State Graduate Medical Education Financing Reform Efforts*

Summary
States spend $2.3 billion of their Medicaid budgets to finance graduate medical education (GME) activities. Several policy issues are prompting many states to rethink how they pay for GME. These issues include:

- the growth of Medicaid managed care, which has diminished the flow of GME funds to teaching hospitals because health plans do not always direct all of the GME payments that are embedded in capitated payment rates to these institutions;
- a shortage of primary care doctors and other practitioners in underserved rural and urban areas;
- the decline of Medicare GME support; and
- escalating health costs and the need to curb outlays.

Managed care and the pressures of a cost-competitive health care market are forcing teaching hospitals to become more accountable for the unique services they provide and for which they are reimbursed through GME. At the same time, many states are exerting greater control over teaching hospitals. By using the carrot of Medicaid GME to induce teaching hospitals to meet public policy goals linked to state needs, states are showing they can have an impact on health care delivery while controlling health care spending. Some of these goals include producing a better mix of generalists and specialists to address the health care needs of the poor, ensuring that more doctors are willing to practice in areas of the state where access to care is limited, and producing a culturally sensitive health care workforce that can deliver care to an increasingly diverse population.

States are using a variety of strategies to reform their GME payment policies to achieve these public policy goals. A growing number of states are “carving out” or segregating their GME payments from their state-set Medicaid managed care rates. By extracting the GME component from Medicaid payments, states can ensure that these dollars flow directly to the teaching hospitals that rely on GME funds to train residents. Because some teaching hospitals could lose some of these funds in the absence of a carve-out, many are willing to accept requirements to meet workforce needs rather than lose GME support. Often these segregated funds are funneled through designated funding pools that provide a vehicle to more explicitly target their use. Many states also are building on these efforts by targeting state general-fund dollars or tax revenues to affect health professions education and practice and improve health care delivery.

At a recent National Governors’ Association Center for Best Practices’ roundtable on GME in Washington, D.C., participants discussed the challenges, practices, and opportunities for GME reform at the state level.1 Many of the issues and examples highlighted in this StateLine are drawn from the
discussions at this March 1999 meeting. It describes states’ traditional role in financing GME and the strategies that several states are using to connect GME financing to state health policy goals.

GME Financing Defined
Medical education financing extends to undergraduate training in medical school as well as post-graduate education. This includes the training of medical residents in hospitals and non-institutional sites such as clinics and physician offices. This StateLine focuses only on the graduate medical education component of medical education.

Graduate medical education financing includes the direct and indirect costs associated with the training of medical residents. Direct medical education (DME) payments cover hospital overhead, which includes rent and supplies; teaching and salaries for medical residents and teaching faculty; and fringe benefits. Indirect medical education (IME) payments cover the added costs and lost productivity that a teaching hospital incurs as a result of the extra time, procedures, and equipment necessary for training residents.

States have been financing the education and training of medical residents since Medicare and Medicaid began nearly thirty-five years ago. States spend about $5 billion per year on undergraduate and graduate medical education activities. In recent years, a growing number of states have been using their purchasing authority to steer their Medicaid budgets to affect GME workforce policy and outcomes.

Problems Complicating GME Financing
Many of the issues that are prompting states to examine their GME financing policies are not new. States have been struggling to address health care access problems and other health care delivery gaps for years. Moreover, like most payers, Medicaid agencies are seeking to be more cost-effective and publicly accountable. States spend billions of their Medicaid dollars on GME, but these funds have not been tied to public policy goals to improve health care delivery or produce more primary care practitioners.

The spread of managed care has made Medicaid support for GME and its related costs less secure. The widespread enrollment of Medicaid recipients in managed care plans has changed the flow of funds to teaching hospitals. Instead of the GME payment being an automatic add-on to teaching hospitals’ reimbursement rates, the GME payment is incorporated into the rate paid to managed care plans, which do not always redirect all of those dollars back to the institutions. Because teaching hospitals are facing fiscal uncertainty, they are more willing to acquiesce to state policies that link workforce needs to funding if it protects their GME dollars.

States also have been focusing more on how they spend their GME dollars because of the growing burden to fill in Medicare GME payment gaps. Medicare spends $7 billion per year to support GME; therefore, it plays a primary role in training future physicians. Yet, in recent years, Congress has limited the federal Medicare contribution to GME as well as reduced Medicare reimbursement rates to hospitals. These federal actions are causing teaching hospitals to pressure states to broaden their role in funding GME.

How GME Is Paid For
GME has multiple sources of funding, including Medicare and Medicaid, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, university and hospital practice plans, state and local governments, and third-party payers. Medicare is the largest spigot through which GME support
flows, but Medicaid contributes the second-largest share. States contribute $2.3 billion in Medicaid dollars to GME.³

**State Payment Sources for GME**

There are three basic sources of state funds for GME: Medicaid, state tax revenues, and private payers. Most states rely on Medicaid dollars to pursue GME reforms, and many states also leverage a small portion of their general-fund appropriations— independent of Medicaid—to support undergraduate medical education. About $200 million of the $3 billion in general-fund support for medical education is directed to GME activities, mostly to underwrite family practice residency programs that can help expand the pool of primary care doctors.⁴ Minnesota and New York also require private payers to contribute to GME activities through a tax or assessment on premiums.

Forty-three states make GME payments through their traditional Medicaid fee-for-service program.⁵ Under the fee-for-service system, states have traditionally paid for GME by incorporating it into hospital payment rates or by passing through these costs and directly paying teaching hospitals. Virtually all states have GME money flowing to teaching hospitals.

**New Methods of State GME Payment: Managed Care Carve-Outs and Funding Pools**

Seventeen states specifically include Medicaid GME payments in their capitated payment rates to managed care organizations (see Table 1).⁶ States expect health plans to direct those payments to teaching hospitals, but many states do not require health plans to do so. Florida, Kentucky, and West Virginia explicitly require health plans to direct GME payments to teaching hospitals.⁷

**How States Are Redirecting the Money: Managed Care Carve-Outs**

A growing number of states are searching for ways to ensure that GME funds go directly to teaching hospitals in order to achieve broader state policy goals. One key mechanism is to “carve out” or segregate GME dollars from managed care rates. Sixteen states carve out Medicaid GME payments from their managed care rates so the funds can flow directly to teaching hospitals or other teaching programs (see Table 2).⁸

Most states have the authority to implement these carve-outs either through Medicaid state plan amendments or approved Section 1115 waivers. States that simply want to carve out GME funds to redirect them to teaching hospitals usually can easily do so through a state plan amendment, rather than the more lengthy waiver route. Health Care Financing Administration (HCFA) approval is more difficult when a state wants to distribute its Medicaid GME dollars to nonhospital providers for ambulatory-based training, pool Medicaid GME funds with other non-Medicaid dollars, or use GME funds to test new training models. States pursuing these less-traditional initiatives have often found the approval process lengthy and cumbersome. The federal government wants to ensure that these initiatives maintain a close link between Medicaid GME payments and the provision of hospital care to beneficiaries.

States pursue carve-outs in different ways and for different purposes. For Michigan and Minnesota, carving out GME dollars from their managed care rates has enabled them to manage their costs and meet public policy goals linked to state needs. The carve-out enables teaching hospitals to compete on a more even footing with nonteaching institutions for managed care business because GME costs are removed from their rates.

**Michigan’s Carve-Out.** In 1997 Michigan decided to carve out its $196-million GME contribution from Medicaid hospital payment rates to address several policy issues. The state was concerned that Medicaid GME costs were escalating and that institutions were not spending GME dollars to better
meet the health needs of Medicaid beneficiaries. The state also wanted to ensure that managed care plans that contracted with teaching hospitals to serve Medicaid beneficiaries passed on all of the GME dollars that were incorporated into the state’s capitated payment rate.

By segregating out its GME dollars, Michigan could more accurately track its GME expenditures and ensure that GME dollars flow directly to teaching hospitals. Carving out rates also gave the state an opportunity to move away from a cost-based system of hospital payment to a predetermined rate system. Using predetermined rates enables the state to limit escalating costs and achieve expenditure predictability.

Minnesota’s Carve-Out. Like Michigan, managed care plans that contracted with teaching hospitals in Minnesota were not required to direct the GME portion of their capitated rate to these institutions. Minnesota commissioned a study to determine how much of the state’s teaching hospital revenues were at risk as a result of market competition and managed care. The study exposed a nearly $40-million deficit in medical education funding attributable to managed care and competition. As a result, in 1997 the legislature directed the department of human services to carve out the GME component of the Medicaid managed care capitated rate starting in 1999. These funds will be transferred to the department of health for distribution to teaching facilities. The goal is to ensure that the teaching institutions receive the GME funding intended for them. The funds will be carved out of capitation rates from the prepaid medical assistance program and prepaid general assistance medical care program. The legislature ordered that the approximately $18 million in funds be transferred to a state-run trust fund to support various GME activities.

How States Are Using the Money: Funding Pools and Trust Funds
States have shown that when these carved-out funds are targeted through vehicles such as designated trust funds or funding pools, they can reshape the health care workforce to meet local needs. Medicaid carve-outs or funding from general revenue or other sources have increased states’ ability to develop financing pools or trust funds dedicated to GME. These pools or funds separate and isolate GME dollars and provide a vehicle to more explicitly target their use. Pools can link GME financing with state policy goals, such as encouraging the production of certain types of physicians and supporting GME training in ambulatory-care sites.

Michigan’s Funding Pool. By carving out all of its GME Medicaid dollars and dividing the $196-million among three different pools, Michigan hopes to improve care to Medicaid beneficiaries. The state legislature appropriates the money each year and decides how it should be distributed in consultation with the department of community health. The state is committed to supporting the research, education, and specialized care missions of its teaching institutions. Yet it also views the pooling of money as a means to align funding incentives with state health policy goals, such as providing health professionals in underserved areas, emphasizing the importance of primary care, and promoting community-based managed care and population-based care training.

The state has designated three pools. About $166 million pays hospitals for GME activities. Another $20 million funds a primary care pool that aims to encourage primary care education in the fields of general practice, family practice, preventive medicine, obstetrics, and geriatrics. A third pool, the $13-million multiyear Innovations in Health Professions Education Fund, is designed to foster new strategies for health professions education and reward training programs that use creative teaching approaches to advance state goals. For example, the education fund supports a program that uses allied health professionals to help deliver care to Medicaid high-risk populations and a program that combines a medical residency in psychiatry and primary care in urban settings.
**Minnesota’s Trust Fund.** Minnesota has set up a Medical Education and Research Cost Trust (MERC) fund that collects money from Medicaid and other payers to support GME activities. The state believes that the trust fund is the best way to ensure flexibility to achieve broader state health policy goals, though it has not yet decided whether to tie the distribution of funds to various performance outcomes. For now, funds are distributed to institutions based on costs and the number of trainees. In time, the state plans to explore directing money away from or toward specific areas of practice or specialization that it deems important. Most of the trust fund dollars are directed to programs that train physicians, but the fund also supports advanced practice nurses, physician assistants, doctors of pharmacy, dentists, and chiropractors.

The fund was established to support clinical training for certain medical professions and compensate training sites for some of their costs. In 1999 the fund will include $10 million from a new general-fund appropriation. The state was able to obtain federal matching dollars, bringing the total to $20.6 million. Minnesota’s legislature decides how GME funds are distributed. The formulas are set in law, but the legislature seeks input from the state health department on how to distribute direct appropriations and carve-out amounts.

The state also plans to pool its Medicaid carve-out money, totaling about $18 million, into the same trust fund. It is awaiting approval from HCFA to carve out the GME component of its prepaid medical assistance program and prepaid general assistance medical care capitation rates so it can transfer those funds to MERC.

**New York’s Funding Pools.** New York has taken a slightly different approach in creating its funding pools. Prior to 1997, New York paid teaching hospitals $1.8 billion in GME payments that were folded into state-set hospital rates paid by Medicaid and private payers. Today, under a reformed system, the state carves out from its Medicaid managed care rates the amount estimated to be associated with GME. Hospitals bill Medicaid for the GME component of the claim directly. The state Medicaid agency spends $900 million on GME through both Medicaid fee-for-service rates and the managed care carve-outs. However, unlike Michigan, New York has decided not to pool those Medicaid managed care funds.

The state has generated another $544 million through an assessment on private payers, about half of which was included in the hospital rate-setting system that was reformed in 1997. The monies are directed to a professional education fund. Most of the funds—about $490 million—are distributed to teaching hospitals based on their share of residents in 1995 and their GME costs per resident. These payments are based on historical costs, so the state believes the teaching hospitals have no incentive to increase the number of residents. About $54 million of the fund is deposited in a GME Reform Incentive Pool. Through this pool, the state hopes to achieve certain workforce policy goals. These goals include downsizing the number of residents trained and the number of specialty residency positions; boosting the number of residents in primary care; encouraging ethnic diversity among practitioners; promoting practice in underserved areas; and retaining primary care doctors. Hospitals or groups of training institutions are eligible to receive the funds, and distribution is performance-based and linked to achieving any of the workforce policy goals.

**State Strategies to Supplement GME through Targeted State Revenues**

In addition to Medicaid, several states are tapping general revenues to support GME. Most of these efforts supplement the larger Medicaid pool. Yet states are showing that even limited funds from state appropriations or provider assessments can leverage change in the health care workforce. These states are trying to tie performance measurements to goals and appropriations, and some of their efforts are yielding positive outcomes.
New York’s Efforts to Promote GME Reform

New York has three initiatives designed to influence GME policy: a Designated Priority Program, a Minority Recruitment and Retention Program, and a Reform Incentive Pool.

- **Designated Priority Program.** The Designated Priority Program was established in 1990 to provide enhanced Medicaid GME reimbursement for primary care providers who meet certain state criteria, including having more than half of program graduates practice in primary care. Under the plan, hospitals with higher ratios of primary care residents receive additional indirect medical education payments. Programs receiving funds also have to show that residents spend a portion of their training time in community settings that offer a comprehensive range of services.

- **Minority Recruitment and Retention Program.** The state also provides $3 million to medical schools, primary care residency programs, and groups of teaching hospitals to enhance minority recruitment and retention in medicine, establish mentoring programs, and encourage faculty role models.

- **Reform Incentive Pool.** The state’s $54-million Reform Incentive Pool distributes monies to teaching hospitals that meet certain state policy goals, including reducing residency positions and programs, increasing the number of primary care specialists, boosting underrepresented minorities in training, and placing residents in ambulatory-care sites and underserved areas of the state.

Some of these efforts, combined with other market pressures to be cost-effective or decrease costs, have been successful, according to the state. Under the Reform Incentive Pool, more than 1,400 specialty slots were converted to primary care slots and 740 positions were eliminated. A Medicare demonstration project to encourage residency downsizing also contributed to these results. In addition, the pool has increased the percentage of underrepresented minorities from 11.0 percent to 12.5 percent.

California’s Approaches to Targeting Revenue

For twenty-five years, California has been providing incentives to encourage family practice and other primary care specialties. The program, administered by the California Office of Statewide Health Planning and Development in collaboration with the Health Manpower Policy Commission, now provides more than $5 million each year for the training of family practice physicians, primary care physicians, primary care physician assistants, and family nurse practitioners.

The program aims to support training in areas key to the state, including those that promote a focus on managed care, rural health, elderly health care, and HIV treatment. Although the amount each institution receives is relatively small, state officials say that the funding has brought about changes in primary care training. For example, California has seen a steady increase in the number of graduates who remain in the state and practice in health professions shortage areas. The state also has seen significant increases in the number of residents who practice family medicine, internal medicine, and pediatrics, while it has seen a substantial decline in the number of residents who specialize in surgery, anesthesiology, and psychiatry.

After the failure of a bill that would have required the University of California medical school system to achieve a fifty-fifty split between its proportion of primary care and nonprimary care residents, the university agreed to devise strategies for training generalist physicians. In a memorandum of understanding with the state health planning department, the university sets yearly targets for increasing family practice and other primary care medical residency positions and for decreasing nonprimary care residency positions. Since 1992, the state estimates that the university has added more
than 300 primary care residency positions, including 203 family practice positions, and eliminated slightly more than 200 nonprimary care positions in its university-based and university-affiliated programs.

The state also has set up a Medi-Cal medical education supplemental payment fund that relies on intergovernmental transfers to promote more primary care training. California Medi-Cal negotiates contracts with hospitals to pay for services for beneficiaries. In 1997 the university system, concerned about the potential loss of Medicare GME funds triggered by congressional action, proposed making an intergovernmental transfer of $50 million in university clinical education funds to obtain federal matching funds. In return, it wanted the Medi-Cal Commission to enhance contract rates for university hospitals to recognize the medical education costs they incur for services rendered to Medi-Cal beneficiaries. As a result, the legislature also expanded the number of institutions, including large teaching institutions and children’s hospitals, eligible for the enhanced contract rates. The distribution of funds is tied to the volume of Medi-Cal hospital days, the mix of primary care and specialist residents, and data indicating that the institution is meeting additional service obligations.

The Federal Perspective: Are Medicare GME Reforms Aligning with State Efforts?

As states pursue strategies to reform their GME financing policies, Medicare is taking some smaller steps but facing some larger hurdles. One step was the New York Medicare pilot program, which the federal government is now expanding nationwide.

New York teaching hospitals, particularly city-based ones, initially sought and embraced the idea of having Medicare pay hospitals under a new formula if they trained fewer doctors. The pilot program calls for phasing out lost Medicare dollars to help hospitals transition to training fewer residents. To receive the funds, hospitals are required to cut 20 percent to 25 percent of their residents over five years. The demonstration pays hospitals the money they would lose from eliminating residents—-but at a declining rate. The federal government is paying about $400 million in incentives, which is $300 million less than what it would pay under the existing system.

In 1997 dozens of teaching hospitals across the state lined up in support of the pilot as a way to ease the glut of physicians in the United States. That same year, the state eliminated a policy dictating the rates that hospitals could charge insurers. In addition, Medicare was set to reduce payments to hospitals for training doctors under the 1997 Balanced Budget Act. New York hospital officials reasoned that the federal subsidy program would enable them to end their reliance on medical residents and withstand the Medicare payment cuts.

Yet, in recent months, numerous hospitals have been dropping out of the pilot program after realizing how difficult it is to replace the low-cost labor that residents provide. The hospitals found that they had to replace the low-cost residents with more costly practicing doctors who work half the hours. Although the hospitals knew this was likely to happen, they also have been faced with increasing patient loads and looming cuts in Medicare GME payments.

Given the outcome in New York, few expect this project to have a nationwide impact. The Health Care Financing Administration admits that only a few hospitals will be interested in participating in the national program because of the large cut they would have to make in their residency program.
Outlook

Despite the challenges in pursuing GME reform, states have made progress in setting goals that reflect their needs. For states, a carve-out can provide a clearer recognition of the total value of GME expenses because it exposes costs that historically have been hidden. Some states report that carving out GME payments enables them to establish mechanisms to achieve health workforce goals and provides them with greater predictability of expenditures as well as control over outlays. From the perspective of teaching hospitals, carving out GME funds enables them to be shielded from the volatility and influences of managed care. It also helps ensure that the dollars designated for GME can go directly to teaching programs.

Although each state has different needs, all are pursuing two key objectives: more control over their GME dollars and improved health care delivery. However, it is still too early to assess the effectiveness of many of these new financing mechanisms.

States also have to be aware that there is no consensus on what constitutes a “reasonable” cost to train physicians. States have experienced difficulty in trying to quantify these costs and have tried to do so in different ways. For example, the Texas Medicaid agency has changed how it pays for GME, partly in response to complaints from teaching hospitals that they are at an unfair disadvantage when it comes to vying for Medicaid managed care contracts because their costs are higher than other hospitals. The state has decided to quantify those costs by embarking on a rigorous process—called a “time/motion” study—that can be very resource-intensive, expensive, and, perhaps, nondefinitive. Nevertheless, the state believes that carefully tracking how much time is spent on all residency-training components is the best way to determine the real cost of GME. Minnesota used internal estimates of direct costs and consultant estimates of indirect costs to quantify the state’s GME costs. In contrast, Michigan attempted to assess its GME costs by basing them on what it paid hospitals on a historical cost basis.

States that have embarked on GME financing reforms offer some lessons learned.

- Much of what drives GME policy is sensitive to the political environment in each state. Academic medical centers have a lot of clout, so they need to be involved in discussions.
- Reaching agreement with stakeholders is critical to effective policy development and implementation.
- States should know what policy goals they want to achieve before embarking on GME reform. They should also know where GME dollars are going, what hospitals in their state are providing GME, and how those dollars are serving the Medicaid population.
- The magnitude of the problem should guide decisions about how much money the state should try to funnel into the system. A fundamental understanding of how GME works within a state is essential before reshaping policy. States need to know exactly what they are spending on GME because legislators need a good sense of how much money they should invest in reform efforts.

Medicaid’s importance as a GME payer will be enhanced as Medicare support for GME declines and private payers such as managed care plans fund less GME. Teaching hospitals have expressed concerns about the financial effects of the Medicare payment cuts stipulated under the Balanced Budget Act, including the proposed cuts in indirect medical education payments and the cap on residency slots. Hospitals also are worried about a congressional proposal that would change direct medical education Medicare GME payments from an entitlement to an appropriation, forcing Medicare GME to compete with other discretionary health programs for revenues each year. These proposals will put pressure on states to increase their Medicaid GME support to help keep these institutions afloat. Says one state health official, “There is tremendous pressure…. As Medicare support dwindles, hospitals want the
state to replace what the federal government won’t be providing.” As laboratories of change, states can help set the national GME reform stage by making strategic decisions about how they spend and direct their own dollars and tie these funds to state health policy goals.

*This StateLine was written by Janet Firshein, an independent health writer in Washington, D.C., and Tracey Orloff, formerly a senior policy analyst in the Health Policy Studies Division of the National Governors’ Association Center for Best Practices. Funding for this StateLine was provided through a cooperative agreement with the Bureau of Primary Health Care, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

1 Representatives from California, Georgia, Michigan, Minnesota, New York, and Texas participated in the roundtable.
2 Tim Henderson, *Funding of Graduate Medical Education by State Medicaid Programs* (Washington, D.C. National Conference of State Legislatures for the Association of American Medical Colleges, April 1999).
3 Ibid.
4 Tim Henderson, personal communication with authors, May 1999.
5 Tim Henderson, *Funding of Graduate Medical Education by State Medicaid Programs*.
6 Ibid.
7 Ibid.
8 Ibid.
Table 1: States Including Medicaid Graduate Medical Education Payments in Capitation Rates to Managed Care Organizations, March 1999

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Requires Managed Care Organizations to Distribute Payments to Teaching Hospitals</th>
<th>Medicaid Assumes Managed Care Organizations Will Distribute Payments to Teaching Hospitals</th>
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<td>Wisconsin</td>
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Notes:  
1 Minnesota currently includes Medicaid graduate medical education (GME) payments in managed care organization rates, but it plans to make GME payments directly to teaching programs under capitated managed care as part of a federal waiver that allows federal financial participation in the state’s medical education and research trust fund. Approval is expected by mid-1999.  
2 In Ohio Medicaid leaves it up to managed care organizations to consummate private agreements with teaching hospitals that include how Medicaid GME payments are handled.  
3 In West Virginia, indirect GME payments remain in the capitation rates paid to managed care plans, but direct GME are made directly to teaching hospitals.

Table 2: States Making Medicaid Graduate Medical Education Payments Directly to Teaching Programs under Managed Care, March 1999

<table>
<thead>
<tr>
<th>State</th>
<th>Rationale for Making Medicaid Graduate Medical Education Payments Directly to Teaching Programs (Carve-Outs)</th>
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<tbody>
<tr>
<td>Arizona</td>
<td>Opposition from teaching hospitals to losing GME payments; GME seen as public good.</td>
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<tr>
<td>Colorado</td>
<td>Opposition from teaching hospitals to losing GME payments; GME seen as public good; desire to use Medicaid funds to advance state policy goals.</td>
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<tr>
<td>Iowa</td>
<td>Opposition from teaching hospitals to losing GME payments.</td>
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<tr>
<td>Maryland</td>
<td>GME seen as public good; desire to use Medicaid funds to advance state policy goals.</td>
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<td>Michigan</td>
<td>Opposition from teaching hospitals to losing GME payments; GME seen as public good; desire to use Medicaid funds to advance state policy goals.</td>
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<td>Minnesota1</td>
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<td>Missouri</td>
<td>GME seen as public good.</td>
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<td>Nebraska</td>
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<td>New York</td>
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<td>Oklahoma</td>
<td>GME seen as public good; desire to use Medicaid funds to advance state policy goals.</td>
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<td>Pennsylvania</td>
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<td>South Carolina</td>
<td>Opposition from teaching hospitals to losing GME payments; GME seen as public good; desire to use Medicaid funds to advance state policy goals; follow Medicare to make GME payments to teaching hospitals for Medicare managed care enrollees.</td>
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<tr>
<td>Tennessee</td>
<td>Desire to use Medicaid funds to advance state policy goals.</td>
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<td>Virginia</td>
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<tr>
<td>Washington</td>
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<tr>
<td>West Virginia2</td>
<td>Follow Medicare to make GME payments to teaching hospitals for Medicare managed care enrollees.</td>
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</tbody>
</table>

Notes: 1 In Minnesota plans to make Medicaid graduate medical education (GME) payments directly to teaching programs under managed care are pending approval of a federal waiver that would allow federal financial participation in the state’s medical education and research trust fund.

2 In West Virginia, indirect medical education payments remain in the capitation rates paid to managed care plans.

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