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

Erin Fraher, PhD, MPP
Julie Spero, MSPH, Tom Bacon, DrPH

Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
GMEI Summit, Albuquerque, New Mexico
January 23, 2017
Disclaimer/No Conflict of Interest

- Study supported by the National Center for Health Workforce Analysis (NCHWA), Health Resources and Services Administration (HRSA) under cooperative agreement #U81HP26495. 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.

- I declare no conflict of interest.
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
Why Study States?

• Federal GME reform efforts have stalled
• States are “policy laboratories” for GME innovation
• Thanks to Tim Henderson, good state data:
  – 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
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 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
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
“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
• “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.
Access the report at
Contact Information

Erin Fraher
(919) 966-5012
erin_fraher@unc.edu

Program on Health Workforce Research & Policy
http://www.shepscenter.unc.edu/hp
http://www.healthworkforce.unc.edu