GME Payments by State Medicaid Programs

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Medicaid and GME

Medicaid is the 2nd largest explicit payer for GME. *(behind Medicare)*

- Payments are intended to cover hospital teaching costs, not address physician workforce needs.
- States are not required by CMS to report GME payment amounts.

AAMC surveys are the sole source of nationwide payment information.

State Medicaid programs are not required to pay for GME.

- *Yet,* nearly all states (historically) follow Medicare in making payments under their FFS program.

Now, most states also pay for GME under their managed care program.

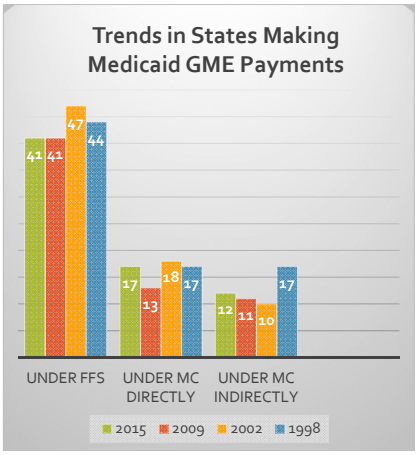
- Of 39 states with risk-based managed care, 26 states and DC (69%) fund GME (2015).

Total of 42 states* and DC provide GME payments under Medicaid (2015).

- The remaining states, at one time, made payments.

* 43 *(includes NC, post-survey)*

Medicaid and GME - 2015



16 states & DC make Medicaid GME payments directly to teaching programs under risk-based managed care.

Major reasons:
- Desire to use Medicaid to advance state policy goals.
- Desire to help train next generation of physicians who will serve Medicaid beneficiaries.
- Belief that GME is a public good.

12 states recognize/include Medicaid GME payments in their capitated payment rates to MCOs.

MCOs may not be bound to distribute these dollars to hospitals with training programs:

- **Half** the states require MCOs to distribute these payments in their negotiated rates to teaching hospitals *(up from 2 states in 2005).*
- All but 1 state provide MCOs a specific methodology for determining GME add-on payments.

Medicaid and GME - 2015

3 states identify medical schools as eligible to receive GME payments.
- Tennessee and Oklahoma – **Medical schools** are the only training institution eligible for payments *directly under managed care*.
- Minnesota -- **Schools of medicine, nursing, dentistry and pharmacy** are eligible for payments *under FFS* and *managed care*.

2 states pay individual teaching physicians (ITPs) for GME costs. *(1st time on survey)*
- Florida pays ITPs *under FFS*.
- South Carolina pays ITPs *under FFS* and *managed care*.

32 states make GME payments with expectation of producing more physicians.
(who will serve Medicaid beneficiaries).
- A significant *increase* over 22 states having expectation in 2012.
- Over two-thirds of states have difficulty ensuring a sufficient supply of providers for beneficiaries.

Medicaid and GME - 2015

Medicaid payments for GME nationwide continued to rise. **However:**

- 3 states — *Iowa, Michigan, and New Mexico* — reported they have explicitly reduced payments.
- Another 7 states reported payments that were more than 10% less than those in 2012.

For first time:
Proportion of payments made under **MC** ***exceeded / was significantly higher*** than proportion of payments made under **FFS**.

	2015	2012	2009	2002
Total GME Payments	$ 4.26 billion	$ 3.87 billion	$ 3.78 billion	$2.5–$2.7 billion
Proportion Made Under FFS	39 %	59%	63%	---
Proportion Made Under MC	61 %	41%	37%	---

Nine (9) states use a special financing mechanism (DSH, IGT, PT) **to pay for GME.**

Policy issues **not** addressed in this survey

Transparency and accountability of Medicaid GME payments, regarding:

Stewardship and performance of public dollars

Do payments flow clearly, and fully reach their intended destination for their intended use?

Achievement of physician workforce needs

Do payments support innovation in teaching, and actually contribute to producing physicians who will more likely serve Medicaid beneficiaries?

Do Medicaid agencies routinely audit the distribution and use of GME payments within teaching hospitals and MCOs? **GAO and IOM (NAM) would like them to!**

Medicaid

The nation's largest health insurer, covering 73 million persons.

Largest source of federal funds to states.
Plus, federal spending to states up 22% since 2014 when Medicaid expansions began under ACA.

Single largest expense in most state budgets - 27% on average of all state spending (2015).

Improved state finances have allowed more states (overall) to restore/enhance provider rates.

Over 70% of beneficiaries now in managed care, largely in risk-based MCOs.
New federal rules to modernize regulation of MCO contracts/performance *(including rate setting).*

BUT.....
Will Medicaid continue to look like this in the future?

Medicaid Reform *(Reducing Federal Spending)*
Hints from the **New Congress and Administration**

- States to receive federal funds *via*: **a capped, per capita or state-based allotment *or* block grant**:

  Per capita *or* state-based allotment: Follows 4 beneficiary categories *(aged, blind/disabled, children, adults).*

  Block grant: States have more control over costs, benefits and design, *but* **receive less federal funds**.
  Any costs above grant are paid by the state; any savings would be kept by the state.

  Could eliminate: 1) coverage for all who are eligible, *and* 2) the federal-state matching structure.

  Possible backlash for Republican Governors in Medicaid expansion states *(about half the total)*

- Create a **broader state-waiver program** that would allow the Administration to achieve **cuts** in federal spending *state by state.*

Will such Medicaid reforms impact
support for GME *?*

? Less Federal Funds

? Loss of Federal-State Matching