

Are We There Yet?

Success and Barriers to Federal Graduate Medical Education Reform

Issues for Action
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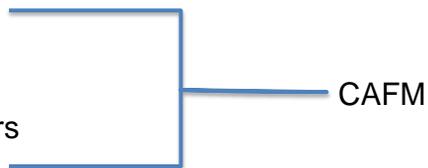
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How Does Family Medicine Work Together?

North American Primary Care Research Group
Society of Teachers of Family Medicine

Association of Family Medicine Residency Directors
Association of Departments of Family Medicine

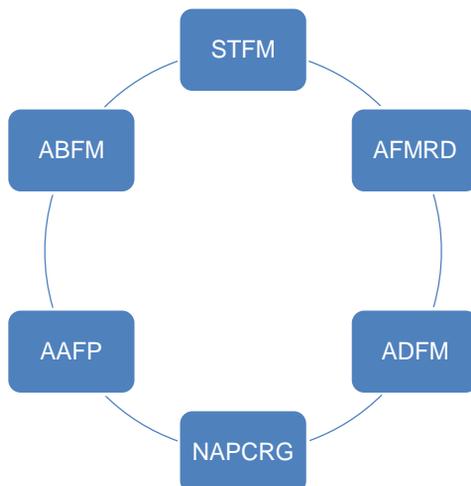
American Academy of Family Physicians
American Board of Family Medicine



$$\text{CAFM} + \text{AAFP} + \text{ABFM} = \text{AFMAC}$$

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Academic Family Medicine Advocacy Committee - AFMAC



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Topics for Today

- Congressional Climate
- Appropriations – finding champions
- GME –
 - Overall Reform
 - THC
 - Low Cap – Low PRA
 - Rural GME
 - VA GME
- PCORI
- NIH – training awards

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Hazards and Opportunities

Hazards:

- Budget/Approps
- GME for Deficit Reduction
- Inertia or Impasse
- Lack of Legislative Days

Opportunities:

- THC Reauthorization
- GME Rural “technicals”
- Veteran’s Administration
GME Slots
- GME Reform
Conversation
- FMCC April 18-19
- Revised Advocacy
Course

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Elections and Regular Order

- 110 Legislative Days
- Promised all 12 appropriations bills
- Senate – perhaps occupied with Supreme Court Nominee
- CR and Lame Duck Distinct Possibilities

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Appropriations Funding

- Need for Champions – Need your help
 - Homework
- AHRQ – Restore \$30 million - \$364 m
 - It's not “the boy who cried wolf”
- Title VII primary care - \$59 m – enough to have another competitive cycle

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GME Issues

- Overall Reform
- THC
- Low Cap – Low PRA Ribble/Nelson Legislation
- Rural GME
- VA GME

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Overall GME Reform

- Some discussion – little action
- GAO report – Transparency and Accountability
– due in Spring; result of FMCC
- Some want global reform before they will do anything
- Others recognize need for piecemeal approach

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Congressional Appetite for GME Reform

- Potential alignment of interests for transparency ↑
 - GAO report
- Somewhat less for accountability ↓
 - No serious movement
- IME is still a “slush fund” or target for deficit reduction ↓
 - Still in President’s budget
- Urban vs. Rural (Haves vs the Have Nots) ↓
 - Schumer in charge – no support for change
 - House somewhat interested in rural solutions

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THC Permanency

- Medicare Reimbursement – permanent and stable
- Similar structure – rules of eligibility, etc.
- Set the funding amount so it’s not easily cut
- Heavy lift – but needed solution

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Low Cap – Low PRA

- Hospitals that have never sponsored a teaching program, but hosted residents rotating for short experiences
- Triggered the CAP setting
- Often triggered a PRA amount - \$0
- Many still think they are “virgin” or non-teaching hospitals
- Large problem for Rural Hospitals
- Potential legislation introduced next week in House and Senate

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Ribble/Nelson Legislation

- Group 1: Prospective - no cap or PRA until accepting more than 1 FTE per year;
- Group 2: One time pass everyone since 1997 with 3 or less FTEs on a cost-report – from newly accredited training programs.; and
- Group 3: Less than 1 FTE in 1996 base year – one time opportunity to establish a new cap.

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Supporting the Ribble/Nelson Legislation

- American Academy of Family Physicians
- American Medical Group Association
- Association of American Medical Colleges
- Association of Departments of Family Medicine
- Association of Family Medicine Residency Directors
- Medical College of Wisconsin, U of WI, WHA, and many other Wisconsin-based entities
- North American Primary Care Research Group
- Society of Teachers of Family Medicine

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Homework

- Please let me know if this is an issue for your institution
- List serve announcement (bill numbers, talking points)
- Will need everyone to ask their legislators to cosponsor the bills.

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Rural GME - Coalition groups

- Council of Academic Family Medicine (CAFM)
- American Academy of Family Physicians (AAFP)
- National Rural Health Association
- Association of American Colleges of Osteopathic Medicine (AACOM)
- American Osteopathic Association (AOA)
- American College of Osteopathic Family Medicine (ACOFM)

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Remove RTT Concurrent Growth Requirement

Problem: Urban hospitals must establish All rural training tracks in a specialty at the same time

Legislative Solutions:

- Allow an urban hospital to expand its cap for the purposes of establishing a new RTT (training at a new site) whenever they occur and in whatever specialty they train.
- Set the expanded cap at the actual number training in PGY1 who will be going to RTT in PGY2&3

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Critical Access Hospitals (CAH)

Problem:

- CAHs only allowed to put direct GME on cost reports = roughly equivalent mathematically to about one-third of typical total GME payments. They are not eligible for Indirect GME (IME.)
- No other hospital can claim the residents either

Legislative Solution:

- Change definition of CAH to non-hospital and non-provider for GME purposes only.

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Sole Community Hospitals (SCH)

Problem:

- Payment only covers indirect medical education costs for hospitals that had teaching programs in FY 2006, or three other previous base year periods.
- Essentially eliminates reasonable funding for new training programs in sole community hospitals.

Legislative Solution:

- Allow SCH to rebase their Hospital Specific Rate (HSR)

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Cost of Rural Expansion Important Consideration

Per Resident Payment (not PRA which is specific to DME)

- Ensure reasonable payment amount ~ \$150 K – pinned to another payment rate so it won't be cut. For example, 85% of IME and DME together.

How much expansion is possible, realistic?

- Total Number of FTEs

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VACAA 2014

1500 Slots –

- Only 24.15 FTEs in FM were funded.
- Of 168 new FTEs in the second round,
 - 58% were in primary care or mental health,
 - 6.5% were rural.
- Initiated a coalition similar to our Rural GME coalition to work with VA and Congressional Offices

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PCORI

PCORI culture - somewhat problematic; reauthorization FY2019

FM - Permeate PCORI with:

- comparative effectiveness primary care research questions
- Primary care reviewers and advisory panel members
- Primary care topic refinement panel members
- Undifferentiated patients – not disease-specific or industry-related patients

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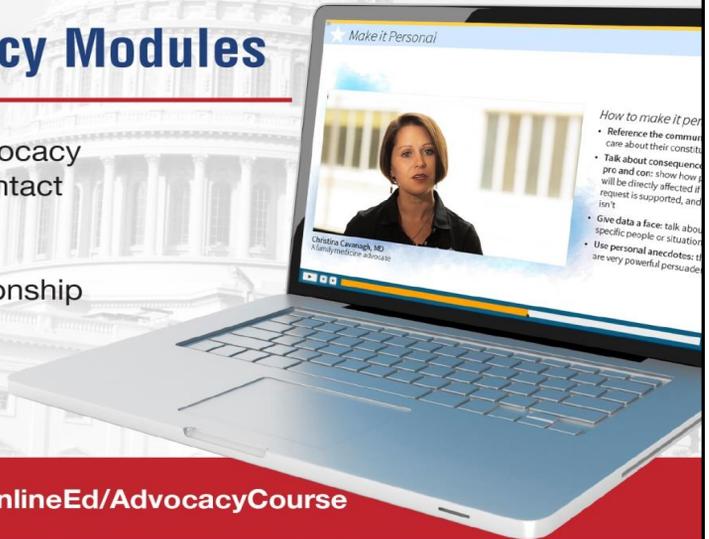
Primary Care Research Legislative Funding Proposal at NIH

- a targeted and small award program
- \$20 million per year over 10 years within the NIH Common Fund, or other areas within NIH,
- For training/development awards
- Beginning to look for primary care partners – SGIM for example.

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- Module 2: Prepare and Make Contact
- Module 3: The One-Pager
- Module 4: The Visit
- Module 5: Maintaining the Relationship



www.stfm.org/OnlineEd/AdvocacyCourse



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