Lessons Learned from State Efforts to Leverage Medicaid Funds for Graduate Medical Education

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I. Introduction

Federal efforts to reform Medicare funded graduate medical education (GME) to make it more accountable and responsive to population health needs have stalled. Despite this inaction, states are actively engaged in finding policy levers to address their health workforce needs. One lever is Medicaid GME payments which are increasingly being used by states to expand physician supply in needed specialties and settings, respond to population growth and medical school expansions, and sustain existing GME training programs.

Forty-four states and the District of Columbia made Medicaid GME payments in 2022. Total state and federal Medicaid GME investments increased nearly 96% from $3.78 billion in 2009 to $7.39 billion in 2022.[1] Unlike Medicare or other federal GME payment systems, states have considerable flexibility in designing and administering their Medicaid GME payments to address population health needs.[2] This study used states as "policy laboratories" to identify the lessons learned and challenges encountered as states leveraged Medicaid funding for GME. We used a qualitative approach to gain a richer understanding of states' impetus for using Medicaid funds, the structure of their investments, the composition and charge of advisory bodies that helped guide these investments, and the degree of transparency and accountability to track whether Medicaid GME investments achieved desired workforce outcomes.

Policy Implications

Medicaid is the second-largest funder of Graduate Medical Education in the United States, and states have significant flexibility in designing their Medicaid GME programs. The goal of this study was to use states as "policy laboratories" to identify the lessons learned and challenges encountered as states leveraged Medicaid funding for GME, finding that:

1) States are using Medicaid GME payments to increase physician workforce capacity in underserved communities, respond to population growth and medical school expansion, and sustain training programs launched using state appropriations and through the Teaching Health Center program.
2) States leveraged Medicaid expansion funds to capture the larger federal match, modified State Plan Amendments, and re-designed formulas to dynamically address specific state workforce needs.
3) GME advisory bodies are being convened to educate legislators, reach consensus on workforce needs, and recommend reforms.
4) Improved data systems are needed to assess workforce needs, track funding, and evaluate health workforce outcomes.

Findings from this study can help inform individual state efforts and guide federal policy makers interested in convening learning collaboratives to share best practices and address common challenges.

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II. Methods

We used peer-reviewed and gray literature, state legislation, news reports, and GME subject matter experts to identify states to include in the sample. Based on this review, and using a purposive sampling strategy, we selected ten states for our first round of interviews in 2015-2016: Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, New York, Ohio, South Carolina, and Virginia that were using Medicaid GME funds to address state health workforce and population health needs. We conducted a second round of interviews during the first two years of the COVID-19 pandemic (2020-2021) with eight of the same states that participated in 2015-2016 interviews: Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, South Carolina, and Virginia. Representatives from Ohio and New York were unavailable for re-interviewing in 2020-2021, so we interviewed two additional states, Florida, and Wisconsin. Selected states were generally representative of the nation in terms of geographic regions of the US; the percent of the state's population in urban areas; percent uninsured; the state's per capita supply of physicians and residents; the percent of active physicians who were trained in the state; the federal match rate for Medicaid expenditures, and Medicaid expansion status. Interviewees were based in the Governor's office, Departments of Health and Human Services, Medicaid and Offices of Rural Health, primary care offices, universities and medical schools. Interview transcripts were coded independently using consensus coding and analyzed using directed content analysis.

III. Findings

Impetus for Using Medicaid Funds for GME: States used funds to address a maldistribution of physicians by geography, setting, and specialty and to increase physician workforce capacity in response to population growth and the expansion of undergraduate medical education. Medicaid funds were also used as a mechanism ensure the sustainability of programs, developed using state appropriations and through the Teaching Health Center program.

Funding Strategies: States leveraged Medicaid expansion funds to capture the larger federal match, modified State Plan Amendments to change how Medicaid funds are allocated, and re-designed formulas to address specific state workforce needs. States funded residency training in community-based settings and needed specialties, and dynamically adjusted investments over time based on changing workforce needs.

Advisory Bodies: Many states had an advisory or oversight body to educate legislators, reach consensus on workforce needs, and recommend how to disburse funds while navigating the competing interests of stakeholders. The long-term sustainability and level of authority of these bodies is unclear.

Transparency: States identified a need for improved data and analytic systems to assess their workforce needs, track GME funding flowing to training institutions, and evaluate the outcomes of GME investments.

Accountability: States voiced a strong desire to better align funding with population health needs, but determining which accountability measures to use and implementing metrics was a challenge.

IV. Policy Implications

These findings raise several implications for policy interventions:

Growing and Sustaining GME in Underserved Areas: Several states have used Medicaid GME funds to establish and sustain residency programs in underserved areas. However, they have struggled to launch programs in resource-limited environments. To address these barriers, some states are now using state appropriations and Medicaid funds to provide technical assistance to launch new programs and sustain existing ones in health centers and small rural hospitals.

Design Flexibility: States have viewed the flexibility available to design and implement Medicaid GME reforms as a strength. However, they varied in their utilization of this flexibility. Some states continue to use traditional, Medicare-based funding formulas, while others have opted to modify formulas to distribute funds to meet specific health workforce or population health needs.

Barriers to Reform: States cite opposition from some GME stakeholders, challenges in developing accountability metrics, lack of workforce data, and the difficulty of implementing accountability measures in their political environment as barriers to reform. They have expressed a need for resources and technical assistance to develop, collect, and analyze data on the state health workforce and GME outcomes.

Shared Learning: States are pursuing a variety of Medicaid GME reforms and can learn from one another about strategies for using Medicaid GME to meet population health needs. The formation of learning collaboratives would enable states to share best practices, develop data infrastructure, and distribute educational materials on Medicaid GME. Organizations such as the National Council of State Legislatures, Milbank Memorial Fund, the National Academy of Medicine, National Governors Association, and the Health Resources and Services Administration could play key roles in providing leadership and funding for learning collaboratives.

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