

# Minnesota Department of Health

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## Recommendations for a Modified PMAP/PGAMC Distribution Formula *Report to the Minnesota Legislature*

**January, 2001**



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### Formula

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## Executive Summary

Since 1996, when a carveout of medical education payments from capitated Medicaid rates was first proposed by a subcommittee of the MERC Advisory Task Force, there has been continued interest in the formula for distributing these funds to teaching institutions throughout Minnesota. The 1998 Minnesota Legislature adopted a distribution formula that equally weights public program volume and medical education volume at each training facility. However, rather than ending the debate, the adoption of this formula led to increasing debate regarding the original intent behind the inclusion of medical education payments in Medicaid rates, the impact of the distribution formula on individual providers and safety-net providers as a whole, and, fundamentally, the types of training that the state wishes to support. Given this ongoing lack of consensus, the 2000 Minnesota Legislature directed the Department to convene a group of stakeholders to reevaluate the current formula governing distribution of these funds. In response to this charge and after consultation with the MERC Advisory Committee, the Department convened an ad hoc committee on Medicaid Financing of Medical Education in October, 2000. The committee met four times during fall, 2000, and its recommendations to the Commissioner of Health are included in Appendix A of this report.

MDH staff has drawn heavily on the work of the committee in the development of its recommendations to the Legislature. This report presents the recommendations of the committee, discusses the range of issues that were debated by the committee, and recommends a change to the current PMAP distribution formula to reflect concerns about the level of support offered to facilities that train a large number of public program clients, while also continuing to include a factor that explicitly supports the training of medical professionals wherever training occurs.

## MDH Recommendations to the Legislature

In its recommendations to the Commissioner, the ad hoc Committee on Medicaid Financing of Medical Education provided a compelling argument for increasing the weight given to Medicaid volume in the PMAP distribution formula; after much discussion, the committee came to the conclusion that while these funds were always intended for distribution to teaching facilities, these facilities should only benefit to the extent that they provide care to Medicaid patients. The majority of committee members felt that only Medicaid volume should be used for the distribution, with the medical education component being removed from the formula.

While acknowledging the hard work of the committee and the compelling argument for including only Medicaid volume in the distribution formula, the Department believes that the state also has an obligation to support training where it actually occurs. When the Medicaid program was originally implemented, the link between high teaching volume and high Medicaid volume was much stronger than it is today. The majority of medical education took place in large urban teaching hospitals, which tended to treat high numbers of Medicaid clients. Under such a system, tying medical

education funds solely to Medicaid volume was an effective way of directing funds to the facilities where training was occurring. Today, however, the training of physicians and other healthcare professionals is more widely dispersed across all types of facilities, including a wide variety of ambulatory and rural sites, and less strongly related to service to Medicaid clients. Given this change in how and where training takes place, distributing PMAP carevout funds based solely on Medicaid volume could lead to a misallocation of funds to sites that do only small amounts of training. For this reason, while supporting the ad hoc Committee on Medicaid Financing of Medical Education's recommendation to more highly reward facilities that serve a high volume of Medicaid clients, the Department feels that a portion of the formula should continue to be based on medical education volume at each facility.

**The Department recommends that:**

1. *The current formula for distribution of carved-out PMAP funds should be modified to give greater weight to public program volume while retaining medical education volume as a factor. Specifically, the Department recommends the following change:*

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**Current Formula**

(Education Factor x 50%) + (Public Program Factor x 50%)

**Proposed Formula**

(Education Factor x 25%) + (Public Program Factor x 75%)

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The MERC Trust Fund and, to an extent, the PMAP carveout were instituted in recognition of the fact that funding for health professions education - and in particular graduate medical education - is insufficient in a cost-containment environment and that teaching facilities are under increasing pressure to find new ways to support this function in a time of increased competition. A recent estimate by MDH put the funding gap for graduate health professions education in Minnesota at approximately \$175 million for 1997, even before many provisions of the federal Balanced Budget Act and Balanced Budget Refinement Act had been put into effect. This funding gap is spread among all teaching facilities, independent of patient mix, and is felt more strongly by institutions with a larger teaching burden. Given limited resources, it is vital to ensure that funds earmarked for health professions training go to the institutions that provide that training.

Given the current funding gap, an appropriate State role in financing health professions education lies in supporting that training, at least in some part, where it occurs, regardless of patient mix at each training site. Removing medical education volume from the distribution formula would run counter to this goal and would potentially transfer funds to sites that, while serving a large number of public program clients, may not face the large teaching burdens that these payments were designed to offset. Obviously, facilities that serve large numbers of public program clients face other financial burdens as well; the current

formula should be modified to increase the weight given to Medicaid volume for that reason. But medical education volume should remain a factor, albeit with a smaller weight than that which it is given in the current formula.

2. ***To the extent that the data permit, only PMAP/PGAMC revenues should be included in the measure of public program volume, rather than including both fee-for-service and prepaid revenues.***

The ad hoc Committee argued compellingly that only PMAP revenue should be used in the allocation formula, rather than all public program volume. Members were concerned that including all public program volume would amount to a 'double payment' for those facilities doing a large level of fee-for-service business, since medical education funds still flow directly to those facilities under fee-for-service payments.

When the original PMAP distribution formula was developed, it was noted that the current system of encounter data maintained by the Department of Human Services was not yet of sufficient coverage and quality to allow its use as the sole measure of public program volume. While this data source has improved greatly in the intervening years, there are still some concerns about its completeness and accuracy. Given these concerns, it is likely necessary for the Department to continue using revenue from both PMAP/PGAMC and fee-for-service MA/GA for the PMAP distribution in the short term. As data quality continues to improve, however, MDH will reevaluate this position and determine whether or not the use of encounter data alone will be sufficient for calculation of the public program component of the PMAP distribution. The Department is committed to making this change as soon as possible.

3. ***The Department should work closely with the MERC Advisory Committee to determine what the future directions should be for medical education and medical education funding in Minnesota.***

During its deliberations, the ad hoc Committee at various times noted the difficulty in determining policy for the PMAP carveout without having a sense of the broader issues facing graduate health professions education in Minnesota and the manner in which the state wishes to prioritize and address these problems. Several members noted that their recommendations might have been different depending on how (or if) the state decided to prioritize policies related to medical education and medical education funding.

Issues such as the health care workforce shortage, an increasingly diverse and aging Minnesota population, and the need for well-trained medical professionals in rural and underserved urban areas will need to be addressed in the coming years, and the Department believes that there should be a renewed effort to develop consensus on the most critical next steps for medical education in Minnesota. As a result, in the Spring of 2001, the Department will charge the MERC Advisory Committee with examining next steps for medical education in Minnesota, so that future discussions around these issues can be guided by clearer policy.



## Introduction

Since 1996, there has been continued interest in the development of a formula for the distribution of the medical education dollars carved out of capitated Medicaid (PMAP) rates. Between 1998 and 2000, the Department has convened and staffed two separate committees primarily concerned with this formula and provided technical assistance to a third informal committee, in addition to bringing the issue before the MERC Advisory Committee. During the 2000 legislative session, the Department was once again directed to establish a committee to evaluate the current distribution formula, which equally weights medical education volume and public program volume in the distribution of funds:

“The commissioner of health shall convene a group of stakeholders that includes representatives of teaching programs and training sites throughout the state and members of the medical education and research advisory committee for the purpose of evaluating the appropriateness of the current distribution formula and considering alternatives for allocating the amount transferred in accordance with Minnesota Statutes, section 256B.69, subdivision 5c. The commissioner shall report the findings and recommendations of this group to the legislature by January 15, 2001. “ (Minnesota Laws, Chapter 488, Article 9, Section 35)

In June of 2000, the MDH brought this study charge before the MERC Advisory Committee. The Committee recommended to the Commissioner that, in spite of their best efforts in the past, that committee had failed to reach broad consensus over an appropriate distribution mechanism for PMAP carveout funds. They therefore recommended to the Commissioner that the Department convene a group of disinterested but policy-focused individuals to examine, from a policy perspective, the best disposition for the PMAP carveout funds. Therefore, at the advice of the MERC Advisory Committee, the MDH, during the fall of 2000, convened an ad hoc committee on Medicaid financing of medical education to reexamine the current formula. This report to the Legislature draws heavily on the work and recommendations of this committee, whose report to the Commissioner is included as Appendix A.

This ad hoc committee provided to the Commissioner of Health a set of well-reasoned, policy based, and compelling recommendations for revision of the current PMAP distribution formula as well as a recommendation related to the development of a larger vision for medical education funding - and the State's role in providing and directing this funding. The committee's discussions helped to refocus attention on the original intent behind the inclusion of medical education funds in Medicaid rates. Perhaps even more important than the discussions of the formula itself and what factors it should include, however, has been the reopening of the debate around the guiding principles that should drive medical education funding in Minnesota.

## History

The issue of the PMAP carveout first came up during discussions related to possible funding sources for the MERC Trust Fund in 1996, when a revenue/financing subcommittee of the MERC

Advisory Task Force was established to explore alternative funding mechanisms for the Trust Fund. This subcommittee recommended that the Minnesota Department of Human Services carve out the medical education 'add-on' funds from the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) and direct these funds to the Minnesota Department of Health for distribution through the MERC Trust Fund. In this way, the distribution of medical education funds in Medicaid rates could be more specifically directed to teaching institutions, while at the same time eliminating any concerns that GME funds were being retained by health plans, and not being passed through.

The 1997 Minnesota Legislature directed the Commissioner of Health to develop a process to "recognize those teaching programs which serve higher numbers or high proportions of public program recipients and ...report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system." Working through the MERC Advisory Committee, the Department established a "PMAP Subcommittee" to address the relevant issues.

In 1998, the PMAP subcommittee recommended a formula which distributed the PMAP carve-out based on a medical education factor (average clinical training costs by provider type times the number of clinical FTEs at the site) and public program volume factor (each site's total public program revenues divided by the grand total of all sites' public program revenue). To minimize any adverse effects, this formula was intended to be phased in, initially weighting medical education and public program volume equally (50% each) and gradually moving toward an emphasis on medical education. In year three, the education factor was to be weighed at 75% and public program volume at 25%.

As there was not consensus on this formula recommendation, the Commissioner of Health worked to find common ground and met again with stakeholders to develop a more widely accepted formula. As a result of this meeting, the Commissioner recommended and the legislature adopted a formula in which the education factor and public program volume factor, described above, receive equal weight (50% each), with no phase in or change in future years.

In January 2000, MDH staff presented the MERC Advisory Committee with preliminary figures showing what the impact of the 50/50 formula would be by facility and county. Based on the disparate impact that the formula would have on some counties and on providers who serve a high proportion of public program clients but do not train large numbers of FTEs, the Advisory Committee recommended to the Commissioner that the PMAP carveout be delayed for a period of two years. However, the Department felt and still feels that the PMAP carveout is the appropriate state policy, and chose not to accept the Advisory Committee's recommendation on this issue. The Department agreed to provide technical assistance to a voluntary group of stakeholders who decided to meet to attempt to resolve this issue. This group met a number of times, with the Department providing technical assistance on the impact of various formulas on the distribution of funds.

This group developed and the full MERC Advisory Committee, with some dissent, ultimately recommended a formula that would return 65% of any carve-out to the region from which the funds

originated, with the remaining 35% pool distributed state-wide based on state-wide medical education volume. The 65% returned to Hennepin County and the Metro regions would be distributed within the region based on medical education volume within the region; the 65% returned to non-metro areas of the state would be distributed based on the current statutory formula of 50% public program volume/50% medical education volume. While noting the shortcomings of the current formula, the Commissioner felt that this proposed alternative did not have any policy rationale nor was it a formula with broad consensus among stakeholders. Ultimately, the Commissioner could not support the formula.

## Ad Hoc Committee on Medicaid Financing of Medical Education

In response to continuing dissent regarding the current 50/50 formula, the 2000 Legislature directed the Department of Health to convene a stakeholder group to examine the formula and make recommendations to the Commissioner of Health as to the desirability of amending the formula. As noted earlier, the MERC Advisory Committee recommended to the Commissioner that a disinterested group of individuals be convened to examine this issue and provide recommendations to the Commissioner. In response, the Department of Health convened an ad hoc Committee on Medicaid Financing of Medical Education. This committee was made up of persons involved in public policy work in Minnesota, including rural representation, and was a combination of persons involved in academics, private foundations, and direct care delivery. In addition, the Department retained the services of two out-of-state experts on the issue of Medicaid financing for medical education to serve on, and work with, the committee.

This committee met four times during the fall and winter of 2000, and discussions focused largely on whether the medical education funds being carved out of PMAP rates were originally intended for the support of medical education or for service to public program clients, which often takes place disproportionately in teaching facilities. A more detailed discussion of the ad hoc Committee's charge and deliberations can be found in its report to the Commissioner, located under Appendix A. Membership of this Committee can be found in Appendix C. At its final meeting, in December, 2000, the committee made four recommendations to the Commissioner:

- ***The current 50/50 distribution formula should be amended to more heavily weight Medicaid volume. The majority of the members believed that only Medicaid volume should be used for the distribution.***

All committee members agreed that the original intent of the carved out funds was to support training sites, but only to the extent to which those sites served Medicaid clients. While a minority of committee members argued for a formula that would include some weight for medical education volume, the majority felt that allowing medical education volume to drive any portion of the formula would dilute the policy rationale for the formula as a whole.

- ***To the extent that the data permits, only PMAP/PGAMC revenues should be included in the measure of public program volume, rather than including both fee-for-service and prepaid revenues.***

Given that medical education add-on funds are still included in the fee-for-service (FFS) Medicaid rates paid to teaching facilities, the inclusion of FFS Medicaid revenue in the PMAP distribution formula's measure of public program volume would allow facilities to be, in effect, paid twice for medical education related to their FFS clients. For this reason, the Committee argued that only PMAP/PGAMC revenues should be included in the formula's measure of public program volume.

- ***It would be appropriate for the Department to consider health policy goals in its distribution of medical education funds or to establish a separate pool of funds to incent innovation. However, funds from the PMAP carveout should not be used for these purposes.***

The committee unanimously recommended that the Department begin to explore the linkage of medical education dollars to health policy goals. However, committee members also felt that incenting innovation or progress towards statewide health goals was not part of the original intent of PMAP funds, which they came to believe were intended solely to cover a portion of the costs of teaching in facilities serving Medicaid clients. Therefore, the Department should not use any portion of the PMAP carveout funds for these purposes, but should either explore the use of existing MERC dollars or work to obtain new funds to be set aside in a separate 'innovations' pool.

- ***The Department should work to develop broader goals related to the direction of graduate health professions education in the state.***

Committee members advocated for a broader discussion of the direction in which the Department, and the State, would like to move medical education. Currently, there is no state plan for medical education that includes goals for quantity of health professionals to be produced, composition of the workforce, geographic or specialty distribution of the workforce, the relative importance of service to underserved populations, or any other performance threshold. If the Department chooses to begin linking a portion of medical education dollars to performance, as recommended above, or to encourage innovative training models, those goals need to be developed with the broader direction of health professions education, and the state's role in financing that education, in mind.

## MDH Recommendations to the Legislature

In its report to the Commissioner, the ad hoc Medicaid Financing Committee provided a set of compelling arguments for including only public program volume in the PMAP distribution formula. The Committee spent a great deal of time debating the original intent behind the inclusion of medical education funds in Medicaid rates, and determined that these funds were always intended to be directed to teaching institutions, but only to the extent to which those facilities provide care to Medicaid patients.

While the Department acknowledges the compelling argument made by the Committee, we also believe that a compelling argument can be made that the original purpose of these Medicaid funds was to support teaching where it occurred. Since most medical education occurred in large teaching hospitals when the Medicaid program was implemented, hospitals which tended to have large levels of Medicaid clients, tying medical education funds to Medicaid rates was a logical tie. However, as training has moved into other settings, some of the logic of this initial tie has weakened.

Therefore, while accepting the Committee’s recommendation that service to the Medicaid population be given more weight in the distribution formula, the Department also strongly feels that the formula should continue to acknowledge the volume of medical education at each site. Given the uncertainty of future directions around medical education, as well as the Department’s view that teaching should continue to be supported at the sites where it occurs, MDH believes that a portion of the formula should continue to be based on a teaching factor. Removing medical education entirely from the distribution formula could result in a misallocation of funds to sites that do only minuscule amounts of training but do a great deal of PMAP business, a misallocation as serious as that which originally led to the carveout.

In recognition of these concerns, the Department recommends that:

1. *The current formula for distribution of carved-out PMAP funds should be modified to give greater weight to public program volume while retaining medical education volume as a factor. Specifically, the Department recommends the following change:*

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**Current Formula**

(Education Factor x 50%) + (Public Program Factor x 50%)

**Proposed Formula**

(Education Factor x 25%) + (Public Program Factor x 75%)

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The issue of whether the carved-out PMAP funds were intended to reward service to Medicaid populations or to reward large teaching institutions dominated discussion at meetings of the ad hoc Committee. And while the Committee’s recommendation of a 100% Medicaid formula was based on a consensus that this was how the funds were originally meant to be distributed, the question of original intent will likely never be resolved and has in fact been answered differently by each successive committee. The current 50/50 formula itself represents a political compromise that was developed in acknowledgment of the complexity of this question rather than as an official statement on the relative importance of Medicaid volume and medical education volume. But regardless of the original intent of these monies, it is not evident that the Department or legislature should feel bound by that intent in determining an appropriate distribution formula.

The MERC Trust Fund and, to an extent, the PMAP carveout were instituted in recognition of the fact that funding for health professions education - and in particular graduate medical education - is insufficient in a cost-containment environment and that teaching facilities are under increasing pressure to find new ways to support this function in a time of increased competition. Given limited resources, it is vital to ensure that all funds earmarked for education actually go to the institutions that provide that training - the primary rationale behind the PMAP carveout. Since the inception of MERC and the first discussions of the PMAP carveout, this financial pressure has only worsened. A recent estimate by MDH put the funding gap for graduate health professions education in Minnesota at approximately \$175 million for 1997, even before many provisions of the federal Balanced Budget Act and Balanced Budget Refinement Act had been put into effect. This funding gap is spread among all teaching facilities, independent of patient mix, and is felt more strongly by institutions with a larger teaching burden.

The training of health professionals benefits all Minnesotans, regardless of financial or insurance status. Therefore, given the current funding gap, an appropriate State role in financing health professions education lies in supporting that training, at least in some part, where it occurs, regardless of patient mix at each training site. Removing medical education volume from the distribution formula would run counter to this goal and would potentially transfer funds to sites that, while serving a large number of public program clients, may not face the large teaching burdens that these payments were designed to offset. Obviously, facilities that serve large numbers of public program clients face other financial burdens as well; the current formula should be modified to increase the weight given to Medicaid volume for that reason. But medical education volume should remain a factor, albeit with a smaller weight than that which it is given in the current formula.

In addition, the Department feels that such a formula is also more closely parallel to the method through which medical education payments are allocated to teaching facilities under fee-for-service Medicaid than the formula recommended by the Committee. Under fee-for-service Medicaid, payments for medical education are not uniform across teaching facilities. There was and is no standard or threshold of training program size that a facility has to meet in order to be considered a training facility and to be eligible for these payments. Rather, the size of the add-on payment is based on training costs at each facility as reported in the facility's annual Medicare cost report, with those facilities that report higher training costs receiving a larger payment. Clearly, facilities that train a higher number of residents would be expected to have higher training costs than those that train a smaller number. Thus, while facilities which do a greater amount of Medicaid business will receive a larger sum of money, that sum is determined in part based on medical education volume.

2. ***To the extent that the data permit, only PMAP/PGAMC revenues should be included in the measure of public program volume, rather than including both fee-for-service and prepaid revenues.***

The ad hoc Committee argued compellingly that only PMAP revenue should be used in the allocation formula, rather than all public program volume. They were concerned that

including all public program volume amounts to a 'double payment' for those facilities doing a large level of fee-for-service business, since medical education funds still flow directly to those facilities under fee-for-service payments.

When the original PMAP distribution formula was developed, it was noted that the current system of encounter data maintained by the Department of Human Services was not yet of sufficient coverage and quality to allow its use as the sole measure of public program volume. While this data source has improved greatly in the intervening years, there are still some concerns about its completeness and accuracy. Given these concerns, it is likely necessary for the Department to continue using revenue from both PMAP/PGAMC and fee-for-service MA/GA for the PMAP distribution in the short term. As data quality continues to improve, however, MDH will reevaluate this position and determine whether or not the use of encounter data alone will be sufficient for calculation of the public program component of the PMAP distribution. The Department is committed to making this change as soon as possible.

3. ***The Department should work closely with the MERC Advisory Committee to determine what the future directions should be for medical education and medical education funding in Minnesota.***

In making its recommendations, the committee noted the difficulty in determining policy for the PMAP carveout without having a sense of the broader policy direction in which the state wishes to go. Several members noted their recommendations might have been different depending on how (or if) the state decided to prioritize policies related to medical education and medical education funding.

During its deliberations, the committee examined models currently in use in other states to incent the training of certain types of providers or training in certain types of facilities, to increase the proportion of program graduates who remain in the state after completion of training, and to increase the representation of communities of color in graduate health professions training programs and discussed how or whether such models could be adapted to Minnesota. While committee members felt that Minnesota should in the future explore providing financial incentives to encourage changes to the existing training system, they also felt that the guidance for such a program would have to come from another body with a more detailed understanding of the problems facing the health professions training system and the ability to prioritize areas where change to this current system is necessary.

In Minnesota, issues such as the health care workforce shortage, an increasingly diverse and aging population, and the need for well-trained medical professionals in rural Minnesota and in underserved urban areas will need to be addressed in the coming years. The Department believes that there should be a renewed effort to develop consensus on the most critical issues facing medical education in Minnesota and to explore ways in which the state should begin to address these issues. As a result, in the Spring of 2001, the Department will charge the MERC Advisory Committee to begin examining next steps for medical education in Minnesota, so that future discussions around issues like the PMAP carveout can be guided by clearer policy.



# Appendix A

## Ad Hoc Committee on Medicaid Financing for Medical Education

### Recommendations to the Commissioner of Health regarding the distribution of PMAP/PGAMC carveout funds

#### Executive Summary

The Medical Education and Research Costs (MERC) Fund was established in 1996 as a mechanism for offsetting a portion of the higher costs faced by teaching facilities. Funded for the first time in 1997 with a general fund appropriation of \$5 million and \$3.5 million from the Health Care Access Fund, the MERC Trust Fund is now entering its fourth annual distribution cycle. The size of the Fund has ranged from a low of approximately \$15 million in FY2000 to a high of just over \$20 million in FY 1999, with a total of over \$53 million distributed since its inception.

In 1997, the Minnesota legislature authorized removal of the ‘medical education component’ of Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) capitation rates and a transfer of these funds to the Minnesota Department of Health (MDH) for distribution through the MERC Trust Fund. The 1997 Minnesota Legislature directed the Commissioner of Health to work with stakeholders to develop a distribution process that would “recognize those teaching programs which serve higher numbers or high proportions of public program recipients and...report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system.”

That report, released in February 1998, recommended the use of a formula that would equally weight public program volume and teaching volume in the distribution of funds, and outlined the process through which the committee arrived at their recommendation. This “50/50” formula was put in statute during the 1998 legislative session. Although the formula was in place, the carveout itself would not commence until the Minnesota Department of Human Services received a waiver from the federal Health Care Financing Administration (HCFA), which ultimately did not happen until August 2000.

In late 1999 and early 2000, once the potential financial impact of the 50/50 formula on individual facilities became more apparent, several PMAP and MERC Advisory Committee members expressed concern with the 50/50 formula, and worked with a voluntary group of stakeholders, with technical assistance provided by MDH, to develop an alternative distribution formula. The Commissioner of Health ultimately was unable to support this formula.

Given continuing controversy about the impact of the 50/50 formula, the 2000 Minnesota Legislature directed the Commissioner of Health to convene a new group of stakeholders to further review the current formula, the rationale through which it was developed, and its appropriateness as a tool for redistributing carved-out PMAP funds and report back to the legislature by January 15th, 2001. This report summarizes the work of this advisory committee and the recommendations which they presented to the Commissioner of Health.

## Key Issues

In arriving at its recommendations, the committee grappled with a number of thorny policy questions, which are summarized below.

- Were medical education funds included in Medicaid rates as a means of covering a portion of the higher costs associated with the education mission of teaching hospitals or with the intention that they be used to treat Medicaid patients?
- Should the recommended PMAP distribution formula seek to replicate the distribution that resulted from the old system (where GME funds were distributed through rate cell add-ons)? Or should the Department more explicitly pursue redistribution to sites where teaching occurs?
- Should the measure of public program volume that is used in the PMAP distribution include only revenue from PMAP or also fee-for-service Medicaid funds?
- To what extent should the development of a distribution formula for PMAP funds, or the modification of the existing formula, be driven by broad State or MDH goals related to medical education funding?

## Recommendations

1. The current 50/50 distribution formula should be amended to include as a factor only the relative Medicaid volume at each training site. Medical education volume should not be considered in the formula.
2. To the extent that the data permits, only PMAP/PGAMC revenues should be included in the measure of public program volume, rather than including both fee-for-service and pre-paid revenues.
3. It would be appropriate for the Department to consider health policy goals in its distribution of medical education funds or to establish a separate pool of funds to incent innovation. However, funds from the PMAP carveout should not be used for these purposes.
4. The Department should work to develop broader goals related to the direction of graduate health professions education in the state.

## Background

The Medical Education and Research Costs (MERC) Fund was established in 1996 as a way to offset a portion of the higher costs traditionally faced by the facilities that train physicians, dentists, pharmacists and other selected health professionals. Recognizing that these facilities are less able to cover such costs through higher patient care rates in today's more competitive market, the Minnesota Legislature funded MERC for the first time in 1997 with a \$5 million allocation from the General Fund and \$3.5 million from the Health Care Access Fund.

Including state General Fund and Health Care Access Fund appropriations, federal Medicaid matching funds, and, beginning in SFY2000, interest income from the tobacco settlement endowment fund established by the 1999 Legislature, the MERC Trust Fund has distributed \$53.4 million since 1998 and is currently midway through its fourth annual distribution cycle. Funds are distributed based on a formula that calculates an average cost per trainee for each of the nine provider types that are included in MERC's authorizing legislation, then calculates a grant amount for each clinical training site that represents a fixed percentage of per-trainee costs for each FTE trainee at the site.

Although the MERC Trust Fund has become an established funding source for facilities involved in the clinical training of health professionals, the funds it disburses make up only a small portion of total funding for health professions education in Minnesota. Federally, the largest funder of graduate medical education (GME) is the Medicare program, which in FY2000 directed almost \$8 billion dollars to teaching facilities through GME payments that are added to the Medicare rates paid to these facilities<sup>1</sup>. These 'add-on' payments are designed to offset a portion of the higher direct and indirect costs faced by these institutions.

Medicaid, the federal/state program for lower-income individuals, has also traditionally been a major funder of graduate medical education. Medicaid uses a system similar to Medicare to direct additional funds to teaching hospitals in an attempt to offset a portion of their higher costs. Under fee-for-service Medicaid, a medical education payment is added on to the rates paid by the Department of Human Services (DHS) to each teaching facility; non-teaching facilities do not receive these extra funds.

In Minnesota, however, only a small portion of all Medicaid enrollees are enrolled in traditional FFS Medicaid. The majority are enrolled in the Prepaid Medical Assistance Program (PMAP), in which the state contracts a capitated monthly rate with health plans for serving MA recipients. Under PMAP, health plans receive per-member per-month payments from DHS that include a medical education add-on. This differs from fee-for-service, where the provider directly receives payment from DHS, thereby ensuring that medical education funds go to teaching facilities. Under capitation, health plans receive the funds from DHS. These plans then subsequently contract with

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<sup>1</sup> Council on Graduate Medical Education. "Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment." Rockville, Maryland: Department of Health and Human Services, December 2000.

providers to deliver services to Medicaid enrollees. Depending on the extent to which each plan's members utilize teaching facilities and the rates that each health plan negotiates with a given facility, this medical education component might be passed on from the health plans to teaching facilities in full, in part, or not at all. While it is difficult, if not impossible, to determine the extent to which these medical education add-on funds have been received by non-teaching facilities, clearly under this system the possibility exists that some dollars intended for medical education were never used for that purpose.

During 1996, before MERC had yet received funding from the Minnesota Legislature, a revenue/financing subcommittee of the MERC Advisory Task Force was established to explore alternative funding mechanisms for the Trust Fund. This subcommittee recommended that the Minnesota Department of Human Services carve out the medical education 'add-on' funds from the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) and direct these funds to the Minnesota Department of Health for distribution through the MERC Trust Fund. In this way, the distribution of medical education funds in Medicaid rates could be more narrowly directed to teaching institutions, at the same time eliminating the concern that GME funds were being retained by health plans or otherwise misallocated.

Partly as a result of this recommendation, the 1997 Minnesota Legislature directed the Commissioner of Health to develop a process to "recognize those teaching programs which serve higher numbers or high proportions of public program recipients and ...report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system." The Commissioner utilized the MERC Advisory Committee to develop that process. The Committee established a "PMAP Subcommittee" to address the relevant issues and tasks.

## Establishment and Activities of PMAP Subcommittee

### *1997-1999*

The PMAP subcommittee initially recommended a formula which distributed the PMAP carve-out based on a medical education factor (average clinical training costs by provider type times the number of clinical FTEs at the site) and public program volume factor (each site's total public program revenues divided by the grand total of all sites' public program revenue). To minimize any adverse effects, this formula was intended to be phased in, initially weighting medical education and public program volume equally (50% each) and gradually moving toward an emphasis on medical education. In year three, the education factor was to be weighed at 75% and public program volume was 25%. As there was not consensus on this formula, the Commissioner of Health met again with key stakeholders to develop a more widely accepted formula. As a result of this meeting, the Commissioner recommended and the legislature adopted a formula in which the education factor and public program volume factor, described above, receive equal weight (50% each), with no phase in or change in future years.

In January 2000, MDH staff presented the MERC Advisory Committee with preliminary figures showing what the impact of the 50/50 formula would be by facility and county. Based on the disparate impact that the formula would have on some counties and on providers who serve a high

proportion of public program clients but do not train large numbers of FTEs, the Advisory Committee recommended to the Commissioner that the PMAP carveout be delayed for a period of two years. However, the Department felt and still feels that the PMAP carveout is the appropriate state policy, and chose not to accept the Advisory Committee's recommendation on this issue. The Department agreed to provide technical assistance to a voluntary group of stakeholders who decided to meet to attempt to resolve this issue. This group met a number of times, with the Department providing technical assistance on the impact of various formulas on the distribution of funds.

This group developed and the full MERC Advisory Committee, with some dissent, ultimately recommended a formula that would return 65% of any carve-out to the region from which the funds originated, with the remaining 35% pool distributed state-wide based on state-wide medical education volume. The 65% returned to Hennepin County and the Metro regions would be distributed within the region based on medical education volume within the region; the 65% returned to non-metro areas of the state would be distributed based on the current statutory formula of 50% public program volume/50% medical education volume.

While noting the shortcomings of the current formula, the Commissioner felt that the proposed alternative did not have any policy rationale nor consensus among stakeholders, and could not be supported by the Commissioner.

## Establishment of ad hoc Committee on Medicaid Financing of Medical Education

In light of continuing concerns about the impact of the existing formula and the inability to reach consensus on an alternative formula, the 2000 Minnesota Legislature again directed the Commissioner of Health to study the impact of the current 50/50 distribution formula:

“The commissioner of health shall convene a group of stakeholders that includes representatives of teaching programs and training sites throughout the state and members of the medical education and research advisory committee for the purpose of evaluating the appropriateness of the current distribution formula and considering alternatives for allocating the amount transferred in accordance with Minnesota Statutes, section 256B.69, subdivision 5c. The commissioner shall report the findings and recommendations of this group to the legislature by January 15, 2001. “ (Minnesota Laws, Chapter 488, Article 9, Section 35)

During the summer of 2000, having been directed by the legislature to convene a new PMAP advisory group, MDH staff raised this charge to the MERC Advisory Committee and asked for guidance in the formation of this new panel and in determining what the role of the Advisory Committee should be. At that time, Advisory Committee members expressed concerns that, as recipients of both MERC and PMAP funds, they were not the appropriate body to be making decisions about the formula to use for distribution of carveout funds. Members felt that it would be difficult, if not inappropriate, for the group to be making decisions that would impact both their own financial bottom lines and those of others around the table, and that it would be difficult for

them to keep in mind the larger policy picture that the Department wanted considered in the development of the PMAP distribution formula. The Committee suggested removing any discussion of an amended PMAP distribution formula from the purview of the Advisory Committee and convening a totally new group that would be less 'attached' to the outcome of the distribution.

Given this direction from the Advisory Committee, the Department worked to identify members for the new committee who, although they had some basic knowledge of health care and medical education, would more importantly bring to the table a broader policy perspective from which to discuss the myriad issues surrounding the PMAP carveout. This new 10-member ad hoc committee met for the first time in October, 2000. Members of the ad hoc committee are listed in Appendix C, and were chosen to bring expertise in broad policy issues as well as knowledge of health care matters. In addition, the Department retained the services of a nationally recognized expert on state approaches to the financing of medical education and brought in assistance from another state (Texas) that had recently concluded a debate over Medicaid financing for medical education similar to the one currently underway in Minnesota. The committee met four times during the fall of 2000.

## Issues raised by Medicaid financing committee

In its meetings during the fall of 2000, the committee discussed many facets of the PMAP carveout issue. While the original charge to the committee was relatively narrow - to examine the current distribution formula and make recommendations to the Commissioner of Health as to its appropriateness - it was necessary for the committee to step back and examine broader questions before coming to a recommendation regarding the formula itself. It would be impossible and beyond the scope of this report to summarize all of the discussions that took place during these meetings; the following section provides an overview of the key policy questions with which the committee wrestled as it debated amending the current distribution formula.

***Were medical education funds included in Medicaid rates as a means of covering a portion of the higher costs associated with the education mission of teaching hospitals or with the intention that they be used to treat Medicaid patients?***

In many ways, this is the core issue with which the committee had to struggle. In the four years since a carveout of medical education funds from PMAP rates was first proposed, discussions have centered around the original intent of these funds. The inclusion of the medical education add-on in Medicaid rates would seem to imply that it was intended for facilities that serve Medicaid clients - facilities that are also often teaching facilities - and that those facilities that served a higher proportion of Medicaid patients should receive a greater share of the funds. However, others argue that these funds were intended for medical education and that Medicaid, like other payers, should contribute to the broad support of medical education. Under this argument, a larger proportion of funding would go to facilities whose education burden is relatively larger.

This question - are the dollars for Medicaid services or for medical education - is one that can be answered and argued effectively both ways. The existence of medical education funding in a feder-

al/state program indicates the value placed on training by the original policymakers, and therefore one could argue that the funds were intended for medical education where education occurs. By the same token, a compelling case can be made that the funding was originally tied to Medicaid, and that the dollars followed Medicaid patients. Therefore, this view holds that funding should flow based on Medicaid patient volume as it originally did.

Generally speaking, those facilities that do a large volume of training are also the facilities that see a large volume of Medicaid patients. Therefore, Medicaid rates were and are a convenient way to distribute funding to teaching facilities. The situation is more complicated in Minnesota, however, as certain facilities do a great deal of training but see a more limited number of Medicaid clients. Therefore, if Medicaid were simply a vehicle for getting funds to teaching facilities, basing a formula merely on Medicaid volume would not achieve that broader purpose in Minnesota. However, if the fact that distributions under fee-for-service were tied directly to patient volume rather than resident counts means that the funds were intended for teaching facilities that serve a larger volume of Medicaid clients, a formula that considered only medical education volume would not achieve that goal.

In short, a compelling argument can be made for either of these positions: basing funding 100% on Medicaid patient volume or 100% on teaching volume. It is important to remember that these two views were discussed by previous Advisory Committees and legislatures, with the political compromise being the current distribution formula which weights medical education and Medicaid volume equally.

***Should the recommended PMAP distribution formula seek to replicate the distribution that resulted from the old system (where GME funds were distributed through rate cell add-ons)? Or should the Department more explicitly pursue redistribution?***

The current distribution formula is already redistributing funds in several ways. For example, severing the tie to the geographic region from which the funds originated redistributes funds geographically, returning to Greater Minnesota a larger piece of the pie than this region originally lost (in fact, Greater Minnesota is exempt from the carveout until 2002, meaning that facilities in this region have not yet lost any funds due to the carveout and receive only “redistributed” funds). Additionally, certain MERC provider types are included in the distribution of PMAP funds even though the services provided by these professions are not eligible for reimbursement under PMAP, further skewing the distribution.

Throughout the original discussions of the PMAP carveout, redistribution of funds was not explicitly stated as a goal of the PMAP distribution - the goal was, at its most basic level, simply to ensure that funds intended for teaching institutions were not retained by health plans or disbursed to non-teaching facilities. Recent debate around the carveout has centered around whether or not funds should be returned, to the greatest extent possible, to the regions, if not the facilities, from whence they came through a formula that mirrors the ‘pre-carveout’ methodology, or whether the state should explicitly seek to further redistribute these funds.

However, determining the amount of “pre-carveout” PMAP funds received by each facility is extremely difficult. As a result, replicating the original distribution methodology to ‘hold harmless’ individual institutions is a difficult task. The question for the committee, then, was the extent to which the formula should be revised to make it more consistent both with the pre-carveout distribution method and with the existing fee-for-service Medicaid methodology.

***To what extent should the development of a distribution formula for PMAP funds, or the modification of the existing formula, be driven by broad State or MDH goals related to medical education funding?***

Several committee members expressed difficulty discussing the PMAP distribution formula “in a vacuum” without considering the state’s larger goals related to health professions education and its financing. Currently, many other states that have implemented carveouts of GME funds from Medicaid rates or that have established medical education funding pools have linked distribution of these funds to policy goals related to workforce composition or size, geographic distribution of health professionals, or service to underserved populations. Two states, Michigan and New York, have established separate pools of funds that are distributed competitively to facilities or programs that have made progress towards those states’ health policy goals. To date, Minnesota has not developed a similar set of goals for health professions education, nor has the State set aside funds for this purpose.

***Should the measure of public program volume that is used in the PMAP distribution include only revenue from PMAP or also fee-for-service Medicaid funds?***

In Minnesota, as in many other states, a portion of Medicaid clients receive services under the traditional fee-for-service model, while others receive funds through a prepaid or capitated plan. While the PMAP carveout removes the medical education component from rates paid to facilities for PMAP clients, teaching facilities continue to receive larger payments to reflect their higher costs under fee-for-service Medicaid. Given that this medical education add-on continues to be received by teaching facilities under fee-for-service MA, including these patients in the estimate of public program volume at a facility results in a double count of a portion of MA revenue. Facilities in counties where PMAP does not operate would, in effect, be double winners in that they would lose no money from the carveout yet would receive money for their FFS MA clients through the PMAP distribution.

## Recommendations To the Commissioner of Health

After debating these and other issues, the Committee on Medicaid Financing of Medical Education arrived at four recommendations, which it presented to the Commissioner of Health in December, 2000:

1. ***The current 50/50 distribution formula should be amended to include as a factor only the relative Medicaid volume at each training site. Medical education volume should not be considered in the formula.***

All committee members agreed that the original intent of the carved out funds was to support training sites, but only to the extent to which those sites served Medicaid clients. While a minority of committee members argued for a formula that would include some weight for medical education volume, the majority felt that allowing medical education volume to drive any portion of the formula would dilute the policy rationale for the formula as a whole.

2. ***To the extent that the data permits, only PMAP/PGAMC revenues should be included in the measure of public program volume, rather than including both fee-for-service and prepaid revenues***

Given that medical education add-on funds are still included in the fee-for-service (FFS) Medicaid rates paid to teaching facilities, the inclusion of FFS Medicaid revenue in the PMAP distribution formula's measure of public program volume would allow facilities to be, in effect, paid twice for their FFS clients. For this reason, only PMAP/PGAMC revenues should be included in the formula's measure of public program volume.

However, there is still the possibility that concerns about the quality of available data on site-level PMAP/PGAMC revenue will preclude the use of these data alone for determining public program revenue at each site. It should be left to the Department's discretion to determine the extent to which use of PMAP/PGAMC revenue alone will be feasible for measuring relative public program volume.

3. ***It would be appropriate for the Department to consider health policy goals in its distribution of medical education funds or to establish a separate pool of funds to incent innovation. However, funds from the PMAP carveout should not be used for these purposes.***

The committee was unanimous in its recommendation that the Department begin to explore the linkage of medical education dollars to health policy goals. However, committee members also strongly felt that incenting innovation or progress towards statewide health goals was not part of the original intent of PMAP funds, which were intended solely to cover a portion of the costs of teaching in facilities serving Medicaid clients. Therefore, the Department should not use any portion of the PMAP carveout funds for these purposes, but should either explore the use of existing MERC dollars or work to obtain new funds to be set aside in a separate 'innovations' pool.

4. ***The Department should work to develop broader goals related to the direction of graduate health professions education in the state.***

Committee members advocated for a broader discussion of the direction in which the Department, and the State, would like to move medical education. Currently, there is no state plan for medical education that includes goals for quantity of health professionals to be produced, composition of the workforce, geographic or specialty distribution of the workforce, the relative importance of service to underserved populations, or any other performance threshold. If the Department chooses to begin linking a portion of medical edu-

cation dollars to performance, as recommended above, or to encourage innovative training models, those goals need to be developed with the broader direction of health professions education, and the state's role in financing that education, in mind.

# Appendix B

## PMAP Legislation

Current PMAP Distribution Formula: MN Statute 62J.692

### **Subd. 7. Transfers from the commissioner of human services.**

(a) The amount transferred according to section 256B.69, subdivision 5c, shall be distributed by the commissioner to clinical medical education programs that meet the qualifications of subdivision 3 based on a distribution formula that reflects a summation of two factors: (1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and (2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool created under this subdivision.

In this formula, the education factor shall be weighted at 50 percent and the public program volume factor shall be weighted at 50 percent.

(b) Public program revenue for the formula in paragraph (a) shall include revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care

(c) Training sites that receive no public program revenue shall be ineligible for funds available under this subdivision.

PMAP Distribution Formula Study: 2000 Minnesota Laws, Chapter 488, Article 9, Section 35

### **Sec. 35. [MEDICAL EDUCATION DISTRIBUTION FORMULA STUDY.]**

The commissioner of health shall convene a group of stakeholders that includes representatives of teaching programs and training sites throughout the state and members of the medical education and research advisory committee for the purpose of evaluating the appropriateness of the current distribution formula and considering alternatives for allocating the amount transferred in accordance with Minnesota Statutes, section 256B.69, subdivision 5c. The commissioner shall report the findings and recommendations of this group to the legislature by January 15, 2001.

## Appendix C

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