

Council on Graduate Medical Education  
**Resource Paper**

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**State and Managed Care Support  
for Graduate Medical Education:  
Innovations and Implications for  
Federal Policy**

**July 2004**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Health Resources and Services Administration



The views expressed in this document are solely those of the Council on Graduate Medical Education and do not necessarily represent the views of the Health Resources and Services Administration nor the U.S. Government.

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## THE COUNCIL ON GRADUATE MEDICAL EDUCATION

The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues, and financing policies and to recommend appropriate Federal and private-sector efforts to address identified needs. The legislation calls for COGME to advise and make recommendations to the Secretary of the Department of Health and Human Services (DHHS); the Senate Committee on Health, Education, Labor, and Pensions; and the House of Representatives Committee on Commerce. Section 219 of the Departments of Labor, Health and Human Services, and Education and Related Agencies' Appropriations Act, 2004, Public Law 102-394, 106 Stat. 1825, resulted in the Secretary of DHHS extending COGME through September 30, 2004.

The legislation specifies 17 members for the Council. Appointed individuals are to include representatives of practicing primary care physicians, national and specialty physician organizations, international medical graduates, medical student and house staff associations, schools of medicine and osteopathy, public and private teaching hospitals, health insurers, business, and labor. Federal representation includes the Assistant Secretary for Health, DHHS; the Administrator of the Health Care Financing Administration, DHHS; and the Chief Medical Director of the Veterans Administration.

### Charge to the Council

The charge to COGME is broader than the name would imply. Title VII of the Public Health Service Act, as amended, requires COGME to provide advice and recommendations to the Secretary of DHHS and Congress on the following issues:

1. The supply and distribution of physicians in the United States;
2. Current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties;
3. Issues relating to international medical school graduates;
4. Appropriate Federal policies with respect to the matters specified in items 1–3, including policies concerning changes in the financing of undergraduate and graduate medical education (GME) programs and changes in the types of medical education training in GME programs;
5. Appropriate efforts to be carried out by hospitals, schools of medicine, schools of osteopathy, and accrediting bodies with respect to the matters specified in items 1–3, including efforts for changes in undergraduate and GME programs; and
6. Deficiencies and needs for improvement in databases concerning the supply and distribution of, and postgraduate training programs for, physicians in the United States and steps that should be taken to eliminate those deficiencies.

In addition, the Council is to encourage entities providing GME to conduct activities to achieve voluntarily the recommendations of the Council specified in item 5.

### COGME Publications

Since its establishment, COGME has submitted the following reports to the Secretary of DHHS and Congress:

#### Reports

- First Report of the Council (1988);
- Second Report: The Financial Status of Teaching Hospitals and the Underrepresentation of Minorities in Medicine (1990);
- Third Report: Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century (1992);
- Fourth Report: Recommendations to Improve Access to Health Care Through Physician Workforce Reform (1994);
- Fifth Report: Women and Medicine (1995);

- Sixth Report: Managed Health Care: Implications for the Physician Workforce and Medical Education (1995);
- Seventh Report: Physician Workforce Funding Recommendations for Department of Health and Human Services' Programs (1995);
- Eighth Report: Patient Care Physician Supply and Requirements: Testing COGME Recommendations (1996);
- Ninth Report: Graduate Medical Education Consortia: Changing the Governance of Graduate Medical Education to Achieve Physician Workforce Objectives (1997);
- Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas (1998);
- Eleventh Report: International Medical Graduates, The Physician Workforce and GME Payment Reform (1998);
- Twelfth Report: Minorities in Medicine (1998);
- Thirteenth Report: Physician Education for a Changing Health Care Environment (1999);
- Fourteenth Report: COGME Physician Workforce Policies: Recent Developments and Remaining Challenges in Meeting National Goals (1999); and
- Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment (2000).

## **Other COGME Publications**

2002 Summary Report (2002)

## **COGME Resource Papers**

Preparing Learners for Practice in a Managed Care Environment (1997);

International Medical Graduates: Immigration Law and Policy and the U.S. Physician Workforce (1998);

Update on the Physician Workforce (2000);

Evaluation of Specialty Physician Workforce Methodologies (2000);

Scholar in Residence Report: Reform in Medical Education and Medical Education in the Ambulatory Setting (1991);

Process by which International Medical Graduates are Licensed to Practice in the United States (September 1995);

Council on Graduate Medical Education & National Advisory Council on Nurse Education and Practice: Collaborative Education to Ensure Patient Safety (February 2001);

Proceeding of the GME Financing Stakeholders Meeting (April 11, 2001), Bethesda, Maryland, Public Response to COGME's Fifteenth Report (September 2001);

The Effects of the Balanced Budget Act of 1997 on Graduate Medical Education (2000); and

Council on Graduate Medical Education: What is it? What has it done? Where is it going? 2nd Edition (2001).

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## EXECUTIVE SUMMARY

Significant changes in the financial climate of State governments may adversely influence their continuing support of graduate medical education (GME) and the resultant physician supply. The role of State government in supporting medical education is well established. Since the late 1940s, States have subsidized loan and scholarship programs as financial incentives for medical students and physicians in training, and most States have provided some level of institutional support through general appropriations for undergraduate medical education. Several States also provide matching funds for the support of federally funded Area Health Education Centers (AHECs). Furthermore, most States elect to provide some level of support for GME, primarily through Medicaid payments to teaching hospitals. This paper looks at different innovative strategies adopted by various States to support GME programs and to ensure the production and distribution of the supply of physicians and other health professionals appropriate to their individual needs.

Most States now earmark funds for training in family medicine and other primary care residencies. At least 15 States have enacted laws that specifically encourage or

mandate creation of departments of family medicine or other family practice training programs in State-supported schools. More than 40 States have created special grant programs for family physician training and about half of all States specify appropriations for family practice education. Nearly all States have in place scholarship and loan forgiveness programs targeted to placing small numbers of primary care professionals in medically underserved areas. Many States with few primary care residencies, or with such residencies that have fewer filled positions, are offering loan repayment incentives to medical students who select in-State primary care residencies.

The explosion of health care costs and a deteriorating tax basis have resulted in budget deficits in a majority of States. These deficits have forced nearly every State to reduce significantly spending for Medicaid and other public health programs that account for 30 percent of State expenditure. Increased pressure for accountability of public monies will result in increased scrutiny of all health care expenditures, including monies provided to support GME. This paper concludes with a Statement of Principles for GME payment policies by Federal and State governments.



## **THE CURRENT CLIMATE IN THE STATES AND MANAGED CARE INFLUENCING THE PHYSICIAN WORKFORCE**

A number of significant changes affecting State and managed care markets in recent months and years have had an impact on, or have the potential to affect significantly, GME and physician supply. This section briefly describes the major changes and issues confronting GME and related public policy.

### **Rising Numbers of Uninsured and Increasing Health Care and Malpractice Insurance Costs**

One in seven Americans now lacks necessary health insurance coverage, despite the fact that more than 80 percent hold jobs and almost a quarter earn \$50,000 or more a year. Yet, 8 of 10 uninsured are in working families who cannot afford health insurance and that are not eligible for public assistance programs. The cost to society in the form of expanding uncompensated care, higher insurance premiums, and higher taxes is estimated at \$35 billion annually.<sup>1</sup>

The uninsured issue and its resultant cost are now viewed as a crisis in several States. One of California's largest health insurers, Blue Shield, recently took the unusual position of calling for the State to provide universal coverage.<sup>2</sup> A 2001 survey of California's physicians suggests that large numbers of physicians whose practices are suffering major financial problems soon plan to retire or leave the State. Most physicians surveyed also said that the high cost of living in many areas of the State affected practice recruitment.<sup>3</sup>

Overall health care costs are also increasing again at significant rates. In 2001 alone, premiums for employer-sponsored coverage rose 11 percent. In the past few years, huge increases in medical malpractice insurance rates also are driving physicians out of business temporarily or permanently in many States.<sup>4</sup> A 2002 report on the practice environment in Massachusetts found that rising malpractice insurance premiums, home prices, and business costs were associated with more physicians' leaving and fewer young physicians' practicing in the State.<sup>5</sup>

In particular, the drastic rise in malpractice premiums is a growing crisis in many places. At least 60 specialists at the University Medical Center in Las Vegas walked off their jobs in the summer of 2002. This action forced the 24-hour trauma center, which treats as many as 11,000 people a year—victims of car accidents, major falls, and gunshot and stab wounds—to close its doors immediately. For Nevada lawmakers, who would meet in special session only days after the physicians ended their 10-day walkout, it was only one more controversy in a serious public health crisis made complex by its many parts.<sup>6</sup>

These trends may have important implications for physician training. Significant changes in physician supply and practice patterns in some States that result from these factors could require some GME programs to reexamine their size and curriculum.

### **Government Budgetary Shortfalls, Medicaid Fiscal Pressures, and Accountability of Public Funds**

The explosion of health care costs and a deteriorating tax basis have resulted in budget deficits in a majority of States. Thirty-nine States and the District of Columbia (DC) faced budget shortfalls totaling about \$30 billion at some point during Fiscal Year (FY) 2003, after the \$49 billion shortage that States had to resolve when they were originally enacting their FY 2003 budgets. As of April 2003, 41 States and DC were projecting shortfalls that could exceed \$78 billion. These fiscal problems have forced virtually every State to reduce significantly spending for Medicaid and other public health programs that account for 30 percent of State expenditures nationwide. Some experts believe that this trend will require major changes to these programs in the long term.<sup>7</sup>

States' alterations to Medicaid may include reduced reimbursements to physicians and hospitals, increased control over prescription drug coverage, and eliminated or curtailed optional benefits or services such as payments for GME. A few States, such as Kansas, Nebraska, Texas, and Wisconsin, have very recently considered or actually eliminated or curtailed optional Medicaid payments for GME.<sup>8</sup> Increased calls by States for the Federal Government to provide relief from soaring Medicaid costs prompted the Bush Administration in early 2003 to

announce its own Medicaid reform proposal. The proposal would give States more freedom to decide what medical services are provided to Medicaid beneficiaries and would no longer require States to apply for Federal waivers to deviate from Federal Medicaid eligibility and benefits standards. In addition, the U.S. Senate in May 2003 approved \$10 billion in temporary Medicaid funding to the States as part of its tax cut package and \$10 billion to be allocated among other State programs.<sup>9</sup>

Such conditions and changes are likely to spur States to develop new means of accounting for spending on Medicaid and other State health programs. A few States, such as Colorado, are slowly abandoning their Medicaid Health Maintenance Organization (HMO) programs. Colorado now views its move to managed care in the mid-1990s to reduce Medicaid costs and improve spending accountability as a failed experiment that did not save the State enough money. It is not clear what impact such changes will have in these States on payments for physician services and GME.

### **Expanding Scopes of Practice and Practice Opportunities for Non-Physicians**

There has been a dramatic increase in the supply of non-physician clinicians (NPCs) and in the extent of health care they deliver that previously was provided principally by physicians. These NPCs include nurse practitioners, certified nurse midwives, physician assistants, psychologists, optometrists, podiatrists, and nurse anesthetists, as well as practitioners from “alternative” or “complementary” disciplines such as chiropractors, naturopaths, and acupuncture practitioners.

Anecdotal evidence suggests that State support, as a revenue source, is very important to many schools that train these health professionals. In particular, many schools of nursing with master’s degree programs depend heavily on State funding. According to a 1997 study,<sup>10</sup> about half of all nurse practitioner training programs received external support, and a large proportion of them obtained State government appropriations either directly or through their parent school of nursing. For these programs, the study found that State funding was very important to their financial livelihood. About two-thirds of these programs reported that they would have to close or severely curtail their program activities if State funding were withdrawn.

NPCs—many who traditionally were used as physician extenders—now operate with a new degree of practice autonomy as defined by changes in the laws and regulations of many States. These are practitioners whose defined scope of practice often overlaps in varying degrees with that of physicians. In fact, their scope of practice may even compete with that of physicians. Many workforce experts believe that the growth in both supply and demand for NPCs, while presenting new opportunities for increased collaboration and interdisciplinary practice, is likely to dampen the demand for physician services. This might be the case particularly in managed care settings and from consumers seeking alternative or non-traditional forms of health care.

### **Shifting Specialty Supply and Persistent Shortages of Physicians Serving Low-Income and Rural/Inner-City Populations**

Although the supply of physicians has grown rapidly for several decades, debate remains about the adequacy of overall physician supply, and in particular, the supply of specialists. Several recent reports suggest shortages exist in certain selected physician specialties such as pediatric subspecialties<sup>11</sup> and geriatric medicine.<sup>12</sup> There is also indication that the demand for primary care physicians is softening as managed care organizations (MCOs) become less centralized and emphasis on the primary care physician as “gatekeeper” changes.

Regardless of specialty mix in the physician supply, inadequate access to physician care by medically underserved populations nationwide is ongoing and likely to worsen. Maldistribution of physicians in many rural areas and inner cities continues despite efforts by the National Health Service Corps and other government programs to recruit and retain health providers to these communities. Physicians may be available in many places but located too far away to provide timely service, and clients may have difficulty finding transportation, even to a nearby service site. Alternatively, providers may not be willing to serve the uninsured or underinsured or may treat them differently from their privately insured patients. Individuals may also delay seeking care or fail to seek it because of a lack of knowledge about their own health needs or where those needs may be met.

## **Practice Location of Physician Graduates and the Importance of States as Markets**

Despite the debates over whether the United States has too many or too few physicians overall, there is consensus that tremendous variation exists across the States in both the number of physicians in training and the number and specialty of physicians in practice. These variations in geographic and specialty distribution have been associated with unequal access to physician services.<sup>13</sup>

States remain concerned about the return on their investments in medical education and physician recruitment and retention for health professional shortage areas (HPSAs). To determine whether such investments by States and training programs make a difference in where physician graduates locate their practice—and if most physicians ultimately enter practice in the same State where they completed their medical school and GME training—the National Conference of State Legislatures (NCSL) conducted an analysis. NCSL recently analyzed the American Medical Association’s Physician Masterfile and found that a majority of generalist physicians and

physicians in metropolitan areas practice in the same State where they completed their most recent GME. Although most States do not retain a majority (or import a minority) of their total physicians, some States fare better than others. Seventeen States retain at least half of all physicians who completed their GME in State.<sup>14</sup>

Data from the NCSL study suggest that there is a relationship between location of medical school training and location of most recent GME. Data also suggest that the existence of such a relationship would and does influence practice location. States with a higher percentage of physician residents from in-State medical schools are more likely to retain (or import fewer) physicians of all specialties and in all geographic locations. This finding suggests that location of medical school is important to location of residency training and practice. In 2001, nearly 40 percent of all allopathic residents graduated from an in-State medical school. Public medical schools appear to be more important to location of residency than private schools. The 12 States in which at least one third of physician residents are from in-State medical schools have a predominance of publicly supported schools.<sup>15</sup>





## TRADITIONAL APPROACHES BY STATES TO FINANCING MEDICAL EDUCATION

The role of State government in supporting medical education is well established. Since the late 1940s, States have subsidized loan and scholarship programs as financial incentives for medical students and physicians in training, and most States have provided some level of institutional support through general appropriations for undergraduate medical education. Several States also provide matching funds for the support of federally funded AHECs. Furthermore, most States elect to provide some level of support for GME, primarily through Medicaid payments to teaching hospitals.

Despite such initiatives, the environment in which this financing takes place has significantly changed in recent years. Although State appropriations to medical schools have increased steadily since the early 1980s, the percentage that these funds represent to the revenue base of the average medical school is declining. Major payments for GME that most States make through their Medicaid programs, second only in size to Medicare's contribution, are threatened by new cost controls and cuts in spending. States increasingly rely on loan repayment programs, tax credits, practice development subsidies, and other strategies, rather than scholarships, to encourage small numbers of graduating physicians to practice primary care in HPSAs.

### Undergraduate Medical Education

Historically, State general revenue appropriations for medical education have been largely directed to undergraduate training. In 2001, allopathic medical school revenue from State and local government general funds was worth over \$3.6 billion. Most of the money was unrestricted, and often those funds going to single institutions were difficult to isolate and analyze.<sup>16</sup>

Although the *amount* of funds that States devote to medical education has more than doubled since the early 1980s, the *proportion* of allopathic medical school revenue from State and local appropriations in 2001 was less than 8 percent compared to 23 percent in the early 1980s. The shift in the payer mix of medical schools reflects in part the growing importance of revenue to the programs from either patient care or faculty practice plans (34 percent of total revenue in 2001).<sup>17</sup>

About 60 percent of all allopathic medical schools and 30 percent of osteopathic medical schools are State owned or State related and receive State appropriations. Some States also subsidize private schools.

### Graduate Medical Education

#### *Medicaid Payments to Teaching Hospitals*

Since the inception of the Medicaid program in the 1960s, States have paid what they believe to be their fair share of GME costs. Second to Medicare, Medicaid is the largest explicit payer of GME, providing teaching hospitals between \$2.5 and \$2.7 billion in 2002, amounts slightly higher than the \$2.3 to \$2.4 billion estimate of total Medicaid GME payments in 1998. Although Medicare has a statutory requirement to support GME, State Medicaid programs have no such formal obligation. However, most States historically have made payments for GME under their fee-for-service (FFS) programs. (States have the option to support such additional services as GME and to receive matching Federal funds for them.) In 2002, all States except Illinois, Kansas, and South Dakota volunteered to make GME payments under FFS programs. Even those States without medical schools provide GME support from their Medicaid programs to residency programs within their States.

Of the 46 States and DC that made GME payments under their Medicaid FFS programs in 2002, the majority of States (24) and DC recognize and reimburse for both direct graduate medical education (DGME) and indirect medical education (IME) costs. Although most States acknowledge and pay for direct and indirect medical education costs, nine States make no distinction in their GME payments between DGME and IME. One State, Tennessee, pays for GME only under its managed care program.

When asked how GME payments are calculated, nearly half of the States and DC (21) that pay for GME under FFS programs say they use methods similar to those used to pay for GME under the Medicare program. Nearly an equal number of States report using some "other" method for calculating DGME or IME that was not specified in the survey. Three-fourths of States and DC (35) that pay for GME under FFS programs distribute GME payments through the hospital's per-case or per-diem rate. Fifteen States reimburse teaching hospitals for GME costs by making a separate direct payment to these institutions.<sup>18</sup>

State Medicaid GME payments on average are about 8 to 9 percent of total Medicaid inpatient hospital expenditures. By comparison, Medicare's over \$6 billion in GME payments (for both DGME and IME) represent about 7 percent of its total inpatient hospital expenditures.<sup>19</sup> State GME proportions range from less than 1 percent to 32 percent.<sup>20</sup>

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

### ***Line-Item/State Agency Funding for Family Medicine Departments and Primary Care Residencies***

Most States now earmark funds for training in family medicine and other primary care residencies. At least 15 States have enacted laws that specifically encourage or mandate creation of family medicine departments or other family practice training programs in State-supported schools. More than 40 States have created special grant programs for family physician training and about half of all States specify appropriations for family practice education. Other States have enacted laws that call for studying the feasibility of establishing residency programs in family practice, based on using clinical sites in rural areas.<sup>21</sup>

According to the American Academy of Family Physicians, in the mid-1990s a State on average provided about \$3.6 million a year (or about \$21,000 for each State-funded residency position) to support family practice residencies. At least eight States each appropriated more than \$7 million annually for such programs.<sup>22</sup> Although family practice residencies have grown significantly in number and size in recent years, State support in general has remained stagnant or declined. Depending on the size of the programs, State expenditures vary tremendously in the amount of a resident's salary or in total costs covered by the funds.<sup>23</sup> State legislators often have viewed support for primary care residencies through placement of their graduates as solving rural residents' and indigent populations' problem of access to primary care.

### ***Student and Resident Scholarships and Loans With Service Obligations***

Nearly all States have in place scholarship and loan forgiveness programs targeted to placing small numbers of primary care professionals in medically underserved areas. Many States with few primary care residencies, or with such residencies that have fewer filled positions, are offering loan repayment incentives to medical students who select in-State primary care residencies. Such initiatives are viewed as effective because the site of residency training is thought to be a strong predictor of future practice location. To discourage defaulting on loans, most States levy penalties on students who do not meet their obligations. Financial incentives to medical students and residents are increasingly targeted to those who wish to practice primary care in medically underserved areas. A few States are considering using loan forgiveness to relieve educational indebtedness for would-be primary care practitioners.



## **QUESTIONS TO BE ADDRESSED BY STATE OFFICIALS IN CONTINUING TO SUPPORT MEDICAL EDUCATION**

As evident by their long history of extensive financial support, most States believe medical education to be a public good. That is, they believe it to be a good or service that benefits the public at large and will not be produced at the appropriate level in the private market because of difficulty in pricing it. Although the community at large, including future patients and physicians, benefits from medical education, it is impossible to charge future beneficiaries. If left to itself, the private market will underproduce GME. MCOs and other private health plans are not investing significant support for medical education. Moreover, the costs of training are too great for many medical trainees to pay entirely without incurring large debts.

However, in deciding how to continue their support for medical education, States should be prepared to address the following questions:

### **What does the State want from its medical school(s)?**

More specifically, what are the State's current priorities versus those of the State's medical school(s)? Do common or differing missions exist regarding:

- training an appropriate supply of physicians to address State health workforce needs,
- attracting Federal and private research dollars,
- producing and harboring innovative biotechnology, and
- developing and sustaining a reputation for community service?

### **How effective are State-supported medical schools and residencies in preparing physicians to meet public needs?**

- What is the school's mission with respect to specialty and geographic distribution of graduates?
- Does the school have a department of family medicine? What proportion of the clinical faculty is primary care

physicians? How many schools require a family practice clerkship for students?

- What proportion of medical school applicants graduated from high school in non-metropolitan counties and inner-city communities? How does that proportion compare with the proportion of the State's population living in these areas?
- What proportion of graduates is doing residency training in the State? How many residencies are located in medically underserved areas of the State? What proportion of graduates is doing State-based residency training in primary or specialty care in shortage areas? What proportion of the residencies requires a rural or inner-city rotation?
- What proportion of physicians completing residency training is practicing in the State's rural and medically underserved areas? What proportion of physicians is practicing primary care or shortage specialties in the State? Is there a process for tracking and reporting such information to training programs and the general public?

### **How can States improve the chances that their State-supported medical schools and residencies will prepare physicians to meet public needs?**

#### ***Monitoring and Oversight***

- Is it appropriate for State legislatures to become involved in defining and monitoring the missions or expected achievements of State-supported medical schools and residencies? Should State appropriations remain unrestricted or should they be linked to performance with respect to these achievements?
- Does a State have the right to oversee and perhaps direct a public medical school's placement and expenditure of revenue for clinical practice plans?
- Should the State establish regular reporting requirements for training programs and enforceable penalties for non-compliance?

#### ***Level of Funding***

- What is an appropriate and fair level of State support for graduate training? How understood, documented, and justified are statewide GME costs and revenue?

- How should a State determine the importance and level of Medicaid GME support in comparison to GME funds from State appropriations and other sources? Is there value in having Medicaid pay for GME in other ways that better match the State's workforce needs? Will the needs of Medicaid's managed care "gatekeeper" workforce be met without its having to be funded through GME?
- In determining Medicaid's fair share, should a State continue to link GME payments to patient care or weigh the value of making payments based only on education costs? Should Medicaid GME funds go to training institutions that provide little or no service to Medicaid recipients?
- Can Medicaid use more efficient means to pay for GME? Should the number of filled residency and graduate nursing positions that qualify for Medicaid GME payments or total funding levels be capped to control costs and to allow the State to pay only for those physicians it needs?
- Should the State enhance its investment in GME by establishing a dedicated medical education and research trust fund that pools general revenue funds, Medicaid, other State monies, provider or insurer taxes, and other funds? Should such a trust fund be created to offset a proportion of teaching hospital revenue at risk of being lost to health plans?
- Should a statewide health professions education council be created to determine, justify, receive, and distribute all State Medicaid and general fund GME payments to training programs to achieve workforce goals?

### ***Funding Efficiency and Accountability***

- How can a State maximize its funding and public accountability for GME? Should State support for graduate training be weighted to creating new programs or to strengthening existing programs?

## **EMERGING STATE POLICIES AND PROGRAMS FOR SUPPORTING MEDICAL EDUCATION**

In fact, many States have come under pressure in recent years to scrutinize more effectively their support for medical education and teaching hospitals. In the late 1980s, and again currently, major fiscal crises have plagued most States. Concurrently, States have become increasingly concerned about the maldistribution of primary care physicians and the unmet needs of many rural and inner-city areas and Medicaid beneficiaries.

To achieve some congruence between public need and the existing supply of physicians, and to account more carefully for limited State resources provided for medical education, a number of States have implemented—or are considering implementing—the following strategies.

### **Medicaid GME Payments Under Managed Care Channeled Directly (Carved Out) to Teaching Programs**

Under growing pressure to reduce costs and improve access to care, most States, beginning in the mid-1990s, began to enroll their Medicaid population rapidly in MCOs. (As of 2000, over 550 Medicaid MCOs were in operation, and 56 percent of all Medicaid beneficiaries were enrolled in MCOs.)<sup>24</sup> Consequently, Medicaid support for GME and related costs faces increased risk.

Without some specific type of adjustment, MCO rates include historical payments for GME, and MCOs are neither bound to distribute those dollars to hospitals with GME programs nor to provide GME themselves. About half of States that have capitated their Medicaid program leave GME historical payments in the base used for calculating MCO payments. In 1995, Illinois actually eliminated Medicaid GME funding because of funding constraints.

More recently, changing market conditions, growing pressure on Medicaid agencies to be more efficient and publicly accountable, and current State budget shortfalls are compelling more States to reduce significantly Medicaid spending and to examine their DGME or IME financing policies. Anecdotally, a number of teaching hospitals remain concerned about the loss of Medicaid

patients because of managed care and decreased patient care payments under managed care. Concurrently, many of these hospitals have found their IME payments under Medicare reduced.

More of these hospitals are realizing the importance of Medicaid GME funds and are putting pressure on their States to have GME payments carved out from capitated MCO rates and rechanneled to them.<sup>25</sup> In 2002, 17 States and DC made Medicaid GME payments explicitly to teaching hospitals (or other teaching programs) under capitated managed care. Another 10 States recognized and included GME payments in their capitated payment rates to MCOs. The most common reasons cited by States in continuing to pay directly for GME under managed care include: a perception of GME as a public good; a desire to help train the next generation of physicians who will serve Medicaid beneficiaries; and a desire to use Medicaid funds to advance State policy goals. In 2002, GME payment amounts under capitated managed care represented 22 percent of total GME payments distributed in those States.<sup>26, 27</sup>

In 2002, final issuance of new Medicaid managed care regulations governing capitation payments by the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services [CMS]) reflect the Federal Government's growing concern with excessive health care costs. Particular concern over potential duplicate payments—especially to providers that receive payment under MCO contracts—is reflected in a provision prohibiting such payments.<sup>28</sup>

For the increasing number of States that carve out GME payments, the proposed provision required those States to show the Federal Government that such payments were not for duplicative services. In response to concerns raised by States of preventing harm to teaching hospitals, the original provision was amended by HCFA to exclude GME from this prohibition on direct payment to providers. In making this exception, HCFA noted that it plans to study existing GME payment arrangements to improve the fiscal integrity of Medicaid payments.<sup>29</sup> The Department of Health and Human Services Office of Inspector General (OIG) is currently conducting a review of Medicaid and Medicare GME payments in at least five States—California, Michigan, New York, Ohio, and Tennessee.<sup>30</sup>

## Medicaid GME Payments Targeted to Address State Health Workforce Needs

Seeking to be more prudent, farsighted purchasers of care, several Medicaid programs recognize that support for GME is a valuable tool for meeting the future health care provider needs of Medicaid beneficiaries as well as the public-at-large. These concerns have prompted more State Medicaid programs to view GME as a public good that they should support. In a small number of States, there is interest in making a stronger connection between distributed funds and training program accountability. In these States, some or all the following elements are addressed:

- *Incentives for and measures of greater accountability in distribution of payments,*
- *Significant documentation of GME costs and benefits, and*
- *Innovative means for pooling Medicaid GME funds with other payers.*

Many of these approaches require Federal approval, which typically has been sought as part of a State's request to amend its Medicaid plan or to obtain a waiver to operate a mandatory managed care program. Although States have more flexibility than ever to modify their Medicaid programs, gaining approval from the Federal Government to test innovations remains cumbersome or questionable. This is the case for States that want the flexibility and incentive to distribute GME payments to non-hospital training programs, to pay for training of non-physicians (e.g., advanced practice nurses and dentists), to pool payments, and to conduct other activities. This situation can be attributed in part to the fact that GME payments are a relatively minor issue to most State and Federal officials in the context of the entire Medicaid program.

Traditionally, State Medicaid programs have followed the lead of the Medicare program and have adopted open-ended GME reimbursement policies that have had no restriction on the specialty of physicians being trained. Moreover, because most States have followed a Medicare methodology that reimburses for clinical education and service provided only in hospital-based settings, Medicaid programs have done little to cover teaching costs in various non-hospital ambulatory sites.

In 2002, 10 States required that some or all Medicaid GME payments be directly linked to State policy goals intended to vary the distribution of, or limit, the health care workforce. The goal of encouraging training of physicians in certain specialties (e.g., primary care) is applied to GME payments by all 10 States. Five of the States use these payments to encourage training of physicians in certain settings (e.g., ambulatory sites, rural locations, and medically underserved communities). Four States link payments to efforts to increase the supply of health professionals trained to serve Medicaid beneficiaries.<sup>31</sup>

## Creation of a Medical Education Trust Fund Funded by Multiple Payers

A State's ability to justify establishing a GME fund that pools Medicaid dollars with new and existing State GME appropriations, and perhaps Medicare dollars, makes State (and Federal) support more open to public scrutiny, focuses attention on how the funds are used, and facilitates a link with State workforce needs. Having a dedicated pool also makes it easier to identify spending levels and to rationalize distribution of funds in accordance with workforce needs. In addition to New York, which for many years has supported GME through an all-payer fund, Minnesota's legislature in 1997 approved and funded the creation of a similar fund. One other State, Utah, has recently obtained a Federal waiver that allows Medicare GME funds to be pooled and distributed through its statewide medical education council.<sup>32</sup>

## Use of Special Financing to Establish or Expand Medicaid GME Payments

Because of competing demands for public services, especially with recent budget shortfalls, many States exceed their fiscal capability that gives their Medicaid programs the incentive to substitute Federal funds for State funds. The Medicaid program's Federal-State matching payment structure for covered services provides the mechanism for this substitution.<sup>33</sup> In general, this process of "Medicaid maximization" allows States to cover services that have traditionally been State or local responsibilities and to receive Federal matching funds for the costs of furnishing these services to Medicaid beneficiaries. The higher the State's matching rate, the greater the replacement potential.

States have the flexibility in particular to import Federal Medicaid dollars into State university-teaching hospitals through the GME reimbursement methodology. The major Medicaid maximization strategies most applicable for States to employ in this way include: 1) disproportionate share hospital (DSH) payments, 2) intergovernmental transfers (IGTs), and 3) taxes on health care providers.

Federal Medicaid DSH payments, authorized by Congress in the 1980s and directed to hospitals that serve a disproportionate number of Medicaid and low-income patients with special needs, are allocated among States in amounts set forth as ceilings in Federal statutes. Although States may claim Federal matching funds for DSH payments made to qualifying hospitals up to these ceilings, recent reductions in these ceilings by Congress may have had a chilling effect on Medicaid GME payments. In the past, many teaching hospitals that receive Medicaid DSH payments have viewed these payments as an important source of support for their GME activities.

Although use of health care provider tax and donation programs became a common practice among States to raise the State share (and thus increase Federal matching payments) for making Medicaid payments (especially DSH payments) by the early 1990s, Congress in 1991 banned States' use of provider donations and imposed restrictions on provider taxes. Despite these changes, several States are now using or considering use of provider taxes to supplement stagnant or declining provider reimbursement rates. It is not known to what extent provider taxes are used explicitly to support Medicaid GME payments.

Many States have turned to IGT programs as the best strategy to raise their State Medicaid shares. IGTs are fund exchanges between different levels of government and are a common feature in State finance. In the early 1990s, many States began to use IGTs as a way to leverage Federal Medicaid dollars to continue or expand coverage of optional services (e.g., GME) or to pay higher reimbursement rates to providers. States can use State (or county) expenditures to generate a Federal match to support Medicaid services. As a mechanism to initiate or expand support for GME, IGTs are being considered or used in a few States. Recent Federal changes may limit the ability of some States and certain hospitals in those States to take advantage of this revenue maximization strategy.

Creative use of the above-noted strategies and innovation of other GME financing strategies will become increasingly important as States seek to ameliorate the adverse impact of reduced revenue and as their increasing efforts to offset reduced revenue fail to be sufficient. Alterations by State Medicaid programs may include reduced reimbursements to physicians and hospitals, increased control over prescription drug coverage, and elimination or curtailment of optional benefits or services.





## MODEL STATE GME FINANCING INITIATIVES

Several States in particular are using or considering new and innovative GME financing approaches that improve their accountability to address State health workforce needs and that serve as potential models for national GME financing.

### State Appropriations

#### Arkansas

State support for community-based family practice started in 1973. From 1975–1980, Arkansas created six new family medicine residency programs (in addition to one existing in Little Rock, the State’s largest city) in collaboration with the State’s AHECs. The only residency programs located outside of Little Rock are in family medicine. Although it is more expensive to operate seven residency programs spread statewide, State officials in 1973 demanded a new model that would be more effective in distributing physicians to needy populations across the State.

These six community-based family medicine residencies have made a significant impact on physician supply in Arkansas. In their over 25 years of existence, the residencies provide most of the State’s rural physicians. Forty-five percent of graduating residents practice in communities with populations of fewer than 20,000. As the number of residents graduating from these programs has grown, most have sought work in rural areas of the State where practice opportunities are more plentiful. Arkansas is a leader among States in the proportion of its physician residents choosing family medicine who remain in the State to practice.

All the State’s students in its one (public) medical school are currently from Arkansas. State law prohibits the medical school from taking any out-of-State students if there is a qualified Arkansas resident. Under the State’s recently established community match program, eligible communities in Arkansas are encouraged to make agreements with medical students in their first year of training. The agreements entail their willingness to pay half the student’s tuition. In return, the student must choose a primary care residency and must agree to practice in that community for a designated period upon completion of the training.

Recently, the Arkansas legislature agreed to appropriate \$4 million of the State’s tobacco settlement to support the community residency programs. There is interest in using these funds as a State match to receive additional Federal matching funds through the State Medicaid program. These funds would enhance the GME payments that Medicaid makes to teaching hospitals affiliated with the community residency programs.

#### Colorado

State statutes creating the Commission on Family Medicine in 1977 call for all of Colorado’s family medicine residencies to work together to address issues on physician workforce access in the State. A key focus of the Commission is to meet the need of rural and urban underserved communities for family physicians. The Commission is governed by representatives from training programs, Governor-appointed consumer representatives from across the State, the medical school dean, and a representative of the Colorado Academy of Family Physicians.

Colorado has a higher percentage of medical school graduates who were first-year residents in family medicine than the United States as a whole, and over half of Colorado graduates who chose a family medicine residency enter an in-State family medicine residency. The State’s 10 family practice residencies currently train about 200 residents. Although about 80 percent of these residents typically are from medical schools outside Colorado, two-thirds of graduating residents remain in the State to practice. Of those remaining in the State, about 25 to 30 percent opt for a rural or urban underserved area practice. The Commission requires that all family medicine residents training in Colorado complete a rural rotation. To this end, the Commission has approved 13 rural practices and coordinates the scheduling of the rotations.

The Commission reports to the State legislature through the Governor’s Office of State Budgeting and Planning and the Joint Budget Committee. The Commission’s Executive Director is employed by the University of Colorado Health Sciences Center. The annual appropriation by the legislature to support the Commission and affiliated residencies is about \$2.4 million. Commission staff works to fulfill the legislative charge to the residency programs and to collect statewide data on physician workforce needs in the State.

## Texas

In 1977, the legislature made State financial support available for postgraduate training in family medicine. The law gives the Texas Family Practice Residency Program, administered by the Higher Education Coordinating Board (HECB), authority to allocate State funds to family practice residencies on a contract basis. The program initially appropriated about \$852,000 to 12 operating residencies to support 267 positions and to 9 new programs for planning activities. By the late 1990s, the State provided about \$11 million to 26 programs sponsored by Texas medical schools, supporting more than 700 positions. Six other family practice residency programs and 100 positions do not receive State support.

HECB requires all programs to have substantial sources of support from other entities, such as patient revenue, hospital and local funds, or medical schools. Funds are limited to no more than 35 percent of a program's total budget. HECB also is required by law to perform the following functions: 1) provide for prior budget review and audits of all funded programs and 2) collect information from programs about the area distribution of family physicians and about the improvement of medical care in underserved communities.

An extensive 1989 law required HECB, the newly established Center for Rural Health Initiatives, and medical and other health care education schools to cooperate to improve and expand programs for rural areas, including the following: 1) encourage and coordinate the creation or expansion of a rural preceptor program among medical schools and teaching hospitals; 2) require family practice residency programs to provide an opportunity for residents to have a 1-month rotation through a rural setting; 3) develop relief service programs for rural physicians to facilitate access to continuing medical education; and 4) require medical schools to incorporate into their programs a third-year clerkship in family practice for all medical students and to report on its efforts to fulfill the intent of having at least 25 percent of first-year primary care residents in family practice.

A follow-up 1995 law included several new provisions to improve the supply of family practice physicians. The new provisions pertaining to medical education include: 1) new statewide preceptorship programs in both general internal medicine and general pediatrics modeled after the existing family practice preceptorship program; 2) an additional \$1

million for a family practice residency training program; 3) three family practice residencies to provide services in economically depressed or rural areas of the State; and 4) support for 150 additional community-based primary care residency positions phased in over 5 years, although per-resident allotments will not increase.

Although the number and size of Texas's family practice residencies have grown, per-resident spending (adjusted to 1996 dollars) has declined since the early 1980s. The aforementioned 1995 law provided an enhanced level of funds for family practice training and expanded the number of State-supported primary care residency positions but did not increase the per-resident allotment.

Many workforce experts believe that an increasing number of residency programs will operate from a service vantage rather than from an educational perspective. In response, some medical educators in 1996 proposed that the State cover the entire cost for a primary care resident that can be attributed to education. They also proposed that the State pay up to 35 percent of a program's current total resident training costs, including a portion of faculty expenses, through direct general revenue appropriations. In part, the rationale behind seeking further State support for graduate training is that funds for community-based faculty to supervise residents is inadequate. The further rationale is that revenue to support academic missions is threatened by the reduction of Medicare GME support and the explosive growth of commercial and Medicaid managed care plans, which may exclude these teaching programs from participation.

In addition, the Texas Medicaid program makes payments to support DME and IME in the State's teaching hospitals. A 1997 law authorizing Medicaid to up-weight GME payments to favor primary care residency training was never funded. Recently, the State has considered various ways to increase Medicaid GME payments including use of an IGT of State general funds that support public medical schools to draw down additional Federal matching funds.<sup>34</sup>

## Medicaid Payments Linked to State Goals

### Georgia

Beginning in the late 1990s, Georgia became interested in finding ways to enhance support for medical education



programs in the State. The legislature created a GME study commission to examine the feasibility of creating a GME trust fund to finance physician education in Georgia. At the same time, the State's AHECs and affiliated rural residency training programs were losing Federal seed funds and began seeking other sources of financial support.

Beginning in 2000, Georgia's Medicaid program agreed to pay the Medical College of Georgia a lump sum amount provided through an existing legislative line-item appropriation. The purpose of these funds was largely to support core clinical training activities in the State's five AHECs. These State funds are made available through the resident instruction budget within the State university system and are allocated to a budget account to support the AHEC program. Using the IGT mechanism, the college agrees to transfer these funds temporarily back to the Medicaid program. In this way, Medicaid can draw down additional Federal matching funds to finance further AHEC activities that benefit Medicaid beneficiaries in the State's rural and medically underserved communities. Matching funds are intended to provide educational support for clinical training of physician residents affiliated with the AHECs. Georgia's State-Federal Medicaid match rate is 1:1. The current value of this reimbursement in State funds and Medicaid Federal matching payments totals \$1.45 million.

Request for State support in 2003 reflected an increase of \$300,000 to fund a new AHEC and to support the clinical training of medical students, physician assistant and nurse practitioner students, and other health professional students. The State deemed these students to be needed within medically underserved regions of the State served by AHECs. With Federal matching funds, the total AHEC budget was increased to \$1.8 million.

## **Michigan**

Medicaid GME policy in Michigan changed significantly in 1997 when the State sought to structure payments to bring physician education more in line with its specific public policy goals: 1) to train appropriate numbers of primary care providers, 2) to enhance training in rural areas, and 3) to support education in ways of particular importance in the treatment of the Medicaid-eligible population. Historically, training programs were not obligated to meet accountability requirements because funding was based on cost and because the State had no idea how much money it was contributing to GME.

Most of the nearly \$200 million in GME funds previously included in both Medicaid payments for FFS hospital patient care and MCO capitation rates were carved out and directed for redistribution into two different pools. For the first 3 years of the new policy, a historic cost pool reimbursed each hospital the same amount in payments that it received in 1995 based on that year's costs for medical education. A second pool, the primary care pool, seeks to encourage the education of young physicians in the primary care fields of general practice, family practice, preventive medicine, obstetrics, and geriatrics. Payments from the primary care pool to hospitals are based on the institution's number of residents in primary care and its share of Medicaid patients. To qualify for reimbursement from either pool, a hospital must submit a report to the State detailing resident profiles and the way in which it is using the funds to support specific public policy goals and priorities.

A third pool, the Innovations in Health Professions Education Grant Fund, was established with GME funds formerly included in capitation payments to MCOs. The purpose of this pool was to foster innovations in health profession education and to accelerate the pace of change currently sweeping the State's health care delivery system. Grants are awarded competitively to programs that support the goals of the new GME initiative, with emphasis on innovative training in managed care arrangements. Only consortia consisting of at least a hospital, a university, and an MCO are eligible to apply. Early funding under this pool supported such activities as making changes in curriculum to add exposure to managed care (physician profiling—a resident "report card"); developing teaching experiences in evidence-based medicine—case management, disease management, training of public health nurses, and epidemiology; and establishing an interdisciplinary education curriculum with other health professions. The funding size of the pool depends on the annual availability of funds.

The State has concluded that funds in this pool have been well spent. Residency educators say that they can now make much-needed changes. University, hospital, and health plan officials have been forced to communicate with one another in productive and positive ways on GME issues. The new managed care curriculum is largely viewed as useful, but it is too soon to tell whether such changes can be sustained.

The initiative's overall impact on addressing State workforce goals is not yet known. The State does believe that such programs would be more effective if a more coherent policy approach could be developed between Medicaid and Medicare and other payers. Such State efforts as Michigan's may need to exercise caution in the specific ways in which they direct their initiatives to State workforce needs. Physicians have typically responded to other market changes more quickly than to State financing changes. In Michigan, there appears to be no shortage of primary care physicians, but there is evidence of a shortage of some specialists willing to be part of managed care networks.

In 2001, a new formula was established that takes into consideration use by and service to the State's Medicaid population. Previously, funds were distributed based on hospital costs. New formulas use physician intern and resident full-time equivalents (FTEs) with weighting for Medicaid use, hospital case mix, physician enrollment in Medicaid, and physician board certification to distribute funds. Teaching hospitals are now required to submit annual updates on their intern and resident FTEs. The new policy also required participation in a managed care plan for a hospital to receive GME funds.

Furthermore, beginning in 2001, Medicaid agreed to provide funding to educate third- and fourth-year students at the State's one public dental school that is developing specialized curricula and programs intended to increase further the participation of dentists in Medicaid. Funding covers teaching and other administrative costs that are matchable under Medicaid's IGT mechanism. The State match is used to draw down additional Federal matching funds and to provide new revenue for the State's dental school.

Recently, Medicaid also agreed to use the IGT mechanism to fund two physician residency programs in psychiatry that provide a lot of training in community mental health settings. The programs' affiliated universities use State general funds and a Medicaid GME innovations grant as the State match under IGT to obtain Federal matching funds. These non-hospital-based residencies are not otherwise eligible for the State's Medicaid GME payments.

## **Tennessee**

In 1996, Tennessee, under its replacement Medicaid program (TennCare), became the only State to stipulate

that GME money flow directly to medical schools. This stipulation circumvented the requirement that teaching hospitals may use only GME funds to educate students in hospital-based settings. GME funding now follows residents to training sites and is distributed to the State's medical schools to pay the residents' basic stipend. This funding also provides conditional stipend supplements that encourage primary care training in community sites as well as the placement of those trainees in underserved areas. Thus, these new provisions represent a radical departure from Medicaid's typical support for GME before TennCare and from the turmoil that followed in 1995 when it briefly stopped paying for GME altogether.

Early problems with TennCare centered on the lack of primary care providers in many rural areas of the State. The need became apparent to change the manner in which GME funds were distributed and to set new standards of performance during the process of restoring GME support by TennCare. The plan developed by the TennCare GME Working Group was to be phased in over a 5-year period. By July 1, 2000, 50 percent of the aggregate residency positions under the sponsorship of the State's four medical schools were to be in one of the primary care specialties. For any school not achieving this target, that school's allocation from the TennCare GME fund for that year was reduced by one percentage point for each percentage point that it failed to reach its filled residency target. In addition, each medical school was required to comply with rigorous annual State reporting requirements.

Upon completion of the phase-in period, TennCare officials concluded that linking GME payments to health workforce objectives does produce results. They also concluded that having a separate program from Medicaid promotes accountability for reaching objectives. The number of training sites has expanded, but almost all GME funding is still passed on to hospitals from the medical schools. However, the GME funding formula does not appear to attract and retain primary care physicians in underserved areas (because there have been few takers on the program's stipend). Rather, the formula penalizes medical schools for training specialty physicians by deterring them from procuring funding for specialty education and clinical research (e.g., National Institutes of Health fellowships). Out-of-State migration of graduating physicians also has increased.

TennCare has extended the GME program through 2007 as part of its Federal waiver, hoping to better integrate GME

into the overall TennCare program. In this process, GME payments now flow first through the managed care plans before being distributed to the medical schools. Payments to the medical schools cover teaching physician and resident salaries. The medical school may distribute these payments to an affiliated hospital or clinic setting where residency education occurs.

More important, State workforce priorities will be better linked to GME program design. For example, evidence indicates that statewide interest by physician residents in the TennCare primary care stipend and loan repayment program has been minimal. Therefore, TennCare has agreed instead to set aside \$2 million to support new efforts by the State's medical school to recruit and retain residents interested in rural practice. The medical schools have funded a recent statewide assessment of physician demand to be used to plan this new physician recruitment and retention program. The program is being modeled after a similar program in Minnesota where recruiters work with communities and with physicians and look for opportunities for spouses and their children. Other future uses of the \$2 million set-aside suggested for consideration by State officials include support for training other needy health professions in short supply, including dentists, advanced practice nurses, and psychologists.

## **Utah**

In 1995, two technical advisory groups to the Utah Health Policy Commission concluded that the State's major academic health center and residency training programs were being significantly threatened by changes occurring in the health care system and by projected changes in Federal policy for GME funding. To develop a basis for making policy decisions in response to these changes, the Commission requested an independent study to determine GME costs and revenue sources statewide. The Commission anticipated that Utah's academic training centers would have to compete further on price and quality for patients. Therefore, it was interested in possibly using the study results to begin the difficult task of separating the cost of training from the cost of patient care in these institutions.

With the study concluding that GME funding sources were being eroded, the State legislature in 1997 created the Medical Education Council to address various issues associated with funding for health profession education in Utah. The Council's mission is to find ways to stabilize such funding by effectively determining the costs of health

profession education and to better understand and address the State's health workforce needs. The Council is currently conducting extensive workforce planning and analyses that, combined with the cost study findings, will provide the basis for distributing GME payments more accountably and for developing a rational policy for the State health workforce.

In its effort to improve GME funding and to address State health workforce needs, the Council in the late 1990s developed and submitted a proposal to HCFA (now CMS) that would allow Utah to establish a broad-based, multiple payer mechanism to finance GME. The proposal called for payments under this mechanism to be made directly to the training programs and not to the affiliated service institutions (teaching hospitals). Payments would reward outcomes that address State workforce objectives.

Although HCFA initially insisted the demonstration incorporate Medicare, Medicaid, and other State funds, ultimately the Federal waiver that was approved will apply only to Medicare GME payments. Effective January 2003, all Medicare funds covering direct and indirect GME costs are being paid directly to the statewide Council for 5 years. Under the demonstration, the Council will create a new formula for distributing Medicare indirect GME funds based on actual documented costs. The Council also will develop a statewide physician resident rotation information system to assist with payment verification.

In 2001, the Council reached an agreement with the State Medicaid program to begin using appropriated State medical school funds as the State share for drawing down Federal matching funds under the IGT mechanism to enhance Medicaid support for GME to Utah's three teaching hospitals. The total amount in the Medicaid GME payment pool is estimated at close to \$20 million. Funds in the Medicaid pool also cover dental and podiatry education based at these hospitals. The additional Federal matching funds are weighted to provide increased support to train certain physician specialties that the Council considers to be in short supply.

Furthermore, the Utah legislature in 2001 appropriated \$566,000 in general funds to the University of Utah regional dental education program. The legislature's intended for the funds be used as the State share under IGT to obtain Federal matching funds to enhance dental residency education at the university. Utah does not have a dental school.

## Pooling Multiple Payment Sources

### Minnesota

Finding that medical education was important to the State's economy and that a more competitive health care market threatened many State teaching hospitals, the Minnesota legislature in 1993 charged the Commissioner of Health with estimating the total costs of medical education and research in the State. A subsequent series of advisory committee reports rigorously identifying the need and support for explicit funding of medical education and research culminated in a 1996 estimate that approximately \$37 million (the deficit between teaching program costs and revenue) was at risk of being lost to competition in the State's managed care market (excluding any reductions in Medicare GME payments).

To partially address the deficit, the legislature that same year authorized creation of a medical education and research cost (MERC) trust fund to capture new and existing State sources of medical education funds. In 1997, lawmakers appropriated \$5 million in new funding from the State's general fund and \$3.5 million from an existing State health care provider tax pool.<sup>35</sup> Sponsoring institutions are eligible to apply on behalf of their accredited programs and are responsible for distributing the funds to the more than 300 training sites that actually incur the cost of medical education (including non-hospital settings). Eligible applicants are accredited programs that train physicians, advanced practice nurses, physician assistants, doctor of pharmacy practitioners, and dentists. Reports from the training institutions are required to document that the distribution was made appropriately. In 1998, the legislature provided ongoing support for the trust fund by appropriating \$10 million from the State general fund for distribution in FY 1999 and by increasing the Department of Health budget by \$5 million annually beginning in FY 2000.<sup>36</sup>

Lawmakers also agreed in 1997 to carve out GME funds from Medicaid managed care rates beginning in 1999. The funds are directed to the MERC trust fund for direct distribution to teaching programs. Distribution of payments, which did not begin until 2001, is based on the amount of medical education and on Medicaid revenue volume at a given teaching site.

Currently, funding sources for the MERC trust fund include:

- *Tobacco settlement fund.* Payment of \$350 million to a medical education endowment is divided between MERC and the State's academic health centers. In 2001, MERC received \$7.3 million.
- *Medicaid matching funds.* Through an amendment to the State Medicaid plan, Federal matching funds procured through the IGT mechanism have increased GME payment levels to teaching hospitals. The State share of about \$5 million annually is provided by the University of Minnesota Academic Medical Center to Medicaid from State funds received from the State tobacco settlement. The University of Minnesota also transfers as the State share about \$2.4 million annually to Medicaid, a portion of the achieved Federal matching funds that are used to fund MERC's new dental GME innovations pool. The Department of Health distributes Medicaid matching funds for GME provider distribution to MERC.
- *State general fund payments.*
- *Medicaid managed care carve-out.*

MERC funds go to support over 2,000 FTE trainees at 400 training sites. The funding formula is cost based—for the cost per trainee in each discipline. In the first 3 years, MERC has distributed over \$53 million. Distribution of payments is not linked to State workforce or policy goals because officials do not feel that they have enough good data to determine for what professions and objectives they would want to develop incentives.

### New York

New York's payer pool is funded by both Medicaid and commercial insurers in the State. All payers pay the same rate. In 1997, the State managed to negotiate new payment rates for every payer except Medicaid. Public policy objectives are financed through surcharges that are intended to cover hospitals that provide uncompensated care. Through negotiated rates, hospitals are guaranteed a stable form of payment.

The State's goal in supporting GME through this stable funding pool allows teaching hospitals to continue research and teaching as well as to negotiate for additional funds that they were unable to receive through the pool. Funds from the pool are distributed regionally based on a 1995 resident count and are weighted to emphasize



primary care. All payments, made quarterly, go directly to the affiliated service institution based on receipts. There is no requirement to link GME expenditures with GME revenue received.

In 1997, the State set aside \$54 million (\$31 million in 2000) to establish GME reforms. The Commissioner of Health is authorized to distribute these funds annually from the GME reform pool to approved GME consortia and hospitals. This distribution is based on performance in achieving workforce goals consistent with recommendations of the Commissioner and the New York Council on Graduate Medical Education. Goals include reducing the number of physician residents trained in the State, increasing the percentage trained in primary care, and increasing the number of underrepresented minorities and those trained in ambulatory settings.

State officials conclude that the payer pool has helped to reduce the number of physician residents trained in the State, has increased the emphasis on primary care education, and has established funding through the innovations pool to support education related to addressing State workforce policy goals.

## **Use of Special Medicaid Financing Strategies**

Little is known about how widespread the use of special Medicaid financing strategies, such as disproportionate share hospital payments, provider taxes, and the ITG mechanism, for supporting GME is by States. Medicaid programs in at least 10 States, Arkansas, California, Georgia, Idaho, Michigan, Minnesota, New York, Oklahoma, South Carolina, and Utah, have adopted IGT in various forms to help pay for GME. In addition, Missouri uses provider taxes to support GME. Other States, including Nevada, Texas, and West Virginia, have discussed or considered using the IGT mechanism to expand GME payments. Recent legislation in Nevada to create a statewide Medical Education Council (similar in mission to Utah's Medical Education Council) promotes Medicaid's use of IGT to support various Council initiatives. In the late 1990s, Medicaid and higher education officials in West Virginia discussed options for using IGT to expand support for GME in community-based, rural settings.<sup>37</sup>



## MODELS OF PRIVATE-SECTOR GME FINANCING

Although it is known that Medicare and Medicaid are the largest explicit payers of GME, experts argue that GME receives significant implicit support from several private payment sources. Regarding many private sources of payment, the key word is “implicit,” because it is not possible to identify most, if any, amounts specifically allocated for GME. Teaching hospitals often refer to such non-labeled funds as core budget dollars that support GME rather than those that are identified as originating from service reimbursements of private payers. Despite continued efforts by private health plans and payers to negotiate lower rates for teaching hospitals, the Medicare Payment Advisory Commission in 2001 reported that private payers in 1999 were on average still paying teaching hospitals over 100 percent of their costs. This finding suggests that at least a portion of these higher payments were available for GME as Medicare payments to these institutions. However, a 2002 survey of acute care hospitals found that almost 60 percent of the Nation’s largest hospitals (many of which provide physician training) have canceled one or more contracts with private health plans because of poor financial results and overall financial pressures.<sup>38</sup> What impact this situation will have on private sources of implicit GME payments to these institutions is not known.

In addition to payments from traditional private payers (e.g., Blue Shield), teaching hospitals and training programs may receive private funding from several sources that more likely are identified as providing explicit support for GME. These sources include philanthropy, industry grants and contracts, professional associations, faculty practice plans, and subsidies from sponsoring or affiliated managed care plans. This section of the report briefly describes some exemplary efforts by several large MCOs to use member dues and foundation funding to train physician residents.

### Partnerships for Quality Education

Partnerships for Quality Education (PQE), based at the Harvard Pilgrim Health Plan in Boston, Massachusetts, has received support from The Robert Wood Johnson Foundation since 1999<sup>39</sup> to fund new “managed care” and interprofessional training models in several primary care residency and nurse practitioner education programs

nationwide. With foundation funding, PQE is currently supporting four programs:

- **PQE** funds medical residency and nurse practitioner programs to partner with MCOs to develop new curricula and new methods for teaching about managing care. To date, PQE has awarded thirty-two 2-year grants to residency programs and twenty-seven 2-year grants to nurse practitioner training programs, each worth \$30,000.<sup>40</sup>
- **Collaborative Interprofessional Team Education (CITE)** funds partnerships that use interprofessional teams to improve care delivery and patient outcomes. Each CITE partnership includes at least one primary care medical residency program and one nurse practitioner program working with a managed care organization or practice. Most partnerships also include schools of social work and pharmacy. To date, CITE has awarded five 3-year grants worth approximately \$450,000 each.
- **Take Care to Learn: Teaching Clinical Care Management** funds training institutions to improve the care of patients with asthma or diabetes. Grants allow the institutions to develop or enhance chronic illness management programs that serve as innovative platforms for teaching about managing clinical care. To date, this program has awarded nine 2-year grants worth about \$315,000 each.
- **Achieving Competence Today (ACT)** is a new program that supports efforts by residency programs to focus on training in system and practice improvement. ACT has awarded nineteen 2-year grants worth \$25,000 each.<sup>41</sup>

### Group Health Cooperative of Puget Sound Family Practice Residency Program

This staff model HMO’s family practice residency program (the only physician residency program at Group Health) is accredited by the Accreditation Council on Graduate Medical Education (ACGME) and has been training board-certified family physicians since 1969. The program is affiliated with the University of Washington and its network of family practice residencies in Washington, Wyoming, Alaska, Montana, and Idaho. Group Health member premiums partially subsidize educational costs associated with the residency program.

The residency also is the training site for nurse practitioner students. Group Health also offers continuing education programs for physicians and registered nurses, and plans to offer a fully paid 5-week extended orientation for newly graduating licensed practical nurses beginning in summer 2003.

Group Health's medical staff in large part comprises primary care physicians; thus, the HMO values the importance of the family practice residency as an accessible and high-quality source of future medical staff. Educational emphasis is on primary care, family medicine, and prevention and includes state-of-the-art population management and full-spectrum family practice for a managed care environment.<sup>42</sup>

## **Kaiser-Permanente Medical Groups**

One example of Kaiser-Permanente's involvement in GME is the Southern California Kaiser-Permanente Medical Group (SCPMG). SCPMG currently trains more than 250 residents in 21 Kaiser-administered GME programs in metropolitan Los Angeles. These programs include five separate family medicine residencies as well as a number of subspecialty residencies. The costs of residency education are partially funded through Kaiser's Community Affairs initiative, and funds are administered by the SCPMG Clinical Services Department. A significant number of the new physicians graduating from these residency programs go on to become SCPMG physicians. In 2001, SCPMG's residency programs were awarded a 5-year accreditation by ACGME, and many of these residencies began operating in Kaiser's newly opened Center for Medical Education that same year. Each of SCPMG's 12 different medical centers also employs a director of medical education who is responsible for the overall quality of programs and for maintaining State continuing medical education accreditation. SCPMG also provides clerkships for 400 to 500 medical students annually and in 1972 began a school to train nurse practitioners.

Under current Federal statutes, GME qualifies as a community service; therefore, the providers of this education are entitled to receive tax benefits. SCPMG residency programs in Los Angeles view their role as providing a direct community benefit not only by producing practicing physicians for the community, but also by involving residents in actual volunteer community service and in the care of medically underserved populations. Since the mid-1980s, the Kaiser Permanente Los Angeles Family Practice Residency Program has provided volunteer medical services at a couple of free clinics on a weekly basis. In the late 1990s, an SCPMG residency program director, Jimmy Hara, was appointed to the California Health Manpower Policy Commission, whose charge is to provide State funding to family practice residencies and nurse practitioner and physician assistant training programs.<sup>43</sup>

Another example of Kaiser's involvement in GME is the New York branch of the Northeast Permanente Medical Group (NPMG), a small physician group in a less populated area of the State. In the late 1990s, NPMG and the New York Medical College jointly applied for and were awarded a small seed grant from the Josiah Macy, Jr. Foundation in New York City to fund planning and development of NPMG's initial GME activity. Through earlier medical school teaching relationships, New York Medical College had a strong interest in working with NPMG to promote primary care and to develop sites for ambulatory training. In particular, NPMG was viewed by the college as an excellent training site for preparing residents for managed care practice. The ultimate arrangement involved the establishment of a managed care rotation for second- and third-year primary care residents in ambulatory sites of the group model HMO. Benefits to Kaiser of this arrangement include enhanced opportunities for physician recruitment and access to useful quality management projects conducted by participating residents.<sup>44</sup>



## CONCLUSIONS AND IMPLICATIONS FOR GME FINANCING AT THE NATIONAL AND STATE LEVELS

Rapidly changing conditions in the delivery and financing of health services—and growing pressure on government to be more efficient and accountable with shrinking public funds that face greater competition in their allocation—provide a compelling case for reform of GME payment policy at both the national and State levels. At the same time, the need for effective government support for GME persists as the private market fails in any major way to distribute the physician workforce to medically underserved and uninsured areas, to provide adequate information and analysis on the nature of the workforce, to improve the racial and ethnic diversity and cultural competence of the workforce, or to assess the quality of education and practice.

With the inconsistency of market forces and absence of Federal policy to correct local and regional imbalances in physician supply, State governments continue to be concerned about the return of their limited investments in physician training and placement. Although State appropriations to medical schools have increased steadily at least since the early 1980s, the percentage that these funds represent to the average medical school's revenue base is declining. Major payments for GME that most States make through their Medicaid programs, second only in size to Medicare's contribution, are threatened by Medicaid cost controls and major State budget deficits. States increasingly rely on loan repayment programs, tax credits, practice development subsidies, and other strategies, in lieu of scholarships, to encourage small numbers of graduating physicians to practice primary care in HPSAs.

One means that many States use to increase their return on investment involves encouragement of physician graduates to establish in-State practices. Several States stipulate that a high percentage of newly entering students to public medical schools be State residents. If States could keep more residents from matriculating to out-of-State schools by expanding medical school capacity, the question remains whether their graduates would more likely do their residency training and practice in State. To address this issue, State policymakers should consider, of course, their State's physician workforce needs and financial ability to

expand medical school capacity. Given most States' tight fiscal condition, a more feasible and effective strategy for many States might be to: 1) support an increase in the number or size of GME programs in certain specialties or locations based on State physician workforce needs, and 2) provide incentives to: a) medical school graduates to select in-State residencies as their top GME choices, and b) residencies to recruit more in-State medical school graduates. To this end, public medical schools could be encouraged to expose students systematically to the values and opportunities of in-State residencies, particularly ones located in medically underserved settings. Besides increasing training at residency sites, this goal might be accomplished by offering graduates who attend in-State GME programs full-cost stipends or by linking fulfillment of student scholarships and forgivable loans to a graduate's match and education with an in-State residency. In turn, grant funds could be provided to State GME programs to inform in-State medical students about residency training opportunities and to encourage them to apply to these programs.

As shown previously, several States have developed and demonstrated some innovative approaches to paying for GME that address one or more of the following strategies: incentives for and measures of greater accountability in distribution of payments; significant documentation of GME costs and benefits; and innovative means for pooling Medicaid GME funds with other payers.

Similarly, **the Federal Government is now in a position to reform national GME payment policy as well as to encourage States to reform their own policies for financing GME.** Such reforms should reflect:

1. Government's larger desire for publicly funded GME programs to be more efficient and accountable to public needs; *and*
2. Value in developing a more stable and equitable means for financing GME through the creation and demonstration of a multiple, public-private payer fund that draws on innovative State and private-sector financing experiences.

## Principles for GME Payment Policy by Federal and State Governments

1. *Government should pay its fair and appropriate share of GME costs by clearly determining and justifying how much it will pay and whom it will pay.* In doing so, Federal and State governments should:

- compare and weigh the value of GME support from general appropriations and entitlement programs;
- consider the appropriateness of continuing to link Medicare and Medicaid GME payments to patient care, and determine whether such payments should go to training institutions that provide little or no service to Medicare and Medicaid recipients;
- determine and become more familiar with physician workforce needs; and
- more effectively understand all current costs and revenue sources in publicly funded GME programs, and develop more equitable and up-to-date standards for measuring reimbursable costs.

2. *Government should require teaching programs receiving public funds to be more directly accountable to pertinent public policy goals of the health workforce.* Performance requirements for training programs should be established that emphasize, but are not limited to, the following:

- a) **Training in certain specialties, skill areas, and settings** (e.g., primary care, cultural competence, managed care, community and rural practice, geriatrics, and interdisciplinary teamwork) known to be in short supply or related to achieving better service, particularly for patients with low incomes and other populations that are underserved or uninsured;
- b) **Training in certain non-physician professions** (e.g., nursing, dentistry, and pharmacy) known to be in short supply or related to achieving better service, particularly for patients with low incomes and other populations that are underserved or uninsured; and
- c) **Improving the geographic distribution and racial/ethnic diversity of the health workforce** by linking government provision of supplemental training stipends for eligible physician trainees to:

- obligated service in a medically underserved area, health professional provider shortage area, or other geographically needy area upon graduation; and
- education of underrepresented minorities and other disadvantaged students more inclined to want to serve underserved populations.

To this end, government payers should be encouraged and granted flexibility to test innovative strategies for distributing such payments to various training institutions and settings in ways that best address health workforce needs. In determining which organizations should be eligible to receive GME funding, Medicare and Medicaid should examine alternatives beyond hospital teaching programs to consider other settings currently providing the training and the environments where graduates will be likely to practice. Although more training occurs outside of the hospital, and many physician residency review committees have increased requirements for training in ambulatory sites, existing funding streams largely do not cover the costs of graduate training in non-hospital settings. Moreover, the current system of making Medicare and Medicaid GME payments directly to hospitals perpetuates incentives for hospitals to expand the number and size of their residency programs with little regard given to public cost or State workforce needs.

*Medicare and Medicaid should be required to deem certain non-hospital (as well as hospital) teaching programs as qualified to receive GME payments directly.* These institutions may include, but are not limited to:

- a. Schools of medicine and other health professions training programs;
- b. Ambulatory care sites such as federally qualified health centers, other community health clinics, private group practices, and managed care plans that provide training; and
- c. GME consortia.

3. *In determining performance requirements, it is incumbent upon government to scrutinize closely training programs through establishment of regular reporting requirements and enforceable penalties for non-compliance.*

To affect a State's policy goals and health workforce priorities, new distribution formulas, training program performance requirements, and incentive programs must

produce desired results (e.g., an increase in primary care providers serving Medicaid recipients). Requiring training programs to submit performance data that track such factors as specialty mix and practice location of physician graduates could strengthen efforts by training programs and public funders to document and assess accountability, to forecast effectively, and to distribute data on physician supply and demand, both nationally and on a State or regional basis. Moreover, the format and degree of detail required in performance reports should be stringent enough to eliminate practically all opportunities for payment recipients to “game the system.”

For example, under Tennessee’s (TennCare’s) GME payment system, any medical school not achieving its target percentage of filled residency positions in primary care will have its Medicaid GME allocation for that year reduced one percentage point for each percentage point by which it fails to reach its filled residency target. The funds made available by these penalties will then be allocated to the State’s other medical schools. A penalized medical school’s full funding will be restored once it achieves its target.

4. *Government must do a better job of documenting and rationalizing GME costs and payments.*

Government payers as well as teaching programs have been given little impetus to overcome the complex challenges of isolating and documenting the actual costs of GME. Medicare and Medicaid historically have tied GME payments to patient care costs, and hospital accounting systems have done little to quantify most reimbursable teaching expenses. Thus, there has been little incentive to develop better approaches to separating out and measuring GME costs. In addressing these challenges, government payers (Medicare and Medicaid in particular) should be encouraged to conduct rigorous studies to determine and document total reimbursable GME costs in a variety of training program settings.

5. *Pooling GME funds from public and private payers can be an equitable and accountable means of distributing such funds in accordance with health workforce needs.*

For better or worse, establishing a GME fund that pools general appropriations and entitlement funds and private-sector dollars is more open to public scrutiny, focuses attention on how funds are used, and facilitates a link with State workforce needs. Having a dedicated funding

pool also makes it easier to identify spending levels and to rationalize distribution of funds in accordance with workforce needs.

States interested in establishing a dedicated GME payer pool must consider establishing some statewide entity charged with effectively distributing pooled revenues. To carry out its mission, such a State entity could conduct major assessments of State health workforce needs, could determine current training costs and revenue, could shift funds across training programs to achieve workforce goals, could set aside funds in a reform incentive pool, and could perform other functions. A reform incentive pool could provide grants through a Request for Proposal (RFP) process to teaching programs and affiliated ambulatory education locales effective in training students in needed specialties, skill areas, and settings.

6. *Government interagency and intergovernmental collaboration is essential for reform of GME financing.*

To be effective at GME reform, government payers should provide or be granted additional flexibility to test innovative strategies to analyze and distribute GME funds to various training institutions and settings in ways that best address health workforce needs. Strengthened collaboration is required in particular among and between these government institutions:

- CMS and HRSA, both with and without congressional oversight;
- CMS and State Medicaid agencies; *and*
- State Medicaid agencies and legislatures.

Two examples of the need for such collaboration include:

- Establishing a GME funding pool at the national level would require a new working relationship between CMS and HRSA (with congressional oversight). Collaboration would entail having productive decision-making discussions on linking general appropriations and entitlement funds that support GME.
- As Medicaid operates within a Federal-State partnership—and both Federal and State governments are increasingly concerned with having Medicaid funds spent efficiently and appropriately—CMS should develop a national policy (that is not preemptive or oppressive) that

promotes Medicaid GME reforms and grants States the flexibility and incentive to experiment with GME policies that are innovative and more accountable to public need. Such State models also can serve as suitable alternatives or lessons learned for HRSA, CMS, and Congress in reforming national GME policy.

## NOTES

<sup>1</sup><http://www.kff.org/kcmu> (The Kaiser Commission on Medicaid and the Uninsured, supported by the Kaiser Family Foundation, Washington, DC: 2002)

<sup>2</sup>MSNBC News, “Uninsured on the Rise,” <http://msnbc.com>, February 10, 2003.

<sup>3</sup>Jay Greene, “California Laws to Address Physician Shortages,” *American Medical News* (Washington, DC: American Medical Association, December 3, 2001): 18.

<sup>4</sup><http://www.ncsl.org/programs/insur/medmal.htm>

<sup>5</sup>Massachusetts Medical Society, *The MMS Physician Practice Environment Index Report—March 2002*, <http://www.massmed.org>. Accessed March 26, 2002.

<sup>6</sup><http://www.ncsl.org/programs/insur/medmal.htm>

<sup>7</sup>*State Budget Update: April 2003* (Denver, CO: Office of Publications, National Conference of State Legislatures, April 2003).

<sup>8</sup>*Health Policy Tracking Service Analysis of 2002-2003 Budget Change* (Denver, CO: Office of Publications, National Council of State Legislatures, September 2003).

<sup>9</sup>National Journal, *American Health Line, National Journal's Daily Briefing* (Washington, DC: The Advisory Board Company, May 16, 2003).

<sup>10</sup>Tim Henderson, *Training Nurse Practitioners and Physician Assistants: How Important is State Financing?* (Denver, CO: Office of Publications, National Conference of State Legislatures, November 1997).

<sup>11</sup>Richard A. Cooper, “There’s a Shortage of Specialists. Is Anyone Listening?” *Academic Medicine*, 22, No. 8 (August 2002): 763.

<sup>12</sup>The Association of Directors of Geriatric Academic Programs, *Geriatric Medicine Training and Practice in the United States at the Beginning of the 21<sup>st</sup> Century* (July 2002).

<sup>13</sup>Tim Henderson, *Practice Location of Physician Graduates: Do States Function as Markets?* (Denver, CO: Office of Publications, National Conference of State Legislatures, January 2003).

<sup>14</sup>Ibid.

<sup>15</sup>Tim Henderson, *Practice Location of Physician Graduates: Do States Function as Markets?* (Denver, CO: Office of Publications, National Conference of State Legislatures, January 2003).

<sup>16</sup>Tim Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (Washington, DC: Association of American Medical Colleges, December 2003).

<sup>17</sup>Association of American Medical Colleges, 2002, <http://www.aamc.org/data/finance>.

<sup>18</sup>Tim Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (Washington, DC: Association of American Medical Colleges, December 2003).

<sup>19</sup>Ibid.

<sup>20</sup>Ibid.

<sup>21</sup>Tim Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (Washington, DC: Association of American Medical Colleges, December 2003).

<sup>22</sup>[www.aafp.org](http://www.aafp.org), American Academy of Family Physicians, *State Legislation and Funding for Family Practice Programs, 1995-1996*, 1996.

<sup>23</sup>In general, all residency programs are financed through a mix of patient fees, grants, and medical education reimbursements.

<sup>24</sup><http://www.cms.gov/medicaid/>

<sup>25</sup>Medicare began “carving out” GME payments from MCO rates effective with the 1997 Balanced Budget Act of Congress.

<sup>26</sup>Tim Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (Washington, DC: Association of American Medical Colleges, December 2003).



<sup>27</sup>Although GME payments under managed care in most States now are carved out from MCO rates, there is often an inadequate accounting of the exact amount of these funds.

<sup>28</sup>Duplicative payments refer to reimbursements made more than once for the same service. In the situation of GME, such payments would include those made to a teaching hospital for the same GME costs—both as a separate direct payment and as part of capitation to MCOs that contract with such hospitals.

<sup>29</sup>*Federal Register*, Vol. 67, No. 115, Rules and Regulations, 41023; 41103, June 14, 2002.

<sup>30</sup>Lynn Barker, telephone conversation with Tim Henderson, OIG, DHHS, Indianapolis, IN, February 10, 2003.

<sup>31</sup>Tim Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (Washington, DC: Association of American Medical Colleges, December 2003).

<sup>32</sup>Utah's original waiver application also proposed to include pooling Medicaid GME payments.

<sup>33</sup>Medicaid's Federal-State matching payments rely on a formula that is tied to State per-capita income. States with per-capita incomes above the national average have a lower Federal matching rate, and those with incomes below the national average have a higher rate. States have a fiscal and political incentive to minimize the amount of their own funds spent on Medicaid and to maximize the amount of Federal matching funds that they draw down under their formulas.

<sup>34</sup>In 2003, Texas eliminated Medicaid support for GME because of budgetary shortfalls, but observers widely expect the State to consider reinstating some form of GME funding in the near future.

<sup>35</sup>These dollars were matched with approximately \$9.3 million in Federal Medicaid funds for 1 year only. A new assessment of private payers was considered, but was rejected because the assessment could not include self-funded plans. Such plans were excluded because of restrictions under the Federal Employee Retirement Income Security Act (ERISA), which prevents States from regulating the health plans of large employers that self-insure.

<sup>36</sup>New York is the only other State that supports GME through an all-payer fund.

<sup>37</sup>Alicia Tyler and other officials with the West Virginia Higher Education Policy Commission, telephone conversation with Tim Henderson, National Conference of State Legislatures, May 12, 2003.

<sup>38</sup>National Journal, "HMOs: Hospitals Canceling Contracts at 'Surprising Rate,'" *American Health Line, National Journal's Daily Briefing* (Washington, DC: The Advisory Board Company, July 5, 2000).

<sup>39</sup>PQE's funding of primary care resident education in managed care settings was launched in 1996 with a grant from The Pew Charitable Trusts.

<sup>40</sup>Under phase 1, PQE also awarded 66 partnership grants with support from The Pew Charitable Trusts.

<sup>41</sup><http://www.pqe.org> and Elizabeth March, personal e-mail communication with Tim Henderson, National Conference of State Legislatures, March 11, 2003.

<sup>42</sup><http://www.ghc.org>

<sup>43</sup>The Commission is also charged with using State of California census tracts to identify geographic areas where health care professionals are in short supply and where the population has a substantial unmet need for health care.

<sup>44</sup><http://www.kp.org/medicine/permjournal/>