



Medical Education Funding Is Complex; Better Expenditure Data Is Needed

at a glance

During the 2007 regular legislative session, the University of Florida and the University of South Florida raised, as part of a budget request, the issue of parity in state funding among the current and proposed public colleges of medicine. The parity request was based on State University System (SUS) expenditure data. While the use of official SUS expenditure data is a reasonable starting point, we found that the data reflects inconsistent reporting practices across universities and lacks sufficient detail to determine the costs of the state's colleges of medicine. Insufficient information on current spending and funding by the colleges of medicine including all revenue sources limits the state's ability to assess funding parity across institutions

In addition, few states have funding models that specifically address medical education programs, and those few states with models use them for different functions in the state budgeting process. Ohio is the only state in which the state legislature uses a formula to appropriate funding directly to multiple public colleges of medicine.

Finally, patient care provided by medical schools, known as faculty practice plans, has historically provided funding to help support medical education programs. However, changes in the healthcare industry may lessen the ability of these plans to provide this support in the future.

Scope

Proviso language associated with Specific Appropriations 167 through 170A (Ch. 2007-072, *Laws of Florida*) directed OPPAGA, with the assistance of the Board of Governors, to review funding models used for public medical education programs leading to the Doctor of Medicine degree. This report addresses three issues: (1) trends in medical school funding; (2) funding models for medical education in other states; and (3) medical education costs.

Background

Florida is expanding its medical education programs and schools. Seven public and private medical schools are currently serving medical students in the state, with two additional public medical schools in the planning stage.

Three public medical schools are currently operating in the state. Florida currently supports public medical schools at three state universities: (1) the University of Florida—authorized by the Legislature in 1949 with the first students admitted in 1956; (2) the University of South Florida—authorized in 1965 with the first students admitted in 1971, and (3) Florida State University—authorized by the Legislature in 2000 with the first students admitted in 2001 and full accreditation granted in 2005. The University of Florida and the University of South Florida

Colleges of Medicine are part of Health Science Centers, while the College of Medicine at Florida State is free standing.

Three private medical schools operating in the state receive state funds. The University of Miami operates a medical school, and Nova Southeastern University and Lake Erie College of Osteopathic Medicine operate osteopathic medical schools. Since 1951, the Legislature has provided financial support to the University of Miami, which was the first accredited medical school in Florida. Nova Southeastern University also receives annual support from the Legislature. In addition, Lake Erie College of Osteopathic Medicine receives support for medical and pharmacy students at its Bradenton campus.

One public/private partnership is operating in the state. In 1998, the Board of Regents (predecessor to the Board of Governors) authorized Florida Atlantic University to begin a collaborative arrangement with the University of Miami through which the latter's medical students received their first two years of instruction at FAU. In 2005, the Board of Governors approved expansion of this initiative to a four-year regional medical campus of the University of Miami School of Medicine at Florida Atlantic University.

Two new public medical schools are in the planning stage. In 2006, the Legislature authorized additional public medical schools at the University of Central Florida and Florida International University. These two schools are in the planning stage and have not yet served medical students. The American Medical Association's Liaison Committee on Medical Education approved preliminary accreditation for these medical schools in February 2008.

Programs include instruction and clinical practice in residence. Medical schools include two major programs (1) instruction in the basic sciences as well as behavioral and socioeconomic subjects leading to the Doctor of Medicine (MD) degree sometimes referred to as undergraduate medical education; and (2) graduate medical education which involves instruction, research, and practice in one or more clinical settings through a residency

program. Residency programs are separately accredited by the Accreditation Council for Graduate Medical Education. The only source of direct state funding for graduate medical education is the Community Hospital Education Program, which was administered by the Board of Regents of the State University System until 2000-01 and now is housed in the Department of Health. This report examines the undergraduate component of medical education.

Trends in Medical School Funding

Patient care provided by medical schools, known as faculty practice plans, has historically provided funding to help support medical education programs. However, changes in the healthcare industry may lessen the ability of these plans to provide this support in the future. Two of Florida's three currently operating public medical schools rely on practice plan revenues to subsidize their medical education programs, and the two public medical schools in the planning stage are intending to use faculty practice plans to subsidize their programs.

Federal program expansions over the last 40 years helped shape current practices for funding medical education. The current financial structure for medical education in the United States began developing in the 1960s based largely on funding and program expansion initiated by the federal government. These initiatives occurred in three major areas.

- **Medical Research.** Building on the success of federal investments in medical research during World War II (which led to advances such as penicillin and synthetic anti-malarial drugs), the federal government increased funding for university biomedical research from \$2 billion in 1960 to \$8 billion in 1990. Since this funding (in the form of grants) would pay for up to 40% of the salary of medical researchers, medical schools quadrupled the size of their basic science faculty during this period.

- Medical Education.** During the 1960s, inaccurate population projections led to the anticipation that a shortage of physicians would occur by the end of the century. To address this problem, the federal government provided grants through the Health Professions Educational Assistance Act of 1963 to subsidize construction of medical school facilities and to provide scholarships to students pursuing medical degrees. This grant funding helped increase the number of accredited United States medical schools from 89 in 1965 to 125 today.
- Patient Care.** While educational and research programs were growing, faculty practice plans emerged as the largest single source of revenue to medical schools. The creation of Medicare and Medicaid in the mid-1960s spurred the development of practice plans. These federal programs provided medical schools with new sources of revenue, which in turn led medical schools to organize practice plans to improve billing and collection for medical services by their faculty.

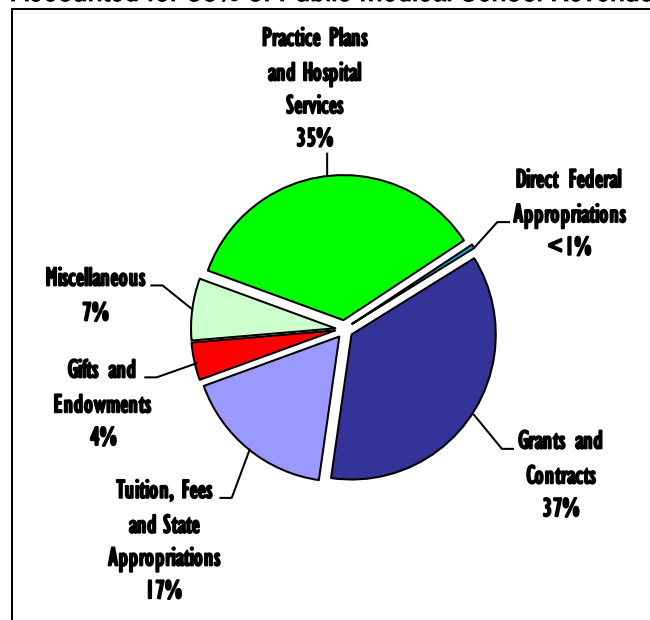
While faculty practice plans provide the largest revenue source for colleges of medicine nationally, the majority of these revenues support direct patient care. While most of the patient care revenues support the cost of providing patient care, most schools negotiate arrangements with their clinical faculty to “tax” a portion of their clinical earnings. Medical schools use the “tax” funds to help pay other medical school costs.

According to data collected by the Liaison Committee on Medical Education, 125 of the accredited medical schools in the United States and their teaching hospitals/other affiliated organizations spent approximately \$71 billion in 2005-06.¹ As shown in Exhibit 1, the revenues for public medical schools are derived from a diverse array of sources, with faculty practice plans and

hospital services accounting for 35% of the revenue.

According to the American Medical Student Association, colleges of medicine have historically used up to eight cents of every practice plan dollar to support the teaching of medical students. The colleges use clinical revenues to pay faculty for time spent teaching students. Other uses of these funds are to underwrite the training of residents and to support faculty research projects.

**Exhibit 1
Nationwide, Fiscal Year 2005-06 Faculty Practice Plans Accounted for 35% of Public Medical School Revenues**



Source: Liaison Committee on Medical Education Part I-A Annual Medical School Financial Questionnaire Fiscal Year 2006, compiled by the Association of American Medical Colleges, October 2007.

Several reports indicate that faculty practice plans are becoming less profitable nationwide. According to a recent publication by the American Medical Student Association, the average revenue per clinical faculty member in constant dollars has been declining since 1993.² Among schools in areas with high managed care penetration, practice plan profit margins declined from 20% in 1991 to a low of 9% in 1995. This leaves

¹ The Liaison Committee on Medical Education is the nationally recognized accrediting authority for medical education programs leading to the M.D. degree in U.S. and Canada. The committee, sponsored by the Association of American Medical Colleges and the American Medical Association, collects annual reports from the schools it accredits that describe college revenues and expenditures.

² *Academic Medicine and Managed Care: an Uncertain Future*, American Medical Student Association, October 15, 2007 <http://www.amsa.org/programs/gpit/acadmed.cfm>.

proportionately less money to fund students and subsidize state funded education. The publication noted that “U.S. medical students are caught in a period of sweeping change in academic medicine....In Washington, D.C., Louisiana, and California, universities have sold their ailing and unprofitable teaching hospitals to national for-profit hospital corporations...The impact that managed care is having on academic medical centers in this country cannot be overstated. The previous era of generous government subsidies and liberal cost sharing between research, clinical practice and the teaching mission is giving way in the face of rising federal debt and the demands of the market...” Such managed care plans have continued to increase since 1995.

The American Medical Student Association’s publication also describes several reasons why managed care is negatively affecting faculty practice plans. It notes that the competition fostered by managed care diminishes the appeal of faculty practice plans. The article notes that the most important drawback of practice plans is cost. “Although private insurers in the past have been willing to pay up to 15% to 35% more for care delivered at academic centers, the managed care revolution is fostering price-based competition that leaves little room for such generosity.” In addition, the emergence of multi-specialty group practices that can coordinate patient care or administrative functions more effectively than academic organizations puts practice plans at a disadvantage. Finally, colleges of medicine and their practice plans include a relatively small number of primary care physicians. This runs counter to the HMO "gatekeeper" strategy and makes practice plans less attractive providers.

While two of Florida’s public medical schools use practice plan profits to help fund their medical education programs, university officials voiced concerns about the long-term sustainability of these profits at current levels. Two of Florida’s currently operating public medical schools—the University of Florida and the University of South Florida—rely on practice plan revenues to help fund their programs and operations.

The University of Florida reports that its faculty practice plans generated approximately \$14.4 million in profits (net revenues) in Fiscal Year 2006-07 that were used to support its medical education instruction program. However, the university indicates that it is becoming increasingly difficult to maintain the profitability of the practice plans. To maintain net practice plan revenues, the College of Medicine has reduced the number of academic tenure track faculty and hired more non-academic (clinical track faculty) physicians who are primarily involved in seeing patients and generating practice plan revenues (see Exhibit 2). University data indicates that net practice plan revenues have gone up slightly since 2002.

**Exhibit 2
As a Result of Emerging Financial Issues, the University of Florida’s College of Medicine Has Reduced the Number of Tenure Track Faculty and Hired More Clinical Track Faculty to Maintain Practice Plan Revenues ^{1,2}**

	2002	2007	Percentage of Change
Net practice plan revenue	\$12,424,311	\$14,361,546	16%
Tenure track (academic) faculty	460	385	-16%
Clinical track faculty	314	591	88%

¹ The faculty numbers in this table are headcounts and include some part-time staff.

² The increase in 2007 was due to increases in the federal upper payment limit.

Source: University of Florida.

Unlike the other public medical schools, Florida State University is minimally supported by practice plans. Florida State University’s medical education program is focused on training general practitioners. Accordingly, the university designed its program so that the clinical rotation during the second two years is taught by community physicians in general practice rather than full-time faculty seeing patients in hospitals. As a result, the university does not have a large number of full-time medical faculty who conduct patient care through a university practice plan.

For 2006-07, Florida State University's gross practice plan revenue was approximately \$5 million, almost all of which paid for patient care rather than student education.

Funding Models for Medical Education in Other States—

Few states have funding models that specifically address medical education, and those few states with funding models use them for different functions in the state budgeting process. Ohio is the only state in which the state legislature uses a formula to appropriate funding directly to multiple public colleges of medicine.

In July 2007, we surveyed all states with the assistance of the Board of Governors and the State Higher Education Executive Officers Association to determine the extent to which funding models and formulae were in place to support undergraduate medical education.³ Specifically, we examined other states' funding models to identify (1) the purpose of the funding models and (2) their components or elements. In addition, we contacted the Association of American Medical Colleges for information about medical education funding policy in other states.

Most states (36) only have one or no public college of medicine. Education funding models are typically used to distribute state funding among multiple public education entities (i.e., school districts, universities, community colleges) involved in delivering educational services. However, most states (36) do not need to allocate state medical education funding to more than one public institution. Association of American Medical Colleges data shows that 8 states do not have a public college of medicine, and 28 states only have one public college of medicine. While some of these states may have multiple campuses for medical education these sites are all associated with one university. As a result, these states have

not needed to develop funding models for their medical education programs.

Ohio is the only state with more than one college of medicine where the legislature uses a formula to distribute funding directly to universities with medical education programs. While 7 of the 13 other states with multiple colleges of medicine reported having funding models that affect funding for public medical education programs, only the Ohio legislature is using the formula to directly appropriate funding to medical education programs. The Ohio legislature appropriates a lump sum of funding to universities, but includes a formula in the appropriations act that prescribes how university governing boards are to distribute the money for medical education programs.

While the Ohio formula is based on the system's average costs by program, the enrollment policies in the formula for Colleges of Medicine results in unequal funding because the formula does not fund growth above an enrollment cap. However, a program may voluntarily reduce enrollment below its funded cap and retain funding for two-thirds of the lost enrollment. The newer, smaller programs tend to enroll students above their caps, while the older, larger programs are well below their caps.

Among the other six states reporting funding models, there is little consistency in how the models are used for state budgeting purposes and in the models' components. For example, in some of the states, universities and state agencies use these funding models to create budget requests or to allocate funds appropriated by their legislatures.^{4,5} Funding models in three states are primarily based on historical funding levels, with incremental adjustments and, therefore, do not clearly represent legislative policy for determining the appropriate level of funding among institutions. See Appendix C for additional

³ In the fall of 2007, 23 states responded to the Board of Governors request. We contacted five additional states that had multiple colleges of medicine.

⁴ North Carolina and Tennessee use a formula to create budget requests to their legislatures, while the State University of New York uses a formula to distribute funds across institutions. Agencies and institutions in Texas and South Carolina use funding models to both create budget requests and distribute funding.

⁵ In New York the allocation is among four colleges of medicine at separate campuses of a single university so the situation is not the same as allocations among different universities.

information on medical education funding in each of the seven states.

Medical Education Costs —

During the 2007 regular legislative session, the University of Florida and the University of South Florida raised the issue of parity in state funding among the current and proposed public colleges of medicine. In order to accurately assess parity issues for Florida’s colleges of medicine, it is first necessary to identify the current level of funding and spending by these programs. However, limitations in the state-level expenditure data for universities greatly diminished its usefulness for identifying and analyzing the costs of colleges of medicine. Without sufficient information on current spending by colleges of medicine from all revenue sources, it is extremely difficult to analyze and to assess funding parity across institutions. We sought to remedy this problem by working with the University of Florida to develop an alternative methodology for identifying the costs associated with colleges of medicine. This alternative methodology will provide a basis for future analyses of funding and spending differences among Florida’s colleges of medicine.

The expansion of medical education programs in Florida has led to parity concerns among the more established medical schools. During the 2007 legislative session, the University of Florida and the University of South Florida raised the issue of parity in funding among the current and proposed public colleges of medicine. The two universities asserted that their medical schools’ level of state support per student was much less than the state funding planned for the new colleges of medicine. Specifically, the universities requested additional funding to provide \$58,000 per student for the University of Florida and the University of South Florida, which includes \$45,000 of state funding (in 2006-07 dollars) with the remainder coming from tuition and practice plans. At that time the parity request estimated the current levels of state support per student at \$7,271 for the University of Florida and \$14,345 for the University of South Florida.

Current state-level expenditure data for universities lacks sufficient detail to accurately determine the cost of medical schools. The University of Florida and the University of South Florida used the official State University System (SUS) Expenditure Analysis as the basis for their 2007 parity request and calculations. While the use of official SUS expenditure data is a reasonable starting point, we found limitations in the data that diminish its usefulness for analyzing medical school costs and parity issues.

The State University System Expenditure Analysis data is based on faculty time on instruction, research, and public service. For colleges of medicine, public service includes patient care. The expenditure analysis procedure is to summarize each faculty member’s time on these activities, by discipline. This allocation of faculty time is then used as the basis of distributing departmental expenditures. Other university costs (indirect costs) are then based on the total employee time or numbers of students.⁶

However, the reporting process for this analysis does not provide consistent data on the costs of the instruction during the last two years of medical education programs, which primarily involve clinical experiences in which students study and interact with clinical (physician) faculty as they see patients. The instructional cost is the difference between the time it takes faculty to see patients versus the time it takes them to see patients and teach medical students at the same time. The difficulty in identifying costs lies in determining how much additional time is required to teach students, and the current state expenditure reporting process does not address this issue. As a result, without a formal system for determining how much of the clinical activity is instruction, faculty subjectively divide their time between these two activities when filling out their activity reports, producing unreliable results.

⁶ Some indirect costs, such as student services are allocated only to instruction and are based on other data such as student credit hours, while other costs such as central administration are assigned to all final cost objectives.

In addition, the current SUS Expenditure Analysis does not clearly report the total support costs associated with some colleges of medicine. For example, the SUS expenditure data for the University of Florida combines the administrative and support costs for the College of Medicine with other professional degree programs (such as dentistry and veterinary medicine) in the university's Health Sciences Center. As a result, the total costs of the university's medical education program cannot be determined from the SUS data.

Finally, the current SUS Expenditure Analysis does not include practice plan revenues used to support academic programs. Therefore, the results are incomplete and unrepresentative of the total resources necessary to support instruction.

Data limitations required the development of an alternative method for analyzing costs. To address these data limitations, we developed an alternative method for identifying the costs associated with colleges of medicine. Our method was conceptually based on the Mission-Based Budgeting process developed by the University of Florida College of Medicine during the 1990s to improve its ability to manage college resources. Mission-Based Budgeting standards are designed to accommodate the financial complexity of medical schools and provide a systematic way to link money and faculty effort for the college's three traditional missions of education, research, and clinical care. (See Appendix A for a more detailed discussion of this process.) Because Mission-Based Budgeting clearly ties state funding provided to departments to specific activities, it has become a national model for financial management of medical centers and is now promoted by the Association of American Medical Colleges.

Our alternative method applied the Mission-Based Budgeting procedures for determining faculty effort to our analysis of the total costs associated with the college of medicine. This addressed (for purposes of our analysis) some of the limitations associated with using the SUS Expenditure Analysis to identify the costs of medical education programs. This alternative

methodology will provide a basis for future analysis of funding and spending differences among Florida's colleges of medicine. (See Appendix B for a more detailed description of our methodology.)

Policy Considerations

Based on our analysis of financial trends in medical education and state-level expenditure data, we identified several options that the Legislature and the Board of Governors may wish to consider in future considerations of medical school funding.

1. Information systems and reporting practices should be refined to better support state funding decisions and provide oversight of the resources associated with the university system medical education initiative.
 - a. The biomedical science departments and programs that provide education to medical students should be clearly identified and reported on the Instruction and Research Data File and the Operating Budget, so that the expenditures of colleges of medicine can be identified. If existing science departments were provided additional financial resources to support the medical education program, these additional resources should be accounted for separately so that the total cost of educating medical students can be determined, including the source of funds. The expenditure system should allow for the oversight and identification of all revenues that support medical education in the operating budget, and faculty activity files submitted to the Board of Governors for all state colleges of medicine and Florida Atlantic University's partnership with the University of Miami's medical school.
 - b. The instruction in other programs provided by colleges of medicine, such as the biomedical science and physician assistant programs at the University of Florida should be clearly associated with

- the college of medicine so that the entire enterprise is portrayed and costs are appropriately allocated among these programs.
- c. For colleges of medicine, State University System data should be revised to clearly identify the role of non-state funding sources used by colleges of medicine to support their general operations.
 2. For colleges of medicine, the university system should consider policies and procedures such as mission based budgeting that allow the multiple sources of funding received by colleges of medicine and the University of Miami/Florida Atlantic University joint program to be managed and accounted for.
 3. The Board of Governors should evaluate the current level of support for instruction from practice plans and develop a policy that provides for equity among institutions in the demands on these funds for instruction. This policy should be considered in the development of budget requests.
 4. The Board of Governors should carefully monitor the practice plan revenues of colleges of medicine for changes that may impact state-supported programs.

5. The Legislature may wish to consider requiring an independent analysis of the costs associated with the Board of Governor’s plan for expanding medical education in Florida. This analysis should review the current, new, and expanded medical education programs supported by the plan and the associated costs for each program. Because of problems and inconsistencies in the universities’ data systems, this will require a separate analysis of each individual college and the University of Miami/Florida Atlantic University joint program.

Agency Response ---

In accordance with the provisions of s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Board of Governors of the State University System to review and respond. We met with Board representatives to discuss report findings; the Board chose not to submit a formal, written response.

Appendix A

Mission-Based Budgeting at the University of Florida

The University of Florida's College of Medicine developed Mission-Based Budgeting during the 1990s to more effectively manage the college's resources. This approach provides a systematic way to link money and faculty effort to the college's three traditional missions of education, research, and clinical care. Decisions regarding departmental support by the dean are made based on standard rates of funding for the activities assigned to faculty in a department rather than on incremental budget allocations. Because Mission-Based Budgeting resolves a number of problems that are encountered in analyzing university and college of medicine data, it has become a national model for financial management of medical centers and is now promoted by the Association of American Medical Colleges. The process also provides information that allows policy makers an opportunity to understand how colleges of medicine operate.

University of Florida College of Medicine officials stated that Mission-Based Budgeting is based on the concept of linking instructional costs to the time budgeted for individual faculty to participate in specific teaching assignments. Faculty time is calculated at two hours of preparation time for each contact hour of classroom teaching (the standard established in the state's 12-hour law).⁷ Clinical work involving teaching and supervision of residents and MD students on clinical rotation (third and fourth year of the MD program) while treating patients is reported as 70% clinical and 30% instructional time. As a result, clinical teaching (teaching conducted while treating patients) is calculated at two hours per day. The time devoted to instruction is then used by the dean as the basis for distributing funds to the departments.

Under Mission-Based Budgeting, the reimbursement of state revenues to a University of Florida medical department for teaching is the same for all faculty, \$82 per hour in Fiscal Year 2005-06, whether physician faculty or scientist and regardless of the actual salary of the faculty member. This fixed financial structure for state support facilitates the analysis of other revenues which make up the deficit between \$82 per hour and actual faculty salaries. The university reports that the average cost per hour of faculty who taught was \$88 for basic science faculty and \$144 for clinical science (physician) faculty. As a result, 7% of basic science instruction and 43% of clinical instruction salary costs were supported by other sources than state funds and tuition. Thus, when faculty are assigned to teaching, non-teaching (non-state) sources of revenue must supplement the teaching revenue provided by the dean in order to maintain their actual hourly rate of pay. This gap is primarily filled by profits from faculty practice plans.

⁷ Section 1012.945, F.S.

Appendix B

Methodology for Determining College of Medicine Instructional Costs at the University of Florida

As a result of limitations with the university expenditure data collected by the Board of Governors, we developed an alternative method for examining the parity issue raised by the University of Florida and the University of South Florida. Our method is based on the Mission-Based Budgeting fiscal management techniques developed at the University of Florida College of Medicine. Specifically, we analyzed the University of Florida Expenditures for Fiscal Year 2005-06 by using the Mission-Based Budgeting allocation for instruction as the cost estimate for instruction. The difference between the state allocation for faculty salaries and the total state expenditures on faculty salaries for Fiscal Year 2005-06 we assigned to the research and public service cost center. Expenditures by the dean's office, the total departmental expenditures, and the portion of the Health Science Center library expenditures estimated by University of Florida to be used to support the College of Medicine we allocated across the instructional programs of the college (MD, physician assistants, biomedical science, and undergraduate instruction), research, and public service based on the allocation of both state and university funds.

We estimated the value of donated teaching and contract and grant-funded teaching of MD program courses based on the contact hours and the average faculty salaries per contact hour calculated in Mission-Based Budgeting. We added this amount to the state costs and the salary supplement provided from other university funds to produce the total cost of the MD program.

Since any expenditure analysis is sensitive to the methods and assumptions used, we conducted two different analyses of the parity request based on slightly different assumptions about the allocation of administration and support funds among the instruction and research missions; they are described below.

- **Method 1 - Allocation based on General Revenue.** This approach allocates all general revenue funds among instruction and research missions based on general revenue expenditures. This assumes that each fund source, including practice plan revenues, helps fund or support the administration of all activities (instruction, research, and faculty practice plans) associated with medical school operations. Such costs are the basis of the overhead assessment the universities negotiate on contracts and grants.
- **Method 2- Allocation based on All Funds.** This approach allocates all general revenue funds based on general revenue and the practice plan funds that support instruction. This assumes that practice plan revenues support the administration of faculty practice plan activities but do not provide funds to support the administration of instructional and research activities. The result produces a larger estimate of general revenue support for instruction.

Appendix C

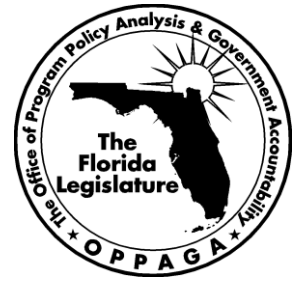
States With Funding Models That Address Medical Education

Seven of the 13 other states with multiple colleges of medicine reported having funding models that affect funding for public medical education programs. In one state (Ohio), the legislature uses the formula to distribute funding directly to individual universities with medical education programs. The funding models in the remaining six states are used by universities and state agencies to create budget requests and allocate funds appropriated by their legislatures. Table C-1 describes the purpose and components of the funding models used in the seven states.

Table C-1
Seven States with Multiple Colleges of Medicine Have Funding Models That Affect Funding for Medical Education

State	Description
New York	Legislative appropriations to the State University of New York are based on incremental budgeting. The university has four campuses with individual colleges of medicine, and it uses a formula to distribute funds to individual campuses. The formula provides funding based on average costs of all medical schools. Practice Plan revenues are not considered in the formula. All schools have the same tuition and retain and spend their own tuition.
North Carolina	North Carolina's formula is only used to request funding for enrollment growth. Funding is the average instructional cost per Full-Time Equivalent student for each individual university and percentage increases based on the percentage of enrollment growth. System average costs are not used. In recent years the Legislature has funded 100% of the enrollment growth request.
Ohio	Ohio's formula is used to prorate state appropriations for basic instructional services among higher education institutions. The pro-ratio is based on system-wide average program costs and a uniform fee assumption by program level. Actual fees are set under the authority of local boards of trustees. Other higher education priorities are funded outside the formula. The legislature does not appropriate directly to individual universities but does prescribe the distribution formula in proviso. Medical education has enrollment caps which preclude funding for growth. This is complicated by a buffering system which only reduces funding by one-third of the average cost for each FTE below the cap. The older, larger programs are typically well below the cap while the newer programs are above the cap. This results in a disequalization of funding. Funding for growth has not kept pace with enrollment growth, so other university programs, without caps have experienced declines in average funding per FTE and redistributions from stable or declining programs to growing programs and institutions.
South Carolina	South Carolina's formula is only one part of the justification used to request funds and is not used by the legislature. Appropriations are made directly to universities as a lump sum, without being tied to a program such as medical education. The formula considers student/faculty ratio standards set by the Commission on Higher Education, southern regional salaries, physical plant cost increases, and base funding.
Tennessee	The Tennessee formula is used to request funding from the legislature. The formula is based on Association of American Medical Colleges average student faculty ratios, average salaries, and base funding. The legislative appropriation is a lump sum to the university and the university has discretion on allocating funds among programs.
Texas	The Texas formula is used to request funds for nine stand-alone health institutions and to allocate the legislative appropriation. These institutions provide a variety of health related programs and two do not provide medical education, although they conduct medical treatment and research. The formula includes program weights and enrollment, inflation, infrastructure expansion, matching for research expenditures, and mission-specific support for the two programs that do not provide medical education. The legislature funds all these institutions in a single appropriation, which is then pro-rated by the Coordinating Board to individual institutions using the formula.
Virginia	Virginia uses a formula for a portion of the budget request referred to as the base funding. The medical component only addresses instruction. This formula is based on student-faculty ratios derived from a research and consensus process among the universities, funded by using individual university's average faculty salary. The legislature does not make an appropriation based specifically on this component of the request: rather it appropriates a single amount to each institution, which has discretion on allocating funds to its programs.

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