



## **MEDICAID TOPICS**

### **Funding of Graduate Medical Education**

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### **Issue Summary**

The role of state government in supporting medical education is well established. Since the late 1940s, states have subsidized loan and scholarship programs as financial incentives for medical students and physicians in training, and most states have provided some level of institutional support through general appropriations for undergraduate medical education. Since the inception of the Medicaid program in the 1960s, states have also paid what they believe to be their fair share of graduate medical education (GME) costs, primarily through payments to teaching hospitals.

Second to Medicare, Medicaid is the largest explicit payer of GME, providing teaching hospitals between \$2.5 and \$2.7 billion in 2002, amounts slightly higher than the \$2.3 to \$2.4 billion estimate of total Medicaid GME payments in 1998. Although Medicare has a statutory requirement to support GME, state Medicaid programs have no such formal obligation. Yet, most states historically have made payments for GME under their fee-for-service (FFS) programs. (States have the option to support such additional services as GME and to receive matching Federal funds for them.) In 2002, all states except Illinois, Kansas, and South Dakota volunteered to make GME payments under FFS programs. Even those states without medical schools provide GME support from their Medicaid programs to residency programs within their states. Of the 46 states and DC that made GME payments under their Medicaid FFS programs, the majority of states (24) and DC recognize and reimburse for both direct graduate medical education (DGME) and indirect medical education (IME) costs. Three-fourths of states and DC (35) that pay for GME under FFS programs distribute GME payments through the hospital's per-case or per-diem rate; these GME payments on average are about 8 to 9 percent of total Medicaid inpatient hospital expenditures.

Under growing pressure to reduce costs and improve access to care, most states, beginning in the mid-1990s, began to enroll their Medicaid population rapidly in managed care organizations (MCOs). Consequently, Medicaid support for GME and related costs has faced increased risk. Without some specific type of adjustment, MCO rates include historical payments for GME, and MCOs are neither bound to distribute those dollars to hospitals with GME programs nor to provide GME themselves. As of 2002, about half of states that have capitated their Medicaid program leave GME historical payments in the base used for calculating MCO payments. More teaching hospitals are realizing the importance of Medicaid GME funds and are putting pressure on their state Medicaid programs to have GME payments carved out from capitated MCO rates and rechanneled to them.

However, recent fiscal problems have forced virtually every state to reduce significantly spending for Medicaid and other public health programs that account for 30 percent of state expenditures nationwide. States' alterations to Medicaid include reduced reimbursements to physicians and hospitals, increased control over prescription drug coverage, and eliminated or curtailed optional benefits or services such as payments for GME. A few states, such as Kansas, Nebraska, Texas, and Wisconsin, have very recently considered or actually eliminated or curtailed optional Medicaid payments for GME.

## Importance to Family Physicians

Most state support for GME through Medicaid has been without restriction on the specialty of physicians being trained. Because most states, in paying for GME, follow the Medicare methodology that reimburses for education and service provided in hospital-based settings only, Medicaid programs have done little to allow payment for the additional costs of teaching in ambulatory sites. For most ambulatory education programs that train primary care residents, care is provided to large numbers of Medicaid and indigent patients. Typically, such sites, which are not connected to a teaching hospital, earn no additional revenues from Medicaid to cover teaching costs.

However, several state Medicaid programs, seeking to be more prudent, farsighted purchasers of care, recognize that support for GME is a valuable tool for meeting the future health care provider needs of Medicaid beneficiaries as well as the public-at-large. In a small number of states, there is interest in making a stronger connection between distributed GME funds and training program accountability. In 2002, 10 states required that some or all Medicaid GME payments be directly linked to state policy goals intended to vary the distribution of, or limit, the health care workforce. The goal of encouraging training of primary care physicians is applied to GME payments by all 10 states. These states are Florida, Maryland, Massachusetts, Michigan, New Mexico, New York, Oklahoma, Tennessee, Utah and West Virginia. Five of the states use these payments to encourage training of physicians in certain settings (e.g., ambulatory sites, rural locations, and medically underserved communities). Four states link payments to efforts to increase the supply of health professionals trained to serve Medicaid beneficiaries.

## State-by-State Data

See attached

## References

Tim Henderson, National Conference of State Legislatures. *State and Managed Care Support for Graduate Medical Education: Innovations and Implications for Federal Policy* (for the U.S. Department of Health and Human Services, Council on Graduate Medical Education), 2004.

Tim Henderson, National Conference of State Legislatures. *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (for the Association of American Medical Colleges), August 2003.

**MEDICAID DGME/IME PAYMENT AMOUNTS**  
**FY 2002<sup>1</sup>**

STATE	DGME/IME Payments (Explicit) Under Fee-for-Service (Millions of Dollars)	DGME/IME Payments Under Managed Care (Millions of Dollars)		Total Explicit DGME/IME Payments <sup>2</sup> (Millions of Dollars)	Total DGME/IME Payments (Millions of Dollars)	Total DGME/IME Payments: % of Inpatient Hospital Expenditures	Total DGME/IME Payments: State Rank
		Implicit Payments <sup>3</sup>	Explicit Payments <sup>4</sup>				
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Alabama	\$4	\$8	\$0	\$4	\$12	3.2	31
Alaska	\$0.64	\$0	\$0	\$0.64	\$0.64	8.0	46
Arizona	Unreported	\$0	Unreported	\$18.6	\$18.6	3.4	27
Arkansas	\$7.1	\$0	\$0	\$7.1	\$7.1	1.8	35
California	\$159.4	\$0	\$0	\$159.4	\$159.4	1.6	3
Colorado	\$9.5	\$0	\$5.9	\$15.3	\$15.3	7.9	30
Connecticut	\$6.3	\$0	\$0	\$6.3	\$6.3	3.6	37
Delaware	\$1.6	\$0.36	\$0	\$1.6	\$1.6 / \$1.96	8.0 / 9.6	41
District of Columbia	\$16.4	\$0	\$2.8	\$19.2	\$19.2	8.6	26
Florida	\$34.8	\$0	\$0	\$34.8	\$34.8	2.7	20
Georgia	\$80.0	\$0	\$0	\$80.0	\$80.0	8.0	7
Hawaii	\$1.5	\$0.34	\$0	\$1.5	\$1.5 / \$1.84	1.9	42
Idaho	\$0.66	\$0	\$0	\$0.66	\$0.66	1.2	45
Illinois *	*	*	*	*	*	*	*
Indiana	\$12.7	\$2.8	\$0	\$12.7	\$12.7 / \$15.5	5.9 / 7.2	29
Iowa	Unreported	\$0	Unreported	\$50.6	\$50.6	20.0	13
Kansas *	*	*	*	*	*	*	*
Kentucky	\$7.3	\$0	\$0	\$7.3	\$7.3	1.6	34
Louisiana	\$40.4	\$0	\$0	\$40.4	\$40.4	5.4	19
Maine	\$2.2	\$0	\$0	\$2.2	\$2.2	1.1	20
Maryland	Unreported	\$0	Unreported	\$30.9	\$30.9	9.0	22
Massachusetts	\$30.5	\$11.8	\$0	\$30.5	\$42.3	7.4	17
Michigan	Unreported	\$0	Unreported	\$173.3	\$173.3	31.5	2
Minnesota	\$36.0	\$0	\$33.0	\$69.0	\$69.0	18.4	11
Mississippi	\$18.4	\$0	\$0	\$18.4	\$18.4	5.7	28
Missouri	\$40.3	\$0	\$29.8	\$70.1	\$70.1	9.4	10
Montana	\$0.12	\$0	\$0	\$0.12	\$0.12	1.0	48
Nebraska	Unreported	\$0	Unreported	\$11.4	\$11.4	9.0	32
Nevada	\$2.4	\$0	\$0	\$2.4	\$2.4	2.2	39
New Hampshire	\$3.1	\$0	\$0	\$3.1	\$3.1	8.7	38
New Jersey	\$20.0	\$23.4	\$0	\$20.0	\$43.4	3.8	16
New Mexico	\$3.4	\$0	\$3.1	\$6.5	\$6.5	7.0	36
New York	Unreported	\$0	Unreported	\$992	\$992	19.5	1
North Carolina	\$45.1	\$0	\$1.6	\$46.7	\$46.7	5.6	15
North Dakota	\$1.25	\$0	\$0	\$1.25	\$1.25	4.0	43
Ohio	Unreported	Unreported	\$0	Unreported	\$154.3	8.0	4
Oklahoma	\$60.3	\$0	\$47.4	\$108.3	\$108.3	30.0	5
Oregon	\$27.1	\$6.0	\$0	\$27.1	\$27.1 / \$33.0	6.5 / 8.0	21
Pennsylvania	\$54.8	\$0	\$20.4	\$75.2	\$75.2	7.0	8

STATE	DGME/IME Payments (Explicit) Under Fee-for-Service (Millions of Dollars)	DGME/IME Payments Under Managed Care (Millions of Dollars)		Total Explicit DGME/IME Payments <sup>2</sup> (Millions of Dollars)	Total DGME/IME Payments (Millions of Dollars)	Total DGME/IME Payments: % of Inpatient Hospital Expenditures	Total DGME/IME Payments: State Rank
		Implicit Payments <sup>3</sup>	Explicit Payments <sup>4</sup>				
Rhode Island	\$8.2	\$1.8	\$0	\$8.2	\$10.0	8.0 / 10.0	33
South Carolina	\$51.4	\$0	\$0.84	\$52.3	\$52.3	5.5	12
South Dakota *	*	*	*	*	*	*	*
Tennessee	\$0	\$0	\$48.0	\$48.0	\$48.0	8.0	14
Texas	Unreported	Unreported	\$0	\$41.0	\$41.0	2.3	18
Utah	\$22.3	\$0	\$0	\$22.3	\$22.3	17.6	25
Vermont	\$.71	\$0	\$0	\$.71	\$.71	2.5	44
Virginia	\$58.7	\$0	\$12.9	\$71.6	\$71.6	11.3	9
Washington	\$79.3	\$0	\$8.7	\$88.0	\$88.0	19.3	6
West Virginia	\$22.3	\$0	\$0	\$22.3	\$22.3	15.4	24
Wisconsin	\$28.1	\$0	\$0	\$28.1	\$28.1	9.2	23
Wyoming	\$0.19	\$0	\$0	\$0.19	\$0.19	0.5	47
<b>TOTALS OR AVERAGE</b>	**	**	**	**	<b>\$2.5 / \$2.7 billion</b>	<b>8.0% / 9.6%</b>	**

\* The Medicaid agency does not pay for graduate medical education.

\*\* Totals cannot be calculated because of unreported data.

NOTE: Amounts shown in *italics* are NCSL estimates in lieu of unreported data. Assumptions used by NCSL in making estimates are:

- For those states that report making DGME/IME payments under their Medicaid programs (either under FFS or managed care), but did not report these amounts (Alaska, Delaware, and Rhode Island), an estimate of total DGME/IME payments was made. This estimate was based on each state's total Medicaid inpatient hospital expenditures, which they did report. For states that reported total DGME/IME payments, the proportion of those payments to total Medicaid inpatient hospital expenditures was calculated. This proportion—8.0 percent—was multiplied by the total Medicaid inpatient hospital expenditure amounts for the unreporting states to arrive at an estimate of total DGME/IME payments.
- For those states that report making DGME/IME payments under managed care (either directly to teaching programs or as part of MCO capitation rates), but only reported DGME/IME payments made under FFS (Indiana, Oregon and Virginia), an estimate for DGME/IME payment amounts under managed care was made. This estimate used those states that reported DGME/IME payment amounts—both total and under managed care—to calculate the proportion that DGME/IME payments under managed care represent of total DGME/IME payments. This proportion—22 percent—was utilized, along with FFS DGME/IME payments, to arrive at an estimate of DGME/IME managed care payments for these states.

For Virginia—a state that makes explicit DGME/IME payments to teaching hospitals under managed care—the estimated DGME/IME payment amounts under managed care was added to the reported FFS DGME/IME payments to determine an estimate of total, and explicit total, DGME/IME amounts. For Indiana and Oregon, states which include those DGME/IME payments in MCO rates, two estimates of total DGME/IME payments are provided. The low estimate reflects only state-reported DGME/IME payments made under FFS and assumes that no DGME/IME payments included in MCO rates are distributed by the MCO to teaching programs. The higher estimate includes the state-reported FFS DGME/IME payments plus the estimated amount of DGME/IME payments included in MCO rates, with the assumption that all of the DGME/IME payments included in MCO rates will be distributed by the MCO to teaching programs.

NOTE: Certain states reported a total DGME/IME payment amount but provided no specific breakdown amounts for FFS and/or managed care DGME/IME payments (Arizona, Iowa, Maryland, Michigan, Nebraska, New York, and Texas). Other states provided no information on DGME/IME payment amounts—either total, FFS, and/or managed care (Alaska, Delaware, Hawaii, Indiana, Ohio, Oregon, Rhode Island, and Virginia), and thus, an estimate was made of such amount(s).

SOURCE:

**Tim Henderson, National Conference of State Legislatures. *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (for the Association of American Medical Colleges), TABLE 11 fully extracted. August 2003.**

**End Notes**

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<sup>1</sup> The start and end date for each state's fiscal year varies.

<sup>2</sup> The total amount of DGME/IME payments made directly to teaching programs under both fee-for-service and managed care, including state-reported and NCSL-estimated amounts.

<sup>3</sup> Implicit DGME/IME payments are those recognized and included in capitation rates to managed care organizations.

<sup>4</sup> Explicit DGME/IME payments are those made directly to teaching programs under managed care.