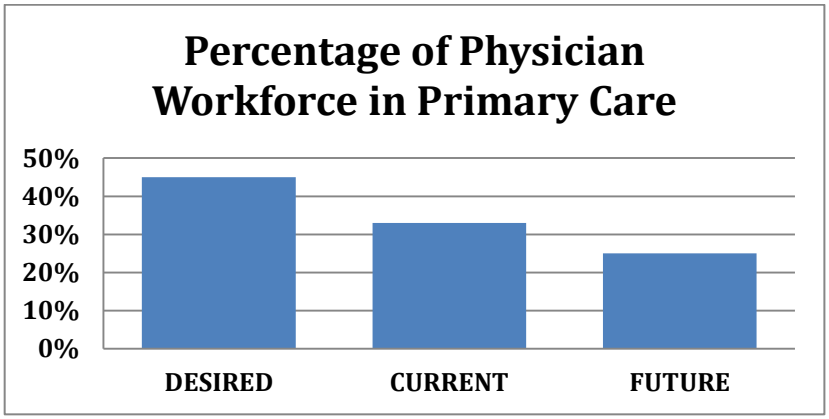
Colorado Commission on Family Medicine

GME Summit

GME Reform: Permanent Solutions to the Primary Care Shortage

Colorado Commission on Family Medicine
www.cofmr.org

The GME problem: If things stay the same, then they will only get worse.



References:
1. Council on Graduate Medical Education. Advancing primary care. Rockville, MD: Council on Grad Med Educ, 2010.
2. Chen C, et al. Toward GME Accountability: Measuring the Outcomes of GME Institutions. Academic Medicine 2013; 88(9):1267–1280.

Essential Elements for Reforming Medicare GME

1. **<u>Set a goal</u>: To improve health care outcomes and reduce costs, the primary care workforce should be increased to at least 40% of physicians**.
    a. Effective healthcare systems have a physician workforce comprised of 40-50% primary care.
    b. The current US physician workforce is 33% primary care.
    c. The US GME system currently produces primary care physicians at a rate of less than 25% of the total physician workforce.
    d. The nation needs an unequivocal policy statement to correct this imbalance.

2. **<u>Measure primary care accurately</u>: The number of physicians in primary care should be counted five years after graduating from medical school, not at the time of entering residency.**
    a. The resulting data will accurately reflect whether residencies are truly producing primary care physicians, as opposed to starting in an internal medicine or pediatrics residency and then going on to sub-specialize in an area such as cardiology or pulmonology. (Reference: Accounting for Graduate Medical Education Production of Primary Care Physicians and General Surgeons: Timing of Measurement Matters. Petterson, S, Burke M, Phillips R, Teevan, B; Acad Med 2011; 86(5), 605–608)

3. **<u>Change the routing of GME payments</u>: Payment should be made directly to programs and sponsoring organizations where primary care training occurs.**
    a. Examples include direct funding of Teaching Health Centers, educational consortia, and/or residency programs rather than teaching hospitals.
    b. Uncouple GME payments from Medicare hospital payments.
    c. Payment to a hospital based on its percentage of Medicare patients does not correlate with the cost of running a residency.

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Commentary on Current GME Bills

S. 577: Resident Physician Shortage Reduction Act of 2013; Nelson/Reid/Schumer

Summary: This bill proposes to add 15,000 new residency positions over 5 years, prioritizes the hospitals to receive the new positions, and identifies the specialties to be prioritized.

Concerns:

- Will do little to correct the shortage of PCPs.
- Prioritizing hospitals with new medical schools and hospitals that have already expanded over the cap is *not* placing a priority on primary care.
- The third priority (hospitals in which primary care training occurs) lacks the details and breadth necessary for an accurate description of primary care training programs, such as community hospitals, rural hospitals, Teaching Health Centers, Critical Access Hospitals, and outpatient care.
- The bill relies on a key reference (2008 HRSA report) to identify medical specialties currently in shortage. The report uses 1998 data that does not reflect the current workforce needs of the country and prioritizes medical sub-specialties.
- There is no increased support for existing family medicine residencies. A substantial number of existing family medicine residencies run at a significant deficit and are at risk for closure by the sponsoring hospitals.

H.R. 1201: Training Tomorrow's Doctors Today Act; Schock/Schwartz

Summary: This bill proposes the addition of 15,000 training positions over 5 years, describes the distribution of the positions, and includes several rules pertaining to residency programs.

Concerns:

- The bill will not correct the shortage of primary care physicians. Adding new primary care training positions should be the first priority, not the third.
- Similar to S. 577, the bill limits training to hospitals, therefore preventing the addition of training slots where primary care training occurs, like in Teaching Health Centers, outpatient clinics, rural hospitals, and educational consortiums.
- To prioritize primary care for additional slots, it is not sufficient to require that students *match* in primary care, as many who enter internal medicine or pediatric residencies do not remain in primary care. Rather, positions should go to programs that show their graduates are *practicing* primary care 5 years after medical school.
- There is no increased support for existing family medicine residencies. A substantial number of existing family medicine residencies run at a significant deficit and are at risk for closure by the sponsoring hospitals.
- The bill has an unusually broad definition of primary care. Multiple studies show that primary care (family medicine, general internal medicine, general pediatrics) results in improved health care outcomes and decreased costs.

S. 2229: The Expanding Primary Care Access and Workforce Act; Sanders

Summary: This bill increases funds for primary care training, expands primary care training sites, increases reimbursement for primary care providers, and enhances accountability and transparency of GME funds.

Concerns:

- Increases in the Teaching Health Center program should be permanent. Uncertainty of sustainable funding will prevent many organizations, such as THCs associated with rural hospitals, from starting new programs.
- There is no increased support for existing family medicine residencies. A substantial number of existing family medicine residencies run at a significant deficit and are at risk for closure by the sponsoring hospitals.
- There is little additional support for training of primary care in rural locations. There is a chronic need for more PCPs in rural areas, and traditional GME funding is often inadequate.

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"Report Card" for Evaluating GME Bills

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1. Sets a goal that primary care physicians should be 50% of the total physician workforce.
2. Measures primary care production accurately by counting number of physicians practicing primary care 5 years after completion of residency.
3. GME payments are made directly to sponsoring organizations where primary care training occurs.
4. Provides funding that is long-term and sustainable.
5. Provides funding to support existing family medicine residencies.
6. Increases the number of training positions in primary care.
7. Corrects the geographical maldistribution of GME payments among states.
8. Provides funding to support training of primary care in rural locations
9. Incentivizes students to choose primary care by providing loan repayment programs, e.g.
10. Corrects the primary care reimbursement differential.
11. Establishes an all-payer system to support GME.
12. Funds the National Health Care Workforce Commission.

Ratings of GME Bills

Criteria	Nelson/Reid/ Schumer S. 577	Schwartz/ Schock H.R. 1201	Sanders S. 2229
1. Set a goal	-	-	+/-
2. Count primary care correctly	-	-	+
3. Change formula and routing of payment	-	-	+/-
4. Sustainable funding	+/-	+/-	+/-
5. Help existing primary care residencies	-	-	-
6. Specifically increase primary care training	-	+/-	+
7. Geographically uneven funding	-	-	-
8. Support rural training	-	-	+/-
9. Loan repayment	-	-	+
10. Primary care reimbursement	-	-	+
11. All payer system	-	-	-
12. Workforce Commission	-	+/-	+
Summary	1(+)/12(-)	3(+)/12(-)	9(+)/7(-)