Washington State Health Care Authority

Report to the Legislature

Medicaid Funding Options for Clinical Training Programs

Envisioning a statewide program for GME and Post-Graduate APP Training

Engrossed Substitute Senate Bill 5187; Section 211(54); Chapter 475; Laws of 2023

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Introduction

The Washington State Health Care Authority (HCA) is submitting this report to the Legislature as required by Engrossed Substitute Senate Bill 5187:

> Sec. 211 (54) Within the amounts appropriated in this section the authority in collaboration with UW Medicine shall explore funding options for clinical training programs including, but not limited to, family medical practice, psychiatric residencies, advanced registered nurse practitioners, and other primary care providers. Options should include, but not be limited to, shifting direct medicaid graduate medical education payments or indirect medicaid graduate medical education payments, or both, from rates to a standalone program. The authority in collaboration with UW Medicine shall submit a report outlining its findings to the office of financial management and the fiscal committees of the legislature no later than December 1, 2023.

As directed by the Legislature, this report outlines options available for funding clinical training programs. HCA collaborated with UW Medicine in creation of this report including reviewing drafts and holding meetings to discuss options.

Background

Physicians, after completing medical school, typically go on to a Graduate Medical Education (GME) program for further training in a supervised program in their chosen area of specialization. Direct costs of GME (DGME) include payment of trainee physicians and associated administrative costs. Indirect medical education (IME) costs include higher costs of delivering health care services in teaching hospitals relative to non-teaching hospitals[1].

GME has multiple funding sources, including Medicare, Medicaid, Veterans Affairs, and private funding sources. The federal government is the largest funder of GME programs– in 2020, nationwide Medicare GME payments totaled over $16 billion dollars from the federal government[2]. Medicare GME funding is congressionally authorized, fixed in terms of the number of positions funded, and based on hospital cost reports submitted to the Centers for Medicare and Medicaid Services (CMS). Medicaid is the second largest source of GME funding[3]– in 2018, nationwide Medicaid GME payments totaled nearly $5.6 billion[4]. Medicaid GME payments are derived from formulas designed by the state, conditional on CMS approval.

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[1] Congressional Research Service. 2022. Medicare Graduate Medical Education Payments. Accessed November 2023. Available: https://crsreports.congress.gov/product/pdf/IF/IF10960

[2] American Medical Association. 2023. Compendium of Graduate Medical Education Initiatives. Accessed November 2023. Available: https://www.ama-assn.org/system/files/2023-gme-compendium-report.pdf

[3] American Medical Association. 2023. Compendium of Graduate Medical Education Initiatives. Accessed November 2023. Available: https://www.ama-assn.org/system/files/2023-gme-compendium-report.pdf

[4] Fraher, E., St. Onge, J., & Alfero, C. (2023, May 12). *Understanding Medicaid's Role in Graduate Medical Education* [Webinar presentation]. National Conference of State Legislatures. GMEwebinar51223_Alise Garcia.pdf (ncsl.org)

Compared to Medicare funding, state Medicaid programs have signficantly greater flexibility in how to disburse GME payments.

Washington has three medical schools (two allopathic, one osteopathic), 19 teaching hospitals, and 1200 residents in training[5]. There are 86 residency programs across the state[6]. Of these training programs, 26 programs train family medicine physicians focused on primary care. Ninety-two percent of the family medicine residency programs are in a federally designated Health Professional Shortage Area (HPSA)[7]. Additionally, there are two psychiatry training programs, ten internal medicine training programs and three pediatrics training programs in the state.

In terms of workforce distribution, 41% of Washington's physicians practice in King County. Washington's physician workforce is unevenly distributed; some counties have less than 40 physicians per 100,000 people while other counties have more than 300 physicians per 100,000 people[8]. Disparities also exist in mental health; as of 2016, 17 counties in the state did not have practicing psychiatrists.

Advanced practice providers (APP), which include Nurse Practitioners and Physician Assistants, can elect to participate in post-graduate training known as residencies or fellowships. Though some APPs may exit school without any clinical experience, residency programs are seen as essential for helping APPs develop confidence and expertise in a specific area of clinical medicine[9]. While not mandatory, post-graduate training for APPs has become increasingly prevalent nationwide. Generally, funding for APP clinical training programs is significantly more limited than funding for physician GME. CMS conducted a limited Graduate Nursing Education (GNE) pilot from 2012-2015, but does not have ongoing sources for GNE. The Health Resources and Services Administration (HRSA) awards grants annually for a small percentage of Nurse Practitioner Residency Programs in the US. Otherwise, funding for APP clinical training programs can also be self-funded by health care organizations.

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[5] American Association of Medical Colleges. *State-by-State Graduate Medical Education Data*. https://www.aamc.org/advocacy-policy/state-state-graduate-medical-education-data

[6] American Medical Association. *FREIDA (Fellowship and Residency Electronic Interactive Database)*. https://freida.ama-assn.org/

[7] Washington State Department of Health. (2022). *Family Medicine Residency Report* (DOH Publication No. 609-021) https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=Family%20Medicine%20Residency%20Report_23e926f4-3e40-41ee-9af4-a8d87129cb95.pdf

[8] Health Care Research Center. (2020). *2019-20 Physician Supply Estimates for Washington State*. Washington State Office of Financial Management. https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2019-20.pdf

[9] Wiltse Nicely, Kelly L. PhD, RN; Fairman, Julie PhD, RN. Postgraduate Nurse Practitioner Residency Programs: Supporting Transition to Practice. Academic Medicine 90(6): p707-709, June 2015. | DOI: 10.1097/ACM.0000000000000567

Current State of Clinical Training Program Funding in Washington

There are currently three main streams of GME funding from HCA, including hospitals, Federally Qualified Health Centers (FQHC), and grants. For hospital GME funding, prior to 2008, Medicaid GME payments in Washington were paid separately from hospital reimbursement rates as a distinct stream of funding. In 2009, GME payments were included in hospital reimbursement rates as a factor of the hospital base payment and continue to be reimbursed as such. The factor is added to rates for any institution that has reported GME costs through the Medicare cost report. Because this funding is administered through hospital reimbursement by Apple Health Managed Care Organizations (MCO), MCOs currently receive administrative funding through their usual rate setting mechanisms. The current exact amount of WA Medicaid GME funding is unknown. Because of the way the GME factor is included in the overall base rate calculation, identification of the precise dollar amount of payments is time and resource intensive, and would require additional funding to support.

In addition to hospital GME funding, some allowable costs of clinical training programs at Federally Qualified Health Centers (FQHC) may also be included in FQHC cost based reimbursement rates, if they are not otherwise covered by other funding sources such as HRSA grants.

GME programs also receive HCA funding through state-funded grants. The University of Washington receives $4 million annually for their family medicine residency program and $2 million annually for their evidence-based psychiatry program from hospital safety net grants. Aside from this targeted grant funding, GME payments in Washington are not otherwise specifically apportioned to primary care settings, nor are they tied to outcomes. Some teaching programs in Washington have previously shared with HCA that combined GME payments do not fully cover the cost of GME training.

Washington has over 30 APP post-graduate clinical training programs, many of which are associated with Federally Qualified Health Centers, or in underserved or rural regions. Each program has 2-10 trainees. The programs are funded through a combination of HRSA grants and a grant from Premera through the University of Washington, but the majority of programs have private funding through their sponsoring organizations. These funding mechanisms are not guaranteed and require reapplication every few years. There is no ongoing state-funding for APP post-graduate clinical training programs.

Envisioning a Future State for Funding Washington's Clinical Training Programs

Given the flexibility in directing Medicaid GME payments and the ability to utilize payments to advance policy goals, changing the methodology of Medicaid GME payments and enhancing APP postgraduate clinical training funding presents an opportunity for Washington. Specifically, Washington can utilize GME payments to advance the goals of:

- Increasing the primary care and psychiatry workforces,
- Improving patient access to providers in rural areas, and
- Enhancing transparency and accountability.

First, Washington can allocate GME funding to underserviced specialties, such as primary care and general psychiatry. Targeted funding towards clinical trainees in underserviced specialties has the potential to grow the number of practicing clinicians in these areas. According to national survey data from the Association of American Medical Colleges (AAMC), 13 states direct GME payments to primary care and other undersupplied specialties[10]. For example, New Mexico enhanced funding for primary care focused residencies through a CMS-approved State Plan Amendment that allowed for increasing funding per primary care resident full time equivalent (FTE)[11]. Funding can potentially be directed to training programs at Federally Qualified Health Centers in recognition of the need for a greater number of providers serving the underserved. Additionally, funding can be utilized to promote a more diverse health care workforce.

Second, Medicaid GME payments can also be utilized to improve geographic distribution of physicians. Evidence suggests that where physicians complete residency is associated with the location of practice after completing residency as well as population served, and thus directing funding to rural training programs has the potential to positively influence physician supply and distribution in needed places.

Finally, in order to increase transparency and accountability, GME funding could be more closely associated with the number of trainees per program, and could also potentially be tied to outcomes. Outcomes aligned with Washington's policy goals could include the number of residents continuing to practice primary care in the state after completing their training program, or residents practicing in rural communities after training.

Additionally, Washington can explore Medicaid funding options for post-graduate clinical training programs for APPs. Goal-directed funding of APP clinical training programs has the potential to enhance the primary care workforce, improve workforce diversity, and reduce geographic disparities as well.

Due to the complex nature of implementation of new funding programs, changes to funding of GME, and APP clinical training programs should be implemented on a statewide basis. Changes to trainee funding may require updates to state plans, certifications, and other payment adjustments. The viability of increasing primary care training slots or directing funding to psychiatry may depend on which funding option is selected. Furthermore, implementing payment system changes on a statewide basis will maximize the potential to produce positive outcomes like growing the primary care workforce and improving health care access in rural areas.

Options for Future State of Funding Clinical Training Programs

To support the policy goals outlined above, Washington State has several options to modify its GME funding program. Changes implemented on a statewide basis allow for greatest impact and successful

[10] AAMC. (2022). *Medicaid Graduate Medical Education Payments, Results from the 2022 50-State Survey*. Association of American Medical Colleges. https://store.aamc.org/downloadable/download/sample/sample_id/590/

[11] Human Services Department. (2022, January). *Graduate Medical Education Expansion in New Mexico*. https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/559d9767-951e-4240-a21a-6a462e3c8096/2022%20NM%20GME%20Expansion%20Strategic%20Plan

implementation. All options could be eligible for federal match contingent on approval from the Centers for Medicare and Medicaid Services (CMS) and per CMS guidance must be economic and efficient. Options include:

- Standalone GME payments,
- Directed payment to hospitals or health centers, and
- Increasing the GME base rate add on.

Standalone GME Payments to Hospitals

Washington could create standalone GME funding directly between HCA and teaching hospitals and health centers. For hospitals, this would require removing the GME base rate add on from rates; hospitals' GME payments would shift from their reimbursement to a standalone stream of funding. If base rates remain the same without a GME factor, there would be other modifications to hospital rates. The state appropriated funds could be sourced from certified public expenditures, intergovernmental transfers, or state general funds. Standalone GME payments would be more readily quantifiable and timelier – the current method of using a GME factor means that inpatient adjustments can only be made when hospital rates are rebased, which typically occurs every five to seven years. The DGME factor is considered in the annual rate adjustments of outpatient rates. Under a standalone payment system, certain outcomes or quality goals could potentially be incorporated via a value-based payment structure. Standalone payments could also be directed to APP training programs provided this was allowable on a federal basis. Removing the GME factor from rates would require changes to state plans and certifications. Managed Care Organizations (MCO) may see a reduction in administrative dollars if the GME base rate add on is removed. Additionally, removing GME from rates may impact payments through the Safety Net Assessment Fund (SNAF) and may impact federal Medicaid upper payment limits as well. Reducing current base rates by removing the GME factor may also result in other additional expenditures for HCA, for example, rebasing and additional claims qualifying for outlier enhancements. Additional conversations with the Centers for Medicare and Medicaid Services (CMS) would be required to understand the full impact of these payments on the federal Medicaid upper payment limits.

Directed Payment to Hospitals

Alternatively, Washington could utilize State Directed Payments to hospitals through the MCOs to fund GME and potentially APP training programs. The state appropriated funds could be sourced from intergovernmental transfers or general state funds. This funding could be paid on a regular interval. Payment could be contingent on outcomes reporting, which advances the goal of transparency. A State Directed Payment could potentially reduce payments to MCOs (similar to any option that removes the GME factor from rates) and may impact SNAF payments as well. This option would require changes to state plans and certifications as well as annual payment pre-prints submitted to CMS for approval. Directed payments are also subject to an aggregate federal upper payment limit. The full impact of these payments would need to be reviewed with CMS to determine if directed payments are possible after taking into account other supplemental directed payments for teaching hospitals.

Increasing the Existing GME Base Rate Add On

Finally, Washington could build upon the status quo by increasing the GME base rate add on currently used in hospital reimbursement rates (including those paid by MCOs). This would increase payments to all GME programs statewide. As this would increase the premiums that MCOs receive, it would also proportionately result in additional administrative dollars. Implementation would require updating base rates to account for fully funding the cost of GME through additional add ons. Though implementation would be more straightforward, this option does not function as a lever to achieve policy goals and may still lack transparency.

Future Recommendations

In summary, Washington can leverage Medicaid GME payments to address the policy goals of increasing primary care and behavioral health providers, balancing geographic distribution, and increasing transparency and accountability. To strategically utilize Medicaid GME funds, Washington may want to further analyze the current state of funding, as well as develop a deeper understanding of how changes to GME payment and APP post-graduate clinical training funding will affect an array of training programs in the state. A more detailed and robust fiscal analysis would require a state resource investment.

An advisory board made up of stakeholders, state representatives, and subject matter experts could help guide Washington's Medicaid GME reform.