

Florida Medicaid & GME Solutions

March 25, 2026


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Professor



UNIVERSITY OF FLORIDA


Florida Physician Workforce Policy Cards

DGME 

\$337M
annually

Direct Graduate Medical
Education Payments


STATE PLAN

IME 

\$705M
annually

Indirect Medical Education
Payments

STATE PLAN

DPP 

\$372M
annually

Directed Payment Program
Supplemental Payments

438.6(c) PREPRINT

TEACH

\$25M
annually

Training, Education, and
Clinicals in Health

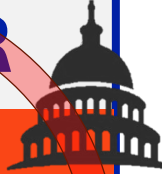
STATE STATUTE

GAP

1
annually

Graduate Assistant Physicians

STATE STATUTE

WAIVER 

\$617M
annually

Health Care Workforce
Medicaid Demonstration

1115(a) WAIVER

Accountability

DGME



- Hospitals
- % of state's residents
- % of state's Medicaid payments
- Minimum 14% Medicaid payer mix
- NO OUTCOME ACCOUNTABILITY

IME



- Hospitals
- Resident-to-Bed ratio
- Hospital's Medicaid inpatient and outpatient payments
- NO OUTCOME ACCOUNTABILITY

DPP



- Inter-Government Transfer (IGT) Funding
- Faculty Physicians and Dentists
- Work Relative Value Units
- Patient Outcomes (OBSERVATIONAL ONLY)

TEACH

- FQHCs, RHCs, CBHCs
- Hourly rate by discipline
- Quarterly surveys of trainees
- Longitudinal follow-up by NPI number

GAP

- Passed all USMLEs
- Two-year limit
- NO OUTCOME ACCOUNTABILITY
- In review. McCraney, et al. *Academic Medicine*. 2026.

WAIVER



- # residency slots in FQHCs, CCBHCs, rural health clinics.
- Service commitments to practice in Florida HPSA and accept Medicaid pts.
- Length of service in Florida HPSA.

Florida's
Oversight Bodies
for its
Physician
Workforce

Florida
HEALTH

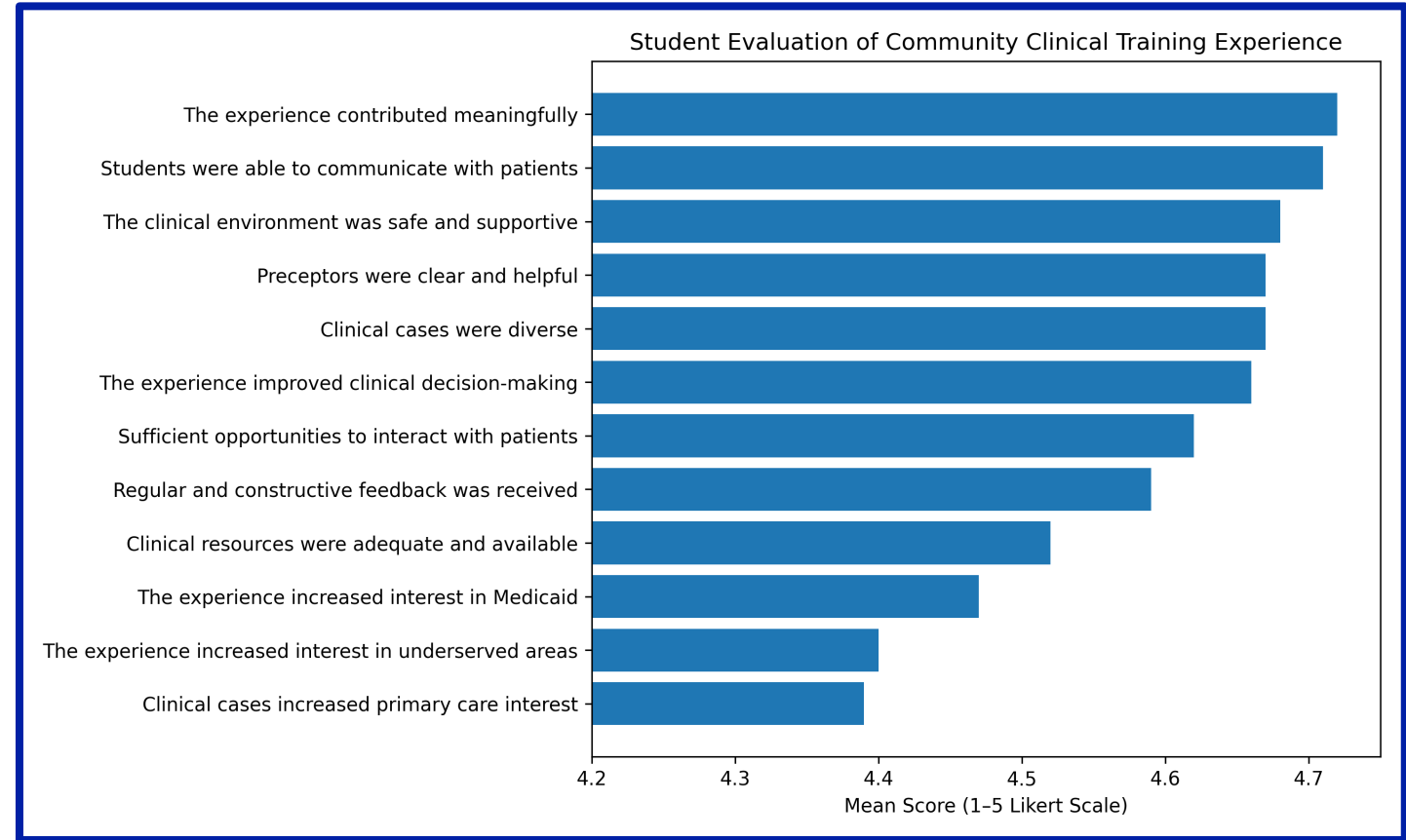
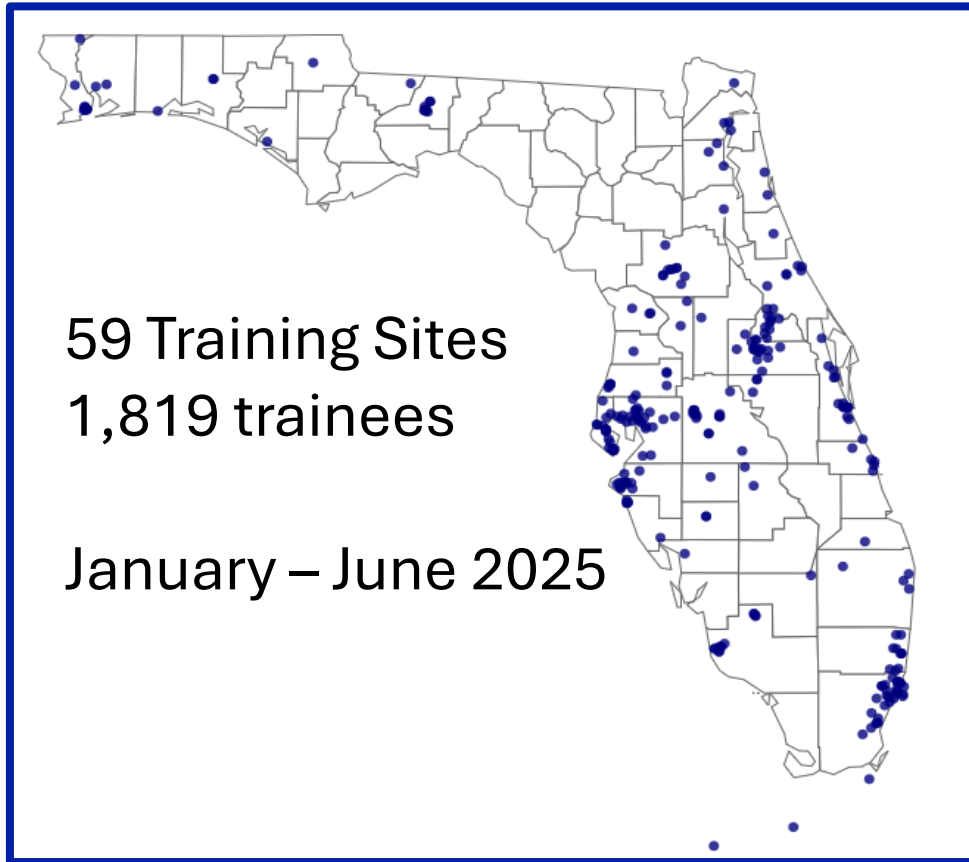
Physician
Workforce
Advisory
Council



Graduate
Medical
Education
Committee



Florida TEACH Funding Program



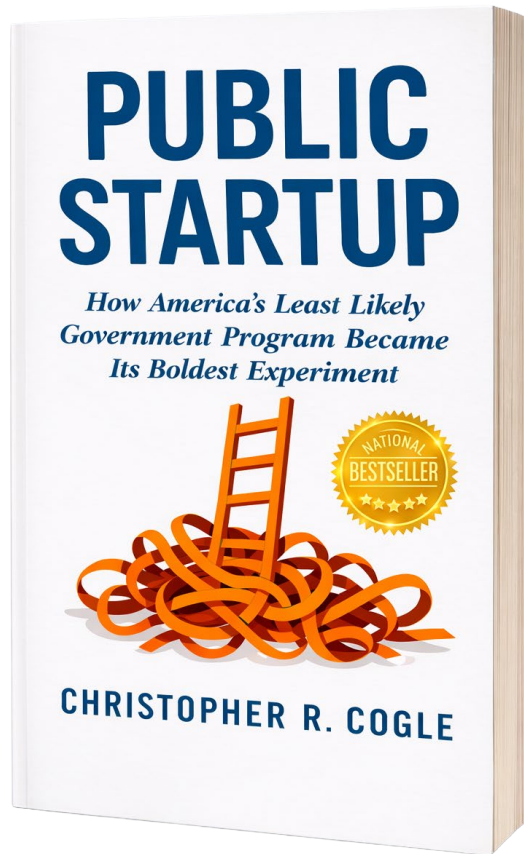
Early Positive Accountability

- ✓ Increased interest in accepting Medicaid in future practice.
- ✓ Increased interest in primary care and underserved areas.
- ✓ Longitudinal tracking via NPI number.

Barriers to Aligning GME with Workforce Needs

- ❑ Medicaid GME payments tied to service volume, not education or workforce outcomes.
- ❑ Medicaid Directed payments tied to patient quality metrics, not education or workforce outcomes.
- ❑ Community training sites lack access to IGT funding for federal match.
- ❑ CMS announced it will not approve new workforce-focused Medicaid 1115 demonstration waivers ([July 17, 2025 letter to states](#)).
- ❑ No federal/national body to orchestrate or disseminate state workforce policy strategies or evaluate outcomes across states.
- ❑ No national data infrastructure tracking physician training workforce outcomes. (However, good regional demonstrations that could be expanded.)

Medicaid as America's Largest Medical School



www.cogle.com

“Medicaid is America’s largest, least acknowledged medical school.”

- Pays for patient care (FFS, Managed Care)
- Pays for trainee support (TEACH)
- Pays for accreditation costs (TEACH, DPP)
- Pays for trainee salary (DGME)
- Pays for faculty (TEACH, DPP)
- Pays extra for clinical infrastructure (IME)
- Pays extra for disproportionate care (DSH)
- Pays extra for EMS transportation (DPP)



MISSOURI DEPARTMENT OF
**HEALTH &
SENIOR SERVICES**

BUILDING OUR PHYSICIAN WORKFORCE

Missouri Growth of GME

National Academies - GME Workshop – 3/25/2026

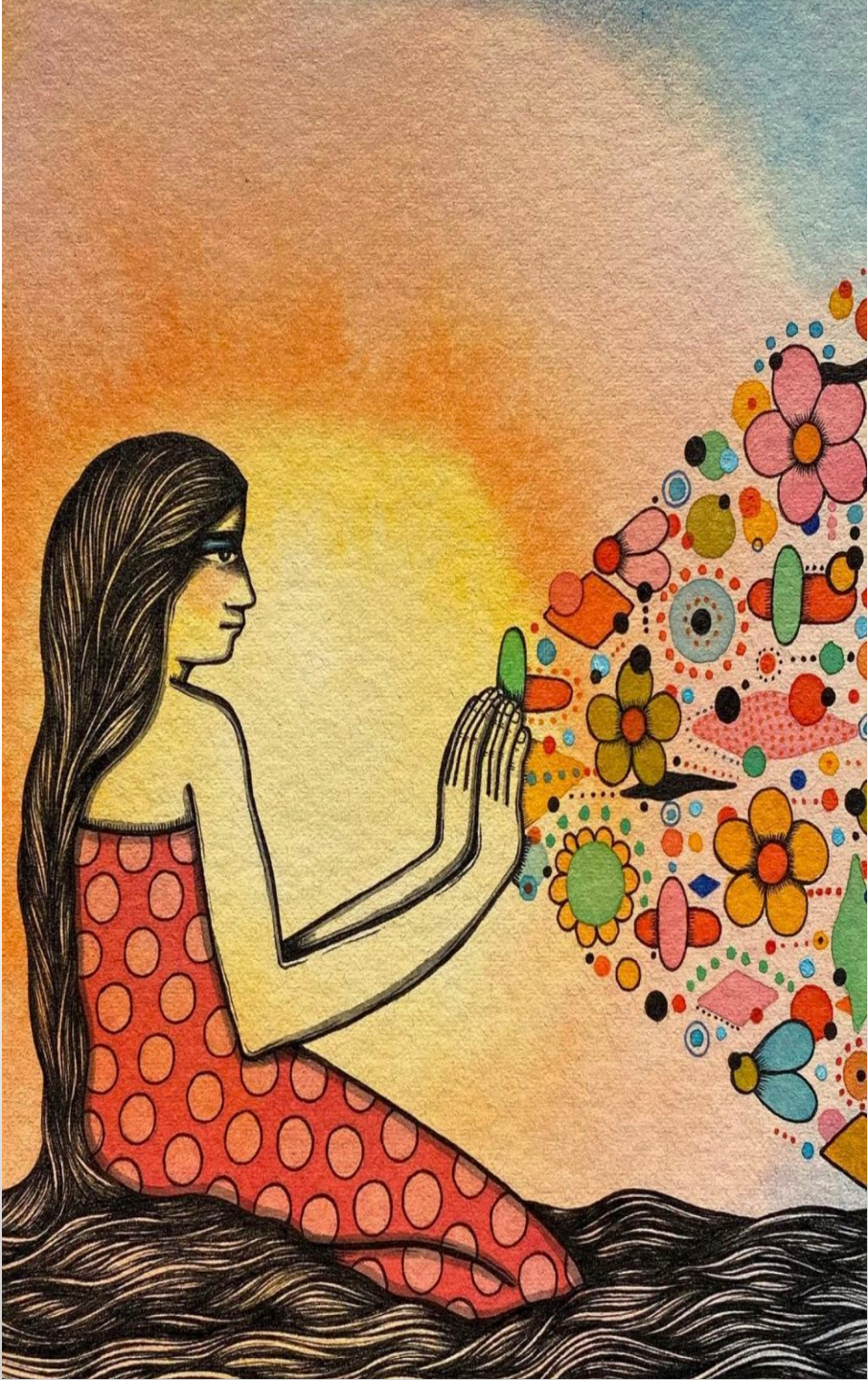
**Heidi B. Miller, MD, Chief Medical Officer
Missouri Dept. of Health & Sr. Services**

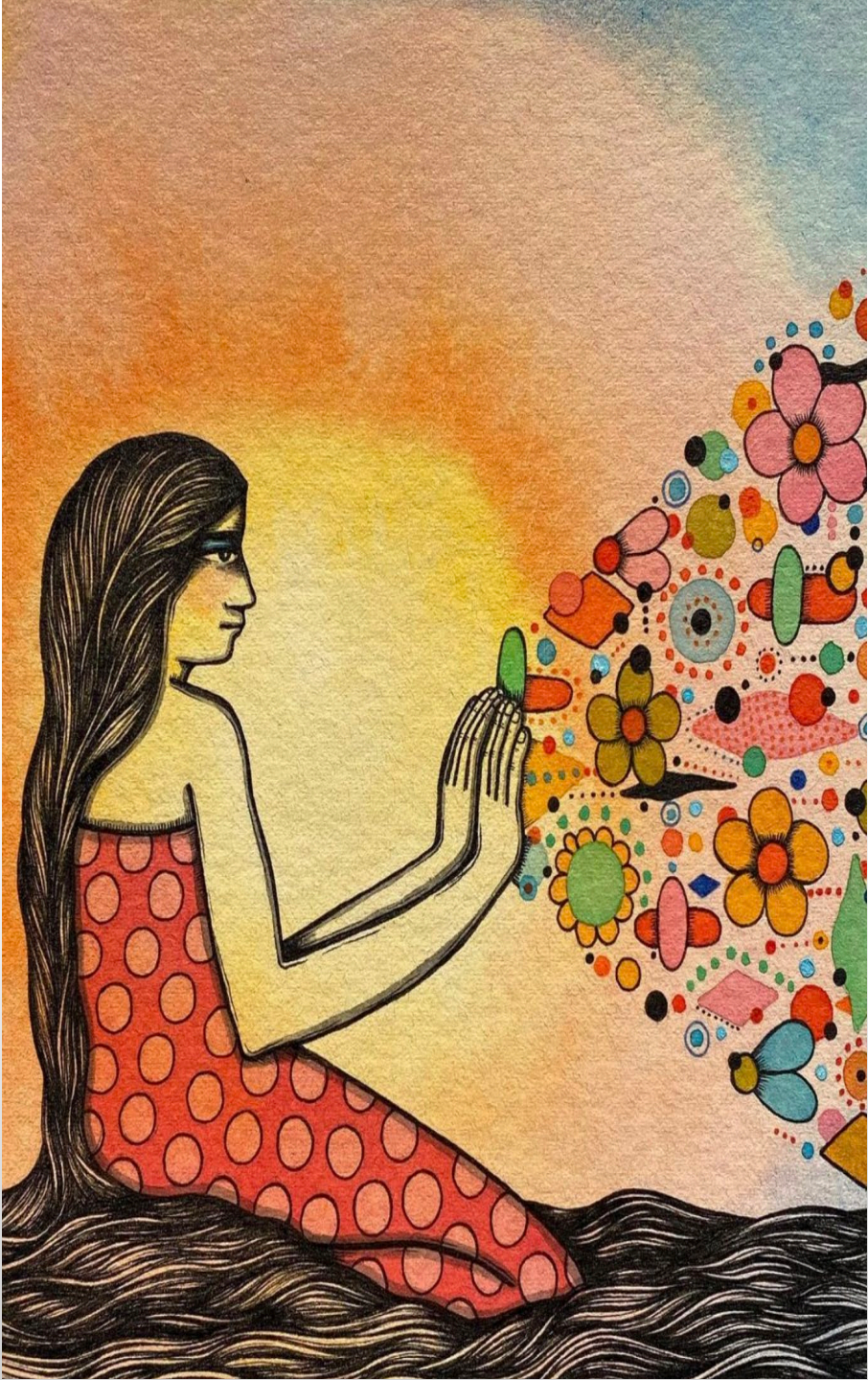
Our GME Journey & Juicy Lessons from MO

1. Spark change:

- Rage against sad statistics
- Celebrate state assets
- Seize glaring opportunities

We'd be fools not to.





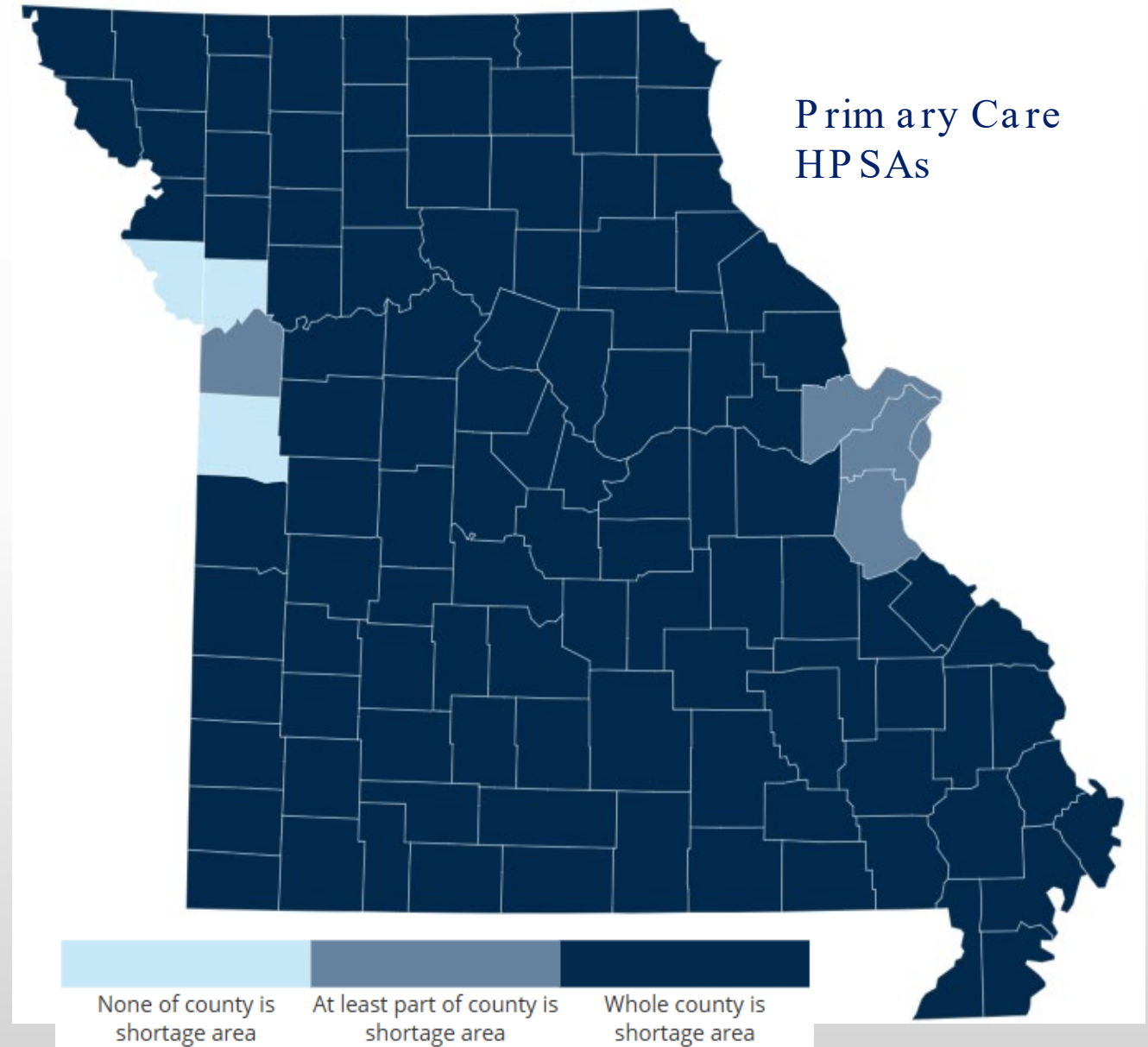
>2100
Physician
Shortage
in MO
2026

Now in Missouri: HPSA in MO

Nearly every county in MO
has HPSA designations

- Only 3 counties do not
have a primary care HPSA
- Only 1 county is without a
primary care, dental, or
mental health HPSA.

HRSA HPSA - Quarterly Report
9/30/25



MO Health Outcomes

in Missouri



MO Medical School Enrollees

MISSOURI

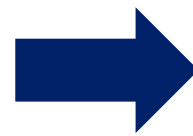


9th

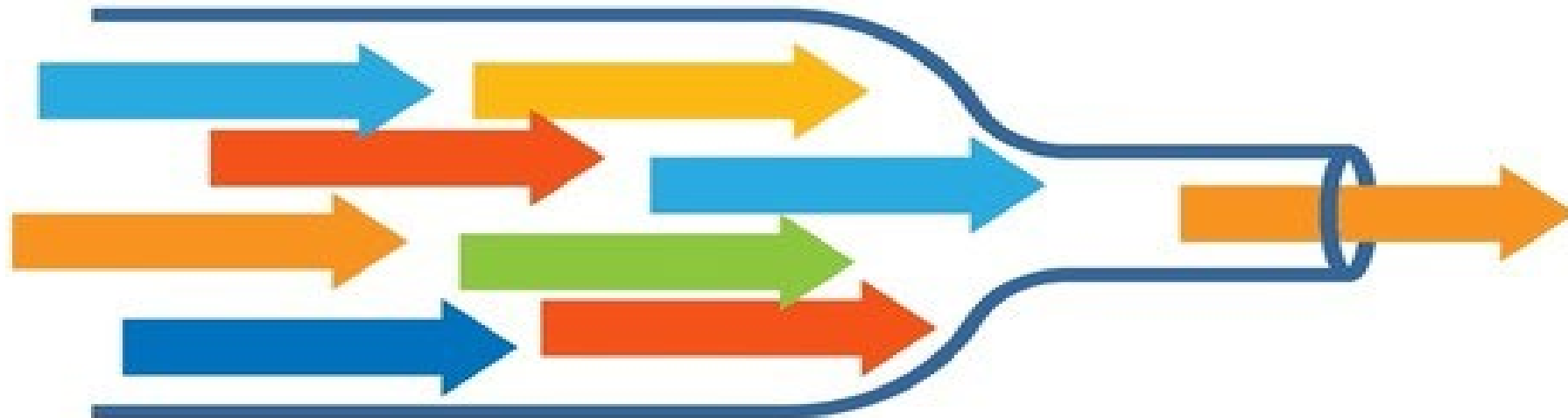
We have 7 Medical Schools!

MO Bottleneck

~1100 Medical School
Graduates in MO Every Year

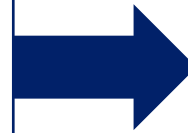


~750 First-Year
Residency Slots in MO



MO Bottleneck

~1100 Medical School
Graduates in MO Every Year



~750 First-Year
Residency Slots in MO

But Nationally:

~30,000 Graduates



~40,000
First-Year
Residency Slots

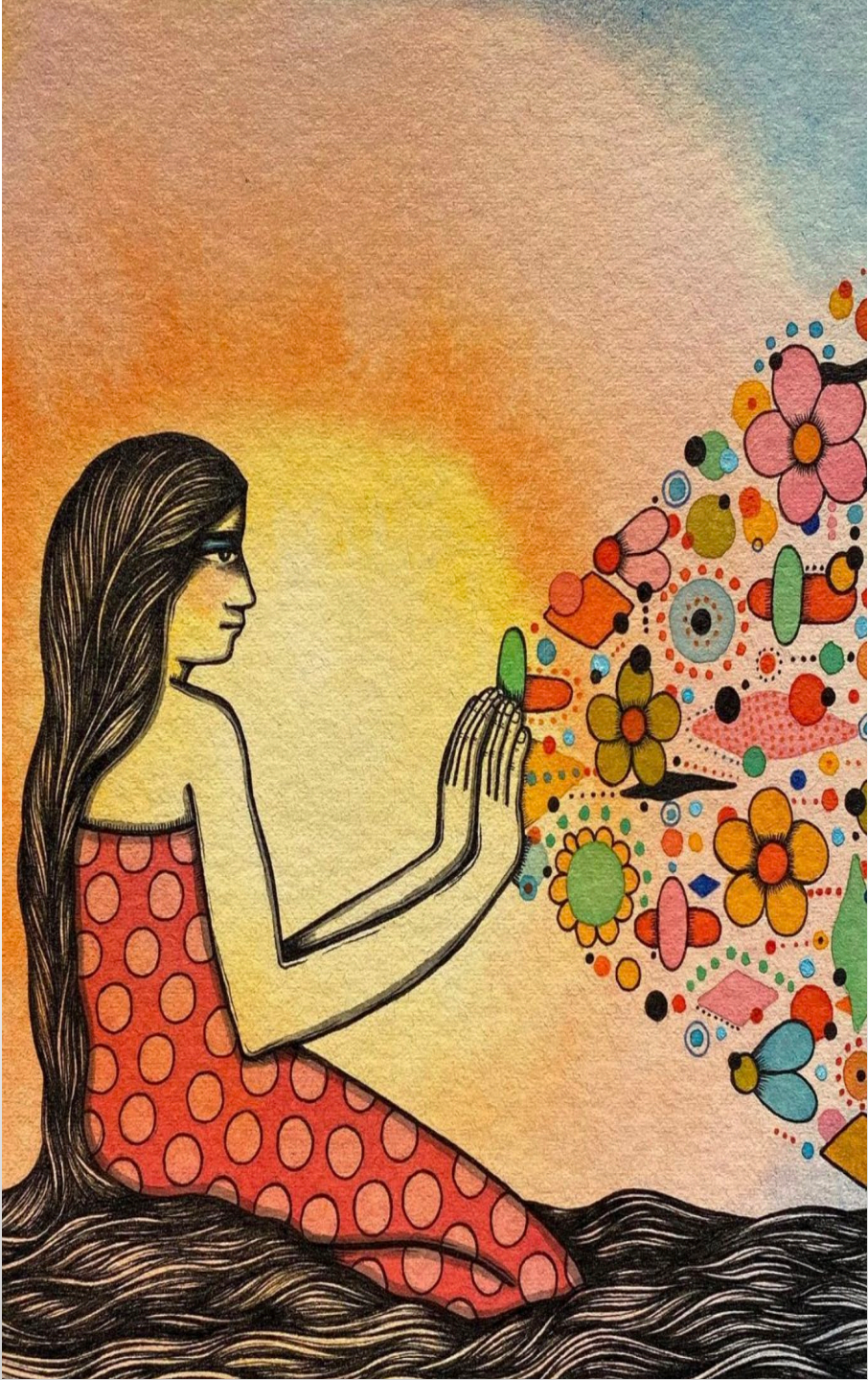
Our GME Journey & Juicy Lessons from MO

1. Spark change:

- Rage against sad statistics
 - Celebrate state assets
 - Seize glaring opportunities
- We'd be fools not to.*

2. Explain GME to stakeholders

What's your elevator speech?



**What
is
GME?**



**And
what
is the
ROI? \$**



Our GME Journey & Juicy Lessons from MO

1. Spark change:

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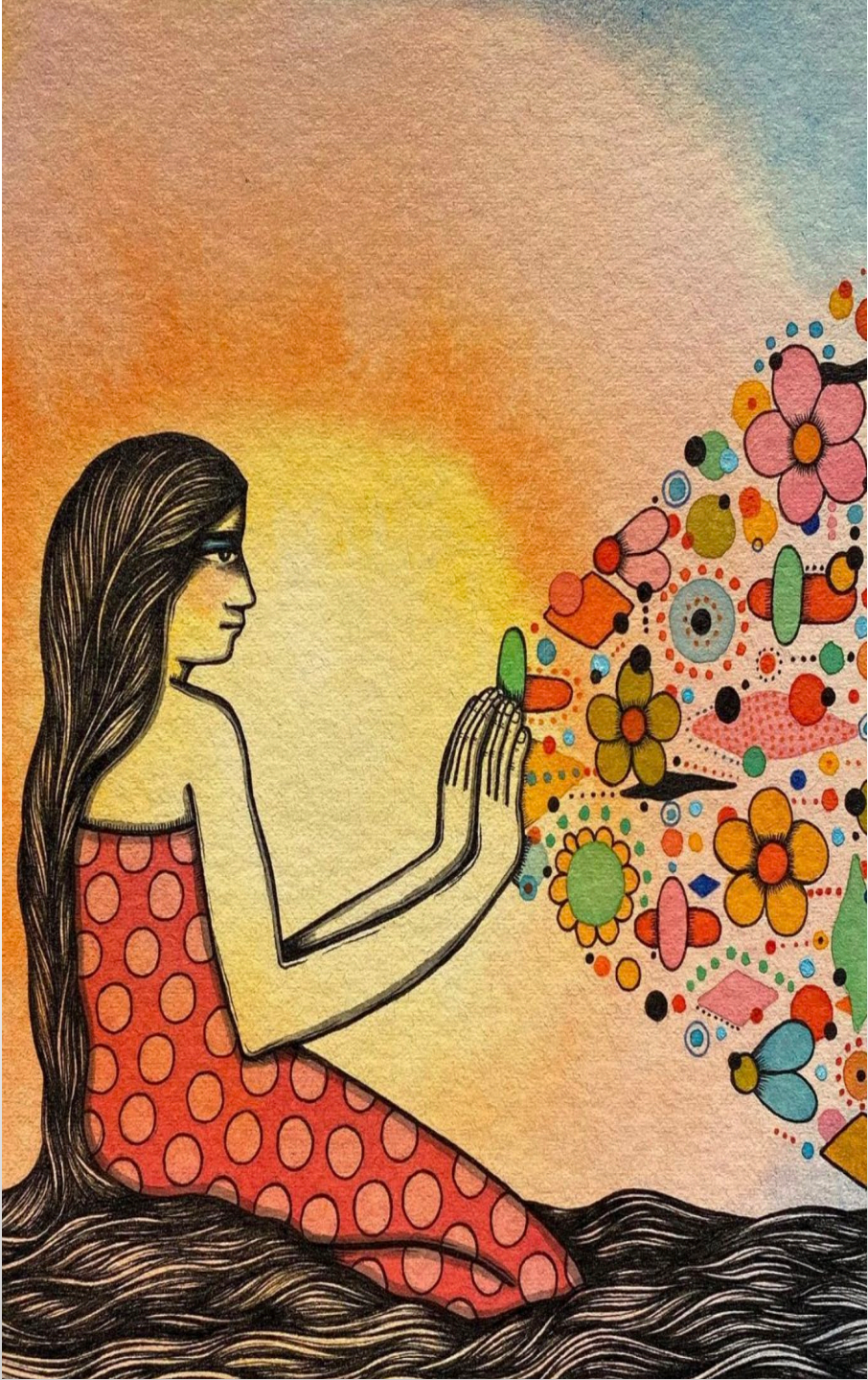
We'd be fools not to.

2. Explain GME to stakeholders

What's your elevator speech?

3. Engage and convene

Something for everyone every time. Action!



Partnerships

State Government Departments

Physician and Healthcare Associations

Policymakers

GME Stakeholder Partner Workgroup

- MO Hospital Association
- MO Medicaid
- MO Dept of Mental Health
- MO Dept of Higher Education and Workforce Development
- MO Primary Care Association
- MO Physician Board of Healing Arts (Physician Licensing)
- MO Rural Health Association
- MSMA, MAOPS, MAFP, MO-ACOG
- Legislative Health Committee Members

MO GME Advisory Council

MO GME Technical Assistance Center

MO GME Stakeholder Survey

MO GME Annual Summit

Our GME Journey & Juicy Lessons from MO



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What's your elevator speech?
3. Engage and convene
Something for everyone every time. Action!
4. Implement and sustain

GME State Strategic Plan

Needs to be
Evolving &
Dynamic



MO DHSS Funding Opportunities

\$10-million State Gen. Rev. & Opioid Settlement Funds/yr

Technical Assistance

New GME

GME Expansion

GME Feasibility

GME Curriculum

MO GME
Technical Assistance
Center

MO GME
New Program
Development

MO GME
Rural Program
Expansion

MO GME
Feasibility
Assessment

MO GME
Curriculum
Enrichment:
Rural & Addiction

MO GME
(Expanded
Slots)
Grant Program

Our GME Journey & Juicy Lessons from MO



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What's your elevator speech?
3. Engage and convene
Something for everyone every time. Action!
4. Implement and sustain
5. **Accountability throughout!**

GME – State Accountability

- **Initial missteps in accountability:** The first bill...
- **Then recalibrated recipient accountability:**
 - **Selection priority rubric for funding**
 - % training time rural
 - HPSA score
 - Continuity clinic – rural, FQHC, AHEC, rural family medicine practice
 - % residents ties to MO (high-school, college, medical school)
 - % graduates who: in MO, in rural
 - Tie-breakers: ob/gyn train FM, FM with higher vaginal deliveries, more rural, HPSA
 - **Curricular requirements:**
 - (1) Rural training 8 weeks, and (2) Addiction training 8 weeks. (Can overlap.)
 - **Deliverables:**
 - Track grads x 5 yrs: in MO, rural, underserved, stayed as generalist within their field
- **Systems accountability:**
 - Medicaid GME payments – ensure they go to the GME programs directly!
 - Synergize federal/state efforts
 - Private insurance needs to be accountable
 - Retention = Function of the Pipeline. When the pipe is hemorrhaging twice:



Our GME Journey & Juicy Lessons from MO



1. Spark change:
 - Rage against sad statistics
 - Celebrate state assets
 - Seize glaring opportunities

We'd be fools not to.
 2. Explain GME to stakeholders
 3. Engage and convene
 4. Implement and sustain
 5. Accountability throughout!
- What's your elevator speech?*
- Something for everyone every time. Action!*

*Questions?
Reflections?*

Thank you!

[Health.mo.gov/GME](https://health.mo.gov/GME)

Heidi.Miller@health.mo.gov



MISSOURI DEPARTMENT OF
**HEALTH &
SENIOR SERVICES**



GME Accountability Strategies

Arizona Case Based, Data Informed Interventions

Measuring Effectiveness and Return on Investment

Dan Derksen, MD, Associate VP for Rural Health Workforce Development Initiatives
Director, Arizona Center for Rural Health and AZ State Office of Rural Health
Senior Advisor, Arizona Area Health Education Centers Program



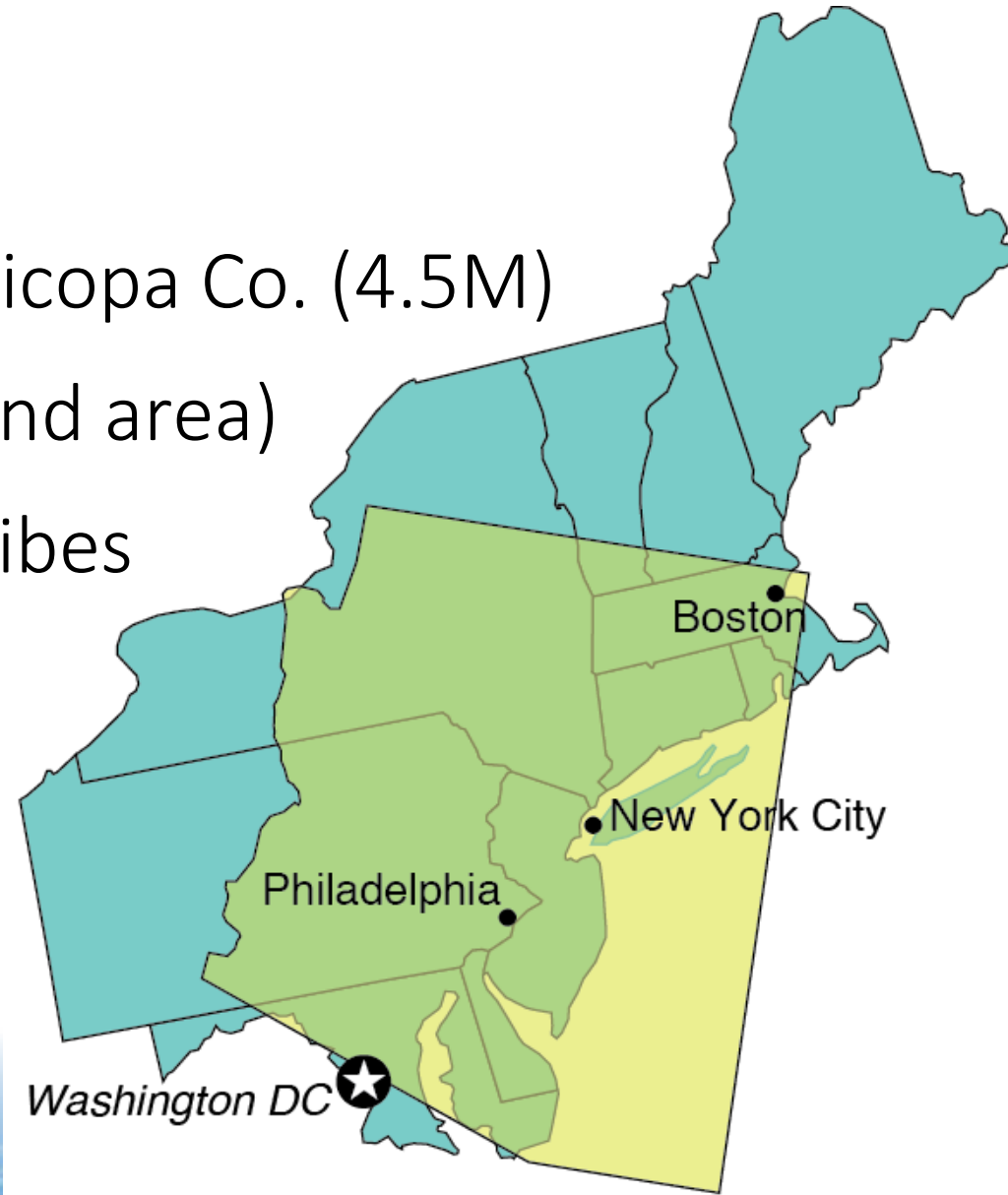
Arizona Profile

AZ Pop. 7.5 Million (#14 in pop): 60% Maricopa Co. (4.5M)

15 Counties span 114,000 sq. mi. (#6 in land area)

27% Tribal Land, 22 federal-recognized Tribes

370 mi. AZ-Mexico border



Land Area: <https://www.census.gov/geographies/reference-files/2010/geo/state-area.html>
KFF uninsured data: <https://www.kff.org/state-category/health-coverage-uninsured/>
Pop Data: <https://www.census.gov/quickfacts/AZ>

Case 1: State Policy to Collect Workforce Data

Arizona Health Boards – Minimum Data Set (MDS)



Aim: MDS data to inform state health workforce policy

Why: Active licensing data alone overestimates supply

Use: Target high need areas in policy interventions; track outcomes

e.g.: Expand primary care GME in rural, Tribal, border communities

2017 AZ Legislature [Ad Hoc Committee on Health Workforce](#)

2018 [HB2197](#) Req. Boards to Collect Data (Med, Nursing, Behavioral) at licensing & renewal

2019 [SB1096](#) Health Professional Workforce Data Repository

2022 Final Rule ([9 A.A.C. 11 Article 602](#))

Source: 2023 Developing Arizona Health Workforce Minimum Data Set ([AZ MDS](#))



Case 2: Primary Care Physician (PCP) Scholarship Program (2020 Gov. Ducey, R-AZ)

Aim: Increase PCP in AZ HPSAs

Why: Align incentives with desired outcomes

Use: Address PCP rural shortages

Type: Recurring \$8M/yr state appropriation

Data: PC HPSA/MUA/P; AZ Lic. Data

Policy: provides UA med students (TUC/PHX)
tuition scholarships: agree to return after PC
residency to practice in AZ HPSAs



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MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health



3/25/2026 Dan Derksen MD

Case 3: Creating a Tribal AHEC: American Indian Health AHEC Regional Center: 2021 [SB1301](#)

Aim: Increase health workforce & training in AZ IHS and 638 Tribal-run sites

Why: 22 Tribes, 27% land area, >50% health workforce vacancies

Use: Identify, address unmet health needs; community-academic partners

Type: State, federal funding

Data: UA Health Workforce Data System

Challenge – creating GME sponsoring institution in Indian country, one example: academic-Tribal partnership (UNM-Shiprock IHS) PC GME



Case 4. Addressing Unmet Health Needs – Rural PC GME

Gov. Hobbs (D-AZ) signed [SB1727](#) in 2023

\$5M to AzAHEC: expand existing, create new rural PC GME programs (one-time, non-lapsing appropriation)

Private Foundation – Halle Foundation

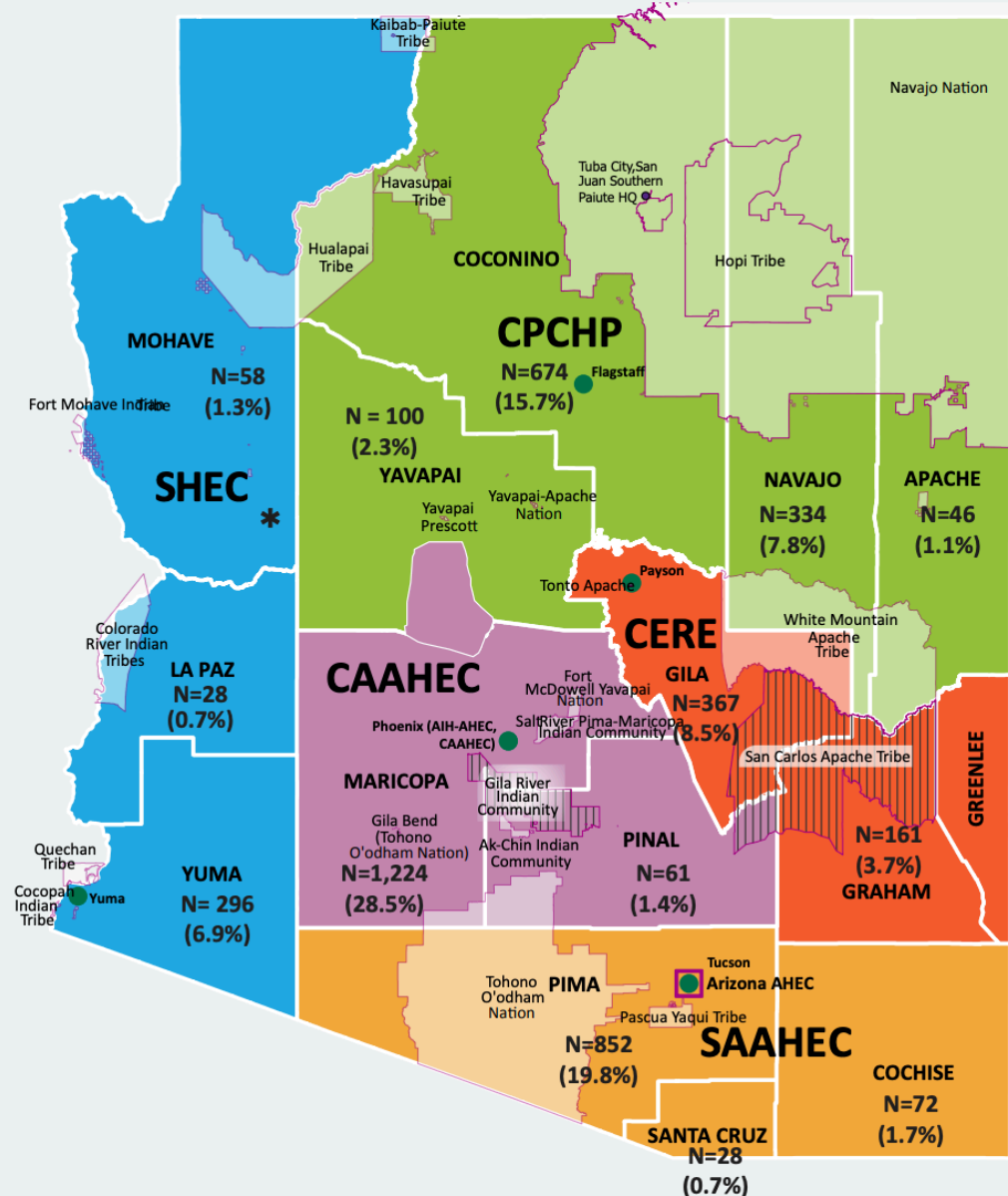
5-year PC-GME funding – prioritizing rural, Tribal & border communities 2025-2030



Leveraging AzAHEC to Expand Rural, Tribal, Border Health Professions Education

AzAHEC Health Professions Field Experiences by County (Total N= 4,302)

Number (N) and percent (%) of field experiences for each county.

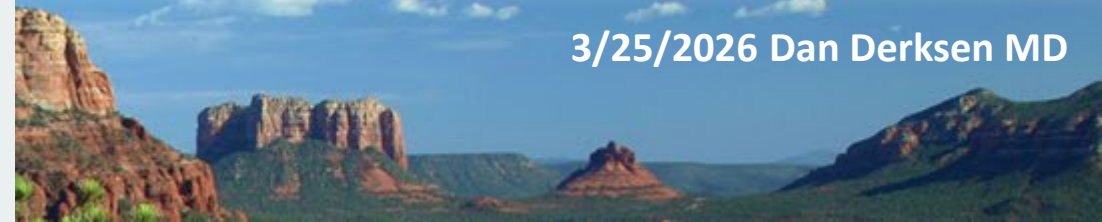


-  Arizona Area Health Education Center Program (AzAHEC) Tucson
-  Tribal Nations
-  American Indian Health Area Health Education Center (AIH-AHEC)
-  Southern Arizona Area Health Education Center (SAAHEC)
-  Central Arizona Area Health Education Center (CAAHEC)
-  Center for Excellence in Rural Education (CERE)
-  Colorado Plateau Center for Health Professions (CPCHP)
-  Southwest Health Education Collaborative (SHEC)



THE UNIVERSITY OF ARIZONA
Arizona AHEC
 Area Health Education Centers

3/25/2026 Dan Derksen MD



Case 5: Arizona Rural Health Transformation (RHT)



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Center for Rural Health

H.R. 1, Title VII, Sec. 71401

Aim: Inform State of Arizona RHT development, implementation

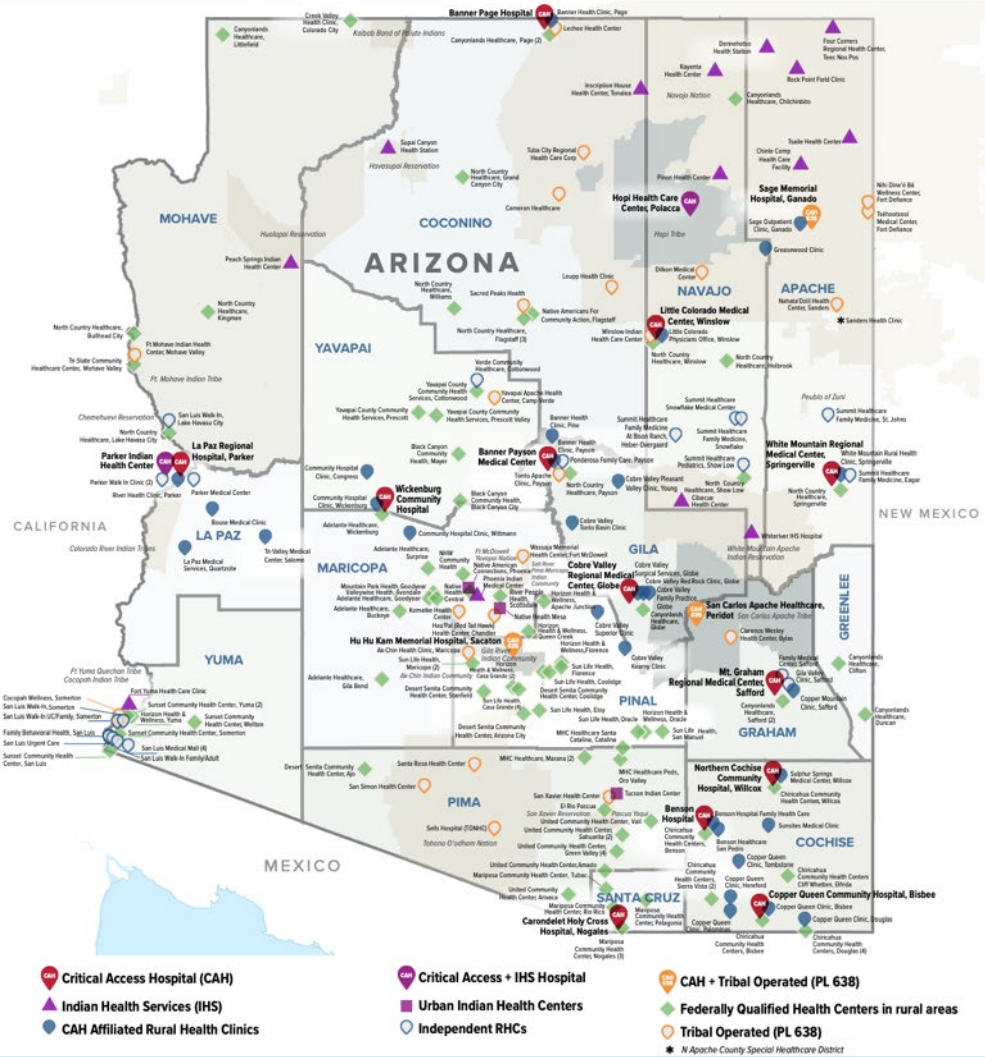
Why: CMS awarded AZ RHT: \$167M/yr X 5 years

Use: Identify, address unmet rural, Tribal, border health needs

- Total: 28% (\$47 M) Rural Health Ed, Training**
- a. 19% (\$32 M) Rural Education & Training Expansion
 - b. 5% (\$8 M) Rural Practice Incentives
 - c. 3% (\$5 M) Upskilling, Residency Support, Training Capacity Grants
 - d. 1% (\$2 M) AZ Health Workforce Proj., Innovation Learning Network



Design: Ann Garn (Updated 8/22/25)



Key Partners: AZ Rural Health Safety Net:

17 Critical Access Hospitals

54 Rural Health Clinics (RHCs), 31 CAH-affiliated

26 Health Centers operating 175 FQHC Sites

16 Indian Health Service IHS hospitals, clinics

28 Tribal-operated (P.L. 638) hospitals, clinics

Map: <https://crh.arizona.edu/sites/default/files/2025-08/250822SN2025Map.pdf>

About This Map

This map intends to inform the efforts of the AZCRH and rural healthcare partners statewide. Only selected rural and safety net facilities are included. Many of these facilities are served by federal and state funded projects at the AZCRH. These facilities have definitions and criteria established by federal health policy to meet the needs of rural and underserved populations. They also may have geographic, population service, and clinical services requirements. This list is not exhaustive of health facilities in Arizona. More information about this map can be found on our website.



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MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health

Dan Derksen MD, Director
Jill Bullock, Associate Director

Phoenix and Tucson
Federally Qualified Health Centers

Design: Ann Garn (Updated 7/28/25)



3/25/2026 Dan Derksen MD



Daniel Derksen, MD, is the University of Arizona Health Sciences Associate Vice President for Rural Health Workforce Development Initiatives. He is a Professor in the College of Public Health with joint appointments in the Colleges of Medicine in Tucson and Phoenix and in the College of Nursing. His current service, education and research activities include informing legislative, regulatory and program policy to improve access to health care and health insurance coverage; developing, implementing and evaluating interprofessional service-learning sites; and working to assure a well-trained and distributed health workforce to meet the needs of all Arizonans.

In his University of New Mexico and University of Arizona academic career he has been principal investigator (PI) of more than \$100 million in federal, state, and private foundation grant funding.



House Committee on Ways & Means in 2015

Contact: dderksen@arizona.edu Academic CV at: <https://publichealth.arizona.edu/directory/daniel-derksen>

Center for Rural Health: <https://crh.arizona.edu/> Area Health Education Centers Program: <https://azahec.arizona.edu/>



WISCONSIN: RURAL GME DEVELOPMENT & SUPPORT

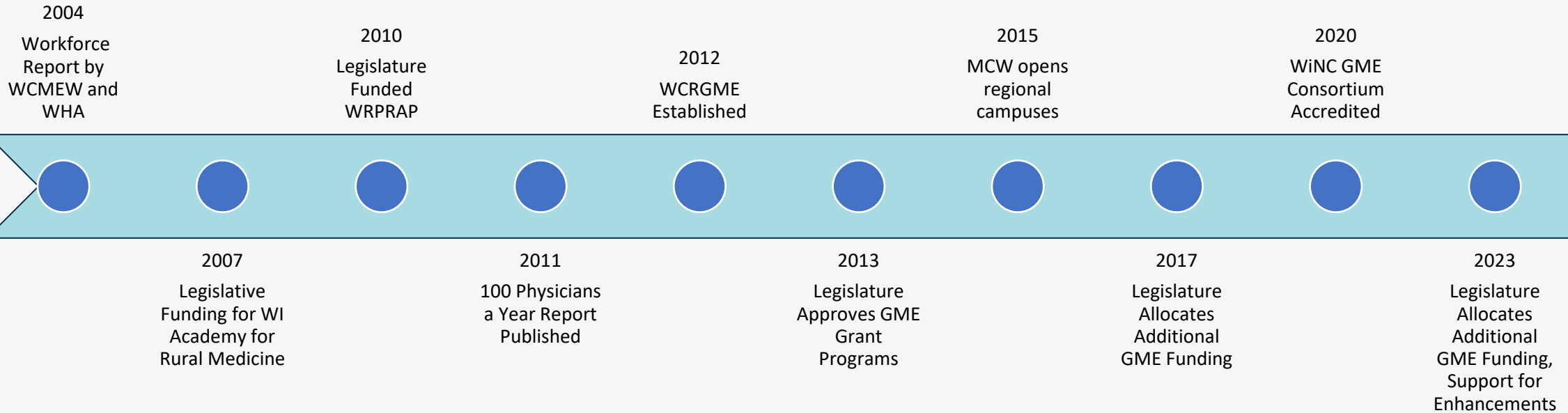
March 25, 2026

Lori Rodefeld, MS

Director of Rural GME Development & Support



State GME Strategy Timeline



Getting Started in Wisconsin

Data Collection

- Several workforce reports issued and distributed to policymakers
- Needs Assessment conducted with GME programs and stakeholders

Collaborative Effort Across Organizations

- Workgroup established with coalition of partners
- GME Task Force established

Identified Gaps in Workforce & Prioritized Needs

- Creation of technical assistance entity to support growth and sustainability
- Grants to support capacity building with rural rotations
- Drew on lessons learned from closures of 5 RTTs in early 2000s
- Built “grow our own” equation into grants and GME development
- Flexibility over time has supported growth strategy

100 New Physicians a Year
An Imperative for Wisconsin

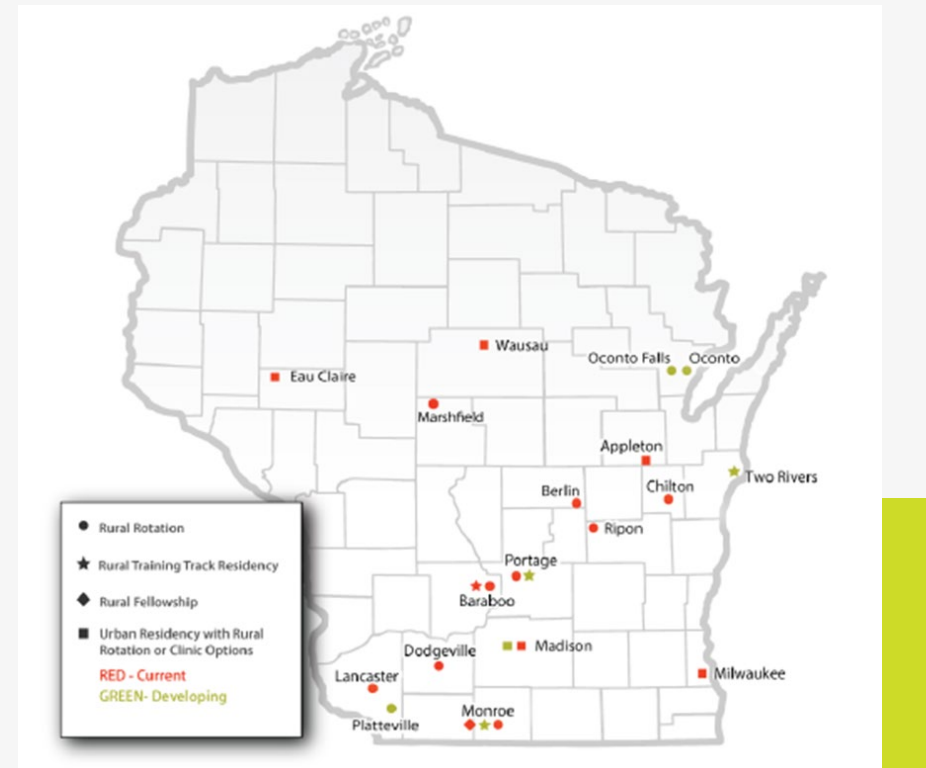


Getting Started – Launching a Technical Assistance Center (WCRGME)

- 13 initial partners including:
- 1 rural track program (RTP)
- 1 rural hospital with 5 residency programs
- 7 interested rural hospitals
- 4 interested urban hospitals and sponsoring institutions

Recommended by WI GME Task Force

Funded by WI Rural Physician Residency Assistance Program (WRPRAP)



Sustainable Growth With Technical Assistance

Wisconsin pairs investments with technical assistance to maximize ROI and ensure new programs are sustainable

New Program Planning

- High-level financial planning
- Administrative and accreditation support
- Scenario planning



Best Practice Resources

- WCRGME bi-monthly meetings
- Annual meeting
- Education coordinator trainings
- Recruitment workshop

Marketing Rural GME

- Medical student advisory committee
- Medical student outreach
- Social media and promotional videos

Faculty Development

- GME Leadership Academy
- Annual Conference

Data & Dissemination

- Graduate outcomes tracking
- Program training site updates
- GME analysis for stakeholders

GME Funding in Wisconsin

WRPRAP Grants

- Supports rural rotations, feasibility assessments, rural curriculum, technical assistance, new program costs

WI DHS Expansion Grants

- Allows GME programs to expand and add rural training
- Funds **\$150K per resident per year**
- Prioritizes primary care and high need specialties
- Two months or more of rural rotations required
- 50% in-state retention requirement for continuation funding

WI DHS Program Development Grants

- Provides start-up funding of up to **\$1 million**
- Required rural training component
- Prioritizes primary care and high need specialties, recruitment of in-state medical students

Other State GME Support: Medicaid GME provides approx. \$20-25K/resident



Wisconsin's State Funding Impact



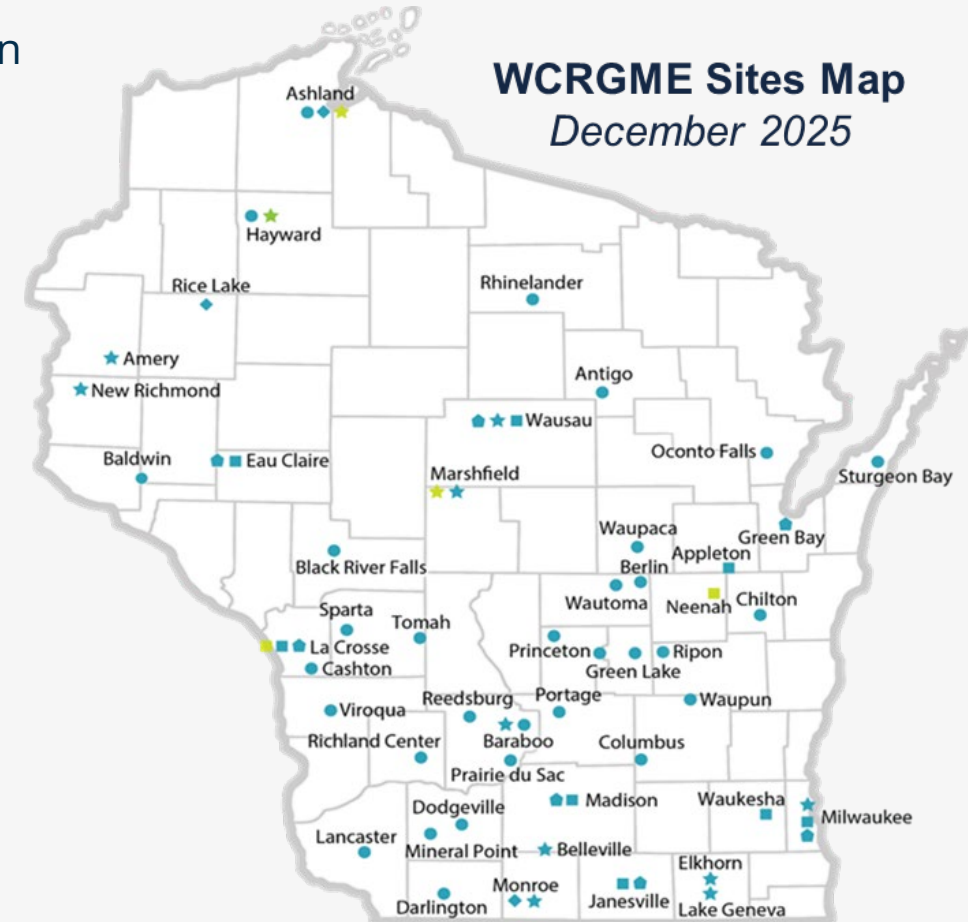
30 New and Expanded GME Programs + 9 In Development

Residency Development & Expansion

- Family Medicine – Amery/New Richmond, Eau Claire, Elkhorn, Green Bay, La Crosse, Lake Geneva, Madison, Monroe, Fox Valley
- Internal Medicine – Milwaukee Primary Care Track, Neenah, Marshfield
- OB/GYN – Madison, Milwaukee
- Psychiatry – Green Bay, Madison, Wausau
- Surgery – Madison, Milwaukee

Fellowship Development & Expansion

- Addiction Medicine – Madison
- Child & Adolescent Psychiatry Fellowship – Green Bay
- FM OB Fellowship: La Crosse and Madison
- Emergency Medicine Fellowship: Ashland, Monroe, Rice Lake
- Hospitalist Fellowship: Eau Claire, Janesville, Monroe, Wausau
- Endocrinology Fellowship - Milwaukee



Wisconsin's Return on Investment

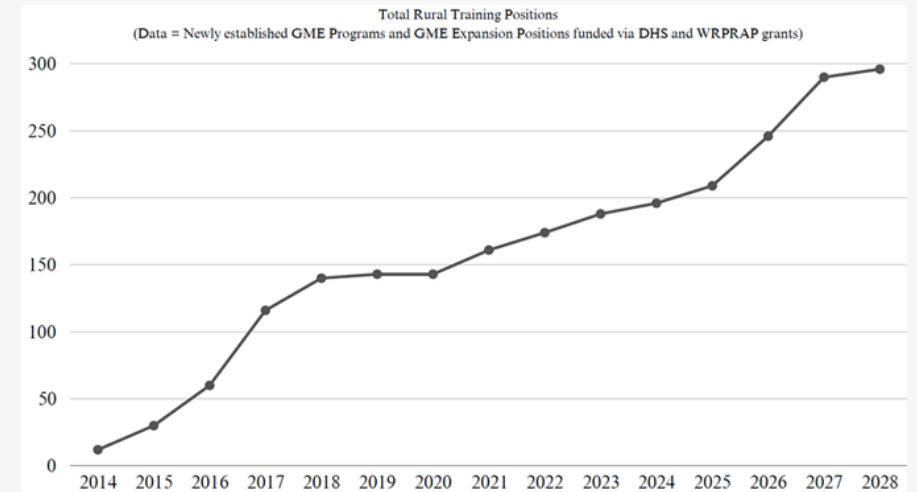


Technical Assistance has supported:

- 300+ new GME positions at full complement
- 100 physicians each year entering programs in Family Medicine, Surgery, Psychiatry, OB/GYN, Internal Medicine, and more
- 39 new and expanded programs with 2+ months of rural training

Impact of Policy:

- 21% of all residents train 2+ months rural
- 70% in-state expansion grant retention
- 60-65% of rural GME grads in rural practice
- Increased state support:
 - Planning and development grants at \$1 million
 - Expansion to \$150K per position



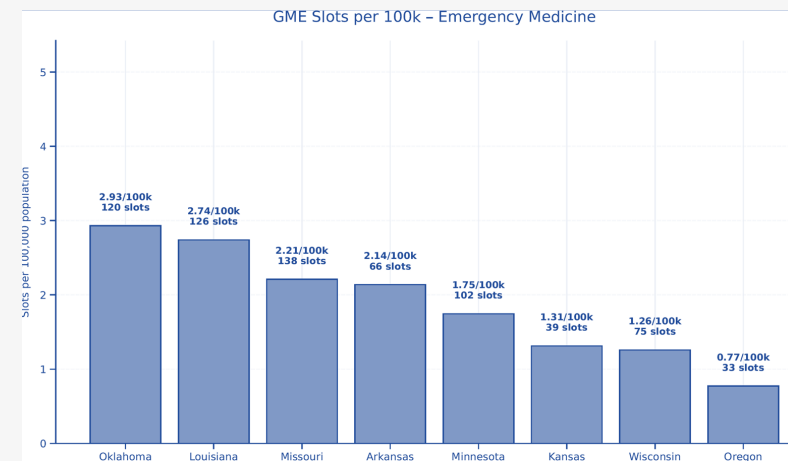
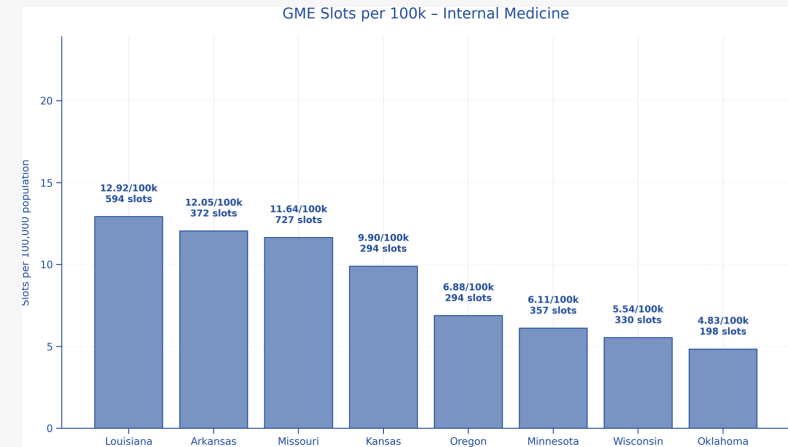
Lessons Learned & Next Steps

Lessons Learned:

- Collaboration across organizations and specialties helped support growth statewide.
- Technical assistance is the facilitator that turns interest in GME into accredited programs.
- Flexibility allowed for changes as strategy evolved over time.

Next Steps:

- Continued support for growth and expansion, especially in northern Wisconsin
- Analysis of specialty needs and hospitals poised for further growth and expansion.
 - GME Capacity Modeling: Potential for 700+ additional positions.
 - Peer State Analysis: Rank last or near last for Internal Medicine and Emergency Medicine. Middle tier for Psychiatry, Surgery, OBGYN, and Family Medicine.



QUESTIONS?

