Commonwealth of Massachusetts
Executive Office of Health and Human Services

Report of the Special Commission on Graduate Medical Education

July 30, 2013
# Table of Contents

**Table of Contents**

1. Executive Summary ................................................................. 3
2. Overview of Commission................................................................ 7
3. Overview of Graduate Medical Education in the Commonwealth and the United States............ 10
4. Relationship of Graduate Medical Education to the state’s physician workforce and emerging models of delivery of care .............................................................................................................. 19
5. Overview of Health Care Workforce Center activities ......................................................... 21
6. Financial analysis of Graduate Medical Education ................................................................ 24
7. Approaches taken by other states ......................................................................................... 31
8. Findings and Recommendations ........................................................................................ 37
Appendix : Briefing Book........................................................................................................ 40
7. Approaches taken by other states

To better understand different states’ approaches to GME, the Commission reviewed the Association of American Medical Colleges’ (AAMC) 50-state survey. This survey asks states to report on the types of GME funding provided, through Medicaid or other programs. The Commission reviewed the report to gauge Medicaid GME spending around the nation.

In 2012, forty-two states and the District of Columbia provided funding for GME through their Medicaid program. Of these, forty states and the District of Columbia fund GME under their fee-for-service programs with twelve states using payment calculation methods similar to Medicare. The remaining twenty-eight states (and the District of Columbia) use methods that differ from Medicare. Examples of the different methods employed by states include a per-resident method based on the teaching hospital’s share of total Medicaid revenues, costs or volume (six states) a modified Medicare methodology (three states) and a lump sum amount (three states). An additional three states make their payments to teaching hospitals using a state subsidy approved through state appropriations.

Teaching hospitals are the primary training institution for most states. Four states stated that they provided Medicaid funding to non-hospital based teaching sites (Kansas, Minnesota, Mississippi, and Virginia). Three states give Medicaid funding to medical schools as well (Oklahoma, Tennessee, and Minnesota). Twelve states allow or require funding for non-physician trainees, including nine that explicitly included graduate nursing programs.

To better understand states’ approaches to GME, staff from the Executive Office of Health and Human services conducted phone interviews with staff from several states. Five states were chosen for interviews and four of those states responded to the interview request. The states were selected for the diversity of their GME funding mechanisms, based upon examination of the AAMC 50-State Survey and interviews with experts in the field. Interviews were conducted with Minnesota, New York, Oklahoma and Texas. Characteristics of these states, compared to Massachusetts, are shown in the tables below.

<table>
<thead>
<tr>
<th>State</th>
<th>Population</th>
<th>Residents</th>
<th>Residents/100,000</th>
<th># of sponsoring institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>6.6 million</td>
<td>5,414</td>
<td>82.2</td>
<td>25</td>
</tr>
<tr>
<td>MN</td>
<td>5.3 million</td>
<td>2,183</td>
<td>40.8</td>
<td>10</td>
</tr>
<tr>
<td>NY</td>
<td>19.5 million</td>
<td>15,989</td>
<td>82.1</td>
<td>58</td>
</tr>
<tr>
<td>OK</td>
<td>3.8 million</td>
<td>810</td>
<td>21.4</td>
<td>7</td>
</tr>
<tr>
<td>TX</td>
<td>25.7 million</td>
<td>7,395</td>
<td>28.8</td>
<td>38</td>
</tr>
</tbody>
</table>

The state interviews focused on the governance structures for GME, types of funding mechanisms used, the eligibility criteria for institutions to receive funding (i.e. hospitals, training programs, or non-hospital clinical sites), and the types of trainees targeted by these arrangements (e.g. primary care residents, specialty care residents, nurse practitioners, and physician assistants).

Minnesota

Minnesota primarily provides state funds for GME through the Medical Education and Research Cost Fund (MERC). MERC was established in 1996 by the Minnesota legislature. The legislature found that teaching facilities were facing a competitive disadvantage as third party payers were becoming less willing to pay the higher costs associated with such facilities. The MERC fund was created to pay a portion of the costs of clinical training to alleviate some of the burden on these facilities.

The MERC funding mechanism has changed since its inception. Currently, the fund combines revenue from a per-pack cigarette tax and the Prepaid Medicaid Assistance Program (PMAP). The cigarette tax nets roughly $3.9 million in state taxes that are transferred to the MERC fund. This amount receives the standard Medical Assistance Federal Match which is roughly one-to-one for Minnesota. This amount is also added to the fund.

In addition, Minnesota “carves out” a percentage of its state general funds used for capitation payments to health plans under the PMAP. These carve outs also receive the standard federal match. The amount of the carve outs have diminished over the past few fiscal years. For FY14 and FY15, an estimated $49 million in combined state and federal funds will be distributed.

Finally, the University of Minnesota makes several transfers to the Department of Human Services for the purposes of supporting Graduate Medical Education.

The MERC fund distributes its funds to “training sites” by transferring funds to those sites’ “sponsoring institutions.” The sponsoring institutions then must transfer to each training site the funds they are entitled to as defined by the initial distribution from the MERC fund. The first barrier that sponsoring institution must pass is to demonstrate that they are a teaching program. From there, each site is

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>n/a</td>
<td>$597.8 million</td>
</tr>
<tr>
<td>MN</td>
<td>$40.1 million</td>
<td>$165.4 million</td>
</tr>
<tr>
<td>NY</td>
<td>$1,815.0 million</td>
<td>$2,028.5 million</td>
</tr>
<tr>
<td>OK</td>
<td>$73.4 million</td>
<td>$53.8 million</td>
</tr>
<tr>
<td>TX</td>
<td>$32.0 million</td>
<td>$296.9 million</td>
</tr>
</tbody>
</table>
allocated funds based on the individual training sites’ relative public program volume. The relative public program volume is determined by calculating each individual training site’s percentage of the total training sites' public program volume.

The MERC also adds a supplemental grant of 20% on top of the original grant to any site whose Medicaid revenue accounted for more than 0.98% of the total Medicaid revenue. The 20% supplemental grant is borne by the sites whose revenue accounts for less than 0.98% of the total Medicaid revenue pool. Sites whose total grant would be less than $1,000 are eliminated from the distribution. Portions of the distribution formula were changed in Minnesota’s most recent legislative session. Changes included a gradual phase-out of the 20% supplemental grant, which will decrease to 10% in SFY14 and disappear thereafter, and the addition of community health workers, community paramedics, and other provider types to the list of eligible providers for MERC.

Funds support training for medicine, physician assistants, dentistry, advanced practice nursing, chiropractic and pharmacy.

New York

New York has more medical residents than any other state. New York has a number of programs to support GME, with Medicaid being by far the largest source of state funds. In 2012, New York made $1.8 billion in Medicaid GME payments. New York’s Medicaid program pays GME through both FFS and managed care. New York’s Medicaid funding for GME includes both DME and IME payments. It funds GME through state appropriation as well as a “covered lives assessment” on third party payers.

New York created the New York State Council on Graduate Medical Education by Executive Order in 1987. The Council consists of 30 members appointed by the Governor. The Council provides the Governor and Commissioner of Health with advice and guidance on Graduate Medical Education policies in the state. The Council is charged with the following:

1. Graduate medical education programs including the composition, supply and distribution of residency programs, subspecialty programs and fellowship training;
2. Efforts to increase the number of minority physicians in training in New York and to increase and improve the training of physicians who will serve as medical residents, and subsequently as practitioners, in underserved areas of the State and serve populations with special health needs;
3. The number and specialties of physicians needed in New York State;
4. Policies and programs to increase the training of primary care physicians and the training of physicians in non-hospital settings; and

5. Promotion of high quality residency and training programs.\textsuperscript{33}

The Council has created several sub-committees and work groups that develop policy and individual programs which are administered by Council staff. The Council staff is located in the Office of Health Insurance Premiums in the Department of Health. The Council and its staff helped to create and oversee the Empire Clinical Research Investigators Program (ECRIP); grant programs to promote minority participation in medical education; the NYS Area Health Education Center (AHEC) program; the Institutional GME Budget; and the DOH Clinical Clerkship Survey.

In addition, the Council and its staff helped create and administer the Doctors Across New York (DANY) programs, which are aimed at training and placing physicians in underserved communities. These programs include Physician Practice Support, Physician Loan Repayment, Ambulatory Care Training, Diversity in Medicine and Physician Workforce Studies. New York also has a GME reform incentive pool/innovation pool which is aimed at encouraging new approaches to enrich teaching and address statewide residency and physician workforce goals. This pool is currently unfunded. In the past, New York also had a Designated Priority, or “Upweighting” program, that applied a tiered adjustment to Medicaid GME rates so that certain primary care programs received enhanced payments, but this program ended in 2009.

\textbf{Oklahoma}

The Oklahoma Health Care Authority (OHCA) oversees the majority of GME funding in Oklahoma. There are three types of payments: DME and IME payments to hospitals, and payments made under Oklahoma’s managed care waiver that are provided to medical schools.

Oklahoma makes quarterly direct GME supplement payments to hospitals based on resident months weighted for Medicaid days and acuity. This methodology was created to enhance GME payments and to replace reimbursements lost through implementation of managed care systems of payment. The payments are made from a pool of funds made available by matching the State funds transferred to the OHCA by the University Hospital Authority from general appropriations. In SFY 2012, the total amount of direct GME supplement payments was $16 million with roughly $5.5 million being provided by the state through the University Hospital Authority and $10.5 million being provided by the federal government.

Oklahoma also makes Indirect Graduate Medical Education payments to major teaching hospitals. To be eligible for this payment, the teaching hospital must have 150 or more resident full-time equivalents (FTEs). Only two hospitals are eligible and they split the funds equally. Payments are made once a year, with state funds coming from the Oklahoma University Hospital Trust/Authority and the Oklahoma State University Hospital Trust/Authority. For SFY 2013 (for which payments were made in

August 2012), each hospital received $15.2 million in funds with $5.5 million from the state and $9.7 million from the federal government.

Under the managed care waiver, payments are made directly to three major colleges of medicine – University of Oklahoma – OKC, University of Oklahoma – Tulsa, and OSU School of Osteopathy. These schools operate clinics throughout the state in both hospital and non-hospital settings. The payments are made in support of a contracted number of managed care recipients with a PCP who is a member of the college of medicine’s staff and in support of contractually defined specialty care services. In SFY 2013 the schools received $74 million in payments.

The payments are intended to support GME but also ensure access to care for SoonerCare recipients. Payments are contingent on the contractors’ continued performance in providing primary care and specialty services to Oklahoma Medicaid recipients, with the following requirements:

**SoonerCare member months**: a pre-established minimum number of member months (131,400 per quarter for OSU and 137,850 for OU OKC and Tulsa combined) will be maintained.

**Emergency Room utilization rate**: a pre-established maximum utilization rate established as that occurring during the first quarter of SFY 2006 (65 visits per 1,000 members for OU and 63 visits per 1,000 members for OSU) will be maintained.

**Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening rate**: a pre-established minimum screening rate (45% for OU and 63% for OSU).

**Breast Cancer and Cervical Cancer screening rates**: pre-established minimum screening rate (4% for breast cancer and 48% for cervical cancer for OU; 37% for breast cancer and 55% for cervical cancer for OSU).

**Specialty physicians employed by contractor**: minimum number of specialty physicians (350 for OU and 200 for OSU) actively enrolled as Medicaid Providers.

In terms of governance, Oklahoma created the Physician Manpower Training Commission (PMTC) in 1975 to administer programs with the goal of encouraging medical and nursing personnel to practice in rural and underserved areas. The PMTC oversees the Oklahoma Rural Medical Education Scholarship, the Oklahoma Intern-Resident Cost-Sharing Program, the Physician Placement Program, the Nursing Student Assistance Program, the Family Practice Resident Rural Scholarship Program, the Physician/Community Match Loan, and the Physician Assistant Scholarship Program. These programs have been utilized to increase the numbers of residents, physicians, nurses and physicians assistants serving rural areas in Oklahoma.

**Texas**

Texas funds GME through three sources: Medicaid, formula funding provided directly to medical schools, and the Texas Higher Education Coordinating Board (THECB). Texas’ organizational structure separates reimbursements for education expenses and medical expenses. Under Texas’ system, Medicaid reimburses certain hospitals for medical expenses incurred through GME, the formula funding supports the education and operation of residency training programs affiliated with one of the
state's eight public and one independent medical schools, while the THECB programs fund specific residency programs and support educational costs. This structure allows the THECB to focus solely on coordinating the educational aspects of GME in relation to all Texas' higher education needs.

The THECB has several programs to fund GME. All funds go directly to residency programs or to the health-related institutions. The first program provides roughly $4,400 per resident through an allocation formula. The total allocation was $56 million over 2012-2013. In addition, the THECB provides an additional payment of $3,800 per resident to family medicine residents through a trusteed fund that the THECB administers. There are 26 programs, and a total of $5.6 million was provided in 2012-2013. Appropriations have been declining; however, the Texas Legislature recently appropriated an additional $16.35 million for six new programs to support medical and graduate medical education efforts to address concerns about the need for additional GME positions.

Additionally, Medicaid provides about $32 million per year for GME. To be eligible for Medicaid GME payments, the teaching hospital must be state-owned or operated. There are a total of five eligible hospitals. Each of these hospitals provides funds to match dollars appropriated by the legislature.

Summary

In summary, most states provide Medicaid GME funding, and some states have additional funding streams such as cigarette taxes, general fund appropriations, insurer assessments, and other special funds. Some states have coordinating bodies or councils that oversee GME policy and/or funding. There is some variation across states as to the inclusion of non-hospital sites. Across states, it is clear that overall funding levels are subject to state budgetary pressures.