State-Based Approaches to Reforming Medicaid-Funded Graduate Medical Education

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Disclaimer/No Conflict of Interest

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This presentation in one slide

- High level of interest, limited implementation
- Most states seeking new funds, not redistributing existing funds
- Oversight bodies play critical role in educating legislature and navigating competing interests
- We heard loud call for increased accountability/transparency
- Critical need for better data and metrics to measure workforce outcomes
- Findings not earth shattering but study (literally) gives voice to critical enablers/barriers to state GME reform

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Why Study States?

- Federal GME reform efforts have stalled
- States are “policy laboratories” for GME innovation
- Thanks to Tim Henderson, good state data:
  - 32 states made Medicaid GME payments in 2015, up from 22 states in 2012
  - Total Medicaid GME payments increased 10% from $3.87 billion in 2012 to $4.26 billion in 2015

Study is Timely

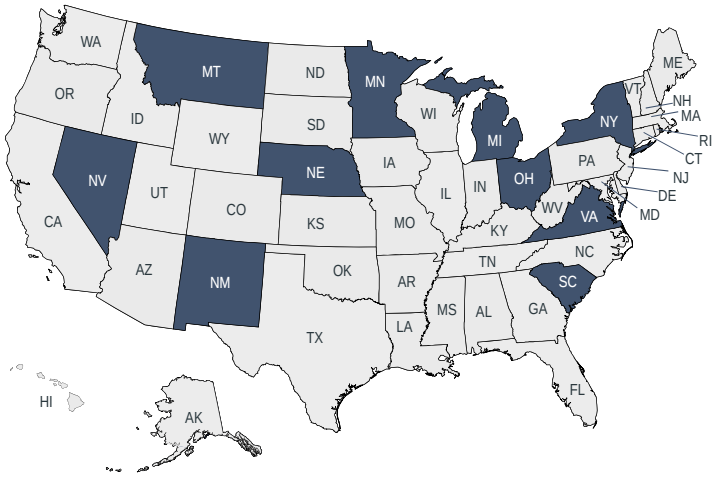
- With change of federal administration, policy window may be opening for increased state involvement in GME
- Potential for Medicaid block grants could accelerate state-level GME reform
- States facing budget constraints and pressure to identify return on investment for public funds spent on GME
- This study sought to:
  - Investigate how states are reforming Medicaid and state-funded GME financing
  - Identify innovations and challenges

Sampling Frame

- **Purposive sampling strategy**: 10 states engaged in GME reform. Represent balance of regions, high/low urban, % non-elderly, % uninsured, residents per capita and physicians per capita, % of physician workforce trained instate, federal match rate for Medicaid, Medicaid expansion/not
- **Structured Interviews**: 2 interviews per state, 29 interviewees
- **Timeframe:** December 2014 and July 2015
- **Snowballing sampling to identify interviewees**: DHHS officials (Medicaid, Rural Health), Governor's office staff, university/med school faculty, residency program directors, primary care associations

States in Our Sample

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



Source: Carolina Health Workforce Research Center, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill

Study Design

- **Interview questions**
  payment, transparency, accountability, governance and innovation
- **Qualitative analysis**
  - Interviews transcribed and sent to interviewees to review
  - Directed content analysis to identify themes, patterns and relationships
  - Iterative, consensus coding between three investigators
  - "Member checking"—interviewees reviewed study findings and conclusions

Finding #1: Lots of talk, limited action

- More states in planning stages than have implemented changes
- Heterogeneity between states—states with long history in GME (New Mexico) vs. new to GME (Nevada)
- Heterogeneity within states—interviewees in same state sometimes had differing opinions about the likelihood of success of GME reform

Illustrative Quote

"Currently, all we have is handshake agreements. There has been no ink on paper. There has been no contractual legal work that's been done. For all I know, when we get to that stage, this whole thing could just blow up."

Finding #2: Impetus for Change Stemmed from Multiple Sources

- 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 undertook GME reform to address concerns about:
  - maldistribution by specialty, geography, setting
  - having enough GME slots to match medical school expansions
  - potential loss of Teaching Health Center funds
  - disparities in GME funding received by different training institutions

Illustrative Quote

- "So we had some folks getting paid about $4,000 per trainee and we had a couple of places paid in excess of $60,000 per trainee…Folks never wanted to fiddle with it because the folks who were getting paid $60,000 per trainee kind of liked it. What we did was publish what everybody was getting paid and it created this bit of an uproar where folks realized what the variation was. Then the conversation became 'This is clearly unfair. It's not rooted in policy. What do we do instead?'"

Finding #3: Reforming GME Financing is Harder than It Looks

- State approaches to reforming GME financing:
  - Better leveraging Medicaid funds
  - Pursuing 1115 waivers to modify federal rules for allocating GME funds
  - Delinking GME funding from claim
  - Creating innovation pools
  - Providing seed money for new training programs
  - Funding rural rotations
- Many states identified resistance from teaching hospitals as reason for seeking new funds rather than redistributing existing funds

Illustrative Quote

- "For a few years they actually tried to appoint some task forces, a task force to look at this issue, but when the Governor's Office put this task force together it was essentially made up of folks from these academic medical centers and so the result of these kind of inquiries never really went too far because the hospitals of course have a vested interest in these funds just staying the way that they are."

Finding #4: Oversight bodies play critical role

- Most states had oversight body to:
  - Reach consensus on state workforce needs
  - Decide where funds should be targeted
  - Educate legislature and DHHS about GME
  - Navigate competing interests of stakeholders
- Oversight bodies included range of GME stakeholders
- All were advisory, none were authoritative

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"

Finding #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
- In one state, GME funding was cut from Governor's budget because of lack of data on return on investment (ROI). It was later restored by legislature.

Illustrative Quote

"Nobody owns this. That's one of the things we're trying to convince the state is somebody needs to own this and take interest in it, whether it be in terms of accountability, in transparency, because as we seek more funding people are going to say you need to be able to demonstrate to us that you're making a difference."

Finding #6: We also 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
- 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 are trying to move into a more results, performance-based system that payments will be tied into satisfactory demonstration of a commitment to the health care needs of the state. There's been no accountability, no reporting, no nothing, so the hope is eventually things will evolve and there'll be accountability as far as of a redistribution of existing resources in a way that behooves the citizens with better access in rural and underserved areas".

Finding #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
- 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 tricky

Two Illustrative Quotes

"Connecting the dots precisely gets tricky"

"What I want to stress though is that was a fight that I did not want to fight. I purposely have left that out. For us, all these dollars are just to do training in these areas. Getting the person to remain in that and/or keep doing it over 5 years or 10 years was just too complicated to track at this point. Every time we went there, it just began to derail everything."

Conclusions

- Study found limited progress on GME reform but states have much to learn from each other
- Diffusion of lessons learned and challenges encountered by National Governors Association, this group and others needed to inform policy efforts at state and federal level
- 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"
- Better data collection, analysis and metrics to measure workforce outcomes are needed to support GME reform.

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Background: The National Academy of Medicine, MedPAC, the Josiah Macy Jr. Foundation and other organizations have called for increased transparency and accountability for public funds invested in GME but federal efforts have stalled. In the absence of federal GME reform, states are increasingly exploring ways to leverage Medicaid funds to shape the size, specialty mix and geographic distribution of their workforce. This study sought to investigate how states are reforming Medicaid GME with the goal of identifying innovations and challenges at the state level.

Thirty-two states made Medicaid GME payments in 2015, up from 22 states in 2012 (Henderson 2016). Total Medicaid GME investments increased 10% from $3.87 billion in 2012 to an estimated $4.26 billion in 2015. With Republican control of both the executive and congressional branches of the federal government, observers have speculated about a possible transition to Medicaid block grants for funding GME. A 2014 Heritage Foundation report recommended that federal funding for GME be combined into a single source that could be distributed to states based on agreed upon metrics (O'Shea 2014). If Medicaid block grants become a reality, it may provide another stimulus to change the way state invest in Medicaid GME.

Methods: Ten states that had implemented, or planned to implement, GME reform were included: Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, New York, Ohio, South Carolina and Virginia. Study states were representative of the nation in terms of geographic diversity; percent of the state's population in urban areas, percent uninsured; the state's per capita supply of physicians and residents; percent of active physicians who were trained in the state; the federal match rate for Medicaid expenditures; and percent of states expanding Medicaid. Average Medicaid GME payments per 10,000 population were higher in selected states. Structured interviews were conducted with 29 key informants in 10 states between December 2014 and July 2015. Eleven interviewees worked in government offices including Departments of Health and Human Services, Medicaid or Offices of Rural Health, seven were in a university/medical school, four were residency program directors, five were in the Governor's office or part of a Commission focused on GME, and two were in a primary care association. Directed content analysis was used to code and analyze interview transcripts around four key areas: payment, transparency, accountability and innovation.

Conclusions and Policy Implications

1) More states were in the planning stages of GME reform than had actually implemented changes.
2) States tackled GME reform to address maldistribution of physicians by geography, specialty and setting; to respond to expansions in undergraduate medical education; to increase funding by leveraging the federal Medicaid match; and to address disparities in the amount of GME funding received by different training institutions
3) In most states, some type of oversight body had been created to bring stakeholders together, reach consensus on workforce needs, decide how funds could be targeted to needed specialties, geographies and populations; and educate the legislature. In all states interviewed, the oversight body was advisory, not authoritative.
4) Interviewees voiced a desire to increase transparency and emphasized that little or no transparency or accountability currently existed in their state.
5) Many states want to implement accountability metrics to measure ROI for state GME investments, but they need technical assistance to make tracking a reality.

Access the report at

http://www.shepscenter.unc.edu/programs-projects/workforce/projects/carolina-health-workforce-research-center/

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