Extending Pay for Value to GME: Operationalizing Social Accountability

Health Workforce Policy Seminar
January 19, 2017
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Chris Collins, MSW

Thanks to….

- Julie Spero, Soobin Seong, Erin Fraher
- DHHS Leadership (Brajer, Richard, Williams)
- Tom Bacon
- North Carolina's DIOs
- …and many others across the state and nationally.

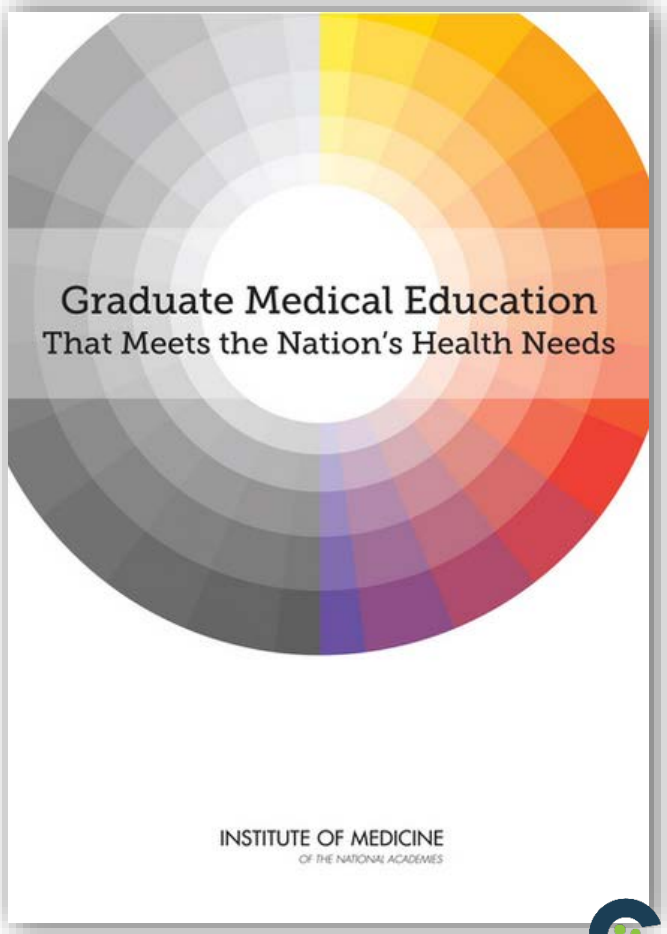
Goals for Today

- Give national and state context of GME reform and outcomes
- Describe our rationale, strategy and methodology
- Get input on approach and next steps—politics, strategy measurement, residency responses

2014 IOM GME Report

Report calls for:

- Creation of transformation fund to finance GME innovations that "**produce a physician workforce in sync with local, regional and national health needs**"
- Creation of GME Policy Council to use workforce data to determine the specialties, health care settings and geographies to invest GME transformation funds
- Greater transparency and accountability

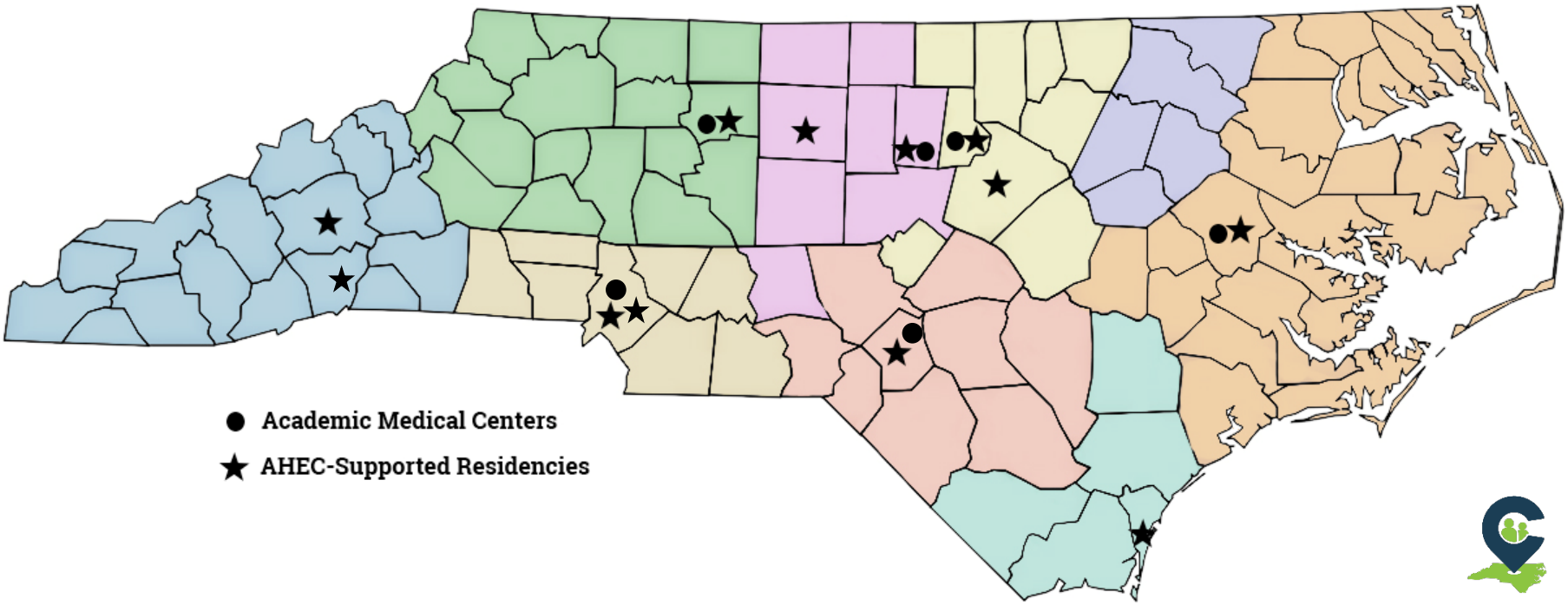


National Interest in Medicaid GME and GME Outcomes

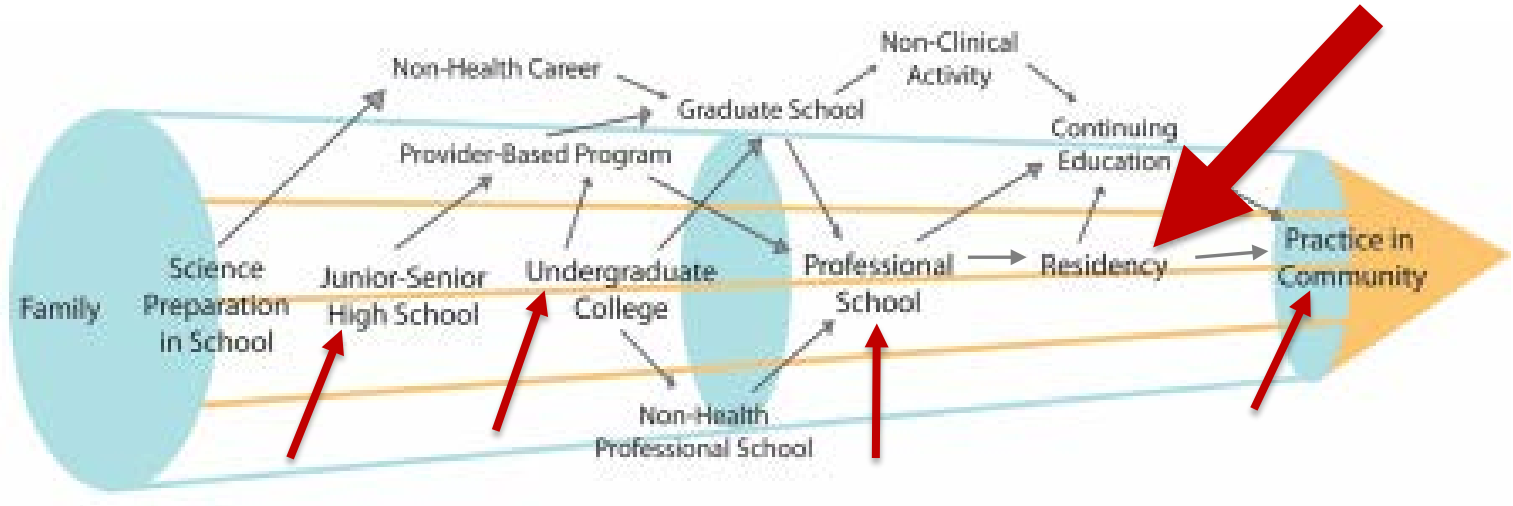
- 42/50 states have Medicaid GME
- >10 looking at reform/targeted expansion
- National Governors Association initiative
  - Bipartisan support
  - Technical Assistance
  - Financing White Paper 2/17
- Small emerging literature on outcomes, including clinical signatures, state outcomes

NC AHEC

- Founded 1972 as bridge between academic centers and communities
- Medicine initial focus, now all health professions



GME Pipeline



Strategy for GME Reform

- Be small rock triggering national avalanche
- Pilot pay for outcomes with AHEC residency stipends, with state DIOs as partners, then extend to Medicaid and all GME
- Embed GME reform and workforce development into Medicaid 1115 Waiver
- Develop plan for rural GME expansion in needed specialties
- Hardwire pay for value into Medicaid GME

GME Reform

INVITED COMMENTARY

Improving the Return on Investment of Graduate Medical Education in North Carolina

Warren Newton, Noah Wouk, Julie C. Spero

The National Academy of Medicine has called for fundamental reform in the governance and accountability of graduate medical education, but how to implement this change is unclear. We describe the North Carolina graduate medical education system, and we propose tracking outcomes and aligning residency stipends with outcomes such as specialty choice, practice in North Carolina, and acceptance of new Medicaid and Medicare patients.

It is clear that so long as a man is to practise [sic] medicine, the public is equally concerned in his right preparation for that profession.

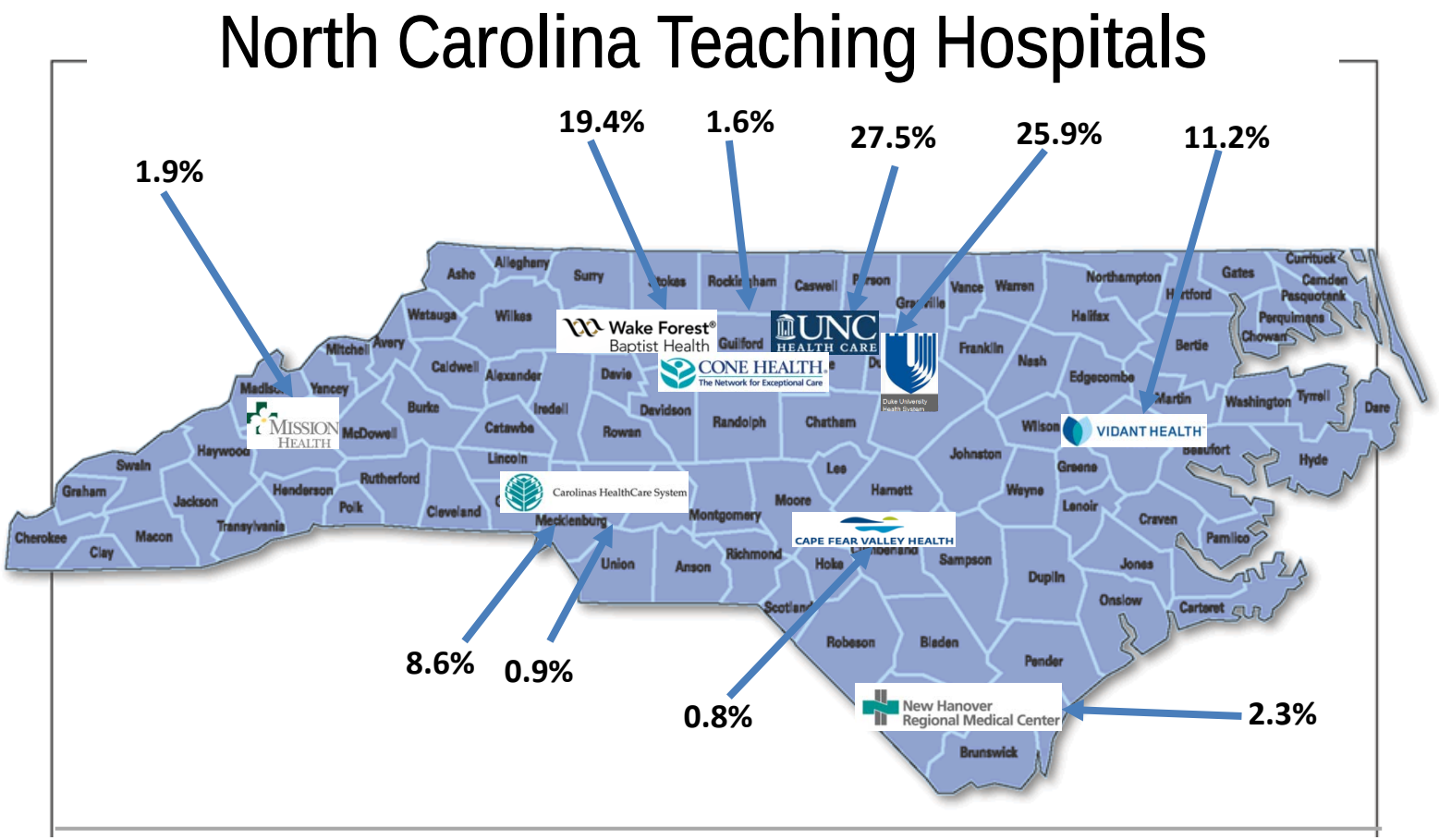
Abraham Flexner [1]

to public funds, the major teaching hospitals fund many residency slots themselves.

Across the country, state contributions to Medicaid GME funding are increasingly under scrutiny, and many states are exploring how they could target Medicaid GME funding to better support the workforce that Medicaid patients need. In North Carolina, the legislature reduced the state contribution to Medicaid GME funding during the 2015 session and requested a formal recommendation about Medicaid GME strategy by March 1, 2016 [7].

Discussion at the national level has highlighted multiple concerns about the current GME system. A recent report from NAM calls for a major overhaul of GME governance

GME in North Carolina



GME Reform

Restructuring Graduate Medical Education Payments

Session Law 2015-241, Section 12H.23.(d)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

The Fiscal Research Division

by

North Carolina Department of Health and Human Services

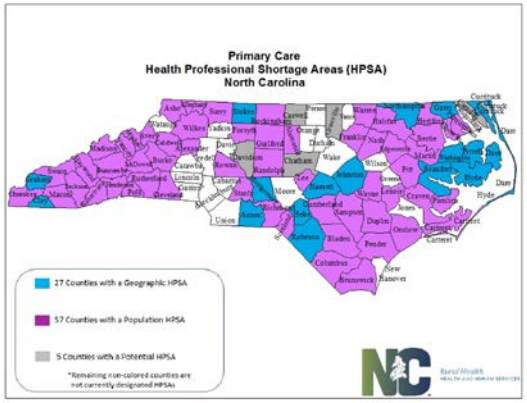
March 1, 2016

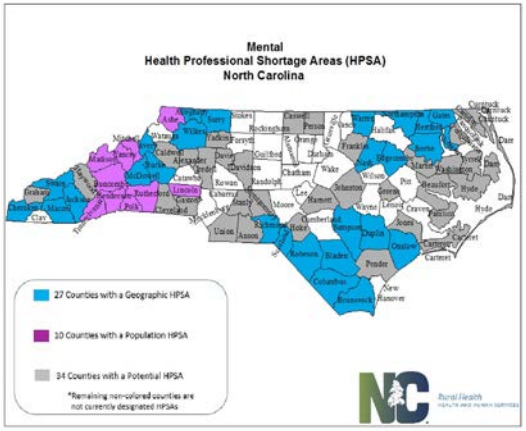
Health Care Shortages

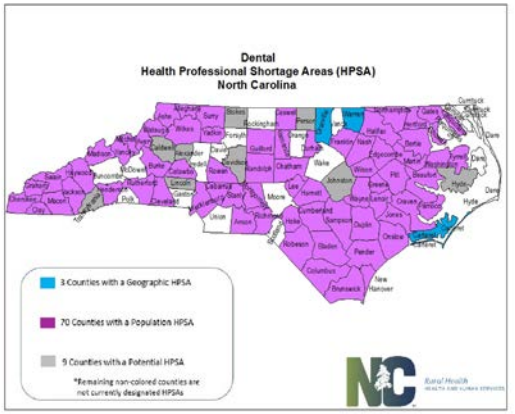
Long standing persistent health care shortages that hold true across multiple health professional disciplines.

North Carolina's rural and underserved communities continue to experience long-standing health professional service shortages. The Cecil G. Sheps Center for Health Service Research reports:

- North Carolina is facing physician workforce shortages in three specialty areas: primary care, general surgery, and psychiatry. Demand will likely increase as Medicaid reform and commercial insurers implement capitation and pay for value coinciding with an aging workforce.
- North Carolina (42%) lags behind the national average (48%) in retaining physicians in-state after completing residency training
- While North Carolina retains about 40% of its medical students, only 21% go into primary care and at best only 5% go into rural primary care







Economic Impact

The Economic Impact of a Rural Primary Care Physician & the Potential Health Dollars Lost to Out-migrating Health Services

Total Impact of a Physician on Revenues, Incomes and Employment at Physician Clinic and Hospital

	Revenue	Output Multiplier	Total Impact
Clinic	$394,275	1.37	$540,157
Hospital	$751,949	1.32	$992,573
Total	$1,146,224		$1,532,730

	Income	Income Multiplier	Total Impact
Clinic	$286,925	1.16	$332,833
Hospital	$434,627	1.28	$556,323
Total	$721,552		$889,156

	Employment	Employment Multiplier	Total Impact
Clinic	4.0	1.38	5.5
Hospital	12.6	1.38	17.4
Total	16.6		22.9

* Income includes wages, salery and benefits

Eilrich FC, Doeksen GA, St.Clair CF *The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-migrating Health Services* January 2007 website http://ruralhealthworks.org/downloads/Economic/Physician_Dollars_Jan_2007.pdf

New Factors

New Factors that compound the problem

- CMS's authorization allows NC DMA to provide additional payments (includes federal Medicaid service match) to be made to these qualified GME providers. However Session Law 2015-241 SECTION 88**.** Section 12H.23(a) removed State match for academic GME.
- Several teaching health center residency programs will experience the elimination of federal and other grant funds.
- Medicare and NC Medicaid have funded GME by adding on payments to eligible hospitals for inpatient services provided to their recipients.

Concern is that DHHS will not have adequate health care workforce:

- Provide access to primary care, mental and oral health for rural and underserved populations
- Meet Medicaid's new access mandates particularly with regards to primary and behavioral health care
  - Assuring Access to Covered Medicaid Services (CMS-2328-FC) Final Rule
- Staff local health departments and state-operated facilities

GME Survey

Association of American Medical Colleges
Medicaid Graduate Medical Education Payments:
A 50-State Survey

Medicaid GME Payment Amounts by the Top 5 States 2012	Total GME Payments Under Fee-for-Service & Managed Care (Millions of Dollars)
New York	$1,815.00
Michigan	$163.10
Virginia	$142.00
Pennsylvania	$124.20
North Carolina	$115.70

Medicaid GME Payment Amounts by the Top 5 States 2015	Total GME Payments Under Fee-for-Service & Managed Care (Millions of Dollars)
New York	$1,640.00
Florida	$350.00
Virginia	$263.00
South Carolina	$241.10
Arizona	$163.00

https://members.aamc.org/eweb/upload/Medicaid%20Graduate%20Medical%20Education%20Payments%20A%2050-State%20Survey.pdf
http://members.aamc.org/eweb/upload/Medicaid_Graduate_Medical_Education_Payments--A_50_State_Survey.docx.pdf

Estimated Reduction in Medicaid IME & GME Expenditures for State Fiscal Year 2016 - 2017

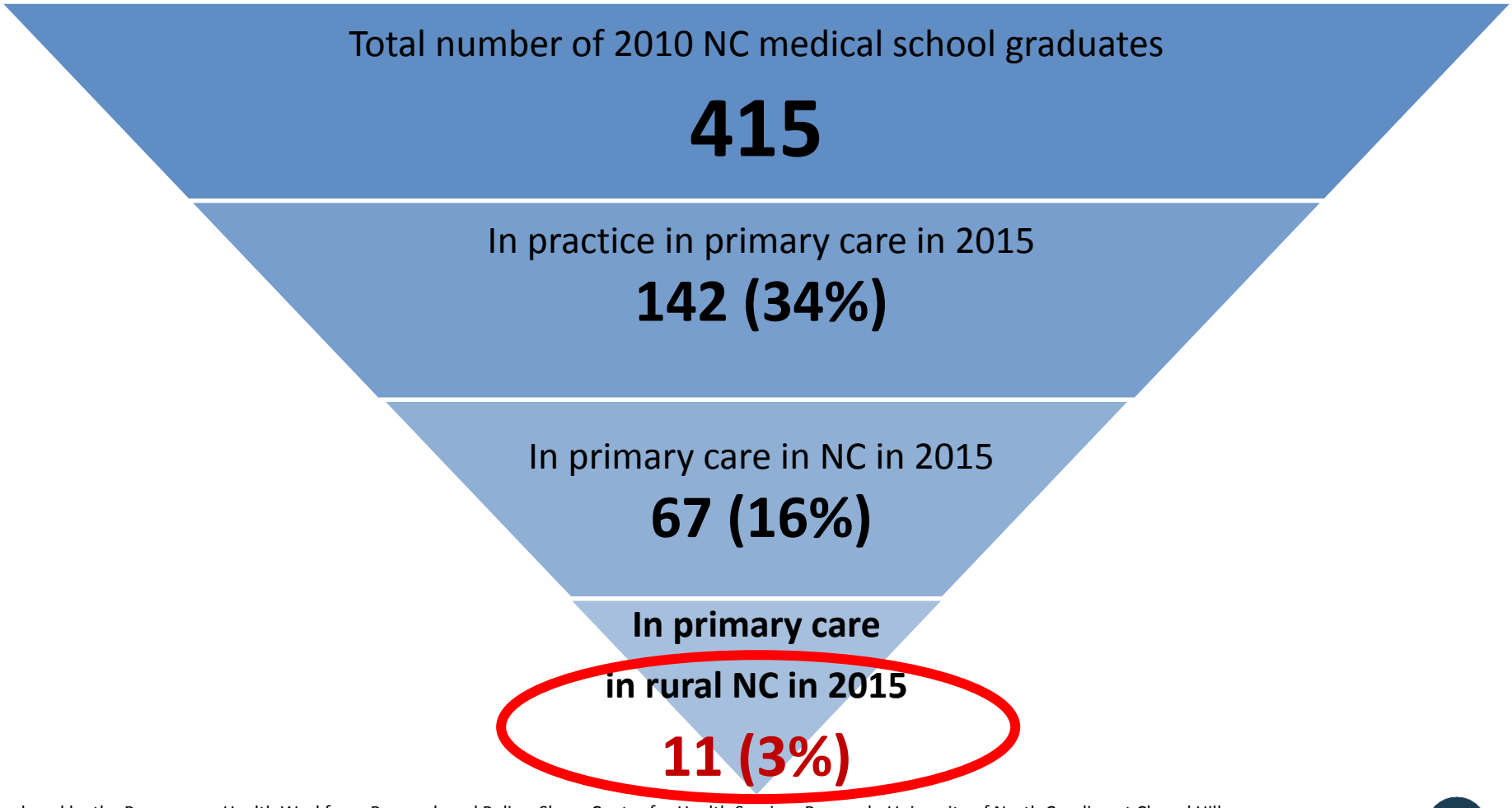
Hospital Facility	Total Expenditure IME & GME	Federal Share	State Share
University of North Carolina Hospital	($26,692,938)	($17,809,528)	($8,883,410)
North Carolina Baptist Hospital	($17,256,344)	($11,513,433)	($5,742,911)
Duke University Hospital	($14,861,863)	($9,915,835)	($4,946,028)
Vidant Medical Center	($13,540,793)	($9,034,417)	($4,506,376)
Carolinas Medical Center	($8,669,018)	($5,783,969)	($2,885,049)
Wake Medical Center	($1,866,744)	($1,245,492)	($621,252)
New Hanover Regional Medical Center	($1,502,623)	($1,002,550)	($500,073)
Mission Hospital	($1,394,649)	($930,510)	($464,139)
Moses H. Cone Memorial Hospital	($1,250,752)	($834,501)	($416,250)
Cape Fear Valley Medical Center	($831,568)	($554,822)	($276,746)
Durham Regional Hospital	($581,703)	($388,112)	($193,591)
Forsyth Memorial Hospital	($529,834)	($353,505)	($176,329)
Carolinas Medical Center - Northeast	($518,021)	($345,624)	($172,397)
Blue Ridge Healthcare Hospitals	($466,049)	($310,948)	($155,101)
Carolinas Rehabilitation	($189,937)	($126,726)	($63,211)
Union Regional Medical Center	($116,798)	($77,928)	($38,870)
Margaret R. Pardee Memorial Hospital	($73,277)	($48,891)	($24,387)
Carolinas Medical Center - Mercy	($66,415)	($44,312)	($22,103)
Total of Estimated Reduction	**($90,409,327)**	**($60,321,103)**	**($30,088,224)**

DHHS Current Efforts

- **Maintaining current academic funding**
- **Advocate to build community based residency programs**
  - Maintain our current teaching health centers
  - Leverage existing federal funds to the extent possible
  - 1115 Waiver supported cost settlement for outpatient residency and fellowship programs
- **Improve the ability to document the outcome of DHHS's investments**
  - North Carolina's data is limited and DHHS cannot provide comprehensive data on:
    - The number of medical students receiving in-state tuition, by county and statewide
    - The number of students receiving state-supported GME, by county and statewide
    - The types of specialties trained with state-supported GME
    - The specialties in which health professionals practice after receiving state- supported GME
    - The geographic distribution of health professionals who practice after receiving state-supported GME
- **Work with partners to address the pipeline barriers**
- **Recommended an Advisory Board that incorporates representatives from the various stakeholders**

How should we measure GME outcomes?

2010 Medical School Graduates: Retention in Primary Care in NC's Rural Areas 5 years later



Produced by the Program on Health Workforce Research and Policy, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Source: North Carolina Health Professions Data System with data derived from the Association of American Medical Colleges, and the NC Medical Board, 2015.

Rural source: US Census Bureau and Office of Management and Budget, July 2015. "Core Based Statistical Area" (CBSA) is the OMB's collective term for Metropolitan and Micropolitan Statistical areas. Here, nonmetropolitan counties include micropolitan and counties outside of CBSAs.

Measuring Outcomes of GME

- Stage 1: Developed approach with input of NC DIOs; warn hospital CEOs
- Stage 2: Define AHEC residencies and support
- Stage 3: Learning where stipends go within institutions
  - Stipends to 29 residencies
  - Other Support to Departments/ Residencies (N=8—additional 4)

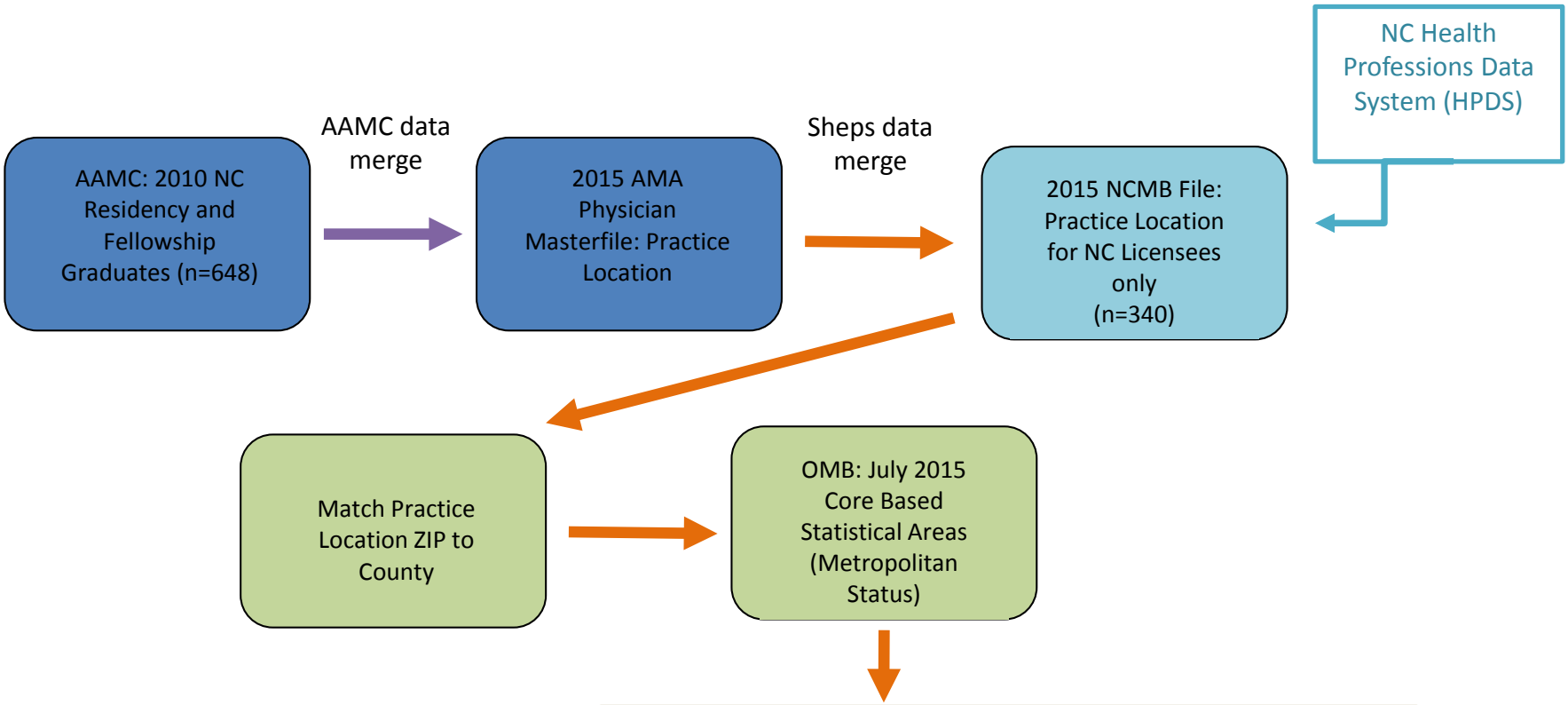
NC AHEC Support of GME

- Stipends: 293.1 x $11,790/stipend distributed to 11 hospitals by formula (see handout)
- Legislatively directed support to Departments of Family Medicine (Duke, ECU, Brody) and Psychiatry (Duke, ECU, Brody, UNC)

Study Design

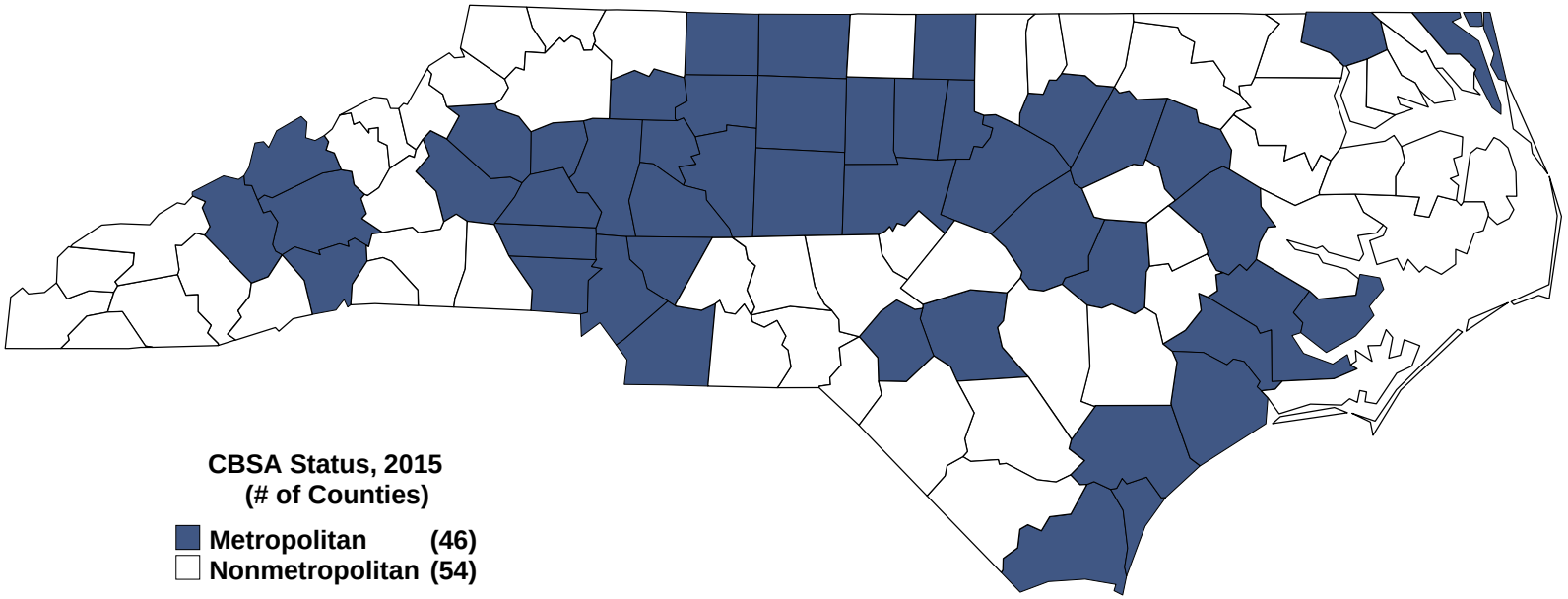
- Cohort study: Where are graduates of NC AHEC supported residency programs practicing 5 years later?
- Key outcome variables:
  A. In practice in North Carolina?
  B. In practice in rural North Carolina county?
- Results reported at two levels:
  - Residency program
  - Institution

Data Sources



Our Rural Definition:
OMB's Core Based Statistical Areas

Metropolitan Status*
North Carolina, 2015



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Produced By: North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Initial Specialty Definitions

- Outcomes shown by residency program
- “Primary Care” Residency Programs include:
  - Family Medicine
  - Internal Medicine
  - Pediatrics
  - Internal Medicine-Pediatrics
  - Obstetrics & Gynecology
- These are not individual physician outcomes or “areas of practice”

Key Limitations: Dataset based on Final Year of GME training

- Data include NC GME grads for whom 2010, 2009, or 2008 was their final year of training in AAMC GMETrack data
- The initial numbers do not show NC grads who continued training after initial residency
  - 29 residents entered UNC IM GME in 2007
    - 6 of 29 completed training in 2010 and entered practice: **included**
    - 23 of 29 entered additional training in GME Track: **not included**
- We plan to update with data on ALL grads from each year when we have the data from AAMC

Residency program outcomes vary between years at the institution level…

(Institution A) GME Outcomes by Graduation Cohort				
GME Graduation Year	GME Outcome Year	Total Physicians in Practice (not in training)	Number of Physicians in Practice in NC	Percent of Physicians in Practice in NC
2008	2013	148	67	**45%**
2009	2014	149	61	**41%**
2010	2015	141	50	**35%**

…and the program level.

GME Program Outcomes by Graduation Cohort						
GME Institution	GME Program	GME Grad Year	GME Outcome Year	Total Physicians in Practice (not in training)	Number of Physicians in Practice in NC	Percent of Physicians in Practice in NC
Institution A	Psychiatry	2008	2013	6	5	**83%**
Institution A	Psychiatry	2010	2015	4	0	**0%**
Institution B	Family Medicine	2009	2014	12	8	**67%**
Institution B	Family Medicine	2010	2015	6	1	**17%**

How can we improve the data? Feedback from DIOs

- Rural definition challenging; be careful with maps.
- Look at what graduates are doing—clinical focus, from medical license dat
- Include general surgery, community psychiatry, med/psych as positive outcomes—and include those going to fellowships in denominator
- Use 3-5 year rolling average
- Include first placement after residency
- Include URMs if possible

Other comments from DIOs

- "Changing the mission from recruiting and graduating residents to being a pipeline to communities"
- Alignment with system mission is critical as well as attitude of system leadership towards GME; consider balanced scorecard approach
- "Focused factories" for specific clinicians being set up
- What about looking at new model of care, with hospitalists and ED doctors playing key roles?
- Look at state impact of institutional GME touches

What are the implications of pay for performance for residencies?

- Recruitment for likelihood of staying in state
- Curriculum—long enough, good quality experience
- Placement after residency

Messaging

- NC Medical Journal: making the case explicitly
- Hospital reactions: CFOs vs. DIOs
- Involving the community
- Language: ROI vs. social accountability
- Politics: the hope of bi-partisan reform and service to rural communities
- The Triple Aim for GME:
  - providers more likely to practice,
  - the goals of actual care and
  - jobs
- Economic Impact: how to measure

Plan for GME Expansion

- March 2016 DHHS Plan
- Key question: replace Medicaid GME or in addition to GME
- NCHA concerns/budget drama
- Consensus Development—strategy
  - Triple Goal: Providers, Needed Care, Jobs
  - Rural focus, needed specialties + wrap around supports
  - $20m Recurring dollars, pull down GME
  - Initial RFP; Broaden to non-physician providers
  - Support for outcomes data
  - DHHS to review data and set GME Policy

NC Medicaid GME Reform

- Summer, 2015: Legislature cuts Medicaid GME, but also funds residencies in needed specialties in rural areas and asks for DHHS recommendations
- March, 2016: DHHS recommends tracking outcomes of Medicaid GME, GME expansion in needed specialties and rural areas.
- June, 2016: Medicaid waiver includes support for GME workforce
- Summer, 2016: Legislature funds additional residencies in Cape Fear Valley in Fayetteville.
- Priority now is **preserving** Medicaid GME and expanding GME in needed areas and specialties, especially with expansion and political wars…

Next Steps

Comments, Questions?

Never Dull: Politics

- State Plan Amendment November 2016
- Cooper Medicaid Expansion, new SPA
- New NC Secretary DHHS
- Pyrotechnics
- Washington Change of Administration, block grants and fate of GME

Next Steps—Policy

- Changing roles (DHHS, Collins, Newton)
- Preserve Medicaid GME
- Push for GME expansion plan
- Support 1115 waiver if approved…

Next Steps— Outcomes Measures

- Get full denominator of graduating residents
- Include all specialties of interest, current practice focus
- Calculate 3-5 year rolling averages
- Include look at first job out
- Consider maps/visualizations
- Explore URM, rural background

Next Steps for AHEC

- Continue convening DIOs, engage Campbell.
- Publish initial results
- Develop strategies to respond to pay for value GME: recruitment, curricula, placement
- By 6/17, develop plan for redistribution of stipends, with gentle pressure.
- 2017-18 an observation year; stipend adjustment starting in 2018-19
- Work nationally with NGA and others