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# Medicaid Graduate Medical Education Payments: A 50-State Survey

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# Medicaid Graduate Medical Education Payments: A 50-State Survey

2016

**Tim M. Henderson, MSPH**  
**Health Workforce Consultant**

Association of American Medical Colleges  
Washington, D.C.

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Questions about the content of this publication may be directed to Merle Haberman, Association of American Medical Colleges, at [mhaberman@aamc.org](mailto:mhaberman@aamc.org), or Tim Henderson, health workforce consultant, at [TimMHend@aol.com](mailto:TimMHend@aol.com).

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## EXECUTIVE SUMMARY

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

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

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

### Key Findings

- Forty-two states and DC made GME payments under their Medicaid program in 2015, the same number as in 2012. Two of the eight states that reported not making GME payments, California and Massachusetts, are among the 10 states with the largest number of GME programs. Moreover, three states reported in 2015 that they had recently considered ending Medicaid GME payments.
- Medicaid remains a major source of funding for GME. In 2015, the overall level of support for GME continued to grow, reaching \$4.26 billion. This represents a significant increase since 1998, when Medicaid GME support totaled \$2.3–\$2.4 billion. However, three states reported in 2015 that they explicitly reduced GME payments; another seven states reported their total 2015 GME payments decreased by 10 percent or more over 2012 levels.
- For the first time in 2015, the proportion of Medicaid GME payments made under managed care (61 percent) was higher than, and significantly exceeded, the proportion of such payments made under FFS (39 percent).
- Under Medicaid FFS, 40 states and DC reported making GME payments, equaling the number of states that reported making such payments in 2012.
- Of the 39 states (and DC) having risk-based Medicaid managed care programs, 69 percent—26 states and DC—made GME payments in 2015 under Medicaid managed care. Of those 26 states, 16 and DC made Medicaid GME payments explicitly and directly to teaching hospitals; 12 states recognized and included such payments in MCO capitation rates. Two states, Georgia and Minnesota, made direct GME payments to teaching programs and included GME payments in MCO rates.

- Although teaching hospitals remained the predominant recipients of Medicaid GME support, medical schools in three states—Minnesota, Oklahoma, and Tennessee—were eligible to receive such payments directly. Two states, Florida and South Carolina, made GME payments to individual teaching physicians.
- In 14 states, nurses and other health professions trainees, as well as medical residents, can have their graduate training subsidized by Medicaid.
- Medicaid programs in 32 states made GME payments with the expectation of producing more physicians, up from 22 states in 2012.

## MEDICAID GME PAYMENTS: A SURVEY OF STATE MEDICAID PROGRAMS

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### Introduction

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

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

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

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

### About the Survey

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

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

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

## Findings

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

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

### GME Payments under Fee-for-Service

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

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

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



### **GME Payment under Risk-Based Managed Care**

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

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

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

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

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

### **Training Institutions and Professions Eligible for GME Payments**

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

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

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

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

### **GME Payments Linked to State Goals**

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

### **Medicaid GME Payment Amounts**

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

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

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

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

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

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

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

#### **Medicaid GME Payments and State Teaching Hospital Capacity**

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

## NOTES

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1. Such funds are non-Medicaid appropriations. Association of American Medical Colleges (AAMC). LCME Part I-Annual Medical School Financial Questionnaire (AFQ), FY2014. Table 1. Washington, DC: AAMC; 2015. [https://www.aamc.org/download/434264/data/fy2014\\_medical\\_school\\_financial\\_tables.pdf](https://www.aamc.org/download/434264/data/fy2014_medical_school_financial_tables.pdf). Accessed March 7, 2016. [Back](#)
2. Kaiser Family Foundation; National Association of Medicaid Directors (NAMD). Medicaid Reforms to Expand Coverage, Control Costs and Improve Care. Washington, DC: Kaiser Family Foundation and NAMD; 2015. <http://files.kff.org/attachment/report-medicare-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicare-budget-survey-for-fiscal-years-2015-and-2016>. Accessed January 22, 2016. [Back](#)
3. Jointly financed by the federal government and individual states (federal government pays at least half the costs), Medicaid is administered by the states that choose to participate (all have done so since 1982) within broad federal guidelines. After meeting federal requirements, states are able to determine key elements of their Medicaid programs, including who is eligible, what benefits are offered (such as payment for GME costs), and how much providers are paid. The result has been wide variation in Medicaid programs across the country. Long-term care services and supports represent at least one-third of Medicaid spending (reflective of the record aging population entering nursing homes), and Medicaid pays for 40 percent of all births in the United States. Snyder L, Rudowitz R. Medicaid Financing. Washington, DC: Kaiser Family Foundation; 2015. <http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>. Paradise J. Medicaid Moving Forward. Washington, DC: Kaiser Commission on Medicaid and the Uninsured (KCMU); 2015. <http://files.kff.org/attachment/issue-brief-medicare-moving-forward>. Accessed January 18, 2016. [Back](#)
4. Medicaid accounts for 19 percent of state general fund expenditures. State and federal Medicaid spending has more than doubled in the past decade, estimated at over \$512 billion in FY 2015. Although Medicaid enrollment growth is expected to slow in FY 2016, total enrollment is predicted to reach 79 million by 2023. National Association of State Budget Officers (NASBO). State Expenditure Report: Examining Fiscal 2013–2015 State Spending. Washington, DC: NASBO; 2015. <https://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202013-2015%29S.pdf>. [Back](#)
5. Kaiser Family Foundation; NAMD. Medicaid Reforms. [Back](#)
6. For those states choosing to participate in Medicaid expansion, the federal government financed 100 percent of the costs during the period 2014–2016, but federal funding will be phased down in 2017. As of January 2016, 31 states and DC had adopted Medicaid expansion. Kaiser Family Foundation. Current Status of State Medicaid Expansion Decisions. Washington, DC: Kaiser Family Foundation; 2016. <http://kff.org/health-reform/slide/current-status-of-the-medicare-expansion-decision/>. <https://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202013-2015%29S.pdf>. Accessed February 4, 2016. [Back](#)
7. Beyond the services that state Medicaid programs are required to cover, states have the option to support additional services such as GME and receive matching federal funds for them. [Back](#)
8. This does not include Medicaid enrollees in less comprehensive managed care arrangements, known as prepaid health plans. Only three states (Alaska, New Hampshire, and Wyoming) report that they do not have any Medicaid managed care. Among the 39 states with risk-based managed care organizations (MCOs) in 2015, 21 states reported that 75 percent or more of their beneficiaries were enrolled in MCOs. In FY 2014, Medicaid MCO spending represented 34 percent (\$162 billion) of total Medicaid spending. Kaiser Family Foundation; NAMD. Medicaid Reforms. Kaiser Family Foundation. Medicaid Managed Care Market Tracker. Washington, DC: Kaiser Family Foundation; 2016. <http://kff.org/data-collection/medicaid-managed-care-market-tracker/>. Accessed February 5, 2016. [Back](#)
9. Paradise J, Musumeci MB. Proposed Rule on Medicaid Managed Care. Washington, DC: KCMU; 2015. <http://files.kff.org/attachment/issue-brief-proposed-rule-on-medicare-managed-care-a-summary-of-major-provisions>. [Back](#)
10. This study examines the special payments that state Medicaid programs make to teaching hospitals and other entities associated with their clinical care and teaching missions. [Back](#)
11. Wisconsin Medicaid did not respond to the AAMC survey. However, at the consultant's request, corresponding survey data from the Wisconsin Medicaid agency were obtained by the Wisconsin Hospital Association (WHA) for use in this report. [Back](#)
12. No attempt was made to verify independently the results of this study. [Back](#)
13. In 2012, Michigan and Tennessee also reported having considered ending GME payments. [Back](#)
14. Such payments may include those made under the state's Medicaid Disproportionate Share Hospital (DSH) program or payments financed by state taxes on hospitals and other Medicaid providers, intergovernmental transfers (IGTs), or certified public expenditures (CPE) used to match the receipt of additional federal funding. For FY 2016, Medicaid provider taxes on hospitals were in place in 39 states and DC. Kaiser Family Foundation; NAMD. Medicaid Reforms. [Back](#)
15. Risk-based managed care is defined as Medicaid's use of capitated payments under contract to managed care organizations and does not include any payments made under a state's primary care case management program model of managed care. KCMU. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. Washington, DC: KCMU; 2015. <http://files.kff.org/attachment/issue-brief-medicare-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts>. Accessed February 6, 2016. [Back](#)
16. Individual teaching physicians eligible to receive GME payments for Medicaid services associated with the cost of instructing medical residents are identified as those employed by or under contract with a medical school in the state that meets participation requirements. [Back](#)
17. U.S. Government Accountability Office (GAO). Medicaid. Washington, DC: GAO; 2012. <http://www.gao.gov/assets/650/649788.pdf>. U.S. Department of Health and Human Services (HHS). Access to Care. Washington, DC: HHS; 2014. <http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>. Accessed February 9, 2016. [Back](#)
18. In 2009, this survey identified DC and 20 states as making Medicaid payments for both direct and indirect GME costs. [Back](#)
19. Arizona, Florida, Georgia, Maryland, Ohio, and Texas reported a total GME payment amount in 2015 but provided no specific breakdown for fee-for-service and/or managed care GME payment amounts. [Back](#)

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

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

Note: MCO = managed care organization.

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

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

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

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

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

*(continued on next page)*

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

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

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

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

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

16. Based on Medicaid utilization and number of medical residents.
17. Per resident amount multiplied by the market basket change and Medicare payment updated for IPPS, then multiplied by number of FTE residents, then multiplied by the Medicaid patient load.
18. Payments are made on a prospective basis as outlined in Medicaid policies.
19. GME payments are an add-on to the case payment rates of teaching hospitals and calculated by dividing the facility's total reported Medicaid GME costs by its total reported Medicaid discharges.
20. A modified Medicare methodology is used to pay hospitals for GME on a prospective basis.
21. Hospitals are allocated a pool of funds by resident-months weighted for Medicaid days and acuity.
22. Eligible providers receive a percentage of funds allocated for GME payments (75 percent) based on inflation adjustments determined in hospital rate agreements. The calculation uses reported cost data from FY 2008 as the base year.
23. Indirect GME cost formula adjusted to include psychiatric and rehabilitation subprovider hospital beds.
24. Lump sum amount based on weighted resident FTE and Medicaid hospital days.
25. Medicare indirect medical education (IME) factor used to calculate add-on payment for IME costs to qualifying urban teaching hospitals.
26. Per resident amount, as a supplemental program in which state teaching institutions provide their own state matching share. Medicaid's rate analysis does not determine the rationale for inclusion or exclusion of GME payments; this is determined through legislative authority.
27. See Utah State Plan Attachment 4.19-A. Inpatient Hospital. Utah Department of Health; 2002. [http://www.health.utah.gov/medicaid/stplan/A\\_4-19-A.pdf](http://www.health.utah.gov/medicaid/stplan/A_4-19-A.pdf).
28. Based on the Medicare cost report and Medicaid hospital days.
29. GME paid per enhanced ambulatory patient group (EAPG) line of a hospital's claim.
30. Modified Medicare methodology.
31. GME costs are a percentage add-on to the hospital rate based on the ratio of GME costs to total hospital operating costs. A modified Medicare methodology is used.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: MCOs = managed care organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Table 10. Medicaid GME Payment Amounts, 2015**

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

(continued on next page)



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

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

Notes:

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

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

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

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

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

Notes:

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

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

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

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

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

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

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

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

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

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

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

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

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

Note: NA = not available.

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

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

## MEDICAID GME SURVEY INSTRUMENT



### MEDICAID PAYMENT POLICY: GRADUATE MEDICAL EDUCATION

State: \_\_\_\_\_ Date Completed Survey: \_\_\_\_\_

Respondent Name/ Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

**DEADLINE TO RETURN COMPLETED SURVEY:** \_\_\_\_\_

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

### FEE-FOR-SERVICE PAYMENTS

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

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

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

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

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

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

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

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

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

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

**a. Calculate Payments**

*(Check all that apply)*

- Follow Medicare methodology;  
 Other, Please describe \_\_\_\_\_)

**b. Distribute Payments**

*(Check all that apply)*

- As part of the hospital's per-case or per-diem rate;  
 As a separate direct payment (monthly, quarterly, etc.);  
 Considered special or supplemental (such as DSH; payments funded by provider taxes, inter-governmental transfers (IGTs), certified public expenditures (CPE), etc.)  
 Other (Specify: \_\_\_\_\_)

**4. Under your FFS system, do GME payments cover training costs for:**

*(Check all that apply)*

- Physician Residents  
 Graduate Nursing Students  
 Other Health Professional Trainees (Specify: \_\_\_\_\_)

### MEDICAID MANAGED CARE PAYMENTS

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

YES  NO

*If you answered NO, proceed to [Question 11](#).*

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

YES  NO

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

**a. If YES, describe the rationale as you understand it for making these GME payments:**

*(Check all that apply)*

- GME seen as a public good;  
 Follow Medicare's decision to make explicit GME payments to teaching hospitals for managed care enrollees;  
 Concern from teaching hospitals about losing GME payments;  
 Desire to use Medicaid funds to advance state policy goals;  
 Desire to help train the next generation of physicians who will serve Medicaid beneficiaries;  
 Other (Describe: \_\_\_\_\_)

**b. If NO, describe the rationale as you understand it for not making GME payments:**

*(Check all that apply)*

- Medicaid payment for GME under managed care is not necessary or appropriate;  
 GME payments under managed care are not a pressing policy issue among many competing issues;  
 Difficulty determining methodology to pay for GME under managed care;  
 Opposition by managed care plans to having GME payments go to teaching hospitals;  
 Medicaid historically paid for GME, but recent budget shortfalls or cost controls no longer allow payment;  
 Other (Describe: \_\_\_\_\_)

*If you answered Question 6b., proceed to [Question 11](#).*

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

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

**How does your Medicaid managed care program calculate GME payments?**

*(Check all that apply)*

- Follow Medicare FFS methodology;  
 On a per Medicaid managed care discharge basis;  
 Payment included in capitation and negotiated by the provider  
 Other (Specify: \_\_\_\_\_)

**8. Under managed care, how does your Medicaid program distribute GME payments to teaching hospitals or other entities?**

*(Check all that apply)*

- a.  Medicaid makes a separate direct payment (per-case or per-diem, monthly, quarterly, etc.) to the hospital or other teaching entity
- b.  Medicaid requires managed care organizations (MCOs) to pay the hospital (or other teaching entity) for GME costs as part of the hospital's per-case, per-diem rate or bundled rate;

*If so, check one of the following:*

- Medicaid provides MCOs a specific methodology for determining GME add-on payments;  
 Medicaid does not provide MCOs a methodology for determining GME add-on payments.

Explain: \_\_\_\_\_

- c.  Medicaid assumes MCOs reflect GME costs in their payments to hospitals (or other teaching entities), but does not require them to do so.
- d.  Medicaid makes special or supplemental payments (such as DSH; ones funded by provider taxes, inter-governmental transfers (IGTs), certified public expenditures (CPE), etc.)
- e.  Other (Specify: \_\_\_\_\_)

**9. What institutions are eligible to receive GME payments under Medicaid managed care?**

*(Check all that apply)*

- Teaching hospitals;  
 Teaching sites in non-hospital patient care settings (such as ambulatory sites, managed care plans, etc.);  
 Medical schools;  
 Other institutions (Specify: \_\_\_\_\_)

**10. Under Medicaid managed care, do GME payments help cover training costs for:**

*(Check all that apply)*

- Physician Residents  
 Graduate Nursing Students  
 Other Health Professional Trainees (Specify: \_\_\_\_\_)



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

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

a. If YES, describe the rationale for *considering* discontinuation of GME payments:

(Check all that apply)

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

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

YES  NO  
(Answer 12a)

### USE OF GME PAYMENTS TO ACHIEVE STATE POLICY GOALS

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

YES  NO

### MEDICAID GME PAYMENT AMOUNTS

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

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

*(Complete all that apply)*

Under Fee for Service (FFS): \$ \_\_\_\_\_

Under Managed Care (MC): \$ \_\_\_\_\_

FFS/MC Combined: \$ \_\_\_\_\_

For FY (if not 2014): \_\_\_\_\_

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

\_\_\_\_\_ % of Inpatient Hospital Medicaid expenditures

*THANK YOU FOR YOUR ASSISTANCE.*

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

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



**Association of  
American Medical Colleges**

655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399

T 202 828 0400

[www.aamc.org](http://www.aamc.org)