



Tomorrow's Doctors, Tomorrow's Cures

Learn

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Lead

Public Policy & Oncology Workforce Issues

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Association of
American Medical Colleges

A little girl asked her father, “Daddy, do all fairy tales begin with ‘Once upon a time’?”

He replied, “No, there is a whole series of fairly tales that begin with ‘If elected, I promise...’”

Campaigns & Elections, December 2005/January 2006

Our Story for Today

- Medical schools' and teaching hospitals' roles in building health care workforce heavily influenced by public policy
- Undergraduate medical education (UME) heavily supported by clinical revenue, tuition, state, other \$
 - § Growing through new schools as well as expansion of MD, DO programs
- Graduate medical education (GME) heavily dependent upon public financing
 - § Some growth despite limited financing

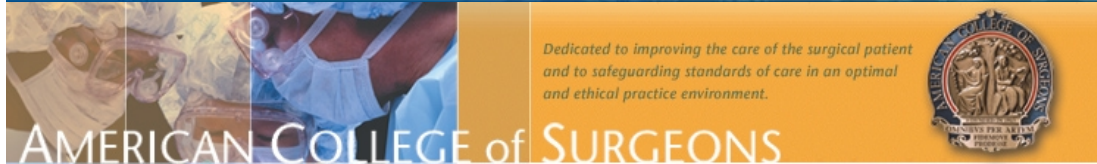
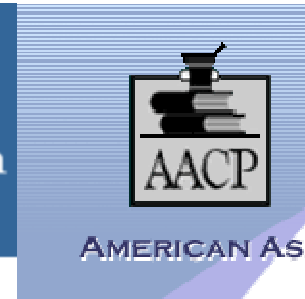
GME Support Comes from Multiple Sources

- Medicare (largest explicit payer)
- Medicaid
- Private patient care revenues
- V A/DoD
- Other Federal and state programs (including Title VII, CHGME)

Each source affected by different stakeholders and policymakers



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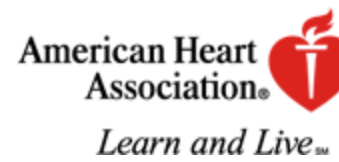
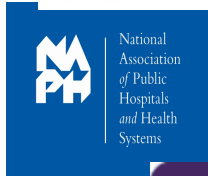
It's time to listen.



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Medicare Makes 2 Specific Payments With an “Education” Label

Direct GME Payments (DGME)

- Partially compensates for residency education costs

Indirect Medical Education (IME) Payments

- Partially compensates for higher patient care costs due to presence of teaching programs

What Are DGME Payments Intended to Cover?

Compensate teaching institutions for costs directly related to educating residents:

- Residents' stipends/fringe benefits
- Salaries/fringe benefits of supervising faculty
- Other direct costs
- Allocated overhead costs

Why Does Medicare Recognizes Direct GME Costs?

The initial Medicare legislation states:

Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.

(House Report, Number 213, 89th Congress. 1st Sess. (1965) and Senate Report, Number 404. Pt 1. 89th Congress. 1st Sess. 36 (1965))

Medicare Payments with an Education Label: IME

Compensates teaching hospitals for higher inpatient operating costs due to:

- unmeasured patient complexity not captured by DRG system
- other operating costs associated with the presence of GME programs (more tests, lower productivity, etc)

Percentage add-on payment to basic Medicare per case (DRG) payment

IME payments made only to hospitals

IME Payments are *Patient Care Payments* with an Education Label

“ This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.”

(House Ways and Means and Senate Finance Committee Reports, March 1983.)

Resident Limit Largely Stuck at 1996 Level; Flexibility is Limited

Urban hospitals:

- new programs through 1997
- rural training track programs

Rural hospitals:

- New programs
- 30 percent expansion

Resident limit affiliation agreements

Temporary expansions

Limits to GME Flexibility Include

- Limitations on total number of positions reimbursed
- Reimbursement for training at non-hospital sites
- Reimbursement considerations for voluntary supervision
- Counting of time spent in didactic, quality improvement, research activity
- Limitations imposed by many non-Federal entities (ACGME, RRC, etc)

Current Exclusion of Resident Time in Research

Nonhospital Settings—According to CMS, research time is not countable for either DGME or IME because does not meet the definition of “patient care activities”

Hospital Settings—

DGME—research time is countable

IME—“time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.” (42 CFR 412.105(f)(iii)(B))

2008: Greatest-Ever Assault on Medical Education Payments

- **Reduction**

- § Medicare IME add-on payments (from 5.5% to 2.2% over 3 years) \$12.9 billion/5 years

- **Elimination**

- § Medicare IME payments to hospitals for treating Medicare Advantage patients \$8.85 billion/5 years

- § Title VII funding (health professions training)

- § Title VIII funding (advance nursing training)

- § Children's Hospital GME

- § Federal match for Medicaid GME costs

- § Reduction in Capital IME payments

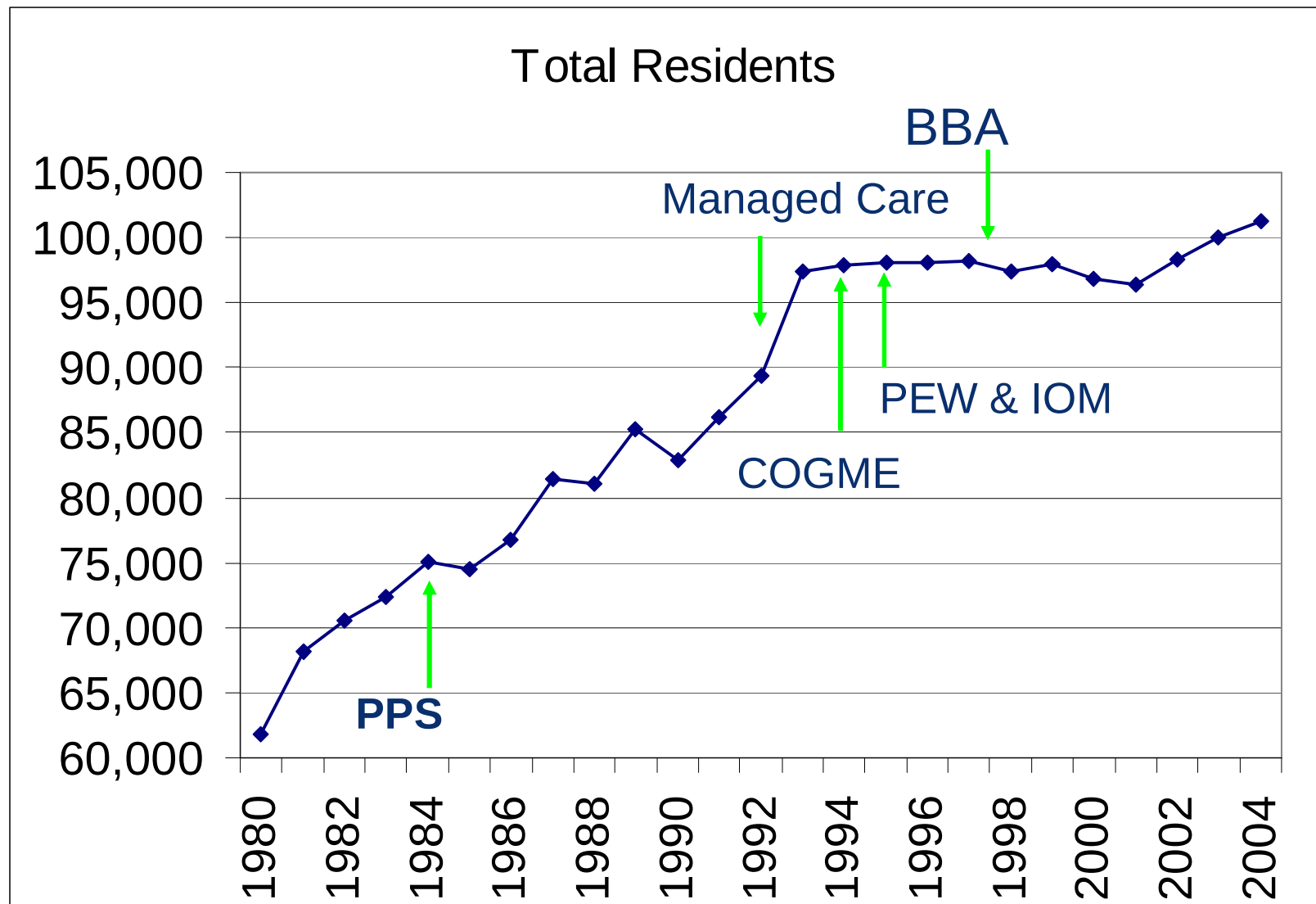
All at a time when we are trying to grow GME positions!

Additional AAMC AAMC Priorities – HHS

	FY 2007 Comp.	06-07 □	FY 2008 Conference	07-08 □
NIH *	\$28.90 B	2.1%	\$30.00 B	3.8%
Title VII	\$184.7 M	27.2%	\$212.0 M	14.8%
Title VIII	\$149.7 M	0%	\$167.7 M	12.0%
AHRQ	\$319.0 M	0%	\$334.6 M	4.9%
Children's GME	\$297 M	0%	\$307 M	3.4%
NHSC	\$125.7 M	0%	\$131.5 M	4.6%
CDC	\$6.203 B	-1.9%	\$6.615 B	6.7%

* NIH totals include funds to be transferred to Global AIDS Fund (\$99 million in FYs 06-07 and \$300 million in FY 08.

Total GME Positions, 1980--2000



Training Positions Respond to Research & Policy

Efforts to eliminate the Medicare Cap

Resident Physician Shortage Reduction Act of 2007 (S. 588 / H.R. 1093)

Introduced Feb. 14 and 15, 2007 by:

Senators

Bill Nelson (D-Fla.)
Harry Reid (D-Nev.)
Joe Biden (D-Del.)

Representatives

Kendrick Meek (D-Fla.)
Jon Porter (R-Nev.)
Kathy Castor (D-Fla.)

As of June 16, 2008:

11 cosponsors on the Senate bill (2 Republicans)
56 cosponsors on the House bill (26 Republicans)

Resident Physician Shortage Reduction Act of 2007 (S.588 / H.R.1093)

- New Medicare-funded slots for teaching hospitals in states with resident physician-to-100,000 population ratios below the national median (24 states affected)
- Secretary determines distribution methodology. Must account for whether the hospital will be able to fill the positions over a 3-year period, as well as whether the filled positions will be in primary care, preventive medicine, or geriatrics.
- Increases Medicare-funded slots by 1,222 residency positions
- Slots will be phased in over 5 years.

AAMC Position On The Bill

“The AAMC believes the *Resident Physician Shortage Reduction Act of 2007* is a useful beginning in meeting the nation’s needs for future physician services. We express support for this important first step in what we hope will be a systematic and rapid process to eliminate the Medicare resident cap . . . **we do wish to be clear that financing this legislation from other cuts in Medicare in which we have any interest will be self-defeating and unacceptable.**”

AAMC Letters to Sponsors of S. 588/H.R. 1093

The Future of Workforce Growth?

- Medicare GME caps (Finance Cmte, Ways & Means)
- Title VII (HELP cmte)
- V A/DoD
- Ability to navigate burdensome regulations (CMS)

Oncology workforce policies hampered by

- Growth of positions in oncology
- Income optics for practicing physicians
- Public policy priorities (e.g., Primary Care)
- Lack of federal resources



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