THE GME INITIATIVE

MEDICAL EDUCATION
FOR AMERICA'S HEALTH

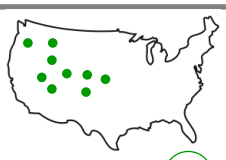
GMEINITIATIVE.ORG

The GME Initiative has taken a lead role in advocating reform of the government's support of GME Programs. We are primary care leaders, educators, and advocates who are passionate about reforming graduate medical education through payment reform, strategic partnerships, state level initiatives, advocacy, and education.

2010

The Commission on Family Medicine makes a commitment to GME.
Family medicine program directors frustrated with chronic funding shortages for residencies, geographic inequities. Started investigating funding issues, looking at "have" and "have not" states.

2011



STATES 9 — 23 — PARTICIPANTS

The GME Initiative is formed. Initial group of GMEI participants convene in Denver to make a plan to ensure the financial viability of family medicine residencies, and develop parity in funding.

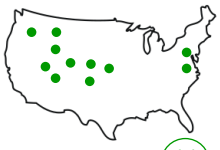
2012-13

If Things Stay the Same, They Will Only Get Worse

33% of current workforce are primary care physicians
<25% in training go into primary care

Therefore: Without reform, America won't have enough primary care docs

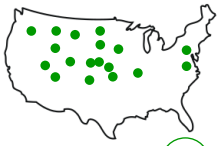
2014



STATES 11 — 30 — PARTICIPANTS

GMEI First Summit, Washington DC:
Met with legislative aides, educated policy makers on importance of reform, alert Congress of IOM GME Report and Medicare GME issues.

2015



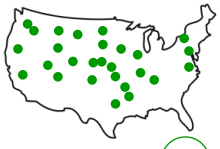
STATES 22 — 50 — PARTICIPANTS

GME Summit West, Denver: Summit of Western and Mid-Western states to create a plan of action.
Products: Legislative report card, letters to Congress, educational video, creation + activation of work groups

2016

Program Coordinator Hired for the GMEI
Activities: Branding, website, monthly conference calls, monthly work group activities, summit planning, outreach, partner projects, ad-hoc work as needed, materials development, shared resources

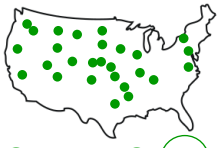
2017



STATES 26 — 76 — PARTICIPANTS

States Initiatives Summit, Albuquerque:
Developing and Sustaining an Accountable Physician Workforce for States & Communities
Products: Research reports, state best practices

2018



STATES 33 — 120 — PARTICIPANTS

CoNGR Convening, Atlanta: Comprehensive National GME Reform. Working meeting to define roles, develop strategy/tactics, draft position paper, and plan for national reform efforts.

CURRENT ACTIVITIES

LEGISLATIVE INITIATIVES FOCUSED TASKFORCE (LIFT)

The LIFT group meets monthly to discuss legislative reform updates, regulatory reform efforts, and other activity related to legislative fixes for GME. Current tracking includes:

- RAP-GME Progress: Senate Bill 3014, The Rural Physician Production Workforce Act of 2018, has been introduced in the Senate by Cory Gardner, and is co-sponsored by Senator Tester. May be attached to "farm bill" out of Mississippi.
- Rural Residency Program Development Program: A funding opportunity has been introduced by HRSA, and we are anticipating the RFP will come out soon. As of right now, the RFP for Technical Assistance has been opened, and a number of proposals have been submitted (with significant participation across the GME Initiative for expert consultants)
- VACA funding: has been approved to use VACA funding to support training that is not on VA "linoleum." Guidance will likely not be issued for another year. Section 403 authorizes VA to pay for GME programs, as a pilot program.
- Data needs: Graham Center data tables, spot checking for accuracy; potential to do a case study for hospitals within GME Initiative participant organizations to ensure methodology is reliable.
- Continually monitoring state strategies for legislative fixes
- Continually reviewing "gotcha" rules and where they come up within other legislative efforts

Comprehensive National GME Reform (CoNGR)

The CoNGR group has been charged with looking at the broader picture of comprehensive reform for GME from a financing, governance, and accountability perspective. This group is reviewing comprehensive reform efforts that have come out of policy briefs, the IOM report of 2014, major organizational policy recommendations and efforts from organizations such as the AAFP, and coming up with a platform for broad reaching reform. Since the last annual convening, hosted and organized by the CoNGR group, the following activity has been taken on:

- Planning the next convening in conjunction with the broader GME Initiative
- A workplan for activities within defined roles (Catalyst, Convening, Data Steward, Advocate)
- A platform for comprehensive reform
- GME "school" - a curriculum that covers GME finance basics, reform attempts, and future direction/priorities

States Initiatives

The GME Initiative also looks at state based initiatives – and sees the states as the innovation labs for enhancing GME funding and reform. States are an essential part of these discussions, due to their significant success in development and support of GME efforts, with a shared common belief in the critical importance of training local workforce for the future, and the strategies on a state level complement those on a federal level. The GMEI uses these state-based initiative discussions to share best practices, collect stories, disseminate information on a state level, survey key players, and advocate for reform. Current activities include:

- A compendium of state strategies to enhance GME funding
- Complementary publications that piggy back off of other organizational resources being produced nationally (such as the National Governor's Association "roadmap", coming soon)
- A national survey to assess strategic GME activity on a state level
- Collecting stories on a state level about challenges, barriers, and successes in attempting the above strategies

RAP-GME: Rural Alternative Payment for Graduate Medical Education

The Current Challenge. Rural America is experiencing a physician workforce crisis. Research shows the greatest indicator of where a physician will practice is the location of their residency training. Most family medicine residency programs are located in urban areas - we need to train more physicians in rural areas. Current CMS policies for GME funding obstruct the development of rural residencies, preventing the expansion of a successful training model for rural practice.

The Concept. A direct per resident payment (PRP) to an accredited residency program's sponsoring institution for weeks spent training in a rural location, unadjusted for Medicare or Medicaid patient ratios, inclusive of all training time (not just patient care), irrespective of specialty.

Key Features

- Fixed Per Resident Payment
- Pays for rural time with two different thresholds (8 weeks, or >50%)
- Will be built into Medicare GME system
- All kinds of hospitals eligible, all specialties
- Broad rural definition, stable over time
- Hospital choice, no triggers for cap or PRA

Budget allocations/limits. Maximum national expected financial impact is likely small relative to current system.

Political Context. Senator interest in rural GME funding legislation, asked GMEI to develop a proposal to increase rural workforce production. S. 3014 Rural Physician Workforce Production Act of 2018 was introduced June 2018.

The GME Initiative Annual Convening

2018 Convening in Atlanta. Invites were sent to GMEI participants to convene in Atlanta, GA to review an educational curriculum for issues on GME reform, to draft a position paper on key reform elements, to develop a plan for strategy, tactics, and outreach, and to define the roles the GMEI will take on as a catalyst for reform. A full summary with materials, presentations, resources can be found: www.gmeinitiative.org/january2018summit

OUTCOMES	GME Reform Curriculum, Planning Activities Drafts (Work Plan, Strategic Plan, Advocacy Plan), RAP-GME Support, GMEI Defined Roles, Platform/Position Paper
GMEI Role: Catalyst for Change	(A) Educators/Facilitators (B) Advocates (C) Conveners (D) Data Stewards
Platform Elements	(1) Finance and Payment, (2) Governance and Accountability (3) Specialty Composition and Geographic Distribution (4) Transformation and Innovation

Future Planning: 2019 Convening. The CoNGR workgroup of the GMEI is currently planning for a 2019 convening in Washington DC. This convening will serve 3 purposes: continue to assess state-based initiatives as the innovation labs for reform, to educate key support on pending RAP-GME legislation, and to bring together the participants committed to comprehensive national reform to build momentum for future activity, education, policy, and advocacy.

JOIN US

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GMEINITIATIVE.ORG

From: gme-initiative@googlegroups.comOn Behalf OfMannat Singh
Sent: Monday, February 4, 2019 10:25:46 AM (UTC-08:00) Pacific Time (US & Canada)
To: gme-initiative@googlegroups.com
Subject: The GME Initiative 2019 Updates - Schedules, Projects, 2019 Convening in Washington DC

Good morning/afternoon GMEI Participants!

1. The GMEI is still growing:

Some of you are new (ish) to this list. Welcome!

If you would like to be removed from this list and from our mailings/calendar invites, please reply with "unsubscribe", or provide information/email address for a colleague who may like to take your place on the GMEI.

If you are staying on our list, please provide a sentence or two on "why" - whether it aligns with your organization's goals, personal/professional goals, in order to remain informed about what activities the GMEI takes on, or any other number of reasons. We'd like to have a "blurb" for each participant and keep that as a living document. I will be following up on this activity on the subsequent conference calls.

For the list we are using Google groups - we had some technical difficulties/glitches with it but I think the kinks have been worked out!

2. 2019 schedule is being sent out now (and revised time/dates for the last two calls of this year):

The bigger group calls took a bit of a break in the late fall to allow for 2019 Convening Planning time, but we are back!

You should all receive calendar invites shortly, for the dates/times below (in MT), and copied below:

Friday, February 15th, 2019 2:30-3:30 pm
Monday, March 11th, 2019 9:00-10:00 am
Thursday, April 11th, 2019 2:30-3:30 pm
Tuesday, May 7th, 2019 9:00-10:00 am
Wednesday, June 5th, 2019 2:30-3:30 pm
Friday, July 12th, 2019 9:00-10:00 am
Tuesday, August 6th, 2019 2:30-3:30 pm
Monday, September 9th, 2019 9:00-10:00 am
Thursday, October 10th, 2019 2:30-3:30 pm
Wednesday, November 6th, 2019 9:00-10:00 am
Friday, December 6th, 2019 2:30-3:30 pm

We try to provide some variety in days of the week/time of day to accommodate as many schedules as possible.

3. Work groups/schedules:

We have the following work groups -

- **Legislative** (LIFT) (calls are typically on first Monday of the month, from 1130-1230 MT)
- **Comprehensive National GME Reform** (CoNGR) (alternates monthly calls with the LIFT time)
- **States Initiatives** (calls are typically on the third Thursday of the month, from 9-10 MT)
- **Partnerships** (need to re-initiate, chair and schedule TBD)

If you are not on a work group and would like to be added/removed to/from any of them, please let me know. I will be following up with work group participants and the chairs of each group in a separate email. The schedules for the work groups who aren't on the calendar yet will also be sent after this email.

4. Dropbox/website/shared resources

Currently in the midst of another dropbox/website/list audit. For those of you who are new to the GMEI, I will be sending out invites to join our shared folder where we keep meeting summaries, resources, work group "charges", event information, participant information, etc. I am currently cleaning up/re-organizing the dropbox and materials shared on the website - and will send a status update and provide an "orientation" to the group about those changes.

We are also continually working to pull together shared resources, event calendars, conference participation - so if you have upcoming events, resources you'd like disseminated, research to share, articles of interest, questions about all of this, or any requests that relates to any of the above, please let me know!

5. 2019 Annual Convening Planning

The date, location and venue have been finalized!

Registration is open, please reserve your lodging!
https://www.gmeinitiative.org/march2019summit
https://2019gmeiconvening.eventbrite.com/

Date: March 20-22, 2019
Location: Washington DC
Venue: Grand Hyatt, Washington (we have a conservative room block reserved, please be sure to make lodging arrangements through the event page if you haven't already)
Purpose: “Building a system for community-responsive GME: Bringing together voices from communities, states, federal agencies, and medical education to build a more community-responsive health workforce."

Snapshot Agenda:
Wednesday, March 20, 2019 4:00 pm - 8:00 pm: GME School and reception/dinner (we are strongly encouraging as many people as are able to join us for this portion)
Full meeting officially convenes Thursday 8:00 am - Friday 12:00 pm
Thursday, March 21, 2019 8:00 am - 5:00 pm: Case studies with response panels, strategic discussions (breakfast and lunch provided)
Friday, March 22, 2019 8:00 am - 12:00 pm: Work group updates, partner updates/projects, future direction discussion (breakfast and box-lunch provided)

6. We have a number of deliverables, activities, projects, and successes over this past year and I would like to share some high level information!

GMEI-Activities Brief:

- Attached (PDF)
- A recent account of some high level activity (includes GMEI history/timeline, work group activities, etc.)

S. 3014: Rural Physician Workforce Production Act 2018.

- Within the GMEI, fondly referred to as "RAP-GME"
- Was introduced in 2018, has recently been reintroduced as S.289 (text on Congress.gov has not been uploaded/updated yet). For more information please contact me directly.

Annals of Family Medicine: published in September 2018 issue

- Link: http://www.annfammed.org/content/16/5/468.full
- Feel free to share!

Rural Residency Planning Development Program, Technical Assistance Center participation/involvement

- The GME Initiative listed as a partner
- Many GMEI individuals, partners, organizations have been included in the accepted proposal for this new Technical Assistance Center for the new HRSA RRPD program
- As we get more information, we will share with the group!

Upcoming conferences/presentations

- The GME Initiative will be presenting at AAFP's PDW-RPS in 2019!
- We will be attending STFM 2019 as well!
- Come see us!

If you have any other thoughts, ideas, questions, please feel free to contact me at any time.

Thanks
Mannat

Family Medicine Updates

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP
From the Association of Departments of Family Medicine

Ann Fam Med 2018;16:468-469. https://doi.org/10.1370/afm.2294.

"THE GME INITIATIVE" AND GME IN STATES

Family medicine struggles to fund graduate medical education (GME) due to antiquated Medicare rules that fund hospitals for GME. Medicare GME funding inadequately covers family medicine residencies, is inequitable with variation across the United States, and does not fill gaps in the cost of training.[1] Program leaders need to identify funding streams which include state initiatives, and learn to advocate for options to create sustainable residency infrastructures to produce needed workforce in their states. Having answers to key questions about state GME funding and collaborative partnership opportunities, and sharing best practices to advance these efforts will support advocates at state levels to optimize opportunities for meeting state and regional workforce needs.

The GME Initiative (GMEI) (http://www.gmeinitiative.org) is a grassroots, volunteer group of roughly 150 members representing approximately 35 states and is comprised of health care learners, educators, advocates, and leaders who are passionate about reforming GME through payment reform, partnerships, state initiatives, legislation, advocacy, and education at the state, regional, and national level. Beginning with a policy brief calling for GME Reform,[2] a GME Summit was held in 2015 (http://www.gmeinitiative.org/november-2015-summit/x0i4v). A key recommendation from this summit was to create a workgroup focused on state-based GME reform initiatives. The goal of the GMEI's State Initiatives Workgroup is to track state initiatives, educate others about state GME activities, look at the finance, accountability, and governance of GME reform, and to host conference(s) on behalf of the GMEI. The first GMEI summit focusing on States was held January 2017 in Albuquerque New Mexico. (http://www.gmeinitiative.org/2017summitmaterials). Thirty-three states were represented at the Summit; since then more states have joined the GME Initiative and work of the States' Workgroup.

In general, states that do support GME do it through Medicaid, through state general funds, taxes, special fees, or some combination of these. To better understand specific sources and availability of funds to support GME at the state level, the GMEI States' Workgroup has developed a template for gathering key information across states. Key areas addressed in this template are: (1) state-specific goals for GME; (2) total annual amount of non-CMS federal dollars; 3) sources of funding—where does the money come from?; (4) strategies (legislative, financial) to expand GME within a state; (5) governance and accountability structures to ensure oversight over finances; and (6) barriers and challenges.

With pilot information from 9 states, the GMEI is beginning to learn about common strategies and common barriers/challenges. A key strategy for any GME activity is to engage stakeholders and legislators to educate them about what GME is and how targeted GME efforts support state workforce needs over time. A number of states are engaged in specific efforts targeting rural areas and often involve a coalition of multiple stakeholders (state Academy of Family Physicians, state medical association, state hospital association, medical school, and others). Barriers and challenges we are learning about include too many disparate stakeholders, administrative burdens related to oversight of funds, continual need to educate and reeducate legislators about what GME is and how long it takes to produce a physician workforce, and Medicare GME cap limits which prevent residency program expansion, especially in underserved areas.

Whatever the strategy or policy in play within a given state, what the GME States' Workgroup strives to do is to "connect the dots" between the intent of a particular policy or strategy and the reality on the ground. An overriding inherent challenge in any state-supported GME effort is the time-limited nature of state funding. This is diametrically opposed to the hard-wired funding through Medicare from CMS which continues to flow with no accountability tied to those funds. State GME efforts require constant attention to data to demonstrate accountability while at the same time constant attention to ensuring that stakeholders continue to see the value.

There is much more to learn about GME at the state level. In a recent survey of Association of Departments of Family Medicine, more than one-half (54%) of the Departments are reportedly involved in formal regional or statewide efforts to address family physician workforce needs and workforce planning. What we have found through the GME Initiative is

that there is much to be gained by learning from each other. For more information about the GME Initiative, and how one can join, contact Mannat Singh at mannat.singh@gmail.com.

Ardis Davis, Chair, GMEI States' Workgroup, Washington State
Mannat Singh, Director, GME Initiative, Colorado State

References

1. Pauwels J, Weidner A. The cost of family medicine residency training: impacts of federal and state funding. *Fam Med*. 2018;50(2):123-127.
2. Voorhees KI, Prado-Gutierrez A, Epperly T, Dirkson D. A proposal for reform of the structure and financing of primary care graduate medical education. *Fam Med*. 2013;45(3):164-170.

AFMRD Association of Family Medicine Residency Directors

From the Association of Family Medicine Residency Directors

Ann Fam Med 2018;16:469-470. https://doi.org/10.1370/afm.2295.

OPIOID PRESCRIBING: A GENERATIONAL PERSPECTIVE

As our nation grapples with an epidemic that fractures families and wreaks havoc in communities, an aspect of the opioid crisis often goes unspoken. How has this complex patient care dilemma affected family medicine education? Can there be a teachable moment in our past to improve our future? The AFMRD leadership shares 2 stories, one from a faculty physician teaching for over a decade and one from a resident physician in the middle of training.

Faculty Physician

Fresh out of residency in 2004, trained in the era of "pain is the fifth vital sign" and the upswell of OxyContin prescribing that began in the mid to late 90s, I felt overwhelmed by the number of my patients suffering from chronic pain and unprepared to help them. A woman with bipolar disorder had compartment syndrome in her right arm after a suicidal ingestion that left her unconscious in her car for 18 hours. The muscle atrophy and scars from fasciotomy were impressive, resulting in a combination of severe neuropathy and hyperalgesia that were impossible to heal, and it was with consultation that I prescribed her fentanyl patches and later methadone for pain. The guidelines at the time purported that patients receiving opioids for pain relief did not become addicted and that doses should be titrated to pain relief without a ceiling. Medicine has no pain-relieving options more immediately effective than opioids, and I remember the discomfort of first realizing I have the power to dispense or withhold them based on my own judgment of someone else's suffering, and first experiencing the anger and fear this can generate in patients. It is much clearer today than it was then, that a policy of unlimited dose escalation for chronic non-cancer pain is a recipe for dependence, addiction, overdose, potential diversion, and little to no benefit. The drawing of rigid lines, however, can disregard the situations where these powerful medications can provide significant improvements in function and quality of life. I see doctors coming out of training today, immersed in the crisis of opioid addiction, and fearful of offering even very small prescriptions of opioids or of taking on the challenge of connecting with patients who have been dependent on them for decades. The laws and regulations that now limit my prescribing are based on better science, and I try not to resent them as I fill out prior authorization paperwork to allow my patients access to pain medication when I believe they do need it. We are all constantly looking for that balance between compassion and caution, between guidelines and individualized medicine.

Resident Physician

She has a deep vein thrombosis (DVT). It is the first textbook DVT I have seen in my short career, but she won't go to the hospital. She is here today for her 50 MME of codeine and morphine. I have never met her before. She is angry at me because I don't want to prescribe her monthly prescription unless she goes to the hospital; I worry her narcotics are concealing her life-threatening pain. I feel helpless; I feel like a drug dealer. I do not feel that I am helping her and I don't know how to help her. The surge of frustration rises; I want to quit. I alternate rapidly between disgust and pity and confusion. The laws are mounting and the insurance coverage is tightening against my choices, but I have not started ANY of my patients on regular controlled substances. I am drowning in evidence against chronic opiates for these diagnoses but cannot follow any of the recommendations without losing these patients or putting them through withdrawal and suffering. I have walked into a trap of addiction and these patients will desperately and persistently strategize ways to maintain access to my prescribing habits. When I start my clinic day, I look up all new patients on the state controlled substance database. I scan for other acute pain complaints to make sure I am prepared for the demands of my opioid-seeking patients. I avoid starting new patients on these high-risk medications unless there is a very clear clinical need. I seek alternative therapies, though most patients cannot afford acupuncture, talk therapy, or topical analgesics. I set appropriate expectations for pain management, but this is not helpful for the patients I inherited. What I am lacking is the ability to safely treat opioid dependence. I don't know how to help them, so I sustain them.

Two stories, two generations, one emotion: frustration. As resident education moves forward, family medicine must be a part of the solution to this epidemic. Resident physicians are an untapped resource

AAMC

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Medicaid Graduate Medical Education Payments: A 50-State Survey

2016

Learn

Serve

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Association of
American Medical Colleges

Medicaid Graduate Medical Education Payments: A 50-State Survey

2016

Association of American Medical Colleges
Washington, D.C.

This is a publication of the Association of American Medical Colleges. The AAMC serves and leads the academic medicine community to improve the health of all. www.aamc.org.

Tim M. Henderson, MSPH, health workforce consultant, conducted the survey and wrote this report under a contract with the AAMC.

Questions about the content of this publication may be directed to Merle Haberman, Association of American Medical Colleges, at mhaberman@aamc.org.

AAMC

CONTENTS

EXECUTIVE SUMMARY

Medicaid represents the single largest expense in state budgets, amounting to over 27 percent of all state spending. Although there is always pressure to control costs, improvements in the economy and a rise in federal spending to states that adopted Medicaid expansion under the Affordable Care Act have allowed states to augment Medicaid reimbursement rates and benefits. States also continue to take actions to increase managed care enrollment, which included nearly 75 percent of all Medicaid beneficiaries in 2013. Calls for more government oversight of Medicaid managed care has led the federal government to propose rules that would modernize regulation of MCO contracts and performance, including capitation rate setting.

In 2015, the Association of American Medical Colleges (AAMC) contracted with an independent health workforce consultant to survey state Medicaid programs and examine their policies for financing GME. The study updates earlier studies of state Medicaid GME policies (published in 1999, 2003, 2006, 2010, and 2013, respectively). An online questionnaire was distributed to Medicaid agencies in each state and the District of Columbia to identify their current policies and issues associated with GME payments. All but one agency responded to the survey; however, corresponding data from the nonresponding state were obtained through another source. The findings from this study will be of particular interest to hospital officials, policymakers, and health care advocates.

This report reflects the climate for state Medicaid GME support as of 2015 and is intended to set a foundation for future analyses. Its content does not reflect any fiscal or policy changes that have occurred since completion of the survey.

Key Findings

- Forty-two states and DC made GME payments under their Medicaid program in 2015, the same number as in 2012. Two of the eight states that reported not making GME payments, California and Massachusetts, are among the 10 states with the largest number of GME programs. Moreover, three states reported in 2015 that they had recently considered ending Medicaid GME payments.

- Medicaid remains a major source of funding for GME. In 2015, the overall level of support for GME continued to grow, reaching $4.26 billion. This represents a significant increase since 1998, when Medicaid GME support totaled $2.3–$2.4 billion. However, three states reported in 2015 that they explicitly reduced GME payments; another seven states reported their total 2015 GME payments decreased by 10 percent or more over 2012 levels.

- For the first time in 2015, the proportion of Medicaid GME payments made under managed care (61 percent) was higher than, and significantly exceeded, the proportion of such payments made under FFS (39 percent).

- Under Medicaid FFS, 40 states and DC reported making GME payments, equaling the number of states that reported making such payments in 2012.

- Of the 39 states (and DC) having risk-based Medicaid managed care programs, 69 percent—26 states and DC—made GME payments in 2015 under Medicaid managed care. Of those 26 states, 16 and DC made Medicaid GME payments explicitly and directly to teaching hospitals; 12 states recognized and included such payments in MCO capitation rates. Two states, Georgia and Minnesota, made direct GME payments to teaching programs and included GME payments in MCO rates.

- Although teaching hospitals remained the predominant recipients of Medicaid GME support, medical schools in three states—Minnesota, Oklahoma, and Tennessee—were eligible to receive such payments directly. Two states, Florida and South Carolina, made GME payments to individual teaching physicians.

- In 14 states, nurses and other health professions trainees, as well as medical residents, can have their graduate training subsidized by Medicaid.

- Medicaid programs in 32 states made GME payments with the expectation of producing more physicians, up from 22 states in 2012.

MEDICAID GME PAYMENTS: A SURVEY OF STATE MEDICAID PROGRAMS

Introduction

States continue to be an important source of support for physician training. State and local governments, as well as parent universities of medical schools in these states, appropriate funds for undergraduate medical education. (In fiscal year [FY] 2014, there was $5.7 billion in government and parent support, up 13 percent in current dollars from FY 2012.[1]) Medicaid programs in most states help offset a portion of graduate medical education (GME) costs incurred by teaching hospitals and other entities.

Medicaid plays a significant role in the U.S. health care system, providing health insurance coverage to more than one in five Americans.[2] It is the largest source of federal funds to states and covers medical and long-term care services for about 70 million people.[3] In FY 2015, Medicaid represented the single largest expense in state budgets, amounting to over 27 percent of all state spending.[4] Given the size of Medicaid in state budgets, there is always pressure to control costs; however, according to findings from the Kaiser Family Foundation, "Improving state finances in recent years has resulted in more states restoring or enhancing rates than restricting rates overall."[5] Moreover, federal spending to states has risen by 22 percent over amounts in FY 2014 when Medicaid coverage expansions began under the 2010 Affordable Care Act.[6]

Although Medicaid programs are not obligated to pay for GME, most states historically have made such payments under their fee-for-service programs.[7] Behind Medicare, Medicaid is the second largest explicit source of funding for GME and the other special missions and services of teaching hospitals. Contrary to Medicare, the federal government has no explicit guidelines for states on whether or how their Medicaid programs should or could make GME payments.

In addition, many states have Medicaid managed care programs that provide some level of GME support. In 2013, 72 percent of all Medicaid beneficiaries were enrolled in managed care, largely in risk-based managed care organizations (MCOs) that operate in 39 states and primary care case management programs in 19 states.[8] States continue to take actions to increase managed care enrollment, but calls for more government oversight of Medicaid managed care led to the release of proposed rules by the federal government in 2015 that would modernize regulation of MCO contracts and performance, including capitation rate setting.[9] Despite these changes, support for GME under managed care remains at risk. Not all states with Medicaid risk-based managed care programs provide GME support under managed care. While Medicaid managed care capitation rates may include historical payments for GME in many states, MCOs often are not bound to distribute these dollars to hospitals with clinical training programs or to sponsor training programs themselves.

About the Survey

In 2015, the Association of American Medical Colleges (AAMC) contracted with an independent health workforce consultant to survey state Medicaid programs and examine their policies for financing GME.[10] In part, the intent of the study was to update earlier studies of state Medicaid GME policies (published in 1999, 2003, 2006, 2010, and 2013, respectively) for the AAMC that were conducted by the author and the National Conference of State Legislatures.

In the summer of 2015, an online questionnaire was developed and distributed to Medicaid agencies in each of the 50 states and the District of Columbia to identify each agency's current policies and issues associated with GME payments (see the survey instrument on page 26). All but one state Medicaid agency responded to the survey; however, corresponding data from the nonresponding state was obtained through another source.[11] Thus, the final count of responses was 51.[12]

This report reflects the climate for state Medicaid GME support as of 2015 and is intended to set a foundation for future analyses. Consequently, its content would not reflect any fiscal or policy changes that have occurred since completion of the survey.

Findings

As of 2015, 42 states and the District of Columbia (DC) provided GME payments under their Medicaid program (Table 1).This does not represent an overall change from 2012. Of note, however, two states that did not make such payments in 2012, Alabama and Illinois, now do, and two states, Alaska and North Carolina, no longer pay for GME. Medicaid agencies in eight states did not pay for such costs, although at one time these eight states had made GME payments under their Medicaid programs.

Additionally, three states in 2015—Alabama, Michigan, and Tennessee—reported having recently considered ending Medicaid GME payments. They identified current budget shortfalls or cost controls as the rationale for considering discontinuation of GME payments.[13]

GME Payments under Fee-for-Service

Forty states and DC reported making GME payments under their Medicaid fee-for-service (FFS) programs (Table 1). This number equals that of states reporting GME payments made under FFS in 2012 but represents a notable decline from 2005 when 46 states and DC made GME payments under FFS (Table 14).

When asked how payments are calculated, DC and 14 states out of the 40 states that help support GME under FFS said they used methods similar to those used under the Medicare program. This number has changed very little in recent years. Twenty-nine states and DC reported calculating GME payments by use of some "other method" not specified in the survey. Of this group, nine states used a per resident method based on a teaching hospital's share of total Medicaid revenues, costs, or patient volume. Another five states employed a method involving a lump sum or pooled amount, and three states paid a fixed amount per Medicaid discharge. Three states—Georgia, South Carolina, and Texas—and DC reported using one method for paying direct GME costs and another for paying indirect GME costs. Florida and Michigan calculated GME payments differently for multiple funding pools (Table 2). DC and the states that made GME payments under FFS distributed these payments using three methods. **States are almost equally split between two of these methods: 21 states and DC made GME payments through a teaching hospital's per case or per diem rate, and 21 states made payments through a separate direct payment to an institution.** Five states—Arkansas, Colorado, Kansas, Maine, and South Carolina—reported using both methods. Kansas made GME payments to public teaching hospitals as part of the hospital per diem rate; all other hospitals received a supplemental quarterly payment for GME (Table 3).

Nine states under FFS used a third distribution method: a supplemental or special GME payment.[14] Applying an intergovernmental transfer methodology, Montana and Texas financed GME payments to state-owned teaching hospitals by transferring to Medicaid a state appropriation to a state university that was matched with federal funds (Table 3).

GME Payment under Risk-Based Managed Care

Of the 39 survey respondents with risk-based Medicaid managed care programs, 69 percent—26 states and DC—provided some level of GME support under the plans in 2015 (Table 1).[15] These payments were made explicitly and directly to teaching programs or indirectly as part of the risk-based MCO capitation rates.

Sixteen states and DC made Medicaid GME payments explicitly and directly to teaching hospitals or other teaching programs under risk-based managed care (Table 4). This represents a net increase from 2012 of two states that made GME payments directly under capitated managed care: four new states—Florida, Louisiana, New Jersey, and Oregon—made direct GME payments; two states, Kansas and Vermont, no longer make such payments. This number is close to the count in 2002, when 18 states "carved out" GME payments from MCO capitation rates (Table 14). The most common reasons cited (as specified in the survey) for continuing direct payments from Medicaid for GME under managed care were a desire to use Medicaid funds to advance state policy goals, a desire to help train the next generation of physicians who will serve Medicaid beneficiaries, and a belief that GME is for the public good (Table 4).

Twelve of the 17 states used a method for calculating GME payments that was unspecified in the survey, although typically it involved a per resident amount, a per diem or per discharge amount, or a lump sum. Six states followed the Medicare FFS methodology, and three states used a process involving per Medicaid discharge amount. Georgia and Virginia employed other methods to pay for direct and indirect GME costs, and Florida paid for GME across multiple funding pools (Table 5).

Twelve states recognized and included Medicaid GME payments in their capitated payment rates to MCOs. Of these, two states—Georgia and Minnesota—also made direct GME payments to teaching programs under managed care (Table 6). The count of 12 states is up from the nine states providing these payments in 2012 and represents the highest number of such states since 1998 (Table 14). Half of the states (Iowa, Kansas, Kentucky, Michigan, Minnesota, and Mississippi) required MCOs to distribute these implicit payments in their negotiated rates to teaching hospitals (up from just two states in 2005); all but Minnesota provided MCOs a specific methodology for determining GME add-on payments. The other six of the 12 states assumed the MCOs would distribute the payments to teaching programs.

The balance of states (eight) with a Medicaid capitated managed care program did not leave GME historical payments in the base used for calculating MCO payments but supported GME under FFS. For these states, the two most common reasons cited were that Medicaid payment for GME under managed care is not necessary or is not a pressing policy issue among competing issues and that there is difficulty in determining a methodology to pay for GME under managed care (Table 7).

Training Institutions and Professions Eligible for GME Payments

Nearly all states that made Medicaid GME payments reported teaching hospitals as the primary training institutions to receive such payments. Three states—Kansas, Minnesota, and West Virginia—specified that teaching sites in non-hospital settings are also eligible.

Three states identified medical schools as eligible to receive GME payments. In Tennessee and Oklahoma, medical schools are the only training institutions allowed to receive Medicaid GME payments directly under managed care. Schools of medicine, nursing, dentistry, and pharmacy in Minnesota are eligible for Medicaid GME payments under both FFS and managed care.

For the first time, this survey asked states whether individual teaching physicians are eligible to receive GME payments.[16] Two states reported making such payments. Florida made GME payments to individual teaching physicians under FFS. South Carolina paid individual teaching physicians for GME under both FFS and managed care.

Training programs for physician residents were the predominant entities eligible for Medicaid GME support. However, in 14 states, Medicaid either required or allowed the subsidization of other health professions training programs, or the agency made no distinction as to which type of training programs could be subsidized (Table 8). Eleven states explicitly required or allowed Medicaid GME support for graduate nursing programs.

GME Payments Linked to State Goals

More than two-thirds of states reported having difficulty ensuring a sufficient supply of providers for their Medicaid beneficiaries. In particular, a large proportion of Medicaid managed care providers found to be unavailable to enrollees raised questions about the abilities of states to ensure that federal access-to-care standards are met.[17] This survey asked states whether they linked Medicaid GME payments to a state policy goal of increasing the size of the physician workforce. **Thirty-two states made Medicaid GME payments with the expectation of producing more physicians** (Table 9). This number represents a significant increase over the 22 states in 2012 that reported doing so (Table 14).

Medicaid GME Payment Amounts

Medicaid continues to be an important source of GME support. The amount of Medicaid GME payments is difficult to quantify precisely. This is, in part, because teaching programs may also receive Medicaid disproportionate share hospital (DSH) payments, which can be difficult to differentiate from GME payments. Several states that pay for both direct and indirect GME costs may also find it burdensome to identify and tabulate GME payments for indirect costs.[18] In addition, states that include GME payments in their MCO rates may find it difficult to identify these payments separately. Determining the level of GME payments even under the Medicaid FFS program requires an extraordinary effort in a few states.

In 2015, DC and 41 of the 42 states supporting GME programs reported total Medicaid GME payments. For the remaining two states, consultant estimates of total GME payments were made in lieu of unreported data. Consultant-estimated payment amounts represented 4 percent of the nationwide GME payment total in 2015.

Assuming these limitations, **total Medicaid GME payments in 2015 by the 42 states and DC were an estimated $4.26 billion** (Table 10). These state-reported and consultant-estimated state GME payments reflect the following: (1) payments made under Medicaid FFS ($1.35 billion), (2) payments (explicit) made directly to teaching programs under managed care ($1.92 billion), and (3) payments (implicit) recognized and included in capitated rates to MCOs ($213.4 million).[19] With the exception of six states that require MCOs to distribute these implicit payments for teaching costs in their negotiated rates to teaching hospitals, the GME-related amounts in MCO payments were not necessarily funneled to teaching hospitals.

Historically, most Medicaid GME payments have been made by states under their FFS programs. **However, for the first time in 2015, the proportion of Medicaid GME payments made under managed care (61 percent) exceeded—and was significantly higher than—the proportion of such payments made under FFS (39 percent)** (Table 14).

Total Medicaid support for GME nationwide continued to rise in 2015. In earlier AAMC surveys, Medicaid GME payments in 2012 were estimated at $3.87 billion, a notable increase over the $2.3–$2.4 billion estimate of total Medicaid GME payments reported in 1998. However, in 2015, three states—Iowa, Michigan, and New Mexico—reported that they have explicitly reduced payments for GME. Another seven states reported 2015 GME payment amounts that were more than 10 percent less than those reported in 2012.

Across states, GME payment amounts varied widely, ranging from about $1.64 billion in New York to $73,500 in Hawaii. Combined, the 20 states with the lowest levels of Medicaid GME funding represented just 5 percent of total support (Table 10).

The 15 states with the highest levels of Medicaid GME spending represented 87 percent of total payments (Table 11). New York's Medicaid program remained the top payer, spending about 38 percent of the national total of state Medicaid GME payments in 2015. Eleven other states—Florida, Virginia, South Carolina, Arizona, Michigan, Missouri, New Jersey, Pennsylvania, Washington, Oklahoma, and Ohio—each spent at least $100 million.

Medicaid GME Payments and State Teaching Hospital Capacity

The states ranking highest in Medicaid GME support did not mirror exactly the ranking of states with the largest number of teaching hospitals and medical residents. Only four of the top 10 states—Florida, Michigan, New York, and Pennsylvania—in total count of both teaching hospitals and medical residents had a similarly high ranking in the amount of total Medicaid GME payments. Meanwhile, two other states—California and Massachusetts—ranking in the top 10 for number of teaching hospitals and medical residents provided no payments under Medicaid for GME (Tables 12 and 13).

NOTES

1. Such funds are non-Medicaid appropriations. Association of American Medical Colleges (AAMC). LCME Part I-Annual Medical School Financial Questionnaire (AFQ), FY2014. Table 1. Washington, DC: AAMC; 2015. https://www.aamc.org/download/434264/data/fy2014_medical_school_financial_tables.pdf. Accessed March 7, 2016. Back
2. Kaiser Family Foundation; National Association of Medicaid Directors (NAMD). Medicaid Reforms to Expand Coverage, Control Costs and Improve Care. Washington, DC: Kaiser Family Foundation and NAMD; 2015. http://files.kff.org/attachment/report-medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016. Accessed January 22, 2016. Back
3. Jointly financed by the federal government and individual states (federal government pays at least half the costs), Medicaid is administered by the states that choose to participate (all have done so since 1982) within broad federal guidelines. After meeting federal requirements, states are able to determine key elements of their Medicaid programs, including who is eligible, what benefits are offered (such as payment for GME costs), and how much providers are paid. The result has been wide variation in Medicaid programs across the country. Long-term care services and supports represent at least one-third of Medicaid spending (reflective of the record aging population entering nursing homes), and Medicaid pays for 40 percent of all births in the United States. Snyder L, Rudowitz R. Medicaid Financing. Washington, DC: Kaiser Family Foundation; 2015. http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/. Paradise J. Medicaid Moving Forward. Washington, DC: Kaiser Commission on Medicaid and the Uninsured (KCMU); 2015. http://files.kff.org/attachment/issue-brief-medicaid-moving-forward. Accessed January 18, 2016. Back
4. Medicaid accounts for 19 percent of state general fund expenditures. State and federal Medicaid spending has more than doubled in the past decade, estimated at over $512 billion in FY 2015. Although Medicaid enrollment growth is expected to slow in FY 2016, total enrollment is predicted to reach 79 million by 2023. National Association of State Budget Officers (NASBO). State Expenditure Report: Examining Fiscal 2013–2015 State Spending. Washington, DC: NASBO; 2015. https://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202013-2015%29S.pdf. Back
5. Kaiser Family Foundation; NAMD. Medicaid Reforms. Back
6. For those states choosing to participate in Medicaid expansion, the federal government financed 100 percent of the costs during the period 2014–2016, but federal funding will be phased down in 2017. As of January 2016, 31 states and DC had adopted Medicaid expansion. Kaiser Family Foundation. Current Status of State Medicaid Expansion Decisions. Washington, DC: Kaiser Family Foundation; 2016. http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/. https://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202013-2015%29S.pdf. Accessed February 4, 2016. Back
7. Beyond the services that state Medicaid programs are required to cover, states have the option to support additional services such as GME and receive matching federal funds for them. Back
8. This does not include Medicaid enrollees in less comprehensive managed care arrangements, known as prepaid health plans. Only three states (Alaska, New Hampshire, and Wyoming) report that they do not have any Medicaid managed care. Among the 39 states with risk-based managed care organizations (MCOs) in 2015, 21 states reported that 75 percent or more of their beneficiaries were enrolled in MCOs. In FY 2014, Medicaid MCO spending represented 34 percent ($162 billion) of total Medicaid spending. Kaiser Family Foundation; NAMD. Medicaid Reforms. Kaiser Family Foundation. Medicaid Managed Care Market Tracker. Washington, DC: Kaiser Family Foundation; 2016. http://kff.org/data-collection/medicaid-managed-care-market-tracker/. Accessed February 5, 2016. Back
9. Paradise J, Musumeci MB. Proposed Rule on Medicaid Managed Care. Washington, DC: KCMU; 2015. http://files.kff.org/attachment/issue-brief-proposed-rule-on-medicaid-managed-care-a-summary-of-major-provisions. Back
10. This study examines the special payments that state Medicaid programs make to teaching hospitals and other entities associated with their clinical care and teaching missions. Back
11. Wisconsin Medicaid did not respond to the AAMC survey. However, at the consultant's request, corresponding survey data from the Wisconsin Medicaid agency were obtained by the Wisconsin Hospital Association (WHA) for use in this report. Back
12. No attempt was made to verify independently the results of this study. Back
13. In 2012, Michigan and Tennessee also reported having considered ending GME payments. Back
14. Such payments may include those made under the state's Medicaid Disproportionate Share Hospital (DSH) program or payments financed by state taxes on hospitals and other Medicaid providers, intergovernmental transfers (IGTs), or certified public expenditures (CPE) used to match the receipt of additional federal funding. For FY 2016, Medicaid provider taxes on hospitals were in place in 39 states and DC. Kaiser Family Foundation; NAMD. Medicaid Reforms. Back
15. Risk-based managed care is defined as Medicaid's use of capitated payments under contract to managed care organizations and does not include any payments made under a state's primary care case management program model of managed care. KCMU. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. Washington, DC: KCMU; 2015. http://files.kff.org/attachment/issue-brief-medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts. Accessed February 6, 2016. Back
16. Individual teaching physicians eligible to receive GME payments for Medicaid services associated with the cost of instructing medical residents are identified as those employed by or under contract with a medical school in the state that meets participation requirements. Back
17. U.S. Government Accountability Office (GAO). Medicaid. Washington, DC: GAO; 2012. http://www.gao.gov/assets/650/649788.pdf. U.S. Department of Health and Human Services (HHS). Access to Care. Washington, DC: HHS; 2014. http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf. Accessed February 9, 2016. Back
18. In 2009, this survey identified DC and 20 states as making Medicaid payments for both direct and indirect GME costs. Back
19. Arizona, Florida, Georgia, Maryland, Ohio, and Texas reported a total GME payment amount in 2015 but provided no specific breakdown for fee-for-service and/or managed care GME payment amounts. Back

AAMC

TABLES

Table 1. Medicaid Payments for Graduate Medical Education (GME), 2015

State	Under Medicaid Fee-for-Service	Under Medicaid Managed Care
Alabama	Yes	No*
Alaska	No	Managed care not implemented
Arizona	Yes	Yes
Arkansas	Yes	No*
California	No	No
Colorado	Yes	Yes
Connecticut	Yes	No comprehensive managed care
Delaware	Yes	GME payments in MCO rates
District of Columbia	Yes	Yes
Florida	Yes	Yes
Georgia[1]	Yes	Yes
Hawaii	Yes	No
Idaho	Yes	No*
Illinois[2]	Yes	No
Indiana	Yes	Yes
Iowa[3]	Yes	GME payments in MCO rates
Kansas	Yes	GME payments in MCO rates
Kentucky	Yes	GME payments in MCO rates
Louisiana	Yes	Yes
Maine	Yes	No*
Maryland	Yes	Yes
Massachusetts	No	No
Michigan	Yes	GME payments in MCO rates
Minnesota[4]	Yes	Yes
Mississippi[5]	Yes	GME payments in MCO Rates
Missouri	Yes	No
Montana	Yes	No*
Nebraska	Yes	Yes
Nevada	Yes	No
New Hampshire[6]	No	Managed care not implemented
New Jersey[7]	No	Yes
New Mexico	Yes	No
New York	Yes	Yes
North Carolina[8]	No	No*
North Dakota	No	No
Ohio	Yes	GME payments in MCO rates
Oklahoma	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	Yes	No
Rhode Island[9]	No	No
South Carolina	Yes	Yes
South Dakota	Yes	No*
Tennessee	No fee-for-service system	Yes
Texas[10]	Yes	GME payments in MCO rates
Utah	Yes	No
Vermont	Yes	No*
Virginia	Yes	Yes
Washington	Yes	GME payments in MCO rates
West Virginia	Yes	No
Wisconsin	Yes	GME payments in MCO rates
Wyoming	No	Managed care not implemented

Note: MCO = managed care organization.
* = As of July 1, 2015, the state Medicaid program operates only a primary care case management (PCCM) form of managed care, which typically does not include payment for hospital-based costs and services.

Source: Henderson, TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. Georgia Medicaid makes managed care GME payments both directly to teaching programs and implicitly through capitation rates of MCOs.
2. Illinois Medicaid reinstituted GME payments effective July 1, 2014.
3. Iowa Medicaid began making GME payments under managed care effective January 1, 2016.
4. Minnesota Medicaid makes managed care GME payments both directly to teaching programs and implicitly through capitation rates of MCOs.
5. The Mississippi legislature granted Medicaid the authority to include inpatient hospital services (including GME) under managed care effective December 1, 2015.
6. The New Hampshire legislature suspended Medicaid GME payments; however, GME payments continue to be authorized under the Medicaid State Plan.
7. Effective July 2013, New Jersey's Medicaid 1115 demonstration waiver revised the distribution of GME payments to teaching hospitals to be included only under managed care.
8. The North Carolina legislature terminated Medicaid payments for GME effective
January 1, 2016.
9. Rhode Island's FY 2015 budget enacted by the state legislature gives Medicaid the authority to establish a hospital funding pool for GME. However, the state's request to obtain federal approval to do so under an amendment to its Medicaid State Plan was denied in early 2016, citing these GME payments, when added to the state's existing Medicaid inpatient hospital supplemental payments, would exceed Rhode Island's Medicaid inpatient upper payment limit. A decision whether to make Medicaid GME payments with state-only funds had not been made at the time of this report's publication.
10. Texas Medicaid makes special GME payments to five state-owned teaching hospitals (University of Texas system) and supplemental payments for indirect medical education (IME) costs to urban, Medicare-accredited teaching hospitals.

Table 2. Methods for Calculating Medicaid GME Payments under Fee-for-Service, 2015

State	Follow Medicare Methodology	Other Method
Alabama		X
Alaska*	*	*
Arizona		X[1]
Arkansas	X[2]	
California*	*	*
Colorado	X	
Connecticut	X	
Delaware	X	
District of Columbia		X[3]
Florida		X[4]
Georgia[5]	X	X
Hawaii		X[6]
Idaho	X	
Illinois		X[7]
Indiana		X[8]
Iowa		X[9]
Kansas	X	
Kentucky	X	
Louisiana		X[10]
Maine	X	
Maryland		X[11]
Massachusetts*	*	*
Michigan		X[12]
Minnesota		X[13]
Mississippi		X[14]
Missouri		X[15]

(continued on next page)

1. Based on number of residents and hospital Medicaid volume.
2. Includes nursery costs in the cost per resident calculation.
3. Indirect GME costs are included in prospective base rates, and direct GME costs are paid as a fixed amount per discharge.
4. Under the Medicaid Disproportionate Share Hospital (DSH) program, supplemental GME payments are allocated to statutory and family practice teaching hospitals and other hospitals participating in GME consortiums based on the sum of the following factors divided by three: (1) number of accredited GME programs offered, (2) number of full-time equivalent (FTE) trainees, and (3) a service index comprising the state agency, volume-weighted service, and total Medicaid payments. Under the Statewide Medicaid Residency program, GME payments are allocated to participating teaching hospitals based on a hospital's number of FTE residents and the amount of its Medicaid payments. As part of the Medicaid Low-Income Pool (LIP) program approved by a federal waiver, GME payments to individual teaching physicians, employed by or under contract with a Florida medical school that meets participation requirements, are allocated based on historical Medicaid volume and designated cost limits.
5. A Medicare methodology is used for pay for indirect GME costs. Direct GME costs are reimbursed from a separate pool of funds based on the 2011 Medicare hospital cost report.
6. Percentage add-on to routine per diem and ancillary per discharge rate.
7. GME paid per all patient refined diagnosis-related group (APR-DRG) add-ons to inpatient base period paid claims based on GME adjustment factor.
8. Per diem calculated by dividing routine and ancillary medical education costs by total patient days multiplied by the DRG average length of stay.
9. The state legislature establishes a pool of money to be used for GME payments. The amount is apportioned to qualifying hospitals based on an allocation methodology.
10. Prospective peer group per diem rate calculated with hospital-specific medical education add-on. Cost settlement process used for public-private partnership and children's hospitals.
11. Per resident amount based on teaching site's share of total Medicaid revenues or patient volume.
12. Medicaid pays GME from two funding pools. In the first pool, a hospital's GME share is based on its portion of total adjusted FTEs (FTEs multiplied by case mix multiplied by Medicaid use). In the second pool, a hospital's share is based on its portion of total adjusted primary care FTEs (FTEs multiplied by Medicaid outpatient charges divided by total charges).
13. The Medical Education and Research Costs (MERC) grant, managed by the Minnesota Department of Health, makes payments by distributing available funds to training sites through sponsoring institutions as an annual lump sum supplemental amount in proportion to Medicaid program volume. Clinical training sites report their trainee and faculty costs to MERC.
14. Hospitals with an approved teaching program receive a medical education per case add-on amount. Effective with the Medicaid program's implementation of APR-DRG in 2012, these hospitals are assigned a base rate using FY 2011 payment information. The add-on is adjusted annually by the market basket increase reported in the inpatient prospective payment systems (IPPS) Final Rule to the previous year's medical education add-on amount.
15. Medicaid calculates GME payments by determining the Medicaid GME cost per patient day based on the fourth quarter cost report of the previous fiscal year and trending to the current state fiscal year (SFY) and multiplying it by the estimated patient days for the SFY. The annual amount is divided by four and paid on a quarterly basis. Qualifying hospitals can also receive annually an enhanced GME payment, which represents the difference between the certified public expenditure (CPE) indices used by Missouri Medicaid to base its trends and the Medicare indices.

Table 2. Methods for Calculating Medicaid GME Payments under Fee-for-Service, 2015 *(continued)*

State	Follow Medicare Methodology	Other Method
Montana		X[16]
Nebraska	X	
Nevada		X[17]
New Hampshire*	*	*
New Jersey*	*	*
New Mexico		X[18]
New York		X[19]
North Carolina*	*	*
North Dakota*	*	*
Ohio		X[20]
Oklahoma		X[21]
Oregon	X	
Pennsylvania		X[22]
Rhode Island*	*	*
South Carolina	X	X[23]
South Dakota		X[24]
Tennessee*	*	*
Texas	X[25]	X[26]
Utah		X[27]
Vermont		X[28]
Virginia	X	
Washington		X[29]
West Virginia		X[30]
Wisconsin		X[31]
Wyoming*	*	*
Total States	**14**	**30**

Note: * = The Medicaid agency does not pay for graduate medical education under its fee-for-service program. Tennessee Medicaid does not operate a fee-for-service program.

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

16. Based on Medicaid utilization and number of medical residents.
17. Per resident amount multiplied by the market basket change and Medicare payment updated for IPPS, then multiplied by number of FTE residents, then multiplied by the Medicaid patient load.
18. Payments are made on a prospective basis as outlined in Medicaid policies.
19. GME payments are an add-on to the case payment rates of teaching hospitals and calculated by dividing the facility's total reported Medicaid GME costs by its total reported Medicaid discharges.
20. A modified Medicare methodology is used to pay hospitals for GME on a prospective basis.
21. Hospitals are allocated a pool of funds by resident-months weighted for Medicaid days and acuity.
22. Eligible providers receive a percentage of funds allocated for GME payments (75 percent) based on inflation adjustments determined in hospital rate agreements. The calculation uses reported cost data from FY 2008 as the base year.
23. Indirect GME cost formula adjusted to include psychiatric and rehabilitation subprovider hospital beds.
24. Lump sum amount based on weighted resident FTE and Medicaid hospital days.
25. Medicare indirect medical education (IME) factor used to calculate add-on payment for IME costs to qualifying urban teaching hospitals.
26. Per resident amount, as a supplemental program in which state teaching institutions provide their own state matching share. Medicaid's rate analysis does not determine the rationale for inclusion or exclusion of GME payments; this is determined through legislative authority.
27. See Utah State Plan Attachment 4.19-A. Inpatient Hospital. Utah Department of Health; 2002. http://www.health.utah.gov/medicaid/stplan/A_4-19-A.pdf.
28. Based on the Medicare cost report and Medicaid hospital days.
29. GME paid per enhanced ambulatory patient group (EAPG) line of a hospital's claim.
30. Modified Medicare methodology.
31. GME costs are a percentage add-on to the hospital rate based on the ratio of GME costs to total hospital operating costs. A modified Medicare methodology is used.

Table 3. Methods for Distributing Medicaid GME Payments under Fee-for-Service, 2015

State	As Part of Hospital's Per Case or Per Diem Rate	As a Separate Direct Payment	As a Supplemental or Special Payment
Alabama			X
Alaska *	*	*	*
Arizona			X
Arkansas	X	X	
California *	*	*	*
Colorado	X	X	
Connecticut		X	
Delaware	X		
District of Columbia	X		
Florida		X	X
Georgia	X	X	
Hawaii	X		
Idaho	X		
Illinois	X		
Indiana	X		
Iowa		X	X
Kansas[1]	X	X	
Kentucky		X	
Louisiana	X		
Maine	X	X	
Maryland		X	
Massachusetts *	*	*	*
Michigan		X	
Minnesota	X		
Mississippi	X		
Missouri		X	
Montana			X[2]
Nebraska	X		
Nevada		X	X
New Hampshire *	*	*	*
New Jersey *	*	*	*
New Mexico		X	
New York	X		
North Carolina *	*	*	*
North Dakota *	*	*	*
Ohio	X		
Oklahoma		X	X
Oregon		X	
Pennsylvania		X	
Rhode Island *	*	*	*
South Carolina	X	X[3]	
South Dakota		X	
Tennessee *	*	*	*
Texas	X		X[4]
Utah			X
Vermont		X	
Virginia		X	
Washington	X		
West Virginia	X		
Wisconsin	X		
Wyoming *	*	*	*
Total States	**22**	**21**	**9**

Note: * = The Medicaid agency does not pay for GME under its fee-for-service program. Tennessee Medicaid does not operate a fee-for-service program.

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. Payments made to public teaching hospitals are part of the hospital's per diem rate. Other hospitals receive a separate direct payment quarterly.
2. Under an intergovernmental transfer methodology, a state appropriation to state universities is transferred to Medicaid and matched with federal funds that are paid directly to the teaching hospitals.
3. In addition to per case hospital payments for GME, the state pays a quarterly enhanced teaching (GME) fee to participating individual teaching physicians equal to 35 percent of actual billed Medicaid charges.
4. Under an intergovernmental transfer methodology, a state appropriation to the University of Texas system is transferred to Medicaid and matched with federal funds that are paid directly to five state-owned teaching hospitals.

Table 4. States Making Medicaid GME Payments Directly to Teaching Programs under Managed Care, 2015

State	Rationale for Making Medicaid GME Payments Directly (carve out) to Teaching Programs
Arizona	Desire to use Medicaid funds to advance state policy goals; increase number of physicians practicing in the state
Colorado	GME seen as a public good; concern from teaching hospitals about losing GME payments; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
District of Columbia	Follow Medicare's decision to make explicit GME payments to teaching hospitals for managed care enrollees
Florida	GME seen as a public good; desire to use Medicaid funds to advance state policy goals; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Georgia	GME seen as a public good; desire to use Medicaid funds to advance state policy goals; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Indiana	GME seen as a public good; follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees; concern from teaching hospitals about losing GME payments; desire to use Medicaid funds to advance state policy goals; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Louisiana	Follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees
Maryland	Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; desire to use Medicaid funds to advance state policy goals; promote training of primary care physicians
Minnesota	GME seen as a public good; follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees; concern from teaching hospitals about losing GME payments; desire to use Medicaid funds to advance state policy goals; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Nebraska	GME seen as a public good
New York	Concern from teaching hospitals about losing GME payments; GME seen as a public good; desire to use Medicaid funds to advance state policy goals; desire to help train the next generation of physicians who will serve Medicaid beneficiaries; follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees
New Jersey	Concern from teaching hospitals about losing GME payments; desire to use Medicaid funds to advance state policy goals
Oklahoma	Desire to use Medicaid funds to advance state policy goals; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Oregon	GME seen as public good; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
South Carolina	GME seen as public good; desire to use Medicaid funds to advance state policy goals; desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Tennessee	GME seen as a public good; desire to help train the next generation of physicians who will serve Medicaid beneficiaries, desire to use Medicaid funds to advance state policy goals; concern from teaching hospitals about losing GME payments
Virginia	GME seen as a public good; follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees; desire to help train the next generation of physicians who will serve Medicaid beneficiaries

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

Table 5. Methods for Calculating Medicaid GME Payments Made Directly to Teaching Programs under Managed Care, 2015

State	Follow Medicare Fee-for-Service Methodology	Per Medicaid Discharge Amount	Other Method
Arizona			X[1]
Colorado	X		
District of Columbia	X		
Florida			X[2]
Georgia[3]	X		X
Indiana			X[4]
Louisiana			X[5]
Maryland			X
Minnesota			X[6]
Maine	X		
Nebraska		X	
New Jersey			X[7]
New York		X	X[8]
Oklahoma			X[9]
Oregon	X		
South Carolina			X[10]
Tennessee			X[11]
Virginia[12]	X	X	

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. Based on number of residents and hospital Medicaid volume.
2. Under the Medicaid Disproportionate Share Hospital (DSH) program, supplemental GME payments are allocated to statutory and family practice teaching hospitals and other hospitals participating in GME consortiums based on the sum of the following factors divided by three: (1) number of accredited GME programs offered, (2) number of full-time equivalent (FTE) trainees, and (3) a service index comprising the state agency, volume-weighted service, and total Medicaid payments. Under the Statewide Medicaid Residency program, GME payments are allocated to participating teaching hospitals based on the hospital's number of FTE residents and the amount of its Medicaid payments. As part of the Medicaid Low-Income Pool (LIP) program approved by a federal waiver, GME payments to individual teaching physicians, employed by or under contract with a Florida medical school that meets participation requirements, are allocated based on historical Medicaid volume and designated cost limits.
3. A Medicare methodology is followed to pay for indirect GME costs. Direct GME costs are reimbursed from a separate pool of funds based on the 2011 Medicare cost report.
4. GME payments made on a per diem cost, calculated dividing routine and ancillary medical education costs by total inpatient days multiplied by the diagnosis-related group (DRG) average length of stay.
5. Prospective peer group per diem rate calculated with hospital-specific medical education add-on; cost settlement process used for public-private partnership and children's hospitals.
6. GME payments are part of a pool teaching facilities can apply for annually and are based on Medicaid volume and number of trainees.
7. Direct medical education (DME) payments are calculated as follows: using 2013 as the base year, percentage of Medicaid HMO days are multiplied by the total median cost per resident (total GME costs) divided by total DME costs. Indirect medical education (IME) payments are calculated as follows: using 2013 as the base year, total inpatient Medicaid managed care payments for 24 months are multiplied by an IME factor of 0.1219 divided by total IME costs.
8. GME for acute DRG cases is calculated in the same way as Medicaid fee-for-service. For exempt unit and exempt hospitals, GME is calculated on an average per discharge basis versus a per diem.
9. Payments are made quarterly to medical schools directly under contracts detailing certain required levels of participation in Medicaid and guaranteeing access to specialty physicians.
10. The state uses Medicaid fee-for-service payment methodology. Supplemental payments are financed by a mix of state appropriations and provider taxes.
11. Fixed annual amount of money is divided among the state's four medical schools using a calculation factoring in the number of primary care residents to the total number of residents.
12. Direct GME payments are based on a pre-managed care organization base period. Indirect GME payments are calculated multiplying an IME factor by a case rate, then multiplying by the number of Medicaid discharges.

Table 6. States Recognizing and Including Medicaid GME Payments in Capitation Rates to Managed Care Organizations, 2015

State	Medicaid Requires MCOs to Distribute GME Payments to Teaching Hospitals	Medicaid Assumes MCOs Distribute GME Payments to Teaching Hospitals
Delaware		X
Georgia		X
Iowa	X[1]	
Kansas	X[2]	
Kentucky	X[3]	
Michigan	X[4]	
Minnesota	X	
Mississippi	X[5]	
Ohio		X
Texas		X
Washington		X
Wisconsin		X

Note: MCOs = managed care organizations.

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. MCOs are provided a specific methodology, which follows that of Medicaid fee-for-service, for determining GME add-on payments.
2. MCOs are provided a specific methodology for determining GME add-on payments. Medicaid fee-for-service provides the GME factors that apply to the peer group hospital rate. Payment is calculated as the peer group rate multiplied by the Medicare Severity–diagnosis-related group (DRG) weight for DRG.
3. MCOs are provided a methodology for determining GME add-on payments.
4. MCOs are provided a specific methodology for determining GME add-on payments.
5. MCOs are provided a specific methodology for determining GME add-on payments. Teaching hospitals are paid on a per case basis using the same methodology for making GME payments under fee-for-service.

Table 7. Reasons for Not Making Medicaid GME Payments under Managed Care, by State, 2015

State	Rationale for Not Making GME Payments under Managed Care
Hawaii	No rationale reported
Illinois	No rationale reported
Missouri	Medicaid payment for GME under managed care not a pressing policy issue among many competing issues; difficulty determining methodology to pay for GME under managed care
Nevada	Payment structure under managed care not yet developed
New Mexico	Medicaid payment for GME under managed care not a pressing policy issue among many competing issues; difficulty determining methodology to pay for GME under managed care
Pennsylvania	Amount added to fee-for-service GME payments to compensate for no longer including payment of GME costs under capitated managed care
Utah	Medicaid payment for GME payment under managed care not necessary
West Virginia	No rationale reported

Note: Only states that make Medicaid GME payments directly to teaching programs under their fee-for-service programs and have implemented a risk-based managed care program are included.

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

Table 8. Health Professions Eligible for Medicaid GME Payments, 2015

State	Medical Residents	Graduate Nurses	Other Professions
Alabama	X		
Arizona	X		
Arkansas	X		
Colorado	X		
Connecticut	X		
Delaware	X		
District of Columbia	X		
Florida	X		
Georgia	X		
Hawaii	X		
Idaho	X		
Illinois	X		
Indiana	X	X	X[1]
Iowa	X	X	
Kansas	X		X
Kentucky	X		
Louisiana	X	X	X[2]
Maine	X	X	
Maryland	X		
Michigan	X		
Minnesota	X	X	X[3]
Mississippi	X	X	
Missouri	X		
Montana	X		
Nebraska	X		X
Nevada	X		
New Jersey	X		
New Mexico	X		
New York	X		
Ohio	X		X
Oklahoma	X		
Oregon	X		
Pennsylvania	X	X	
South Carolina	X	X	X[4]
South Dakota	X		
Tennessee	X		
Texas	X		
Utah	X		
Vermont	X		
Virginia	X	X	X
Washington	X	X	
West Virginia	X		
Wisconsin	X	X	X
Texas	X		X
Utah			X
Vermont		X	
Virginia		X	
Washington	X		
West Virginia	X		
Wisconsin	X		

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. Students in paramedical programs (e.g., emergency medical services, clinical pastoral education, radiology technology).
2. Allowable programs per Medicare-Medical technologists, radiology technologists.
3. Medical, dental, PharmD, chiropractic, and physician assistant students.
4. Laboratory personnel.

Table 9. States Linking Medicaid GME Payments to State Policy Goal of Producing More Physicians, 2015

State	Medicaid GME Payments Made with Expectation of Producing More Physicians in the State
Alabama	Yes
Arkansas	Yes
Arizona	Yes
Colorado	Yes
Connecticut	No
Delaware	No
District of Columbia	No
Florida	Yes
Georgia	Yes
Hawaii	No
Idaho	Yes
Illinois	No response
Indiana	No
Iowa	Yes
Kansas	Yes
Kentucky	Yes
Louisiana	Yes
Maine	Yes
Maryland	No response
Michigan	Yes
Minnesota	Yes
Mississippi	Yes
Missouri	No
Montana	Yes
Nebraska	Yes
Nevada	Yes
New Jersey	Yes
New Mexico	Yes
New York	Yes
Ohio	No response
Oklahoma	Yes
Oregon	Yes
Pennsylvania	Yes
South Carolina	Yes
South Dakota	Yes
Tennessee	Yes
Texas	Yes
Utah	Yes
Vermont	No
Virginia	No
Washington	Yes
West Virginia	Yes
Wisconsin	Yes
Total States	32

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

Table 10. Medicaid GME Payment Amounts, 2015

State	GME Payments (Explicit) under Fee-for-Service (millions of dollars)	GME Payments under Managed Care (millions of dollars)		Total Explicit GME Payments[1] (millions of dollars)	Total GME Payments (millions of dollars)	Total GME Payments: State Rank
		Implicit Payments[2]	Explicit Payments[3]			
Alabama	$28.4	$0	$0	$28.4	**$28.4**	23
Alaska*	*	*	*	*	*	*
Arizona	Unreported	$0	Unreported	$163.0	**$163.0**	5
Arkansas	$11.5	$0	$0	$11.5	**$11.5**	34
California*	*	*	*	*	*	*
Colorado	$10.9	$0	$1.6	$12.6	**$12.6**	31
Connecticut	$19.1	$0	$0	$19.1	**$19.1**	27
Delaware	$0.54	$0.51	$0	$0.54	**$1.06**	42
District of Columbia	$50.8	$0	$13.6	$64.4	**$64.4**	15
Florida[4]	Unreported	$0	Unreported	$350.2	**$350.2**	2
Georgia[5]	Unreported	Unreported	Unreported	Unreported	**$46.6**	19
Hawaii	$0.07	$0	$0	$0.07	**$0.07**	43
Idaho	$2.4	$0	$0	$2.4	**$2.4**	40
Illinois[6]	$3.0	$0	$0	$3.0	**$3.0**	38
Indiana	$17.0	$0	$10.0	$27.0	**$27.0**	24
Iowa	$23.9	$0	$0	$23.9	**$23.9**	25
Kansas	$3.9	$9.5	$0	$3.9	**$13.4**	30
Kentucky	$1.2	$18.2	$0	$6.2	**$19.4**	26
Louisiana	$12.8	$0	$5.9	$48.8	**$18.8**	28
Maine	$12.0	$0	$0	$12.0	**$12.0**	33
Maryland	Unreported	$0	Unreported	$48.6	**$48.6**	18
Massachusetts*	*	*	*	*	*	*
Michigan	$63.1	$85.5	$0	$63.1	**$148.4**	6
Minnesota	$16.1	$6.8	$49.5	$65.6	**$72.4**	14
Mississippi[7]	$32.9	Unreported	$0	$32.9	**$32.9**	21
Missouri	$129.7	$0	$0	$129.7	**$129.7**	7
Montana	$1.5	$0	$0	$1.5	**$1.5**	41
Nebraska	$8.8	$0	$9.1	$17.9	**$17.9**	29
Nevada	$12.6	$0	$0	$12.6	**$12.6**	32
New Hampshire*	*	*	*	*	*	*
New Jersey	$0	$0	$127.3	$127.3	**$127.3**	8
New Mexico	$7.2	$0	$0	$7.2	**$7.2**	35
New York	$466.9	$0	$1,170.0	$1,640.0	**$1,640.0**	1
North Carolina*	*	*	*	*	*	*
North Dakota*	*	*	*	*	*	*
Ohio	Unreported	Unreported	$0	Unreported	**$100.0**	12
Oklahoma	$11.6	$0	$90.5	$102.2	**$102.2**	11
Oregon	$27.6	$0	$15.9	$43.5	**$43.5**	20
Pennsylvania	$118.7	$0	$0	$118.7	**$118.7**	9
Rhode Island*	*	*	*	*	*	*
South Carolina[8]	$69.7	$0	$171.4	$241.1	**$241.1**	4
South Dakota	$2.8	$0	$0	$2.8	**$2.8**	39
Tennessee	$0	$0	$50.0	$50.0	**$50.0**	17

(continued on next page)

Table 10. Medicaid GME Payment Amounts, 2015 *(continued)*

State	GME Payments (Explicit) under Fee-for-Service (millions of dollars)	GME Payments under Managed Care (millions of dollars)		Total Explicit GME Payments[1] (millions of dollars)	Total GME Payments (millions of dollars)	Total GME Payments: State Rank
		Implicit Payments[2]	Explicit Payments[3]			
Texas	Unreported	Unreported	$0	Unreported	**$75.6**	13
Utah	$6.2	$0	$0	$6.2	**$6.2**	37
Vermont	$30.0	$0	$0	$30.0	**$30.0**	22
Virginia	$59.5	$0	$204.0	$263.5	**$263.5**	3
Washington[9]	$61.0	$56.0	$0	$61.0	**$117.0**	10
West Virginia	$6.3	$0	$0	$6.3	**$6.3**	36
Wisconsin[10]	$17.4	$36.9	$0	$17.4	**$54.3**	16
Wyoming*	*	*	*	*	*	*
Totals	**	**	**	**	**$4.26 billion[11]**	

Notes:
- The start and end dates for each state's fiscal year varies. Not all states were able to report payment amounts for state fiscal year (SFY) 2015. Alabama, the District of Columbia, and Maine reported payment amounts for SFY 2014. New Jersey reported payments for SFY 2016.
- Payment amounts are assumed to include reimbursement for both direct and indirect GME costs by those state Medicaid programs that pay for these costs. However, not all such states were able to report Medicaid payment amounts made for indirect GME costs as these amounts are often difficult to identify and tabulate on a statewide basis.
- * = The Medicaid agency does not pay for graduate medical education.
- ** = Totals cannot be calculated because of unreported data.
- Arizona, Florida, Georgia, Maryland, Ohio, and Texas reported a total GME payment amount but provided no specific breakdown of amounts for FFS and/or managed care GME payments.
- Underlined amounts are the consultant's estimates in lieu of unreported data.

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. The total amount of GME payments made directly to teaching programs under both fee-for-service (FFS) and managed care, including state-reported and consultant-estimated amounts.
2. Implicit GME payments are those recognized and included in capitation rates to managed care organizations.
3. Explicit GME payments are those made directly to teaching programs under managed care.
4. Under the Medicaid Disproportionate Share Hospital (DSH) program, supplemental quarterly GME payments are allocated to statutory and family practice teaching hospitals and other hospitals participating in GME consortiums and are not immediately identifiable as paid under FFS or managed care. Under the Statewide Medicaid Residency program, GME payments are allocated to participating teaching hospitals and are not immediately identifiable as paid under FFS or managed care. As part of the Medicaid Low-Income Pool (LIP) program approved by a federal waiver, GME payments are made under FFS to individual teaching physicians, employed by or under contract with a Florida medical school that meets participation requirements.
5. Includes only payments for direct GME costs under both FFS and managed care. Payments for indirect GME costs were not readily available.
6. Medicaid reinstituted GME payments effective July 1, 2014.
7. Implicit GME payments under managed care became effective December 1, 2015. Payment amounts distributed on or after that date were not reported.
8. Includes GME payments under FFS and managed care to individual teaching physicians.
9. GME payment amounts are an estimate determined by the consultant with input from Washington Medicaid. Determining an actual statewide GME amount is quite burdensome for the Medicaid program as the agency has no identifiable pool of GME funds but rather pays individual hospitals a specific GME amount on several different claim items.
10. Wisconsin Medicaid did not respond to the AAMC survey. However, corresponding survey data from Wisconsin Medicaid were collected by the Wisconsin Hospital Association (WHA) and shared with the consultant for this report. In lieu of unreported GME payments, WHA, with input from the consultant, calculated an estimate of GME FFS payments by multiplying the GME add-on amount by projections of Medicaid hospital utilization. An estimate of managed care GME amounts was then calculated using the ratio of Medicaid FFS payments to managed care organization (MCO) payments from a worksheet prepared by Wisconsin Medicaid for a hospital assessment by WHA (B. Potter of WHA, personal communication, November 2015).
11. The national amount does not reflect the precise total of individual state amounts due to rounding.

Table 11. Medicaid GME Payment Amounts, by Top 15 States, 2015

State	Total GME Payments under Fee-for-Service and Managed Care (millions of dollars)	GME Payments under Managed Care (millions of dollars)	
		Implicit Payments[1]	Explicit Payments[2]
New York	$1,640.0	$0	$1,170.0
Florida[3]	$350.2	$0	Unreported
Virginia	$263.5	$0	$204.0
South Carolina[4]	$241.1	$0	$171.4
Arizona	$163.0	$0	Unreported
Michigan	$148.4	$85.5	$0
Missouri	$129.7	$0	$0
New Jersey	$127.3	$0	$127.3
Pennsylvania	$118.7	$0	$0
Washington[5]	$117.0	$56.0	$0
Oklahoma	$102.2	$0	$90.5
Ohio	$100.0	Unreported	$0
Texas	$75.6	Unreported	$0
Minnesota	$72.4	$6.8	$49.5
District of Columbia	$64.4	$0	$13.6

Notes:
- The start and end dates for each state's fiscal year vary. Not all states were able to report payment amounts for state fiscal year (SFY) 2015. The District of Columbia reported payment amounts for SFY 2014. New Jersey reported payments for SFY 2016.
- Payment amounts are assumed to include reimbursement for both direct and indirect GME costs by those state Medicaid programs that pay for these costs. However, not all such states were able to report Medicaid payment amounts made for indirect GME costs as these amounts are often difficult to identify and tabulate on a statewide basis.
- Arizona, Florida, Ohio, and Texas reported a total GME payment amount but provided no specific breakdown of amounts for fee-for-service and/or managed care GME payments.
- Underlined amounts are the consultant's estimates in lieu of unreported data.

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. Implicit GME payments are those recognized and included in capitation rates to managed care organizations.
2. Explicit GME payments are those made directly to the teaching programs under managed care.
3. Under the Medicaid Disproportionate Share Hospital (DSH) program, supplemental quarterly GME payments are allocated to statutory and family practice teaching hospitals and other hospitals participating in GME consortiums and are not immediately identifiable as paid under fee-for-service (FFS) or managed care. Under the Statewide Medicaid Residency program, GME payments are allocated to participating teaching hospitals and are not immediately identifiable as paid under FFS or managed care. As part of the Medicaid Low-Income Pool (LIP) program approved by a federal waiver, GME payments are made under FFS to individual teaching physicians, employed by or under contract with a Florida medical school that meets participation requirements.
4. Includes GME payments under FFS and managed care to individual teaching physicians.
5. GME payment amounts are an estimate determined by the consultant with input from Washington Medicaid. Determining an actual statewide GME amount is quite burdensome for the Medicaid program as the agency has no identifiable pool of GME funds but rather pays individual hospitals a specific GME amount on several different claim items.

Table 12. Medicaid GME Payments in States with Largest Number of Teaching Hospitals, 2015

State	Number of Teaching Hospitals	Provide GME Payments	Total Medicaid GME Payments (millions of dollars)	Average Medicaid GME Payments Per Hospital (millions of dollars)	Medicaid GME Payment Rank
New York	78	Yes	$1,640.0	$21.03	1
California	64	No	$0	$0	—
Pennsylvania	61	Yes	$118.7	$1.95	9
Michigan	48	Yes	$148.4	$3.09	6
Ohio	48	Yes	$100.0	$2.08	12
Texas	42	Yes	$75.6	$1.80	13
Illinois	41	Yes	$3.0	$0.073	38
New Jersey	36	Yes	$127.3	$3.54	8
Florida	33	Yes	$350.2	$10.61	2
Massachusetts	25	No	$0	$0	—

Note: A teaching hospital is defined as a hospital that reports resident full-time equivalents (FTEs) on its Medicare hospital cost report. Hospitals with fewer than five FTE residents and interns were excluded. Not every teaching hospital in each state receives Medicaid GME payments.

Source: Association of American Medical Colleges analysis of Medicare cost report data, FY 2013 (November 2015 release). Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

Table 13. Medicaid GME Payments in States with Largest Number of Medical Residents, 2015

State	Number of Medical Residents[1]	Provide GME Payments	Total Medicaid GME Payments (millions of dollars)	Medicaid GME Payment Rank
New York	16,067	Yes	$1,640.0	1
California	10,281	**No**	**$0**	—
Pennsylvania	7,919	Yes	$118.7	9
Texas	7,754	Yes	$75.6	13
Illinois	6,028	Yes	$3.0	38
Ohio	5,919	Yes	$100.0	12
Massachusetts	5,487	**No**	**$0**	—
Michigan	4,999	Yes	$148.4	6
Florida	3,954	Yes	$350.2	2
North Carolina	3,192	**No**	**$0**	—

Source: Brotherton SE, Etzel SI. Graduate Medical Education, 2014–2015. Appendix II, Table 4. JAMA. 2015;314(22):2436-2454. Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2016.

1. Number of resident physicians on duty as of December 31, 2014.

Table 14. Trends in State Medicaid GME Payments, 1998–2015

Indicator	2015	2012	2009	2005	2002	1998
Number of states and DC making GME payments	43	43	42[1]	48	48	46
Number of states and DC making GME payments under fee-for-service	41	41	41	47	47	44
Number of states and DC making GME payments explicitly and directly to teaching hospitals under managed care	17	15	13	15	18	17
Number of states and DC recognizing and including GME payments in the capitated payment rates to managed care organizations	12	9	11	10	10	17
Number of states and DC linking GME payments to the production of physicians[2]	32	22	—	—	—	—
GME payments: proportion made under fee-for-service/managed care[3]	39% / 61%	59% / 41%	63% / 37%	NA	NA	NA

Note: NA = not available.

Source: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. Washington, DC: Association of American Medical Colleges; 2006; 2009; 2012; 2016. National Conference of State Legislatures. Medicaid Payment Survey. Washington, DC: Association of American Medical Colleges; 1999; 2003.

1. Alabama Medicaid did not respond to the survey.
2. For 2009, 2005, 2002, and 1998, a different question was asked: "Are Medicaid GME payments linked to explicit state physician workforce or related policy goals?" To this question, 10 to 11 states consistently responded "yes."
3. For the years noted, the states listed reported a total GME payment amount but provided no specific breakdown of amounts for fee-for-service and/or managed care GME payments. GME payment amounts from these states are not included in the calculation of the reported percentages as follows: for 2015, Arizona, Florida, Georgia, Maryland, Ohio, and Texas; for 2012, Arizona, Colorado, Hawaii, Maryland, and Ohio; and for 2009, Arizona, Colorado, Hawaii, Maryland, and Ohio.

MEDICAID GME SURVEY INSTRUMENT

MEDICAID PAYMENT POLICY: GRADUATE MEDICAL EDUCATION

State: _____ Date Completed Survey:_____

Respondent Name/ Title: _____ Phone #: _____

***DEADLINE* TO RETURN COMPLETED SURVEY:** _____

Please Return by e-mail: TimMHend@aol.com [to: Tim Henderson, Consultant to Association of American Medical Colleges]

FEE-FOR-SERVICE PAYMENTS

1. Under your fee-for-service (FFS) system, does Medicaid pay hospitals (*or other entities that incur teaching costs) for graduate medical education (GME), or otherwise provide explicit added payments to these hospitals or other* teaching entities?

____ YES *(Answer 1a)* ____ NO *(Answer 1b)* ____ PRESENTLY, WE DON'T OPERATE A FEE FOR SERVICE SYSTEM (*If you answered this response, proceed to Question 5.*)

a. If YES, describe the rationale as you understand it for making these GME payments:
(Check all that apply)

___ GME seen as a public good;
___ Follow Medicare's decision to make explicit GME payments to teaching hospitals for Medicare beneficiaries;
___ Desire to use Medicaid funds to advance state health policy goals;
___ Desire to help train the next generation of physicians who will serve Medicaid beneficiaries;
___ Other (Describe: _____)

b. If NO, describe the rationale as you understand it for *not* making GME payments:
(Check all that apply)

___ Medicaid payment for GME is not necessary or appropriate;
___ GME payments are not a pressing policy issue among many competing issues;
___ Medicaid historically paid for GME, but budget shortfalls or cost controls have necessitated ending payments;
___ Other (Describe: _____)

If you answered Question 1b., proceed to Question 5.

2. What entities are eligible to receive GME payments?
(Check all that apply)

___ Teaching hospitals;
___ Teaching sites in non-hospital patient care settings (such as ambulatory sites, managed care plans, etc.);
___ Medical schools;
___ Individual Teaching Physicians (for services associated with the cost of instructing medical residents)
___ Other institutions (Specify: _____)

3. In making payments for GME costs, how does your Medicaid FFS system:

a. Calculate Payments
(Check all that apply)

___ Follow Medicare methodology;

___ Other, Please describe _____)

b. Distribute Payments
(Check all that apply)

___ As part of the hospital's per-case or per-diem rate;

___ As a separate direct payment (monthly, quarterly, etc.);

___ Considered special or supplemental (such as DSH; payments funded by provider taxes, inter-governmental transfers (IGTs), certified public expenditures (CPE), etc.)

___ Other (Specify: _____)

4. Under your FFS system, do GME payments cover training costs for:
(Check all that apply)

___ Physician Residents

___ Graduate Nursing Students

___ Other Health Professional Trainees (Specify: _____)

MEDICAID MANAGED CARE PAYMENTS

5. Does your Medicaid program operate a managed care system?

____ YES ____ NO

*If you answered NO, proceed to **Question 11**.*

6. Under your Medicaid managed care system, are explicit GME payments made to teaching hospitals (*or other entities that incur teaching costs*)?

____ YES ____ NO

(Answer 6a) *(Answer 6b)*

a. **If YES, describe the rationale as you understand it for making *these GME payments*:**
(Check all that apply)

___ GME seen as a public good;

___ Follow Medicare's decision to make explicit GME payments to teaching hospitals for managed care enrollees;

___ Concern from teaching hospitals about losing GME payments;

___ Desire to use Medicaid funds to advance state policy goals;

___ Desire to help train the next generation of physicians who will serve Medicaid beneficiaries;

___ Other (Describe: _____)

b. **If NO, describe the rationale as you understand it for *not* making GME payments:**
(Check all that apply)

___ Medicaid payment for GME under managed care is not necessary or appropriate;

___ GME payments under managed care are not a pressing policy issue among many competing issues;

___ Difficulty determining methodology to pay for GME under managed care;

___ Opposition by managed care plans to having GME payments go to teaching hospitals;

___ Medicaid historically paid for GME, but recent budget shortfalls or cost controls no longer allow payment;

___ Other (Describe: _____)

*If you answered Question 6b., proceed to **Question 11**.*

7. In making payments for GME costs,— either:

___ directly to teaching hospitals (or other entities) ***OR***

___ as part of payments to managed care plans for them to pass on to teaching hospitals (or other entities),

How does your Medicaid managed care program *calculate* GME payments?
(Check all that apply)

___ Follow Medicare FFS methodology;

___ On a per Medicaid managed care discharge basis;

___ Payment included in capitation and negotiated by the provider

___ Other (Specify: _____)

8. Under managed care, how does your Medicaid program *distribute* GME payments to teaching hospitals or other entities?
(Check all that apply)

a. ___ Medicaid makes a separate direct payment (per-case or per-diem, monthly, quarterly, etc.) to the hospital or other teaching entity

b. ___ Medicaid *requires* managed care organizations (MCOs) to pay the hospital (or other teaching entity) for GME costs as part of the hospital's per-case, per-diem rate or bundled rate;

If so, check one of the following:

___ Medicaid provides MCOs a specific methodology for determining GME add-on payments;

___ Medicaid does *not* provide MCOs a methodology for determining GME add-on payments.

Explain: _____

c. ___ Medicaid *assumes* MCOs reflect GME costs in their payments to hospitals (or other teaching entities), *but* does *not* require them to do so.

d. ___ Medicaid makes special or supplemental payments (such as DSH; ones funded by provider taxes, inter-governmental transfers (IGTs), certified public expenditures (CPE), etc.)

e. ___ Other (Specify: _____)

9. What institutions are eligible to receive GME payments under Medicaid managed care?
(Check all that apply)

___ Teaching hospitals;

___ Teaching sites in non-hospital patient care settings (such as ambulatory sites, managed care plans, etc.);

___ Medical schools;

___ Other institutions (Specify: _____)

10. Under Medicaid managed care, do GME payments help cover training costs for:
(Check all that apply)

___ Physician Residents

___ Graduate Nursing Students

___ Other Health Professional Trainees (Specify: _____)

11. In the past year, has your Medicaid program *considered discontinuing* explicit payments for GME under either FFS or managed care?

___ YES *(Answer 11a and 11b)* ___ NO ___ No GME Payments Are Made Under FFS or Managed Care *(If you answered this last response, you have completed the survey. Thank you.)*

a. If YES, describe the rationale for *considering* discontinuation of GME payments:
(Check all that apply)

___ Medicaid payment for GME is no longer necessary or appropriate;
___ GME payments are no longer an important policy issue among many competing issues;
___ Current budget shortfalls or cost controls may necessitate ending payments;
___ Opposition by managed care plans to having GME payments go to teaching hospitals;
___ Other (Describe: _____)

12. In the past year, has your Medicaid program explicitly *reduced* payments for GME?

____ YES ____ NO
(Answer 12a)

USE OF GME PAYMENTS TO ACHIEVE STATE POLICY GOALS

13. Are Medicaid GME payments (*under either FFS or managed care*) made with the expectation of producing more physicians for your state?

____ YES ____ NO

MEDICAID GME PAYMENT AMOUNTS

14. Please provide your best dollar estimate of the following:

a. Your Total Medicaid GME Payments (*combined federal and state share*) for FY 2014:
Include payments to public and private teaching hospitals/other entities.

(Complete all that apply)
Under Fee for Service (FFS): $ _____
Under Managed Care (MC): $ _____
FFS/MC Combined: $ _____
For FY (if not 2014): _____

b. Your *FFS/MC Combined* Medicaid GME Payments are:

_____ % of Inpatient Hospital Medicaid expenditures

THANK YOU FOR YOUR ASSISTANCE.

YOU WILL RECEIVE A COPY OF THE SURVEY RESULTS ONCE THEY ARE REPORTED.

NOTE: PLEASE PROVIDE DOCUMENTATION (preferably weblinks)
OF EXISTING REGULATIONS OR POLICIES GOVERNING GME PAYMENTS.

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