8:30 - 8:45

Review

Recap & Plan for the Day

8:30 - 8:45

Review

Finance	
■■■■	*Maintain current amount of Medicare GME funding while modernizing (or reforming) it* *+#11 (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)* *+#4 (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.)*
■■■■	*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* *+#5 GME funding should follow trainees into all training settings, rather than being linked to the location of service relative to the sponsoring institutions.*
■■■■	*Money going to primary care positions needs to stay in primary care (can't be reassigned).*
Governance/Accountability	
■■■■	*Create a GME Policy Center in HHS* *+#7 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*
Specialty Composition and Geographic Distribution	
■■■■	*Goal: 40% primary care (with primary care counted accurately, 5 years post medical school)*
Transformation and Innovation	
■■■■	*GME Transformation Fund: pilot alternative payments, develop and evaluate innovations, validate appropriate performance measures.*
■■■■	*Promote alternate mechanisms*

8:45 – 9:00

Preamble draft

The health and well-being of our population and our communities are essential to a fully functioning, equitable society.

Health needs are changing, as the population ages, chronic disease rates increase, and as disparities continue or worsen across gender, race and ethnicity, and rural and urban communities. Partnerships are proliferating across sectors as communities seek to address the roots of illness, rather than wait for illness to strike.

Health care is changing rapidly as well, in response to rising costs and worsening health, with growth of hospital networks, expansion of electronic records and data, growing attention of social determinants, and increasing use of teams at all levels.

Increasingly, states are the sites of innovation in health planning and care delivery, as they respond to their unique challenges and build on their local strengths.

But there is little organized linkage between the health needs and plans of the states and communities, innovations in care delivery, and the health workforce, much less the graduate education programs that produce and sustain the workforce.

Funding for graduate medical education is largely (but not solely) provided to hospitals through Medicare

Attempts to align medical education with local and state needs have been repeatedly thwarted by complex government regulation and lack of transparency. Repeatedly, successful innovations linked to demonstrated needs have been unable to expand, or in some cases even continue.

The result is that our communities are sicker, and we are dying earlier, of conditions which we can prevent and effectively treat.

We must align our health workforce with the evolving health needs of our communities and states.