**Session:** Tackling the Shortage of GME Slots: Solutions Within Reach

**Presenters:**

Moderator:Atul Grover

Panelists: Michelle (Shelley) Nuss – associate dean of GME and DIO at University of Georgia, Karen Sanders – deputy chief officer for academic affiliations at veterans health administration, [Lori Mihalich-Levin](http://www.cvent.com/events/learn-serve-lead-2014-the-aamc-annual-meeting/agenda-a4bfa8584ab64b6fbc0b57e7828f3220.aspx), JD – director of hospital and GME payment policies, translates medicare policies into English, [Rick Bossard](http://www.cvent.com/events/learn-serve-lead-2014-the-aamc-annual-meeting/agenda-a4bfa8584ab64b6fbc0b57e7828f3220.aspx) – government relations officer for University of Michigan Health System

**Contact Information:**

**Date and Time:** 11/8/14

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**Summary:**

Notes:

Lori

* Hospitals that have never trained residents before still have opportunity to open positions and receive medicare GME payments
* Hospitals that have never trained residents but want to
* Hospitals that have never trained residents and don't want to but want to have rotations
* Direct GME payments – paid per resident FTE up to cap, if you’re a new teaching hospital you have to establish a per resident amount
  + Paid based on medicare share, %age of pateints that are medicare patients, multiply share by per resident amount = medicare payment per resident, if resident exceeds time period payment will go down by half
* Indirect Medical education payments – partially compensates for higher patient care costs due to presence of teaching programs, patient complexity etc., add on to DRG payment, based on formula using intern and resident to bed ratio, have to figure out how many residents you have per bed in your hospital
  + Depends on # of FTEs and number of beds, intern/resident: ratio = residents/beds, put it in a formula determined by congress and get add on to DRG payment
* Medicare caps – can only be paid for resident FTEs in 1996, if it didn’t report training residents in 1996 it can become a teaching hospital by building up a cap
  + Establishing PRA – uses lower of first year actual costs or weighted PRA for geographic area
  + Establishing resident caps – 5 yr window, many nuances
  + PRA and cap are permanent after 5 yr window
* What is “new”?
  + Program director is new, teaching staff is new, residents new – if you don’t pass, they won’t give GME payments
* What if hospital hosts rotating students?
  + Triggers PRA – need to incur and record cost of training resident on HCR
  + If resident comes in for rotation from a *new* program then it triggers cap at your hospital from when program started at other hospital
* Becoming a New Teaching Hospital – guide with details, continuously updated

Shelley – real-life example of building a teaching hospital, Georgia

* GA statistics
  + Physician crisis especially bad in Georgia – people living longer and moving down south
  + GA has increased medical student spots and enrollment up to 57%, new DO school in Suwanee
  + GME expansion is only 31% - currently train 2100 residents
  + More students than residents in GA – students who do GME are more likely to practice
  + Ranked low in terms of resident physicians per capita and even worse in 1º care doctors per population
  + No GME in NE GA (Athens)
  + Only 16 hospitals participated in GME when she arrived
* How do you expand GME? New teaching hospitals – have to consider:
  + Sustainable funding
  + Distribution – outside of current GME hubs (Atlanta, Augusta)
  + Specialty – primary care and general surgery
* Challenges to new hospitals:
  + Hospital readiness
  + Medical staff perceptions and willingness
  + Strategic plan
  + Mission changing decision
  + Transformation to community teaching hospital
  + Financial constraints – probably 2-8M in start up costs, must ID source, won’t get any medicare payment until the first resident is on duty
* Takes a lot of education and reiteration to get hospitals on board and infrastructure ready, many times faculty don’t have required credentials – have to recruit directors and faculty, then go through the ACGME steps
* Proposed 400 new resident positions, funding model to help cover costs, hospitals had to focus on primary care and general surgery, hospitals required to match funding 1:1
  + Governor supported and approved funding in 2013
  + Now 6 acgme accredited sponsoring institutitions
  + State appropriations has gone from 1.2M in 2013 to 5.275M in 2016
* Lessons learned
  + Do homework to know workforce data
  + Education and buy-in of key stakeholders
  + Lots of education of legislature
  + GME start up costs high
  + Building relationships key

Rick – Michigan politics of GME

* Michigan has a very mature GME program, fighting to keep it moving forward
* 5k house officers and residents in Michigan
* Governor targeted GME for 40% reduction in budget recommendation – 2011
  + Teaching hospitals have been in battle to make sure GME education remained fully funded – UMHS took lead, led grass roots effort to rally full restoration of $164M budget fully restored
  + Strategy for rallying: identify champions in legislature, change the messenger to hospital CEOs and CFOs, rally the house officers – best messengers, apply gentle but relentless pressure
* Currently a solid republican majority, #1 problem is term limits – will have >70 members in legislature with 2 or fewer yrs of experience beginning in Jan
* GME is currently 1% of Michigan department of community health budget, ranks 5th in country for GME enterprise, supports 5k house officers and residents
* Medicaid enrollment – 2.2M, 1.5M in managed care

Karen

* VA – largest single provider of health professions education in the US, partnership with both allopathic and osteopathic schools
  + Most consist of VA as participating site, <1% of VA GME is sponsored by VA
  + Affiliating VAs with medical schools fills VA physician pipeline, hoped it would also improve veteran healthcare
  + Nearly 2/3 of medical students have trained in VA, has pos impact on willingness to consider VA employment
* Scope of training
  + 40k medical residents annually, 30% of total medical residents
  + 10.5k FTE funded resident positions
  + collaborates with >2400 ACGME accredited programs
* GME Enhancement 1 – driven by maldistribution of residency positions and failure to keep up with emerging specialization
  + 2007-2011
  + corrected geographic maldistribution by sending new positions to SE and SW
* VACAA Choice Act, signed 2014 – expand GME by 1500 positions over 5 yrs
  + Very specific funding priorities (need to meet one of these) – facilities in areas with shortage of physicians, no prior GME, rural locations, high concentration of veterans, HPSAs
  + Programs – primary care, mental health, new affiliations
  + Part of initiative to “staff up” VA
  + Put out request for positions in VA hospitals, rigorously adhering to law and act, will have to report on budgetary allocation and fill rate
  + There has been many applications, 450 positions requested in this round during 4 wk window
  + ACGME is aware of legislation and is going to do everything they can to expedite increase in residency caps
* Ground rules
  + VA pays stipend and benefit costs for time at VA site only, usually through OAA funded disbursement agreement
  + Other program costs paid via outside disbursement agreement
* VA has had underutilization of some facilities, have identified positions and institutions over the last year, these positions may have been underfunded but stayed listed, now correcting how things are reported

Q&A

Launched a grassroots network – aamcaction.org, trying to bring together everyone who needs to have a voice. Despite being on payfor list?? Currently have contacted 170k.

All-payer model – supported by AAMC

IOM – no prescription for how to deal with disruption. Part of the challenge is that we have IME adjustment (proxy for any different types of care). To build system ground up – figure out how to pay for medical education, research and clinical care, and then make that a societal cost. While current care is usually satisfactory, transparency efforts will help tie payment to performance

Residency training is starting to move into non hospital settings, but the how is pretty difficult.

Resources:

AAMC Physician Workforce Data book

AAMCAction.org

Institute of Medicine Report