1:10 - 1:55

Federal Reform Attempts, Proposals, and Controversies

- Problems and Solutions

GME Problems and Solutions

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COMPREHENSIVE GME REFORM
JANUARY 28 – 30
ATLANTA, GEORGIA

Outline

1. IOM problems and recommendations
2. GMEI Problems and Recommendations
3. Anencephaly – Inability to correct problems – *Even When You Want To !*
4. Rural "Gotcha" Rules
5. Other Proposals
6. CoNGR Platform Planks – quick look
7. RAP GME – Technical Problem Solver *(but still no brain)*

IOM 2014 Project Process

Response to
- Macy Foundation conferences in 2010-2011
- request from Senators

Funding
- Macy Foundation and 13 others

Time and Process
- 21 member committee formed summer 2012
- Charge- Develop a report with recommendations
- Sept 2012 – Jan. 2014: 6 in person meetings + conference calls
  - Testimony at two meetings from a variety of stakeholders
- Committees: workforce supply, costs & finances, governance & accountability, residency program outcomes

Problems with the Output of the GME System

CATEGORY ONE –

THE INDIVIDUAL

Not prepared for 21st century practice

- Team Based Care
- Outpatient care
- Care Coordination
- Quality Improvement
- Diverse and Aging Population

CATEGORY TWO

THE WORKFORCE

Specialty Maldistribution

Geographic Maldistribution of training

Geographic Maldistribution of graduates

Role of Governance and Finance

- Opacity
- Lack of accountability
- Inability to innovate
- Inability to leverage the investment

IOM 2014 Report –Goals

GME that Meets the Nation's Health Needs

1. Encourage production of a better prepared physician workforce
2. Encourage Innovation to achieve goal 1
3. Provide Transparency and Accountability
4. Strengthen public policy planning and oversight
5. Ensure rational, efficient and effective use of public funds
6. Mitigate unintended negative effects

IOM 2014 Report –Goals & Next Steps

GME that Meets the Nation's Health Needs

1. Encourage production of a better prepared physician workforce
   - ***Amend Medicare to allow for performance based incentives***
   - ***Create a high level GME Policy Center in HHS and CMS to test and implement new payment methods***

2. Encourage Innovation to achieve goal 1
   - ***National Per Resident Amount (with geographic adjustments)***
   - ***Combine "IME & DME" into a single payment***
   - ***Do Demonstration projects***
   - ***Delink payments form Medicare patient volumes***

IOM 2014 Report –Goals & Next Steps

GME that Meets the Nation's Health Needs

3. Provide Transparency and Accountability
   - ***Require Standardized reports***
   - ***Minimum data sets***
   - ***Develop performance measures***
   - ***Provide stakeholders with access to information***

4. Strengthen public policy planning and oversight
   - ***Create a high-level policy and financing infrastructure in HHS and CMS***

IOM 2014 Report –Goals & Next Steps

GME that Meets the Nation's Health Needs

5. Ensure rational, efficient and effective use of public funds
   - ***Use a portion (10%) of current GME funds to new infrastructure, new training slots and new program evaluation***

6. Mitigate unintended negative effects
   - ***Strategic plan for careful phase-in***
   - ***Rigorous evaluation of impact and effectiveness***

IOM 2014 Report – Recommendations

GME that Meets the Nation's Health Needs

1. **Keep current funding while phasing in a new system**
   - *"The current Medicare GME payment system should be phased out."*

2. **Build a GME policy and financing infrastructure**
   - 2a GME Policy Center
   - 2b GME Center within CMS
     - Manage operations, transformation, data reporting an transparency

3. **Create one GME fund with two subsidiary funds**
   - Operational fund
   - Transformation fund
   - Federal Transparency requirements

IOM 2014 Report – Recommendations

GME that Meets the Nation's Health Needs

4. **Modernize GME payment methodology**
   - 4a – Combine IME/DME into one PRA (PRP)
   - 4b – set at level of operational fund divided by current # of slots
   - 4c – redirect funds directly to GME sponsoring organizations
   - 4d – Performance-based payments through Transformation Fund

5. **Medicaid GME at state's discretion**
   - Federal Transparency requirements

IOM 2014 Report – Policy Center and Financing Infrastructure

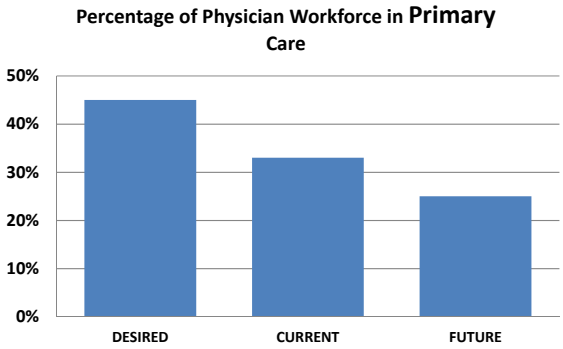
GME that Meets the Nation's Health Needs

2a -Create a GME Policy Council in HHS
- Appointed by Secretary of HHS
- Sufficient staff and technical support
- Develop a strategic plan
- *Study geographic distribution and specialty configuration of the physician workforce*
- Organize the government and non-government GME entities
- Annual reports to Executive and Legislative branches

2b – Establish a GME Center within CMS
- Responsive to guidance of GME Council
- Manage operations of GME funding
- Manage GME Transformation fund
- Data collection and detailed reporting

The 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. Acad Med. 2013;88(9):1267–1280.

Growth by Specialty 2008 - 2012

Specialty	2008	2012	Change from 2008	Percent change from 2008
All (ACGME)	109,482	117,717	8,235	**7.5%**
Neurosurgery	857	1,212	355	41%
Thoracic Surgery	228	276	48	21%
Neurology	1,795	2,139	344	19%
Pulmonary/critical care	1,518	1,771	253	17%
Emergency Medicine	4,763	5,590	827	17%
Plastic Surgery	665	777	112	17%
Dermatology	1,123	1,240	117	10%
Family Med	***9,561***	***10,060***	***499***	***5%***

GME Initiative's Top Three Priorities

~ March 2014

FORTY, FIVE & FLOW:

1. Set a goal of at least **40%** primary care physician workforce

2. Count primary care accurately
   - Count at **FIVE** years post med school graduation

3. Payments **FLOW** directly to training programs
   - E.g. THC program

The GME Initiative's Legislative Report Card

1 . Support existing residencies

2. Payments directly to training organization (THC model)

3. Long term sustainability

4. Increase the number of primary care trainees

5. Count primary care accurately

6. Correct geographical maldistribution of payments

7. Support rural training

8. Incentives for students to choose primary care

9. Correct the primary care/specialty payment gap

10. Establish an all payer system

11. Fund the National Healthcare Workforce Commission

12. Set a goal of 50% primary care physician workforce

Is the relationship between Congress and GME *Anencephalic?*

the current "system" is incapable of addressing workforce needs.

We need a functional nervous system

Anencephalic:
Congress Cannot Control the Outcomes

CONGRESSIONAL INTENT:
- ALLOW FOR MORE RURAL TRAINING

CONGESSIONAL ACTION:
- 1997 RTT Exception to the cap

RESULTS:
- "Gotcha" Rules
- Morgan County Rural Training Track
  - University Hospital $116,000 PRPY
  - Rural Hospital - $Zero

CONGRESSIONAL INTENT:
- TRAIN MORE PRIMARY CARE AND RURAL

CONGRESSIONAL ACTION:
- 2003 Prescription Drug and Improvement Medicare Modernization Act

RESULTS:
- Created more specialists than primary care and rural slots

The "Gotcha" Rules for RTTs

1. Lower Medicare Bed-day ratio

2. Sole Community Hospital

3. Previous residency training activity

4. Previous Attempted RTT

5. Current sponsor of another RTT

Medicare Prescription Drug, Improvement and Modernization Act of 2003

Redistributed **3000 positions** from hospitals that were under the cap

Intention for these slots: Increase primary care and rural training

Look back from 2008

- For hospitals receiving new positions
  - Primary care positions increase 1586
    - Included IM, Peds and OBGyn
  - Specialty positions increased 3433
  - Only 12 positions were rural

Published 2013

Medicare Prescription Drug, Improvement and Modernization Act of 2003

Overestimate of primary care production
- Included IM, Peds and ObGyn

"78 of the hospitals that received positions proceeded to reduce their primary care positions."

"48 of these increased non-primary care positions"

Alliance for Academic IM
ACP GME Task Force
ACP Health & Public Policy Committee

1. Feds should maintain commitment to GME
   - Payments should be used to meet policy goals
2. All Payers should be required to contribute
3. Evaluate the cost of training before making any changes

Alliance for Academic IM
ACP GME Task Force
ACP Health & Public Policy Committee

4. Combine IME and DME into a more functional payment
5. Transparent allocation of funding
   - Ensure funds go to educational activities
   - Funds follow trainees into all locations of training
6. Caps lifted as needed
   - Primary care
   - IM specialties
   - Other specialties facing shortages
     - Including IM-Peds and other IM subspecialties

Alliance for Academic IM
ACP GME Task Force
ACP Health & Public Policy Committee

7. Performance based system – worth exploring
   - Measurements developed by appropriate stakeholders
   - Measures developed and tested before implemented
   - Adequate time for adoption
   - Adequate funding for transition costs
   - Performance align with ACGME
   - Study unintended consequences
8. Pilot projects to evaluate changes in funding
9. IM and IM-Peds should train in well-functioning ambulatory settings

CoNGR Platform Plank Categories

-Finance

-Governance & Accountability

-Workforce: Specialty Composition and Geographic Distribution

-Innovation and Transformation

CoNGR Platform Planks- Finance

*-**Maintain current amount** of Medicare GME funding while modernizing (or reforming) it*

*-Replace IME/DME with **one per resident payment (PRP)** with geographic cost of living adjustments*

*-Redirect Medicare GME payments so they are distributed **directly to GME sponsoring organizations***

*-**All payers** should be required to contribute to a financing pool to support residencies that meet the nation's policy goals related to the supply, specialty mix, and training sites.*

*-GME funding should **follow trainees** into all training settings, rather than being linked to the location of service relative to the sponsoring institutions.*

CoNGR Platform Planks – Governance and Accountability

*Create a **GME Policy Center** in HHS*

*Establish a **GME Center within CMS** to manage GME operations (funding, transformation fund, collect data, responsive to GME Policy Council)*

*Mandate **states** show same transparency at the level required of Medicare*

CoNGR Platform Planks – Physician Workforce Composition and Geographic Distribution

*Rural Alternative Payment (**RAP-GME**) bill being drafted with Senator Cory Gardner*

*Goal: **40% primary care** (with primary care counted accurately, 5 years post medical school)*

***GME caps should be lifted as needed** to permit training an adequate number of primary care physicians including internal medicine specialists, and physicians in other specialties facing shortages, including internal medicine, pediatrics, and many internal medicine subspecialties.*

CoNGR Platform Planks – Innovation and Transformation

***GME Transformation Fund**: pilot alternative payments, develop and evaluate innovations, validate appropriate performance measures.*

- *10% Initially (~ $ 1 Billion per year)*
- *Grows to 30% in five years*
- *Back to 10% in 10 years and stays there*

The GME Initiative's:

RAP GME Legislation

Lots of remedies

– but still no brain