# Impact of 2007 MERC Statutory Changes

## Minnesota Department of Health

January, 2009

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*Protecting, maintaining and improving the health of all Minnesotans*

January 15, 2009

The Honorable Linda Berglin
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Room 309, State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155-1606

The Honorable Thomas Huntley
Chair, Health Care and Human Services
Finance Division
Minnesota House of Representatives
585 State Office Building
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The Honorable John Marty
Chair, Health, Housing, and Family Security
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The Honorable Paul Thissen
Chair, Health and Human Services Committee
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To the Honorable Chairs:

Laws of Minnesota 2007, Chapter 147, directed the Department of Health to evaluate the impact of changes enacted during the 2007 legislative session to modify the Medical Education and Research Costs (MERC) distribution formula, and to recommend any changes in the MERC formula necessary to ensure the financial viability of MERC sponsoring institutions and clinical training sites with low numbers of eligible trainee full-time equivalents. The attached report represents the fulfillment of that assignment, and I am pleased to transmit it on behalf of MDH.

The changes enacted in 2007 have only been implemented through the MERC distribution for one year, which means that their long term impact is unclear at this point. Based on the single available year of data, the report found that the distribution formula changes:

- Decreased the share of the grant pool that was distributed to smaller training sites and sites outside of Hennepin or Ramsey counties;
- Increased the number of sites that receive very small grants, creating a potential administrative burden for sponsoring institutions, and;
- Created a situation in which training sites that support a similar number of trainees receive widely varying amounts of funding.

If you have questions or would like further information on the report, please contact Diane Rydrych at 651-201-3564 or diane.rydrych@state.mn.us

Sincerely,

Sanne Magnan

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Commissioner
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## Background

The Medical Education and Research Costs (MERC) program, which distributes grants to clinical training sites around the state in order to offset the higher cost structures and lost patient care revenue for those facilities, was created by the Minnesota Legislature in 1997. The MERC statute defined the purpose of the program in Minnesota Statutes 62J.691 in the following way:

> "The legislature finds that medical education and research are important to the health and economic well being of Minnesotans. The legislature further finds that, as a result of competition in the health care marketplace, these teaching and research institutions are facing increased difficulty funding medical education and research. The purpose of sections 62J.692 and 62J.693 is to help offset lost patient care revenue for those teaching institutions affected by increased competition in the health care marketplace and to help ensure the continued excellence of health care research in Minnesota."

Since its inception, the MERC program has distributed over $450 million in grant funds to hospitals, clinics, and other clinical training sites throughout Minnesota. The majority of the MERC distribution has been awarded to large teaching hospitals in the Twin Cities metro area or Rochester.

Funding for the MERC program has come from a variety of sources since its inception, including the General Fund, the one-time tobacco endowment, a dedicated cigarette tax, and the Medicaid program. The Medicaid program has provided the bulk of the funding for MERC since its inception, and Medicaid funds currently account for roughly 90 percent of the annual distribution.

The distribution formula that governs the MERC program has also changed over the years. The original MERC distribution formula focused solely on the costs borne by clinical training sites for providing training and the number of FTE students/residents at each training site. Each applicant facility submitted information about clinical training costs, and the available funds were distributed among eligible sites in such a way that each site was reimbursed for a set percentage of their costs, usually six to nine percent.

In 2000, Minnesota was given authority by the Centers for Medicare and Medicaid Services to "carve out" a portion of the Prepaid Medical Assistance Program (PMAP) capitation payments made by the Department of Human Services to each health plan. This "medical education increment" was directed to the MERC program starting in October, 2000 and distributed under a separate formula.

Debate around the MERC distribution formula has generally centered on whether the program is designed to support clinical training wherever it occurs, and thus should be driven by a cost-based formula that allows grant funds to "follow" trainees to their sites of training, or whether the high proportion of Medicaid funding that comprises the MERC fund means that the funds should be directed primarily to those sites that do a larger share of Medicaid business. When the PMAP waiver was authorized in 2000, the Minnesota Legislature directed the Minnesota Department of Health to convene a committee to evaluate the distribution formula.

In recognition of the importance of both of those factors, that group recommended a dual weighting system that considered each facility's share of the Medicaid pool as well as their clinical training costs. Both the relative Medicaid revenue at each facility and the relative training costs at each facility were given equal weight in the PMAP distribution formula.

The MERC statute was revised in 2003 to combine the MERC and PMAP distributions into a single annual distribution. The combined distribution formula was designed to hold all MERC/PMAP recipients harmless. Mirroring their weight prior to the combination of the two distributions, clinical training costs and relative Medicaid costs were given 67 percent and 33 percent of the weight of the distribution, respectively.

## 2007 Legislative Changes

During the 2007 legislative session, the MERC statute was modified in several ways. Most notably:

- The distribution formula was revised to take into account only relative Medicaid volume rather than a combination of Medicaid volume and clinical training costs.
- Eligible clinical training sites whose Medicaid revenue accounted for more than 0.98 percent of the total Medicaid revenue would receive a supplemental grant equal to 20 percent of their original grant, with those funds coming from those sites whose Medicaid revenue accounted for less than 0.98 percent of the total pool.
- Nursing homes were eliminated from eligibility for MERC grants.
- Several direct payments to large providers were added to the distribution formula, with these direct payments to be taken out of the overall pool of available MERC funding prior to the application of the distribution formula for eligible sites. These direct payments included $1.8 million to the University of Minnesota Academic Health Center, $1.475 million to the University of Minnesota Medical Center, Fairview, and $2.075 to the University of Minnesota School of Dentistry.
- The 10% of the MERC fund that was previously awarded to sponsoring institutions to distribute at their discretion to eligible sites was eliminated, and those dollars were returned to the overall MERC pool.
- A $4.85 million transfer from the Academic Health Center was eliminated.

These changes went into effect in state fiscal year 2008. The Minnesota Legislature directed the Commissioner of Health to submit a report to the Legislature in January 2009, describing the impact of these changes, particularly on sites with a smaller number of FTE's or lower MA revenue, and recommending any changes necessary to ensure the financial viability of graduate medical education in Minnesota. To date, only one annual MERC distribution has been released since the statutory changes were made. The following section of this report describes the impact of the formula changes on this initial distribution.

## Impact

The changes enacted in 2007 and implemented for the first time during the 2008 MERC distribution impacted both the shape and the size of the MERC distribution.

As noted above, $5.35 million in direct payments to the University of Minnesota Academic Health Center, University of Minnesota Medical Center, Fairview, and the University of Minnesota School of Dentistry were added to the MERC statute. Two of these three payments are ineligible for federal Medicaid matching funds. As a result, these payments reduce the overall amount of funding available through MERC, as well as the amount of federal match that can be obtained for MERC. Previously, the Department of Human Services was also able to obtain federal matching funds on the $4.85 million

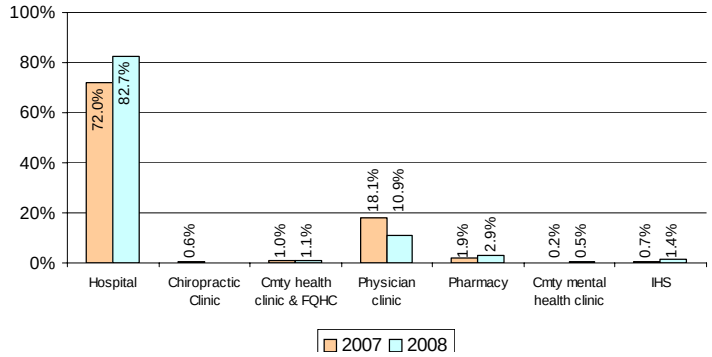
transfer from the Academic Health Center. With those two changes, the amount of funding available to distribute to the remaining MERC providers is roughly $8.5 million less than would otherwise have been available, and the size of the MERC grant for every eligible training site is lower.

Based on a single year of data, the 2007 formula changes appear to have resulted in a number of shifts in the overall shape of the distribution. Those impacts are described below.

## Impact by type of training site

Since its inception, the MERC program has distributed more than $450 million to hospitals, clinics and other training sites around the state. Based on the factors that are used in the distribution formula, the bulk of this funding has gone to a set of roughly 20 large teaching hospitals. In 2007, 72 percent of the distribution went to hospitals and 18 percent to physician clinics, with other types of training sites receiving only a very small share of the total MERC pool.

**Figure 1**
**MERC distribution by type of training site**



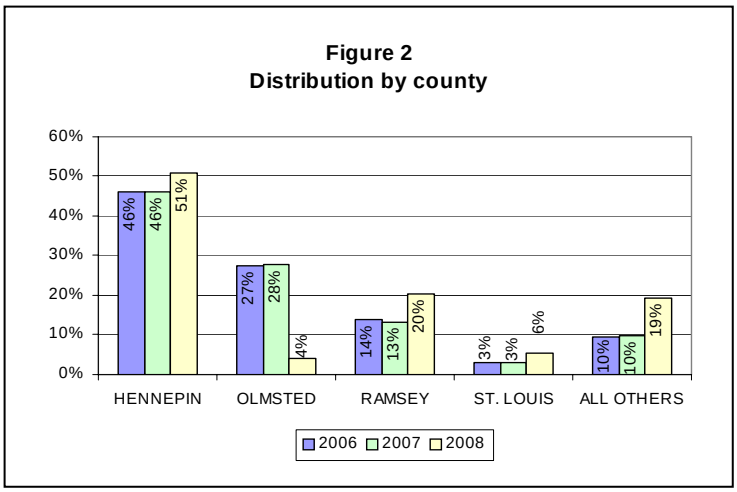

The formula changes that were enacted in 2007 resulted in a greater concentration of MERC grant dollars in hospitals; the hospital share of the MERC distribution rose from 72 percent to 83 percent in 2008. This reflects the larger share of Medicaid business done in hospital, as opposed to clinic or pharmacy, settings.

As part of the 2007 changes to the MERC statute, nursing homes were eliminated from the MERC distribution. In previous years, nursing homes had served as a training site for physicians, advanced practice nurses, and pharmacists, and had received an average of one to two percent of the MERC distribution.

## Impact by county

The geographic distribution of MERC funds also changed as a result of the revision to the MERC formula. In previous years, the bulk of MERC funding has been awarded to training sites in Hennepin, Ramsey and Olmsted counties; these counties are home to most of the teaching hospitals in the state. Hennepin county has traditionally received 45 to 50 percent of the distribution each year. The 2007 formula changes further concentrated the distribution in Hennepin and Ramsey counties. The combined share of the distribution in those two counties rose from an average of 60 percent in 2006 and 2007 to 71 percent in 2008. Most of that increase came from Olmsted county, which saw a reduction in its share of the MERC distribution from 28 percent to 4 percent.

**Figure 2**
**Distribution by county**

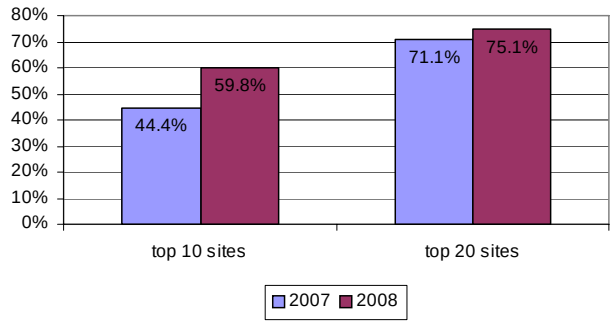


This change is largely due to the relatively smaller share of Medicaid volume at the large Olmsted county training sites (Rochester Methodist Hospital, St. Marys Hospital, and the Mayo Clinic). While two of these sites were above the 0.98 percent line for relative public program volume, and thus received a supplemental grant of 20 percent, their share of public program revenue relative to other sites was still low. In the past, these sites had benefitted primarily from the "educational cost" portion of the distribution formula, as their high number of students and residents allowed them to receive a higher percentage of the distribution.

## Impact on individual training sites

Historically, the majority of MERC funding in any given year has been awarded to a small number of large training sites. The ten sites receiving the largest grants in a typical year generally receive nearly half of the distribution, with the top twenty sites receiving nearly three quarters. Analyzing the 2008 distribution in this way reveals, again, a greater concentration of MERC dollars at a small set of facilities. As Figure 3 shows, the share of the distribution received by the ten largest MERC recipients rose from 44 percent in 2007 to nearly 60 percent in 2008, while the share received by the twenty largest sites rose from 71 percent to 75 percent.

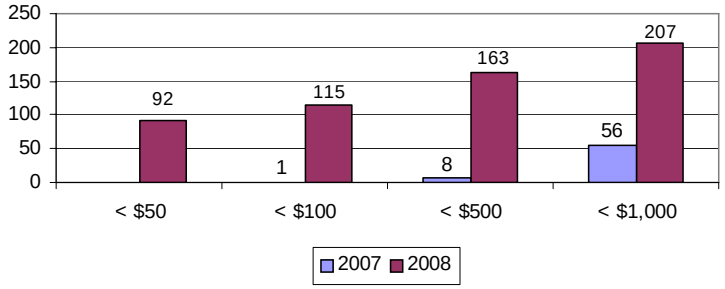
**Figure 3**
**Top 10-20 MERC Recipients**




This greater concentration at the top of the distribution is a result of the 20 percent supplemental grant that the largest Medicaid providers receive under the new distribution; providing that supplemental grant for the largest sites has the effect of reducing the grant for everyone below that line. In 2008, sites below the 0.98 percent Medicaid volume line had their grants reduced by roughly one-third in order to provide a supplemental grant to the sites that were above that line.

On the other end of the spectrum, the 2007 changes to the MERC distribution formula have increased the number of sites that receive very small grants. Given the fact that the amount of funding available for MERC in 2008 was lower than it had been in 2007, the number of sites receiving small grants would likely have risen in 2008 regardless of the formula change. However, a number of the small-grant recipients would have received a greater share of the pool under the previous distribution formula. Figure 4 shows the number of training sites that received grants of less than $50, less than $100, less than $500 and less than $1,000 in the two years.

**Figure 4**
**Small Grants**



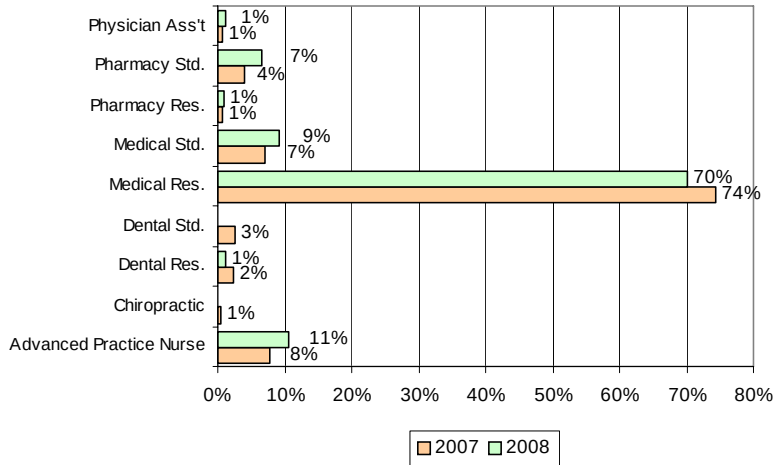

MERC grants are received by sponsoring institutions, who are required to pass them through to each of their eligible training sites. In cases where a training site is used by multiple programs at multiple

sponsoring institutions (as in the case of a hospital that hosts medical students, medical residents, pharmacy students, and advanced practice nursing students from multiple institutions), each sponsoring institution sends the training site a portion of its total grant. The proliferation of sites receiving small grants can create an administrative burden for sponsoring institutions. In some cases, the MERC grant that a sponsoring institution must send to a training site is less than a single dollar, or no more than the cost of postage and administrative time required to prepare and send the funds.

## Impact by provider type

When the changes to the MERC formula were enacted in 2007, some MERC stakeholders were concerned that the revised formula would lead to a reduction in funding for non-physician providers, particularly those that practiced in non-hospital settings such as clinics and pharmacies. In particular, stakeholders expressed concern that chiropractic students would be either effectively eliminated from the distribution or would see a dramatic decrease in their share of the distribution.

**Figure 5**
**Impact by Provider Type**




While the 2008 distribution showed a greater concentration of MERC funding in hospitals, the impact on individual provider types varied. The change in the distribution formula had the effect of slightly reducing the share of the distribution given to medical residents, while increasing the share for Advanced Practice Nurses, medical students, and pharmacy students. Chiropractic and dental students, who had received between one and two percent of the distribution in 2007, were reduced to less than one percent in 2008. The redistribution of grant funds among the provider types was small, though, and was mostly due to different patterns in where the various provider types tend to receive their clinical training. Those who completed more of their training in large hospitals were likely to see an increase, while those who completed their clinical training in clinics or in other sites with lower Medicaid volume saw a decrease.

## Impact on small training sites

**Example MERC grants by FTE count, 2008**

8.6 FTEs: $0.95
7.9 FTEs: $3,599
8.1 FTEs: $1,439,432

2.0 FTEs: $49
2.0 FTEs: $10,279
1.9 FTEs: $107,758

The original MERC formula was based solely on each clinical training site's share of overall training costs across all sites, based on cost information submitted at the training program level. This was done in recognition of the fact that training sites with higher training costs were often not able to receive higher reimbursement rates to cover those additional costs. Under the original formula, then, sites that trained a higher number of students – or more expensive students or residents – received a larger grant than those that trained fewer students. This formula was developed as a strategy for encouraging training outside of large hospitals, in ambulatory sites and rural areas that

might have a more difficult time financially supporting a training program as well as a greater need for the extra hands that students and residents provide.

The changes to the MERC formula that were enacted in 2007 essentially separated the size of any site's grant from the amount of training that site supports. Under the revised formula, the MERC grant that a site receives is independent of their training costs or the number of FTE students or residents that the training site works with. As a result of this change, sites that train similar numbers of residents can now receive very different amounts of funding through MERC, and sites that support fewer students or residents can receive much larger grants than those that support more students. In the most extreme example, one training site with 8.6 FTE trainees received a grant of less than a dollar, while another site with 8.1 FTE's received more than $1.4 million.

## Discussion

In many ways, the true intent of the MERC program has been a subject of debate since its inception. The original language directing the Commissioner of Health to study the financing of medical education activities in Minnesota recognized that medical education is a benefit to society at large and that the costs should not be borne by a few hospitals or medical centers but allocated across the health care system. The Department of Health was directed to develop mechanisms to identify the annual cost of medical education and research, as well as a method for assessing a percentage of those costs from each group purchaser and for distributing the funds to providers.

The original work group that was charged with developing the program recommended that the distribution formula focus solely on average clinical costs per trainee and number of trainees, without the addition of any additional factors. In that way, the program was designed to support clinical training in the many locations in which it takes place, and to encourage non-hospital sites to continue to offer training opportunities to students and residents in hopes that those future practitioners would choose to practice in rural areas or in non-hospital sites based on that exposure.

But with the largest percentage of MERC funding coming via the Medicaid program, some stakeholders have argued that the funds should be awarded on the basis of the volume of Medicaid patients treated at each training site. Once a federal waiver was received for the carveout of the medical education 'add on' funds from the PMAP program, this debate intensified, with some stakeholders believing that the inclusion of these funds in the Medicaid program indicated an intention that they be used solely for Medicaid patients and others believing that their intent was to support medical education more broadly. Advisory groups to MDH have traditionally been split on this issue, with the result being that the distribution formula that governs the MERC grants has, for the last several years, been a hybrid formula that takes into account both of these factors.

The revisions made to the MERC statute in 2007 removed clinical training costs and number of FTE trainees from the distribution formula, so that it is now solely weighted on public program volume. In the first year of implementation of this new formula, several findings are apparent.

The changes to the distribution had the effect of:

- Concentrating the distribution among a smaller group of training sites in the metro area;

- Decreasing the share of the grant pool that was distributed to smaller training sites and sites outside of Hennepin or Ramsey counties;

- Increasing the number of sites that receive very small grants, creating a potential administrative burden for sponsoring institutions that are required to pass these grants through to clinical training sites, and

- By detaching the size of the grant from the volume of training that is done at any given site, creating a situation in which training sites that support a similar number of trainees, or that bear similar costs for training, receive widely varying amounts of funding.

These changes will be felt immediately by the clinical training sites that are part of the 2008 MERC distribution. However, the long-term impact of the formula change will not be felt for several years, and it may take several forms.

In the past, training sites that supported a large number of students/residents received a larger share of the MERC fund. If those sites do not see a large percentage of Medicaid patients, they will have experienced a dramatic reduction in their grant in 2008 as a result of the formula changes. This can pose a challenge for sponsoring institutions and teaching programs, which traditionally work hard to develop and maintain long-standing and consistent relationships with their clinical training sites but now need to convince them to remain as training sites and continue to be part of the MERC program with no financial benefit.

There is a potential that these sites will make a determination that they can no longer financially support the clinical training function, and will cease accepting students or residents. If that occurs, training programs may have difficulty finding clinical sites for their students or residents, and those trainees may not have the opportunity to be exposed to certain practice settings.

The MERC program was designed to support training in all of the locations where it occurs, and in particular to support training in non-hospital and non-metro sites. With a greater share of the distribution going to metro hospitals under the revised formula, it is possible that the sites that MERC was originally designed to financially support will decide that they have less incentive now to continue as clinical training sites and will discontinue their relationship with the programs that they currently support. Again, if this occurs, it is most likely to impact ambulatory sites in urban and rural areas. For those sites that had previously received substantially larger grants from MERC as a result of their volume of training but now receive little or no MERC funding, that decision may need to be made sooner rather than later, if the training function is no longer financially viable.

At this point, it is too soon to know what the long-term impact of these changes will be on the MERC distribution, and on the location, costs, and quality of graduate medical education in Minnesota. Making revisions to the MERC statute and distribution formula requires federal approval through the Centers for Medicare and Medicaid Services as well as a change in the MERC statute; given that, MDH recommends waiting until further information is available on the extent to which these changes are impacting the provision of graduate medical education in Minnesota before making any additional changes to the MERC statute or distribution formula.