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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to support GME without designating the types of physicians trained. This has favored subspecialty positions, and fewer primary care and generalist positions have been added.[17] In addition, there is significant variability in the Medicare GME funds received per state.[16] New York State receives nearly 20% of all Medicare GME funding, while 29 states each receive less than 1%.[18]

States with a projected major increase in medical student graduates recognize a need for GME expansion because residents tend to practice in states where they train.[19] To achieve better specialty and geographic balance, GME expansion must focus on primary care and other high need specialties, targeting states and regions with the greatest need. We propose that Medicaid funds supplement the initial funding for expansion of primary care and psychiatry positions as recently described.[20]

Using Medicaid Funds for GME Expansion to Target States' Workforce Needs

To address these challenges, we propose that states pursue and allocate Medicaid GME funding based on the unique workforce needs of their state or region. To make such decisions based on evidence, we encourage that states or multistate regions authorize the formation of health workforce commissions (HWCs) that would monitor the need for physicians by both geography and specialty. The structure and responsibilities of HWCs are outlined in BOX 1.

The ACA has strengthened states' roles by giving them the authority to expand Medicaid and/or to create state-based insurance exchanges.[21] State roles could be fortified by state or regional HWCs that would select GME programs for expansion or designate new programs that would satisfy the need for additional primary care physicians, general surgeons, psychiatrists, and other specialists in short supply. An example is the Utah Medical Education Council, which has shown the feasibility of using public policy to provide GME funding to meet Utah's physician workforce needs.[22]

Medicaid is the second-largest funding source for GME, after Medicare. Although state Medicaid programs are not required to support GME, states supporting GME are eligible for federal matching funds. In 2012, 42 states and the District of Colombia provided an estimated $3.87 billion in Medicaid GME payments.[23] Funds are largely directed in a manner similar to Medicare GME, with teaching institutions making the allocation decisions.[24] Only 10 states direct all or some of these payments to address primary care shortages and underserved communities.[25] As a supplement to their Medicare GME funding, states could seek additional Medicaid GME funds and exercise greater oversight on how these payments are applied to meet their workforce needs.

BOX 1 **State Health Workforce Commission Features**

Objectives

- Quantify and document the state's medical and dental workforce and continuously identify the state's changing needs in primary and specialty health care.
- Select for expansion and recommend for Centers for Medicare and Medicaid Services (CMS) and State Medicaid funding those graduate medical education (GME), and other health workforce training, programs that could best meet accreditation requirements and address the state's workforce goals.
- Plan for the state's future health workforce needs and seek Medicare and Medicaid support for necessary program expansion. Funding support should be sustainable to ensure long-term stability of training programs.
- Develop state-based accountability measures tied to both health workforce production and patient care quality and access to document how funds are spent.
- Monitor practice locations of graduates from teaching programs that receive state and federal funding, including teaching health center (THC) graduate service in prioritized areas.
- Submit regular reports of results and plans to state governments and CMS.

Administration

- An executive director would work in conjunction with state Area Health Education Centers (AHECs), or similar organizations, to administer a commission composed of representatives from state or regional AHCs, as well as representatives from teaching hospitals, community health centers (CHCs), and rural health clinics.
- GME expansion funding in response to health workforce commission (HWC) recommendations would flow to GME educational consortia.[1] These organizations would facilitate transparency and accountability of funding expenditures.

Support

- The HWCs would be funded by state Medicaid with matching federal funds.

States could address primary care physician shortages in rural and urban underserved communities by expanding teaching health centers (THCs).[4,20,26]

The benefits of THCs for enhancing primary care access and workforce training are shown in BOX 2. More than 40% of community health center (CHC) patients are insured by Medicaid, and use of THCs could achieve cost savings for state Medicaid programs that would offset the costs of GME expansion.[27] Consortia organized to support THCs could enhance residency education by serving as the conduit for the flow of new Medicaid GME payments. Funds would flow based on residents' rotations and be distributed to the teaching hospital for inpatient training and the THC to support ambulatory training.[1,4]

Expanding residency positions in THCs could help states strengthen their primary care workforce, building on the established track record of CHCs and rural health clinics in training physicians with nearly half of those trainees going on to practice in safety net care settings.[28] Once Medicaid GME payments flow to THCs, they could

BOX 2 **Why State Medicaid Programs Should Expand Teaching Health Centers (THCs)**

- More than 40% of community health center (CHC) patients are insured by Medicaid.
- Medicaid is more appropriate than Medicare for support of care for pediatrics patients and pediatrics training programs.
- Support of THCs increases accountability for Medicaid graduate medical education (GME) funding.
- The THCs increase CHC capacity, thereby alleviating community limitations in access to primary care for Medicaid patients.
- The THCs enhance cost effectiveness of CHCs and their capacity to serve the needs of low-income, uninsured patients, giving Medicaid patients greater access to primary care services.
- The THC educational environment optimizes primary care physician education for the 21st century and addresses physician shortage for underserved areas.
- The THCs facilitate referral from CHCs for subspecialty care by creating connections with teaching hospitals that decrease barriers to subspecialty care for Medicaid and uninsured patients.
- The THCs could offer expanded primary care hours, potentially decreasing avoidable emergency department visits.

enhance their academic mission with their academic medical center partners. Many medical students seek rotations in the community, and THC expansion represents an opportunity to integrate faculty, residents, and medical students in interprofessional and interdisciplinary teams in community-based settings. Exposure to underserved patients across the continuum of education is critical to helping trainees choose to care for these populations in their subsequent practice.[28]

Medicaid Section 1115 Waivers

States also could seek new Medicaid GME funds to support promising models, such as THCs, under Medicaid Section 1115 waivers. This program funds pilot and demonstration projects that differ from federal program rules.[29] States could embed workforce innovation as a component of these reforms. Section 1115 waivers require comprehensive evaluation, and this would encourage states to gather evidence on the cost effectiveness, quality of care, and physician workforce outputs provided by CHAMP (community health and academic medicine partnership) THCs and rural THCs in collaboration with their academic referral centers.

One barrier is that 1115 waivers must be cost neutral, and states would need to work with the Centers for Medicare and Medicaid Services (CMS) to identify savings and redirect them into a Medicaid GME innovation pool. Sixteen states participate in the CMS State Innovation Model to transform their delivery systems[30] and could consider including an innovative workforce model to address physician workforce needs. States with an approved waiver for a Medicaid GME primary care innovation pool would receive federal matching funds to match the state's contribution to this pool. The share of matching funds depends on the state's per capita income and ranges from 50% for higher-income states to 73% for low-income states.[30] For states with significant physician shortages, Medicaid GME innovation pools would provide a promising opportunity to employ federal Medicaid dollars to bolster the workforce improve access to primary care.

Illinois has submitted a comprehensive Medicaid section 1115 waiver proposal,[31] which combines meeting the needs of underserved populations and physician workforce development. Illinois has not provided GME funding for many years. A component of the waiver would restore Medicaid funding, aiming GME support to community-based programs that serve Medicaid, uninsured, and other underserved populations. An example mentioned in the proposal is the Northwestern Feinberg School of Medicine THC, the only site in Illinois currently receiving grant support from the Health Resources and Services Administration. The Northwestern family medicine residency program has filled all 4 years with outstanding, bilingual US medical school graduates; it has just launched its first fully trained cohort of 8 family physicians, all of whom took positions in CHCs, and interest in the program has grown every year, with more than 860 applicants for 8 positions this last year (D. S. Clements, written and oral communication). If approved by the CMS, the Illinois waiver would position its Medicaid program to take over the funding of the Northwestern University THC, if its federal funding expires. In addition, Illinois could use its new Medicaid GME payments to expand THCs to rural and urban, underserved areas throughout the state, supplying essential primary care physicians and specialists to communities with the greatest need.

Conclusion

The Medicaid program provides nearly $4 billion annually in state and matching federal funds for GME and allows states flexibility to test workforce innovations. The substantial Medicaid funding for GME requires purposeful redirection. We propose that states direct Medicaid GME funds strategically to address their needs for physicians as documented by data from state health workforce commissions. Medicaid-supported GME expansion via innovative training programs, such as THCs, is a promising approach to ensure access to high-quality, cost-effective ambulatory care for low-income populations, linked to academic partners for specialty care. The proposed approach offers states an opportunity to address their urgent needs for access to health workforce in both primary care and other specialties.

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