GME Policy

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The most powerful prescription?
A well-trained physician.

http://savegme.org
Association Between Teaching Status and Mortality in US Hospitals

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Key Points

Question  Is there a difference in mortality rates at US teaching hospitals compared with other hospitals?

Findings  In an observational study of approximately 21 million hospitalizations of Medicare beneficiaries, adjusted 30-day mortality rates were significantly lower at 250 major teaching hospitals compared with 894 minor teaching and 3339 nonteaching hospitals overall (8.3% vs 9.2% and 9.5%) as well as for several individual common medical and surgical conditions.

Meaning  Major teaching hospital status was associated with lower mortality rates for common conditions.

Figure. Mortality After Hospital Admission Among Major Teaching, Minor Teaching, and Nonteaching Hospitals
States with New Medical Schools or Branch Campuses Since 2000

Source: AMA Physician Masterfile, December 31, 2011
Data compiled by the AAMC Center for Workforce Studies
416 active physicians have missing GME state code or GME in the territories

How many new US SoM since 2000?

31 MD
28 DO
59! New

191 Current US SoM
- 25 pending accreditation
States with Fewer GME Slots than UME Enrollment

Source: AMA Physician Masterfile, December 31, 2011
Data compiled by the AAMC Center for Workforce Studies
416 active physicians have missing GME state code or GME in the territories
U.S. medical school enrollment rises 30%

LINDSAY KALTER, SPECIAL TO AAMCNEWS
JULY 26, 2019

Averting a physician shortage now depends on increasing the number of residencies and clerkship training sites. A new AAMC report examines the issue.
# GME positions grew by 27% since 1997 BBA capped fed funded #
Core Policy Questions

• Is GME a public good or a hospital cost?
• Is GME an educational or patient care expense?
• What is the appropriate role for Medicare in supporting GME?
• Should Medicare GME shape the physician workforce?
• Should Medicare GME remain mandatory spending (Part A) vs. discretionary spending?
US Graduate Medical Education

• GME in the US is the envy of the world, graduating >100,000 new physicians for practice annually

• However, there is broad consensus* that current GME policy and practice are not well aligned with the needs of the US healthcare system in the 21st century

GME Policy Problems

• Poor alignment of GME funding policy and US workforce needs

• Inadequate accountability by hospitals and GME programs for outcomes

• No transparency regarding use of funds by hospitals

• Inadequate curricular focus on competencies needed for healthcare reform
GME Policy History

• Pre 1965, GME was responsibility of hospitals
• Medicare’s founders debated its role in funding GME—concluded that it was *inappropriate* to pay for these training costs with funds intended for health care
GME Policy History

• However, they reluctantly and temporarily decided Medicare would pay its share
  – GME enhances value of patient care

• Subsequent commissions concluded:
  – “It is inappropriate to pay for GME through Medicare”

• Medicare GME funding is now securely ensconced in the Medicare trust fund and has grown
  – 1984 GME formally incorporated into Medicare’s PPS
FIGURE: Estimated sources of $15 billion in public funding for GME

- Medicaid: $3.9 billion (a)
- Medicare: $9.7 billion (a)
- U.S. Department of Veterans Affairs: $1.437 billion (a)
- Health Resources and Services Administration: $0.464 billion (a)

NOTE: Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources. a = data from 2012; b = data from 2011 and 2013.
**TABLE 3-8 Direct GME Costs by Hospital Characteristics, 2008**

<table>
<thead>
<tr>
<th>Hospital Characteristic</th>
<th>Number of Hospitals</th>
<th>Number of Residents</th>
<th>Total GME Costs Per Resident</th>
<th>Total GME Costs: Facility Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospitals</td>
<td>1,141</td>
<td>97,577</td>
<td>$141,240</td>
<td>$95,403</td>
</tr>
</tbody>
</table>

Only ~20% of US hospitals have teaching programs.
GME Finance Policy: Direct and Indirect

• Since 1984, GME funding has been split into
  – Direct (DGME) and Indirect (IME) payments

• DGME:
  – Subsidizes costs of resident and faculty salary/benefits, and administrative costs

• IME:
  – percentage added on to the usual DRG payment to hospitals to account for the higher costs incurred by teaching hospitals that care for sicker patients and inefficiencies of care by trainees
DGME = 

# Residents * PRA * Medicare Share

• # of residents based on 3-year rolling average/hospital
  – Aggregate residency FTEs capped at 1996 levels

• PRA: Per-Resident Amount from 1984 base year, updated annually by Consumer Price Index
  – PRA weighted by
    • 1.0 FTE for initial residency period (IRP), minimum required for board eligibility, usually first 3 years
    • 0.5 FTE beyond IRP (subspecialty fellowship)

• Medicare Share: proportion of Medicare/total inpatient days
\[ \text{IME} = c \times [(1 + \text{IRB ratio})^{0.405} - 1] \]

- Percentage add-on to Medicare DRG payment to adjust for teaching intensity
  - IRB: intern/resident to bed ratio
  - C is an IME multiplier set by policy; \(c=1.34\) \(\rightarrow\) 5.5%
  \(\rightarrow\) 5.5% increase in IME adjustment for every 10% increase in IRB

- \(\sim1,100\) hospitals get IME adjustments to IPPS payments ranging from <1% to 48%
  - \(\sim200\) hospitals get 2/3 of the funds

- MedPAC’s calculation is that across all hospitals, a 10% increase in teaching intensity (IRB) is associated with only a 2.7% increase in Medicare costs per discharge
Follow the GME Money

FIGURE S-1 Current flow of GME funds.
SOURCE: Adapted from Wynn, 2012 (Committee of Interns and Residents Policy and Education Initiative White Paper, “Implementing the 2009 Institute of Medicine recommendations on resident physician work hours, supervision, and safety”).
Stewardship of GME

FIGURE 9-2 Program accreditation and physician certification and licensure.
Goals of GME Policy

- Align GME funding strategy with physician workforce needs
  - Geographic distribution – increase physician/population ratio in rural and inner city regions
  - Specialty distribution – increase PC physicians >40%
- Increase GME grads in PC to 50%
- Incentivize GME in competencies needed for reform
  - Ambulatory, team, evidence-based, coordination, cost-effective
- Increase transparency and accountability of hospitals and GME programs in their use and outcomes of GME funds
GME Advisors/Stakeholders

Advisory Organizations
• MedPAC
• HRSA
  – COGME
  – ACTPCMD

Stakeholders
• AAMC
• APDIM
• ACGME
• Hold back $3.5B and pay out via pay for performance program as per Secretary’s standards and metrics

• HHS should collect data and publish annual report GME funding, costs, and use per institution

• Conduct workforce analysis number and mix of physicians needed in US

• HHS to report on financial impact of GME on institutions with focus on variable impact by specialty

• HHS to study strategies for increasing the diversity of our health professional workforce
• Increase the percentage of PC physicians in the US to 40%

• Increase reimbursement for PC physicians such their median income is 70% of that for all other physicians (currently is 52%)

• Medical schools should develop an accountable mission statement and measures of social responsibility … to foster a physician workforce of 40% PC

• GME payment and accreditation reform to increase # of PC training slots (Title VII) and move more training into ambulatory, community practice environment

• Expand focus on geographic and socioeconomic distribution
• **We need more docs!**
  • Lift the GME cap

• “Cuts to GME would jeopardize our ability to train physicians, nurses, and other health care providers, and limit critical services to the community”

• “Cutting physician training at a time when our nation faces a critical shortage of doctors would threaten the health of all Americans”
• DGME funding should reflect true cost – CPI updates not keeping pace with program changes
• Need transparency – can’t get data from one’s own hospital
• Worry that struggling programs will collapse if IME reduced
  – Regs went from 2 pages in 1984 to >30 pages in 2019!
ACGME

• Evaluates and accredits more than 9,000 GME programs in 135 specialties and subspecialties
• The Next Accreditation System (NAS) – 2013 outcomes-based milestones within six domains of clinical competence
• Advancing Innovation in Residency Education (AIRE) – pilot
• 24 American Boards of Medical Specialties
• CEO Tom Nasca
  – ACGME will transform GME
  – Self-regulation > federal funding policy
GME Policy Strategies

• Market-based approach – feds hands-off educational policy and workforce distribution

• Incentive-based approach – influence GME education and workforce via funding policy

• Regulatory approach – explicitly align support with educational and workforce outcomes
Graduate Medical Education That Meets the Nation’s Health Needs (2014)

www/iom.edu/GME


BOX S-2

IOM Committee’s Goals for Developing Graduate Medical Education (GME) Policy Recommendations

1. Encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost.

2. Encourage innovation in the structures, locations, and designs of GME programs to better achieve Goal #1.

3. Provide transparency and accountability of GME programs, with respect to the stewardship of public funding and the achievement of GME goals.

4. Clarify and strengthen public policy planning and oversight of GME with respect to the use of public funds and the achievement of goals for the investment of those funds.

5. Ensure rational, efficient, and effective use of public funds for GME in order to maximize the value of this public investment.

6. Mitigate unwanted and unintended negative effects of planned transitions in GME funding methods.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Recommendation 1: Maintain Medicare GME support at the current aggregate amount, adjusted annually for inflation, while taking steps to modernize GME payment methods based on performance, to ensure program oversight and accountability, and to incentivize innovation in the content and financing of GME.
Graduate Medical Education That Meets the Nation’s Health Needs

Recommendation 2: Build a GME policy and financing infrastructure

- Create a GME Policy Council in the Office of the Secretary of the DHHS
- Establish a GME Center within CMS
Graduate Medical Education That Meets the Nation’s Health Needs

**Recommendation 3**: Create one Medicare GME fund with two subsidiary funds

3a. A GME Operational Fund to distribute ongoing support for residency training positions that are currently approved and funded.

3b. A GME Transformation Fund to finance initiatives to develop and evaluate innovative GME programs, to determine and validate appropriate GME performance measures, to pilot alternative GME payment methods, and to award new Medicare-funded GME training positions in priority disciplines and geographic areas.
Graduate Medical Education That Meets the Nation’s Health Needs

Recommendation 4: Modernize Medicare GME payment methodology

4a. Replace the separate indirect and direct GME funding streams with one payment based on a national per-resident amount (PRA)

4b. Set the PRA to equal the total value of the GME Operational Fund divided by the current number of full-time equivalent Medicare-funded training slots

4c. Redirect the funding stream so that GME operational funds are distributed directly to GME sponsoring organizations

4d. Implement performance-based payments using information from Transformation Fund pilots
Graduate Medical Education That Meets the Nation’s Health Needs

**Recommendation 5**: Medicaid GME funding should remain at the state’s discretion. However, Congress should mandate the same level of transparency and accountability in Medicaid GME as it will require under the changes in Medicare GME herein proposed.
SGIM’s Position on Medicare GME

Leave-Behind re Education

• SGIM strongly urges Congress to establish a GME payment structure that
  – adequately supports primary care, is transparent, holds teaching institutions accountable for their training outcomes, and results in a highly trained, appropriately distributed workforce well-equipped to meet the nation's health care needs

Addressing the Nation’s Physician Workforce Needs: The Society of General Internal Medicine (SGIM) Recommendations on Graduate Medical Education Reform

Angela Jackson, MD\(^1\), Robert B. Baron, MD, MS\(^2\), Jeffrey Jaeger, MD\(^3\), Mark Liebow, MD, MPH\(^4\), Margaret Plews-Ogan, MD, MS\(^5\), and Mark D. Schwartz, MD\(^6\) For the Society of General Internal Medicine Health Policy Committee
Growing pressures to reduce deficit
$3-4B in empirically unjustified IME
Physician shortage – desire to raise GME cap by hospital community
Desire to increase accountability and transparency of GME by MedPAC, CMS, and policy-makers

→ trade increased GME funded positions for P4P