



# Understanding Medicaid's Role in Graduate Medical Education

National Conference of State Legislatures

May 12, 2023

# Agenda



Understanding Graduate Medical Education  
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State Respondent: Florida  
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State Respondent: New Mexico  
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Audience Q&A

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# Lessons Learned from States Leveraging Medicaid Funds to Support Graduate Medical Education

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NCSL Medicaid GME Webinar

May 12, 2023



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HEALTH SERVICES RESEARCH**

# Acknowledgments

## Collaborators

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- Tom Bacon, DrPH
- Emily Hawes, PharmD BCPS, CPP
- Julie Spero, MSPH

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# This presentation in one slide

- Redesigning GME funding is hard—can be like touching the 3<sup>rd</sup> rail
- What it takes:
  - Data agitators
  - Champions and implementers
  - Oversight bodies
  - Payment reform
  - Transparency
  - Accountability
  - Workforce data and analytics
  - Patience



[Electric Third Rail Do Not Enter](#) by [Richard Masoner](#) used under [CC BY](#)

# Medicaid GME Funding is More Flexible than Medicare Funding

## Medicare GME

- GME funded through a formula based on hospital costs from the 1980s
- The number of resident positions supported by Medicare GME is fixed
- Changes to Medicare GME require an act of Congress

## Medicaid GME

- GME funded based on a payment formula designed by the state
- Medicaid GME is flexible—can be altered with CMS approval

# Why Should States Care about Leveraging Medicaid funding for GME?

- Federal GME reform efforts have stalled
- In past 20 years, state Medicaid GME payments have more than doubled
- In 2018, Medicaid GME payments totaled nearly \$5.6 billion—an amount second only to Medicare
- States are “policy laboratories” for GME innovation





# Study Aims

- In 2015-16, we undertook a study to investigate how states are using Medicaid funding to support GME
- In 2020-21, we updated earlier study
- Conducted interviews to understand states':
  - impetus for using Medicaid funds for GME
  - structure of GME payments
  - composition and charge of advisory bodies
  - degree of transparency and accountability to track whether Medicaid GME investments achieved desired workforce outcomes



# States in Our Sample

## **Study 1 (2015-2016)**

Michigan  
Minnesota  
Montana  
Nebraska  
Nevada  
New Mexico  
**New York**  
**Ohio**  
South Carolina  
Virginia

## **Study 2 (2020-2021)**

**Florida**  
Michigan  
Minnesota  
Montana  
Nebraska  
Nevada  
New Mexico  
South Carolina  
Virginia  
**Wisconsin**



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# Lesson #1: Impetus for Medicaid GME Reform is State Specific

States used Medicaid GME to:

- Expand workforce supply in primary care, behavioral health and specialties
- Address maldistribution of physicians by geography, setting, and specialty
- Meet needs of growing population and expansion of undergraduate medical education
- Offset potential loss of Teaching Health Center funds
- Develop and sustain new residency programs, particularly in underserved areas



## Illustrative quote

“They commissioned a group to do a forecast of physician needs and potential shortages in the state, and out of that came some pretty interesting data...the areas that they identified were pretty starkly described in terms of the number of physicians we are going to need and the forecasted shortages of those physicians”



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## Lesson #2: Need a GME champion and a plan to educate policy makers (repeatedly!)

- Many states had “champion” who articulated vision, coalesced stakeholders and worked with executive/legislative branches
- Many had “implementer” who focused on logistics of changing GME payment mechanism, applying for 1115 waiver or revising State Plan Amendment
- States often struggle to keep momentum when there is leadership turnover
- Keep re-educating policy makers how it works, why it is important and what needs to change
  - Every state needs a basic primer on GME. See example from Michele L. Chesser

<https://public3.pagefreezer.com/content/health-resources-and-services-administration/11-08-2022T12:49/https://www.hrsa.gov/sites/default/files/advisorycommittees/cogme/COGME%20Meetings/2016/20160407-chesser.pdf>



## Lesson #3: States are Designing GME Investments to Meet Changing Needs

- Flexibility in Medicaid GME allows states to design to address specific population health and workforce needs
- State appropriations and Medicaid funds are being combined to:
  - Provide technical assistance to enhance capacity to start and expand existing programs
  - Fund new residency programs in areas of need and community-based settings
  - Sustain existing residency programs



## Illustrative Quote

“I'd like to say I really like our program. I like how flexible it is. I like that if a facility increases or decreases their programs that it'll be reflected in their reimbursement. Compared to Medicare GME, I think our program is more reactive and proactive in reflecting their actual programs”



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# Lesson #4: Advisory bodies can play a critical role

- Most states had an advisory body with diverse range of stakeholders to:
  - Reach consensus on state workforce needs
  - Decide where funds should be targeted
  - Educate legislature and DHHS about GME
  - Navigate competing interests of stakeholders
- Some states have formed consortia:
  - In one state, consortium serves as the sponsoring entity, funded by medical schools and the state medical society
  - In another state, consortium has been driving force for equitable GME funding, and support for expanding residencies in underserved areas





## Illustrative Quote

“We're going to have to play together because this is everyone's problem, and so it became a group championing the effort as opposed to one or two organizations or one or two schools or something like that. We wanted to keep consensus and show that even though a pot of money would potentially land on the floor that we weren't going to pull out knives and swords and start fighting each over scarce resources”



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## Lesson #5: We heard loud call for increased transparency

- States voiced desire to increase transparency about how GME dollars were spent and “what they bought”
- Emphasized that little transparency currently existed
- In few states that had published data, transparency spurred reform
- Interviewees repeatedly noted that training institutions in their state benefited from the lack of transparency and, in many cases, vigorously opposed increasing accountability



## Illustrative Quote

“We’re not collecting data on what kinds of residents and interns are funded and what their specialties are...We’re not capturing information that we could even use to estimate how we would possibly revise our formula and maybe pay a higher per resident amount for certain specialties compared to others.”



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## Lesson #6: We heard loud call for increased accountability

- States were focused on fiscal accountability for Medicaid funds, not workforce outcomes
- Voiced strong desire to move toward system that better aligned funding with population health needs
- Cautious about how much training programs could be held accountable for workforce outcomes given influence of other forces on trainees' practice decisions
- One state created Workforce Council to identify outcomes, data needed and system to measure program's accountability, including location of graduates



## Two Illustrative Quotes

“I think we need to be more responsible stewards for that money spent for the state”

You can't throw \$180 million at a problem and then not expect there to be some kind of outcomes, especially now that we're dealing with COVID and the state budgets...we're going to have to start looking at where these people are training or practicing and seeing whether it's addressing the problem.”



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# Lesson #7. Lack of data and metrics are barrier to measuring workforce outcomes

- Workforce data collection and analysis seen as critical to demonstrate ROI when seeking new GME appropriations
- But most states noted lack of workforce data as barrier to measuring outcomes
- Interviewees voiced need for financial support and technical assistance to develop workforce data and analytical capacity
- Developing and operationalizing metrics that can be tied to funding decisions is challenging



# Two Illustrative Quotes

“Connecting the dots precisely gets tricky”

And I know one thing that we're still looking at is this whole issue about more or less return on investment and accountability and standards and metrics and health outcomes. And to this day, unfortunately, when the group does convene...I feel like we have these same conversations, but nothing has pressed forward because it's such a political thing”



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# Lesson #8: GME reform requires perseverance and patience

- State-level GME reform likely to continue to progress but slowly
- As one interviewee put it “This is a simmer process. This isn’t a microwave process”





# Conclusions

- States are using Medicaid funds to design GME to meet state-specific needs
- Better data collection, analysis and metrics to measure workforce outcomes are needed
- States need forum to share share best practices and strategies for overcoming challenges in modifying SPAs, collecting data to target funding and evaluate workforce outcomes.
- Enhanced coordination with federal efforts—HRSA’s Rural Residency Program Development Program and Teaching Health Center Program—could help states overcome funding and technical assistance barriers



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# Dr. Joan St. Onge

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# Medicaid Funding to Expand GME: The Florida Experience

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# Disclosures

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Nothing to disclose.

# Thank you

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Terry Meek, Executive Director, Council of Florida Medical School Deans

Alma Littles, M.D., Interim Dean, Florida State University College of Medicine

Cindy Kynoch, Florida Medical Association

Mary Thomas, Florida Medical Association

Lindy Kennedy, President, Safety Net Hospital Alliance

# Development of the Case for GME Expansion

1970s and 1980s: Community Health Education Program (CHEP) directly funds primary care residency programs

Late 1990's: Council of Florida Medical School Deans

2001: Florida State University College of Medicine first entering class



1996: Florida Health Services Corps to encourage physicians to work in rural and underserved areas ceases.

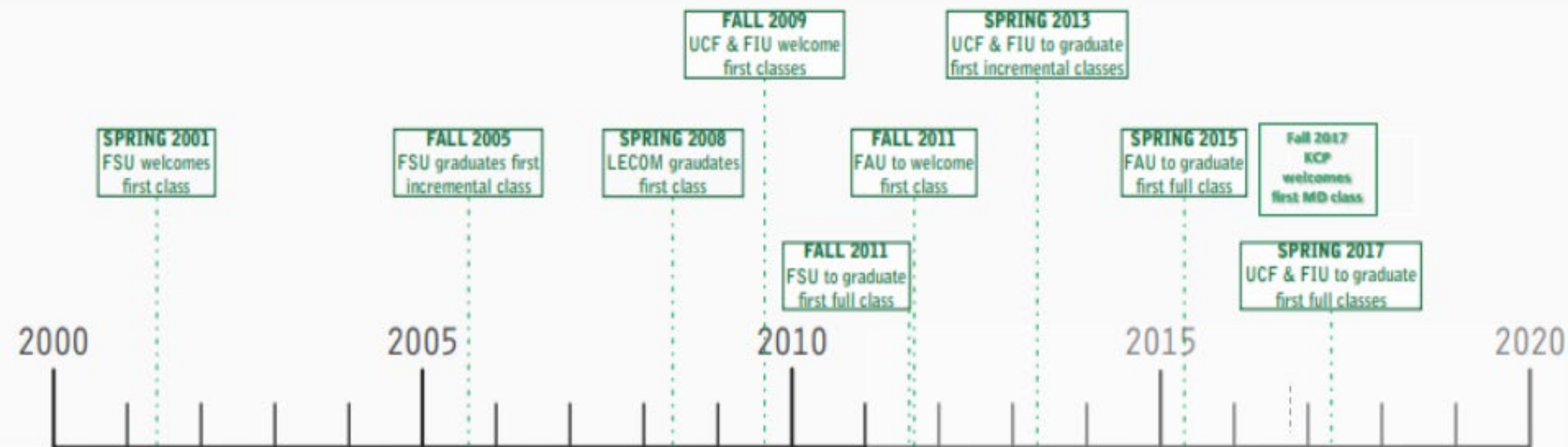
2001: CHEP Program funding folded into Medicaid budget. IGTs allow for more funding, but directly to hospitals.

2004: State University System, Legislature commission a study on medical education





# New Medical School Development



**6 new medical schools since the CEPRI report**

# Development of the Case for GME Expansion

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**2007: Licensure Survey**



**2010: Florida Physician Workforce Advisory Council**



**2013: Teaching Hospital Council of Florida and Safety Net Hospital Alliance of Florida Physician Workforce Study**

# Florida Workforce Study: 2013

## Study Sponsors

**The Teaching Hospital Council of Florida** was founded in 1989, and includes Florida's first teaching hospital that has been training physicians for almost 100 years. Last year, Council member hospitals trained 3,392 medical residents in 268 accredited programs around the state, accounting for 66 percent of Florida's graduate medical education (GME) programs.

*Broward Health | Jackson Health System | Mount Sinai Medical Center | Orlando Health  
UF Health Shands Hospital | UF Health Jacksonville | Tampa General Hospital*

**The Safety Net Hospital Alliance of Florida** includes all members of the Teaching Hospital Council of Florida, and advocates on behalf of its 14 members that are teaching, public, children's and regional perinatal intensive care hospitals. The Alliance members provide the most highly specialized medical care in Florida. Last year, the Safety Net Alliance member hospitals trained 3,646 medical residents in 292 accredited programs around the state, accounting for 72 percent of Florida's graduate medical education programs.

*All Children's Hospital | Broward Health*

*Halifax Health | Jackson Health System | Lee Memorial Health System*

*Memorial Healthcare System | Miami Children's Hospital | Mount Sinai Medical Center*

*Orlando Health | Sacred Heart Health System | Sarasota Memorial Health Care System*

*Tampa General Hospital | UF Health Jacksonville | UF Health Shands Hospital*

## The Research Organization



IHS Global is a leading provider of information, insights and analytics in critical areas that business and academic leaders rely on to make high-impact decisions and develop strategies with speed and confidence.

## Regional Findings

### 2025 Physician Deficits by Specialty & Region (Percentages)

Specialty	Medicaid Region											State
	1	2	3	4	5	6	7	8	9	10	11	
Psychiatry	-51%	-46%	-34%	-108%	-47%	-38%	-122%	-65%	-56%	-61%	-22%	-55%
General Surgery	-17%	-14%	-75%	-46%	-70%	-22%	-47%	-107%	-73%	-74%	-26%	-50%
Rheumatology	0%	-225%	-131%	-139%	-24%	-60%	-153%	-32%	2%	-32%	10%	-43%
Allergy, Immunology, & Infectious Diseases	-32%	-78%	-71%	-5%	-3%	2%	1%	-51%	-63%	-33%	15%	-17%
Thoracic Surgery	-333%	-33%	-6%	-86%	-4%	-29%	-55%	-57%	-30%	-88%	-13%	-38%
Hematology & Oncology	-79%	-214%	-11%	-35%	-40%	-11%	-73%	-97%	-54%	-8%	-5%	-36%
Pulmonology & Critical Care	-68%	-185%	-37%	-36%	-44%	-67%	-84%	-63%	-2%	16%	-1%	-32%
Radiology	-61%	-71%	-40%	-14%	-24%	-13%	-37%	-97%	-35%	-7%	-3%	-29%
Cardiology	-81%	-100%	-47%	-39%	-14%	-43%	-33%	-34%	-15%	-10%	10%	-25%
Anesthesiology	-3%	-113%	-35%	-20%	-47%	-14%	-42%	-107%	-22%	20%	-4%	-23%
Endocrinology	-229%	-340%	-67%	-7%	0%	-91%	-8%	-94%	6%	15%	13%	-19%
Obstetrics/Gynecology	-13%	-44%	-90%	-18%	-26%	-16%	-34%	-57%	-6%	17%	4%	-18%
Orthopedic Surgery	6%	-25%	-78%	-47%	-8%	-21%	-32%	-27%	8%	7%	1%	-17%
Ophthalmology	-96%	-58%	-43%	-50%	4%	-7%	-41%	8%	6%	-5%	-2%	-15%
Otolaryngology	0%	-26%	-55%	-21%	-9%	-26%	-28%	-14%	16%	-28%	-5%	-15%
Urology	-20%	-17%	-21%	-48%	-17%	-4%	-12%	-21%	-3%	-15%	-10%	-15%
General/Family Practice	7%	7%	-29%	10%	15%	-37%	-7%	-54%	-56%	-17%	1%	-13%
Nephrology	-257%	-29%	7%	15%	13%	-4%	4%	-27%	-42%	25%	-17%	-4%
Neurology	-17%	-42%	-21%	11%	-22%	-1%	-18%	-18%	-12%	4%	24%	-4%

■ Demand is Greater Than Supply by 20% or More

■ Demand is Greater Than Supply by 10-19%

■ Demand is Greater or Less Than Supply by 9%

■ Demand is Less Than Supply by 20% or More

## Legislative and Regulatory Changes

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2014: The Graduate Medical Education (GME) Statewide Medicaid Residency Program expands

- Specifically identified Medicaid support for GME funding
- Per resident amount based upon Medicaid based formula.
- \$80 Million per year initially, increased to \$93 Million
- Legislature recently approved additional \$97 Million

# Graduate Medical Education Statewide Medicaid Residency Program

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Total allocation based upon the hospital's number of full-time equivalents and the amount of its Medicaid payments.

Full time equivalent (FTE) count:

- Each resident in their “Initial Residency Period” up to 5 years, counted as 1.0 FTE
- After Year 5, each resident is calculated at 0.5 FTE
- Exceptions to the 0.5 FTE count:
  - Family medicine; General internal medicine; General pediatrics; Preventive medicine; Geriatric medicine; Osteopathic general practice; Obstetrics and gynecology; Emergency medicine; General surgery.

# Calculation of a Hospital's Allocation

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The agency shall use the following formula to calculate a participating hospital's allocation fraction:

$$\text{HAF} = [0.9 \times (\text{HFTE}/\text{TFTE})] + [0.1 \times (\text{HMP}/\text{TMP})]$$

Where:

HAF=A hospital's allocation fraction.

HFTE=A hospital's total number of FTE residents.

TFTE=The total FTE residents for all participating hospitals.

HMP=A hospital's Medicaid payments.

TMP=The total Medicaid payments for all participating hospitals.

# Legislative and Regulatory Changes

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## 2015-16: Graduate Medical Education Startup Bonus Program

- \$100,000 per newly approved residency position approved through the ACGME or OPTI, the accrediting bodies for residency programs.
- \$100 Million: funded through IGTs
- <https://www.flsenate.gov/laws/statutes/2015/409.909>

## 2021: Florida Medicaid IME

- ~\$328 Million through Intergovernmental transfers (IGTs)
- Available to statutory teaching hospitals, public hospitals and children's hospitals
- The funding includes both IGTs and federal dollars.



# Graduate Medical Education Startup Bonus Program 2015-16

The Graduate Medical Education Startup Bonus Program was established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit.

- First allocation to hospitals with newly approved residency or fellowship positions in shortage specialties
  - Start-up funding to cover initial costs of new residency position
- Remainder of funds
  - Support for the maintenance of existing training in shortage specialties
  - Two hospitals who have the most trainees in the shortage specialties.

# List of specialties supported in GME Startup Bonus Program

Allergy or Immunology

Anesthesiology

Cardiology

Endocrinology

Family Medicine

Gastroenterology

General Internal Medicine

Geriatric Medicine

General Surgery

Hematology

Infectious Diseases

Neonatology

Nephrology

Neurology

Obstetrics/Gynecology

Oncology

Ophthalmology

Orthopedic Surgery

Otolaryngology

Psychiatry

Physical Medicine and Rehabilitation

Plastic Surgery

Pulmonary

Radiology

Rheumatology

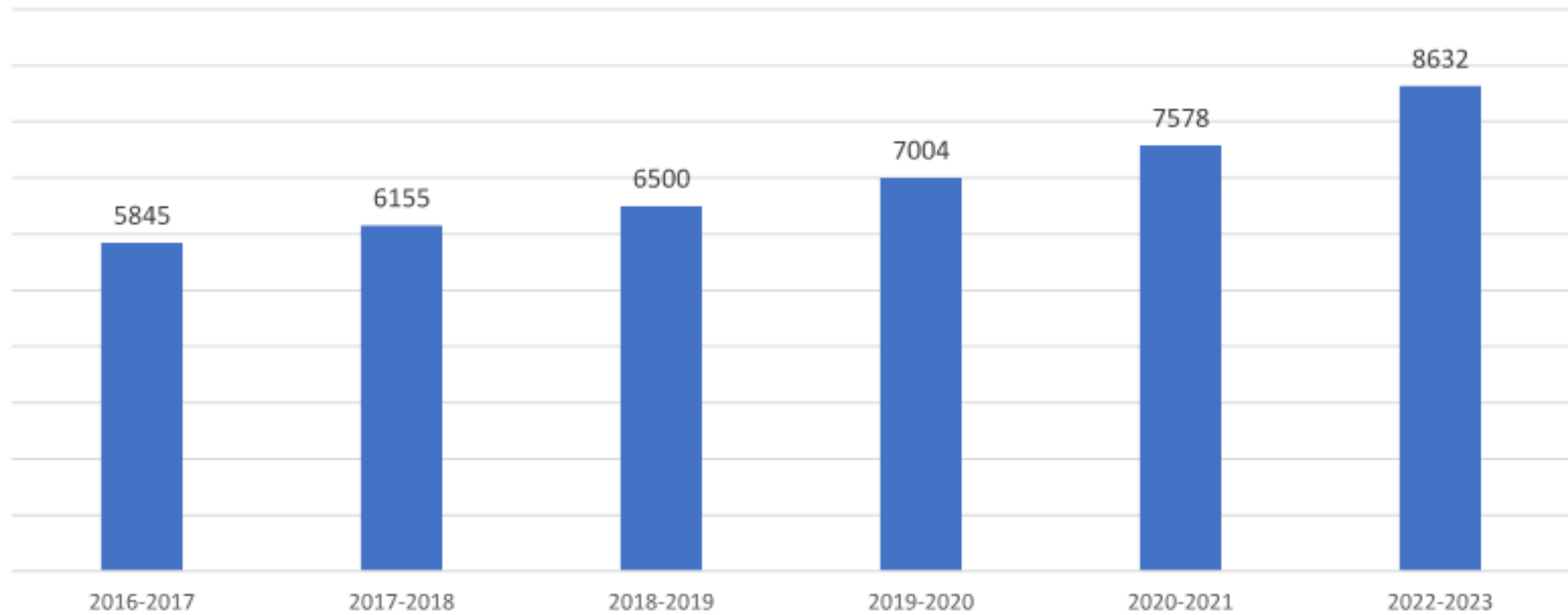
Thoracic Surgery

Urology

Vascular Surgery

# GME Trainees in Florida

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# All specialties 2013-2019

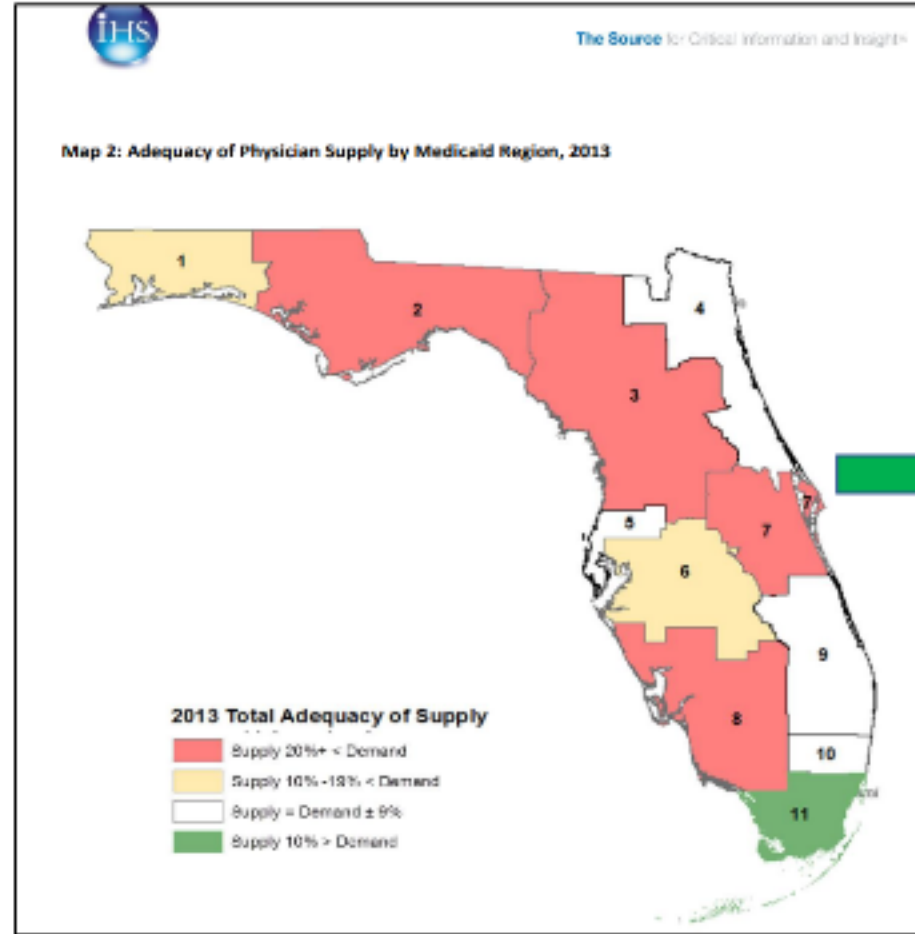
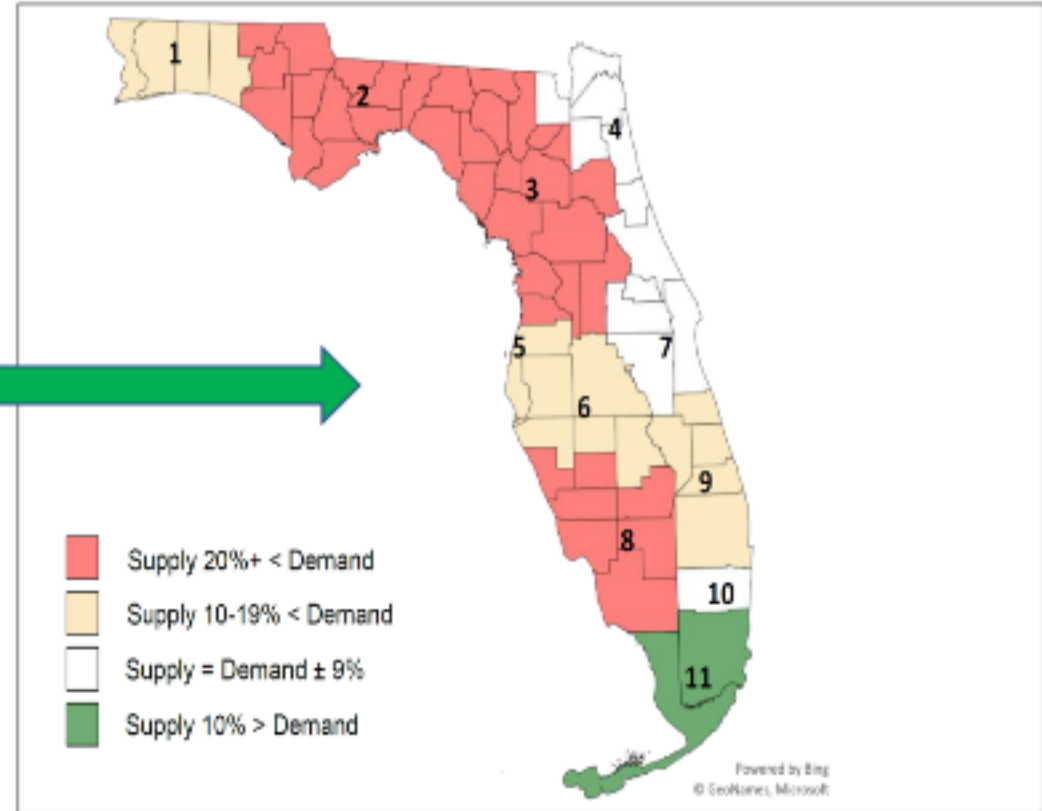


Exhibit 18. Adequacy of Physician Supply by Medicaid Region, 2019



# Non-Primary Care Physicians 2013 and 2019



The Source for Critical Information and Insights™

Map 4: Adequacy of Non-Primary Care Physician Supply by Medicaid Region, 2013

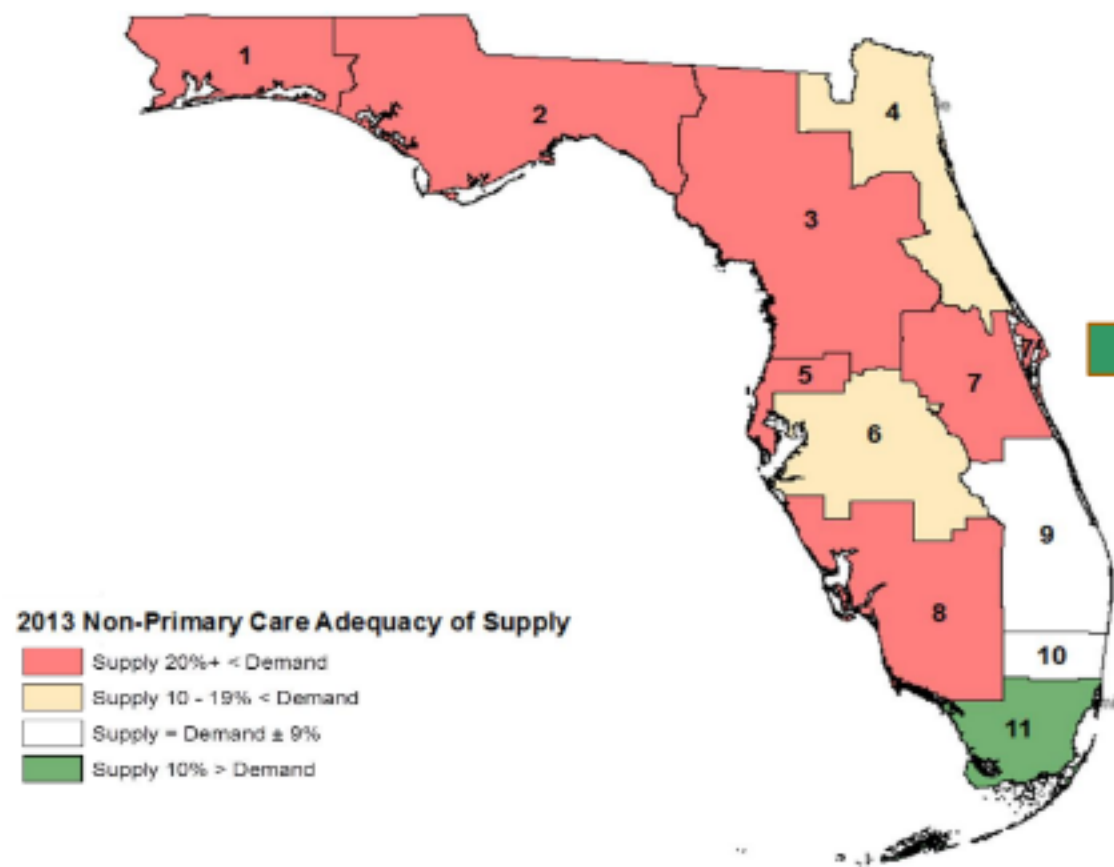
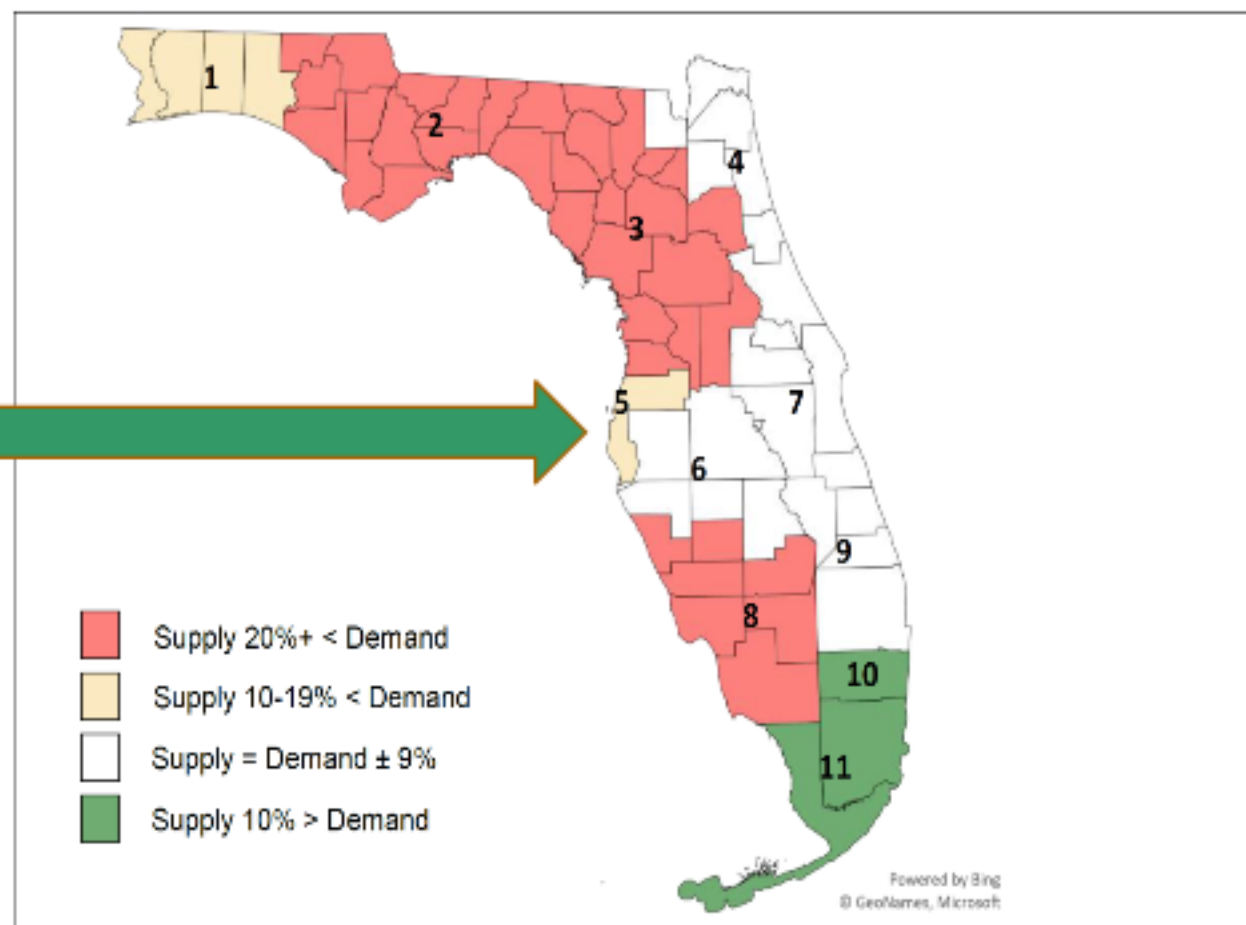


Exhibit 21. Adequacy of Non-Primary Care Physician Supply by Medicaid Region, 2019



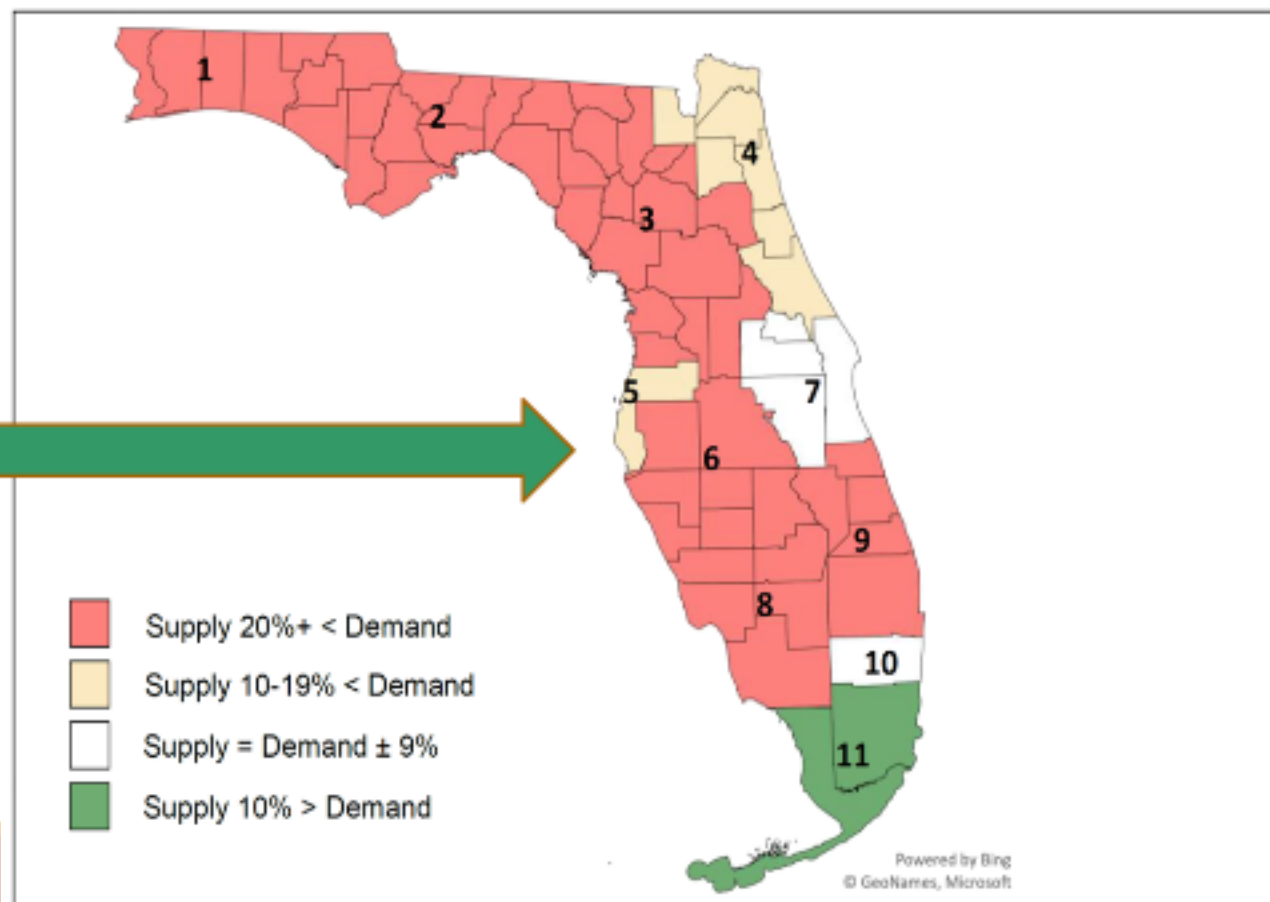
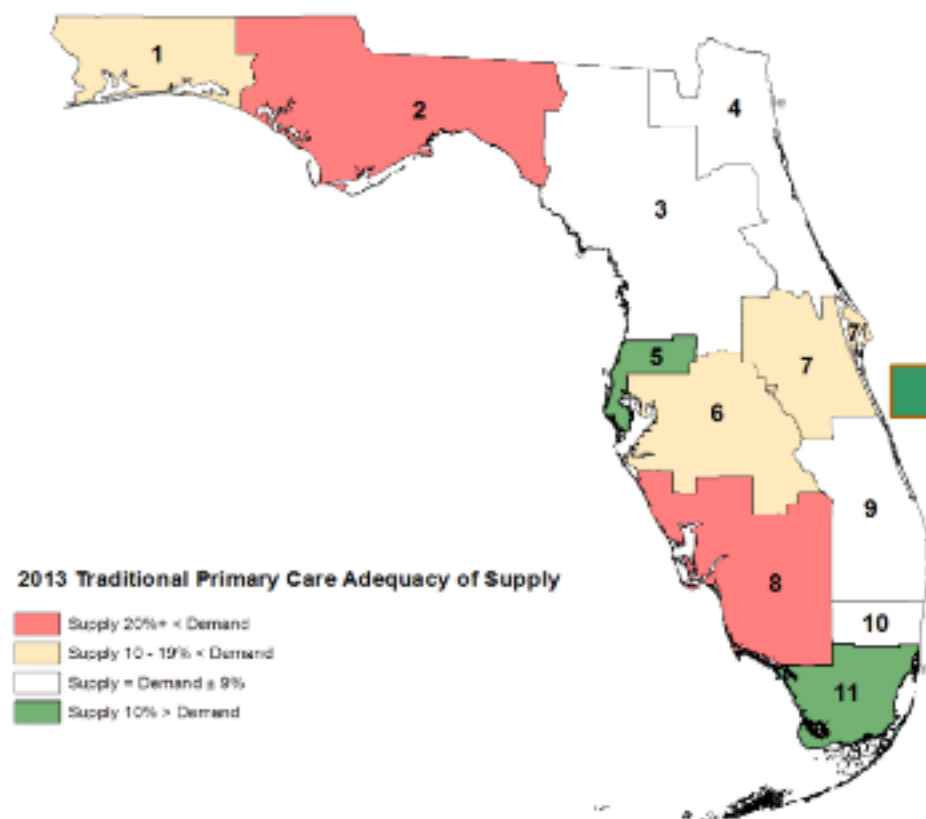
# Primary Care Physicians 2013 and 2019



The Source for Critical Information and Insight™

Exhibit 19. Adequacy of Traditional Primary Care Physician Supply by Medicaid Region, 2019

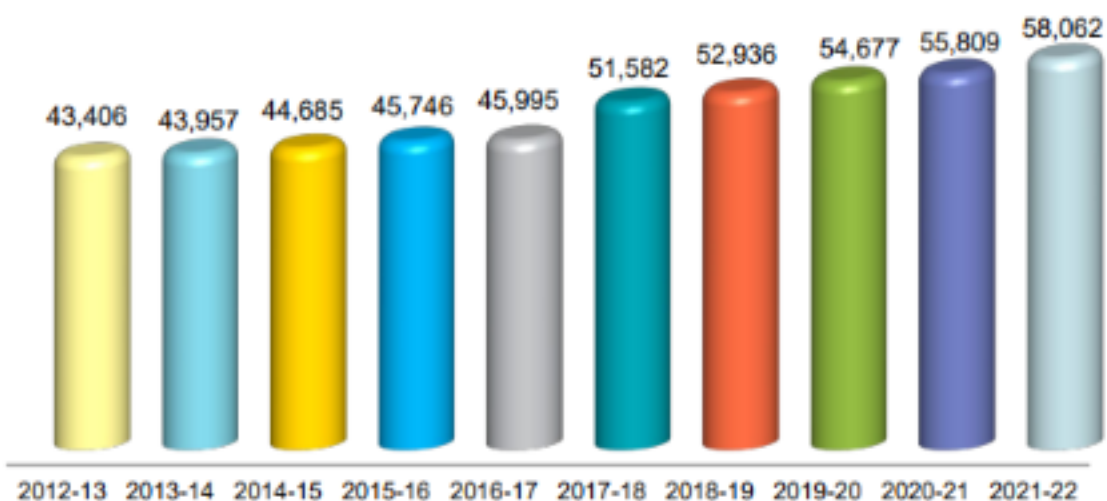
Map 3: Adequacy of Traditional Primary Care Physician Supply by Medicaid Region, 2013



# Florida Department of Health 2022 Physician Workforce Annual Report

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Active Physicians in Florida from 2012-13 to 2021-22



# Other legislative initiatives

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## **Florida Reimbursement Assistance for Medical Education: FRAME**

### Medical Education Reimbursement and Loan Repayment Program

- Aim: to increase primary care physicians and advanced practice providers in underserved communities
- Up to \$20,000 per year for physicians
- Up to \$15,000 per year for advanced practice registered nurses in autonomous practice
- Funding began at \$6 Million per year. Given response, an additional \$10 Million was approved for FY23, and increased to \$16 Million

## **Slots for Docs: \$30 Million**

- Funding for 300 new positions in shortage specialties
- \$100,000 per year for each position.



# Challenges

- Geographic distribution of the workforce
- Diversity of the workforce: aim is to mirror the communities served, which is shown to enhance quality and outcomes
- Quality of the programs: new programs, some without academic affiliation: How to assess quality?
- Tracking graduates of the program
- Specialty choice and addressing changing societal needs and innovation in medicine :
  - Aging population
  - Chronic disease management
  - Precision medicine
  - PRIMARY CARE

*All in the setting of an increasing population*

# Charlie Alfero

Director

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# GME Financing in New Mexico

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# General - State Options for Financing GME

- Direct State General Funds
  - Legislative Appropriations for GME programs are often in the form of Grants to Residency Programs
    - May be limited to state Academic Medical Centers or other publicly operated GME programs
    - No federal matching funds
- Medicaid Options
  - May or may not require legislation to allow state funds to be matched by the federal Centers for Medicare and Medicaid Services (CMS)
  - Requires state funds to be identified in state Medicaid program budget
  - May require an 1115 Waiver by CMS that identifies the role of Medicaid in GME financing
  - May require a State Plan Amendment (SPA)
- 42 States have some form of Medicaid GME financing
  - Unique to states - No overriding federal regulations regarding state GME payment models
  - May use Medicare payment methods as basis for GME payment models
  - May create a unique state program with federal approval for matching funds
- May have programs that support technical assistance, planning and development of residency programs that are federally matched as well.

# New Mexico Medicaid GME Support Program

- NM Human Services Department (NMHSD)- Secretary-level Primary Care Expansion Board since 2019
  - Now integrated with NM Primary Care Council
- NMHSD 5-year Strategic Plan for Primary Care GME Expansion
  - Annual Updates
- Program development technical assistance and residency support systems
  - Contract with the New Mexico Primary Care Training Consortium (501c3) with Board membership representing Medical Schools, Family Medicine and Psychiatry programs
  - Legislatively Appropriated Funds - Federally matched
- Grant Funds
  - Communities, hospitals, Federally Qualified Health Centers, etc. for Residency Planning and Development
  - Annual Application Process
  - Legislatively Appropriated funds
- Medicaid GME Financing and Payments
  - Provides financial incentives for Primary Care residency program growth

# Creative Use of Traditional Payment Models

- Indirect Graduate Medical Payments (IME)
  - Compensates Hospitals for additional residency related costs serving Medicaid patients
  - NM uses federally-determined IME calculations for Hospitals
  - Eligibility
    - Be licensed by the State of New Mexico; and
    - Be reimbursed on a DRG basis under the plan; and
    - Have 125 or more full time equivalent (FTE) residents enrolled in approved teaching programs or operate one or more nationally-accredited residency programs.
  - Quarterly Payments based on Costs Reporting rather than patient payment
- Direct Graduate Medical Education Payments (DGME)
  - Provides uniform Fixed Payments per Resident for Resident and Faculty Salaries, benefits, other direct costs of training based on program start date and specialty.

# Expansion Planning and Development Grant Support Since 2019

- Family Medicine - Espanola (Rural)
- Family Medicine - Las Cruces (Urban) - Alamogordo (Rural)
- Family Medicine - Hobbs (Rural)
- Family Medicine - Santa Fe (Urban / Rural Support)
- Psychiatry - Las Cruces (Urban)
- Psychiatry - Hobbs (Rural)
- Total - \$1.9 Million
- 25 Resident Positions
- Potential New Site Funding 7/1/2023 - Farmington (Remote Urban)

# Highlights of Significant GME Improvements effective 7/1/2020 - SPA

- IME
  - Historically only UNM received IME Payments due to resident FTE minimum
  - Added all ACGME accredited programs in eligible hospitals to IME eligibility
  - Quarterly Direct Payments
  - Subject to CMS annual global inflation Factor
- DGME
  - Specifies eligible entities
    - Academic Medical Centers
    - Hospitals
    - Federally Qualified Health Centers
    - Rural Health Clinics
  - Eligibility
    - ACGME Approved Program
    - Hospitals must have 5% Medicaid payor mix
    - FQHCs and RHCs must have 35% Medicaid Payor Mix



# Highlights of Significant GME Improvements effective 7/1/2020 - SPA (Continued)

- DGME (continued)
  - Creates 2 categories of resident training
    - Primary Care - Family Medicine, General Pediatrics, General Internal Medicine and General Psychiatry
    - All Others
  - Existing Programs prior to 7/1/2020
    - All Categories of Residency - \$50,000 per resident Per Year
  - After 7/1/2020
    - Primary Care residencies - \$100,000 per resident per year
    - All Other - \$50,000
  - Reflects growth detailed in the State Strategic Plan for GME Expansion
  - DGME funds to go Directly to the Program
  - Subject to CMS annual global inflation Factor
  - Quarterly Payments

# New or Expanded Programs

- New Primary Care Positions since 7/1/2020
  - Shiprock - Indian Health Service /University of New Mexico (UNM)
  - Santa Fe - Christus - Saint Vincent Regional Medical Center / UNM
  - Alamogordo Rural Training Program with Memorial Medical Center - Las Cruces
  - Espanola - El Centro Family Health (FQHC) - ACGME Approved 5/2/2023
  - Hobbs and Carlsbad via Texas Tech - Midland/Odessa

# Pending Language in Draft 1115 Waiver 2023

- Amendment Proposal #3: Create GME expansion funding mechanism designed to develop new and/or expanded GME programs focusing on the specialties of General Psychiatry, Family Medicine, General Pediatrics, and General Internal Medicine.
- Establishes a federally matched Planning and Development grant program
  - Developing new or expanded primary care programs
  - Increasing other medical specialties with shortages in NM
  - Increasing positions in MUAs
- Not yet submitted

# Reference Documents

- New Mexico Human Services Department - GME Expansion Website
  - <https://www.hsd.state.nm.us/gme-expansion/>
- NM GME Expansion 5-Year Strategic Plan
  - <https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd27559d9767-951e-4240-a21a-6a462e3c8096/2022%20NM%20GME%20Expansion%20Strategic%20Plan>
- NMHSD CMS Approved State Plan Amendment (SPA) Approved 5/2021 - Retro to 7/1/2020
  - <https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd27333e1818-14f6-4f1a-aef1-8a411b13cd48/NM%20Medicaid%20SPA%2020-0019%20Approved.pdf>
- NM Primary Care Training Consortium
  - <https://newmexicoresidencies.org/>