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

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• I declare no conflict of interest
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

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 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
“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
"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.”
Our new DocFlows Mapping App Seeks to Provide States with Data

- Data visualization tool allows users to query, download and share maps showing interstate moves by residents and actively practicing physicians in 36 specialties
- Stakeholders: HRSA, COGME, MedPAC, ACGME, professional associations, state policy makers
- DocFlows available at: docflows.unc.edu
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)

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