



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

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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.

Forty-three states and the District of Columbia made Medicaid GME payments in 2015 (Henderson 2016; Henderson personal communication 2017). 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 2015 and July 2016. 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

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.

analyze interview transcripts around four key areas: payment, transparency, accountability and innovation.

Findings: More states were in the planning stages of GME reform than had actually implemented changes.

Impetus for reform: States initiated GME reform to address maldistribution of physicians by geography, specialty and setting; to respond to expansions in undergraduate medical education; and to address equity concerns about the amount of GME funding received by different training institutions. The drive for change was reinforced in some study states by a “champion” who had a vision for a transformed Medicaid GME system. The role of the champion was to articulate the vision, coalesce the stakeholders, and to work with the executive and/or legislative branches to implement change.

Approaches GME Funding Reform: State approaches to reforming GME funding included better leveraging Medicaid funds to capture the federal match; pursuing Medicaid 1115 waivers to modify federal rules for allocating Medicaid funds; and allocating state appropriations to create GME innovation pools, fund rural rotations and/or provide seed money to fund new residencies or expand existing programs. Medicaid funds were seen as a key policy lever in most states. States increasingly recognized the need to shift from claim-based GME payments to mechanisms that supported and reinforced desired workforce outcomes. Due to resistance from teaching hospitals, states found it easier to seek new funding in fairly modest amounts from the legislature rather than redistribute existing GME funds.

GME Governance: In most states, some type of oversight body had been created to bring stakeholders together, reach consensus on workforce needs, and decide how funds could be targeted to needed specialties, geographies and populations. In all states interviewed, the oversight body was advisory, not authoritative. Most oversight bodies included representatives from the academic health centers, the major teaching hospitals, the hospital and medical associations and other significant stakeholder groups with an interest in GME reform, such as primary care associations, offices of rural health, and senior state health officials. Broad representation on the oversight body helped states navigate competing stakeholder interests. Oversight bodies played a critical role in educating the legislature about GME.

Transparency/Accountability: Interviewees voiced a desire to increase transparency but emphasized that little or no transparency or accountability currently existed in their state. In one state, the lack of data to justify the return on investment (ROI) of GME funds resulted in GME funds being cut from the Governor’s budget. Most states acknowledged that collecting data to demonstrate ROI was critical to securing new GME appropriations but as one interviewee noted “[n]obody 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.”

Conclusion/Policy Implications: In the few states where information about GME payments have been made public, disparities between institutions are readily apparent and have motivated change. States are hungry for data to better inform decision-making about how best to invest scarce resources. At the same time, an understanding of how to obtain and track data on physician workforce outcomes is lacking.

Limitations- Policy change in how states are using Medicaid funds to shape their workforce are occurring rapidly. Our study does not capture initiatives undertaken after interviews were conducted. State selection was based on willingness to participate and ability to identify individuals willing to be interviewed.

References

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