GRADUATE MEDICAL EDUCATION SUMMIT

State Medicaid Examples

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Colorado Medicaid Support of Family Medicine GME

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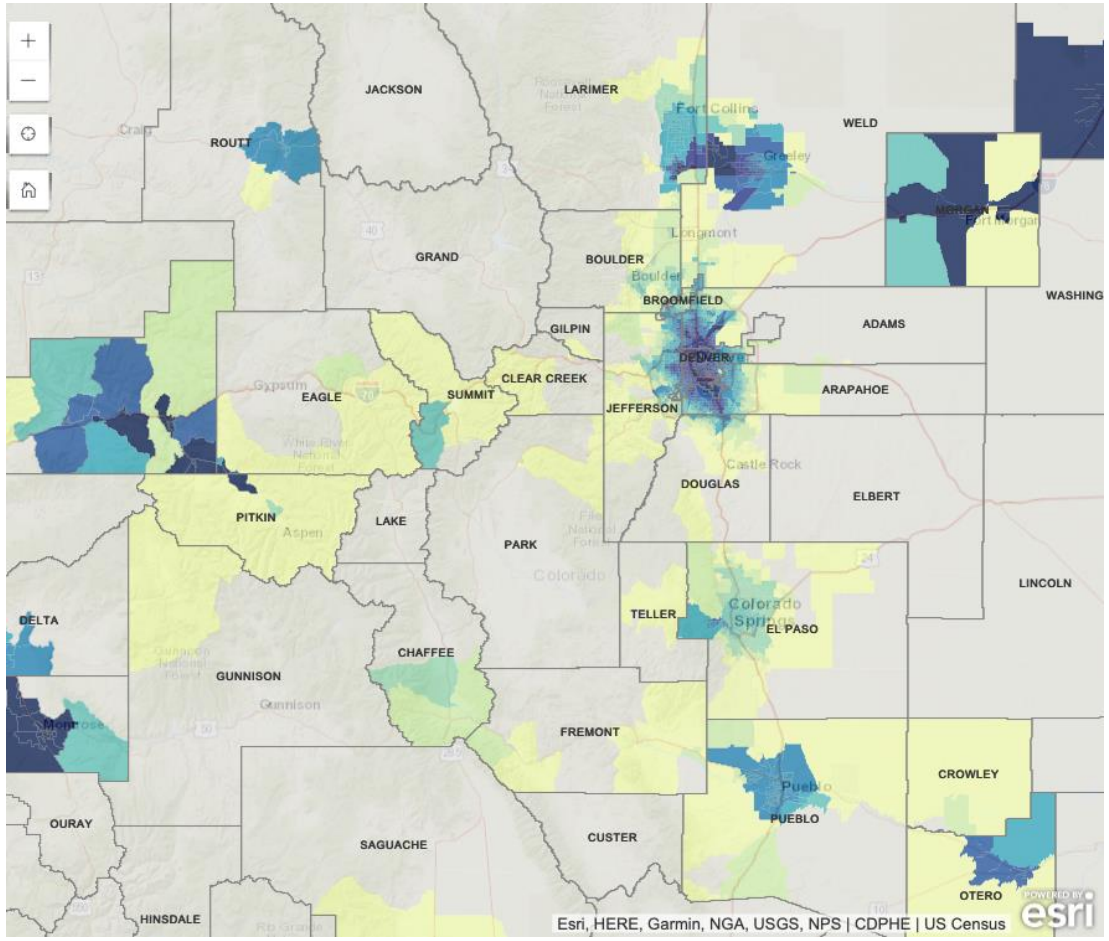
Many Thanks To:

- Kent Voorhees, MD
  - Professor Emeritus, University of Colorado School of Medicine
- Lynne Jones
  - Executive Director, Colorado Commission on Family Medicine
- Julie Herzog
  - Director of Operations, Colorado Association of Family Medicine Residencies

Colorado Basics

- Large rapidly growing metro area but rest of state is very rural
- Growing primary care workforce shortage worse than many other states
- Worsening (and already poor) rural healthcare access
- Primary care more dependent on FM than many other states



Decile 1 (Lowest Need)

Decile 2

Decile 3

Decile 4

Decile 5

Decile 6

Decile 7

Decile 8

Decile 9

Decile 10 (Highest Need)

Colorado FM GME

- 10 FMRPs
- 4 Rural Training Tracks
- 249 residents
- Output 83 graduates per year
  - 60% remain in state after graduation
  - Majority in rural or underserved settings

Colorado Medicaid Support of GME

- Total $13.7 million in 2022
  - 38th of 44 states who provide Medicaid GME payments
- FMAP rate 0.5 (1:1 matching)
- $4.3 million in DGME payments to 17 teaching hospitals
  - 1,200 total residents
  - Based on hospital Medicaid discharges
  - Averages $3,600 per resident but varies by institution
- $9.4 million specifically directed to support FM GME
  - 249 residents

Commission on Family Medicine-1977

- Created by two rural, bipartisan, non-physician legislators to ensure a rural primary care workforce to meet community needs
- Composition
  - Citizen representatives from each Congressional District appointed by Governor
  - Directors of each Colorado FMRP
  - Deans of Colorado Medical Schools
  - Representative from Colorado Academy of Family Physicians
- Legislative line item funding- currently $3,300,000 annually
  - Supports recruitment, development and collaboration among FMRPs via the Colorado Association of Family Medicine Residency Programs
  - Direct support to each FMRP
- Requires all Colorado FM residents complete a one month rural rotation

Rural Training Tracks- 2014

- Initial startup funds for 3 RTTs
  - $3,000,000
  - Half from a private foundation
  - Half from state legislature
- Maintenance funds for ultimately 4 RTTs
  - $3,000,000 annually

Additional Funding- 2015

- Support for 5 residents committed to 3 years in-state rural or underserved practice after graduation including loan repayment
  - $2,700,000 annually
- Loan repayment for FMRP Faculty committed to 3 years in state
  - $400,000 annually

Take Home Messages

- It’s possible to strongly support FM even in a state with relatively little Medicaid GME funding
- Enlisting legislative support specific to FM is crucial
- A collective approach to funding benefits everyone
- Building in robust collaboration between FMRPs is a critical success factor

Medicaid GME Funding in Montana

April 2024

Rob Stenger, MD, MPH

Chair
Montana GME Council

Program Director
Family Medicine Residency of Western Montana

Acknowledgements and Disclosure

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CFO (Retired), Family Medicine Residency of Western Montana

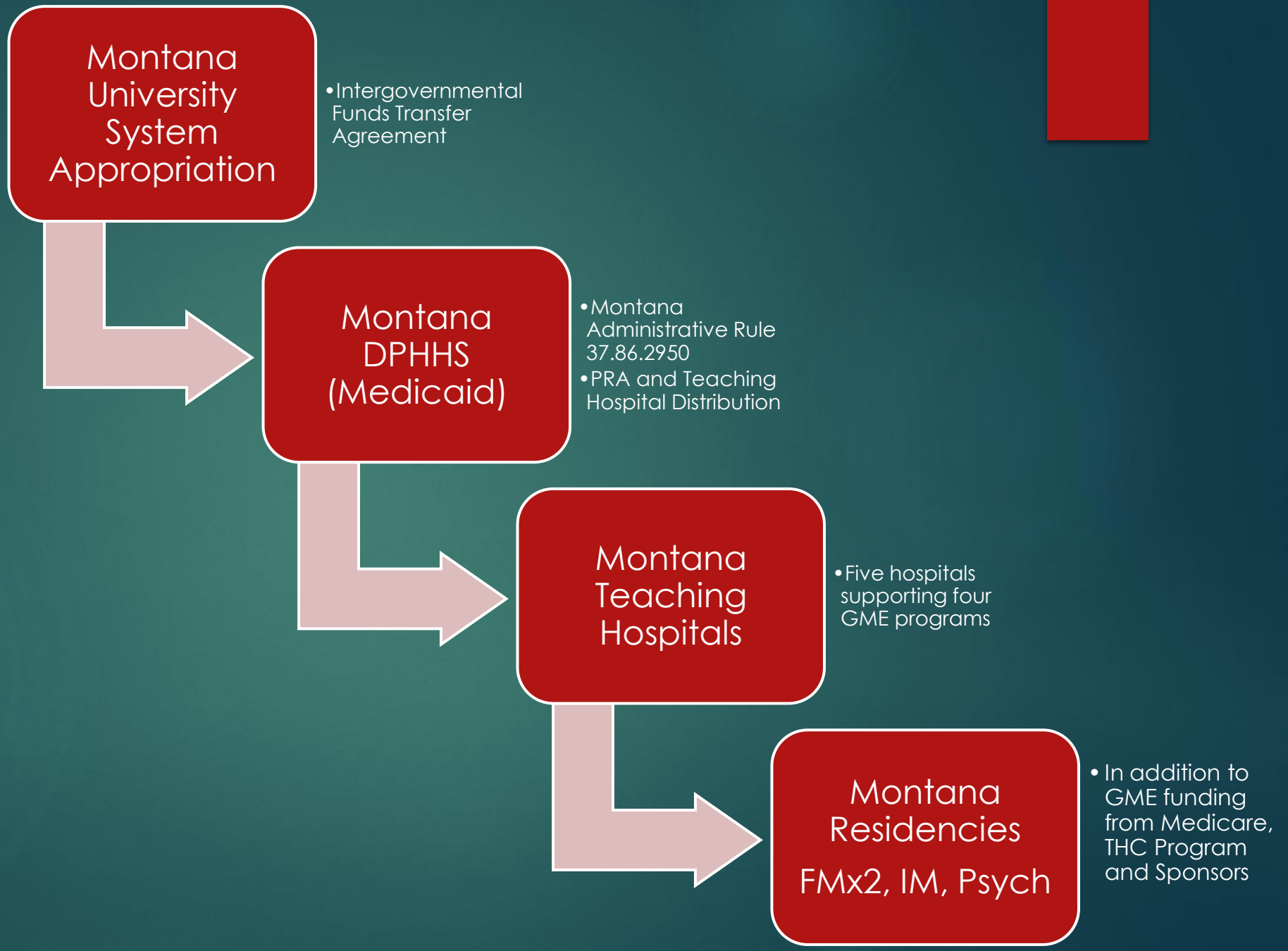
Bob Olsen

President and CEO, Montana Hospital Association

History of Montana GME Funding

- **Pre 1990s** – Medicaid GME
- **1990s** – state budget cuts eliminated Medicaid GME
- **2000s** – MT GME funding restarted as direct funding through the Montana University System (MUS), state appropriation of $400,000
- **2012** – Interagency Funding Agreement between MUS and MT DPHHS reestablished Medicaid GME
- **2014** – State appropriation for GME increased to $915,000 (new FM and IM programs)
- **2015** - Montana expanded Medicaid under the ACA, significant increase in available GME funds
- **2018-19** - Montana GME Council worked with DPHHS to adjust the hospital payment formula to more fairly calculate resident funding

Flow of Montana GME Funds

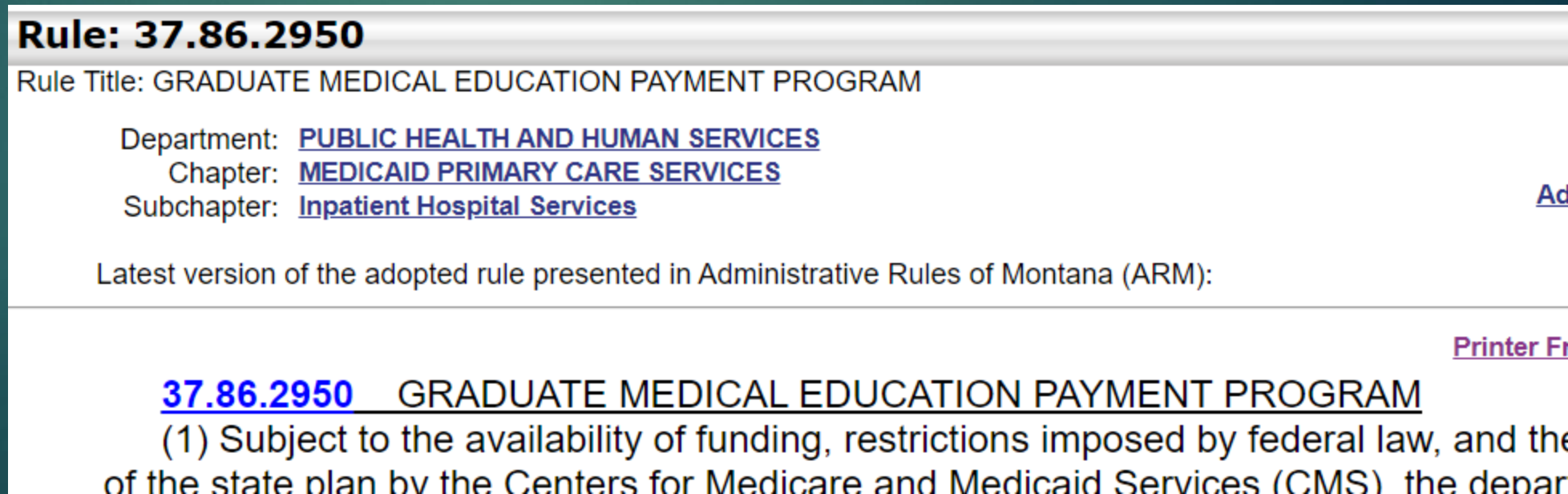


Montana GME Payment Rules

- Total GME funding pool based on state appropriation and Federal Medicaid Assistance Percentage (FMAP)

- Annual Per-Resident payments to teaching hospitals based on:
  - Primary care or psychiatry resident FTE percentage supported by hospitals, and
  - Hospital's weighted Medicaid utilization percentage

Rules.mt.gov



Rule: 37.86.2950

Rule Title: GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

Department: PUBLIC HEALTH AND HUMAN SERVICES
Chapter: MEDICAID PRIMARY CARE SERVICES
Subchapter: Inpatient Hospital Services

Latest version of the adopted rule presented in Administrative Rules of Montana (ARM):

37.86.2950 GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

(1) Subject to the availability of funding, restrictions imposed by federal law, and the

Calculation of the MT GME Pool

Claiming Methodology Percentages	
Standard Medicaid	**45.36%**
HELP Medicaid	**54.64%**

GME POOL SFY 2023:	**$ 914,769.00**	**FMAP**	**Total w/Fed Match**
Standard Medicaid	$ 414,949.31	66.62%	$ 1,243,107.59
HELP Medicaid	$ 499,819.69	90.00%	$ 4,998,196.86
Total	**$ 914,769.00**		**$ 6,241,304.45**

Calculation of Annual Payments to Teaching Hospitals

Total Computable GME Pool	**6,241,304.45**					
Total FTEs in State	83.75					
Per Resident Amount (PRA) (1)	74,521.53					
	Hospital A	**Hospital B**	**Hospital C**	**Hospital D**	**Hospital E**	**Total**
FTE Count	43.18	10.63	21.13	6.18	2.63	**83.75**
FTE Percent of Total	51.56%	12.69%	25.23%	7.38%	3.14%	**100%**
Medicaid Inpatient Days	23,587	16,392	8,931	7,813	11,785	**68,508**
Total Inpatient Days	87,717	58,385	44,832	24,533	41,066	**256,533**
Medicaid Utilization Percentage (2)	26.89%	28.08%	19.92%	31.85%	28.70%	**26.71%**
Weighted Medicaid Average (3)	13.86%	3.56%	5.03%	2.35%	0.90%	**25.70%**
Medicaid Utilization Index (4)	1.046	1.092	0.775	1.239	1.116	
Adjusted PRA (5)	77,957.33	81,395.18	57,753.73	92,328.38	83,198.45	
GME Distribution (6)	**3,366,197.71**	**865,369.17**	**1,220,336.27**	**570,589.38**	**218,811.92**	**6,241,304.45**

Policy Considerations

- Direct funding of programs or other GME efforts?
- Specialty preference?
- What about residents not supported by hospitals?
- Vulnerability of funding in the state budget?
- Changes to Medicaid Program over time?
- Residency Growth over time?

Potential GME Pool w/o Medicaid Expansion

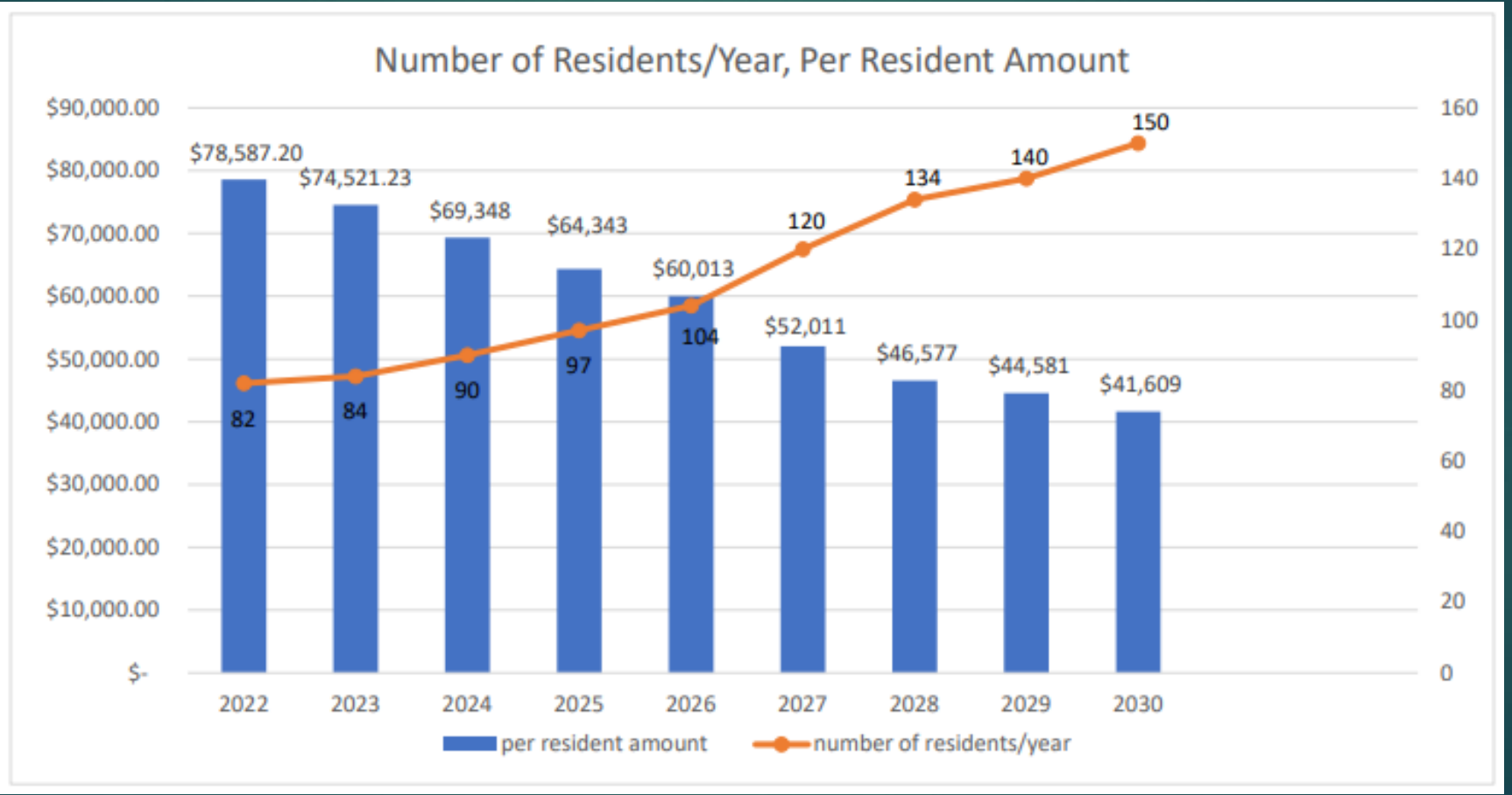
Claiming Methodology Percentages	
Standard Medicaid	100.00%
HELP Medicaid	0.00%

GME POOL SFY 2023:	$ 914,769.00	FMAP	Total w/Fed Match
Standard Medicaid	$ 914,769.00	66.62%	$ 2,740,470.34
HELP Medicaid	$ 0	%	$ 0.00
Total	**$ 914,769.00**		**$ 2,740,470.34**

Without Medicaid Expansion MT Medicaid GME PRA $74,500 >> $32,700

Additional state appropriation of $1.2m to maintain current funding levels

Potential Medicaid GME PRA with anticipated residency growth



Additional state appropriation proportional to GME growth, needed to maintain current funding levels

Elements that assisted Montana Medicaid GME Development

- The State's Medicaid Plan stated support for primary care
- The one existing FM Residency at that time had developed a rich history of graduates remaining in the State
- The existence of the State GME Council which coordinated and advocated for GME was essential
- Collaboration between residency programs, teaching hospitals, hospital association, higher education and others was present
- Teaching Hospitals utilize GME funds to support GME and are transparent in accounting

Medicaid GME Funding in New Mexico

John Andazola, MD FAAFP

Disclosure

This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by the State of New Mexico, CMS or the U.S. Government.

States Can Transform Their Health Care Workforce

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Abstract

The United States faces the simultaneous challenges of improving health care access and balancing the specialty and geographic distribution of physicians. A 2014 Institute of Medicine report recommended significant changes in Medicare graduate medical education (GME) funding, to incentivize innovation and increase accountability for meeting national physician workforce needs. Annually, nearly $4 billion of Medicaid funds support GME, with limited accountability for outcomes. Directing these funds toward states' greatest health care workforce needs could address health care access and physician maldistribution issues and make the funding for resident education more accountable. Under the proposed approach, states would use Medicaid funds, in conjunction with Medicare GME funds, to expand existing GME programs and establish new primary care and specialty programs that focus on their population's unmet health care needs.

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Introduction

A growing and aging population, plus expanded coverage under the Affordable Care Act (ACA), have increased the demand for primary care and many other specialties that are in short supply,[1] yet a declining percentage of physicians enter practice in rural and underserved inner-city areas.[1–4] Lack of access to services for populations with the greatest need threatens the ACA's promise to provide affordable health care to more than 25 million newly insured Americans.[1] The public expects value for the substantial federal investment in graduate medical education (GME). An Institute of Medicine report in the summer of 2014 recommended that Medicare payments for GME be restructured, to incentivize innovation and increase accountability for meeting national physician workforce needs.[5] As rapid and radical GME financing reform could threaten the financial position of many teaching hospitals, the challenge is finding a balance between achieving better value and accountability for GME funding while maintaining the viability of teaching hospitals.

A number of states have financed medical school expansions, and the number of US medical school graduates has risen substantially.[6] In contrast, entry-level residency positions have grown by less than 1% per year during the past decade.[7] Some states have appropriated funds to expand their GME positions,[8–10] while others are seeking Medicaid waivers to fund workforce expansion,[11–14] and 1 state considered a tax on health insurance to fund additional GME positions.[15]

Discussions of GME financing have been largely framed as a funding issue for teaching hospitals rather than as a workforce planning approach to meet states' health care needs.[16] Medicare funds are paid to teaching hospitals

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Why Should States Care About Leveraging Medicaid Funding for GME?

- Federal GME reform efforts have stalled
- In past 20 years, state Medicaid GME payments have more than doubled
- Medicaid GME payments totaled nearly $8 billion—an amount second only to Medicare
- States are “policy laboratories” for GME innovation

Medicaid in New Mexico

- New Mexico is a Medicaid expansion state
- 17.1% poverty rate
- Federal Match is 73%
- 2.113 million people live in New Mexico
- 890,778 people in New Mexico on Medicaid
    - 42% of population

New Mexico Medicaid GME Prior to 2019

- To qualify for IME
  - Licensed by the State of New Mexico
  - Be reimbursed on a DRG basis
  - Have **125** or more full time equivalent residents enrolled in an approved teaching program

New Mexico Medicaid GME Prior to 2019

The IME payment amount is determined by multiplying DRG operating payments, which are DRG payments and outlier payments, by the IME adjustment factor computed by the following formula:

1.89*((1+R)'405-1)

New Mexico Medicaid GME Prior to 2019

- For DGME
  - Licensed by the state of New Mexico,
  - Be currently enrolled as a Medicaid provider, and
  - Must have a Medicaid inpatient utilization rate of 5% or greater
  - Cap at $18,500,000
    - Primary care/obstetrics resident: $41,000
    - Rural health resident: $52,000
    - Other resident: $50,000

New Mexico Medicaid GME Now

- To qualify for IME
  - Licensed by the State of New Mexico
  - Be reimbursed on a DRG basis
  - Have **125** or more full time equivalent residents enrolled in an approved teaching program **or operate one or more nationally-accredited programs**

New Mexico Medicaid GME Now

- For DGME
  - Licensed by the state of New Mexico,
  - Be currently enrolled as a Medicaid provider, and
  - Must have a Medicaid inpatient utilization rate of 5% or greater
- Existing GME positions:
  - $50,000/resident per year
- Expansion GME positions:
  - Primary Care and General Psychiatry resident $100,000
  - Other resident $50,000

New Mexico Medicaid GME Now

- DGME Expansion Strategic plan and shall not exceed 101.
  - SFY 2021 - 2 FTE
  - SFY 2022 - 21 FTE
  - SFY 2023 - 31 FTE
  - SFY 2024 - 32 FTE
  - SFY 2025 - 15 FTE
  - Each year after shall be limited by 10 FTE per year or as determined by the Secretary of HSD

FQHCs and RHCs

- Must be licensed by the state of New Mexico,
- Be currently enrolled as a Medicaid provider,
- Must have achieved a Medicaid utilization rate of **35** percent or greater,
- Participate in the costs of a nationally accredited residency program either directly or under contract with an ACGME-accredited program.

- Working on an IME strategy

Extra Stuff

- An attempt at accountability
  - “The annual Medicaid payment amount per resident FTE as set forth in paragraph c.3(ii) above is contingent upon the certification of each participating GME program director that increased DGME funding will go directly to the GME program.”

Extra Stuff

Working on including Inpatient Psychiatric Facility PPS in GME funding

Thank You

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