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Medicaid Graduate Medical Education Payments

RESULTS FROM THE 2022 50-STATE SURVEY

Association of
American Medical Colleges

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AAMC
Washington, D.C.

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EXECUTIVE SUMMARY

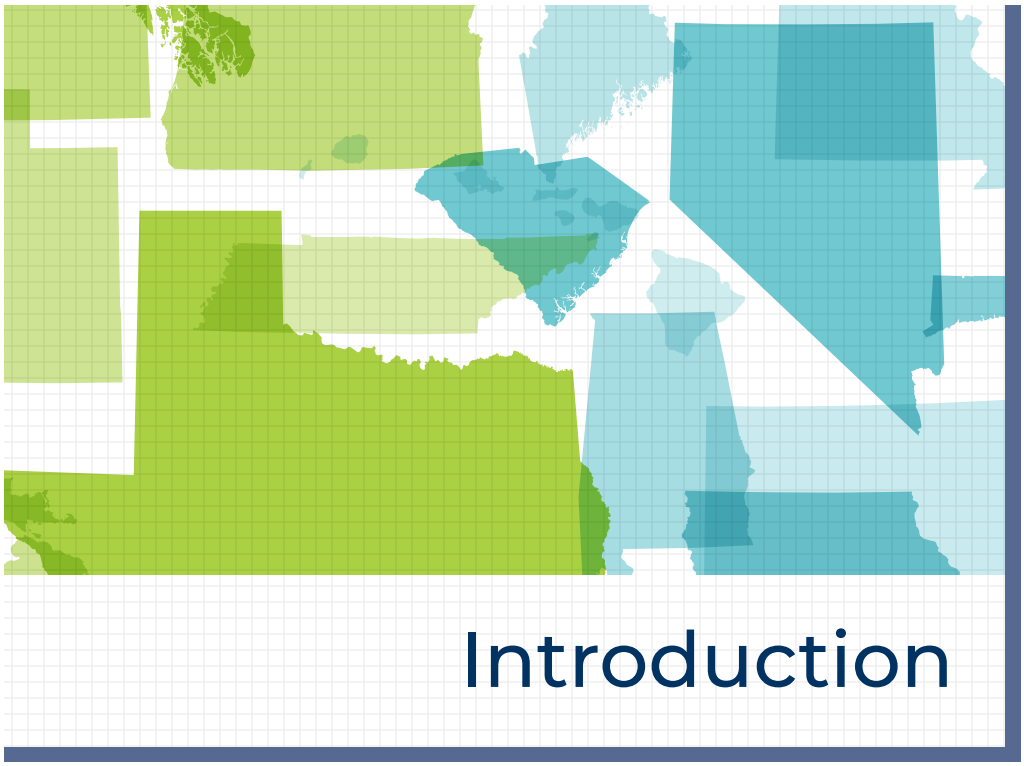
Jointly administered by the federal government and the states, Medicaid provides health insurance to one-fourth of the U.S. population and represents nearly one-fifth of U.S. health expenditures. In most states, Medicaid is the single biggest budget item of total spending (federal and state funds). After the Medicare program, Medicaid is also the second largest explicit source of funding for graduate medical education (GME).

In 2022, the AAMC contracted with a consultant to survey state Medicaid programs to examine their policies for financing GME. The AAMC and its consultant produced a survey instrument that was distributed to Medicaid agencies in all 50 states and the District of Columbia to identify each program's current GME policies and payments. This study updates earlier AAMC studies of state Medicaid GME policies and sets a foundation for future analyses.

KEY FINDINGS

- Forty-four states, including the district, made GME payments under their Medicaid program in 2022, an increase of one state from 2018. One of the seven states that did not make Medicaid GME payments, Massachusetts, is among the 10 states with the highest number of physician residents.
- In 2022, federal and state Medicaid payments for GME nationwide continued to grow, reaching nearly $7.39 billion.
- Twenty-four states that made Medicaid GME payments in 2022 recognized the costs of both direct graduate medical education (DGME) and indirect medical education (IME). About 60% of these states' payments were for IME costs.
- Under Medicaid fee-for-service, 41 states (including the district) reported making GME payments in 2022, equaling the number of states that have reported making such payments since 2009. Most of these states (32) used supplemental payments as the primary means of distribution.
- Twenty-seven of the 41 states (including the district) that have risk-based Medicaid managed care programs made GME payments in 2022 under managed care. Eighteen of the 27 states (including the district) made GME payments explicitly and directly to teaching hospitals; 12 states recognized and included such payments in managed care organization (MCO) capitation rates. Three states made GME payments using both forms of distribution.
- In 2022, the proportion of Medicaid GME payments made under managed care (57%) continued to exceed the proportion of such payments made under fee-for-service (43%), a trend that began in 2015.
- Although teaching hospitals were the predominant recipient of Medicaid GME support, 11 states also made GME payments directly to other teaching providers, including community-based health centers with approved training programs, medical schools, and teaching physicians. In addition, 12 states made GME payments that cover the training of health professionals other than physician residents.

- In 2022, a number of states had policies governing the financial and social accountability of their Medicaid GME payments. Eleven states required teaching hospitals to report their DGME costs, and another 27 states collected this information from another source. Fifteen states required all teaching providers to report data on physician residents covered by GME payments, and 11 states routinely audited their GME payments to teaching providers. Also, 13 states designated residents in primary care and other undersupplied specialties as explicitly covered by GME payments, and five states documented and reported to state authorities the outcomes of their GME payments on the supply and distribution of the state's health care workforce.



Introduction

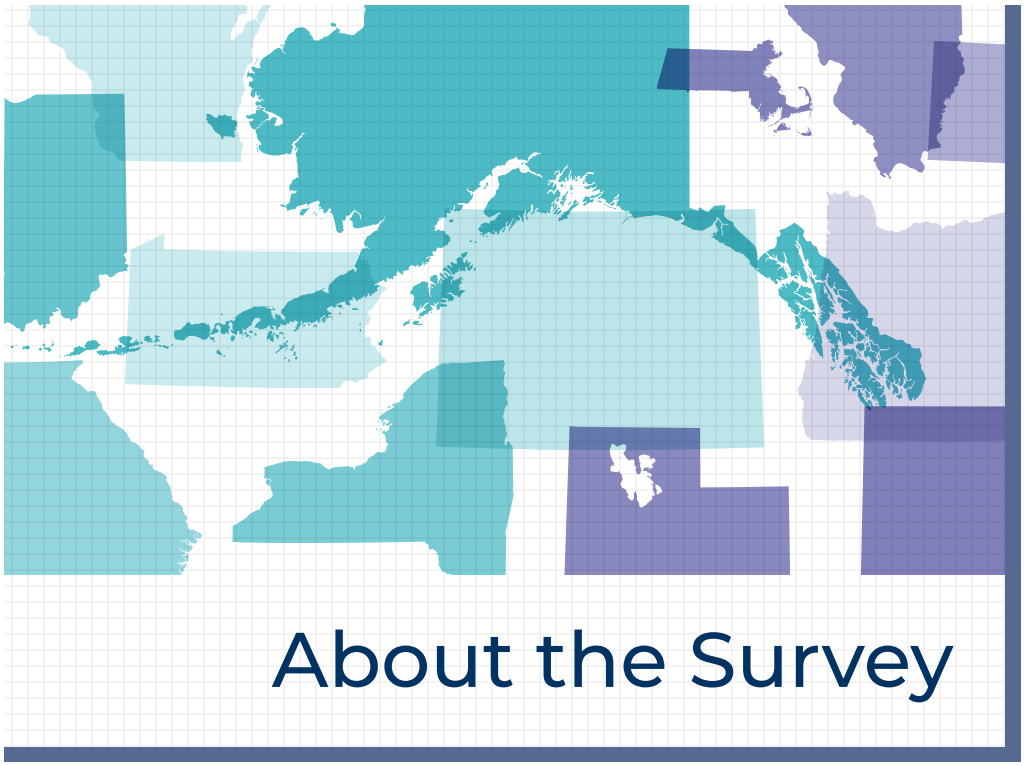
States are a long-standing source of support for physician training. State and local governments, along with parent universities of medical schools, appropriate funds for undergraduate medical education.[1] Also, most states pay hospitals and other teaching providers for graduate medical education (GME) costs associated with care to Medicaid enrollees.[2]

As the nation's largest health insurer by enrollment, Medicaid in 2022 provided health care coverage for a record-high 85.3 million beneficiaries, one-fourth of the U.S. population.[3] Concurrently, federal and state Medicaid spending was projected to increase to $783 billion, amounting to 19% of total U.S. health expenditures.[4] In most state budgets, Medicaid represents the single largest program (including federal and state funds), equal to nearly 28% of all spending in the state fiscal year 2022.[5]

The surge in Medicaid enrollment and spending between 2020 and 2022 was due largely to the continuous enrollment requirement (CER) and temporary federal funding instated during the onset of the COVID-19 pandemic and public health emergency (PHE).[6] As the pandemic subsided, the 2023 Consolidated Appropriations Act ended the link between the CER and PHE and terminated the CER effective April 2023, allowing states to end Medicaid enrollment for individuals no longer eligible. The law also phases out the provisional federal subsidies to states that will end December 2023.[7] Consequently, in 2023 and 2024, Medicaid enrollment is expected to sharply decline, and the state share of Medicaid spending is projected to rise.[8]

The predominant means of delivering care to Medicaid recipients are risk-based managed care organizations (MCOs).[9] Among the 41 states with MCOs in 2022, 35 reported that 75% or more of their Medicaid beneficiaries were enrolled in MCOs.[10] Yet, the availability of health care providers for these enrollees is often limited. Care is frequently concentrated among a small percentage of participating physicians, and many MCOs report having a shortage of physicians.[11]

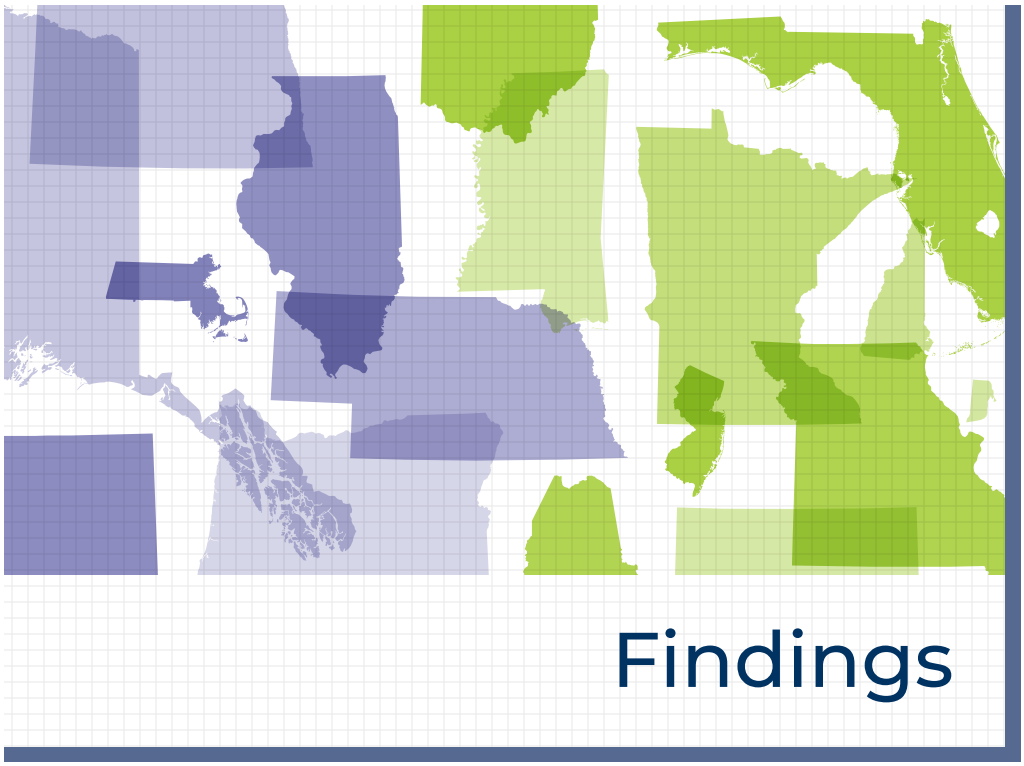
After the Medicare program, Medicaid is the second largest explicit source of funding for GME. Contrary to Medicare policy, the federal government provides no direction to state Medicaid programs on whether and how they should or could make GME payments.[12] Although Medicaid programs are not obligated to pay for GME, most states historically have followed Medicare and made such payments under their fee-for-service programs. More recently, Medicaid managed care programs in a majority of states have also provided a significant amount of GME support; in fact, the majority of Medicaid GME payments are now made under managed care. However, in a few states that include GME payments in their Medicaid managed care capitation payments to MCOs, the MCOs are not required to distribute these payments to teaching hospitals and other clinical training entities.



About the Survey

In July 2022, the AAMC contracted with an independent health workforce consultant to survey state Medicaid programs to examine their policies for financing GME.In part, this report updates the findings on state Medicaid GME policies from earlier AAMC surveys.[13] The survey instrument was modified and distributed to Medicaid agencies in all 50 states and the District of Columbia[14] to identify each program's current GME policies and payments (see the survey instrument on page 42). All but two state Medicaid programs responded to the survey; corresponding data from the nonresponding states was obtained from other sources.[15] Thus, the final count of state responses is 51.[16]

This report reflects the status of state Medicaid GME support as of 2022 and sets a foundation for future analyses. Consequently, it does not reflect any fiscal or policy changes that have occurred since completion of the survey.



Findings

Forty-four states (including the district) provided GME payments under their Medicaid program (Table 1). This includes California, which was added since the survey was last conducted, in 2018.[17]

Twenty-four states recognized both direct graduate medical education (DGME) and indirect medical education (IME) costs in their Medicaid GME payments (Table 1). Another 11 states recognized and paid only for DGME costs.[18] Ten states did not distinguish between DGME and IME costs in some or all of their Medicaid GME payments.

STATE FINANCING OF GME PAYMENTS

States use three recognized sources to finance the nonfederal share of Medicaid GME payments: (1) state general fund revenue (from broad-based state taxes) appropriated to the Medicaid agency or transferred from other state agencies; (2) contributions from local governments (including hospitals and other providers they operate) through intergovernmental transfers or certified public expenditures; and (3) mandatory taxes on hospitals.[19]

The most common source of nonfederal financing for Medicaid GME payments was state general fund revenue (39 states), followed by local government contributions (16 states) (Table 2). Eleven states received support from both sources. Seven states also used hospital taxes to help finance GME payments.

TEACHING ENTITIES AND PROFESSIONS SUPPORTED BY GME PAYMENTS

Teaching hospitals are the predominant recipient of Medicaid GME payments in all states (Table 3). **Sixteen states designated certain types of teaching hospitals as eligible for some or all GME payments.**

Eleven states also made Medicaid GME payments directly to other teaching providers (Table 3). Five states paid federally qualified health centers (FQHCs) and other

community-based providers with approved training programs for their GME costs.[20] Four states made GME payments to teaching physicians who supervise physician residents in conjunction with patient care and who meet certain participation requirements.[21] Three states (Michigan, Minnesota, and South Dakota) distributed GME payments to medical schools.

Physicians in residency training are the principal health professionals who benefit from Medicaid GME payments (Table 4). In 13 states, particular specialties of physician residents were designated as explicitly covered by some or all GME payments. Twelve states also made Medicaid GME payments that cover trainees in other health professions.

GME PAYMENTS UNDER FEE-FOR-SERVICE

Forty-one states made GME payments under their Medicaid fee-for-service (FFS) program (Table 1).

Calculation of Payments. For teaching hospitals, most states (16) used a Medicare method to make GME payments, followed by 14 states that applied a per-resident method (Table 5). Twenty-four states used more than one method, which largely reflects differences in how hospitals are paid for DGME and IME costs or receive base and supplemental payments. The 10 states that made GME payments to other teaching providers used a different calculation method.

Distribution of Payments. **Thirty-two states made a supplemental GME payment to hospitals and other teaching providers (Table 6).[22] Eighteen states paid for GME as part of the hospital's base rate for Medicaid services.** Nine states made GME payments using both means of distribution. Two states made a separate, nonsupplemental GME payment to teaching hospitals.

For the 32 states making supplemental GME payments, 30 distributed the payments to teaching hospitals in accordance with their federally defined upper payment limit (UPL).[23] Four states made these payments to teaching hospitals deemed disproportionate-share hospitals (DSHs) under federal statute.[24] One state, Florida, continued to distribute supplemental payments to eligible hospitals and other teaching providers using an uncompensated-care pool (UCP) authorized by the state's Section 1115 federal waiver.[25] Supplemental payments to nonhospital teaching providers were made in nine states. Ten states distributed supplemental payments to more than one type of teaching provider.

GME PAYMENTS UNDER RISK-BASED MANAGED CARE

Twenty-seven of the 41 states that operate a comprehensive, risk-based Medicaid managed care delivery system (including the district)[26] provided GME payments under this system (Table 1). These states distributed GME payments directly to teaching programs or indirectly as part of the risk-based capitation rates paid to MCOs.[27] Three states made both types of payments (Table 7).

Direct Payments. **Eighteen states (including the district) made GME payments directly to hospitals and other teaching programs** (Table 7). For hospitals, most states (eight) used a per-resident method to calculate GME payments (Table 8). Seven states used more than one method, and the main differences were in how hospitals are paid for DGME and IME costs. The two states that made GME payments to other teaching providers each used a different method of calculation.

Indirect Payments. **Twelve states recognized and included GME payments in their capitated payments to MCOs** (Table 7). Six of these states required MCOs to pass through GME payments in their negotiated rates to teaching hospitals and provided the MCOs with a specific method for determining these payments (Table 9). The other six states assumed the MCOs distributed GME payments to teaching providers.[28]

The balance of states (nine) with a Medicaid risk-based managed care program did not leave GME payments in the base used for calculating MCO payments but did support GME under FFS (Table 1).[29]

FEDERAL DEMONSTRATION WAIVERS GOVERNING GME PAYMENTS

Section 1115 of the Social Security Act provides state Medicaid programs with an avenue for testing new approaches otherwise not permissible under federal law.[30] Until the end of 2022, Minnesota's 1115 waiver had a provision that specifically governed the design and execution of Medicaid GME payments under managed care.[31] New Mexico awaits approval of an amendment to their 1115 waiver that would create a mechanism for Medicaid funding of GME expansion under managed care.[32]

PUBLIC ACCOUNTABILITY OF GME PAYMENTS

Public funding of GME is known to lack financial and social accountability.[33] This survey examined financial accountability of Medicaid GME payments by asking states about their (1) requirements for teaching providers to report related GME costs and data on physician residents and (2) practices to routinely audit GME payments. Social accountability of Medicaid GME payments was ascertained by asking states whether they (1) designated particular resident specialties in undersupply as covered by their GME payments and (2) documented and reported to state officials the outcomes of their GME payments on the supply and distribution of the state's health care workforce.

Financial Accountability

Eleven states required teaching hospitals to report their Medicaid DGME costs (Table 10).[34] Twenty-seven of the 32 states that did not require hospitals to report DGME costs reported they obtain these costs from another source. Thus, **the total number of states that collected Medicaid DGME costs of teaching hospitals was 38.**[35]

Fifteen states required hospitals and other teaching providers to report data on physician residents covered by Medicaid GME payments (Table 10). All these states required teaching providers to report the total number of covered residents. Ten states required resident specialty to be reported. Eight states required the reporting of resident year and location of training. Three states required teaching providers to report the number of days or hours a resident works for a given period.[36]

Eleven states routinely audited their Medicaid GME payments to teaching providers (Table 10). The most frequent reasons these states gave for doing so are to identify overpayments and underpayments and to verify that payments are made only for specified allowable costs.

Social Accountability

Thirteen states designated resident positions in primary care and other specialties in undersupply as explicitly covered by some or all of their Medicaid GME payments (Table 4). Five of these states covered residents trained in rural and medically underserved communities or health professional shortage areas. Three states made GME payments that support residents in settings that serve Medicaid beneficiaries.

Also, the above 13 states were asked whether the resident positions their GME payments support are existing or expansion (new) positions. **Eleven of the 13 states covered existing resident positions** (Table 4). **Six states covered expansion resident positions,** and four supported both existing and expansion positions.

Five states documented and reported to state authorities the outcomes of their Medicaid GME payments on the supply and distribution of the state's health care workforce (Table 10). For the residents these states supported with Medicaid GME payments, the data on resident positions the states most commonly reported as indicators of these outcomes were the number of total positions, new positions, positions by specialty or subspecialty, positions trained in primary care and/or other high-need specialties, and positions trained in rural or medically underserved areas.

GME PAYMENT AMOUNTS

Medicaid payments for GME nationwide continued to grow (Table 15). Quantifying the amount of these payments remains challenging in some states. In particular, a few states that pay for IME, or GME generally under MCO capitation, found it burdensome to readily identify these costs and tabulate payment amounts. Also, one state (Washington) that uses a diagnosis-related group (DRG) cost-based method to pay hospitals for GME on a per-claims basis stated that it was impractical to tabulate and report GME payment amounts.

With these limitations, **total Medicaid GME payments reported by the states amounted to $7.39 billion.** These GME payments to hospitals and other teaching providers included the following: (1) payments made under FFS ($3.07 billion); (2) explicit payments under managed care made directly to teaching providers ($3.41 billion); and (3) implicit payments under managed care included in the capitated rates to MCOs ($616 million) (Table 11).[37] With the exception of six states that required MCOs to distribute these payments in their negotiated rates to hospitals or other teaching providers, the GME amounts included in MCO capitation were not necessarily passed on to these providers.

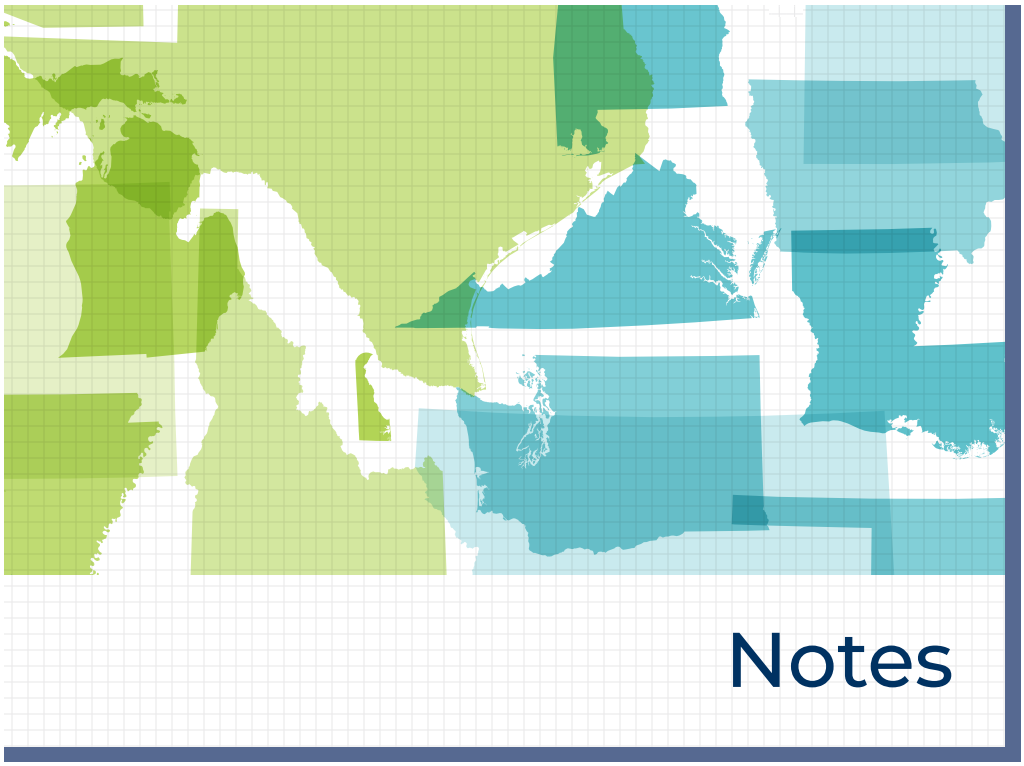
Fifty-seven percent of all Medicaid GME payments were made under managed care (Table 15). Since 2015, the proportion of GME payments under managed care has exceeded the proportion of such payments under FFS.

In those states that recognize and pay for both DGME and IME costs or only DGME costs, **59% of payments covered IME costs and 41% covered DGME costs** (Table 15). Six states that pay for both DGME and IME costs were not included in this calculation because they did not provide a complete breakdown of these costs in their reported payment amounts.[38]

Medicaid GME payment amounts differed widely across the states, ranging from $1.92 billion in New York to $0.08 billion in Hawaii (Table 11). **The 15 states with the highest levels of GME spending represented 84% of the national total of state payments** (Table 12). New York alone spent about one-fourth of the national total. Three other states made payments that exceeded $400 million. Another six states spent between $200 and $400 million.

MEDICAID GME PAYMENTS AND STATE TEACHING HOSPITAL AND PHYSICIAN RESIDENT CAPACITY

The states ranking highest in Medicaid GME funding partly mirrored the ranking of states with the highest number of teaching hospitals and physician residents (Tables 13 and 14). **Six of the 10 states with the highest number of both teaching hospitals and physician residents had a similarly high ranking in the amount of Medicaid GME payments.** Conversely, Massachusetts, which ranks among the 10 states with the highest number of teaching hospitals and physician residents, made no Medicaid GME payments in 2022.



Notes

1. In federal fiscal year (FY) 2021, these funds amounted to more than $7.1 billion for MD-granting medical schools alone. AAMC (Association of American Medical Colleges). Liaison Committee on Medical Education Part I-A Annual Medical School Financial Questionnaire, FY 2021. U.S. Medical School Revenues. Table 1: Revenues Supporting Programs and Activities at all LCME-Accredited U.S. Medical Schools. https://www.aamc.org/data-reports/interactive-data/table-1-revenues-supporting-programs-and-activities-millions-dollars-fy-2021. Accessed Jan. 14, 2023.

2. A few states also appropriate non-Medicaid funds to support GME.

3. As of December 2022. Centers for Medicare & Medicaid Services (CMS). Medicaid and CHIP Enrollment Data Highlights. December 2022. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed April 20, 2023.

4. Of total Medicaid spending, the federal government recently has paid an increasing portion (69% in FY 2021, up from 61% in FY 2017). This is due largely to Medicaid expansion under the Patient Protection and Affordable Care Act and temporary fiscal relief to states during the COVID pandemic. Kaiser Family Foundation (KFF). State Category: Medicaid & CHIP Indicators. https://www.kff.org/state-category/medicaid-chip/. Accessed Feb. 25, 2023. CMS. National Health Expenditure Data: NHE Projections - Tables, Table 3. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected. CMS. *Financial Report FY 2022.* Baltimore, MD: CMS. https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2022.pdf.

5. National Association of State Budget Officers. *2022 State Expenditure Report: Fiscal Years 2020-2022.* Washington, DC: NASBO; November 2022. https://www.nasbo.org/reports-data/state-expenditure-report.

6. Williams E, Burns A, Rudowitz, R. *Fiscal Implications for Medicaid of Enhanced Federal Funding and Continuous Enrollment*. Washington, DC: KFF; June 2023. https://www.kff.org/medicaid/issue-brief/fiscal-implications-for-medicaid-of-enhanced-federal-funding-and-continuous-enrollment.

7. In January 2023, the federal government also announced that the public health emergency would end on May 11, 2023. CMS. *CMCS Informational Bulletin*. Jan. 5, 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf. Cox C, Kates J, Cubanski J, Tolbert J. *The End of the COVID-19 Public Health Emergency: Details on Health Coverage and Access*. Washington, DC: KFF. Feb. 3, 2023. https://www.kff.org/policy-watch/the-end-of-the-covid-19-public-health-emergency-details-on-health-coverage-and-access/.

8. The termination of the continuous enrollment requirement effective April 2023 triggered a Medicaid eligibility redetermination process that is expected to cause a major disenrollment of beneficiaries. Over the course of a year, CMS estimates that up to 15 million people could lose health coverage. CMS. *Medicaid and CHIP Continuous Enrollment Unwinding: A Communications Toolkit*. Baltimore, MD: CMS; October 2022. https://www.medicaid.gov/resources-for-states/downloads/unwinding-comms-toolkit.pdf#page=2. Burns A, Williams E, Corallo B. Rudowitz R. *How Many People Might Lose Medicaid When States Unwind Continuous Enrollment?* Washington, DC: KFF; April 2023. https://www.kff.org/medicaid/issue-brief/how-many-people-might-lose-medicaid-when-states-unwind-continuous-enrollment/.

9. Risk-based managed care is defined as Medicaid's use of capitated payments to MCOs (and prepaid health plans in some states). MCOs are health plans that contract with states to provide comprehensive benefits to enrolled Medicaid beneficiaries for a preset, per-member-per-month premium paid under capitation. MCOs are at financial risk for the Medicaid services specified in their contracts. A comprehensive risk contract must cover inpatient hospital services plus any one of the following services, or at least three of the following services: outpatient hospital; rural health clinic; federally qualified health center; lab and X-ray; nursing facility; early and periodic screening, diagnostic, and treatment (EPSDT); family planning; physician; or home health services. States can choose to exclude certain benefits, such as behavioral health services, from the capitated benefit package and provide these separately under their fee-for-service (FFS) program. MACPAC. Types of Managed Care Arrangements. https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/. Accessed Jan. 23, 2023.

10. Managed care enrollees not served by MCOs are covered mainly by fee-for-service, primary care case management programs. Hinton E, Guth M, Raphael J, et al. *How the Pandemic Continues to Shape Medicaid Priorities: Results From an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023*. Washington, DC: KFF; October 2022. https://www.kff.org/medicaid/report/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023/.

11. At least one study suggests that MCO provider network directories overstate the availability of physicians to serve Medicaid beneficiaries. Ludomirsky A, Schepero W, Wallace J, et al. In Medicaid managed care networks, care is highly concentrated among a small number of physicians. *Health Affairs*. 2022;41(5):760-768. doi:10.1377/hlthaff.2021.01747. Garfield R, Hinton E, Cornachione E, Hall C. *Medicaid Managed Care*

Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans. Washington, DC: KFF; March 2018. https://files.kff.org/attachment/Report-Medicaid-Managed-Care-March-Plans-and-Access-to-Care.

12. Consequently, states have significant flexibility in designing and executing their Medicaid GME payments, including determining which professions and which settings and organizations are eligible to receive support. State Medicaid programs seeking to pay for GME or to alter how they pay for GME must obtain approval from CMS through either an amendment to their Medicaid state plan or a waiver of current federal program rules. Congressional Research Service. *Federal Support for Graduate Medical Education: An Overview.* Washington, DC: CRS; 2018. https://www.everycrsreport.com/reports/R44376.html.

13. This report examines payments that state Medicaid programs made to teaching hospitals and other entities related to their clinical care and teaching missions in 2022. Previous reports published by the AAMC in 2006, 2010, 2013, 2016, and 2019 were conducted by the author; reports published by AAMC in 1999 and 2003 were administered by the National Conference of State Legislatures. Surveys for previous reports asked state Medicaid programs why they do or do not pay for GME. Programs that paid for GME typically cited their desire to use Medicaid funds to advance state policy goals and to help train the next generation of physicians who will serve Medicaid beneficiaries. For those state Medicaid programs that did not pay for GME, the states most frequently stated that making GME payments is either not necessary or is not a pressing policy issue among competing issues.

14. The District of Columbia is considered a state for purposes of this report.

15. The Illinois Medicaid program did not respond to the AAMC survey; however, at the author's request, the Illinois Health and Hospital Association obtained corresponding survey data from the Medicaid agency for use in this report. The Utah Medicaid program, while unable to provide an official response to the survey, notified the consultant that its GME payment policies and procedures had not changed since the last AAMC survey, in 2018. The consultant obtained recent GME payment amounts from the Medicaid program's website.

16. No attempt was made to independently verify the results of this study.

17. Tennessee's authority to make Medicaid GME payments to medical schools under their Section 1115 waiver ended June 30, 2021. In December 2022, Tennessee received federal approval to make GME payments to teaching hospitals under its Medicaid state plan, effective July 1, 2022. Rhode Island began making Medicaid GME payments to teaching hospitals for the first time in July 2019, but it obtained federal approval to end these payments effective July 1, 2021.

18. Eighteen of the 34 states that distinguish between and pay for DGME and/or IME costs provided information on how they **define** these costs. *DGME costs* are commonly defined as a teaching hospital's reimbursable salaries, fringe benefits, nonsalary costs, and overhead teaching costs for residents and interns trended for inflation to the base year of rate setting, as noted on the hospital's Medicare cost report (CMS Form 2552). For states making payments for DGME costs to federally qualified health centers and/or Medicare-certified rural health clinics, these costs are those noted on the Medicare cost report for these centers (CMS Form 222-92) and the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care Uniform Data System report.

IME costs are commonly defined as estimates of an individual teaching hospital's costs associated with the additional ancillary intensiveness of medical care, more aggressive treatment regimens, and increased availability of state-of-the-art testing technologies resulting from the training of residents. All states reported how they **calculate** payments for these costs (see Tables 5 and 8). For *DGME costs,* most states pay hospitals using a formula that is the product of the institution's base-year average per-resident amount, current number of FTE residents, and ratio of Medicaid inpatient days to total inpatient days. For *IME costs,* the formula by which payments are made is most commonly a product of each hospital's total Medicaid revenue for inpatient operating costs and a hospital-specific education-adjustment factor or percentage increase, which applies the hospital's ratio of FTE residents to available beds (excluding nursery) for Medicaid patients. However, the particular equation that states use varies. Several states base IME payment on Medicare's adjustment factor, which includes a multiplier set by federal statute that limits the number of resident FTEs as stipulated under the Medicare formula (42 CFR Part 412.105). Other states use a formula that places no explicit limits on resident FTEs and applies a different adjustment factor. A few states reported using a payment method that defines available hospital beds differently or that varies according to the type of teaching hospital. CMS. *CMS-2552-10: Hospital Medicare Cost Report.* Baltimore, MD: CMS. https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-2552-10. CMS. *CMS-222-92: Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Medicare Cost Report.* Baltimore, MD: CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Health-Clinic-222-92-form. HRSA Bureau of Primary Health Care. *Uniform Data System Reporting Requirements for 2022 Health Center Data.* Rockville, MD: HRSA. https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf. 42 CFR Part 412.105. https://www.law.cornell.edu/cfr/text/42/412.105.

19. If a state administers its Medicaid program within federal requirements, it is entitled to receive federal matching funds (federal financial participation, or FFP) toward allowable state expenditures. To receive FFP to support services included in their Medicaid state plan, states must ensure that they can fund their share of expenditures. Pursuant to 42 CFR Part 433.51, public funds may serve as a state's share for drawing federal funds if the public funds are appropriated directly to the state Medicaid agency or are transferred from other public agencies to the state agency and are under its administrative control. Section 1902(a)(2) of the Social Security Act requires that at least 40% of the nonfederal share of Medicaid come from state governments. Up to 60% of the needed state funds may come from local governments; such contributions are made to the Medicaid agency either (1) as an intergovernmental transfer (IGT) from eligible entities operated by state or local governments (e.g., counties, hospital taxing districts) or (2) through state certification of public expenditures by a local public provider (e.g., county hospital) used to cover the full cost of delivering a Medicaid-covered service. MACPAC. The Effect of State Approaches to Medicaid Financing on Federal Medicaid Spending. November 2021. https://www.macpac.gov/wp-content/uploads/2021/11/The-Effect-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf. MACPAC. Non-Federal Financing. https://www.macpac.gov/subtopic/non-federal-financing/. Accessed Jan. 20, 2023. Code of Federal Regulations. 433.51 Public Funds as the State Share of Financial Participation. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-B/section-433.51. Social Security Act, Section 1902. https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

20. Community-based providers that qualify for Medicaid GME payments must receive federal permission to amend their Medicaid state plan to include GME as an allowable cost in their defined scope of services. Also, like teaching hospitals, these providers typically are required to have a residency training program approved by the Accreditation Council for Graduate Medical Education. The types of community-based providers that receive GME payments in these states include one or more of the following:

    (1) *Federally qualified health centers* that provide comprehensive primary and preventive health care in federally designated health professional shortage areas (HPSAs) to individuals with low incomes who are uninsured or underinsured, as well as other vulnerable populations. Nationwide, Medicaid enrollees represent these centers' largest proportion of patients and source of revenue.

    (2) *Medicare-certified rural health clinics* that are located in rural HPSAs and use a team approach where physicians working with nonphysician providers such as nurse practitioners, physician assistants, and certified nurse midwives to provide primary and preventive services.

    (3) *Behavioral health providers,* which may include (a) *community mental health centers* that typically deliver a comprehensive range of coordinated mental health services including partial hospitalization, (b) *substance abuse treatment centers* eligible in some states to provide services to Medicaid enrollees as an optional benefit at the state's discretion, and (c) *community service boards* created in state statutes to provide community-based, safety-net services for mental illness, intellectual and developmental disabilities, and/or addictive diseases.

    (4) *Other providers,* which may include dental service providers, pharmacies, home care service providers, ambulatory surgery centers, and other community clinics.

    42 CFR Part 405.2400. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-X. 42 CFR Part 491. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-491. KFF. State Health Facts: Community Health Center Patients by Payer Source. 2021. https://www.kff.org/other/state-indicator/chc-patients-by-payer-source/. Accessed Feb. 2, 2023. Rosenbaum S, Sharac J, Shin P, Tolbert J. *Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained*. Washington, DC: KFF; 2019. https://files.kff.org/attachment/Issue-Brief-Community-Health-Center-Financing-The-Role-of-Medicaid-and-Section-330-Grant-Funding-Explained. CMS. *Rural Health Clinic.* Baltimore, MD: CMS; January 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf. 42 CFR Part 410.2. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-A/section-410.2. 42 CFR Part 485.0 Subpart J. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485. Gateway Behavioral Health Community Service Board. Savannah, Ga. https://gatewaypsychiatry.org/gateway-csb/. Accessed Jan. 25, 2023. Minnesota State Statutes, Section 62J.692. 2021. https://www.revisor.mn.gov/statutes/cite/62J.692.

21. *Teaching physicians* are commonly defined as physicians who involve physician residents in the care of their patients. This means that patient care is either personally furnished by the teaching physician or furnished by a resident under the supervision of a teaching physician, where the teaching physician is physically present during the critical or key portions of the service. This professional service takes place in a teaching setting where supervised physician residents are those in an approved GME program. For purposes of making Medicaid payments to teaching physicians, several states follow Medicare

rules (42 CFR Part 415 Subpart D) when specifying various participation requirements and teaching settings. Many states require that teaching physicians be employed by or under contract to a public university teaching hospital or medical school faculty practice plan. Other states limit the teaching setting to particular academic medical centers or safety-net hospitals. Medicaid payments for teaching physician services in most states are made to the faculty practice plan of the medical school or teaching hospital that employs or contracts with the teaching physician. In some cases, payments may go directly to the individual teaching physician, depending on the state's participation requirements or if the teaching physician is located primarily in a community setting. Most states that make Medicaid payments to teaching physicians do not recognize these payments as GME payments (see Table 3, footnote 2). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-415/subpart-D?toc=1.

22. Supplemental payments typically are made as a lump sum for a fixed period (month, quarter, or year) and are not directly tied to a particular Medicaid service or visit. For hospitals, these payments are above what they may have received for services under their Medicaid base rate and are intended to offset any uncompensated costs for the care of Medicaid patients. Also, CMS may provide Medicaid waiver authority to permit states to make certain supplemental payments that they are not otherwise permitted to make under Medicaid rules. States receiving such federal waivers are allowed to continue making supplemental payments under managed care at an amount less than or equal to the amount of their current upper payment limit (UPL) under fee-for-service. Congressional Research Service. *Medicaid Supplemental Payments*. Washington, DC: CRS. Updated Dec. 17, 2018. https://www.everycrsreport.com/files/20181217_R45432_e7264e139470177b402b2ddf06220f50a36322fa.pdf.

23. Federal regulations prohibit states from receiving federal matching funds for Medicaid FFS payments in excess of a UPL, which is intended to prevent Medicaid from paying more than Medicare would pay for the same services. Under these UPL rules, payments are tied to services rendered by an entire class of providers rather than individual providers. States make most UPL supplemental payments to hospitals, but they may also make UPL payments to physicians and other institutions. MACPAC. Upper Payment Limit Supplemental Payments. November 2021. https://www.macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf. MACPAC. Chapter 2: Oversight of Upper Payment Limit Supplemental Payments to Hospitals. In: MACPAC. *Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC; March 2019. https://www.macpac.gov/wp-content/uploads/2019/03/Oversight-of-Upper-Payment-Limit-Supplemental-Payments-to-Hospitals.pdf.

24. Federal law requires states to make Medicaid FFS supplemental payments to hospitals deemed disproportionate-share hospitals (DSHs) to help offset their uncompensated costs for serving a high proportion of Medicaid and other low-income, uninsured patients. Medicaid payments for DSH hospitals are governed by hospital-specific limits (HSLs) set under 42 CFR Part 447.295 and are bound by the state's annual federal DSH allotment. In 2018, 64% of all teaching hospitals were designated as DSH, and DSH-designated teaching hospitals received 72% of total DSH payments. MACPAC includes GME as one of 10 essential community services that DSHs may provide. Social Security Act, Section 1923. https://www.ssa.gov/OP_Home/ssact/title19/1923.htm. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-E/section-447.295 MACPAC. Chapter 4: Annual Analysis of Disproportionate Share

Hospital Allotments to States. In: MACPAC. *Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC; March 2023. https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf.

25. Florida is one of seven states that as of FY 2020 reported having active uncompensated-care pools (UCPs) authorized under the state's 1115 demonstration waiver. As states expanded their use of managed care, UCPs initially were used to preserve FFS supplemental payments to hospitals and other providers that deliver large amounts of uncompensated care to uninsured and/or underinsured patients or that are generally paid less by Medicaid than private insurance. MACPAC. Medicaid Base and Supplemental Payments to Hospitals. March 2023. https://www.macpac.gov/wp-content/uploads/2023/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals-Issue-Brief.pdf.

26. Hinton E, Guth M, Raphael J, Haldar S, et al. How the Pandemic Continues to Shape Medicaid Priorities: Results From an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023. Washington, DC: KFF; October 2022. https://www.kff.org/medicaid/report/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023/.

27. For managed care, direct and indirect Medicaid payments for GME are permitted under federal rules (42 CFR Part 438.6) that otherwise (1) prohibit states from making Medicaid supplemental payments directly to providers other than MCOs (outside of capitation) for contracted services and (2) require states to phase out the use of Medicaid "pass-through" payments by MCOs (under capitation) to hospitals, physicians, and nursing facilities intended to offset their loss of fee-for-service supplemental payments. 42 CFR Part 438.6. https://www.law.cornell.edu/cfr/text/42/438.6. U.S. Government Accountability Office (GAO). *Medicaid: State Directed Payments in Managed Care*. GAO-22-105731. June 2022. https://www.gao.gov/assets/gao-22-105731.pdf. CMS. Centers for Medicaid and CHIP Services. Additional Guidance on State Directed Payments in Medicaid Managed Care, State Medicaid Director Letter. January 2021. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf. Mytelka C, Gaffner A, Laudenscharger C. *Pass-Through Payment Guidance in Final Medicaid Managed Care Payment Regulations: Transitioning to Value-Based Payments, Delivery System Reform, and Required Reimbursement*. Seattle, WA: Milliman. May 2016. https://us.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2016/2232hdp_20160518.ashx.

28. In these states, MCOs, not the Medicaid agency, are generally responsible for negotiating rates with hospitals and other teaching providers to pay for their GME costs. Moreover, these rates are not subject to review and approval by CMS. Marks T, Gifford K, Perlin S, Byrd M, Berger T. *Factors Affecting the Development of Medicaid Hospital Payment Policies: Findings From Structured Interviews in Five States*. Washington, DC: MACPAC; 2018. https://www.macpac.gov/wp-content/uploads/2018/10/Factors-Affecting-the-Development-of-Medicaid-Hospital-Payment-Policies.pdf.

29. These states are Arizona, Louisiana, Mississippi, Missouri, New Mexico, North Carolina, Pennsylvania, Utah, and West Virginia.

30. Section 1115 of the Social Security Act provides broad authority to the secretary of the U.S. Department of Health and Human Services to approve any demonstration likely to assist in promoting the objectives of a state Medicaid program. This includes the authority to provide federal matching funds for costs that would not otherwise be eligible for matching funds under a state's Medicaid plan, such as supplemental payments in managed care delivery systems. States have used Section 1115 to waive requirements related to eligibility, benefits, service delivery, and payment methods they use to administer their managed care programs. CMS. About Section 1115 Demonstrations. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html. CMS. State Waivers List. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html. Accessed March 2, 2023.

31. Under the waiver, managed care payments were made directly to teaching hospitals, medical schools, and other clinical schools or consortia and, in turn, to a variety of health professions training sites for the general purpose of funding GME and, specifically, for the innovative education and training of primary care physicians and dental health professionals in rural areas. The initiative was administered through the auspices of the state Department of Health's Medical Education and Research Costs (MERC) trust fund. Approval by CMS to temporarily extend Minnesota's Prepaid Medical Assistance Project Plus waiver beyond the end of 2022 does *not* include expenditure authority for GME payments. Minnesota reportedly is working with CMS to transition authority for GME payments under managed care to their Medicaid state plan. CMS. Minnesota Prepaid Medical Assistance Project Plus Section 1115 Waiver, Extension Request. June 2020. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mn-pmap-pa.pdf. CMS. Temporary Extension of Prepaid Medical Assistance Project Plus 1115 Waiver. Dec. 27, 2022. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mn-pmap-cms-temp-ext-12272022.pdf.

32. Submitted in March 2021, the proposed amendment calls for establishing a funding mechanism designed to develop new and/or expanded GME programs in general psychiatry, family medicine, general pediatrics, and general internal medicine not to exceed 101 resident positions, as approved in the state's annual GME expansion strategic plan. Teaching providers receiving funding priority would include federally qualified health centers that provide GME training; providers delivering services in rural or frontier communities; providers delivering services to underserved populations; programs demonstrating commitment to recruit diverse New Mexican residents; and programs demonstrating a commitment to retain residents in New Mexico upon completion of GME. As of March 2023, the proposed amendment remained under development. In May 2021, the state was granted authority under an amendment to their Medicaid state plan to make payments that support the expansion of GME

programs effective July 1, 2020 (to be implemented once the waiver amendment is approved). CMS. New Mexico Department of Human Services, Centennial Care 2.0 1115 Waiver Amendment #2 Request. March 1, 2021. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-pa3.pdf. CMS. New Mexico State Plan Amendment (SPA) 20-0019. May 25, 2021. https://www.medicaid.gov/medicaid/spa/downloads/NM-20-0019.pdf.

33. Institute of Medicine. *Graduate Medical Education That Meets the Nation's Health Needs.* Washington, DC: The National Academies Press; 2014. https://www.nap.edu/catalog/18754/graduate-medical-education-that-meets-the-nations-health-needs. GAO. *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding.* Washington, DC: GAO; 2018. https://www.gao.gov/assets/700/690581.pdf. Henderson TM. How accountable to the public is funding for graduate medical education? The case for state Medicaid GME payments. *Am J Public Health.* 2021;111(7):1216-1219.

34. An additional state, Idaho, required only FQHCs to report their DGME costs.

35. California did not respond to this question on the survey.

36. The federal government (CMS) does not require states or teaching institutions to report any information about the number or characteristics of physician residents supported by Medicaid GME payments. GAO. *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding.* Washington, DC: GAO. 2018. https://www.gao.gov/assets/700/690581.pdf.

37. Maryland and Texas reported a total GME payment amount but provided no breakdown of specific amounts for their GME payments under FFS and managed care. Georgia, Hawaii, and Illinois only reported FFS GME payments; GME payments included in MCO capitation rates were not readily identifiable.

38. These states are Georgia, Hawaii, Illinois, Indiana, Kansas, and South Carolina. Washington is excluded here because the state reported no GME payment amounts.

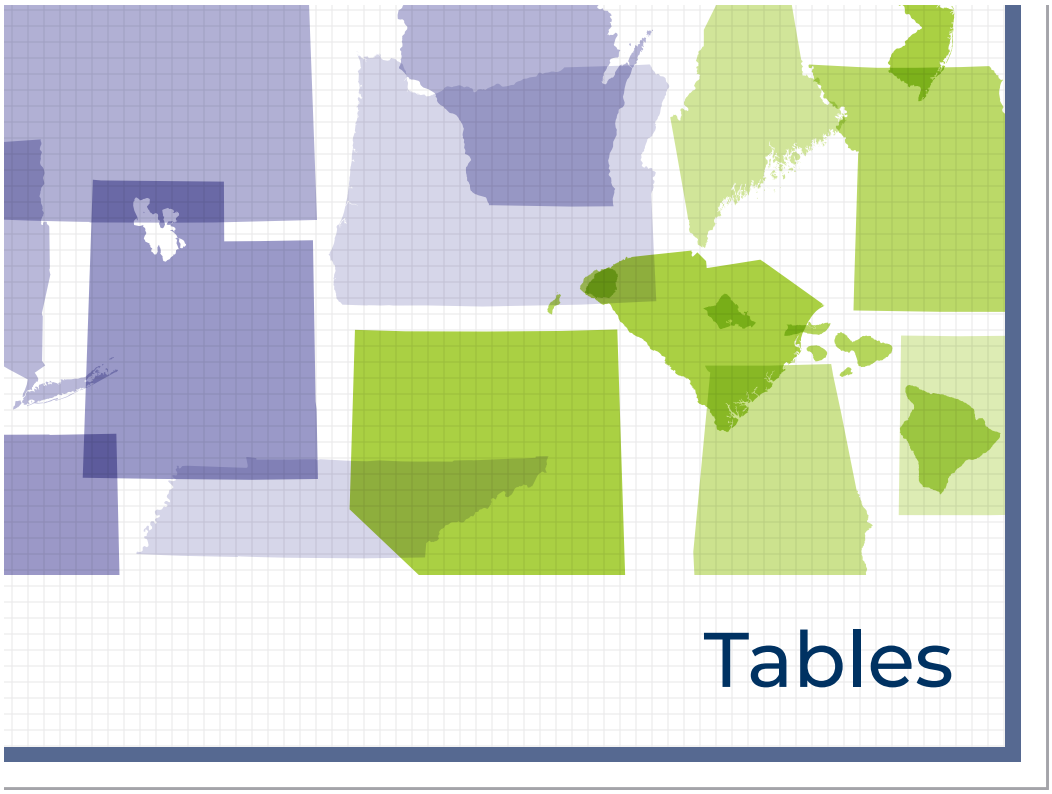


TABLE 1. Medicaid Payments for Graduate Medical Education (GME), 2022

State	Fee-for-Service	Managed Care
Alabama	No	No risk-based managed care
Alaska	No	No managed care
Arizona	DGME and IME	No
Arkansas	DGME	No risk-based managed care
California	No	DGME and IME
Colorado	DGME	DGME
Connecticut	DGME and IME	No managed care
Delaware	Do not distinguish between DGME and IME	Do not distinguish between DGME and IME
District of Columbia	DGME and IME	DGME and IME
Florida	DGME and IME	IME
Georgia	DGME and IME	IME
Hawaii	DGME and IME	DGME and IME
Idaho	DGME	No risk-based managed care[1]
Illinois	DGME and IME	IME
Indiana	DGME	DGME
Iowa	DGME and IME	DGME and IME
Kansas	DGME and IME	DGME and IME
Kentucky	DGME and IME	DGME and IME
Louisiana	DGME	No
Maine	DGME and IME	No Managed Care
Maryland	Do not distinguish between DGME and IME	Do not distinguish between DGME and IME
Massachusetts	No	No
Michigan	Do not distinguish between DGME and IME	Do not distinguish between DGME and IME
Minnesota	Do not distinguish between DGME and IME	Do not distinguish between DGME and IME
Mississippi	DGME	No
Missouri	DGME	No
Montana	Do not distinguish between DGME and IME	No risk-based managed care
Nebraska	DGME and IME	DGME and IME
Nevada	Do not distinguish between DGME and IME	Do not distinguish between DGME and IME
New Hampshire	No	No
New Jersey	No	DGME and IME
New Mexico	DGME and IME	No[2]
New York	DGME and IME	DGME and IME
North Carolina	DGME and IME	No
North Dakota	No	No
Ohio	Do not distinguish between DGME and IME	Do not distinguish between DGME and IME
Oklahoma	DGME and IME	No risk-based managed care
Oregon	DGME and IME	DGME and IME
Pennsylvania	DGME	No
Rhode Island	No	No
South Carolina	DGME and IME	DGME and IME
South Dakota	Do not distinguish between DGME and IME	No risk-based managed care
Tennessee	No fee-for-service	Do not distinguish between DGME and IME
Texas[3]	DGME and IME	DGME and IME
Utah	DGME	No
Vermont	DGME and IME	No managed care[4]
Virginia	DGME and IME	DGME and IME
Washington	DGME and IME	Do not distinguish between DGME and IME
West Virginia	DGME	No
Wisconsin	DGME	DGME
Wyoming	No	No managed care

Sources: Hinton E, Guth M, Raphael J, et al. How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023. *Washington, DC: KFF; October 2022. Centers for Medicare & Medicaid Services.* Medicaid Managed Care Enrollment and Program Characteristics, 2020. *Washington, DC: CMS; 2020. https://www.medicaid.gov/medicaid/managed-care/downloads/2020-medicaid-managed-care-enrollment-report.pdf*

Notes: In 2022, Alabama, Alaska, Massachusetts, New Hampshire, North Dakota, Rhode Island, and Wyoming did not pay for GME under their Medicaid program. New Hampshire continued to suspend Medicaid GME payments in FY 2022 and FY 2023 under an amendment to their Medicaid state plan. DGME = direct graduate medical education (payment for the direct costs of GME); IME = indirect medical education (payment for the indirect costs of GME); No Managed Care = No form of comprehensive managed care as of July 1, 2022; No Risk-Based Managed Care = No form of comprehensive capitated managed care as of July 1, 2022.

1. The Centers for Medicare & Medicaid Services (CMS) counts Idaho's Medicaid-Medicare coordinated plan under the comprehensive managed care organization (MCO) category in its managed care enrollment report.
2. New Mexico awaits federal approval of an amendment to their Section 1115 waiver demonstration that authorizes Medicaid GME expansion payments under managed care.
3. Medicaid payments for DGME costs in Texas are considered a special initiative mandated by the state legislature in a rider to the state fiscal year (SFY) 2009 General Appropriations Act. These payments are not separately linked to either fee-for-service or managed care.
4. CMS counts Vermont's public managed care model under the comprehensive MCO category in its managed care enrollment report.

TABLE 2. State Sources for Nonfederal Financing of Medicaid GME Payments, 2022

State	State General Fund	Local Government Contributions	Hospital Provider Tax
Arizona	●	●	
Arkansas	●	●	
California		●	
Colorado	●		
Connecticut	●		
Delaware	●		
District of Columbia	●		
Florida	●	●	
Georgia	●		●
Hawaii	●		
Idaho	●		
Illinois	●		●
Indiana	●		
Iowa	●	●	
Kansas	●		
Kentucky	●	●	
Louisiana	●		
Maine	●		
Maryland	●		
Michigan	●		
Minnesota	●		
Mississippi	●		
Missouri	●	●	●
Montana		●	
Nebraska	●		
Nevada		●	
New Jersey	●		
New Mexico	●	●	
New York	●		
North Carolina		●	●
Ohio	●		
Oklahoma	●		
Oregon	●	●	
Pennsylvania	●		●
South Carolina	●	●	●
South Dakota	●		
Tennessee	●		●
Texas	●	●	
Utah	●		
Vermont		●	
Virginia	●	●	
Washington	●		
West Virginia	●		
Wisconsin	●		
Total	**39**	**16**	**7**

Notes: Recognized state sources of nonfederal funding for Medicaid GME payments include (1) *state general fund* containing revenue raised from income, sales, and other broad-based taxes, as well as state intra-agency fund transfers; (2) *contributions from local governments* (including hospitals and other providers they operate) received through intergovernmental transfers (IGTs) and certified public expenditures (CPEs); and (3) *mandatory assessments (taxes) on hospitals.* States receiving contributions from local governments and revenue from health care provider taxes are permitted under federal law to use these funds to draw down additional federal matching dollars to help finance Medicaid supplemental GME payments.

TABLE 3. States Making Medicaid GME Payments to Designated Types of Teaching Hospitals and Nonhospital Providers, 2022

State	Designated Types of Teaching Hospitals[1]	Community-Based Providers With Approved Training Programs	Teaching Physicians[2]	Medical Schools
Arizona[3]	●[4]			
California	●[5]			
Colorado	●[6]			
Florida	●[7]	●[8]		
Georgia		●[9]		
Idaho		●[10]		
Illinois	●[11]			
Iowa	●[12]		●	
Kansas	●[13]			
Louisiana	●[14]			
Michigan				●[15]
Minnesota		●[16]		●[17]
Nevada	●[18]		●	
New Jersey	●[19]			
New Mexico	●[20]	●[21]		
Oregon	●[22]			
South Carolina			●	
South Dakota	●[23]			●[24]
Texas	●[25]			
Vermont			●	
Virginia	●[26]			
Wisconsin	●[27]			
Total	**16**	**5**	**4**	**3**

1. These states designated certain types of teaching hospitals (and affiliated residencies in some cases) as eligible to receive some or all Medicaid GME hospital payments in 2022. Excluded here are teaching hospitals, whose eligibility to receive Medicaid GME payments is defined solely by the minimum number of residents and interns they train. This information on designated teaching hospitals was obtained from the state's survey response or Medicaid state plan.
2. According to their Medicaid state plan in 2022, the following 26 states made Medicaid payments to teaching physicians for professional services but do *not* recognize these payments as GME payments: Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Louisiana, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, South Dakota, Texas, Utah, Virginia, Washington, and West Virginia.
3. Arizona is awaiting approval of an amendment to their Medicaid state plan (SPA 21-015) that would authorize GME payments to federally qualified health centers and Medicare-certified rural health clinics with approved training programs, effective Sept. 30, 2021.
4. Hospitals located in counties the federal government identifies as a health professional shortage area (HPSA). GME payments are pooled as (1) hospitals located in HPSA counties with a population of more than 500,000 and (2) hospitals located in HPSA counties with a population of fewer than 500,000.
5. Hospitals operated by state and local governments.
6. *State university teaching hospitals with family medicine residencies* that have a Medicaid utilization rate of at least 1% qualify for additional GME payments. *Privately owned teaching hospitals with family medicine residencies* that are approved for development of family medicine residencies in rural areas qualify for additional GME payments.
7. *State-statutory teaching hospitals,* defined as having at least 100 full-time-equivalent (FTE) resident physicians in seven or more GME programs. These hospitals include public teaching hospitals, children's teaching hospitals excluded from the Medicare Prospective Payment System, and academic medical centers with greater than 650 beds and 500 FTE residents. *Family practice teaching hospitals,* defined as freestanding, community-based hospitals with three-year family practice residency programs.
8. Federally qualified health centers and behavioral health centers (i.e., community mental health centers and substance abuse treatment centers).
9. Behavioral health centers (i.e., community service boards).
10. Federally qualified health centers.
11. Large public hospitals; all other hospitals.
12. State-owned hospitals; all other hospitals.
13. Public hospitals; all other hospitals.
14. *Major teaching hospitals,* defined as having (1) at least two residency programs in medicine, surgery, OB/GYN, pediatrics, family practice, and emergency medicine or psychiatry, (2) at least 20 intern and resident unweighted FTE positions, and (3) an approved family practice residency program located more than 150 miles from the program's medical school. *Minor teaching hospitals,* defined as having at least one residency program in medicine, surgery, OB/GYN, pediatrics, family practice, and emergency medicine or psychiatry.

15. Medical school consortia under the *GME Innovations Michigan Doctors (MIDocs)* program. Payments support the expansion of residencies and subsequent retention efforts for approved high-need specialties in underserved areas of the state where physician shortages undermine access to care for Medicaid beneficiaries.
16. Federally qualified health centers, Medicare-certified rural health clinics, behavioral health centers, dental service providers, pharmacies, home care service providers, ambulatory surgery centers, and other clinics.
17. One medical school and other clinical schools or consortia that train residents and students in other health professions (see Table 4). Payments to these institutions support clinical innovations in GME specifically for the education and training of primary care physicians and dental health professionals in rural areas.
18. Local government-owned and -operated hospitals.
19. Hospitals eligible for GME subsidy payments must have a Relative Medicaid Percentage (RMP) that is among the state's top 14 acute care hospitals with a residency program; all other acute care hospitals.
20. Hospitals with a Medicaid inpatient utilization rate of at least 5% during its most recently concluded fiscal year.
21. Federally qualified health centers and Medicare-certified rural health clinics. To date, New Mexico reportedly has made no GME payments to these providers.
22. Public hospitals with more than 200 residents or interns and private hospitals.
23. Private hospitals.
24. Family medicine residency affiliated with the Sanford School of Medicine at the University of South Dakota. Payments support community-based GME in rural areas.
25. State-owned hospitals and nonstate (local) government hospitals.
26. State-owned hospitals (Type One); all other hospitals (Type Two).
27. Hospitals with one or more residency programs in family medicine, general internal medicine, general surgery, and pediatrics or psychiatry that serve rural and underserved communities. Priority funding is given to those hospitals that (1) have a retention rate of at least 30% of graduating residents remaining to practice in the state's rural and underserved communities and (2) serve underserved areas with fewer than 50,000 people (with higher priority given to rural areas with populations of under 10,000).

TABLE 4. States Making Medicaid GME Payments That Cover Physician Residents in Designated Specialties and Trainees in Other Health Professions, 2022

State	Physician Residents in Designated Specialties in Undersupply	Trainees in Other Health Professions
Arizona	●[1]	
California		●[2]
Colorado	●[3]	
Florida	●[4]	
Georgia	●[5]	
Idaho	●[6]	
Indiana		●[7]
Iowa		●[8]
Michigan	●[9]	●[10]
Minnesota	●[11]	●[12]
Montana	●[13]	
New Mexico	●[14]	
New York		●[15]
Ohio		●[16]
Oregon		●[17]
Pennsylvania		●[18]
South Carolina		●[19]
South Dakota	●[20]	
Tennessee	●[21]	
Texas		●[22]
Virginia	●[23]	●[24]
Wisconsin	●[25]	
Total	**13**	**12**

Note: These states may use *some or all* Medicaid GME payments to cover (1) existing and expansion resident positions in designated high-need specialties and (2) trainees in other health professions. This information was obtained from the state's survey response or Medicaid state plan.

1. Existing and expansion positions in primary care, psychiatry, and general surgery. Positions in other specialties remain eligible for funding. Top priority is given to funding positions at hospitals located in health professional shortage areas (HPSAs) with a shortage of primary care physicians of greater than 85%.
2. Interns, residents, and fellows of dental and podiatry schools and students in nursing and paramedical programs.
3. Existing positions in family medicine. Expansion positions in rural family medicine residencies.
4. Specialties include: (1) expansion positions in allergy or immunology, anesthesiology, cardiology, colon and rectal surgery, emergency medicine, endocrinology, family medicine; gastroenterology, general internal medicine, geriatric medicine, hematology, oncology, infectious diseases, neonatology, nephrology, neurological surgery, OB/GYN; ophthalmology, orthopedic surgery, pediatrics, physical medicine and rehabilitation, plastic surgery/reconstructive surgery, psychiatry, pulmonary/critical care, radiation oncology, rheumatology, thoracic surgery, urology, and vascular surgery deemed in short supply under the *GME Startup Bonus Program;* (2) existing positions in primary care specialties (family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, OB/GYN, emergency medicine, general surgery, and psychiatry) trained in Medicaid regions with primary care demand greater than supply under the *Primary Care GME Program,* with priority given to hospitals with greater than or equal to 14% Medicaid utilization; (3) existing positions in urology, thoracic surgery, nephrology, ophthalmology, infectious disease, and hematology/oncology deemed as severe deficit physician specialties under the *Severe Deficit GME Program,* with priority given to hospitals with greater than 40 unweighted FTEs in specialties in a decline; and (4) existing positions in highly specialized tertiary care disciplines under the *High Tertiary Statutory Teaching GME Program,* with priority given to hospitals with greater than 300 unweighted FTEs.
5. Existing positions in primary care specialties (family medicine, general pediatrics, specialty pediatrics, OB/GYN); general surgery; psychiatry.
6. Existing positions in primary care specialties; general surgery; psychiatry.
7. Students in nursing and paramedical programs (i.e., emergency medical services, clinical pastoral education, radiology technology).
8. Students in graduate nursing programs.
9. Existing and expansion positions in primary care, psychiatry, and/or other high-need specialties. Payments under the *GME Innovations Agreements* initiative also support GME programs that emphasize the importance of coordinated, patient-centered care, health promotion, psychiatric care in integrated health systems, and continuous quality improvement, particularly for Medicaid beneficiaries and other underserved populations.
10. Residents in dentistry and podiatry.
11. Existing positions in primary care or other specialties in undersupply in the state.
12. Medical school students; students trained as doctor of pharmacy practitioners; dental school students and residents; chiropractic school students; advanced practice nursing students trained as clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives; physician assistant students; and students trained as dental therapists, advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers.

13. Existing positions in primary care and psychiatry.
14. Existing positions in primary care (family medicine, general internal medicine, general pediatrics, general psychiatry) and approved residents in other specialties.
15. Approved interns and fellows.
16. Students in nursing and paramedical programs.
17. Students in paramedical programs.
18. Students in graduate nursing programs.
19. Students in nursing and laboratory technology.
20. Existing positions in family medicine based at a rural residency program.
21. Existing positions in primary care (family medicine, general pediatrics, internal medicine, OB/GYN, geriatrics, psychiatry) are counted twice.
22. Interns, residents, and fellows of dental and podiatry schools.
23. Expansion positions in primary care (general pediatrics, general internal medicine, family practice) or a high-need specialty with substantiated need (i.e., psychiatry) or a combination of the two. Positions must be based at hospitals enrolled as Medicaid providers, and preference is given for residencies located in underserved areas of the state that serve Medicaid beneficiaries.
24. Students in dentistry, podiatry, nursing, and paramedical programs.
25. Expansion positions in family medicine, general internal medicine, general surgery, pediatrics, and psychiatry based in hospitals that serve rural and underserved communities in the state. GME payments that support these positions go to teaching hospitals that focus on training residents in (1) team-based care, prevention and public health, cost-effectiveness, and health economics and (2) settings with new service delivery models (e.g., Accountable Care Organizations, patient-centered medical homes).

TABLE 5. Methods for Calculating Medicaid GME Payments Under Fee-for-Service, 2022

State[1]	Medicare Hospital Method	Modified Medicare Hospital Method	Per Medicaid Hospital Discharge	Per-Resident Method		Other Method	
				Hospitals	Other Provider	Hospitals	Other Provider
Arizona				●			
Arkansas		●[1]				●[2]	
Colorado			●				
Connecticut		●					
Delaware	●		●[3]				
District of Columbia	●[4]		●[5]				
Florida				●[6]	●[7]	●[8]	
Georgia	●[9]			●[10]			●[11]
Hawaii			●				
Idaho	●						●[12]
Illinois			●[13]			●[14]	
Indiana		●[15]					
Iowa	●					●[16]	●[17]
Kansas	●[18]		●[19]				
Kentucky	●[20]	●[21]					
Louisiana						●[22]	
Maine	●						
Maryland				●			
Michigan				●[23]		●[24]	●[25]
Minnesota				●			●[26]
Mississippi				●			
Missouri						●[27]	
Montana				●			
Nebraska	●[28]		●[29]				
Nevada				●			●[30]
New Mexico				●[31]		●[32]	
New York			●			●[33]	
North Carolina	●[34]			●[35]			
Ohio	●						
Oklahoma				●			
Oregon	●[36]		●[37]				
Pennsylvania						●[38]	
South Carolina			●				●[39]
South Dakota		●					●[40]
Texas	●[41]			●[42]			
Utah		●[43]					
Vermont	●[44]			●[45]			●[46]
Virginia			●[47]			●[48]	
Washington	●[49]						
West Virginia		●					
Wisconsin	●[50]					●[51]	
Total[11]	**16**	**7**	**11**	**14**	**1**	**12**	**9**

1. Base-rate payments use Medicare reasonable cost rules plus the inclusion of nursery cost in the calculation of the cost per resident.
2. Supplemental payments are equal to the product of (1) direct graduate medical education (DGME) costs as reported in the State-Operated Teaching Hospital (SOTH) Medicare cost report and (2) the ratio of Medicaid patient days to total patient days (i.e., total of Medicaid patient days plus patient days for Medicaid private-option beneficiaries, divided by total hospital patient days).
3. Hospital-specific prospective rate for each accommodation type is based on the percentage of total costs for each hospital represented by medical education costs.
4. IME costs are included in the hospital prospective base rate multiplied by the case-mix index.
5. For DGME costs.

6. DGME costs are paid under a formula that uses each hospital's allocation fraction based on state funds appropriated for their residency programs and the hospital's total number of full-time equivalent (FTE) residents where residents in designated primary care specialties are counted as 1.0 FTE and all other residency specialties are counted as 0.5 FTE.
7. DGME costs for *federally qualified health centers (FQHCs)* are paid under a formula that uses each health center's allocation fraction based on state funds appropriated for these health centers and the FQHCs' total number of FTE residents where residents in designated primary care specialties are counted as 1.0 FTE and all other residency specialties are counted as 0.5 FTE.
8. Indirect medical education (IME) costs are calculated by computing each hospital's ratio of residents to beds and Medicaid inpatient payments in order to determine the IME adjustment amount.
9. IME costs are an add-on to the hospital inpatient prospective payment system (IPPS) rate.
10. For DGME costs.
11. Payment amounts to a *community service board* are calculated by multiplying the residency program's total expenses by percent Medicaid revenue.
12. Payments to *FQHCs* are made using an alternative payment meth that calculates the number of hours worked by primary care residents multiplied by the resident hourly rate multiplied by the ratio of Medicaid patient visits to all patient visits served by the resident for the period.
13. Inpatient base-rate payments include a rate adjuster for IME costs extracted from the current Medicare factor at the time of annual update.
14. Supplemental payments financed by the state's hospital provider tax are a fixed annual amount based on the percentage of DGME costs not already covered by other Medicaid or Medicare reimbursement.
15. Payments are calculated by dividing routine and ancillary medical education costs by total patient days, multiplied by diagnosis-related group (DRG) average length of stay.
16. For both DGME and IME costs in inpatient and outpatient settings, payment is calculated as follows: (1) Multiply the total of all DRG weights for claims paid from the GME and DSH (disproportionate-share hospitals) fund apportionment claim set for each hospital reporting DGME costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's DGME rate to obtain a dollar value; (2) sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage; and (3) multiply each hospital's percentage by the amount allocated for DGME to determine the payment to each hospital.
17. Payments to *teaching physicians* are based on a comparison of Medicaid rates to average commercial rates for physician services.
18. For both DGME and IME costs, payments to *public* hospitals are paid as a percent of charges not to exceed the federal upper payment limit (UPL) based on review of Medicaid reports.
19. *Nonpublic* hospitals are paid as follows: hospital-specific medical education rate (Medicaid DRG group rate multiplied by 1, plus DGME cost percent, plus IME cost percent) multiplied by the number of Medicaid discharges, multiplied by the average case-mix rate.
20. Base-rate payments for DGME and IME costs.
21. Supplemental payments for DGME and IME costs where Medicare resident caps are removed.
22. Payments are calculated using a hospital-specific medical education add-on (based on direct GME cost per day) to the prospective peer group per diem base rate.
23. Per-resident payment methods are calculated annually and vary according to the following formula pools: (1) for the *GME Primary Care Pool,* adjusted number of FTE residents (FTEs multiplied by each hospital's case mix times the ratio of Title V and Title XIX outpatient charges to total charges) factored by the size (number of hospitals) in the pool;(2) for the *GME Funds Pool,* adjusted number of FTE residents (FTEs multiplied by each hospital's ratio of Title V and Title XIX days to total days) factored by the size (number of hospitals) in the pool; (3) for the *GME Dental and Podiatry Pool,* the average FTE payment for dental and podiatry residents is calculated by the summed total of the GME liability to a hospital's residency programs divided by the total number of dental and podiatry FTEs.
24. Grant amounts under the *GME Innovations Hospital Program* and *GME Innovations Sponsoring Institution Program* are based on GME program expenses up to the hospital's upper-payment limit.
25. *Medical schools* participating in the MIDocs consortium under the *GME Innovations Michigan Doctors Program* are paid an amount equal to the amount of their costs otherwise unreimbursed from other sources, Medicaid being the payer of last resort.
26. Payments to FQHCs, *Medicare-certified rural health clinics, dental service providers, pharmacies, mental health centers, home care service providers, ambulatory surgery centers, and other clinics* are calculated using a formula primarily based on Medicaid utilization but taking into account the number of qualifying FTE trainees.
27. Payments are calculated by determining the Medicaid GME cost per inpatient day based on the previous fiscal year's fourth-quarter cost report and trending to current state fiscal year (SFY), and then multiplying 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 an enhanced GME payment paid annually, which represents the difference between the consumer price index (CPI) indices used as the basis for its trends and the Medicare indices.
28. For IME costs.
29. For DGME costs.
30. Payments to *teaching physicians* are calculated using an enhanced rate of reimbursement for outpatient services delivered in a teaching environment.
31. Payments for DGME costs are determined by the number of FTE residents.
32. Payments for IME costs are determined by the number of FTE residents, bed size, and Medicaid utilization.
33. DRG rate per diem calculation.
34. IME payments are calculated as follows: (1) Identify each hospital's Medicare IME adjustment factor based on the method described in 42 CFR 412.105 except for the limits on the total number of FTE residents described in 42 CFR 412.105(f)(iv). To calculate the IME adjustment factor, the Medicaid agency uses the total number of resident FTEs used to calculate DGME payments. (2) Determine the IME base amount by (a) multiplying the IME adjustment factor by the sum of each hospital's Healthcare Cost Report Information System (HCRIS) data extract, divided by each hospital's Medicare case-mix index; (b) for hospitals reporting FTEs, divide the IME adjustment factor by the sum of Medicare discharges from each hospital's HCRIS data extract. Multiply the base rate by the sum of Medicaid discharges and the in-state paid Medicaid managed care discharges. For all other hospitals, divide the IME adjustment factor by the sum of Medicare discharges from each hospital's HCRIS data extract. Multiply the base rate by the sum of Medicaid discharges and the in-state paid Medicaid managed care discharges. (3) Multiply the IME base amount by each hospital's case-mix index for the Medicaid population.
35. DGME payments are calculated as follows: (1) Calculate a statewide per-resident average (PRA) by (a) summing the total interns and residents salary and fringe costs plus interns and residents other program costs as determined from the HCRIS data extract; (b) summing the total number of resident FTEs as determined from each hospital's HCRIS data extract; (c) dividing total allowable direct costs by total resident FTEs.

(2) Multiply the statewide PRA by each hospital's number of resident FTEs by either (a) each hospital's HCRIS data extract or (b) the hospital's most recent Medicare Year End Rate Review letter indicating the projected number of IME resident FTEs for the hospital's current fiscal year using each hospital's HCRIS data extract. (3) Multiply the amount calculated in step 2 by each hospital's Medicaid share of inpatient days.

36. For IME costs.
37. For DGME costs.
38. Costs are reimbursed using the sum of a hospital's total Medicaid fee-for-service (FFS) GME costs using FY 2008 as the base year.
39. Payments to *teaching physicians* are based on a comparison of Medicaid rates to average commercial rates.
40. Payments to a *medical school family medicine residency* are made using a cost-based method that reimburses according to a provider fee schedule.
41. IME costs are paid based on Medicare's teaching hospital operating costs (TCHOP) factor to compensate hospitals with teaching programs for the additional expense of functioning as a teaching hospital.
42. For DGME costs.
43. Payments are based on most recent Medicare cost reports adjusted for inflation and utilization trends.
44. IME payments are the product of total Medicaid DRG revenue for inpatient operating costs and the hospital-specific IME adjustment factor, including weighting factors and caps set forth in 42 CFR Part 412.105.
45. For DGME costs.
46. Payments to *teaching physicians* are based on a comparison of Medicaid rates to average commercial rates.
47. For DGME costs.
48. DGME payments are based on an annual competitive application process that awards grants to support new resident positions in primary care (general pediatrics, general internal medicine, or family practice) or in a high-need specialty with substantiated need (i.e., psychiatry) or a combination of the two. Payments for each new residency slot are $100,000 annually for up to four years and use a per-resident method to calculate grant amounts. IME payments are equal to the hospital's Medicaid operating reimbursement multiplied by an IME percentage.
49. Hospital-specific DGME payments are calculated by dividing the DGME cost reported on worksheet B, part 1 of the CMS cost report by the adjusted total costs from the CMS cost report. The IME adjustment is equal to the IME adjustment factor for the prospective payment system (PPS) available in the most recent CMS final rule impact file on the CMS website as of May 1 of the rate-setting year.
50. Base-rate payments are calculated as a percentage add-on (prospectively established based on the ratio of GME costs to total hospital operating costs) to the hospital DRG rate.
51. Supplemental payments are based on an annual competitive application process that awards grants to support new residents in family medicine, general internal medicine, general surgery, pediatrics, and psychiatry up to $75,000 per resident in 2022 based in hospitals that serve rural and underserved communities in the state.

TABLE 6. Methods for Distributing Medicaid GME Payments Under Fee-for-Service, 2022

State	Part of Hospital Base Rate	Supplemental Payment[1]				Separate Payment
		Hospitals Under UPL	DSH	UCP	Other Provider	
Arizona		●				
Arkansas	●	●				
Colorado	●	●				
Connecticut		●				
Delaware	●					
District of Columbia	●					
Florida		●	●	●[2]		
Georgia	●	●			●[3]	
Hawaii	●					
Idaho	●[4]				●[5]	
Illinois	●	●				
Indiana	●					
Iowa		●			●[6]	
Kansas		●				
Kentucky	●	●				
Louisiana	●					●[7]
Maine	●					
Maryland		●				
Michigan		●			●[8]	
Minnesota		●	●		●[9]	
Mississippi		●				
Missouri		●				
Montana		●				
Nebraska	●					
Nevada		●			●[10]	
New Mexico		●				
New York	●					
North Carolina		●				
Ohio						●[11]
Oklahoma		●				
Oregon		●				
Pennsylvania		●				
South Carolina	●	●	●		●[12]	
South Dakota		●			●[13]	
Texas		●[14]				
Utah		●				
Vermont		●			●[15]	
Virginia		●	●			
Washington	●					
West Virginia	●	●				
Wisconsin	●	●				
Total	**18**	**30**	**4**	**1**	**9**	**2**

Note: UPL = upper-payment limit; DSH = disproportionate-share hospital; UCP = uncompensated care pool.

1. Types of Medicaid supplemental GME payments include (1) payments to teaching hospitals whose payments cannot exceed their federally designated upper-payment limit (UPL), (2) payments to teaching hospitals that are federally designated as disproportionate-share hospitals (DSHs), (3) payments to hospitals and other teaching entities using a federal 1115 waiver-approved UCP to defray GME costs associated with the delivery of charity care services, and (4) payments to other providers, including teaching physicians and community-based providers with approved training programs.

2. In accordance with the state's Section 1115 waiver, Florida uses an uncompensated care pool to distribute supplemental payments to reimburse uncompensated GME costs to (1) *eligible non-DSH, state-statutory teaching hospitals,* (2) *federally qualified health centers,* and (3) *behavioral health centers* (i.e., community mental health centers, substance abuse treatment clinics).
3. Community service boards (CSBs).
4. Effective Oct. 1, 2022.
5. Federally qualified health centers.
6. Teaching physicians.
7. Separate payments to hospitals as an adjustment to the GME add-on payments for managed care organization claims.
8. Medical school consortia.
9. Federally qualified health centers; Medicare-certified rural health clinics; dental service providers; pharmacies; mental health centers; home care service providers; ambulatory surgery centers; other clinics.
10. Teaching physicians.
11. Separate payments to hospitals through Medicaid inpatient claims as a GME add-on which are case-mix adjusted.
12. Teaching physicians.
13. Medical school rural family medicine residency.
14. Payments are not separately linked to either fee-for-service or managed care.
15. Teaching physicians.

TABLE 7. Distribution of Medicaid GME Payments Under Managed Care, 2022

State	Direct Payment to Teaching Hospitals	Payment in Capitation to MCOs[1]
California	●	
Colorado	●	
Delaware		●
District of Columbia	●	
Florida	●	
Georgia		●
Hawaii		●
Illinois		●
Indiana	●	
Iowa	●	●
Kansas		●
Kentucky	●	
Maryland	●	
Michigan		●
Minnesota	●[2]	
Nebraska	●	
Nevada	●[3]	
New Jersey	●	
New York	●	
Ohio		●
Oregon	●	
South Carolina	●	●
Tennessee	●	
Texas	●	●
Virginia	●	
Washington		●
Wisconsin		●
Total	**18**	**12**

Note: MCOs = managed care organizations.

1. Payments in MCO capitation rates are passed on to teaching hospitals with the exception of South Carolina, where payments in MCO capitation rates were distributed to *teaching physicians* in 2022.
2. Minnesota also made direct payments to (1) *medical schools and other clinical training programs* in dentistry, pharmacy, nursing, chiropractic, social work, and paramedical professions and (2) community-based providers with approved training programs, including *federally qualified health centers, Medicare-certified rural health clinics, dental service providers, pharmacies, mental health centers, home care service providers, ambulatory surgery centers, and other clinics.*
3. Nevada also made direct payments to *teaching physicians.*

TABLE 8. Methods for Calculating Medicaid GME Direct Payments Under Managed Care, 2022

State	Medicare-FFS Hospital Method	Per Medicaid Managed Care Hospital-Discharge Method	Per-Resident Hospital Method	Other Method	
				Hospitals	Other Provider
California			●[1]	●[2]	
Colorado		●			
District of Columbia			●		
Florida				●[3]	
Indiana	●				
Iowa	●				
Kentucky	●[4]			●[5]	
Maryland			●		
Minnesota			●		●[6]
Nebraska		●			
Nevada			●		●[7]
New Jersey	●[8]		●[9]		
New York		●			
Oregon	●				
South Carolina		●			
Tennessee			●[10]	●[11]	
Texas			●		
Virginia		●[12]		●[13]	
Total	**5**	**5**	**8**	**5**	**2**

Note: FFS = fee-for-service.

1. For direct graduate medical education (DGME) costs.
2. For indirect medical education (IME) costs, a hospital-specific adjusted Medicaid IME per inpatient day is multiplied by total Medicaid managed care inpatient days.
3. IME costs are calculated by computing each hospital's ratio of residents to beds and Medicaid inpatient payments in order to determine the IME adjustment amount.
4. Base-rate payments for DGME and IME costs.
5. Supplemental payments for DGME and IME costs using a modified Medicare method.
6. (1) Payments to *federally qualified health centers, Medicare-certified rural health clinics, and other nonhospital providers* that train physicians and students in other health professions are calculated using a formula primarily based on Medicaid utilization but taking into account the number of qualifying full-time equivalent (FTE) trainees. (2) Payments to *eligible medical schools and other clinical training programs or consortia* use a formula based on per-resident costs associated with training program Medicaid utilization or are in the form of grants that support clinical innovations in GME. Grant amounts are determined using (a) total statewide average costs per physician resident based on audited clinical training costs per trainee in primary care clinical medical education programs and (b) total statewide average costs per dental resident based on audited clinical training costs per trainee in clinical medical education programs for dental students.
7. Payments to *teaching physicians* are calculated using an enhanced rate of reimbursement for outpatient services delivered in a teaching environment.
8. For IME costs, payments are calculated by multiplying total inpatient Medicaid managed care encounter payments by the Medicare IME factor, divided by total IME costs.
9. For DGME costs, payments are calculated by multiplying the median cost per resident by the 2019 resident FTEs to develop the total median residency program cost for each hospital. These costs are multiplied by the ratio of Medicaid managed care days to determine the total Medicaid managed care DGME costs of each hospital.
10. For Sub-Pool B, supplemental payments are based on each hospital's proportionate share of full-time residents, weighted in favor of primary care residents.
11. For Sub-Pool A, supplemental payments are based on each hospital's proportionate share of Medicaid utilization determined by multiplying the hospital's ratio of Medicaid adjusted days (number of Medicaid adjusted days divided by the sum total of Medicaid adjusted days from all eligible hospitals) by the total amount of pool funds available.
12. For DGME costs.
13. For IME costs, payments are equal to the hospital's Medicaid operating reimbursement multiplied by an IME percentage.

TABLE 9. State Oversight of Medicaid GME Payments in Capitation Rates to Managed Care Organizations, 2022

State	Medicaid Requires MCOs to Distribute Payments to Teaching Providers[1]	Medicaid Assumes MCOs Distribute Payments to Teaching Hospitals
Delaware		●
Georgia		●
Hawaii	●[2]	
Illinois		●[3]
Iowa	●[4]	
Kansas	●[5]	
Michigan	●[6]	
Ohio	●[7]	
South Carolina	●[8]	
Texas		●
Washington		●
Wisconsin		●
Total	**6**	**6**

Note: MCOs = managed care organizations.

1. Payments by MCOs are distributed to teaching hospitals, with the exception of South Carolina**,** where payments were passed on to teaching physicians in 2022.
2. MCOs are provided with a specific method, which follows Medicaid fee-for-service (FFS), for determining GME add-on payments to teaching hospitals.
3. MCOs are encouraged to pay teaching hospitals no less than the base prospective payment system (PPS) rates paid under FFS, including all adjustments such as the IME factor.
4. MCOs are provided with a specific method, which follows Medicaid FFS, for determining GME add-on payments to teaching hospitals. Payments are subject to reconciliation to the provider-specific amount allocated from the GME amount under FFS.
5. MCOs are provided with a specific method for determining GME add-on payments to teaching hospitals. Medicaid FFS provides the GME factors to apply to the peer-group hospital rate. Payment is calculated as the peer-group rate multiplied by the Medicare Severity-Diagnosis Related Group (MS-DRG) weight for diagnosis-related groups (DRGs).
6. MCOs are provided with a specific method for determining GME add-on payments to teaching hospitals.
7. Contracts between MCOs and hospitals generally state that the MCO "pays like FFS." Therefore, the assigned GME rate to a teaching hospital is also paid on claims for managed care enrollees.
8. A third party is provided with a specific method for handling the distribution of GME payments from MCOs to *teaching physicians.*

TABLE 10. States With Accountability Measures Governing Medicaid GME Payments, 2022

State[1]	Teaching Hospitals Required to Report DGME Costs[2]	Teaching Providers Required to Report Physician Resident Data[3]	Payments Routinely Audited[4]	Outcomes of Payments on State Physician Supply Documented and Reported[5]
Arizona		●[6]		●[7]
Arkansas			●[8]	
Colorado				●[9]
Florida		●[10]	●[11]	●[12]
Georgia		●[13]		
Hawaii	●			
Idaho[14]		●[15]	●[16]	
Iowa			●[17]	
Kansas	●			
Louisiana	●	●[18]	●[19]	
Maine			●[20]	
Michigan	●	●[21]		
Minnesota		●[22]		
Montana	●	●[23]		
Nevada			●[24]	
New Jersey	●	●[25]		
New Mexico	●	●[26]		
New York	●	●[27]		
Ohio	●	●[28]		
Oklahoma		●[29]		
South Dakota			●[30]	
Tennessee		●[31]		●[32]
Texas			●[33]	
Virginia	●	●[34]	●[35]	●[36]
West Virginia	●		●[37]	
Total	**11**	**15**	**11**	**5**

Notes: An additional measure of social accountability, *residents in high-need specialties designated as covered by GME payments,* is referenced in Table 4 (see footnotes from column 1). States may have other accountability measures affecting Medicaid GME payments that are not addressed in this report. DGME = direct graduate medical education.

1. California did not provide a response to these questions in the survey.
2. Twenty-seven states that do not require hospitals to report their direct GME costs specified that they obtained these GME costs from another source (i.e., Medicare cost report): Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Vermont, Washington, and Wisconsin.
3. If a state answered "YES" to the survey question *"Does your Medicaid program require hospitals and other teaching providers to report data on physician residents covered by your GME payments?"* then the resident characteristics the state indicated for reporting are provided in the footnote for that state in this column.
4. If a state answered "YES" to the survey question *"Does your Medicaid program routinely audit its GME payments to hospitals and other teaching providers?"* then the purpose(s) the state indicated for auditing GME payments is provided in the footnote for that state in this column.
5. If a state answered "YES" to the survey question *"Does your Medicaid program document and report to state authorities the outcomes of GME payments on the supply and distribution of the state's health care workforce?"* then the data on physician residents the state supported and used to indicate and report these outcomes are provided in the footnote for that state in this column.
6. *Resident characteristics reported:* number of residents (full-time equivalent [FTE] or count), specialty, year of training, and location of training.
7. *Resident positions reported:* all positions (unspecified), new positions and/or residencies, and positions in rural and medically underserved areas.
8. *Routine audit purpose(s):* identify overpayments and underpayments.
9. *Resident positions reported:* new positions and/or residencies, positions trained in hospital versus community settings, positions trained in rural and medically underserved areas, residents who go on to practice in a rural and medically underserved area, and residents who go to practice in the state.
10. *Resident characteristics reported:* number of residents (FTE or count), specialty, year of training, and location of training.
11. *Routine audit purpose(s):* identify overpayments and underpayments, verify that GME payments are made only for specified allowable costs, and identify and/or verify counts of residents supported.
12. *Resident positions reported:* all resident positions (unspecified), new positions and/or residencies, positions by specialty/subspecialty, positions trained in primary care and/or other high-need specialties, positions trained in rural and medically underserved areas.
13. *Resident characteristics reported:* number of residents (FTE or count), specialty, year of training, location of training, and number of days employed at a specific hospital.

14. Only federally qualified health centers (FQHCs) are required to report their DGME costs.
15. *Resident characteristics reported:* number of residents (FTE or count), Medicaid cost per resident (number of hours worked times hourly rate times ratio of Medicaid encounters to all encounters).
16. *Routine audit purpose(s):* for federally qualified health centers, verify that GME payments are made only for specified allowable costs.
17. *Routine audit purpose(s):* identify overpayments and underpayments.
18. *Resident characteristics reported:* number (FTE or count); specialty; year of training; location of training.
19. *Routine audit purpose(s):* identify and/or verify counts of residents supported.
20. *Routine audit purpose(s):* identify overpayments and underpayments and verify that GME payments are made only for specified allowable costs.
21. *Resident characteristics reported:* number (FTE or count).
22. *Resident characteristics reported:* number (FTE or count); specialty; year of training; location of training.
23. *Resident characteristics reported:* number (FTE or count).
24. *Routine audit purpose(s):* identify overpayments and underpayments.
25. *Resident characteristics reported:* number (FTE or count), specialty, location of training, and number of hours worked per month.
26. *Resident characteristics reported:* number (FTE or count).
27. *Resident characteristics reported:* number (FTE or count); specialty.
28. *Resident characteristics reported:* number (FTE or count).
29. *Resident characteristics reported:* number (FTE or count), specialty, and year of training.
30. *Routine audit purpose(s):* identify overpayments and underpayments.
31. *Resident characteristics reported:* number (FTE or count); specialty; year of training; location of training.
32. *Resident positions reported:* positions by specialty/subspecialty. Primary care positions are counted twice.
33. *Routine audit purpose(s):* identify overpayments and underpayments.
34. *Resident characteristics reported:* number (FTE or count); specialty; year of training; location of training.
35. *Routine audit purpose(s):* identify overpayments and underpayments and verify that payments were made only for specified allowable costs.
36. *Resident positions reported:* new positions and/or residencies, positions by specialty/subspecialty, and positions trained in primary care and/or other high-need specialties.
37. *Routine audit purpose(s):* verify that payments are made only for specified allowable costs and investigate integrity concerns.

TABLE 11. Medicaid GME Payment Amounts, 2022

State[1]	GME Payments Under Fee-for-Service (millions of dollars)	GME Payments Under Managed Care (millions of dollars)		Total Explicit GME Payments[2] (millions of dollars)	Total GME Payments[3] (millions of dollars)
		Explicit Payments[4]	Implicit Payments[5]		
Arizona	$386.8	$0	$0	$386.8	$386.8
Arkansas	$10.5	$0	$0	$10.5	$10.5
California	$0	$415.1	$0	$415.1	$415.1
Colorado	$11.6	$2.1	$0	$13.7	$13.7
Connecticut	$164.5	$0	$0	$164.5	$164.5
Delaware	$3.2	$0	$11.8	$3.2	$15.0
District of Columbia	$24.4	$50.9	$0	$75.4	$75.4
Florida	$334.1	$463.7	$0	$797.9	$797.9
Georgia[6]	$55.0	$0	Unreported	$55.0	$55.0
Hawaii	$0.076	$0	Unreported	$0.076	$0.076
Idaho	$3.0	$0	$0	$3.0	$3.0
Illinois	$158.5	$0	Unreported	$158.5	$158.5
Indiana	$15.0	$24.0	$0	$39.0	$39.0
Iowa	$51.8	$1.2	$22.6	$53.0	$75.6
Kansas	$0.30	$0	$23.5	$0.30	$23.8
Kentucky	$10.7	$105.6	$0	$116.3	$116.3
Louisiana	$23.9	$0	$0	$23.9	$23.9
Maine	$16.6	$0	$0	$16.6	$16.6
Maryland[7]	Unreported	Unreported	$0	$59.8	$59.8
Michigan	$31.2	$0	$131.7	$31.2	$162.9
Minnesota	$7.5	$71.0	$0	$78.5	$78.5
Mississippi	$39.9	$0	$0	$39.9	$39.9
Missouri	$179.4	$0	$0	$179.4	$179.4
Montana	$6.4	$0	$0	$6.4	$6.4
Nebraska	$1.8	$18.3	$0	$20.1	$20.1
Nevada	$14.8	$18.9	$0	$33.7	$33.7
New Jersey	$0	$242.0	$0	$242.0	$242.0
New Mexico	$188.7	$0	$0	$188.7	$188.7
New York	$445.0	$1,474.0	$0	$1,919.0	$1,919.0
North Carolina	$308.2	$0	$0	$308.2	$308.2
Ohio	$47.9	$0	$257.6	$47.9	$305.5
Oklahoma	$46.6	$0	$0	$46.6	$46.6
Oregon	$15.5	$135.5	$0	$151.0	$151.0
Pennsylvania	$111.4	$0	$0	$111.4	$111.4
South Carolina	$90.2	$68.9	$132.5	$159.1	$296.6
South Dakota	$3.1	$0	$0	$3.1	$3.1
Tennessee	$0	$48.0	$0	$48.0	$48.08
Texas[9]	Unreported	Unreported	Unreported	Unreported	$226.6
Utah	$7.0	$0	$0	$7.0	$7.0
Vermont	$30.0	$0	$0	$30.0	$30.0
Virginia	$180.3	$269.7	$0	$449.9	$449.9
Washington	Unreported	$0	Unreported	Unreported	Unreported[10]
West Virginia	$13.8	$0	$0	$13.8	$13.8
Wisconsin	$33.0	$0	$36.2	$33.0	$69.2
Total[11]	**$3.07 billion**	**$3.41 billion**	**$616 million**	**$6.48 billion**	**$7.39 billion**

Note: Alabama, Alaska, Massachusetts, New Hampshire, North Dakota, Rhode Island, and Wyoming did not make Medicaid payments for graduate medical education (GME).

1. The start and end dates for each state's fiscal year (SFY) vary. Not all states reported payment amounts for SFY 2022. New Jersey and Tennessee reported payments for SFY 2023. Illinois reported payments for calendar-year 2023. States reporting payments for SFY 2021 are District of

Columbia, Iowa, Kentucky, Maine, Ohio, Texas (for direct GME [DGME] only), and Utah. Nebraska reported managed care payment amounts for SFY 2020. South Carolina reported payment amounts to hospitals based on federal fiscal year (FY) 2020 data adjusted for fee-for-service (FFS) rate changes effective federal FY 2022.

2. The total amount of GME payments made directly to hospitals or other teaching entities under both FFS and managed care.
3. Total payment amounts (unless indicated otherwise) include reimbursement for direct and indirect GME costs by those state Medicaid programs that distinguish between and pay for one or both of these costs (see Table 1).
4. Explicit GME payments are those made directly to teaching hospitals and other teaching entities under managed care.
5. Implicit GME payments are those recognized and included in the capitation rates paid to managed care organizations.
6. Payments for indirect medical education (IME) costs made under FFS and managed care were not reported.
7. Maryland reported a total GME payment amount but provided no specific breakdown amounts for FFS and managed care GME payments.
8. Amount paid as of February 2023 for SFY ending June 30, 2023.
9. Texas reported only a total GME payment amount. GME payments are not separately linked to FFS or managed care.
10. For Washington, GME payment amounts were not readily available. Determining an actual Medicaid GME amount under both FFS and managed care is quite burdensome for the state. The Medicaid program has no identifiable pool of GME funds; instead, it pays individual hospitals a GME amount that varies widely per claim or case and is not an easily distinguishable cost as part of the hospital's base rate.
11. National amounts do not precisely reflect the total of individual state amounts due to rounding.

TABLE 12. Medicaid GME Payment Amounts for the Top 15 States, 2022

State[1]	Total GME Payments Under Fee-for-Service and Managed Care[2] (millions of dollars)	GME Payments Under Fee-for-Service (millions of dollars)	GME Payments Under Managed Care (millions of dollars)	
			Explicit Payments[3]	Implicit Payments[4]
New York	**$1,919.0**	$445.0	$1,474.0	$0
Florida	**$797.9**	$334.1	$463.7	$0
Virginia	**$449.9**	$180.3	$269.7	$0
California	**$415.1**	$0	$415.1	$0
Arizona	**$386.8**	$386.8	$0	$0
North Carolina	**$308.2**	$308.2	$0	$0
Ohio	**$305.5**	$47.9	$0	$257.6
South Carolina	**$296.6**	$90.2	$68.9	$132.5
New Jersey	**$242.0**	$0	$242.0	$0
Texas[5]	**$226.6**	Unreported	Unreported	Unreported
New Mexico	**$188.7**	$188.7	$0	$0
Missouri	**$179.4**	$179.4	$0	$0
Connecticut	**$164.5**	$164.5	$0	$0
Michigan	**$162.9**	$31.2	$0	$131.7
Illinois	**$158.5**	$158.5	$0	Unreported

1. The start and end dates for each state's fiscal year (SFY) vary. Not all states reported payment amounts for SFY 2022. Illinois and New Jersey reported payment amounts for SFY 2023. States reporting payment amounts for SFY 2021 are Ohio and Texas (for direct graduate medical education [DGME] costs only).
2. Payment amounts (unless indicated otherwise) include reimbursement for direct and indirect GME costs by those state Medicaid programs that distinguish and pay for one or both of these costs (see Table 1).
3. Explicit GME payments are those made directly to teaching hospitals and other teaching entities under managed care.
4. Implicit GME payments are those recognized and included in capitation rates to managed care organizations (MCOs).
5. Texas reported only a total GME payment amount. GME payments are not separately linked to fee-for-service or managed care.

TABLE 13. Medicaid GME Payments in States With the Highest Number of Teaching Hospitals, 2022

State	Number of Teaching Hospitals[1]	Total Medicaid GME Payments (millions of dollars)
New York	83	$1,919.0
California	80	$415.1
Pennsylvania	64	$111.4
Michigan	51	$162.9
Florida	48	$797.9
Ohio	47	$305.5
Texas	47	$226.6
Illinois	43	$158.5[2]
New Jersey	38	$242.0
Massachusetts	25	$0

Source: AAMC analysis of Medicare Cost Report data, FY 2020 (July 2022 release).

1. As of federal FY 2020. A "teaching" hospital is a hospital that reports resident full-time equivalents (FTEs) on its Medicare hospital cost report. Hospitals with fewer than five residents and interns are excluded from the number of teaching hospitals in this table. Cost report data can be found here: https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports.
2. Total Medicaid GME payment amounts in Illinois do not include managed care payments made under MCO capitation, which were not readily available.

TABLE 14. Medicaid GME Payments in States With the Highest Number of Physician Residents, 2022

State	Number of Physician Residents[1]	Number of Physician Residents Per 100,000 State Population	Total Medicaid GME Payments[2] (millions of dollars)
New York	18,578	94	$1,919.0
California	13,515	34	$415.1
Texas	9,850	33	$226.6
Pennsylvania	9,730	75	$111.4
Florida	7,808	36	$797.9
Ohio	7,468	63	$305.5
Michigan	7,349	73	$162.9
Illinois	6,567	52	$158.5[3]
Massachusetts	6,092	87	$0
North Carolina	4,150	39	$308.2

Source: Brotherton SE, Etzel SI. Graduate Medical Education, 2021-2022. *Appendix II, Table 4.* JAMA. *2022;328(11):1133-1134. doi:10.1001/jama.2022.13081.*

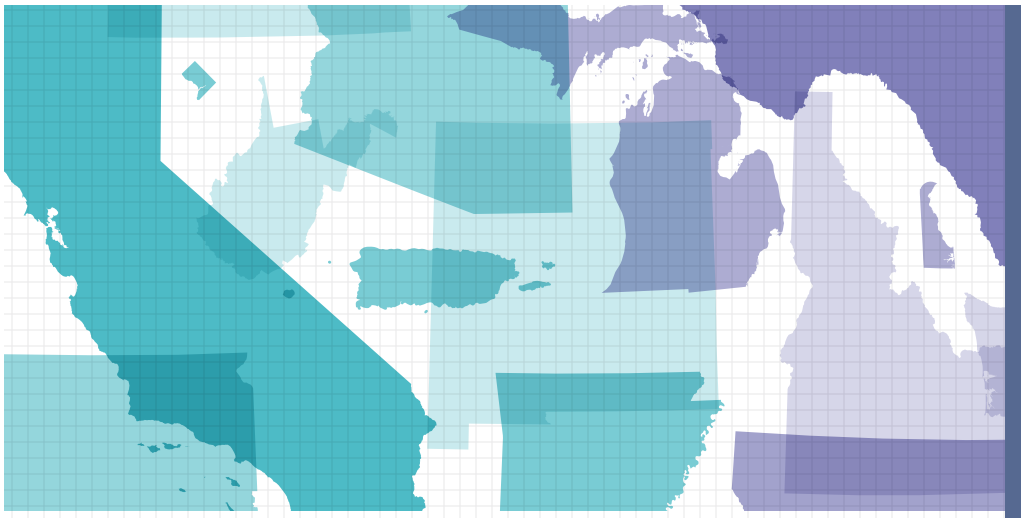
1. Number of resident physicians on duty as of Dec. 31, 2021.
2. In each state, not all physician residents may be covered by some or all Medicaid GME payments. See Table 4.
3. Total GME payment amounts in Illinois do not include managed care payments made under managed care organization (MCO) capitation, which were not readily available.

TABLE 15. Trends in State Medicaid GME Payments, 2002-2022

Indicator	Year						
	2022	2018	2015	2012	2009	2005	2002
States making GME payments	44	43	43	43	42[1]	48	48
States making GME payments under fee-for-service	41	41	41	41	41	47	47
States making GME payments directly to teaching providers under managed care	18	16	17	15	13	15	18
States including GME payments in capitated rates paid to MCOs	12	13	12	9	11	10	10
States requiring MCOs to "pass-through" GME payments to teaching providers	6	6	6	5	5	2	1
Total GME payments[2] (billions of dollars)	$7.39	$5.58	$4.26	$3.87	$3.78	$3.18	$2.70
Proportion of GME payments made under fee-for-service[3]	43%	48%	39%	59%	63%	DNC	DNC
Proportion of GME payments made under managed care[3]	57%	52%	61%	41%	37%	DNC	DNC

Sources: Henderson TM. Medicaid Payment Policy: Graduate Medical Education. *Washington, DC: AAMC; 2006, 2009, 2012, 2016, 2019. National Conference of State Legislatures.*

1. Alabama did not respond to the survey.
2. Total GME payment amounts include funds from federal and state sources. Before 2018, amounts include consultant estimates of some GME payments unreported in a small number of states. These estimates represent less than 5% of total GME payment amounts reported nationwide. In 2018 and 2022, the state of Washington was unable to report GME payment amounts, and the consultant made no attempt to estimate these amounts.
3. The below states, for the years noted, reported a total GME payment amount that either excluded or did not specify some or all GME payments made under FFS and/or managed care. As such, these states are *not* included in the calculation of the reported percentages.
   - 2022: Georgia, Hawaii, Illinois, Maryland, and Texas
   - 2018: Georgia, Illinois, Maryland, and Texas
   - 2015: Arizona, Florida, Georgia, Maryland, Ohio, and Texas
   - 2012: Arizona, Colorado, Hawaii, Maryland, and Ohio
   - 2009: Arizona, Colorado, Hawaii, Maryland, and Ohio



AAMC Medicaid GME Survey Instrument

STATE MEDICAID POLICY: GRADUATE MEDICAL EDUCATION PAYMENTS

1. Provide your contact information:

State: _____ Respondent Name(s): _____

_____

_____

Email Address: _____

Phone Number: _____

FEE-FOR-SERVICE PAYMENTS

2. Under your fee-for-service (FFS) program, does Medicaid pay teaching hospitals *(or other providers incurring teaching costs)* for graduate medical education (GME), or provide explicit added payments to these hospitals or other teaching providers?

☐ Yes

☐ No *Proceed to* ***Question 6***

☐ We do not operate a fee-for-service program. *Proceed to* ***Question 6***

3. Under FFS, does your Medicaid program pay for:
Check all that apply

☐ Direct costs of GME. [*Define:* _____]

☐ Indirect costs of GME. [*Define:* _____]

☐ Do not distinguish between direct and indirect GME costs.

4. How does your Medicaid program calculate GME payments under FFS?
Check all that apply

NOTE: If you checked more than one method of payment for hospitals *or* other teaching provider, use the "Explain" area below to specify which method(s) apply to: **a)** payments for direct *and/or* indirect costs; **b)** base rate *and/or* supplemental/separate payments.

☐ Medicare method for hospitals.

☐ Modified Medicare method for hospitals.

☐ Per Medicaid Discharge method for hospitals.

☐ Per Resident method for hospitals *or* other teaching provider.
[*Specify provider type:* _____]

☐ Other method for hospitals *or* other teaching provider.
[*Specify method, provider type:* _____]

Explain: _____

_____

_____

_____

_____

5. How does your Medicaid program distribute GME payments under FFS?
Check all that apply

☐ Payment as part of the base rate for hospitals.

☐ Payment as part of the base rate for other providers (e.g., FQHCs).
[*Specify provider type:* _____]

☐ Supplemental payment:
Check all that apply

- ☐ To teaching hospitals under their upper-payment limit (UPL).
- ☐ To teaching hospitals deemed disproportionate share hospitals (DSH).
- ☐ To teaching hospitals and other providers using an uncompensated care pool (UCP) authorized by a federal waiver.
- ☐ To teaching physicians. [for services associated with supervising residents at a state university hospital or medical school]
- ☐ To other teaching provider. [*Specify type:*_____]

☐ Separate (nonsupplemental) payment. [*Specify provider type:* _____]

MANAGED CARE PAYMENTS

6. Does your Medicaid program operate a comprehensive, risk-based managed care delivery system?

☐ Yes

☐ No *Proceed to* ***Question 11***

7. Under your managed care program, does Medicaid make GME payments either directly to teaching hospitals *(or other teaching providers)* or to managed care organizations (MCOs) as part of their capitated rates?

☐ Yes

☐ No *Proceed to* ***Question 11***

8. Under managed care, does your Medicaid program pay for:
Check all that apply

☐ Direct costs of GME.
[*Define if different than under FFS:* _____]

☐ Indirect costs of GME.
[*Define if different than under FFS*: _____]

☐ Do not distinguish between direct and indirect GME costs.

9. How does your Medicaid program calculate GME payments under managed care?
Check all that apply

NOTE: If you checked **more than one** method of payment for hospitals *or* other teaching provider, use the "Explain" area below to specify which method(s) apply to payments for direct *and/or* indirect costs.

☐ Payment included in MCO capitation and negotiated by provider.

☐ Medicare FFS method for hospitals.

☐ Per Medicaid Managed Care Discharge method for hospitals.

☐ Per Resident method for hospitals *or* other teaching provider.
[*Specify* provider type: _____]

☐ Other method for hospitals *or* other teaching provider.
[*Specify method, provider type:* _____]

Explain: _____
_____
_____
_____
_____

10. How does your Medicaid program distribute GME payments under managed care?
Check all that apply

☐ Direct payment to the hospital *or* other teaching provider.
[*Specify provider type(s):* _____]

☐ As part of the capitated rates paid to MCOs, **for which:**

☐ Medicaid **requires** MCOs to pay the hospital *or* other teaching provider* for their GME costs.
Check one of the following:

☐ Medicaid provides MCOs a specific methodology for determining GME add-on payments. [*Specify:* _____]

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

☐ Medicaid **assumes** MCOs reflect GME costs in their payments to the hospital *or* other teaching provider,* but does **not** require them to do so.

*Specify provider type(s) paid by MCOs: _____.

PAYMENTS UNDER FFS AND/OR MANAGED CARE

11. In the past year, has your Medicaid program considered discontinuing payments for GME?

☐ Yes *Proceed to* ***Question 11a***

☐ No *Proceed to* ***Question 12***

☐ No GME payments are made under FFS or managed care. *If you checked this response, you have completed the survey.* ***Thank you.***

11a. If YES, what is the rationale as you understand it 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.

☐ Other. [*Describe*: _____]

12. What sources are used to finance the non-federal (state) share of Medicaid GME payments?
Check all that apply

☐ State general fund revenue.

☐ Local government contributions (using IGT or CPE).

☐ Provider taxes. [*Specify provider type:* _____]

13. What teaching providers are eligible to receive Medicaid GME payments?
Check all that apply

NOTE: Use the "Explain" area below to specify if these providers are eligible under FFS *and/or* managed care. Also, *if applicable,* indicate the: a) eligible types of teaching hospitals *and/or* community-based providers; b) participation requirements *for* teaching physicians.

☐ Teaching hospitals.

☐ Community-based providers with approved training programs. (e.g., FQHCs, behavioral health centers)

☐ Teaching physicians. [for services associated with supervising residents in conjunction with patient care]

☐ Other. (e.g., medical schools) [*Specify:* _____]

Explain: _____
_____
_____
_____
_____

14. Does your Medicaid program designate the specialty *or* specialties of physician residents that are covered by some or all GME payments?

☐ Yes *Answer* ***Question 14a***

☐ No *Proceed to* ***Question 15***

14a. If yes, which physician specialty or specialties are designated?

Check all that apply

NOTE: Use the "Explain" area below to indicate if the specialty or specialties designated apply to payments: **a)** under FFS *and/or* managed care; **b)** for existing *and/or* expansion resident positions; **c)** for resident positions in rural or medically underserved areas.

☐ Primary Care. [*Specify specialties if designated:* _____]

☐ Psychiatry.

☐ General Surgery.

☐ Other. [*Specify:* _____]

Explain: _____

_____

_____

_____

_____

15. Do Medicaid GME payments cover training costs for health professions other than physician residents?

NOTE: If yes, use the "Explain" area below to specify: **a)** the professions *(and education level if applicable);* **b)** the training setting *(e.g., hospitals);* **c)** if payments are under FFS *and/or* managed care.

☐ Yes

☐ No

Explain: _____

_____

_____

_____

_____

16. Does your Medicaid program have a federal demonstration waiver (approved or pending) **that specifically governs the design and/or execution of GME payments?**

☐ Yes *Answer* ***Question 16a***

☐ No *Proceed to* ***Question 17***

16a. If yes, briefly describe (or upload a file with) the waiver's special terms and conditions that pertain to GME payments.

_____

_____

_____

_____

17. Does your Medicaid program require hospitals and other teaching providers to report data on physician residents covered by your GME payments?

☐ Yes *Answer* ***Question 17a***

☐ No *Proceed to* ***Question 18***

17a. If yes, what data on these residents are reported?

Check all that apply

☐ Count (number or FTE).

☐ Specialty.

☐ Year of training.

☐ Location of training.

☐ Other. [*Specify:* _____]

18. Does your Medicaid program document and report to state authorities the outcomes of GME payments on the supply and distribution of the state's health care workforce?

☐ Yes *Answer* ***Question 18a***

☐ No *Proceed to* ***Question 19***

18a. If yes, what data on the residents you cover are used to indicate the outcomes of GME payments?
Check all that apply

☐ All resident positions (unspecified).

☐ New positions *and/or* residencies.

☐ Positions by specialty/subspecialty.

☐ Positions trained in hospital *vs.* community settings.

☐ Positions trained in primary care *and/or* other high-need specialties.

☐ Positions trained in rural *or* medically underserved areas.

☐ Residents that go on to serve Medicaid beneficiaries in practice.

☐ Residents that go on to practice in a rural *or* medically underserved area.

☐ Residents that go on to practice in the state.

☐ Other data on residents. [*Specify*: _____]

19. Does your Medicaid program require hospitals and other teaching providers to report their direct GME costs?

☐ Yes *Proceed to* ***Question 20***

☐ No *Answer* ***Question 19a***

19a. If no, does your Medicaid program obtain these GME costs from other sources (e.g., Medicare cost report)?

☐ Yes

☐ No

20. Does your Medicaid program routinely audit its GME payments to hospitals and other teaching providers?

☐ Yes, *Answer* ***Question 20a***

☐ No, *Proceed to* ***Question 21***

20a. If yes, what is the purpose(s) for conducting these routine audits?
Check all that apply

☐ Identify GME overpayments and underpayments.

☐ Verify that GME payments are made only for specified allowable costs.

☐ Identify *and/or* verify counts of residents supported.

☐ Investigate integrity concerns.

☐ Other. [*Describe:* _____]

PAYMENT AMOUNTS

21. Provide an accounting or best dollar estimate of your state's Medicaid GME payment amounts for SFY 2022.
Specify all applicable payment amounts

NOTE: Include amounts for: **a)** the federal and state share *and* **b)** ALL teaching providers receiving payments.

GME payments under fee for service (FFS): $ _____

GME payments under managed care (MC): $ _____

TOTAL GME PAYMENTS (FFS and MC): $ _____

- Total GME Payments for Direct Costs: $ _____
- Total GME Payments for Indirect Costs: $ _____

For SFY *(if not 2022)*: _____

THANK YOU!

Along with your completed survey, please upload any documentation that provides further detail or explanation about your GME payments. Email the survey and any documentation to Tim Henderson at thender1@gmu.edu.

We will contact you if there are any questions about your responses.

You will receive a copy of the survey report once it is published.

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American Medical Colleges
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23-062 (06/23)