	280	280	280	280
3rd year			50	125	200	280	280	280
	50	175	375	605	760	840	840	840
	$14,625,000		$63,700,000		$104,000,000		$109,200,000	
	$35,000	new slots						
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
1st year			120	120	120	120	120	120
2nd year				120	120	120	120	120
3rd year					120	120	120	120
	0	0	120	240	360	360	360	360
	$0		$12,600,000		$25,200,000		$25,200,000	
	$16,875,000		**$76,300,000**		**$129,200,000**		**$134,400,000**	

Graduate Medical Education

What is GME?
Graduate medical education (GME), or residency training, is the post-medical school training of doctors. Medical school graduates must complete one year of training to be licensed and most complete full residency programs (3 to 7 years) in order to become board certified. Certification is important for participation in health plan networks and hospital admitting privileges.

GME programs are partnerships between academic health institutions, which provide faculty to supervise residents, and clinical facilities, usually hospitals, where residents care for patients. Residents cannot bill for services they provide. The Texas Higher Education Coordinating Board (THECB) has estimated the annual cost of a resident at $150,000. These costs include: residents' stipends, benefits, and malpractice insurance; faculty time supervising residents; program administration; and higher medical costs due to less efficient delivery of care (more tests and faculty see fewer patients when supervising residents).

Why does GME matter?
Although medical residents cannot bill for the services, they play a critical role in providing patient care, particularly to indigent patients. Texas leads the United States with the highest rate of uninsured—25% compared to a 15% national average—and the uninsured receive a significant amount of health care through the state's teaching hospitals.

Physicians tend to practice where they do their residency and 80% of Texas medical school graduates who complete residency in Texas remain here to practice (3rd in the nation). Texas graduates who complete a residency elsewhere return to practice about 60% of the time (2nd in the nation).

How is GME funded?
GME is financed through a combination of federal, state, and local/institutional funding—Medicare being the largest source overall. The Medicare payments go to hospitals as partial compensation for salaries for a limited number of residents and for the higher patient care costs incurred by teaching hospitals (due to less efficient care delivery and patients at teaching hospitals who are relatively sicker than patients at other hospitals). Medicare limits the number of residents for which hospitals generate Medicare GME payments. Of the approximately 6,100 filled residency positions (not including military programs) in Texas, approximately 2,300 positions are above the Medicare cap and not supported by this critical GME funding source.

State funding (General Revenue and General Revenue-Dedicated) for GME is appropriated to a number programs but overall this funding as decreased by 43.8% since 2002-03: the GME Formula, created in 2005 reimburses HRI for less than 30% of the estimated costs of supervising residents (and equals about 3% of the total estimated cost of a resident); funds trusteed to the THECB provide minimal support for certain types of residency programs (and have been cut by 89% since 2002-03; a few GME-related Special Items to HRI; and effective FY 2009 the state reinstituted Medicaid GME only for state-owned hospitals (no GR is provided).

General Revenue (GR) and GR-Dedicated (GR-D) Support for Graduate Medical Education

	2002-03 Biennium *(in millions)*	2010-11 Biennium *(in millions)*	2012-13 Biennium *(in millions)*	Change 2002-03 to 2012-13
Texas Health and Human Services Commission				
Medicaid GME (estimated GR)	$67.5	$0.0	$0.0	-100%
Medicaid GME (estimated Federal $)	*$101.7*	*$17.5*	*TBD*	
Article III Health-Related Institutions *				
GME Formula (GR)	$0.0	$79.1	$56.9	
Texas Higher Education Coordinating Board**				
Family Practice Residency Program (GR)	$20.6	$21.2	$5.6	-72.8%
Primary Care Residency Program (GR)	$5.9	$5.0	$0.0	-100%
GME Program (GR)	$15.2	$0.6	$0.0	-100%
Resident Physicians Compensation Program (GR)	$8.1	$0.0	$0.0	-100%
Family Practice Pilot Projects (GR)	$2.0	$0.0	$0.0	-100%
Texas Department of State Health Services				
Phys & Nurse Trauma Fellowship Slots (GR-D)	$0.0	$0.0	$4.5	
TOTAL, GR and GR-D	*$119.2*	*$105.9*	*$67.0*	*-43.8%*

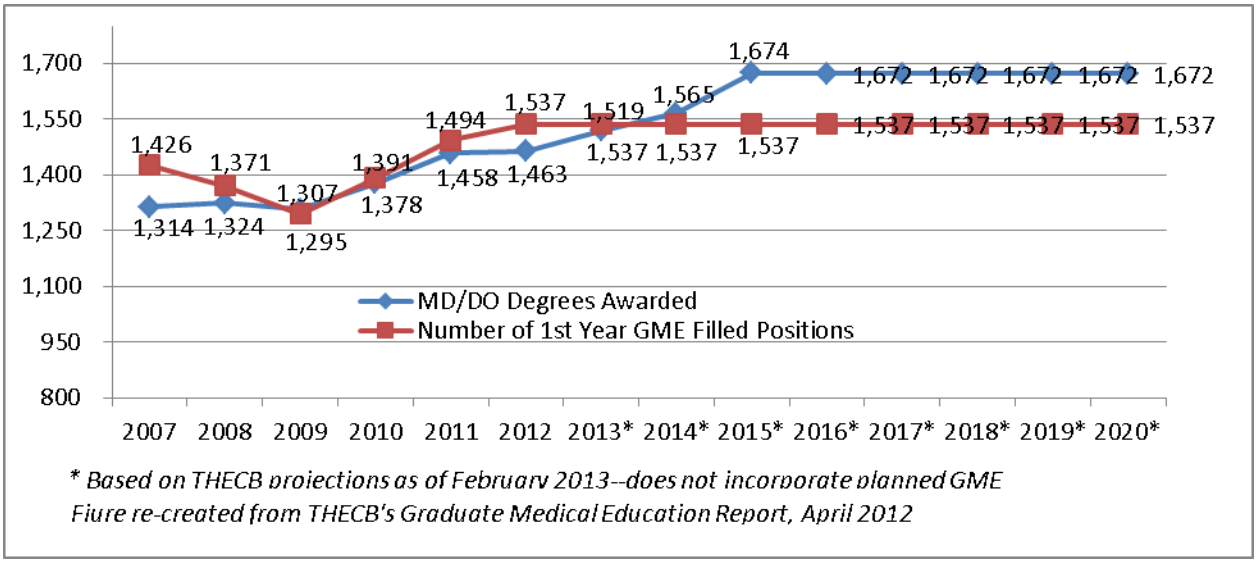
** Does not include Special Item appropriations to health institutions for residency related programs.*
*** Data from THECB, July 2012 report of GME Programs.*

Why more GME slots are needed?

Texas ranks 46th in the nation in active patient care physicians per 100,000 population and 47th in the nation in active primary care physicians. With Texas' fast growing population, these ratios will only decline without continued expansion of the health care workforce. Texas medical schools have made a concerted effort to expand class sizes and medical school applications continue to increase by 5% each of the last three years, ensuring a high quality pool of candidates. Texas schools are an incredible bargain—a Texan would pay about $16,300 tuition and fees per year, compared to the nearly $28,700 an in-state student would pay nationally. A Texan enrolled as a nonresident at a public medical school in another state would pay on average $51,700 per year.

While the number of GME slots have increased—total GME slots at academic health institutions have increased more than 25% since 2003—the increases in first year GME slots have not kept pace with the increase in medical school graduates in Texas. THECB has predicted that Texas medical school graduates in 2014 will outnumber first year GME positions available in Texas. This means some Texas graduates will have to leave Texas to find a GME position in his/her chosen area of practice.

Projections of Medical School Graduates versus 1st Year GME Slots

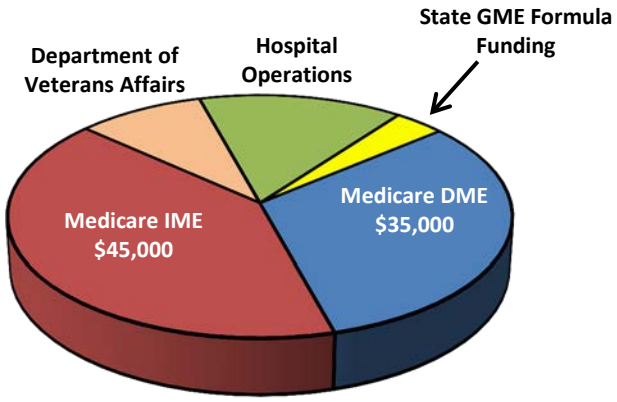


** Based on THECB projections as of February 2013--does not incorporate planned GME*

Figure re-created from THECB's Graduate Medical Education Report, April 2012

Funding Streams for Current and New Graduate Medical Education

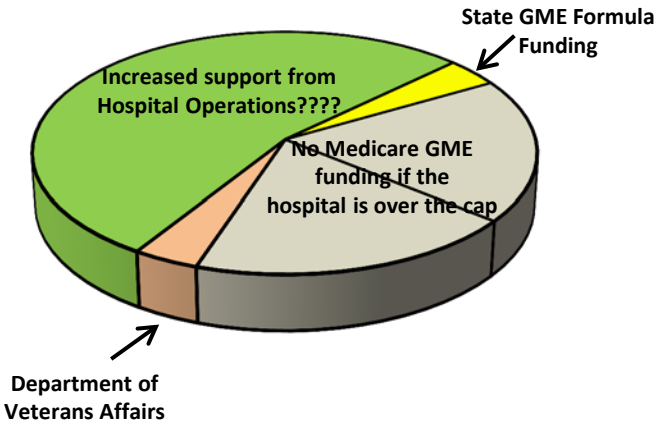
Current GME estimated $150,000/resident/year



The rapid and necessary production of new physicians requires growth in both undergraduate (medical school) and graduate medical education (GME)(residency training). Nationwide and in Texas, medical school growth has outpaced GME.

Medicare is the primary payer for GME, yet federal funding reductions are expected. The Simpson-Bowles Commission suggested 60% cuts, which would destroy the country's residency programs and our means for training the worlds' best physicians.

New GME estimated $150,000/resident/year*



Medicare GME funding is capped at 1997 levels meaning if programs add positions, new funds are needed to replace the IME/DME.

New, sustainable GME funding sources are needed to add first-year positions as quickly as possible to retain current Texas medical school graduates and address our state's physician shortage. A minimum of 63 first-year positions are needed in 2014; 220 are needed to reach 110% of first-year GME to graduates. By 2015, more than 300 new first-year slots are needed.

IME – Indirect Medical Education
DME – Direct Medical Education
UME – Undergraduate Med. Ed.
GME – Graduate Medical Education

TAFP

Issue Brief: **SUPPORT AND INCREASE FAMILY MEDICINE RESIDENCY TRAINING**

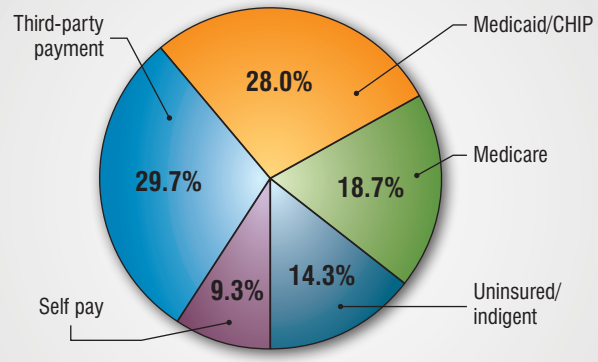
Texas Academy of Family Physicians | 12012 Technology Blvd., Ste. 200 | Austin, TX 78727 | (512) 329-8666 | www.tafp.org

Family Medicine Residency Programs Are Critical in Training Texas' Physician Workforce

The most effective way to increase the number of primary care physicians practicing in our communities is to train them right here in Texas. Our state's 28 family medicine residency programs are the lifeblood of the state's primary care physician workforce, preparing more than 200 new family physicians for practice each year. More than 70% of family doctors completing residency in Texas remain in the state.

Family medicine residency programs deliver well-coordinated, cost-effective care to communities that need it. A significant portion of the care they provide is for Medicaid and CHIP patients, Medicare patients, and the uninsured.

PATIENT MIX AT TEXAS FAMILY MEDICINE RESIDENCY PROGRAMS



Source: Texas Higher Education Coordinating Board

Since most funding for residency training comes from Medicare and goes to teaching hospitals, family medicine residency programs often suffer from a lack of institutional support.

- Medicare only reimburses teaching hospitals for the time residents are treating patients in the hospital, however most family medicine training happens in outpatient clinics.
- Because procedural residencies generate more clinical revenue than family medicine residencies do, teaching hospitals have a financial disincentive to support family medicine residencies.
- Family medicine residency training occurs mostly in ambulatory medical clinics, which have higher overhead costs per resident compared to teaching hospitals where subspecialty residents are trained.
- Robust subspecialty residency programs present academic medical institutions greater opportunities to receive substantial research grants, while primary care residencies do not.

Since Medicare capped GME funding in 1997, increases in residency training positions have occurred almost exclusively in subspecialty training. The Medicare Payment Advisory Committee, the Council on Graduate Medical Education, and numerous researchers have observed that teaching hospitals and academic health centers have built GME training programs that serve their institutional goals ahead of serving the physician workforce needs of their communities.

- From 2000 to 2012, the number of first-year residency positions offered in Texas through the National Residency Matching Program increased from 1,231 positions to 1,473.
- Over that same period, the number of first-year family medicine residency positions offered in Texas through NRMP fell from 247 to 211.
- 70 family medicine residency programs around the country have closed since 2001.
- Since 2002, three family medicine residency programs have closed in Texas.

over

The Texas Primary Care Two-step:
Support existing family medicine residency programs and increase the amount of training positions offered

If Texas wants more primary care residency training positions, the state is going to have to pay for them. In 2002-2003, Texas spent $51.7 million on a number of programs administered by the Texas Higher Education Coordinating Board that were designed to increase our primary care physician workforce by supporting residency training. Today, most of those programs have been defunded. All that remains is the Family Practice Residency Program fund, which was budgeted for $5.6 million in 2012-2013.

Step 1: Fund family medicine residency training programs at $25 million for 2014-2015

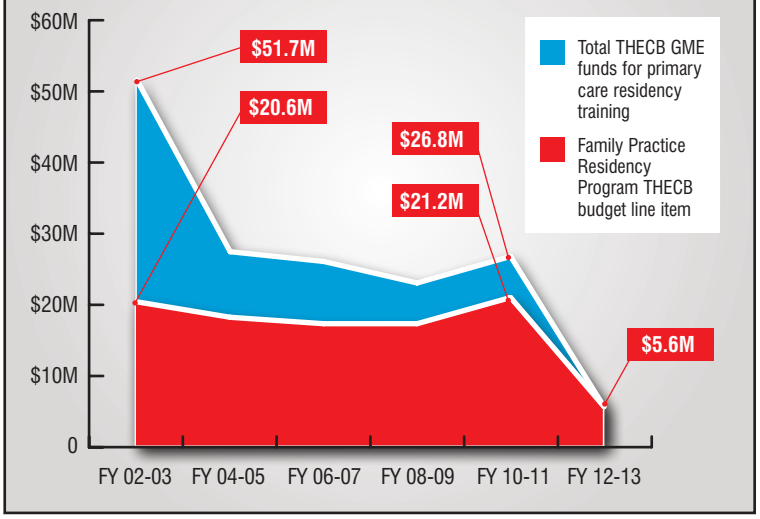
Today there are 716 family medicine residents training in Texas. $25 million would provide almost $17,500 per resident per year, helping to stabilize our state's existing programs and repair damage done by the 74% cut they sustained last session.

Step 2: Invest in new family medicine residency positions

TAFP believes that with adequate funding, there is capacity to increase training positions in existing residency programs by 20 percent. That is 47 new positions each year.

To achieve this goal, the state should establish an incentive program for family medicine residencies that add training positions. The program should provide sufficient funding to cover the salary and benefits of the new residents—$68,500 each—and one quarter of their faculty cost—$50,000 each. With 47 new positions each year funded at $118,500 apiece, the program would cost $5.5 million in 2014, and $11.2 in 2015.

FUNDING FOR PRIMARY CARE RESIDENCY TRAINING ADMINISTERED BY THE TEXAS HIGHER EDUCATION COORDINATING BOARD



STEP 2 FUNDING STRATEGY

2013: 47 positions x $118,500 = $5,546,000
2014: 94 positions x $118,500 = $11,139,000

Step 2 total, FY 2013-2014 = $16,685,000

NOTE: If the percentage of care the programs provide for the uninsured decreases or if potential revenue from Medicaid, CHIP, or Medicare increases, these residency expansion incentives should be adjusted.

Texas' 28 family medicine residency programs have succeeded for years at producing the core of our state's primary care physician workforce. As patient-centered medical homes, heavy users of health information technology, and early adopters of computerized simulation for training, these programs are laboratories for innovation in the provision of high-quality, cost-effective care.

By restoring support for these programs and offering meaningful incentives for those programs that expand training capacity, we can repair and strengthen our state's primary care infrastructure, ensuring access to care for our growing population.

Legislative advertising paid for by the Texas Academy of Family Physicians. For more information, contact Tom Banning, CEO/EVP, 12012 Technology Blvd., Ste. 200, Austin, Texas, 78727.

GME 101

What You Need to Know About Graduate Medical Education in Texas

By The Texas Academy of Family Physicians

What is Graduate Medical Education?

Graduate medical education or residency training is the post-medical school training of physicians. Whereas medical school teaches physicians a broad range of medical knowledge, basic clinical skills, and limited experience practicing medicine, residency provides in-depth training in a particular specialty. Medical school graduates must complete one year of residency training to be licensed and most complete full residency programs (3 – 7 years depending on specialty) to become board certified.

How is GME funded?

Graduate medical education funding is complex and opaque. GME is primarily financed through Medicare in the form of direct medical education payments (DME) and indirect medical education payments (IME) made to teaching hospitals. Other sources of funding include clinical revenue and state support.

Medicare GME: The Medicare program provides subsidies to teaching hospitals to support the residency training of physicians. Medicare DME payments to teaching hospitals cover a portion of the direct costs of training residents, including stipends, teaching physician and resident salaries and benefits, and educational activity costs. Medicare IME payments are intended as compensation for the anticipated higher cost of care in teaching hospitals.

Two fundamental problems with Medicare GME funding combine to jeopardize many primary care residency programs, especially family medicine programs. First, Congress capped Medicare GME funding as part of the Balanced Budget Act of 1997. With few exceptions, a teaching hospital can only receive Medicare GME funding for the number of residents it trained in 1996, and while many teaching hospitals have exceeded that cap, they have done so at their own expense. Of the approximately 6,100 filled residency positions in Texas, nearly 2,300 positions are above the Medicare cap and are not eligible for Medicare DME or IME.

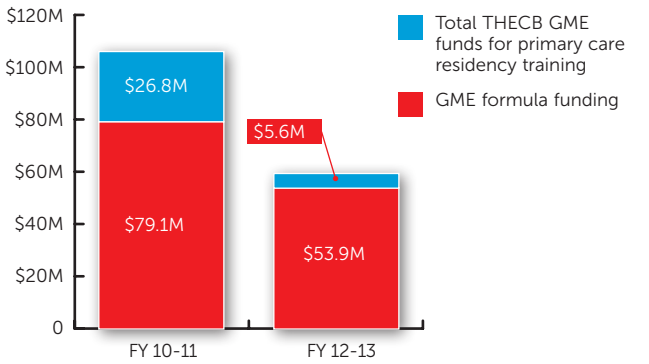
The other problem is that Medicare only reimburses teaching hospitals for the time residents spend treating patients in the hospital, which is fine for most specialties, but detrimental to primary care. For family medicine residents, the majority of training takes place in an outpatient clinic, and therefore can't be counted for Medicare GME payments.

Clinical Revenue: A growing revenue source to cover the cost of providing GME comes from clinical practice plans and patient care revenue. A significant portion of care residency programs provide is for Medicaid and CHIP, Medicare, and the uninsured. As reliance on clinical revenue grows to offset cuts in federal and state support, teaching hospitals and residency programs are forced to seek better reimbursement from commercial payers and to provide higher-level, more lucrative procedural services.

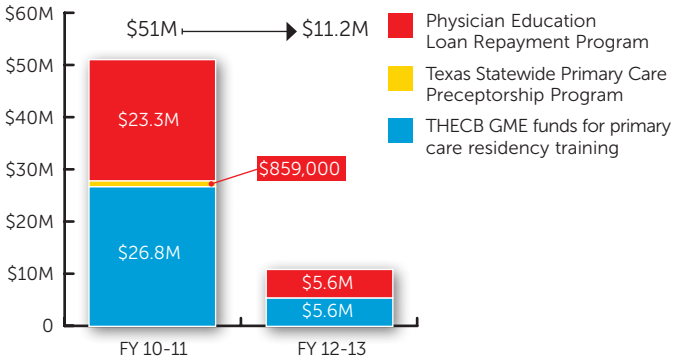
State Support: State support for GME has fluctuated greatly over the past decade, but when you include the elimination of Medicaid GME funds, state general revenue funding for GME has decreased by 48 percent since 2002-2003. Since 2006, medical schools have received some state support in the form of GME formula funding to cover a portion of faculty costs. In FY 2012-2013, they received $4,682 per resident, which is about 3 percent of the total cost to train a resident.

Trusteed funds at the Texas Higher Education Coordinating Board designed to support family medicine and primary care have been cut by 89 percent over the same time period. In 2002-2003, Texas spent $51.7 million to increase our primary care physician workforce. Today, most of those programs have been defunded. All that remains is the Family Practice Residency Program fund, which was budgeted for $5.6 million in 2012-2013.

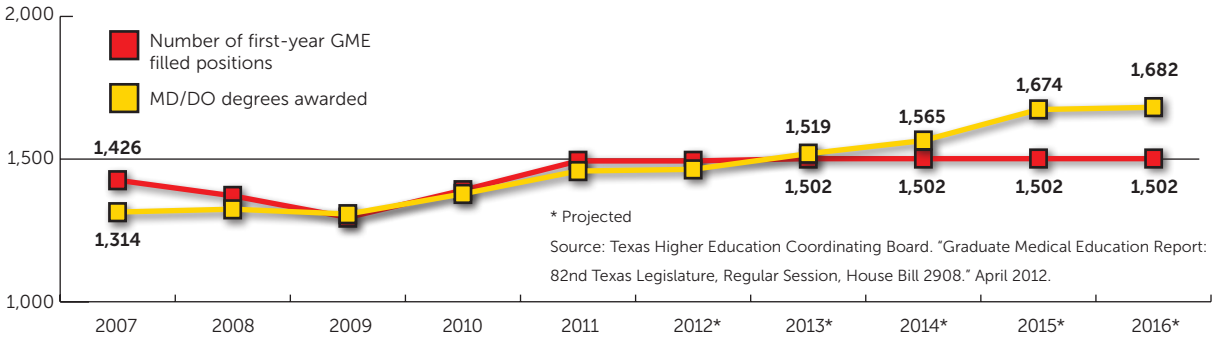
Cuts in total state support for GME training



Cuts in state support for programs designed to recruit and train primary care physicians



The number of Texas medical school graduates versus first-year entering residency positions



* Projected

Source: Texas Higher Education Coordinating Board. "Graduate Medical Education Report: 82nd Texas Legislature, Regular Session, House Bill 2908." April 2012.

What is the true cost of training a resident each year?

The cost of training a resident varies significantly by specialty and by program. Costs include resident salary and benefits, faculty salary, and overhead costs like malpractice insurance, administrative costs, and building maintenance. Family medicine residents are among the most expensive to train because most of their training occurs in ambulatory medical clinics, which have higher overhead costs per resident compared to teaching hospitals where subspecialty residents are trained.

The Texas Higher Education Coordinating Board estimates that across *all* specialties, the average annual cost of training a resident is $150,000. However, the average cost of training a family medicine resident in 2012 was about $250,000, according to annual financial reports family medicine residency programs file with THECB.

Does Texas have an adequate number of first-year GME slots?

No. There is a widening gap between how many medical graduates Texas produces and how many first-year residency positions are available for them. According to THECB, by 2016 Texas will produce 180 more medical school graduates than the amount of first-year residency positions available. Each medical school graduate costs Texas $168,000, so when they leave to find training programs, Texas will lose an investment of more than $30 million in that one year alone. While total GME slots in Texas have increased 27 percent since 2003, the increase has occurred almost exclusively in subspecialty training.

Is GME funding transparent?

Due to the manner in which GME is financed, it is nearly impossible to account for how various funding streams are applied at the institutional level. If the state wishes to increase the number of residency positions available by increasing GME funding outside of the GME formula funds appropriated to health-related institutions, there must be a method to account for how those new funds are used to create additional residency positions.

Legislative advertising paid for by the Texas Academy of Family Physicians. For more information, contact Tom Banning, CEO/EVP, 12012 Technology Blvd., Ste. 200, Austin, Texas, 78727.

FORMULA FUNDING FOR GENERAL ACADEMIC INSTITUTIONS AND HEALTH RELATED INSTITUTIONS

Legislative Budget Board Staff

Presented to the House Appropriations Committee Subcommittee on Education

February 22, 2013

Formula Funding Mechanics

- Formulas are a distribution method for higher education funding. Higher education formulas do not create a statutory or constitutional entitlement.

- Formula Method of Finance.

  All Funds methodology which means that General Revenue and GR-Dedicated–Other Educational and General Income (E&G) are used to fund the formulas. "Other E&G" includes revenue generated by statutory tuition, interest on funds in the state treasury, and various fees. (Board Authorized Tuition is distributed after formula calculation, therefore does not affect the amount of General Revenue.)

General Academic Institutions Formula: Instructions and Operations

Introduced House Bill 2014-15 Biennium: $3,481 million
(includes $94 million for Teaching Experience Supplement)

Semester Credit Hours **X** **Program/Level Weight** **X** **Rate**

Semester credit hours (SCH) SCH is a measure of how many classes an institution delivers. The time for which data is gathered is called the ***base period.*** The base period used for the Introduced Bill 2014-15 biennium is Spring, Summer, and Fall of 2012. In March, the Higher Education Coordinating Board will provide updated numbers based on the base period of Summer and Fall of 2012 and Spring of 2013.

SCH are **weighted** by discipline (e.g. nursing is weighted more than liberal arts) and by level (i.e. lower and upper division, masters, doctoral, and professional). The weights are based on a cost study of relative costs and are listed on the following page.

The Legislature sets the rate based on available funding, including consideration of enrollment changes and other factors.

Teaching Experience Supplement

Semester Credit Hours **X** **Program/Level Weight** **X** **Supplement (0.10)** **X** **Rate**

Hours taught by ***tenured or tenure-track faculty*** qualify for the teaching experience supplement.

The weight functions as it does in the Instruction and Operations formula.

General Academic Institutions Cost Based Matrix
Introduced House Bill 2014-15 Biennium

	Lower Div.	Upper Div.	Masters	Doctoral	Special Professional
Liberal Arts	1.00	1.69	3.87	9.33	15.3
Science	1.76	2.95	7.70	21.78	2.95
Fine Arts	1.43	2.37	5.48	7.44	
Teacher Ed	1.45	1.79	2.30	7.70	
Agriculture	2.09	2.65	7.33	10.12	
Engineering	2.43	3.59	7.58	16.75	
Home Economics	1.02	1.64	3.02	7.77	
Law					4.48
Social Services	1.70	2.04	2.89	15.32	
Library Science	1.50	1.20	2.83	11.95	
Vocational Training	1.37	1.98			
Physical Training	1.36	1.11			
Health Services	1.14	1.76	3.08	9.93	2.67
Pharmacy	1.60	5.28	23.10	36.07	4.03
Business Admin	1.13	1.75	3.19	23.05	4.96
Optometry			41.14	51.63	5.98
Teacher Ed Practice	1.83	1.79			
Technology	2.27	2.52	3.87	4.19	
Nursing	1.92	2.06	3.75	8.55	
Developmental Ed	1.00				
Veterinary Medicine					20.27

Health Related Institutions Formula: Instructions and Operations

Introduced House Bill 2014-15 Biennium: $1,017 million

Full Time Student Equivalent X **Program Weight** **X** **Rate**

Full Time Student Equivalent (FTSE) FTSE is a measure of how many students an institution delivers instruction to. The time for which data is gathered is called the ***base period***. The base period used for the Introduced Bill 2014-15 biennium is Spring, Summer, and Fall of 2012. In March, the Higher Education Coordinating Board will provide updated numbers based on the base period of Summer and Fall of 2012 and Spring of 2013.

FTSE are **weighted** by discipline (e.g. medical students are weighted more than nursing). The weights are set by the Legislature and are listed on the following page.

The Legislature sets the rate based on available funding, including consideration of enrollment changes and other factors.

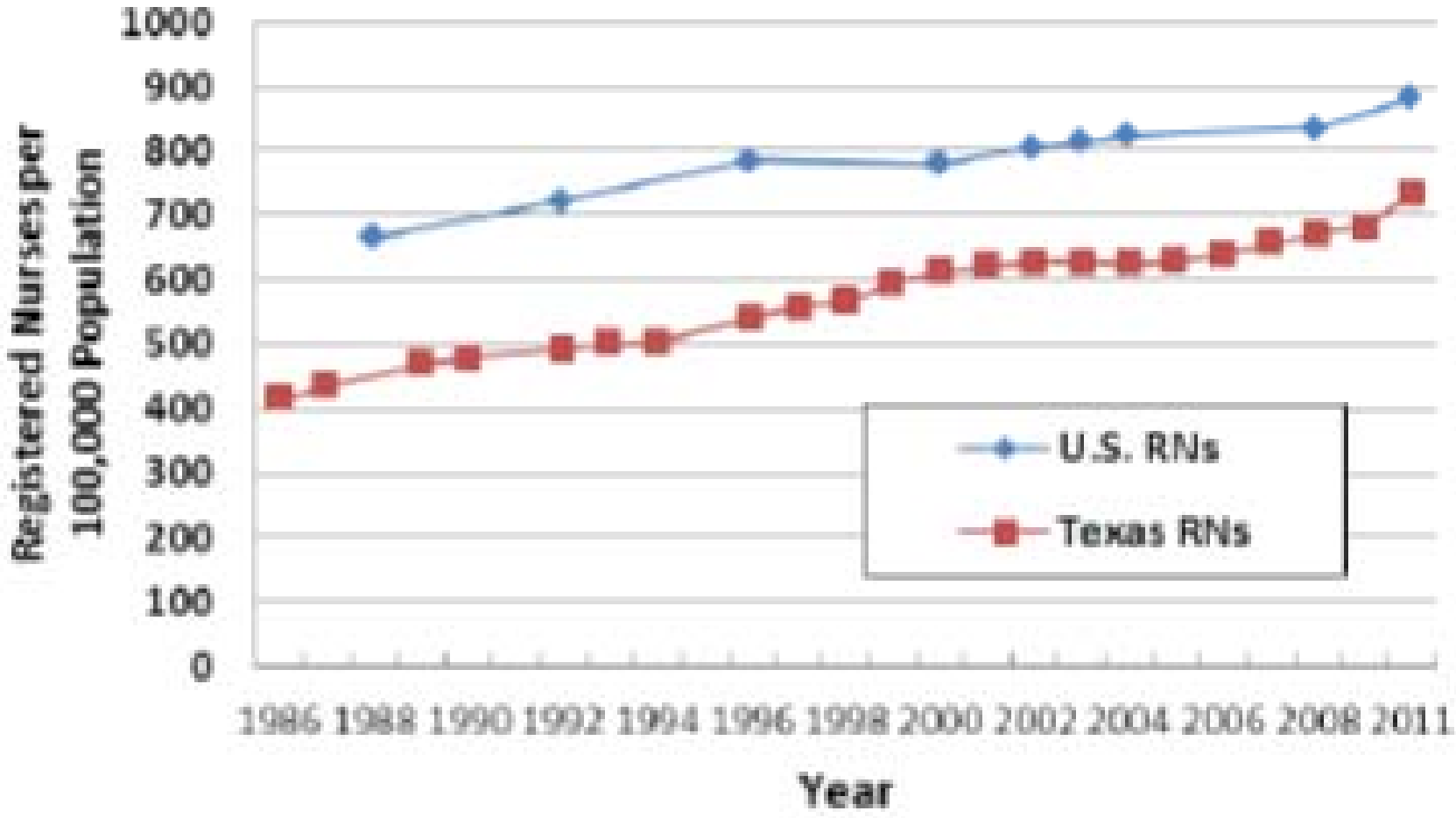
Health Related Institutions Funding Weights
Introduced House Bill 2014-15 Biennium

Program Weight Per Student

Allied Health	1.000
Biomedical Science	1.018
Nursing	1.138
Pharmacy	1.670
Public Health	1.721
Dental	4.601
Medical	4.753

TNA CHART 1

Figure 3. Registered Nurses per 100,000 Population, U.S. and Texas. 1986-2011

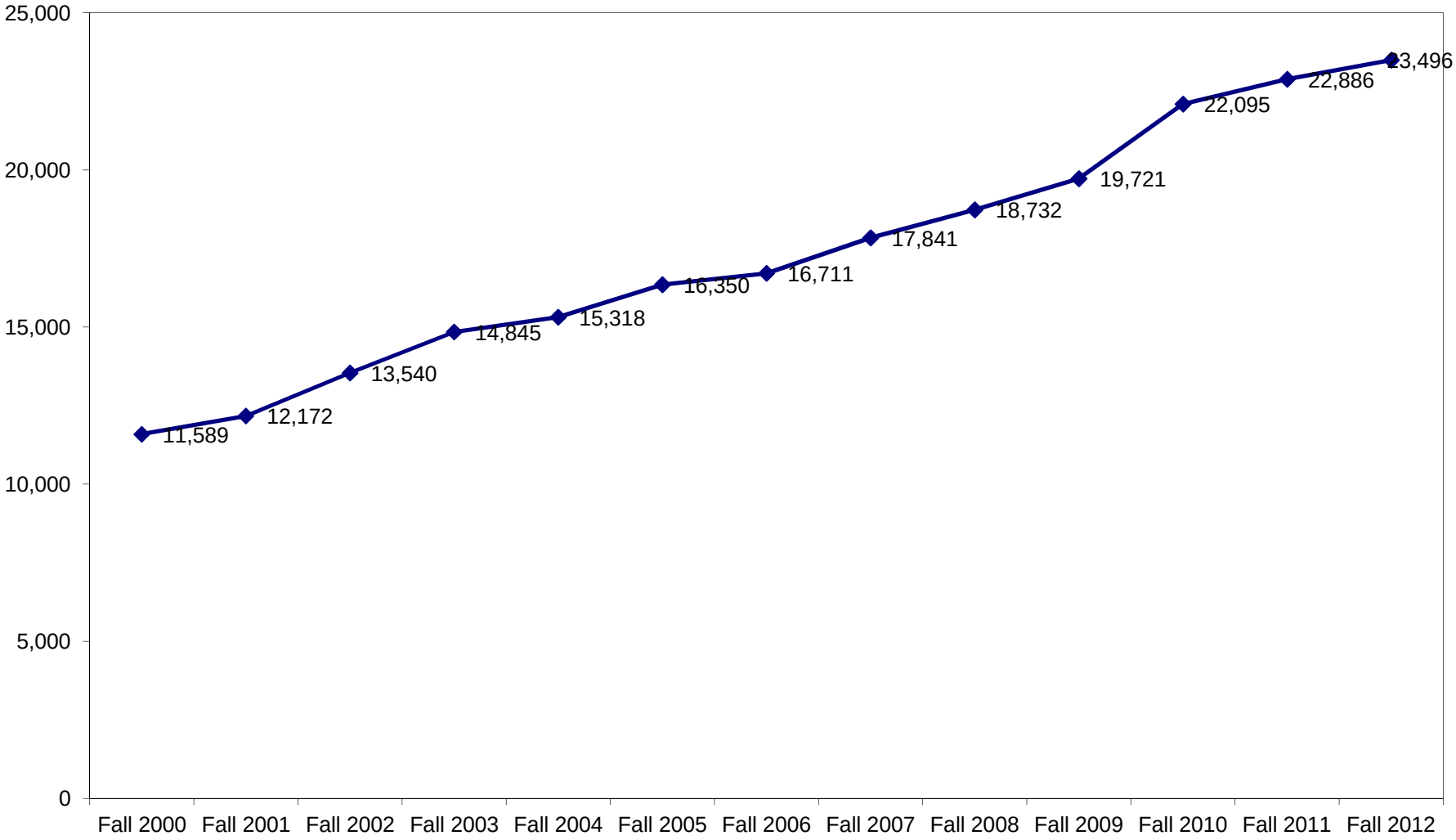


Texas Center for Nursing Workforce Studies. Nursing Workforce in Texas – 2011: Demographics and Trends. (Page 18)

TNA CHART 1

Professional Nursing School Total Prelicensure Enrollments

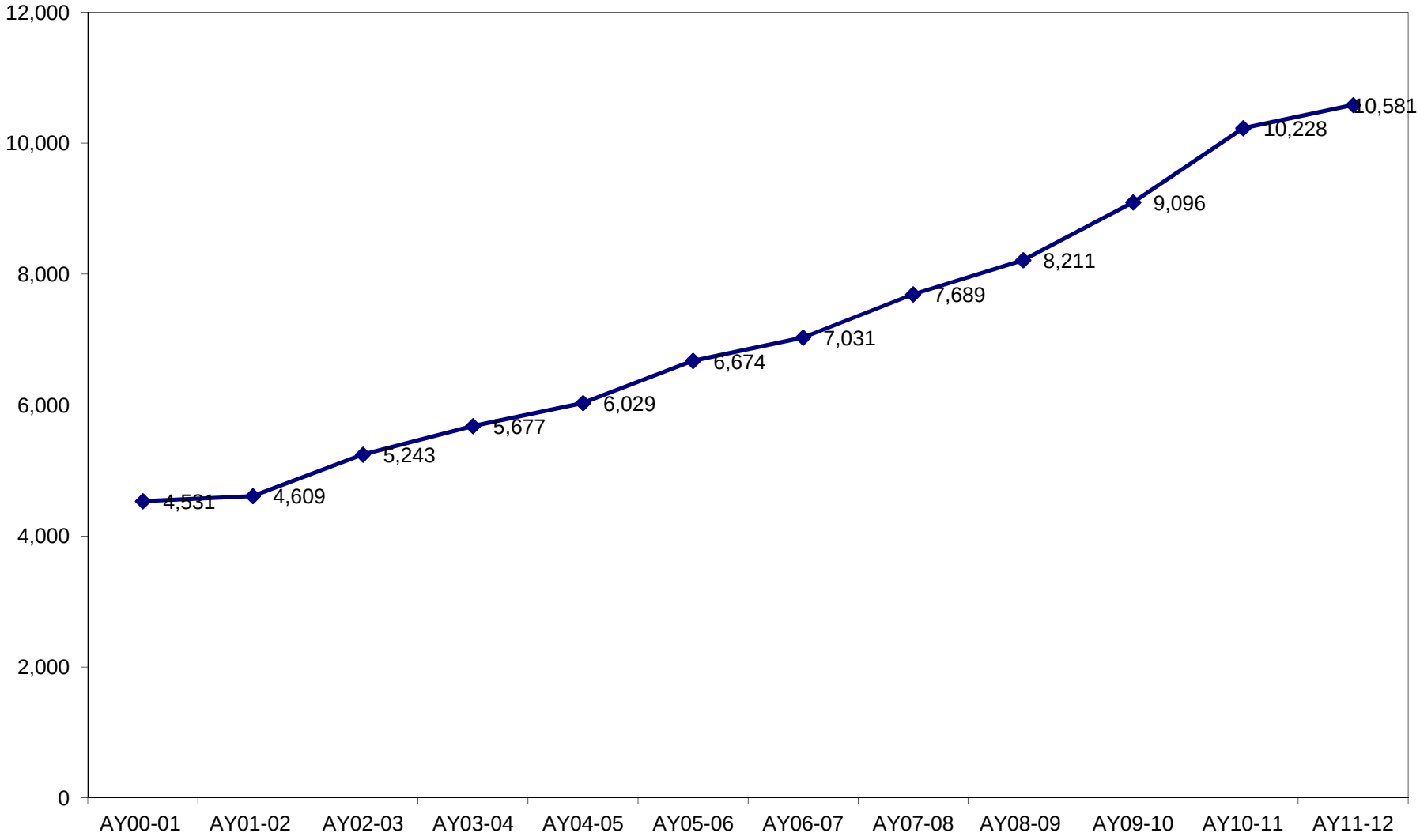
Prepared by Texas Nurses Association Based on TCNWS



TNA CHART 2

Professional Nursing School Prelicensure Graduates

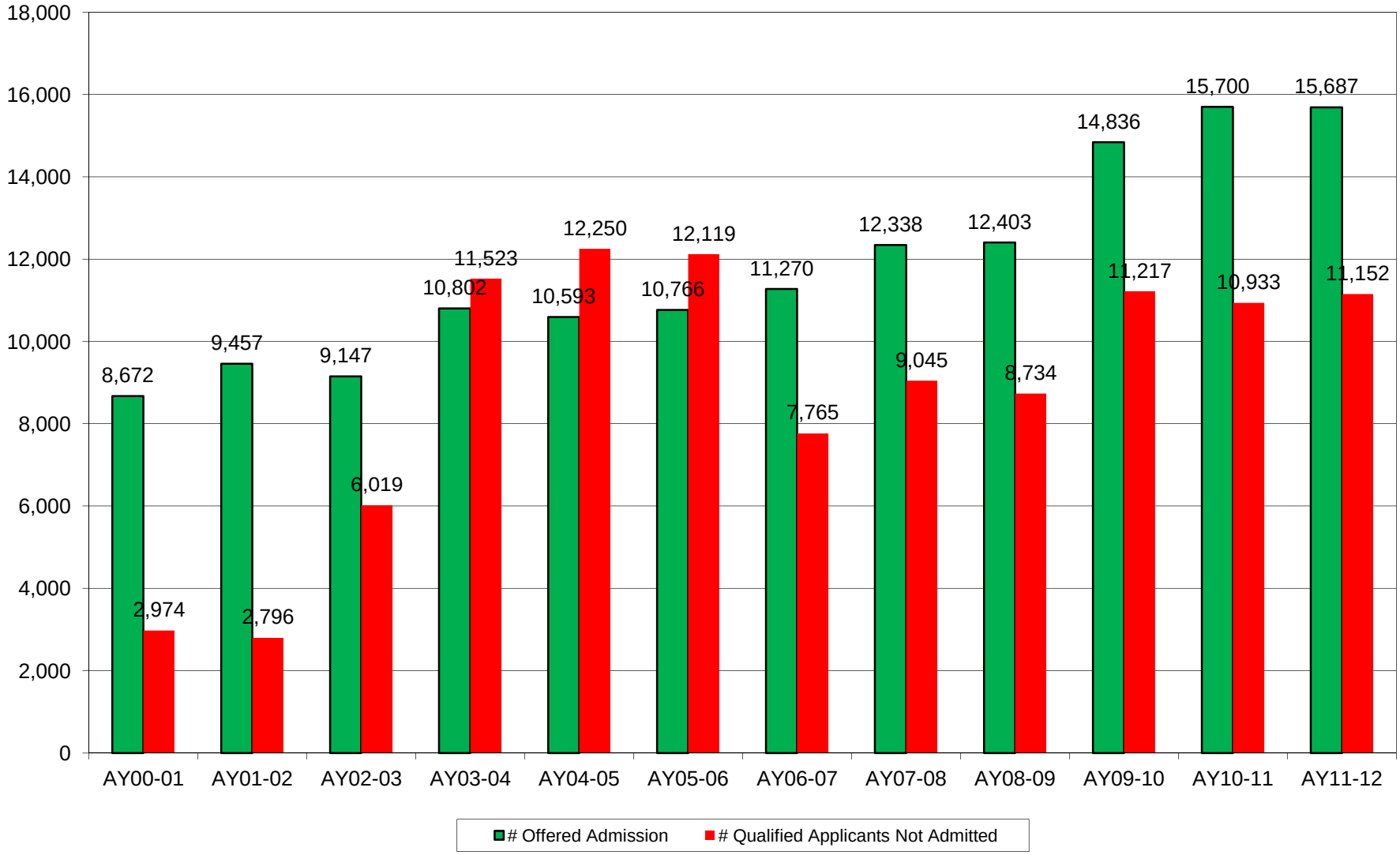
Prepared by Texas Nurses Association Based on TCNWS Data



TNA CHART 3

Qualified Applicants Offered and Not Offered Admission by Professional Nursing Schools

Prepared by Texas Nurses Association Based on TCNWS Data



TEXAS HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON EDUCATION
CHAIRMAN JOHN OTTO

FEBRUARY 22, 2013

PROFESSIONAL NURSING SHORTAGE REDUCTION PROGRAM
TESTIMONY OF ALEXIA GREEN RN, PHD
REPRESENTING THE TEXAS TEAM ADVANCING HEALTH THROUGH NURSING

Mr. Chairman and Subcommittee Members, I am Alexia Green – a Professor at Texas Tech University Health Sciences Center and Dean Emeritus. However, I am here today representing the Texas Team Advancing Health through Nursing. In 2008, Governor Perry appointed a 10 member team – to become the Texas Team – to help lead the state in addressing nursing education capacity. I am honored to have been appointed to lead the Team which was immediately deployed to Washington, DC to represent Texas at a national call to action by AARP and the Robert Wood Johnson Foundation to address the nursing shortage impacting the country at that time. One of the ten members appointed included your own distinguished colleague and committee member – Representative Donna Howard. The Texas Team worked diligently and continues to work – with your help and that of all nursing education programs in the state, to double the number of pre-licensure graduates from Texas Schools of Nursing by 2014. The Texas Team continues to focus on that original charge – however a landmark report was issued by the Institute of Medicine in 2010 that refocused the work of the Texas Team to a larger and what we believe a more impactful vision – that of Advancing the Health of Texans through Nursing.

The Institute of Medicine report, “The Future of Nursing: Leading Change, Advancing Health”, provided our nation a thorough examination of how nurses’ roles, responsibilities and education should change to meet the needs of an aging, increasingly diverse population and to respond to a complex, evolving health care system. The recommendations in the report focus on the critical intersection between the health needs of patients across the lifespan and the readiness of the nursing workforce. These recommendations are intended to support efforts to improve health care for all Americans by enhancing nurses’ contributions to the delivery of care.

Major changes occurring in the U.S. health care system require equally profound changes in the education of nurses. We must improve the nursing education system to

ensure that all nurses are prepared to deliver safe, quality, patient-centered care across all settings. The IOM Report contained 4 Key Messages – one which focused on education – concluding that "Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression."

This message is especially important to Texas – as our state prepares to care for millions of more Texans who are flocking to our state because of a reviving economy creating new opportunities. Texas is also facing a new challenge…that of providing access to care to all Texans through the implementation of the Affordable Care Act.

Registered Nurses are the largest sector of the Texas health profession workforce, numbering approximately 195,000 currently. And as Texas's economy rebounds faster than other parts of our nation – so too is our healthcare sector. According to the Texas Center for Nursing Workforce Studies (TCNWS), 351 Texas hospitals reported an average RN vacancy rate of 8.1% in 2012. The economic impact of these vacancies is more striking – 234 hospitals reported spending a total of $409.6 million on interim staffing methods to fill over 11.5 million hours of care needs ($35.49/hr.). While we can measure the economic impact – think of the societal impact of those patients who had no access to care because a nurse was not there for them. That patient can be one of your family members ….your mother, your father, your child.

We all want the best care for our families – that will require a nursing workforce that is well educated. My testimony today will focus only on the IOM recommendations related to Registered Nurse education. There were a total of 8 major recommendations in the IOM report – but I will focus on the two relating to education:

Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020

Why More BSN-Prepared Nurses Are Needed? The IOM Report States:

"The qualifications and level of education required for entry into the nursing profession have been widely debated by nurses, nursing organizations, academics, and a host of other stakeholders for more than 40 years (NLN, 2007). The causal relationship between the academic degree obtained by RNs and patient outcomes is not conclusive in the research literature. However, several studies support a significant association between the educational level of RNs and outcomes for patients in the acute care setting, including mortality rates (Aiken et al., 2003; Estabrooks et al., 2005; Friese et al., 2008; Tourangeau et al., 2007; Van den Heede et al., 2009)."

The IOM Report goes on to state “an all-BSN workforce at the entry level would provide a more uniform foundation for the reconceptualized roles for nurses and new models of care that are envisioned in a reformed healthcare system”.

The IOM Report specifically defines the role of community colleges in meeting the RN workforce needs of the future, stating: “Community colleges play a key role in attracting students to the nursing education pipeline. Specifically, they provide an opportunity for students who may not have access to traditional university baccalaureate programs because of those programs’ lack of enrollment capacity, distance, or cost.” The IOM report has created momentum for Texas schools of nursing to work collaboratively to achieve the education goals – as we all have a role in meeting the workforce needs of Texas. We need to continue pre-licensure production of both ADN and BSN graduates and concurrently increase the articulation of ADN graduates into RN to BSN programs.

Double the number of nurses with a doctorate by 2020

An all-BSN workforce would also be poised to achieve higher levels of education at the master’s and doctoral levels, required for nurses to serve as primary care providers, nurse researchers, and nurse faculty—positions currently in increasing demand. Shortages of nurses in these positions continue to be a barrier to advancing the profession and improving the delivery of care to Texans. The IOM Report recommends doubling the number of nurses with a doctorate by 2020.

Now Back to the Texas Team

As previously noted – originally established in 2008 by the Governor – the Texas Team was reactivated in 2010 in response to a second “Call to Action” by the Robert Wood Johnson Foundation and AARP - through the launch of a national campaign entitled “The Initiative on the Future of Nursing” Texas applied to become a recognized “action coalition” in 2011 and was approved by the RWJ Foundation to join 51 other state action coalitions with a commitment to achieve the IOM recommendation in Texas by 2020. So the Texas Team Advancing Health through Nursing – has been working since 2011 to create momentum in Texas to support achievement of the IOM recommendations.

I have provided you with a one-page summary of the Texas Team – our lead organizations are the Texas Nurses Association and BlueCross BlueShield of Texas. We now have over 290 member organizations and hundreds of committed individuals who have joined together to help “Advance the Health of Texans through Nursing”.

Examples of Texas Team members include traditional partners such as hundreds of health care organizations and schools of nursing – but we also want you to know that this campaign is broader than just nursing – it is really about Texans…thus we have recruited such organizations as the Texas Association of Business, Associates in Process Improvement, Bell Helicopter, Sirius Computer Solutions, Devenney Group, LTD. Architects, and Texas Manufacturing Assistance Center – to list only a few – who realize the very important role nurses have in the future of Texas and Texans! We hope to recruit hundreds more to join us in achieving the IOM goals in Texas.

Our priority goal is to transform nursing education in the state. We applied for and are one of nine states that received a $300K RWJF Academic Progression in Nursing grant focused on creating a common core curriculum and creating seamless transition from the ADN to the BSN level. We are also working with schools of nursing to develop new educational models – including a "concept based" curriculum which is transforming the way we teach nursing students in the state. Our work has merged with and leveraged other work of the Texas Board of Nursing, the Texas Higher Education Coordinating Board and other policy groups focused on improving nursing education and patient care delivery in our state. Our coalition has no funding – other than the current $300K grant – but we have commitment of key leaders across the state who are working with us to move this agenda forward in Texas.

We are committed to achieving the IOM Future of Nursing goals in Texas by 2020 – and we look forward to working with you – our elected representatives and distinguished leaders of our state government – to help us achieve these ambitious goals – for the future of Texans!

I have provided you with some basic statistics related to the three education goals on which we are focused – the original Texas Team goal established in 2008 of doubling the number of graduates from Texas schools of nursing by 2014 and our two new goals established by the IOM. I welcome your questions and ideas as to how we can achieve these goals in Texas.

"4 Transforming Education." *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press, 2011.

TEXAS TEAM
Advancing Health through Nursing
Initiative on the Future of Nursing

Achieving IOM Future of Nursing Education Goals in Texas February 22, 2014

Texas Team Goal: Increase the Number of Graduates from Texas Pre-Licensure Programs:

TCNWS Reported 106 pre-licensure registered nursing (RN) programs in Texas during 2012

- 7,689 grads in 2008
- 10,584 grads in 2012
- 38% increase in pre-licensure graduates over the four years
- Producing 53% ADN/47% BSN graduates
- Less than 5000 BSN pre-licensure graduates annually

IOM Goal: Increase the Percent of Nurses Prepared at BSN + to 80% by 2020:

- 2005 TCNWS Supply/Demand Study Projected Need for 293,000 Texas RNs in 2020
- 2020 Goal = 234,400 RNs Prepared at BSN or Higher by 2020
- Texas had 95,652 BSN + in 2011 – however 6,809 > 60
- Producing 1800 RN-BSN graduates per year
- Combined less than 7000 BSNs per year
- Need to continue pre-licensure ADN and BSN programs
- Need to produce 17,000 BSNs per year to meet projected need in 2020

IOM Goal: Double the Number of Nurses with Doctorate by 2020:

THECB Reported in 2011:

- In 2011, 10 Texas institutions reported 685 declared majors in doctoral degree programs.
- Since 2003, doctoral graduates increased by 436%.
- In 2011, 63% of doctoral graduates received the DNP degree
- Need additional PhD/DNPs in order to increase production of BSNs

TEXAS TEAM
Advancing Health through Nursing
Initiative on the Future of Nursing

Nursing and the Future of Health Care in Texas

How Can Nurses Contribute to Better Care, Better Health and Lower Costs for Texans?

The Texas Team Advancing Health through Nursing believes all Texans deserve better care, better health and lower costs associated with health care. The Texas Team also believes nurses – as the largest group of healthcare providers in the state – are the key to achieving these three goals in Texas. Texas Team members are enthusiastic about the potential of achieving the Institute of Medicine (IOM) Future of Nursing report goals established in 2010 to transform nursing and health care in Texas.

The Texas Team has joined the national Campaign for Action, which envisions a nation where every American has access to high-quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success. The complexity of the ever-changing health care environment requires even more nurses in practice and with advanced credentials and expertise. In many settings, nurses are not able to work to the full extent of their education and training and too few hold leadership positions.

The Texas Team, as a state action coalition, is an active participant in the Campaign for Action, and working to:

1. Assure by 2020, 80% of Texas RNs hold a baccalaureate degree or higher;
2. Double the number of nurses with a doctorate by 2020;
3. Strengthen the diversity of the Texas RN workforce to better care for the state's multicultural population;
4. Enable all nurses in Texas to practice to the full extent of their education and training;
5. Advance interprofessional collaboration to ensure coordinated and improved patient care;
6. Expand leadership ranks to ensure that nurses have voices on management teams, in boardrooms and during policy debates; and
7. Improve health care workforce data collection to better assess and project workforce requirements.

The Texas Team seeks to further the long-time efforts of many nurse leaders and nursing organizations and to actively engage a wide range of health care providers; consumer leaders; prominent officials; and groups representing government, business, academia and philanthropy. The Texas Nurses Association and BlueCross BlueShield of Texas lead implementation of the IOM recommendations in Texas. Both groups are enthusiastic about the potential for the IOM goals to transform nursing and thus transform health care in the state of Texas.

A 2012 updated report entitled "*Code Red – The Critical Condition of Health in Texas*," (www.coderedtexas.org) continues to believe the overall health condition of Texans is poor – in fact, Texas ranks at the bottom percentiles on health and at the top percentiles on uninsured and cost of care. The Texas Team believes significant improvements in health outcomes and the reduction of healthcare costs for Texans will require transformation and better utilization of the nursing profession.

What is *Campaign for Action*?

The Robert Wood Johnson Foundation, in collaboration with AARP, initiated the Future of Nursing; *Campaign for Action* in late 2010. The initiative builds on the *Future of Nursing: Leading Change, Advancing Health*, a landmark Institute of Medicine (IOM) report that provided a blueprint for transforming the nursing profession to improve health care and meet the needs of diverse populations.

Campaign for Action envisions a nation where every American has access to high-quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success.

For more on Campaign for Action and other health care workforce programs:

Campaign for Action
www.thefutureofnursing.org

Texas Team Advancing Health through Nursing
j.mp/texasnurses

Texas Team on Facebook
www.facebook.com/txteamnursing

For more information about *Campaign for Action* in Texas

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FUTURE OF NURSING™
Campaign for Action

OVERVIEW OF TEXAS HIGHER EDUCATION COORDINATING BOARD HEALTH PROGRAMS

Legislative Budget Board Staff

Presented to the House Committee on Appropriations Subcommittee on Education

February 22, 2013

Family Practice Residency Program and Joint Admission Medical Program

- Family Practice Residency Program

  Funds are allocated based on the certified number of residents training in approved family practice residency programs. The strategy also supports rural and public health rotations. The per resident funding level in fiscal year 2013 was $3,840 and supported 716 residents.

- Joint Admission Medical Program (JAMP).

  Funding supports highly qualified, economically disadvantaged students interested in becoming physicians. Students are identified in their freshman year, selected in their sophomore year, and guaranteed admission to a medical school assuming eligibility in the program is maintained. The students receive undergraduate scholarships and summer stipends. Ninety-six undergraduate students were accepted into the program in fiscal year 2012, for a total of 536 students currently participating in the program.

Professional Nursing Shortage Reduction Program and Physician Education Loan Repayment Program

- Professional Nursing Shortage Reduction Program

  The program consists of three different programs. Funding for the "Regular Program" and the "Under 70 Program" is tied to increases in the number of graduates from professional nursing programs while the "Over 70 Program" is tied to increases in enrollment in professional nursing programs. Allocations for each of the programs is through rider.

- Physician Education Loan Repayment Program

  The purpose of the program is to encourage qualified physicians to practice medicine for at least four years in designated health professional shortage areas. The maximum loan repayment amount is $160,000 over the four-year commitment period and funding for the program is through a tax on smokeless tobacco.

Other Trusteed Programs

- Graduate Medical Education

  The 80th Legislature, 2007, transferred $3 million to the Health Related Institution's Graduate Medical Education Formula from the Texas Higher Education Coordinating Board's Graduate Medical Education strategy. The strategy's remaining funding was intended for independent primary care residency programs.

- Primary Care Residency Program

  Funding under this program was limited to Texas primary care residency programs and in fiscal year 2011 provided support for 122 residents in 23 residency programs.

- Statewide Preceptorship Programs

  Funding under this program was provided to Texas students who completed a month-long experience with a family physician, internist, or pediatrician with the goal of increasing interest in primary care.

Emergency and Trauma Care Education Program

- Emergency and Trauma Care Education Program (ETEP)

  This program was established by Senate Bill 7, 82nd Legislature, First Called Session, and directs the Texas Higher Education Coordinating Board (THECB) to administer the program and make grants to emergency and trauma care education partnerships. In 2012-13, $4.5 million from the General Revenue – Dedicated Account No. 5111, Designated Trauma Facility and Emergency Medical Services Account was appropriated to the Department of State Health Services and transferred to the THECB through an interagency contract.

Texas Higher Education Coordianting Board Health Progams

	2006-07 Appropriations	2008-09 Appropriations	2010-11 Appropriations	2012-13 Appropriations	2014-15 Appropriations in House Bill 1, As Introduced
	General Revenue	General Revenue	General Revenue	General Revenue	General Revenue
D.1.1. Family Practice Residency	$17.4	$16.4	$21.2	$5.6	$5.6
D.1.2. Joint Admissions Medical Program	$3.3	$5.6	$10.6	$7.0	$7.0
D.1.4. Professional Nursing Shortage Reduction Program*	$6.0	$14.7	$49.7	$30.0	$30.0
Graduate Medical Education Program	$3.6	$0.6	$0.6	$0	$0
Primary Care Residency Program	$5.0	$5.0	$5.0	$0	$0
Statewide Preceptorship Programs	$0.9	$0.9	$0.9	$0	$0

	2006-07 Appropriations	2008-09 Appropriations	2010-11 Appropriations	2012-13 Appropriations	2014-15 Appropriations in House Bill 1, As Introduced
	General Revenue and General Revenue - Dedicated	General Revenue and General Revenue - Dedicated	General Revenue and General Revenue - Dedicated	General Revenue - Dedicated	General Revenue - Dedicated
D.1.3. Physician Education Loan Repayment Program**	$1.4	$2.1	$25.4	$5.6	$33.8

Amounts in table above are shown in millions.

*The appropriation for the Professional Nursing Shortage Reduction Program in 2010-11 includes $5 million to support the Nursing Education Center at the University of Texas at Arlington.

**Prior to the 2012-13 Session, appropriations for the Physician Education Loan Repayment program included general revenue and funding through a medical tuition set aside.

THECB Health Professions Grant Programs

Stacey Silverman, Ph.D.
Deputy Assistant Commissioner
Universities and Health-Related Institutions
Workforce, Academic Affairs and Research Division

Presentation to the
House Appropriations Committee
Subcommittee on Education
February 22, 2013

Family Practice Residency Program

- Established in 1977 to increase the number of physicians selecting family practice as their medical specialty, especially in rural and underserved communities.

- Since its inception, the program has provided funding support for more than 8,459 family practice residents.

- Provides grants to Texas' 29 nationally-accredited family practice residency programs located in every region of the state.

Texas Higher Education Coordinating Board

Family Practice Residency Program

Program Operating Funding	
FY 2011:	$9,968,400
FY 2012:	$2,800,000
FY 2013:	$2,800,000

Per-Resident Funding	
FY 2011:	$14,396
FY 2012:	$3,895
FY 2013:	$3,841

THECB Exceptional Item Request: $14,000,000

An additional $14 million above the current biennial level of funding in HB 1 of $5.6 million would restore the per resident funding level to an estimated $13,687 per resident, closer to the 2010-2011 biennium per resident funding average.

Texas Higher Education Coordinating Board

Primary Care Residency Program

- Created in 1995, to increase the number of primary care physicians trained in the state.
- In FY 2011, the funds provided support for 122 residents in 23 primary care residency programs.
- Primary care defined as family practice (not supported by the Family Practice Residency Program), general internal medicine, general pediatrics, or obstetrics/gynecology.
- Funding was provided to residency programs based on residency program directors' identification and designation of residents likely to remain in Texas to practice.

No funding was appropriated in FY12-13 or in HB 1 as introduced.

Texas Higher Education Coordinating Board

Primary Care Residency Program

THECB Legislative Recommendation:

- The Coordinating Board proposes restructuring the statute to create a new Physician Resident Expansion Grant Program.
- Focus would be the funding of additional first year entry physician residency positions in family practice, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and surgery.
- Coordinating Board LAR includes an exceptional item request of $11.5 million for the new program, which would support 10 percent of the cost for 220 first-year entering residency positions beginning in 2014, and an additional 339 first-year entering residents in 2015.

Texas Higher Education Coordinating Board

Graduate Medical Education Program

- Established in 1997 to increase the state's support of medical residency programs.

- Participation in the program was limited to residency programs that incur the costs of faculty supervision and education or the stipend costs of resident physicians in accredited clinical residency programs in the state.

- Provides funding to teaching hospitals with accredited residency programs that are unaffiliated with a Texas medical school – state health-related institutions receive a direct appropriation the Graduate Medical Education formula funding.

  No funding was appropriated in FY12-13 or in HB 1 as introduced.

Texas Higher Education Coordinating Board

Statewide Preceptorship Programs

- Provided funding to Texas medical students who completed a month-long experience (typically during the summer between their first and second year of medical school) with a family physician, internist, or pediatrician.

- Goals were to increase interest in primary care and encourage medical students to choose primary care careers by providing early exposure to a primary care medical specialty.

- Participating medical students received a $500 stipend if they participated in a location near their medical school, and a $1,000 stipend if they participated in a rural location.

No funding was appropriated in FY12-13 or in HB 1 as introduced.

Texas Higher Education Coordinating Board

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No funding was appropriated in FY12-13 or in HB 1 as introduced.

Joint Admission Medical Program (JAMP)

- Created to support and encourage economically disadvantaged Texas resident students pursuing a medical education.
- Participating students are eligible to receive a scholarship each semester beginning in their sophomore year of college and receive mentoring and personal assistance to prepare for medical school.
- If they fulfill all requirements, these students receive a guarantee of admission to attend a Texas medical school.
- Of the 96 JAMP graduates in the first three classes, 61 percent entered into residencies in Texas and 66 percent are training to become primary care physicians.

Biennial Funding	
FY10-FY11:	$10,607,155
FY12-FY13:	$7,006,794
FY12-FY13 (HB 1):	$7,006,794

Texas Higher Education Coordinating Board

Emergency and Trauma Care Education Partnership Program (ETEP)

- SB 7 (82nd Legislature, First Called Session) created this program at the Coordinating Board to support partnerships between hospitals and GME programs that increase the number of emergency medicine and trauma care physician residents and fellows, as well as partnerships between hospitals and graduate nursing programs to increase the education and training experiences in emergency and trauma care for registered nurses.

- FY12-FY13 funding of $4.5 million was appropriated to the Department of State Health Services and transferred to THECB via Interagency Agreement.

- Coordinating Board LAR includes exceptional item request of $4.5 million so that funding will be appropriated directly to the agency.

Texas Higher Education Coordinating Board

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Texas Higher Education Coordinating Board

2013 MEDICAL EDUCATION AND PHYSICIAN WORKFORCE

Consensus Group Members

Baylor College of Medicine

Texas A&M Health Science Center: College Station, Temple, Bryan, Dallas, and Round Rock

Texas Tech University Health Sciences Center: Lubbock, Amarillo, and Odessa; and Paul L. Foster Medical School in El Paso

The University of Texas System

The University of Texas Health Science Center at Houston

The University of Texas Health Science Center at San Antonio; and Lower Rio Grande Valley Regional Academic Health Center in Harlingen and Edinburg

The University of Texas Health Science Center at Tyler

The University of Texas M.D. Anderson Cancer Center at Houston

The University of Texas Medical Branch at Galveston

The University of Texas Southwestern Medical Center at Dallas and Austin

University of North Texas Health Science Center at Ft. Worth

Teaching Hospitals of Texas

Texas Medical Association

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

CONSENSUS STATEMENT

83rd Texas Legislature

All Texas medical schools, teaching hospitals, and the 47,000+ members of the Texas Medical Association agree:

- ✓ **Texas has a shortage of physicians.**
- ✓ **The shortage *will* get worse.**
- ✓ **Texans — whether in rural or urban areas — will be adversely affected, in varying degrees, by the shortage.**
- ✓ **Having insurance coverage will not necessarily ensure access to a physician.**

The future health of Texans is dependent on our ability to educate and train more physicians NOW.

continued on next page

CONSENSUS

All nine Texas medical schools, all regional medical school campuses, other health-related institutions in Texas joined by the state's largest professional associations for teaching hospitals and physicians as listed on the first page, offer our state's leaders this 2013 consensus statement on medical education and the physician workforce.

We agree:

- ✓ **The lack of adequate graduate medical education (GME) funding prevents the state from achieving the needed numbers of GME training positions. GME training is a lengthy and costly process, and funding is required for the full duration of the training, three to seven years depending on the specialty, to qualify a physician for practice.**
- ✓ **The state's ability to retain Texas medical school graduates for training, and ultimately for entry into practice, is seriously jeopardized by recent cuts in state support for GME programs and expansions.**
- ✓ **How successful the state will be in further building the physician workforce to meet growing demands is largely dependent on continued success in recruiting a strong influx of new physicians from outside the state, as well as a stable and adequately resourced medical education and GME pipeline.**

Texas continues to be overly dependent on other states and countries for supplying new physicians to our workforce. Three of four of the newly licensed Texas physicians in the past fiscal year graduated from medical schools outside of Texas. This places the state in a vulnerable position for meeting workforce needs, subject to external forces beyond the state's control that can adversely affect future numbers available for possible recruitment to the state.

We must educate and train sufficient numbers of new doctors. And, we must have adequate numbers of GME slots to keep young doctors in the state for residency training. Physicians who complete both medical school and GME in Texas are three times more likely to remain in the state to practice than those who are educated or trained elsewhere.[i]

Will There Be Enough Physicians for Texans?

In evaluating the state's physician workforce, there is good news, but several factors are likely to serve as barriers to improving access to care.

The Good News: RECORD HIGH NUMBERS OF NEWLY LICENSED PHYSICIANS

The Texas Medical Board licensed the highest-ever number of new licensees in FY 2012. This followed several years of new peaks in the number of newly licensed physicians.

The Barriers to Improving Access to Care

Multiple complicating factors have prevented greater improvement in access to health care in many areas of the state, despite the growth in physician numbers. These factors are not expected to improve in the near future, as discussed below.

INCREASING PHYSICIAN DEMAND

Several powerful trends are generating physician demand that is pushing physician shortages to levels that threaten the ability of Texans, regardless of where they live or whether they have health insurance, to access health care. Those trends include:

- ✓ **No. 1 IN POPULATION GROWTH AMONG ALL STATES FOR TWO DECADES** — Texas' growth has prevented the substantial gains in new physicians from having the full beneficial impact on physician access. Without the large numbers of new physicians, the ratio would have fallen much lower.
  - Addition of 8 million residents from 1990 to 2010
  - Projected net increase of more than 5 million Texans by 2020

- State birth rate that ranks No. 4 among the states[ii]

✓ **AGING OF THE POPULATION** — The first of 5.7 million Texas baby boomers, the age group with the highest demand for physician services, started becoming eligible for Medicare in 2011.

✓ **POTENTIAL FOR INCREASED MEDICAID ENROLLMENT** — There is potential for significant increases in Medicaid-eligible populations in the near future.

✓ **HEALTH STATUS** —The prevalence of chronic diseases, such as diabetes and hypertension, is growing. These diseases frequently require more health care services

STATE RANKING OF NO. 42 IN RATIO OF PHYSICIANS PER PERSON

Texas has historically had a lower ratio of physicians per person. Although there has been some improvement, the high rate of population growth has made it difficult to recruit sufficient numbers of physicians to keep up with gains in population. Of the 50 states (and District of Columbia), Texas ranks 42nd in the ratio of patient care physicians per 100,000 people.[iii]

When focusing only on the states with the largest populations, Texas ranks LAST in a comparison of the ratio of physicians per 100,000 people behind New York, Pennsylvania, Illinois, California, and Florida (see table below).

Most-Populous States by Population Size	TOTAL POPULATION		Patient Care Physicians per 100K Pop.	
	# (in millions)	State Ranking Among Most-Populous States	Ratio	State Ranking Among Most-Populous States
California	37 M	#1	237	#4
New York	20 M	#3	327	#1
Florida	19 M	#4	229	#5
Illinois	13 M	#5	249	#3
Pennsylvania	13 M	#5	266	#2
TEXAS	**25 M**	**#2**	**193**	**#6**
U.S. Total	309 M		240	

M=Millions. Source: Physician Characteristics and Distribution in the U.S., *2012 Edition, American Medical Association.*

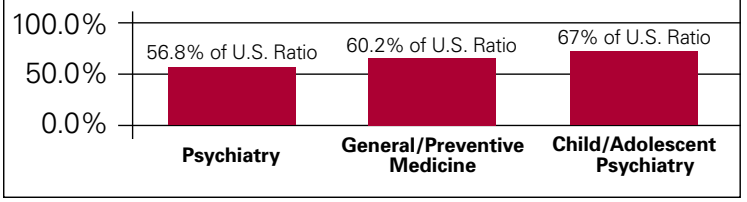
BROAD PHYSICIAN SPECIALTY SHORTAGES

Texas has too few of most medical specialties, falling below U.S. ratios for *36 out of 40 specialties.*

There are shortages in primary care and in 32 nonprimary care specialties. The greatest shortages are in mental health specialties, both child and adult psychiatry.[iv] For example, the Texas ratio of 5.94 psychiatrists per 100,000 population was only 57 percent of the U.S. ratio of 10.46 psychiatrists per 100,000 population. The three major specialties with the lowest Texas specialty ratios in comparison with the United States are shown in the graph below.

TX Specialties With Lowest Ratios per 100,000 Population in Comparison With U.S. Ratios for That Specialty,

% Shown Below is Texas Ratio as a % of U.S. Ratio, 2010



GEOGRAPHIC PHYSICIAN MALDISTRIBUTION

Due to the state's broad geographic expanse and population distributions combined with economic and other factors, geographic physician maldistribution remains a challenge.

✓ Twenty-eight Texas counties, with a combined total of 90,431 residents, have NO physician.

✓ Fifteen additional Texas counties, with a combined population of 66,745, have only one patient-care physician each.

✓ Fifty-five Texas counties have a ratio of primary care/patient-care physicians above 3,500 per person, the federal threshold for primary care physician shortage areas.

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GRADUATE MEDICAL EDUCATION "BOTTLENECK"

With the help of Texas legislators, medical schools are doing their part to grow admissions to better meet physician demands; however, medical school graduates are not qualified to enter medical practice upon graduation. Three to seven years of GME in a particular specialty are required for graduates to qualify for practice.

Texas does a good job of keeping young physicians in the state for residency training, in comparison with other states. In fact, our state ranks No. 2 in the country. But when medical graduates have to leave the state for GME due to a shortage of available positions in their chosen specialty, those physicians are less likely to practice in Texas than a home-trained physician. Further, when they leave Texas for GME and stay away, they take with them the state's investment of more than $170,000 for their four years as a medical student.

Medical school graduates in Texas are projected to reach 1,700 in 2015. This increase will mean an even greater demand for GME to enable graduates to remain in the state for residency training. The Texas Higher Education Coordinating Board recommends a ratio of 1.1 to 1 for entry-level GME positions to number of medical school graduates. To achieve the 110-percent goal after enrollments reach 1,700, an additional 400 entry-level GME positions will be needed to accommodate graduates. This growth will be even more difficult to achieve with the recent 41-percent reduction in overall state support for residency training.

Medicare provides the largest amount of direct GME funding to teaching hospitals, but Congress capped these funds at 1996 levels. Teaching hospitals that received Medicare GME funding in 1996 generally cannot expand this funding to include additional GME positions. Another disadvantage is deep cuts to state Medicaid GME funding after 2005.[v] As a result, hospitals with Medicare GME caps have to cover the full cost of newly added GME positions, without GME funding from Medicare or Medicaid for these positions.

Medical education and GME are considered a public good. Not only do medical schools, GME programs, and teaching hospitals prepare the next generation of physicians, but also residents provide medical care for the sickest and poorest among us as they train in their individual specialties. Teaching facilities typically treat the most complex and challenging diseases and medical conditions. Our academic health centers are among our state's major employers and a tremendous economic asset to their communities. Health-related institutions generate an estimated $1.30 in economic activity for every dollar spent, on average.[vi]

STATE MEDICAL STUDENT FORMULA FUNDING

Support for medical students through state formula funding peaked in the 2002-03 biennium. The per-capita amount for the 2012-13 biennium is the lowest level since formula funding was instituted in 1999, dropping 25 percent from the peak in 2002-03. The Texas Higher Education Coordinating Board recommends restoration of the state formula funding base rates for medical education and other formulas for the health-related institutions over three biennia (six years) to the levels in FY 2000-01.

STATE GME FORMULA FUNDING

Medical schools have received some state support for a portion of faculty costs or the development of new slots from Texas legislators since 2006. This funding was reduced by 30 percent to $4,682 per resident per year for 2012-13 over the prior biennium. Funding at this level represents about one-fourth of the $18,000 in estimated annual faculty costs per resident. Further, this does not provide for the actual stipends for residents, which average about $50,000 a year or the other training-related costs at teaching hospitals which together are estimated to be more than $100,000 per resident. Adequate state GME formula funding is key to the state's ability to maintain, and in some cases, grow the number of GME positions.

JOINT ADMISSION MEDICAL PROGRAM

Texas legislators developed the Joint Admission Medical Program (JAMP) to help economically disadvantaged students achieve success in a medical

career. All nine Texas medical schools work in collaboration with state colleges and universities to provide the additional resources these students need to obtain a medical education. JAMP student admissions have two times more underrepresented minorities than other medical school admissions. And, JAMP students are more likely to stay in the state for residency than other medical graduates. JAMP received the Texas Higher Education Coordinating Board's Texas Higher Education Star Award in 2010 for exceptional contributions toward the agency's initiative, *Closing the Gaps by 2015*.

STATE GME APPROPRIATIONS

Public funding for GME programs has fluctuated in recent years. The current budget, all funds, provides $92.2 million less than a decade ago and $34.6 million less than the previous biennium, as shown in the table below.

TEXAS STATE APPROPRIATIONS FOR GRADUATE MEDICAL EDUCATION	2002-03 Biennium	2008-09 Biennium	2010-11 Biennium	2012-13 Biennium	Difference 2010-11 and 2012-13 *(in millions)*
	(in millions)				
Texas Health and Human Services Commission (Article II, Appropriations Act)					
Medicaid GME (estimated General Revenue [GR])	$67.5*	$9.2**	$18.0**	$27.6**	**$9.6**
Medicaid GME (estimated federal funding)	$101.7*	20.1**	39.4**	38.6**	**-$0.8**
Health-Related Institutions* ** (Article III)					
GME Formula	-0-	62.8	79.1	56.9	**-$22.2**
Texas Higher Education Coordinating Board (Article III)					
Family Practice Residency Program (GR)	$20.6	17.5	22.2	5.6	**-$16.6**
Primary Care Residency Program (GR)	$5.9	5.0	5.0	-0-	**-$5.0**
GME Program (GR)	$15.2	0.6	0.6	-0-	**-$0.6**
Resident Physician Compensation Program (GR)	$8.1	-0-	-0-	-0-	**-$0-**
Family Practice Pilot Projects (GR)	$2.0	-0-	-0-	-0-	**-$0-**
GENERAL REVENUE (GR) TOTAL	$119.3	$95.1	$124.9	$90.1	**-$34.8**
ALL FUNDS TOTAL	$221	$115.2	$164.3	$128.7	**-$35.6**

**Medicaid GME was provided in Fiscal Year (FY) 2002-03 to Texas teaching hospitals, but this funding was discontinued in FY 2006.*
***Since FY 2009, Medicaid GME payments to hospitals has been limited to the five state-owned teaching hospitals. Please note, funding shown in the table for Medicaid GME in FY 2008-09 is for one year only as this funding began in FY 2009. Funding shown for FY 2010-11 is for two years, and funding for FY 2012-13 is projected for two years. Since the funding amount for FY 2013 is not yet known, funding for FY 2012 was used as an estimate for FY 2013 as well.*
****Does not include special item appropriations to health-related institutions for GME programs.*
Note: Detail may not add to totals due to rounding. Base report prepared by The University of Texas System and used by permission, with updates by Texas Medical Association.

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OTHER MEDICAL STUDENT AND PHYSICIAN WORKFORCE-RELATED PROGRAMS	2002-03 Biennium	2008-09 Biennium	2010-11 Biennium	2012-13 Biennium	Difference 2010-11 and 2012-13
State Medical Student Per-Capita Formula Funding	$55,971*	$51,527	$52,896	$42,180*	**-$10,716**
(Numbers below are in Millions)					
Primary Care Preceptorship Programs	$2.0	$0.9	$0.9	$-0-	**$-0.9**
Physician Education Loan Repayment	2.0	2.1	25.4	5.6	**-19.8**
Joint Admission Med. Program (JAMP)	4.0	5.6	10.6	7.0	**-3.6**

**Medical student per-capita formula funding reached a historic peak in 2002-03 and a historic low in 2012-13.*

State support for medical education and other important programs for developing the physician workforce also saw significant reductions in the current biennium, as shown in the table above.

Will There Be Enough Physicians for Texans?

CONSENSUS PRIORITY ISSUES FOR TEXAS

- ✓ **Preserve the state's investment in medical education by:**
  - **Funding sufficient GME positions to meet the goal of 1.1 entry-level GME positions for each medical school graduate in the state, and**
  - **Supporting Texas medical schools in their efforts to secure sufficient clinical clerkship space to enable medical students to remain in Texas for this training.**
- ✓ **Reverse cuts to state formula funding base rates for medical education and other formulas for the health-related institutions over three biennia (six years); restore funding to FY 2000-01 levels, as recommended by the Texas Higher Education Coordinating Board.**
- ✓ **Provide state GME formula funding at the highest per-resident levels possible.**
- ✓ **Restore adequate support for the state's Physician Education Loan Repayment Program as an effective tool for addressing physician shortages in underserved areas.**
- ✓ **Restore support for the state's Joint Admission Medical Program as an effective program for promoting diversity among the state's physician workforce.**

i TMA annual surveys of graduating medical students.
ii U.S. Centers for Disease Control www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf.
iii American Medical Association, "Physician Characteristics and Distribution in the US, 2012."
iv Texas Medical Association analysis of 2010 physician workforce data, American Medical Association, "Physician Characteristics and Distribution in the US, 2012."
v Since 2009, only five state-owned teaching hospitals received Medicaid GME funding, at the exclusion of other teaching hospitals.
vi Study measured the effect of medical education programs on direct and indirect business volume, employment, and government revenue. Association of American Medical Colleges. The Economic Impact of AAMC Medical Schools and Teaching Hospitals, 2012. www.aamc.org/economicimpact.

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

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