Lessons Learned from State-Based Approaches to Reforming Medicaid-Funded Graduate Medical Education

Erin Fraher PhD MPP,

Julie Spero MSPH and Tom Bacon DrPH

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CAROLINA HEALTH WORKFORCE RESEARCH CENTER

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Disclaimer/No Conflict of Interest

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- The information, conclusions and opinions expressed in this presentation are mine and no endorsement by NCHWA, HRSA, HHS, or The University of North Carolina is intended or should be inferred
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This presentation in one slide

- Much focus on GME at national level but states are policy laboratories
- States actively seeking data and metrics to better target GME funding and evaluate return on investment
- Oversight bodies play critical role in interpreting metrics, educating legislature and navigating competing interests
- We heard loud call for increased accountability and transparency
- Findings not earth shattering but study (literally) gives voice to critical enablers and barriers to GME reform

Why study states?

- States increasingly investing Medicaid dollars in GME[1]:
  - In 2015, 43 states and DC made Medicaid GME payments
  - Total Medicaid GME payments increased 10% from $3.87 billion in 2012 to $4.26 billion in 2015
- This study sought to:
  - investigate how states are reforming Medicaid and state-funded GME
  - identify innovations and challenges

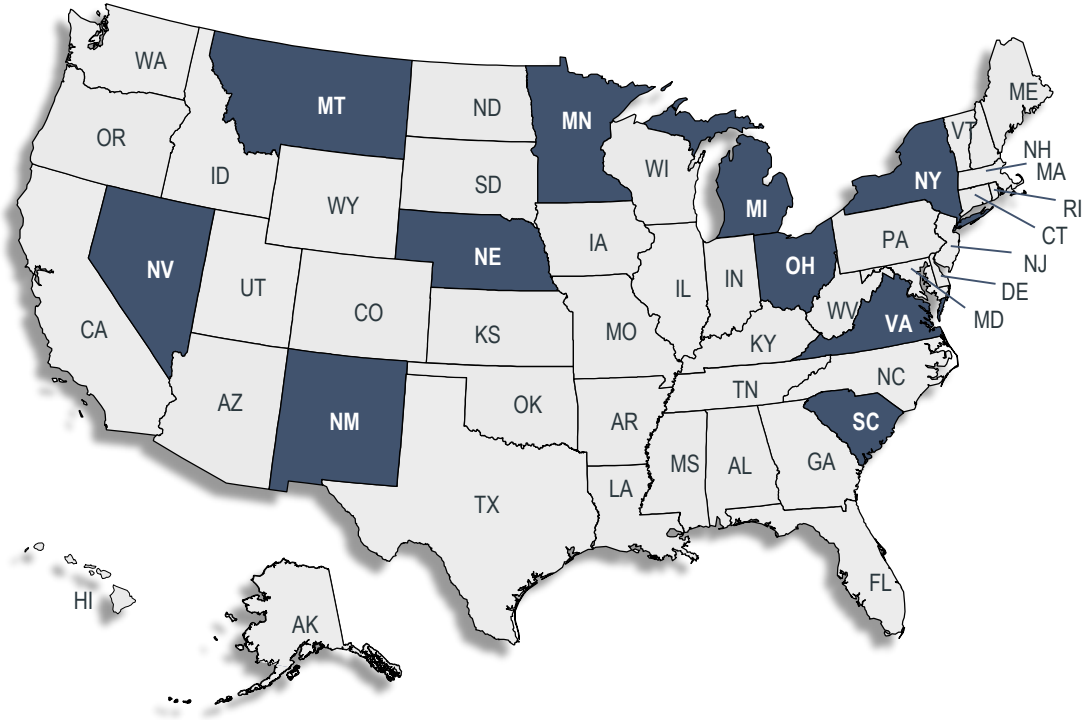
[1] Henderson, TM. Medicaid Graduate Medical Education Payments: A 50-state Survey. Washington DC: Association of American Medical Colleges; 2016.

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 2015 and July 2016
- **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	New Mexico
Minnesota	New York
Montana	Ohio
Nebraska	South Carolina
Nevada	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 question domains**
  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: Impetus for GME reform stemmed from multiple sources

- Many states had “champion”: articulated vision, coalesced stakeholders, worked with executive/legislative branches
- Many had “implementer”: focused on logistics of changing GME payment mechanism, developing metrics etc.
- States undertook GME reform to address concerns about:
  - maldistribution of physicians 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 #2: 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…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 #3:
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 #4:
We heard loud call for increased transparency

- States voiced desire to know 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. 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 #5: We also heard loud call for increased accountability

- States focused on fiscal accountability for Medicaid funds, not workforce outcomes
- Training institutions focused on quality of training; idea of being accountable for outcomes represents paradigm shift
- Interviewees 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
- Interviewees noted that some training institutions 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 #6. Lack of data and metrics are barrier to measuring workforce outcomes

- Workforce data collection and analysis seen as critical component to aligning GME spending with population health needs
- Interviewees voiced need for financial support and technical assistance to develop workforce data, metrics and analytical capacity
- Interviewees noted that developing and operationalizing metrics that can be tied to funding 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."

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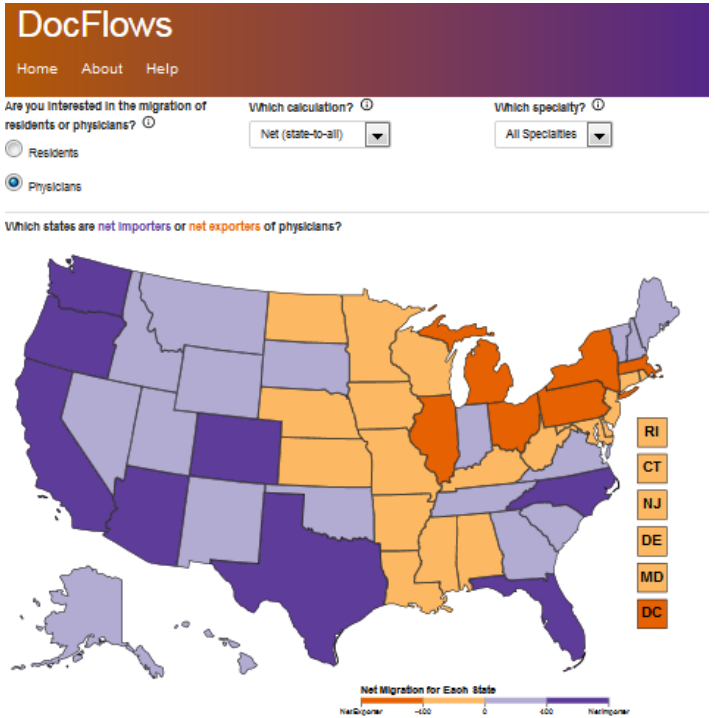
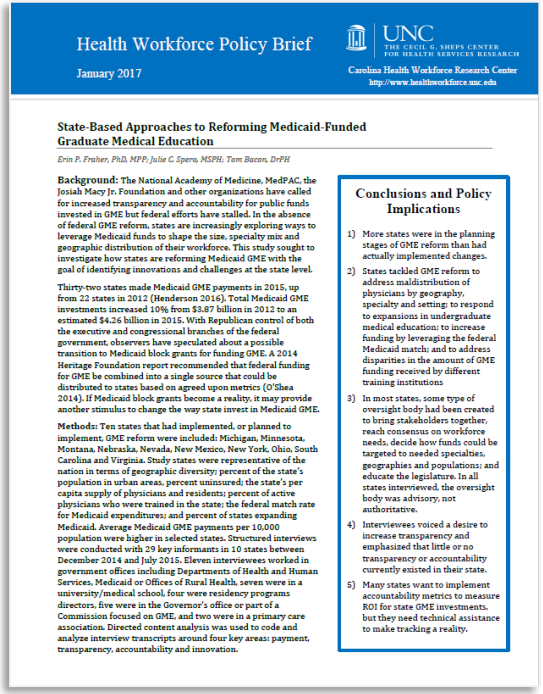


Conclusions

- States seeking better data, analyses and metrics to measure workforce outcomes and align GME with population health needs
- State efforts to develop and operationalize metrics will likely evolve, but slowly. As one interviewee put it, “This is a simmer process. This isn’t a microwave process”
- Despite limited progress, states have much to learn from each other and federal policy makers have much to learn from states

Access the report at our website

(also in your briefing packet)



Health Workforce Policy Brief

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

Erin P. Fraher, PhD, MPP; Julie C. Spero, MSPH; Tom Bacon, DrPH

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 programs 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.

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

Contact Information

Erin P. Fraher, PhD MPP
(919) 966-5012
erin_fraher@unc.edu

Director
Carolina Health Workforce Research Center
University of North Carolina at Chapel Hill
http://www.healthworkforce.unc.edu

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