

REPORT ON WORKGROUP EFFORTS ON GRADUATE MEDICAL EDUCATION FUNDING

(FY2012 Appropriation Bill - Public Act 63 of 2011)

April 1, 2012

Section 1846: (1) The department shall establish a workgroup on graduate medical education funding. The workgroup shall include representatives of teaching hospitals, the Michigan health and hospital association, and other interested parties. (2) The workgroup shall do all of the following: (a) Identify physician specialties where there is a current or potential shortage of practitioners and identify the geographic areas of this state where those shortages exist or potentially could develop. (b) Research efforts by other states to address practitioner shortages by adjusting their graduate medical education payments. (c) Recommend potential policy changes to the graduate medical education program to help reduce practitioner shortages. (3) The department shall report the results of the workgroup's efforts to the senate and house appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director by April 1 of the current fiscal year. (4) It is the intent of the legislature that the report required under subsection (3) be used as a possible basis for the establishment of new graduate medical education funding formulas in fiscal year 2012-2013.

*Michigan Department
of Community Health*



**Rick Snyder, Governor
Olga Dazzo, Director**

Graduate Medical Education (GME) Report to the Legislature

In response to and in accordance with Section 1846(3) of Public Act 63 of 2011, the Department of Community Health (DCH) convened a workgroup to discuss the objectives outlined in the boilerplate language. The following report describes the findings and conclusions of the workgroup and offers recommendations on new graduate medical education (GME) funding concepts for fiscal year 2012-2013.

The GME workgroup began discussions on November 28, 2011 and met for two subsequent meetings. The workgroup consisted of representatives of teaching hospitals, the Michigan Health and Hospital Association, and other interested parties who demonstrated a strong interest in policies and programs related to GME. Over the course of the three meetings, the following conclusions were determined:

- 1) The Medicaid GME program offers great value to the State of Michigan by providing access to care and crucial funding for services provided to Michigan's most vulnerable populations. The State of Michigan also generates a significant financial return on its investment in Medicaid GME funding. Due to the matching nature of the Medicaid program, for every local dollar the State contributes to its GME program the Federal government contributes nearly two additional dollars. GME is not only training future physicians, it is funding a significant component of the care provided to Medicaid beneficiaries.
- 2) GME funding contributes to the retention of physicians in Michigan.
- 3) The use of GME funding to address physician shortages is limited due to the National Resident Matching Program.

- 4) The most effective way to retain Michigan residents within the State is to offer loan forgiveness programs that provide incentives for residents to study in specific specialties and to practice in rural or under-served locations.

The workgroup stressed the importance and value of GME funding and its impact on providing quality health care to Michigan patients. The workgroup noted that the restoration of GME funding to its FY 2011 appropriation level (or higher) is critical in maintaining the viability of a program that provides great value by providing access to care and healthcare services to Michigan's most vulnerable populations. The State of Michigan's FY 2012 Medicaid GME budget appropriation was \$154.3 million, down \$14.7 million from the FY 2011 appropriation. Hospitals commit three or more years of training to the residents matched with their facilities and are reliant upon a consistent and predictable stream of funding in order to operate these programs. Medicaid GME funding decreases make it difficult for hospitals to fulfill their obligation to these residents. In addition, members of the workgroup stressed that GME funding decreases will remove physicians from clinics which will result in Medicaid and uninsured patients seeking care in the more costly emergency room setting.

Historically, the GME program's main objectives focused on training physicians as well as providing a safety net for underserved medical communities. This focus remains relevant today, especially as the number of Michigan residents classified as under or uninsured continues to increase. In addition, Michigan remains a leader among graduate medical education programs by providing quality education for medical students seeking a diverse and enriched curriculum. Workgroup participants stressed that the long-standing partnership between Michigan medical schools and hospitals provides the State with an immeasurable amount of quality patient care, while allowing medical students the opportunity for a dynamic and productive residency experience. The GME

program offers great value for the benefit of Michigan medical schools, hospitals, resident students, and patients throughout the State.

It was determined that Michigan, like other states throughout the country, faces physician shortages in a number of medical specialties. The Graduate Medical Education program is limited in addressing this concern due to the existing National Resident Matching Program. Experts asserted that along with the influence of the national matching program, a variety of resident preferences and priorities contribute to their choice of a medical specialty therefore limiting the influence of the Michigan GME program. Geographic favorites, familial responsibilities, and personal priorities play an intricate part in a physician's field choice. The workgroup established that although the issue of physician shortages remains a concern, the GME program is unable to account for the variance of specialty choice within its current programmatic structure.

Despite the challenge of addressing physician shortages, the workgroup determined that the GME program has proven effective in retaining Michigan physician residents within the State. Participants of the workgroup concluded that a loan forgiveness program could further assist in the retention of Michigan physician residents, while incentivizing resident choice in specialties and contribute to the placement of medical professionals in rural and underserved areas of the State. Such challenges remain unaddressed by the current structure of the GME program, despite the best efforts.

Workgroup participants acknowledged that loan forgiveness programs provided the potential to address specialty shortages and rural and underserved locations, but should be addressed outside the scope of GME funding. Workgroup consensus stressed that GME funding should not be cannibalized to subsidize new incentives such as the proposed loan forgiveness program. Instead a strategic planning process should be initiated to inform next steps for the GME program that offer fair and equitable

strategies to continue the program's viability and promote the immense value provided to program participants and Michigan patients.

The GME Workgroup offered varied expert perspectives on a topic that influences many throughout the State. As described, workgroup members found agreement in the following three points:

- 1) GME funding offers great value to the State of Michigan by providing access to care and crucial funding for services provided to Michigan's most vulnerable populations.
- 2) The use of GME funding in addressing physician shortages is limited due to the Nation Resident Matching Program.
- 3) The most effective way to retain Michigan physician residents within the State is to offer loan forgiveness programs that provide incentives for residents to study in specific specialties and to practice in rural or under-served locations.

It is the recommendation of the GME workgroup that future GME funding be re-established to FY 2011 appropriation levels or greater to maintain the viability of a program that contributes greatly to medical education, access to care, the provision of patient care, and the State as a whole. In addition, the GME workgroup recommends no change to the current GME funding formulas.

Please refer to the following attachments for additional information:

1. 2010 GME Medicaid Survey (PDF)
2. DCH Info on Michigan Primary Care Physician Shortages (PDF)
3. Blue Ribbon Physician Report (PDF)
4. List of GME Workgroup Participants



Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey

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April 2010

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Direct and Indirect Graduate Medical Education Payments By State Medicaid Programs

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April 2010

For the
Association of American Medical Colleges



INTRODUCTION

States provide important support for the education of physicians. State and local governments appropriate funds for medical school training (about \$5 billion annually¹), and Medicaid programs in most states finance the reimbursement of direct graduate medical education (DGME) and indirect medical education (IME) costs in teaching hospitals and other settings.²

Medicaid covers medical and support services for 60 million people. Medicaid enrollment and spending has risen sharply in the past two years amid a slumping economy and is expected to continue growing well into 2010,³ straining state budgets and pressuring officials to significantly reduce costs.⁴ On average, states spend just under a fifth of their own funds on Medicaid, making it the second largest program in most states' general fund budgets following spending for elementary and secondary education.⁵ Recent state efforts to lower Medicaid costs include reduced reimbursements to physicians and hospitals, and the elimination or curtailment of optional benefits or services. In recent years, budgetary concerns have prompted the federal government to propose limits on Medicaid spending. Although these limits were ultimately not implemented, the current budget deficit may again result in Medicaid cuts being considered.⁶

While Medicaid programs are not obligated to pay for graduate medical education, most states historically have made DGME and IME payments under their fee-for-service programs.⁷ In fact, Medicaid is the second largest explicit payer (behind Medicare) of graduate medical education and the other special missions and services of teaching hospitals.⁸ Contrary to Medicare, the federal government has no explicit guidelines for states on whether and how their Medicaid programs should or could make DGME and IME payments.

In addition, most states have managed care programs for their Medicaid enrollees that may provide some level of funding for graduate medical education. Over 70 percent of Medicaid beneficiaries nationwide are now enrolled in some form of managed care.⁹ However, support for DGME and/or IME remains at risk. Not all states with Medicaid capitated managed care programs pay for graduate medical education under managed care. While Medicaid managed care capitation rates may include historical payments for DGME and IME in many states, managed care organizations (MCOs) often are not bound to distribute these dollars to hospitals with clinical training programs or to provide graduate medical education themselves.

¹ Such funds are non-Medicaid appropriations and include support from parent universities of medical schools. Association of American Medical Colleges. 2007-2008 Financial Tables on U.S. Medical Schools, Table 1. <http://www.aamc.org/data/finance/>

² Medicaid is a significant payer for children's as well as adult services in these settings. Financing for Medicaid (including payment for DGME and/or IME costs) is shared by the states and federal government.

³ The Kaiser Family Foundation. http://www.kff.org/medicaid/upload/7523_02.pdf <http://www.kff.org/medicaid/7985.cfm>
<http://www.statehealthfacts.org/comparemaptable.jsp?yr=174&typ=2&ind=797&cat=4&sub=52>

⁴ All but two states face a significant budget gap in FY2010. <http://www.statehealthfacts.org/comparemapreport.jsp?rep=49&cat=1>
Unlike the federal government, states are legally required to balance their budgets.

⁵ Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. <http://www.kff.org/medicaid/upload/7985.pdf>

⁶ Beginning in 2007, President Bush introduced several regulations that would reduce federal Medicaid spending nearly \$20 billion over 5 years, including a rule that would end federal funding for graduate medical education. In 2008, Congress placed a moratorium on finalizing the proposed regulations, and President Obama blocked their implementation in 2009.

⁷ Beyond the services that state Medicaid programs are required to cover, states have the option to support additional services such as DGME and IME and receive matching federal funds for them.

⁸ Inpatient care payments by private insurers to teaching hospitals (that are greater than costs) indirectly help to support clinical training.

⁹ Except for Alaska and Wyoming, every state Medicaid program now has some form of managed care. In most states, managed care refers to prepaid, capitated at-risk managed care organizations operating as licensed health care delivery systems. The Kaiser Family Foundation. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=217&cat=4>
<http://www.kff.org/medicaid/upload/7985.pdf>

MEDICAID DGME and IME PAYMENTS: A SURVEY OF STATE MEDICAID PROGRAMS

In 2009, the Association of American Medical Colleges (AAMC) contracted with the author, an independent health workforce consultant, to survey state Medicaid programs to examine their policies for financing direct and/or indirect graduate medical education (DGME and/or IME).¹⁰ In part, the intent of the study was to update earlier studies in 1998, 2002 and 2005 (published in 1999, 2003 and 2006 respectively) for the AAMC conducted by the author and the National Conference of State Legislatures of state Medicaid DGME and/or IME payment policies.

In the fall of 2009, an online questionnaire was developed and distributed to Medicaid agencies in each of the 50 states and the District of Columbia to identify each program's current policies and issues associated with payment of DGME and IME. (*See Appendix for a copy of the survey instrument*) All but two state Medicaid agencies responded to the survey; however, corresponding data from one of the non-responding states was obtained through another source.¹¹ Thus, the final count of state responses is 50.¹²

This report reflects the climate for state Medicaid support for direct and indirect graduate medical education as of 2009, and is intended to set a foundation for future analyses. Consequently, its content may not reflect any fiscal or policy changes that have occurred since that time.

Findings

As of 2009, forty-one (41) states and the District of Columbia (DC) provided payment for direct and/or indirect graduate medical education costs under their Medicaid program. (*Table 1*) Medicaid agencies in eight (8) states did not pay for such costs; all of these states at one time had made GME payments under their Medicaid program.

This indicates a significant decline since 2005 when 47 states and DC made DGME and/or IME payments. (*Table 14*) Five (5) states—**Massachusetts, Montana, Rhode Island, Vermont and Wyoming**—have stopped making DGME and/or IME payments in the past four years alone.¹³ All but one of the 8 states that have ended Medicaid support for graduate medical education has done so in just the past seven years, due largely to budget concerns.¹⁴

Additionally, nine (9) states in 2009—**Michigan, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, Oklahoma, Oregon and Pennsylvania**—reported having recently considered ending Medicaid payments for graduate medical education.¹⁵ All these states identified current budget shortfalls or cost controls as the rationale for considering discontinuation of DGME and/or IME payments.

¹⁰ This study examines the special payments that state Medicaid programs make to teaching hospitals associated with their clinical care and teaching missions. The report is not intended to discuss disproportionate share payments or other special financing arrangements that Medicaid uses to support care to low-income populations.

¹¹ Alabama and Wisconsin Medicaid did not respond to the AAMC survey. However, at the consultant's request, corresponding survey data were obtained by the Wisconsin Hospital Association (WHA) from the Wisconsin Medicaid agency for use in this report.

¹² No attempt was made to independently verify the results of this study.

¹³ In 2005, one of these states—Massachusetts—reported having considered ending payment for GME.

¹⁴ Illinois ceased making GME payments to all teaching hospitals in 1995 as a cost-savings measure when the state implemented Medicaid managed care. Although the Texas legislature eliminated Medicaid payments for DGME/IME in 2003, the state Medicaid agency received authority by the legislature in 2008 to use funds from five state-owned teaching hospitals to draw down federal matching funds under a special financing arrangement to reimburse these hospitals for their GME costs. Since that time, funds have been appropriated; however, the rule changes governing these payments have not been finalized.

¹⁵ In early 2010, the governors of Arizona, Minnesota and Tennessee proposed to reduce or eliminate Medicaid GME payments for FY 2011.

DGME and/or IME Payment Under Fee-for-Service

Forty (40) states and the District of Columbia report making DGME and/or IME payments under their Medicaid fee-for-service (FFS) programs. Of these, about half (19 states and DC) recognize and reimburse for both DGME and IME costs. (Table 1) This represents a continued decline from 2005 when 21 states and DC paid for both DGME and IME, and 2002 when 24 states and DC made DGME and IME payments. (Table 14)

When asked how payments are calculated, DC and fifteen (15) out of 40 states that pay for DGME and/or IME under FFS, say they use methods similar to those used to pay for GME under the Medicare program. Of the 40 states and DC, sixteen (16) states report using some “other method” for calculating DGME and/or IME which was not specified in the survey. Typically, these methods are defined as some variation of those methods specified in the survey—a per-resident or lump-sum amount based on the teaching hospital’s share of total Medicaid revenues, costs or patient volume. Fourteen (14) states and DC employ a per-resident amount calculation method. Eight (8) states and DC employ two methods of calculation. Most of these states use one method for DGME and another method for IME. (Table 2)

Three states—**Florida, Oregon and Louisiana**—report making other kinds of payments to teaching hospitals under their fee-for-service program. Public teaching hospitals in **Florida** are eligible for additional DGME and/or IME payments under their state’s Disproportionate Share Hospital (DSH) program. In **Oregon**, major teaching hospitals are eligible to receive additional payments intended to compensate them for their inability to capture DGME and/or IME costs when contracting with Medicaid managed care plans. For private teaching hospitals in **Louisiana**, GME costs are included in cost-to-charge ratios used to calculate uninsured costs, and then these hospitals are paid a percentage of the uninsured cost (in addition to receiving a hospital-specific per diem amount). (Table 2)

The states and DC that pay for DGME and/or IME under FFS distribute these payments using two methods. More than half of states use one of the two methods to distribute these payments and seven (7) states use both methods. Twenty-four (24) states and DC make DGME and/or IME payments through the teaching hospital’s per-case or per-diem rate. Twenty-three (23) states reimburse hospitals for DGME and/or IME costs by making a separate direct payment to these institutions. (Table 3) Among the seven states that employ both methods to distribute DGME and/or IME payments, typically they use one method to distribute DGME payments and the other method to make IME payments. However, two states use both methods of distribution depending on the type of teaching hospital. DGME payments in **Arkansas** are distributed as part of a per-diem rate to community hospitals and as a separate direct payment to the state’s academic health centers. In **Kansas**, DGME and/or IME payments to public teaching hospitals are paid as part of the hospital per-diem rate; all other hospitals receive a supplemental quarterly payment for DGME and/or IME.

DGME and/or IME Payment Under Capitated Managed Care

Of the 32 states and DC with capitated Medicaid managed care programs¹⁶, over 70 percent—23 states and DC—included DGME and/or IME payments under Medicaid managed care in 2009. (Table 1) These payments are made either explicitly and directly to teaching programs or indirectly as part of the capitated rates to managed care organizations (MCOs).

¹⁶ Capitated managed care is defined as Medicaid’s use of risk-based capitation payments, and does not include any payments made under a primary care case or disease management program.

Twelve (12) states and DC made Medicaid DGME and/or IME payments explicitly and directly to teaching hospitals (or other teaching programs) under capitated managed care. (*Table 4*) This represents a continued decline in the number of such states that make DGME and/or IME payments directly under managed care. In 2002, 18 states ‘carved out’ DGME and/or IME payments from managed care capitation rates. (*Table 14*) The most common reasons cited (as specified in the survey) for Medicaid continuing to pay directly for DGME and/or IME under managed care include: desire to help train the next generation of physicians who will serve Medicaid beneficiaries; GME is seen as a public good; and desire to use Medicaid funds to advance state policy goals. (*Table 4*)

Most of these states use a method for calculating DGME and/or IME payments that was unspecified in the survey; although typically it represents some variation of a per-Medicaid discharge amount, lump sum, or Medicare FFS methodology. Five states pay for both DGME and IME costs. Three states do not distinguish between DGME and/or IME in their payments. All but one of the remaining states recognizes and pay for only DGME. (*Table 5*)

Another 11 states recognize and include Medicaid DGME and/or IME payments in their capitated payment rates to managed care organizations. (*Table 6*) This number is up slightly from the number of states providing such payments in 2002 and 2005, but still represents a significant decline from 1998. (*Table 14*) Five of the 11 states (**Connecticut, Kansas, Kentucky, Oregon and Washington**) require MCOs to distribute these implicit payments in their negotiated rates to teaching hospitals (up from just two states in 2005). The other six states assume MCOs will distribute the payments to teaching programs.

The balance of states (9) that have a Medicaid capitated managed care program and provide GME payments under their fee-for-service programs, do not leave DGME and/or IME historical payments in the base used for calculating MCO payments. For these states, the most common reason reported is that Medicaid payment for DGME and/or IME under managed care is not necessary or appropriate. (*Table 7*)

Training Institutions and Professions Eligible for DGME and/or IME Payments

Nearly all states that make DGME and/or IME payments report that teaching hospitals are the main graduate training institutions that receive such payments. Four (mainly rural) states—**Kansas, Minnesota, Missouri, and West Virginia**—specify that teaching sites in non-hospital settings are also eligible to receive DGME and/or IME payments.

In four (4) states, medical schools are eligible to receive DGME and/or IME payments. In **Tennessee** and **Oklahoma**, medical schools are the only training institutions allowed to receive Medicaid DGME and/or IME payments directly under managed care. In **Nevada**, the state’s medical school is now the single institution that may receive Medicaid FFS DGME and/or IME funds; teaching hospitals are no longer eligible for such payments. Under **Minnesota’s** managed care program, DGME and/or IME payments may go to schools of medicine, nursing, dentistry and pharmacy, non-hospital training sites, and other settings as well as to teaching hospitals.

Medical residents are the predominant health profession eligible for Medicaid DGME and/or IME payments. However, in 14 states, Medicaid either requires or allows other health professions students to have their training subsidized, or the agency makes no distinction as to which health professions are subsidized. (*Table 8*) Twelve (12) states explicitly require or allow graduate nurses to be eligible for Medicaid DGME and/or IME payments.

DGME and/or IME Payments Linked to State Policy Goals

A number of states continue to use their Medicaid programs to improve the supply and distribution of physicians. **Ten (10) states require that some or all Medicaid DGME and/or IME payments be directly linked to state policy goals intended to vary the distribution of the health care workforce.** (Table 9) The number of states with this requirement has remained largely constant over the past several years. (Table 14) The goal of encouraging training of physicians in certain specialties that are in short supply (e.g., primary care) is applied to DGME and/or IME payments by 9 of the states. Six of the states use these payments to encourage training of physicians in non-hospital and certain other settings such as rural locations and medically underserved communities. Seven states link payments to efforts to increase the supply of health professionals trained to serve Medicaid beneficiaries.

Thirteen (13) states place explicit limits on the amount of Medicaid DGME and/or IME payments. (Table 14) This indicates a decline in the number of states reporting the use of such limits since 2005. This change is largely explained by the drop in the overall number of states that report making DGME and/or IME payments. These limits continue to indicate persistent concerns with overall Medicaid spending levels as part of tight state budgets.

Medicaid DGME and/or IME Payment Amounts

Medicaid continues to be an important payer of a portion of the costs for direct and indirect graduate medical education. The amount of Medicaid DGME and/or IME payments is difficult to quantify precisely. This is due in part to the fact that teaching hospitals may also receive Medicaid disproportionate share (DSH) payments, which often makes it challenging to distinguish them from Medicaid GME payments. In addition, for those states that include DGME and/or IME payments in their MCO rates, it may be difficult to separately identify these payments. Determining the value of DGME and/or IME payments even under the Medicaid fee-for-service program requires an extraordinary effort in a few states.

In 2009, 37 of the 41 states and DC that pay for graduate medical education reported their total Medicaid DGME and/or IME payment amounts. In the remaining states, consultant estimates of total DGME and/or IME payments were made in lieu of unreported data. Consultant-estimated payment amounts represented 4 percent of the nationwide DGME and/or IME payment total in 2009.

Assuming these limitations, **the total Medicaid payment amount in 2009 for DGME and/or IME in the states and DC is estimated to be about \$3.78 billion.** (Table 10) These state-reported and consultant-estimated state DGME and/or IME payments reflect the following: 1) those payments made under Medicaid FFS (**\$2.35 billion**), 2) those payments made directly (explicitly) to teaching programs under managed care (**\$1.1 billion**), and 3) those payments (implicitly) recognized and included in capitated rates to MCOs (**\$323.8 million**). With the exception of five states which require MCOs to distribute these implicit payments for teaching costs in their negotiated rates to teaching hospitals, the amounts in MCO payments may not necessarily get funneled to teaching hospitals.

The 2009 Medicaid DGME and/or IME payment amount is indicative of an ongoing trend in increasing payments. According to earlier AAMC surveys, Medicaid GME payments in 2005 were estimated to be **\$3.18 billion**—noticeably higher than the **\$2.3 to \$2.4 billion** estimate of total Medicaid GME payments reported in 1998.¹⁷

¹⁷ In contrast, Medicare DGME and/or IME payments have remained relatively constant since 1998 when Medicare imposed hospital-specific caps on the number of medical residents it would support.

As reported by states, **Medicaid DGME and/or IME payments in 2009 on average represent 6.6 percent of total Medicaid inpatient hospital expenditures. This percentage represents a significant decline since 2002 when the proportion reported was between 8 and 9 percent.** (Table 14) State DGME and/or IME proportions vary widely from less than 1 percent to 22 percent. Three states—**Missouri, New York, Virginia**—and the **District of Columbia** reported spending 15 percent or more of Medicaid inpatient hospital expenditures on DGME and/or IME. (Table 10) In 2002, eight states had reported that GME payments were at least 15 percent of Medicaid inpatient hospital expenditures.

Across the states, DGME and/or IME payment amounts vary widely, ranging from over \$1.5 billion in **New York** to \$500,000 in **Alaska**. Payment amounts for half of the states (21) together represent just 8 percent of total DGME and/or IME payments. (Table 10) **The 15 states with the highest levels of Medicaid DGME and/or IME spending represent about 80 percent of total such payments nationwide.** (Table 11) Far and away, **New York's** Medicaid program spent the most of any state on DGME and/or IME in 2009—about 40 percent of the national total of state Medicaid DGME and/or IME payments. Nine (9) other states—**California, Michigan, Minnesota, Florida, Virginia, Washington, Missouri, New Jersey and Oklahoma**—each spent at least \$100 million in 2009 on DGME and/or IME. **California, Florida and Pennsylvania** do not make DGME and/or IME payments under their managed care programs. **North Carolina** does not currently operate a capitated managed care program.

Medicaid DGME and/or IME Payments and State Teaching Hospital Capacity

The states ranking the highest in Medicaid DGME and/or IME spending, only partly mirror those states with the largest number of teaching hospitals and medical residents. Half of the top ten states—**California, Florida, Michigan, New York and Pennsylvania**—in total count of both teaching hospitals and medical residents—enjoy similarly high ranking in the amount of Medicaid DGME and/or IME spending. However, three states—**Illinois, Massachusetts and Texas**—that rank in the top ten in number of teaching hospitals and medical residents provide no payments under Medicaid for clinical teaching. (Tables 12 and 13)

Summary

The recent troubled economy and its strain on state budgets and Medicaid spending has begun to have a noticeable impact on Medicaid payments for direct and indirect graduate medical education costs. For the first time in recent memory, the number of states making Medicaid DGME and/or IME payments in 2009 has declined significantly since the 2005 survey. This trend may continue as state Medicaid programs address ongoing fiscal pressures and reforms, and spending for DGME and/or IME faces greater scrutiny and accountability.

In summary:

- **Eight (8) states reported not making DGME and/or IME payments under their Medicaid programs in 2009—an almost tripling of the number of states not making such payments in 2005.** Three (3) of these states—**Illinois, Massachusetts and Texas**—are among the top ten states with the largest number of graduate medical education programs.
- **An additional nine (9) states reported in 2009 that they have recently considered ending Medicaid payments for graduate medical education.**
- **Under Medicaid fee-for-service, 40 states and DC reported making DGME and/or IME payments. About half of these (DC and 19 states) make payments for both DGME and IME costs; 8 states do not distinguish between DGME and IME costs in making such payments.**

- **Of the 32 states and DC with capitated Medicaid managed care programs, over 70 percent—23 states and DC—included DGME and/or IME payments under Medicaid managed care.** Of those, 12 states and DC made Medicaid DGME and/or IME payments explicitly and directly to teaching hospitals; another 11 states recognized and included such payments in the capitated payment rates to managed care organizations.
- Teaching hospitals remain the predominant graduate training institution receiving Medicaid DGME and/or IME payments. However, medical schools in 4 states are eligible to receive such payments directly.
- Although medical residents continue to be the main health profession eligible for Medicaid DGME and/or IME payments, graduate nurse and other health professions students in 14 states may also have their training subsidized with such payments.
- Medicaid programs in 10 states directly link DGME and/or IME payments to state policy goals intended to vary the distribution of the physician workforce.
- **Despite the decline in the number of states paying for graduate medical education, Medicaid continues to be a major payer of DGME and IME costs. In 2009, Medicaid payments for DGME and/or IME were estimated to be \$3.78 billion, a significant increase over the amount of such payments made in 2005 and 1998.** On average, Medicaid DGME and/or IME payments nationwide represent 6.6 percent of total Medicaid inpatient hospital expenditures, a decline since 2002 when the proportion reported was between 8 and 9 percent.

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Copy of Survey Instrument

Table 1
MEDICAID DIRECT AND INDIRECT
GRADUATE MEDICAL EDUCATION PAYMENTS, 2009

STATE	UNDER FEE-FOR-SERVICE		UNDER CAPITATED MANAGED CARE *	
	DGME	IME	DGME	IME
Alabama	**	**	**	**
Alaska	NO	YES	Capitated Managed Care Not Implemented	
Arizona	NO	YES	NO	YES
Arkansas	YES	NO	Capitated Managed Care Not Implemented	
California	Payments Do Not Distinguish Between DGME/IME		NO	NO
Colorado	YES	YES	YES	NO
Connecticut	YES	NO	GME Payments in MCO rates	
Delaware	YES	NO	NO	NO
District of Columbia	YES	YES	YES	NO
Florida	Payments Do Not Distinguish Between DGME/IME		NO	NO
Georgia	YES	NO	YES	NO
Hawaii	Payments Do Not Distinguish Between DGME/IME		GME Payments in MCO rates	
Idaho	YES	NO	Capitated Managed Care Not Implemented	
Illinois	NO	NO	NO	NO
Indiana	YES	NO	GME Payments in MCO rates	
Iowa	YES	YES	NO	NO
Kansas	YES	YES	GME Payments in MCO rates	
Kentucky	YES	YES	GME Payments in MCO rates	
Louisiana	YES	NO	Capitated Managed Care Not Implemented	
Maine	YES	NO	Capitated Managed Care Not Implemented	
Maryland	YES	YES	YES	YES
Massachusetts	NO	NO	NO	NO
Michigan	Payments Do Not Distinguish Between DGME/IME		GME Payments in MCO rates	
Minnesota	Payments Do Not Distinguish Between DGME/IME		Payments Do Not Distinguish Between DGME/IME	
Mississippi	YES	YES	Capitated Managed Care Not Implemented	
Missouri	Payments Do Not Distinguish Between DGME/IME		Payments Do Not Distinguish Between DGME/IME	
Montana	NO	NO	NO	NO
Nebraska	YES	YES	YES	YES
Nevada	Payments Do Not Distinguish Between DGME/IME		NO	NO
New Hampshire	YES	YES	Capitated Managed Care Not Implemented	
New Jersey	Payments Do Not Distinguish Between DGME/IME		GME Payments in MCO rates	
New Mexico	YES	YES	NO	NO
New York	YES	YES	YES	YES
North Carolina	YES	YES	Capitated Managed Care Not Implemented	
North Dakota	NO	NO	NO	NO
Ohio	YES	YES	GME Payments in MCO rates	
Oklahoma	YES	YES	YES	NO
Oregon	YES	YES	GME Payments in MCO rates	
Pennsylvania	YES	NO	NO	NO
Rhode Island	NO	NO	NO	NO
South Carolina	YES	YES	YES	YES
South Dakota	YES	NO	Capitated Managed Care Not Implemented	
Tennessee	No Fee-for-Service System		Payments Do Not Distinguish Between DGME/IME	
Texas	NO	NO	NO	NO

STATE	UNDER FEE-FOR-SERVICE		UNDER CAPITATED MANAGED CARE *	
	DGME	IME	DGME	IME
Utah	YES	YES	NO	NO
Vermont	NO	NO	NO	NO
Virginia	YES	YES	YES	YES
Washington	YES	YES	GME Payments in MCO rates	
West Virginia	YES	YES	NO	NO
Wisconsin	YES	NO	GME Payments in MCO rates	
Wyoming	NO	NO	NO	NO

* Capitated managed care is defined as Medicaid’s use of risk-based capitation payments, and does not include any payments made under a primary care case or disease management program.

** Alabama Medicaid did not respond to the survey.

Legend: DGME: Direct Graduate Medical Education
 IME: Indirect Medical Education
 MCO: Managed Care Organization

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

Table 2
METHODS FOR CALCULATING MEDICAID DIRECT AND INDIRECT
GME PAYMENTS UNDER FEE-FOR-SERVICE, 2009

STATE	Follow Medicare Methodology	Per-Resident Amount ¹	Lump Sum Amount ²	Other Method	Other Payments to Teaching Entities
Alabama **	**	**	**	**	**
Alaska			IME		
Arizona		IME ³			
Arkansas	DGME				
California				No Distinction Between DGME/IME ⁴	
Colorado	IME	DGME			
Connecticut	DGME				
Delaware		DGME			
District of Columbia	DGME/IME	DGME/IME ⁵			
Florida				No Distinction Between DGME/IME ⁶	X ⁷
Georgia	DGME				
Hawaii				No Distinction Between DGME/IME ⁸	
Idaho		DGME			
Illinois *	*	*	*	*	*
Indiana				DGME ⁹	
Iowa		DGME/IME			
Kansas	DGME/IME				
Kentucky		DGME/IME			
Louisiana				DGME ¹⁰	X ¹¹
Maine	DGME				
Maryland		DGME/IME			
Massachusetts *	*	*	*	*	*
Michigan		No Distinction Between DGME/IME ¹²			
Minnesota				No Distinction Between DGME/IME ¹³	
Mississippi				DGME/IME ¹⁴	
Missouri			No Distinction Between DGME/IME		
Montana *	*	*	*	*	*
Nebraska	IME	DGME			
Nevada				No Distinction Between DGME/IME ¹⁵	

STATE	Follow Medicare Methodology	Per-Resident Amount ¹	Lump Sum Amount ²	Other Method	Other Payments to Teaching Entities
New Hampshire	IME			DGME ¹⁶	
New Jersey		No Distinction Between DGME/IME			
New Mexico	IME ¹⁷	DGME ¹⁸			
New York	IME ¹⁹			DGME ²⁰	
North Carolina	DGME/IME				
North Dakota *	*	*	*	*	*
Ohio	DGME/IME ²¹				
Oklahoma		IME		DGME ²²	
Oregon	DGME/IME				X ²³
Pennsylvania				DGME ²⁴	
Rhode Island *	*	*	*	*	*
South Carolina				DGME/IME ²⁵	
South Dakota			DGME		
Tennessee *	*	*	*	*	*
Texas *	*	*	*	*	*
Utah		DGME		IME ²⁶	
Vermont *	*	*	*	*	*
Virginia	IME	DGME ²⁷			
Washington				DGME/IME ²⁸	
West Virginia	DGME/IME ²⁹				
Wisconsin				DGME ³⁰	
Wyoming *	*	*	*	*	*
TOTAL # OF STATES	16	15	3	16	3

* The Medicaid agency does not pay for graduate medical education under its fee-for-service program.

** Alabama Medicaid did not respond to the survey.

Legend: DGME: Direct Graduate Medical Education
IME: Indirect Medical Education

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

¹ Per-resident amount based on the teaching hospital's share of total Medicaid revenues, costs or patient volume.

² Lump sum (not per-resident) amount based on the teaching hospital's share of total Medicaid revenues, costs or patient volume.

³ Following Arizona's elimination of DGME payments to teaching hospitals in 2009, three teaching hospitals continue to receive IME payments through Medicaid's intergovernmental transfer (IGT) funding mechanism.

⁴ Through an 1115 federal waiver, California has a hospital contracting program with GME being one type of supplemental payment based on negotiations with eligible contract hospitals and the California Medical Assistance Commission.

⁵ For cost-based hospitals.

⁶ In Florida, GME payments to teaching hospitals are exempt from any ceiling limitations and payments are allocated based on total Medicaid costs divided by total Medicaid days. DGME/IME costs are allowable as part of total costs.

⁷ Hospitals designated by the state as teaching hospitals and Medicaid disproportionate share hospitals (DSH) receive special quarterly GME payments based on annual legislative appropriations under Florida's DSH program.

⁸ In Hawaii, allowable inpatient DGME/IME costs in the base period are divided by total allowable Medicaid inpatient costs and the result is added to 1.0 to obtain the medical education adjustment factor to be included in the prospective payment rate.

- ⁹ In Indiana, per diem medical education costs are calculated by dividing routine and ancillary medical education costs by total patient days.
- ¹⁰ In Louisiana, private teaching hospitals receive a hospital-specific per diem amount. State hospitals are reimbursed actual Medicaid program costs.
- ¹¹ GME costs are included in cost-to-charge ratios used to calculate uninsured cost in private hospitals and then private teaching hospitals are paid a percentage of the uninsured cost.
- ¹² Michigan pays GME from 2 funding pools. In pool 1, a hospital's GME share is based on its portion total adjusted FTSs (FTEs x casemix x Medicaid utilization). In pool 2, a hospital's share is based on its portion of total adjusted FTEs (FTEs x Medicaid outpatient charges divided by total charges).
- ¹³ In Minnesota, GME payments are included in hospital-specific DRG rates that convert Medicaid claims to cost using the hospital's Medicare cost report. GME payments are also paid to training sites by MERC (Medical Education and Trust Fund) as an annual lump-sum supplemental payment based on Medicaid volume. Clinical training sites report to MERC their trainee and faculty costs.
- ¹⁴ In Mississippi, payments are a per patient per day amount which is a separate component of the rate.
- ¹⁵ In Nevada, Medicaid makes a quarterly "supplemental payment" directly to the University of Nevada School of Medicine based on claims submitted by the "practice plans" operated by medical school. The payment is calculated as follows: Sum of Medicaid services paid for during the quarter x Medicare rate of reimbursement - Medicaid services paid for during the quarter x Medicaid base rate.
- ¹⁶ In New Hampshire, the lump sum payment for DGME is based on a proportionate share of a fixed budgeted amount. Payments are suspended for fiscal years 2010 and 2011.
- ¹⁷ In New Mexico, IME payments follow Medicare methodology except that outlier payments are included in the formula.
- ¹⁸ In New Mexico, DGME payments are a per-resident and a per-resident category amount with an annual upper limit.
- ¹⁹ In New York, IME costs are based on a modified Medicare methodology using 2001 costs adjusted for inflation, 2001 resident & bed counts, and statutorily enacted changes.
- ²⁰ In New York, DGME costs are based on 2001 hospital-specific costs inflated to current payment year and enhanced to accommodate state statutorily enacted changes.
- ²¹ In Ohio, DGME/IME payments are part of a series of formulas used to pay hospitals on a prospective basis and is similar to the Medicare GME calculation.
- ²² In Oklahoma, a pool of funds is allocated by weighted (by days and acuity of service) resident months.
- ²³ In Oregon, major teaching hospitals (those with more than 200 residents or interns) are eligible to receive additional quarterly DGME/IME payments not to exceed those limits as determined by using Medicare reimbursement principles (the upper payment limit). These payments are intended to compensate those teaching hospitals not able to capture GME costs when contracting with Medicaid managed care plans.
- ²⁴ In Pennsylvania, eligible providers receive a percentage of funds allocated for GME payments. Payments were originally based on costs, and hospitals now agree to inflation adjustments via hospital rate agreements.
- ²⁵ In South Carolina, DGME/IME costs are Medicaid's portion of cost as an estimated add-on and cost settled through the cost report.
- ²⁶ In Utah, IME payments are based on several factors including availability of funds under the upper payment limit.
- ²⁷ In Virginia, the per-resident amount is based on Medicaid cost in a base year, adjusted for inflation to current year.
- ²⁸ In Washington, IME payments are based on costs within DRG rates (the DRG conversion factor). DGME payments are based on costs within DRG rates as well as on a per diem/per case rate and a ratio of costs to charges for services exempt from the DRG payment method such as outpatient services.
- ²⁹ In West Virginia, a modified Medicare payment methodology is used.
- ³⁰ In Wisconsin, DGME costs are a percentage add-on to the hospital rate based on the ratio of DGME costs to total hospital operating costs.

Table 3
METHODS FOR DISTRIBUTING MEDICAID DIRECT AND INDIRECT
GME PAYMENTS UNDER FEE-FOR-SERVICE, 2009

STATE	As Part of Hospital's Per-Case or Per-Diem Rate	As a Separate Direct Payment
Alabama **	**	**
Alaska	IME	
Arizona		IME
Arkansas ¹	DGME	DGME
California		No Distinction Between DGME/IME
Colorado	DGME/IME	
Connecticut	DGME	
Delaware	DGME	
District of Columbia	DGME/IME	
Florida	No Distinction Between DGME/IME	
Georgia	DGME	No Distinction Between DGME/IME
Hawaii	No Distinction Between DGME/IME	
Idaho	DGME	
Illinois *	*	*
Indiana	DGME	
Iowa		DGME/IME
Kansas ²	DGME/IME	DGME/IME
Kentucky	IME	DGME
Louisiana	DGME	
Maine		DGME
Maryland		DGME/IME
Massachusetts *	*	*
Michigan		No Distinction Between DGME/IME
Minnesota	No Distinction Between DGME/IME	No Distinction Between DGME/IME ³
Mississippi	DGME/IME	
Missouri		No Distinction Between DGME/IME
Montana *	*	*
Nebraska	DGME/IME	
Nevada		No Distinction Between DGME/IME
New Hampshire	IME	DGME ⁴
New Jersey		No Distinction Between DGME/IME ⁵
New Mexico		DGME/IME
New York	DGME/IME	
North Carolina	DGME/IME	
North Dakota *	*	*
Ohio	DGME/IME	
Oklahoma		DGME/IME
Oregon		DGME/IME
Pennsylvania		DGME
Rhode Island *	*	*
South Carolina	DGME/IME	
South Dakota		DGME
Tennessee *	*	*
Texas *	*	*

STATE	As Part of Hospital's Per-Case or Per-Diem Rate	As a Separate Direct Payment
Utah		DGME/IME
Vermont *	*	*
Virginia		DGME/IME
Washington	DGME/IME	
West Virginia	IME	DGME
Wisconsin	DGME	
Wyoming *	*	*
TOTAL # OF STATES	25	23

* The Medicaid agency does not pay for graduate medical education under its fee-for-service program.

** Alabama Medicaid did not respond to the survey.

Legend: DGME: Direct Graduate Medical Education
 IME: Indirect Medical Education

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

¹ In Arkansas, DGME payments are distributed as part of a per-diem rate to community hospitals and as a separate direct payment to the state's academic health centers.

² In Kansas, DGME/IME payments to public teaching hospitals are paid as part of the hospital per-diem rate; all other hospitals receive a supplemental quarterly payment for DGME/IME.

³ Minnesota's Medical Education and Trust Fund (MERC) also pays for GME as an annual lump-sum supplemental payment to training sites based on Medicaid volume.

⁴ In New Hampshire, the lump sum payment for DGME is based on a proportionate share of a fixed budgeted amount. Payments are suspended for fiscal years 2010 and 2011.

⁵ In New Jersey, GME payment amounts are distributed through a state subsidy approved through the New Jersey Appropriations Act. It is paid out on a monthly basis to eligible acute care teaching hospitals.

Table 4
STATES MAKING MEDICAID DIRECT AND INDIRECT GME PAYMENTS
DIRECTLY TO TEACHING PROGRAMS UNDER MANAGED CARE, 2009

STATE	Rationale for Making Medicaid DGME/IME Payments Directly (Carve-Out) to Teaching Programs
Arizona	Desire to use Medicaid funds to advance state policy goals
Colorado	Follow Medicare to make DGME/IME payments to teaching hospitals for Medicare managed care enrollees; Concern from teaching hospitals about losing GME payments; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
District of Columbia	Follow Medicare to make DGME/IME payments to teaching hospitals for Medicare managed care enrollees
Georgia	GME seen as a public good; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Maryland	Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Desire to use Medicaid funds to advance state policy goals; Promote training of primary care physicians
Minnesota	GME seen as a public good; Follow Medicare to make DGME/IME payments to teaching hospitals for Medicare managed care enrollees; Concern from teaching hospitals about losing GME payments; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Missouri	GME seen as public good; Follow Medicare to make DGME/IME payments to teaching hospitals for Medicare managed care enrollees; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Nebraska	Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
New York	Concern from teaching hospitals about losing GME payments; GME seen as public good; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Oklahoma	GME seen as public good; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
South Carolina	GME seen as public good
Tennessee	GME seen as public good; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Virginia	Concern from teaching hospitals about losing GME payments

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

Table 5
METHODS FOR CALCULATING MEDICAID DIRECT AND INDIRECT
GME PAYMENTS MADE DIRECTLY TO TEACHING PROGRAMS
UNDER MANAGED CARE, 2009

STATE	Follow Medicare FFS Methodology	Lump Sum Amount ¹	Per-Medicare Discharge Amount	Other Method
Arizona		IME		
Colorado		DGME		
District of Columbia	DGME			
Georgia	DGME			
Maryland				DGME/IME ²
Minnesota				No Distinction Between DGME/IME ³
Missouri		No Distinction Between DGME/IME		
Nebraska		IME	DGME	
New York	IME			DGME ⁴
Oklahoma				DGME ⁵
South Carolina			DGME/IME ⁶	
Tennessee				No Distinction Between DGME/IME ⁷
Virginia			IME	DGME ⁸

Legend: DGME: Direct Graduate Medical Education
IME: Indirect Medical Education

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

¹ Lump sum (not per-resident) amount based on teaching site's share of total Medicaid revenues or patient volume.

² Hospital rates are set by the Health Services Cost Review Commission which includes DGME/IME costs in rates paid by all payers including Medicaid. DGME/IME costs are trended from 1995.

³ GME payments are part of a pool (MERC trust fund) for which teaching facilities can apply for an annual basis. Payments are based on Medicaid volume and number of trainees.

⁴ DGME costs are based on 2001 hospital-specific costs inflated to current payment year and enhanced to accommodate state statutorily enacted changes.

⁵ DGME payments are paid directly to medical schools as a per-resident amount weighted for specialty services rendered by a physician contracted or employed by the medical schools.

⁶ DGME/IME payments are based on what Medicaid would have paid for the GME claim add-on payment under fee-for-service.

⁷ GME payments are distributed quarterly based on the number of primary care residents in proportion to the total number of residents in training at the state's four (4) medical schools. A fixed amount of money is divided proportionately among the four medical schools.

⁸ DGME payments are a per-resident amount based on teaching site's share of total Medicaid revenues.

Table 6
STATES RECOGNIZING AND INCLUDING
MEDICAID DIRECT AND INDIRECT GME PAYMENTS
IN CAPITATION RATES TO MANAGED CARE ORGANIZATIONS, 2009

STATE	Medicaid <u>Requires</u> MCOs to Distribute DGME and/or IME Payments to Teaching Hospitals	Medicaid <u>Assumes</u> MCOs Distribute DGME and/or IME Payments to Teaching Hospitals
Connecticut	X	
Hawaii		X
Indiana		X
Kansas	X	
Kentucky	X	
Michigan		X
New Jersey		X
Ohio		X
Oregon ¹	X	
Washington	X	
Wisconsin		X

MCOs = Managed Care Organizations

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

¹ Effective January 1, 2010, capitation rates in Oregon will include reimbursement to teaching hospitals for GME as a separately identified component. Managed care plans will be directed by the state as to how much each plan is to pay each hospital, based on the amount of GME built into the plan's capitation rate.

Table 7
REASONS BY STATES FOR NOT MAKING MEDICAID
DIRECT AND INDIRECT GME PAYMENTS
UNDER CAPITATED MANAGED CARE*, 2009

STATE *	Rationale for <u>Not</u> Making DGME and/or IME Payments Under Capitated Managed Care
California	Medicaid payment for DGME and/or IME under managed care is not necessary or appropriate
Delaware	Difficulty determining methodology to pay for GME under managed care
Florida	Medicaid payment for DGME and/or IME under managed care is not necessary or appropriate
Iowa	An amount was added to fee-for-service DGME and/or IME payments to compensate for excluding payment of GME costs under capitated managed care.
Nevada	Medicaid payment for GME under managed care is not necessary or appropriate; GME payments under managed care are not a pressing policy issue among many competing issues
New Mexico	Medicaid payment for GME under managed care is not necessary or appropriate; GME payments under managed care are not a pressing policy issue among many competing issues. An amount was added to fee-for-service GME payments to compensate for no longer including payment of GME costs under capitated managed care.
Pennsylvania	An amount was added to fee-for-service GME payments to compensate for no longer including payment of GME costs under capitated managed care.
Utah	The Medicaid managed care program only became effective September 2009. GME payment under fee-for-service accounts for needs of entire state.
West Virginia	**

* Only states that at least make Medicaid DGME payments directly to teaching programs under their fee-for-service programs **and** have implemented a capitated managed care program are included.

** State did not report a rationale for not making DGME and/or IME payments under capitated managed care.

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

Table 8

**HEALTH PROFESSIONS ELIGIBLE
FOR MEDICAID DIRECT AND INDIRECT GME PAYMENTS, 2009**

STATE	Medical Residents	Graduate Nurses	Other Professions
Alaska	X		
Arizona	X		
Arkansas	X		
California	X		
Colorado	X	X	
Connecticut	X		
Delaware	X		
District of Columbia	X		
Florida	X	**	**
Georgia	X		
Hawaii	X		
Idaho	X		
Indiana	X	X	X
Iowa	X	X	X
Kansas	X		
Kentucky	X		
Louisiana	X	X	X
Maine	X		
Maryland	X		
Michigan	X		
Minnesota	X	X	X ¹
Mississippi	X	X	
Missouri	X		
Nebraska	X		
Nevada	X	X	
New Hampshire	X		
New Jersey	X		
New Mexico	X ²		
New York	X		
North Carolina	X		
Ohio	X		X
Oklahoma	X		
Oregon	X	X	
Pennsylvania	X	X	
South Carolina	X	X	X ³
South Dakota	X		
Tennessee	X		
Utah	X		
Virginia	X	X	X
Washington	X		
West Virginia	X		
Wisconsin	X	X	X

** Medicaid does not specify which of these professions are eligible for DGME and/or IME payments.

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

¹ In Minnesota, all approved training programs are eligible for DGME and/or IME payments under managed care. Approved professions other than medical residents and advanced practice nurses who are eligible for DGME and/or IME payments under managed care include: medical students, dental students and residents, doctors of pharmacy students and residents, physician assistants and chiropractic students.

² In New Mexico, physician residents approved for GME payment in primary care and obstetrics specialties as well as residents participating in a designated rural residency program receive a higher annual per-resident payment amount than other approved physician residents.

³ In South Carolina, all approved professions are eligible for DGME and/or IME payments under managed care.

Table 9
STATES LINKING MEDICAID DIRECT AND INDIRECT
GME PAYMENTS TO STATE POLICY GOALS, 2009

STATE	State Policy Goal(s) That Apply To Medicaid DGME and/or IME Payments	Applicable to Fee-for-Service or Managed Care?
Alaska	<ul style="list-style-type: none"> • Encourage training in certain specialties (e.g., primary care); • Encourage training in certain settings (e.g., ambulatory sites, rural locations, medically underserved communities) • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health care workforce 	Fee-for-Service
Arizona	<ul style="list-style-type: none"> • Increase the supply of health professionals serving Medicaid beneficiaries 	Both
Florida	<ul style="list-style-type: none"> • Encourage training in certain specialties (e.g., primary care); • Encourage training in certain settings (e.g., ambulatory sites, rural locations, medically underserved communities) 	Fee-for-Service
Kansas	<ul style="list-style-type: none"> • Encourage training in certain specialties (e.g., primary care); • Encourage training in certain settings (e.g., ambulatory sites, rural locations, medically underserved communities); • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health workforce • Help fund teaching programs that have experienced Medicare GME cuts 	Both
Maryland	<ul style="list-style-type: none"> • Encourage training in certain specialties (e.g., primary care) and pharmacy care; • Increase the supply of health professionals serving Medicaid beneficiaries 	Both
Michigan	<ul style="list-style-type: none"> • Encourage training in certain specialties (e.g., primary care); • Encourage training in certain settings (e.g., ambulatory sites, rural locations, medically underserved communities); • Increase the supply of health professionals serving Medicaid beneficiaries • Improve the geographic distribution of the health workforce. 	Both
New York	Encourage training in certain specialties/professions -- such as those in short supply.	Both
Tennessee	<ul style="list-style-type: none"> • Encourage training in certain specialties (e.g., primary care); • Encourage training in certain settings (e.g., ambulatory sites, rural locations, medically underserved communities); • Improve the geographic distribution of the health workforce; • Increase the supply of health professionals serving Medicaid beneficiaries 	Managed Care
Utah	<ul style="list-style-type: none"> • Encourage training in certain specialties such as those in short supply; • Encourage training in certain settings (e.g., ambulatory sites, rural locations, medically underserved communities); • Improve the geographic distribution of the health workforce; • Increase the supply of health professionals serving Medicaid beneficiaries 	Fee-for-Service
West Virginia	Encourage training in certain specialties/professions -- such as those in short supply	Fee-for-Service

SOURCE: From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

Table 10
MEDICAID DIRECT AND INDIRECT GME PAYMENT AMOUNTS, 2009¹

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 ² (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 ³	Explicit Payments ⁴				
-----	-----			-----	-----	-----	-----
Alabama **	**	**	**	**	**	**	**
Alaska	\$0.5	\$0	\$0	\$0.5	\$0.5	< 0.1	42
Arizona	Unreported	\$0	Unreported	\$42.4	\$42.4	Unreported	19
Arkansas	\$11.0	\$0	\$0	\$11.0	\$11.0	Unreported	32
California	\$187.3	\$0	\$0	\$187.3	\$187.3	5.0	2
Colorado	Unreported	\$0	Unreported	\$5.1	\$5.1	Unreported	34
Connecticut	\$8.0	\$6.6	\$0	\$8.0	\$14.6	4.6	30
Delaware	\$3.03	\$0	\$0	\$3.03	\$3.03	4.6	39
District of Columbia	\$54.1	\$0	\$5.5	\$59.6	\$59.6	16.5	16
Florida ⁵	<u>\$145.2</u>	\$0	\$0	<u>\$145.2</u>	\$145.2	Unreported	5
Georgia	\$76.2	\$0	\$13.4	\$89.6	\$89.6	Unreported	12
Hawaii	Unreported	Unreported	\$0	Unreported	\$0.87	< 0.1	41
Idaho	\$1.2	\$0	\$0	\$1.2	\$1.2	< 0.1	40
Illinois * ⁶	*	*	*	*	*	*	*
Indiana	\$15	Unreported	\$0	\$15	\$27.6	4.2	26
Iowa	\$26.7	\$0	\$0	\$26.7	\$26.7	9.0	27
Kansas	\$18.2	\$1.8	\$0	\$18.2	\$20.0	4.5	28
Kentucky	\$6.5	\$30.0	\$0	\$6.5	\$36.5	4.0	24
Louisiana	\$42.3	\$0	\$0	\$42.3	\$42.3	4.2	20
Maine	\$4.1	\$0	\$0	\$4.1	\$4.1	1.8	36
Maryland	Unreported	\$0	Unreported	\$40.5	\$40.5	6.0	21
Massachusetts *	*	*	*	*	*	*	*
Michigan	\$69.0	\$100.0	\$0	\$69.0	\$169.0	7.8	3
Minnesota	\$45.5	\$0	\$109.1	\$154.6	\$154.6	Unreported	4
Mississippi	\$30.9	\$0	\$0	\$30.9	\$30.9	2.8	25
Missouri	\$65.8	\$0	\$49.5	\$115.3	\$115.3	22.0	7
Montana *	*	*	*	*	*	*	*
Nebraska	\$14.0	\$0	\$0.8	\$14.8	\$14.8	7.8	29
Nevada	\$3.3	\$0	\$0	\$3.3	\$3.3	< 0.1	38
New Hampshire	\$4.4	\$0	\$0	\$4.4	\$4.4	6.9	35
New Jersey	\$60.0	Unreported	\$0	\$60.0	\$110.5	Unreported	9
New Mexico	\$7.8	\$0	\$0	\$7.8	\$7.8	2.0	33
New York	\$802	\$0	\$723	\$1,525.0	\$1,525.0	20.0	1
North Carolina	\$99.1	\$0	\$0	\$99.1	\$99.1	10.5	11
North Dakota *	*	*	*	*	*	*	*
Ohio	Unreported	Unreported	\$0	Unreported	\$69.4	Unreported	15
Oklahoma	\$44.0	\$0	\$62.5	\$106.5	\$106.5	6.25	10
Oregon	\$31.4	Unreported	\$0	\$31.4	\$57.9	Unreported	17
Pennsylvania	\$81.9	\$0	\$0	\$81.9	\$81.9	7.9	14

Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey

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 ² (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 ³	Explicit Payments ⁴				
-----	-----	Implicit Payments ³	Explicit Payments ⁴	-----	-----	-----	-----
Rhode Island *	*	*	*	*	*	*	*
South Carolina	\$72.7	\$0	\$14.3	\$87.0	\$87.0	11.0	13
South Dakota	\$3.7	\$0	\$0	\$3.7	\$3.7	3.2	37
Tennessee	\$0	\$0	\$48.0	\$48.0	\$48.0	Unreported	18
Texas *	*	*	*	*	*	*	*
Utah	\$40.0	\$0	\$0	\$40.0	\$40.0	12.8	23
Vermont *	*	*	*	*	*	*	*
Virginia	\$96.6	\$0	\$29.3	\$125.9	\$125.9	16.4	6
Washington	\$64.1	\$48.0	\$0	\$64.1	\$112.1	Unreported	8
West Virginia	\$11.7	\$0	\$0	\$11.7	\$11.7	4.0	31
Wisconsin ⁷	\$18.1	\$22.0	\$0	\$40.1	\$40.1	Unreported	22
Wyoming *	*	*	*	*	*	*	*
TOTALS OR AVERAGE	***	***	***	***	\$ 3.78 billion⁸	6.6%	***

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

** Alabama Medicaid did not respond to the survey.

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

NOTES:

- **Arizona, Colorado, Hawaii and Maryland** reported a total DGME and/or /IME payment amount but provided no specific breakdown amounts for FFS and/or managed care DGME/IME payments.
- **Indiana, New Jersey and Oregon** reported making DGME/IME payments under both their FFS and managed care programs, but did not report the amount paid under managed care, and, accordingly, a total amount paid under FFS and managed care. For these states, an estimate of total DGME/IME payments was made. Underlined amounts are the consultant’s estimates in lieu of unreported data. Assumptions used by the consultant in making these estimates are: A proportion of DGME/IME payments made under FFS for the 15 states that reported DGME/IME payments under both FFS and managed care to the total DGME/IME payments for these states was calculated. The FFS DGME/IME payment amount reported for Indiana, New Jersey and Oregon was divided by this proportion—54 percent—to arrive at an estimate of total DGME/IME payments in each of these states. The estimate of total GME payments for these states includes the 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.
- **Florida** did not report the DGME/IME payment amount the state makes under its FFS program. To estimate the amount of FFS DGME/IME payments for Florida, the consultant used the DGME/IME payment amount the state Medicaid agency reported in 2008 in response to a request from the U.S. Congress to know the impact to the state of a proposed rule that would end federal Medicaid funding for GME, which is \$75 million (*House of Representatives Committee on Government Oversight and Reform. “The Administration’s Medicaid Regulations: State by State Impacts.” March 2008*). The estimate of total DGME/IME payments in this table includes the special payments for DGME/IME that Florida Medicaid makes under its disproportionate share hospital program (\$70.2 million), which was reported.
- **Ohio** did not report the DGME/IME payment amounts the state makes under its FFS and managed care programs. The estimate of total DGME/IME payments for Ohio is based on the state’s total Medicaid inpatient hospital expenditures, which the state did report. A proportion of total DGME/IME payments for the states that reported such payments to the total Medicaid inpatient hospital expenditures reported by these states was calculated. This proportion—6.6 percent—was multiplied by the total Medicaid inpatient hospital expenditure amount for Ohio (\$1,044.5 million) to arrive at an estimate of total DGME/IME payments in the state.

SOURCE: From a 2009 survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

¹ The start and end date for each state’s fiscal year varies. Not all states were able to report payment amounts for fiscal year 2009. States reporting payment amounts for 2008 include Colorado, Delaware, Indiana, Minnesota, Nebraska, North Carolina, Pennsylvania, Virginia and Washington. The District of Columbia, Georgia, and New York reported payment amounts for 2007. Connecticut reported payment amounts for 2006. Payment amounts for Wisconsin are projections for 2010.

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

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

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

⁵ The GME amount in Florida includes the estimate of hospital per-diem payments under fee-for-service (\$75 million), as well as the reported special payments for GME made under the disproportionate share hospital program (\$70.2 million in 2008-09).

⁶ Although Illinois Medicaid ceased making GME payments to all teaching hospitals in 1995, it continues to provide a separate annual subsidy to ten teaching hospitals associated with GME. (Personal communication with J. Holler of Illinois Medicaid, September 2009.)

⁷ Wisconsin Medicaid did not respond to the AAMC survey. However, corresponding survey data was collected by the Wisconsin Hospital Association (WHA) from Wisconsin Medicaid and shared with the consultant for this report. (Personal communications with G. Quinn of WHA, November 2009.)

⁸ The national amount does not precisely reflect the total of individual state amounts due to rounding.

Table 11
MEDICAID DIRECT AND INDIRECT GME PAYMENT AMOUNTS
BY THE TOP 15 STATES, 2009¹

STATE	Total DGME/IME Payments Under Fee-for-Service and Managed Care (Millions of Dollars)	DGME/IME Payments Under Managed Care (Millions of Dollars)	
		Implicit Payments ²	Explicit Payments ³
New York	\$1,525.0	\$0	\$723
California	\$187.3	\$0	\$0
Michigan	\$169.0	\$100	\$0
Minnesota	\$154.6	\$0	\$109.1
Florida	\$145.2	\$0	\$0
Virginia	\$125.9	\$0	\$29.3
Missouri	\$115.3	\$0	\$49.5
Washington	\$112.1	\$48	\$0
New Jersey	\$110.5	Unreported	\$0
Oklahoma	\$106.5	\$0	\$62.5
North Carolina	\$99.1	*	*
Georgia	\$89.6	\$0	\$13.4
South Carolina	\$87.0	\$0	\$14.3
Pennsylvania	\$81.9	\$0	\$0
Ohio	\$69.4	Unreported	\$0

* State does not operate a capitated Medicaid managed care program.

NOTES:

- **Florida** did not report the DGME/IME payment amount the state makes under its FFS program. To estimate the amount of FFS DGME/IME payments for Florida, the consultant used the DGME/IME payment amount the state Medicaid agency reported in 2008 in response to a request from the U.S. Congress to know the impact to the state of a proposed rule that would end federal Medicaid funding for GME (*House of Representatives Committee on Government Oversight and Reform. "The Administration's Medicaid Regulations: State by State Impacts." March 2008*). The estimate of total DGME/IME payments in this table includes the special payments for DGME/IME that Florida Medicaid makes under its disproportionate share hospital program, which was reported.
- **New Jersey** reported making DGME/IME payments under both their FFS and managed care programs, but did not report the amount paid under managed care, and, accordingly, a total amount paid under FFS and managed care. For this state, an estimate of total DGME/IME payments was made. Underlined amounts are the consultant's estimates in lieu of unreported data. Assumptions used by the consultant in making this estimate are:
A proportion of DGME/IME payments made under FFS for the 15 states that reported DGME/IME payments under both FFS and managed care to the total DGME/IME payments for these states was calculated. The FFS DGME/IME payment amount reported for New Jersey was divided by this proportion—54 percent—to arrive at an estimate of total DGME/IME payments. The estimate of total GME payments for this state includes the 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.
- **Ohio** did not report the DGME/IME payment amounts the state makes under its FFS and managed care programs. The estimate of total DGME/IME payments for Ohio is based on the state's total Medicaid inpatient hospital expenditures, which the state did report. A proportion of total DGME/IME payments for the states that reported such payments to the total Medicaid inpatient hospital expenditures reported by these states was calculated. This proportion—6.6 percent—was multiplied by the total Medicaid inpatient hospital expenditure amount for Ohio (\$1,044.5 million) to arrive at an estimate of total DGME/IME payments in the state.

SOURCE: From a 2009 survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

¹ The start and end date for each state's fiscal year varies. Not all states were able to report payment amounts for fiscal year 2009. States reporting payment amounts for 2008 include Minnesota, North Carolina, Pennsylvania, Virginia and Washington. Georgia and New York reported payment amounts for 2007.

² Implicit DGME/IME payments are those recognized and included in capitation rates to managed care organizations.

³ Explicit DGME/IME payments are those made directly to the teaching programs under managed care.

Table 12
STATE MEDICAID DIRECT AND INDIRECT GME PAYMENTS
IN STATES WITH THE LARGEST NUMBER OF TEACHING* HOSPITALS, 2009

STATE	Number of Teaching Hospitals**	Provide DGME and/or IME Payments	Total Medicaid DGME and/or IME Payments (Millions of Dollars)	Average Medicaid DGME and/or IME Payments Per Hospital (Millions of Dollars) **	Total Medicaid DGME and/or IME Payments: % of Inpatient Hospital Expenditures	Medicaid DGME and/or IME Payment Rank
California	123	Yes	\$187.3	\$1.52	5.0	2
New York	108	Yes	\$1,525	\$14.12	20.0	1
Florida	70	Yes	<u>\$145.2</u>	\$2.07	Unreported	5
Pennsylvania	64	Yes	\$81.9	\$1.28	7.9	14
Ohio	56	Yes	<u>\$69.4</u>	\$1.24	Unreported	16
Illinois	50	No	\$0	\$0	0	--
Michigan	44	Yes	\$169	\$3.84	7.8	3
Texas	36	No	\$0	\$0	0	--
New Jersey	33	Yes	<u>\$110.5</u>	\$3.35	Unreported	9
Massachusetts	29	No	\$0	\$0	0	--

* Teaching is defined as hospitals with residency training approval by the Accreditation Council for Graduate Medical Education, a medical school affiliation reported to the American Medical Association, membership in the Council of Teaching Hospitals (COH), an internship or residency approved by the American Osteopathic Association, or reported full-time equivalent (FTE) medical and dental residents and interns. Hospitals with less than five (5) FTE medical and dental residents and interns were excluded.

** Not all teaching hospitals in each state may receive Medicaid DGME and/or IME payments.

NOTE: Underlined amounts are the consultant's estimates in lieu of unreported data.

SOURCES: American Hospital Association data, 2008.

From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

Table 13
STATE MEDICAID DIRECT AND INDIRECT GME PAYMENTS
IN STATES WITH THE LARGEST NUMBER OF MEDICAL RESIDENTS, 2009

STATE	Number of Medical Residents	Provide DGME and/or IME Payments	Total Medicaid DGME and/or IME Payments (Millions of Dollars)	Medicaid DGME and/or IME Payment Rank
New York	15,584	Yes	\$1,525	1
California	9,284	Yes	\$187.3	2
Pennsylvania	7,242	Yes	\$81.9	14
Texas	6,846	No	\$0	--
Illinois	5,745	No	\$0	--
Ohio	5,318	Yes	<u>\$69.4</u>	16
Massachusetts	5,181	No	\$0	--
Michigan	4,514	Yes	\$169	3
Florida	3,279	Yes	<u>\$145.2</u>	5
North Carolina	2,862	Yes	\$99.1	11

NOTE: Underlined amounts are the consultant's estimates in lieu of unreported data.

SOURCES: *Journal of the American Medical Association* (Vol. 302, No.12), September 2009.

From a survey of state Medicaid agencies by Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges.

Table 14
TRENDS IN STATE MEDICAID
DIRECT AND INDIRECT GME PAYMENTS, 1998-2009

INDICATOR	2009	2005	2002	1998
Number of States and DC Making DGME <i>and/or</i> IME Payments	42 ¹	48	48	46
Number of States and DC Making <i>Both</i> DGME and IME Payments	20	22	25	24
Number of States and DC Making DGME/IME Payments Under Fee for Service	41	47	47	44
Number of States and DC Making DGME/IME Payments Explicitly and Directly to Teaching Hospitals Under Capitated Managed Care	13	15	18	17
Number of States and DC Recognizing and Including DGME/IME Payments in the Capitated Payment Rates to Managed Care Organizations	11	10	10	17
Number of States and DC Directly Linking DGME/IME Payments to State Policy Goals Intended to Vary the Distribution of the Physician Workforce	10	11	10	10
Number of States and DC with Explicit Limits on Medicaid DGME/IME Payments	13	16	15	9
Medicaid DGME/IME Payments as a Percentage of Total Medicaid Inpatient Hospital Expenditures	6.6%	7.0%	8-9%	7-8%

SOURCES:

From a survey of state Medicaid agencies by 1) Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges in 2009 and 2006, and 2) the National Conference of State Legislatures for the Association of American Medical Colleges in 2003 and 1999.

¹ Alabama Medicaid did not respond to the survey.



MEDICAID PAYMENT POLICY: GRADUATE MEDICAL EDUCATION

State: _____ Date Completed Survey: _____ Respondent: _____ Phone #: _____

FEE-FOR-SERVICE SYSTEM

1. Under your state’s Medicaid fee-for-service (FFS) system, does your state pay hospitals (or other entities that incur teaching costs) for graduate medical education (GME), or otherwise provide explicit added payments to these hospitals or other teaching entities?

- YES (Answer 1a)
- NO (Answer 1b)
- PRESENTLY, WE DON’T OPERATE A FFS SYSTEM (If you answered this response, proceed to Question 5.)

- a. If YES, describe the official rationale for making these GME payments: (Check all that apply)
- GME seen as a public good;
 - Follow Medicare’s decision to make explicit GME payments to teaching hospitals for Medicare beneficiaries;
 - Desire to use Medicaid funds to advance state policy goals;
 - Desire to help train the next generation of physicians who will serve Medicaid beneficiaries;
 - Other (Describe: _____)
- b. If NO, describe the official rationale for not making GME payments: (Check all that apply)
- Medicaid payment for GME is not necessary or appropriate;
 - GME payments are not a pressing policy issue among many competing issues;
 - Medicaid used to pay for GME, but budget shortfalls or cost controls have necessitated ending payments;
 - Other (Describe: _____)

If you answered Question 1b., proceed to Question 5.

2. What institutions are eligible to receive GME payments?

- (Check all that apply)
- Teaching hospitals;
 - Teaching sites in non-hospital patient care settings (such as ambulatory sites, managed care plans, etc.);
 - Medical schools;
 - Other institutions (Specify: _____)

3. Does your state’s Medicaid FFS system provide teaching hospitals (or other entities that incur teaching costs):

- (Check all that apply)
- a. **Payments for Direct GME Costs** (Costs such as resident stipends, teaching faculty salaries.)
- 1): If so, how are they calculated?
- Follow Medicare methodology;
 - Per-resident amount based on teaching site’s share of total Medicaid revenues or patient volume;
 - Lump sum (not per-resident) amount based on teaching site’s share of total Medicaid revenues or patient volume;
 - Other (Specify: _____)
- 2): If so, how are they distributed?
- As part of the hospital’s per-case or per-diem rate;
 - As a separate direct payment (monthly, quarterly, etc.);
 - Other (Specify: _____)

b. Payments for Indirect GME Costs (Higher inpatient costs related to presence of teaching program.)

1): *If so, how are they calculated?*

- Follow Medicare methodology;
- Per-resident amount based on teaching site's share of total Medicaid revenues or patient volume;
- Lump sum (not per-resident) amount based on teaching site's share of total Medicaid revenues or patient volume;
- Other (Specify: _____)

2): *If so, how are they distributed?*

- As part of the hospital's per-case or per-diem rate;
- As a separate direct payment (monthly, quarterly, etc.);
- Other (Specify: _____)

c. Payments That Do Not Distinguish Between Direct and Indirect GME Costs

1): *If so, how are they calculated?*

- Per-resident amount based on teaching site's share of total Medicaid revenues or patient volume;
- Lump sum (not per-resident) amount based on teaching site's share of total Medicaid revenues or patient volume;
- A per-Medicaid discharge amount based on total Medicaid revenues or patient volume;
- Other (Specify: _____)

2): *If so, how are they distributed?*

- As part of the hospital's per-case or per-diem rate;
- As a separate direct payment (monthly, quarterly, etc.);
- Other (Specify: _____)

d. Other Payments

4. Do GME payments cover: (*Check all that apply*)

- Physician Residents
- Graduate Nursing Students
- Other Health Professional Trainees (Specify: Nursing and other paramedical)

MANAGED CARE SYSTEM

(NOTE: For our purposes, the *managed care system* is defined as Medicaid's use of risk-based capitation payments, and does not include any payments made under a primary care case management program.)

5. Has your state implemented a capitated managed care system as defined above?

- YES NO
- If you answered NO, proceed to Question 13.*

6. Under your state's managed care system, are explicit GME payments made to teaching hospitals (*or other entities that incur teaching costs*) for Medicaid capitated beneficiaries?

- YES NO
- (Answer 6a) (Answer 6b)*

a. If YES, describe the official rationale for making these GME payments: (Check all that apply)

- GME seen as a public good;
- Follow Medicare’s decision to make explicit GME payments to teaching hospitals for managed care enrollees;
- Opposition from teaching hospitals to losing GME payments;
- Desire to use Medicaid funds to advance state policy goals;
- Desire to help train the next generation of physicians who will serve Medicaid beneficiaries;
- Other (_____)

b. If NO, describe the official rationale for not making GME payments: (Check all that apply)

- Medicaid payment for GME under managed care is not necessary or appropriate;
- GME payments under managed care are not a pressing policy issue among many competing issues;
- Difficulty determining methodology to pay for GME under managed care;
- Opposition by managed care plans to having GME payments go to teaching hospitals;
- Medicaid used to pay for GME, but recent budget shortfalls or cost controls no longer allow payment;
- Other (Describe: _____)

If you answered Question 8b., proceed to Question 11.

7. Under capitated managed care, does your state’s Medicaid program make GME payments—*either*:

- ***directly to teaching hospitals (or other entities) OR***
- ***as part of capitated payments to managed care plans for them to pass on to teaching hospitals (or other entities) for: (Check all that apply)***

Direct GME costs

If so, how are they calculated?

- FFS GME payments incorporated in managed care organization (MCO) per-enrollee capitation payments;
- Follow Medicare FFS methodology;
- Per-resident amount based on teaching site’s share of total Medicaid revenues or patient volume;
- Lump sum (not per-resident) amount based on teaching site’s share of total Medicaid revenues or patient volume;
- On a per Medicaid managed care discharge basis;
- Other (Specify: _____)

Indirect GME costs

If so, how are they calculated?

- FFS GME payments incorporated in managed care organization (MCO) per-enrollee capitation payments;
- On a per Medicaid managed care discharge basis;
- Per-resident amount based on teaching site’s share of total Medicaid revenues or patient volume;
- Lump sum (not per-resident) amount based on teaching site’s share of total Medicaid revenues or patient volume;
- Other (Specify: _____)

Do Not Distinguish Between Direct and Indirect GME costs

If so, how are they calculated?

- FFS GME payments incorporated in managed care organization (MCO) per-enrollee capitation payments;
- Per-resident amount based on teaching site’s share of total Medicaid revenues or patient volume;
- Lump sum (not per-resident) amount based on teaching site’s share of total Medicaid revenues or patient volume;
- On a per Medicaid managed care discharge basis;
- Other (Specify _____)

8. Under capitated managed care, how does your state's Medicaid program distribute GME payments to teaching hospitals or other entities? (Check all that apply)

- a. Medicaid makes a separate direct payment (per-case or per-diem, monthly, quarterly, etc.) to the hospital or other teaching entity;
- b. Medicaid **requires** capitated MCOs to pay the hospital (or other teaching entity) for GME costs as part of the hospital's per-case or per-diem rate;

If so, check one of the following:

- Medicaid provides MCOs a specific methodology for determining GME add-on payments;
- Medicaid does not provide MCOs a methodology for determining GME add-on payments.

Explain: _____

- c. Medicaid **assumes** capitated MCOs reflect GME costs in their payments to hospitals (or other teaching entities), **but** does not require them to do so.

Other (Specify _____)

9. What institutions are eligible to receive GME payments under capitated managed care?

Capitation rates include fee for service payments where GME is part of a series of reimbursement formulas for the following. (Check all that apply)

- Teaching hospitals;
- Teaching sites in non-hospital patient care settings (such as ambulatory sites, managed care plans, etc.);
- Medical schools;
- Other institutions (Specify: _____)

10. Under capitated managed care, do GME payments cover: (Check all that apply)

Capitation rates include fee for service payments designed to address GME for the following.

- Physician Residents
- Graduate Nursing Students
- Other Health Professional Trainees (Specify: _____)

11. Under either FFS or capitated managed care, has your state's Medicaid program ever considered discontinuing making explicit payments for GME?

YES NO No GME Payments Are Made Under FFS or Managed Care

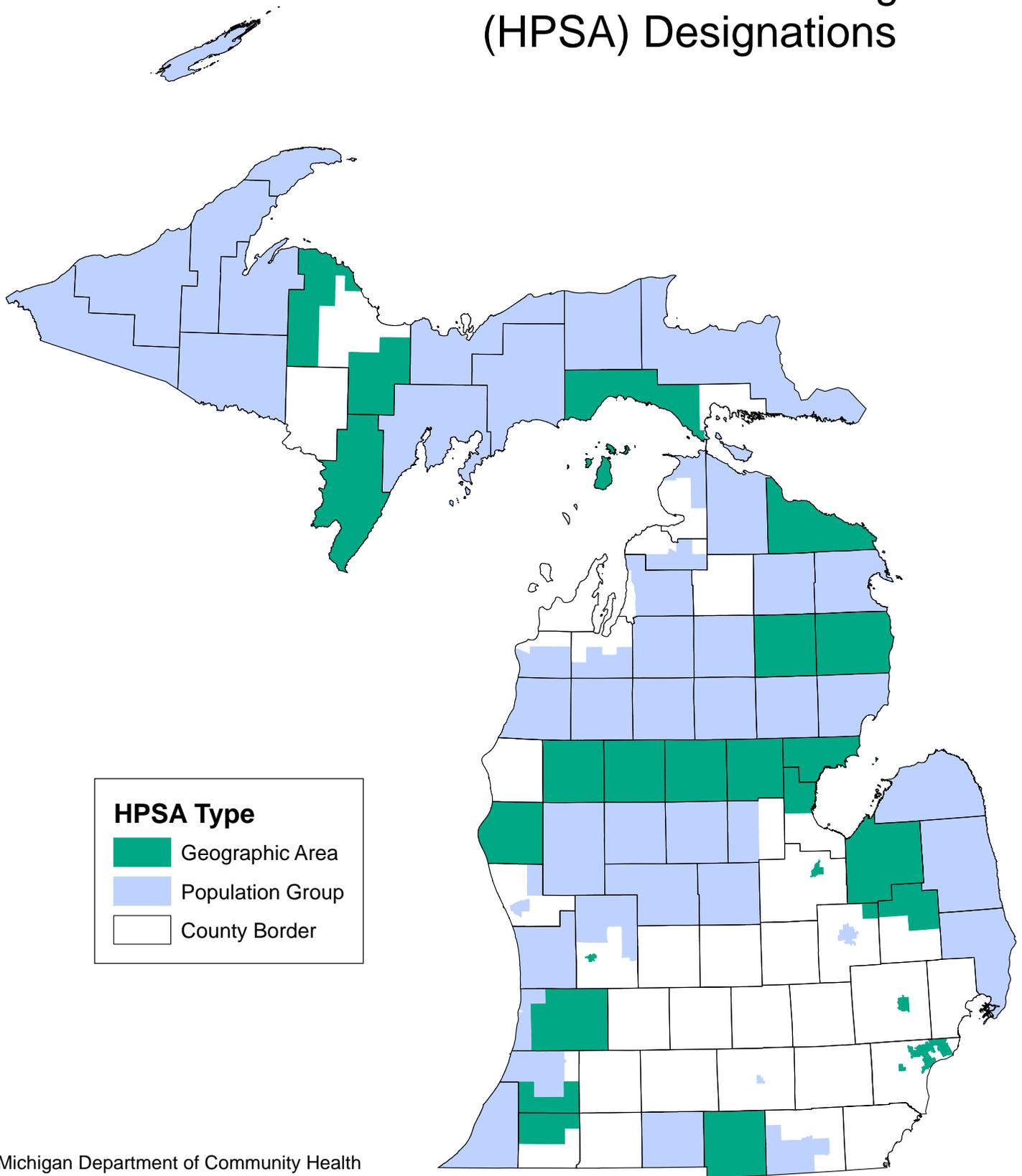
If YES, describe the rationale for considering discontinuation of GME payments: (Check all that apply)

- Medicaid payment for GME is no longer necessary or appropriate;
- GME payments are no longer an important policy issue among many competing issues;
- Current budget shortfalls or cost controls may necessitate ending payments;
- Opposition by managed care plans to having GME payments go to teaching hospitals;
- Other (Describe: _____)



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Primary Medical Care Health Professional Shortage Area (HPSA) Designations



Michigan Department of Community Health
Health Planning & Access to Care Section

Data Source: U.S. Department of Health and Human Services
Health Resources & Services Administration - <http://hpsafind.hrsa.gov/>

03/28/2011

Summary of Findings from the Study of Michigan Physician Supply ***Commissioned by the Blue Ribbon Physician Workforce Committee (membership listed below)***

Conducted by: *G. Forte and C. Roehrig, Center for Workforce Studies, Albany, N.Y. and Altarrum, Ann Arbor, MI*

- In 2004, the Blue Ribbon Committee on Physician Workforce commissioned a study of Michigan’s physician workforce for the future.
- The study was designed to allow comparisons between Michigan and the U.S. as a whole and was modeled after a national study by the same researchers.
- The national study was commissioned by the Council on Graduate Medical Education (COGME) and found that the United States will have between 85,000 and 96,000 fewer physicians than needed by 2020. The American Association of Medical Colleges supports the findings of the national study.

Methodology – Supply

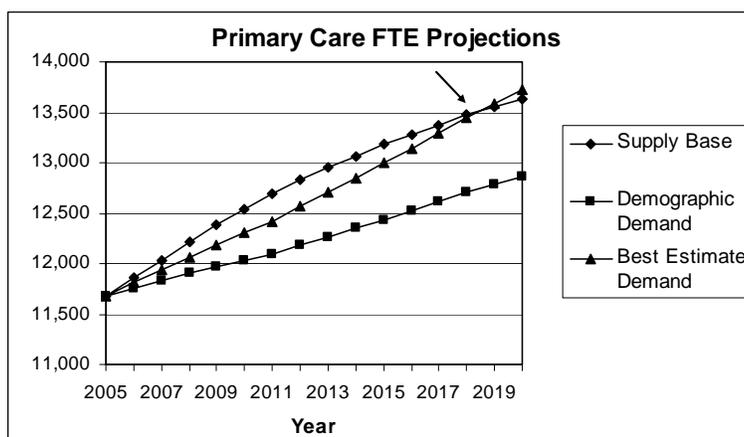
- The methodology of all physician workforce studies is based on the numbers of physicians (supply) calculated against demand for physician services.
- In both the national and Michigan studies, current physician supply was calculated from the AMA database of all licensed physicians (both D.O. and M.D.).
- The expected future production of physicians was calculated based on historic trends of medical school and residency data.
- Physician supply is adjusted for the increasing numbers of women entering medicine and the aging of the physician population (retirements).

Methodology – Demand

- Demand for physician services is based on a formula that takes into consideration the characteristics of the population (age, utilization, insurance type and status) and the physician use patterns of each age range.
- In the economic-trend-based forecast, a factor is added to account for the effect of increased income and advancements in medical technology on physician demand.

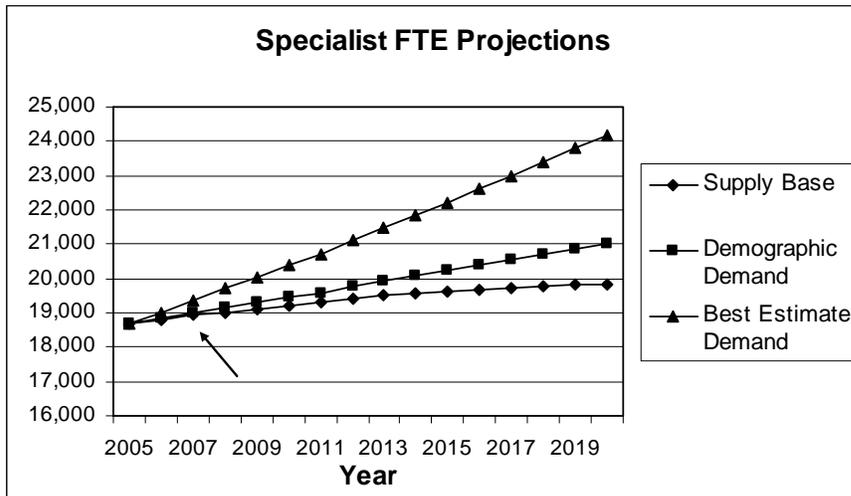
Study Findings

- Michigan currently has approximately 30,000 “active” patient care physicians - i.e. those delivering patient care and will need 38,000 physicians by 2020.
- Michigan will be 900 physicians short by 2010; 2,400 short by 2015; and 4,400 doctors short by 2020.
- Michigan primary care projections indicate that physician supply will be adequate for demand until 2018 although this does not take into



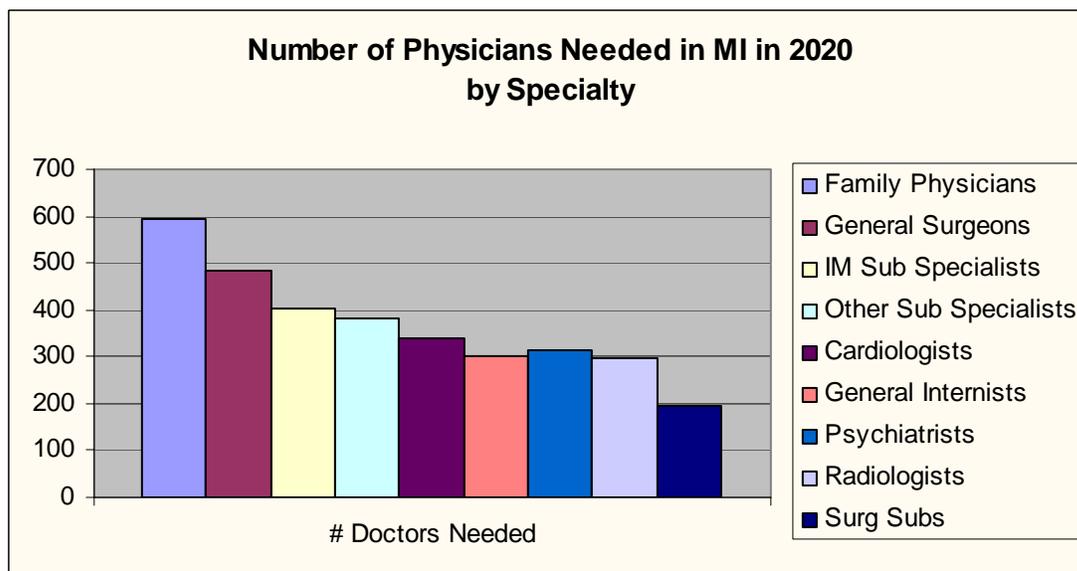
account access issues for those who are uninsured or publicly insured.

- Michigan’s specialist projections indicate that we will see a shortage beginning in 2006.

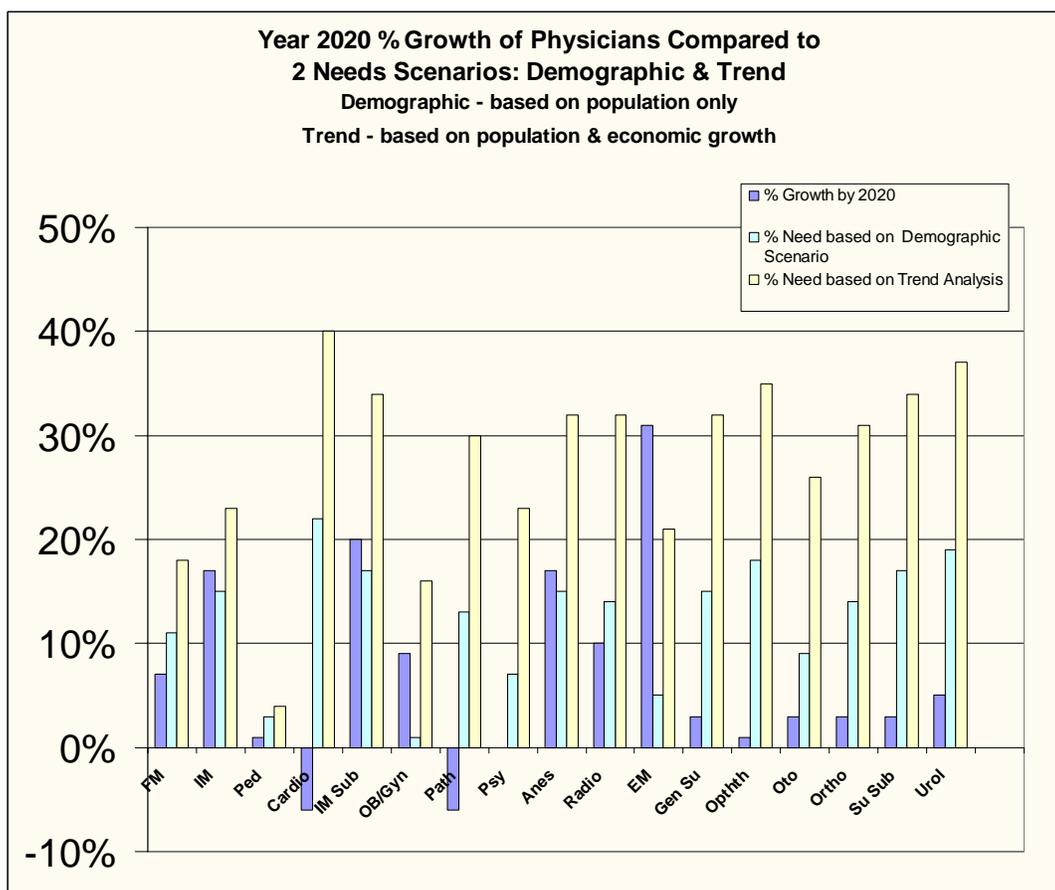


Types of Physicians Most Needed by 2020

- The study provided a list of specialties that are forecast to face the greatest shortages. The list is provided below:
 - Family Physicians
 - General Surgeons
 - Cardiologists
 - Internists
 - Psychiatrists
 - Radiologists
- Other surgical specialists will be needed as well including: urology, otolaryngology, ophthalmology, neurosurgery, abdominal surgery, transplant surgery, and thoracic surgery.



- The model used to forecast the future demand for physicians in Michigan considered the following demand determinants:
 - Physician utilization rates by age, gender, practice setting, insurance status, location of service (rural and urban), and physician specialty.
 - Size and composition (age, gender, and location) of the population of the state and sub-state regions.
- For the state-level demand forecasts, the baseline model assumed that there would be no significant changes to the health care delivery system in Michigan throughout the forecast period. This model is referred to as the demographic model.
- Scenarios allowing for variation in the level of insurance in the population; variation in the age-specific utilization of physician services; the elimination of excess, unnecessary physician service provision; and the effect of the economy on the demand for physicians were also developed. The latter scenario, referred to as the trend scenario model in recognition of Richard Cooper's Trend Model upon which it is based, was determined to be the most likely demand scenario.
- From the chart below, you can easily see the disconnect between the growth in supply and the growth in need under either the demographic or trend need scenarios.



National Comparisons and Contributing Factors

- Health care delivery and medical education is a huge employer in Michigan. Not only can Michigan boast of four medical schools, but the American Hospital Association has identified Michigan as the 7th largest “teaching hospital” state.
- Michigan is 9th in the U.S. in number of general hospitals.
- Michigan is losing physicians after graduation at much the same rate as are many of the northern states. New York has a very similar problem, despite being the largest producer and trainer of physicians in the U.S.
- Physicians are being drawn away from Michigan to warmer climates and stronger economic growth areas.
- Michigan is going to experience a more severe shortage of doctors than is the nation as a whole. The U.S. is going to be 7.9% short, and Michigan is going to be 11.9% short. (*Formula: divide the number of doctors the state (or the nation) is projected to have by 2020 by the number of doctors needed in the state (or the nation) = percentage short*)
- On the basis of population alone, Michigan should only experience a shortfall of 2814 physicians by 2020; this study projects Michigan shortfall at 4,400 physicians by 2020.

Blue Ribbon Physician Workforce Committee Members

Michigan State University College of Human Medicine
 Michigan State University College of Osteopathic Medicine
 The University of Michigan Medical School
 Wayne State University School of Medicine
 Council on Graduate Medical Education – rep: Henry Ford
 Hospital
 Council on Graduate Medical Education – rep: Ingham
 Regional Medical Center
 Michigan Department of Community Health

Michigan Department of Labor and Economic Growth
 Michigan Association of Health Plans
 Michigan Health Council
 Michigan Health and Hospital Association
 Michigan Osteopathic Association
 Michigan Primary Care Association
 Michigan State Medical Society
 Michigan State Area Health Education Center
 MSU Institute for Health Care Studies

Graduate Medical Education Workgroup Members

Brian Connolly – Oakwood Healthcare
Dr. Jeffrey DeVries – Beaumont Health System
Dr. Bill Gifford – Sparrow Health System
Marilyn Litka-Klein – Michigan Health and Hospital Association
Rolland Mambourg, MD – St. Joseph Mercy
Tom Marks – University of Michigan
Dr. Steven Minnick – St. John Ascension
Kevin Murphy – Hurley Health System
Mark O’Halla – Mt. Clemens Regional Medical Center
Dr. Anthony Oliva – Borgess Health System
Jay Rising – Detroit Medical Center
Cathy Sinning – Spectrum Health Services
Mary Whitbread – Henry Ford Health System
Dr. Ernie Yoder and Robert C. Satonik, MD – Central Michigan University