



CRS Report for Congress

Medicaid and Graduate Medical Education

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Summary

Medicaid finances the delivery of primary and acute medical services, and long-term care, for certain low-income populations. Most states make Medicaid payments to help cover the costs of training new doctors in teaching hospitals and other teaching programs. Historically, both Medicare and Medicaid have recognized two components of graduate medical education (GME) costs: (1) direct graduate medical education, or DGME (e.g., resident salaries, teaching supervision), and (2) indirect graduate medical education, or IME (e.g., higher patient care costs because of additional tests ordered by residents). There are no federal reporting requirements to document Medicaid GME payments by states. Survey data show that such costs (federal and state) totaled nearly \$3.2 billion in 2005, representing 7% of Medicaid inpatient hospital expenditures nationwide. In May 2007, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would eliminate federal reimbursement for both DGME and IME under Medicaid. The rule would also change the way in which the Medicaid upper payment limit for hospital services is calculated, which would further reduce the federal share of Medicaid costs for hospitals. Federal savings from the proposed rule were estimated to be \$1.78 billion over five years. P.L. 110-28 (the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act) included a moratorium on further action by the Administration on this proposed rule until after May 25, 2008. Other legislation would extend this moratorium.

Graduate Medical Education

Graduate medical education is clinical training in an approved residency program following graduation from schools of medicine, osteopathy, dentistry, and podiatry. All states require residency training to be licensed. Most states require three years of such training. The residents, who are serving a form of apprenticeship, provide patient care under the supervision of a teaching physician, primarily in teaching hospitals.

GME costs are difficult to determine because teaching occurs in the context of patient care and research. There are direct GME (DGME) costs, which include residents'

stipends, payments to supervising physicians, and direct program administration costs.¹ There are also indirect GME (IME) costs associated with the higher patient care costs in teaching hospitals resulting from treating sicker patients, using more diagnostic tests, and longer patient stays. Under prospective payment systems (PPS), which do not pay entities for each test or procedure performed,² an explicit adjustment (payment increase) for IME is sometimes viewed as necessary.

Medicare and, in some states, Medicaid make explicit payments to teaching hospitals for their GME costs.³ Federal appropriations under the Public Health Service Act support primary care residency programs and other health professional education, as well as support for children's teaching hospitals. Other sources of funding include research grants, endowments, and foundation grants. The Department of Veterans Affairs and Department of Defense also support residency positions.⁴ The flow of funds among those involved in GME is complex and frequently involves cross-subsidies between medical schools, teaching hospitals, and other training sites.

Benefits and Service Delivery Systems Under Medicaid

Medicaid pays for a wide variety of health care benefits for certain low-income populations, including inpatient hospital services. In addition, states have flexibility in designing Medicaid service delivery systems and provider payment rates. States may, for example, provide care through what is called the "fee-for-service" (FFS) delivery system. Under FFS, beneficiaries have unrestricted choice among Medicaid participating providers, and they are largely responsible for their own medical care management and coordination. The state directly (or through a fiscal intermediary) pays each participating provider for covered services received by a Medicaid beneficiary. Generally, FFS payments to hospitals are based on prospective payment systems, as described above.

Medicaid managed care arrangements are significantly different from the FFS delivery system. Beneficiaries choose (or are assigned to) a primary plan that provides care coordination and management. Traditional managed care plans, such as health maintenance organizations (HMOs), make available a specified set of mostly preventive, primary, and acute care benefits for which the state pays a fee on a "per member per month" basis, called a premium or capitation rate. These rates typically reflect the average FFS cost of providing care to specified groups of plan beneficiaries.

In addition to these methods of paying providers for benefits covered under both the FFS and managed care delivery systems, states make other supplemental payments to selected providers. For example, the Medicaid statute requires that states make

¹ These DGME costs may be incurred by multiple entities, including the program sponsor, the faculty practice plan, and the hospitals and ambulatory sites that provide training.

² Payment amounts per day or per case are fixed at the start of a year and generally are not subject to retrospective adjustment on the basis of actual costs incurred.

³ Medicare spent about \$6 billion in IME and \$2.4 billion in DGME in 2007. State support for GME may also include appropriations to state-operated medical schools or residency programs.

⁴ The VA maintains approximately 8,800 or about 9% of all full-time residency positions and is the nation's largest provider of GME.

disproportionate share (DSH) adjustments to the payment rates of hospitals treating large numbers of low-income and Medicaid patients. Federal statute specifies DSH allotments for each state. States must define, in their state Medicaid plan, hospitals qualifying as DSH hospitals and DSH payment formulas.⁵ Most states also make GME payments under Medicaid. Such payments may be made directly to teaching hospitals similar to DSH payments, as a part of capitation rates under managed care, or both.

Medicaid and Graduate Medical Education

In FY2005, total Medicaid spending for the federal and state governments combined was approximately \$273 billion. Almost \$35 billion or 12.8% of total spending was for inpatient hospital services paid for through FFS. Additional payments related to inpatient hospital care under capitated managed care are not separately identifiable.⁶

While there is no formal federal reporting mechanism to document Medicaid GME payments by state, other survey data⁷ show that Medicaid is a major payer of GME. For example, in 2005, total state and federal Medicaid payments for DGME/IME were estimated to be nearly \$3.2 billion. On average, Medicaid DGME/IME payments nationwide represented 7% of total Medicaid inpatient hospital expenditures. State-specific DGME/IME proportions varied widely, from less than 1% to more than 21% of inpatient hospital expenditures.

States made Medicaid DGME/IME payments under both the FFS and managed care delivery systems in 2005. For example, 47 states made DGME and/or IME FFS payments. Twenty-two states reimbursed for both DGME and IME under the FFS delivery system.⁸ Among the 36 states with capitated managed care programs, 25 included DGME and/or IME payment under such care arrangements.

States used different methods to distribute GME-related payments to providers. For example, under the FFS delivery system, 32 states that paid for DGME/IME distributed those payments through hospitals' per case or per diem reimbursement rates. Twenty states made a separate direct payment to these institutions. Five states used both methods.

Under capitated managed care, 15 states made DGME/IME payments explicitly and directly to teaching hospitals and programs. Ten states included DGME/IME payments in their capitation rates paid to managed care organizations (MCOs). Of these 10 states, 2 required MCOs to distribute these payments through their negotiated rates to hospitals, and the other 8 assumed MCOs provide these payments to hospitals.

⁵ For more information on DSH under Medicaid, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

⁶ Based on analysis of the CMS Medicaid DataMart data, downloaded on February 17, 2008. Data for Maine were missing.

⁷ In this report, references to 2005 survey data are to information contained in *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey*, by Tim M. Henderson, published by the Association of American Medical Colleges, November 2006.

⁸ For 10 other states, payments do not distinguish between DGME/IME; 13 states pay only DGME and 2 states pay only IME.

The Proposed Rule on Medicaid GME Payments

On May 23, 2007, CMS issued a proposed rule that would make two specific changes affecting GME payments under Medicaid.⁹ First, it would eliminate all federal payments for DGME and explicit IME. However, states may otherwise recognize the higher costs of teaching hospitals through increased base payment rates or supplemental payments. Second, the rule would also remove Medicare DGME payments from the calculations that set the Medicaid upper payment limit (UPL) for hospital services. In general, Medicaid payments for inpatient hospital services cannot, in the aggregate and within three provider categories (state government, non-state government, and private), exceed a reasonable estimate of what Medicare would pay for the same services. Medicare excludes DGME costs in the calculation of per discharge payment amounts for hospital services. Thus, CMS argued such costs are not appropriate in calculating Medicaid payments either. The proposed rule does not discuss GME in the context of Medicaid waivers.¹⁰

The proposed rule retains the inclusion of Medicare IME payments in the calculations that set the Medicaid UPL for hospital services, because such IME payments are intended to reflect the higher per patient costs in teaching hospitals (e.g., residents order more tests than experienced physicians).

The estimated federal savings for all of these changes under the proposed rule would total about \$1.78 billion over the FY2008 through FY2012 period.¹¹ The rule would apply to all Medicaid providers and must be implemented in the first full state fiscal year following the effective date of the subsequent final rule. A recent congressional study indicates that this rule would result in the loss of roughly \$9.8 billion over the next five years in 36 states affected by the rule that could provide such estimates.¹²

Justification for the Proposed Rule

CMS provided several justifications for its proposed rule on Medicaid GME payments published in May 2007. For example, CMS argued that, in contrast to the Medicare statute, GME payments are not authorized in Medicaid statute. GME is not

⁹ “Medicaid Program; Graduate Medical Education,” 72 *Federal Register* 28930, May 23, 2007.

¹⁰ States have the flexibility to waive certain Medicaid program requirements to, for example, provide services to individuals not traditionally eligible, limit benefit packages for certain groups, and provide home and community-based services to people with long-term care needs, among other purposes. The two primary provisions states use for these purposes are Sections 1115 and 1915(c) of the Social Security Act.

¹¹ CBO estimates that the proposed rule on GME will reduce federal outlays by \$0.8 billion over five years. For such proposed rules, CBO generally assigns a weight of 50% in its baseline to reflect the uncertainties of the administrative process. After a regulation becomes final, CBO fully incorporates the projected effects into the baseline (after any applicable moratorium ends). See Congressional Budget Office, *Medicare, Medicaid and SCHIP Administrative Actions Reflected in CBO’s Baseline*, February 29, 2008.

¹² See *The Administration’s Medicaid Regulations: State-by-State Impacts*, prepared for Chairman Henry Waxman by the Majority Staff, U.S. House of Representatives, Committee on Oversight and Government Reform, March 2008.

included in the list of services considered to be “medical assistance” in Section 1905(a) of the Medicaid statute, and is not recognized in Medicaid statute as a component of the cost of Medicaid inpatient and outpatient hospital services. CMS noted that while Medicaid DSH payments recognize the health service activities of certain hospitals, GME is not a health service. CMS also stated that it has no statutory authority or other existing mechanism or data to track or monitor the efficiency and economy of GME payments, raising concerns about the fiscal integrity of the Medicaid program.

Opposition to the Proposed Rule on Medicaid GME Payments

Hospital industry groups and associations have commented on the proposed Medicaid GME rule.¹³ These organizations note that this rule represents a reversal of long-standing Medicaid policy, and that GME payments have previously been explicitly recognized by CMS. In addition, concerns have been raised that cuts of this magnitude will jeopardize the financial condition of many teaching hospitals right when there is an impending physician shortage.¹⁴ At the winter meeting of the National Governor’s Association,¹⁵ state officials justified GME payments because interns and residents provide a great deal of care to Medicaid beneficiaries.

Some commenters noted that there are explicit references to GME payments in both Medicaid statute and regulations that legitimize such payments under Medicaid.¹⁶ First, Section 1932(b)(2) stipulates that non-MCO providers that deliver emergency care to an MCO beneficiary must accept as payment in full (up to) the maximum amount applicable in the FFS setting, minus any GME payments. Second, Medicaid regulations (42 CFR 438.6(c)(5)(v)) indicate that if a state makes direct GME payments to hospitals, the state must adjust capitation rates for managed care to account for GME payments made on behalf of MCO beneficiaries. In both cases, the provisions were intended to prevent duplicate GME payments under Medicaid managed care. In addition, this regulatory provision, which was added by CMS in 2002, was intended to mirror requirements in Medicare managed care, as well as to jointly address state concerns about preventing harm to teaching hospitals and federal concerns about ensuring fiscal accountability for these

¹³ See Cozen and O’Conner, memorandum to the Association of American Medical Colleges, June 20, 2007, at [<http://www.aamc.org/advocacy/library/teachhosp/corres/2007/062207.pdf>], hereafter referred to as “Cozen and O’Conner/AAMC memo”; American Hospital Association, letter to Leslie Norwalk, Acting Administrator, Centers for Medicare and Medicaid Services, June 20, 2007, at [<http://www.aha.org/aha/letter/2007/070620-cl-cms-2279-p.pdf>], hereafter referred to as “American Hospital Association letter”; and See National Association of Public Hospitals, letter to Leslie Norwalk, Acting Administrator, CMS, June 22, 2007, at [http://www.naph.org/naph/advocacy/NAPH_Medicaid_GME_Comment_Letter_6-22-07.pdf], hereafter referred to as “National Association of Public Hospitals letter.”

¹⁴ See *A Shortage of Primary Care Doctors is Predicted*, at [http://www.ahiphewire.org/News/Print.aspx?doc_id=153130], and U.S. Physician Shortage Particularly Affects Rural Hospitals, at [http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=50619&dr_cat=3].

¹⁵ See “Governors of Both Parties Oppose Medicaid Rules,” *New York Times*, February 24, 2008.

¹⁶ See Cozen and O’Conner/AAMC memo and American Hospital Association letter.

payments. At that time, CMS also signaled that it planned to study existing Medicaid GME payment arrangements and might issue additional policies in the future.¹⁷

Finally, opponents of the proposed GME rule have also noted that, for example, (1) prior approval by CMS of Medicaid state plan amendments (SPAs) specifying coverage of GME constitutes an official interpretation that such SPAs met governing statutory and regulatory requirements,¹⁸ and (2) while GME is not specifically listed in Section 1905(a) of the Medicaid statute, this section of statute is broadly drafted, and even the accompanying regulations do not itemize every element of reimbursable costs.¹⁹

Latest Congressional Action

Two days after the Bush Administration published its proposed rule on Medicaid GME payments, H.R. 2206, the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, became P.L. 110-28. In this law, Congress placed a moratorium on further administrative action with respect to Medicaid GME payments. This moratorium was in place until May 25, 2008. Since then, other bills have also been introduced to address one or more of the Medicaid regulations issued by CMS over the past year or so. For example, with respect to the GME proposed rule, three bills (H.R. 3533, S. 2460, and S. 2819) would extend the moratorium in P.L. 110-28 for different lengths of time beyond May 25, 2008.²⁰

Finally, H.R. 5613, as passed by the House, and H.R. 2642 (a war supplemental spending bill), subsequently passed by the Senate, would also extend the moratorium in P.L. 110-28 on administrative action with respect to Medicaid GME to April 1, 2009.²¹ In late May, one day before the Senate passed H.R. 2642, the Secretary of Health and Human Services issued a press release stating that the Administration would voluntarily refrain from making the GME rule (and a second rule on cost limits for public providers²²) effective until August 1, 2008.

¹⁷ See *67 Federal Register* 41005 and 41023, June 14, 2002.

¹⁸ See American Hospital Association letter.

¹⁹ See National Association of Public Hospitals letter.

²⁰ Another bill (H.R. 1741), which preceded both P.L. 110-28 and the proposed GME rule, would have prohibited the Secretary of HHS from taking any action to restrict payments for GME over a two-year period.

²¹ For more information on H.R. 5613 and H.R. 2642, see CRS Report RS22849, *Medicaid Financing*, by April Grady.

²² See CRS Report RS22848, *Medicaid Regulation of Governmental Providers*, by Jean Hearne.