AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

The Future of AAFP GME Policy

Background and Objective

The current AAFP GME policy was adopted after revision in September 2014. In 2017 the AAFP Congress of Delegates referred a resolution to the AAFP senior leadership titled, *CMS Funding for Graduate Medical Education*, that prompts a reevaluation of the AAFP GME policy. The AAFP is engaged in a period of study to inform recommendations for consideration by the AAFP Board of Directors in July 2018. The objective of the first phase of study is to understand perspectives from a diverse group of influencers and stakeholders by conducting listening sessions.

Methods

A slate of possible "responders" was identified in November 2017 by government relations staff from AAFP CAFM and subject matter experts from the Robert Graham Center for Policy Studies (RGC). The organizations and individuals were prioritized by Dr. Clif Knight and invited to participate in one of four block listening sessions in November or December 2017. Four out of the five invited responders accepted our invitation. The fifth organization, the American Hospital Association, was unable to participate because of conflicting availability. The responding organizations were: AAFP RPS Panel of Consults - represented by the executive committee members; Dr. Candice Chen representing herself though she is a physician leader at the HRSA, Dr. Kristen Goodell representing the Harvard Center for Primary Care, Karen Fisher representing the AAMC, and the GME Initiative represented by their executive director Kim Marvel and physician leads Dr. Dan Burke and Dr. Kent Voorhees.

Each responding organization was asked to review the current AAFP policy titled, *AAFP's Proposal to Reform Graduate Medical Education*, in advance of the listening session. Structured 30-60 minute interviews were conducted via Go-To-Meeting web conferencing software and lead by a family physician facilitator from the RGC or AAFP Division of Medical Education. Each facilitator used a moderator's guide to support consistency in the process. Each responder was asked to consider three primary questions:

1. What elements of the current AAFP GME policy are relevant and should remain?
2. What is missing or needs revising?
3. What can the AAFP realistically hope to change with adjustments to the policy?

Field notes were captured by the facilitator and two AAFP Medical Education team members. One team member displayed the responders' comments so that each responder could view and clarify what was captured. Each of the listening sessions was recorded for playback reference as needed.

Summary of Results

<u>The environment for changes to AAFP policy</u>

- There was consensus among all the responders that changes in health care, medical education, the practice of medicine and the current political environment (since 2014) should prompt the AAFP to update and make more contemporary its GME policy. There was a common belief that the current policy lacked a necessary level of specificity to be actionable especially compared to other writings, in particularly the consensus report from the National Academy of Medicine, titled Graduate Medical Education that Meets the Nation's Health Needs released in July 2014.

- Several responders commented that when efforts to make reforms at federal level were stymied, they were activated and energized by opportunities to advocate and assert changes at the state level. There was a common call to make revisions that can be used by federal and state advocates.

- There was a positive "agitation" among our reactors with several supporting the AAFP to revise its policy and urge organized family medicine to be more active in the implementation and advocacy of the revised policy.

- All responders commented that 2018 is a different world politically from 2014. Some noted that talk of "limiting" portions of GME could be threatening and potentially endanger federal GME support. Several noted that policy makers think if they can make a tradeoff that can sustain a reduction, we won't likely get dollars back. Policy makers don't understand the nuances of GME and our language is important.

Summary of Themes by Policy Statement

Statement #1: **Limit payment for direct graduate medical education and indirect medical education to training for first-certificate residency programs**.

Current View – Overall Theme	Suggestion – Overall Theme
This statement continues to be important and contemporary as the US Congress looks at potential changes to entitlement reforms to address unevenness in the US budget.	This statement should mostly stay as a fundamental principle of the policy as it is likely to enable complimentary workforce policy that calls for the health care system to be based on a primary care workforce.

Related Comments:

"The context of the policy, including statement #1 is missing or has an underdeveloped "why" which may confuse policy makers, potential allies." The way it reads may create unnecessary tension with potential allies in the battle of retain federal GME.

"Current statements, including #1, seem to be about limiting and blocking others. Address priorities in statements that include- our goals and objectives are…"

"Don't mention IME – it is confusing and better to address just DME."

"I would make a new suggestion – funding should be to the residency and it should be a fixed amount rather than the complex formula." "We would also need to understand how many programs, possibly 50-60% would run in the red and require supplementation by another party."

"Get away from IME and go with DME – have a consistent PRA. We would prefer a clear and consistent PRA rather than the complex and non-transparent and inconsistent distribution that exist today."

Statement #2: Establish primary care thresholds and maintenance of effort requirements applicable to all sponsoring institutions and teaching hospitals currently receiving Medicare and/or Medicaid GME financing.

Current View – Overall Theme	Suggestion – Overall Theme
Current policy is too vague to be useful.	The AAFP should put out a specific number(s) and acknowledge that we need more FM slots.

Related Comments:

"Use findings from the THC legislation and research to figure out what number would be sustainable understanding that every residency program should support some of its program with clinical revenue."

"We need to be clear rather than making polite suggestions."

"Use a set of assumptions such as…we now have around 3,000 FTE R1s – I'd say that by 2030 there needs to be 6,000 FTE R1s in FM. Using 150 PRA that would amount to about $2.7 billion a year not accounting for the future value of money calculation and adjustments."

"Thresholds for some sponsoring institutions such as MD Anderson may not be relevant. We need to allow for those institutions that are not training primary care – and community workforce needs.

"Should there be a statement about change needed at the sponsoring institutions to move from just short-term operation and business planning to incorporate mission and community focused workforce planning." *See ACGME December 2017 Report titled Envisioning the Sponsoring Institution of the Future: Report of the SI2025 Task Force.*

"Consider the possibility to address workforce shortage closely aligned with effective delivery of primary care. For example, adolescent psychiatry - is not a first certificate program but the care provided by this specialty is critical to achieving the Triple Aim."

"Thresholds in primary care are tricky. A policy needs to be responsive to state and local needs."

"Reference the COGME 2010 recommendation – 40% of physician workforce is in PC.

"Our policy should focus on what's best for the American public as opposed to what's best for family medicine. The IOM/NAM report from 2014 is a useful reference. The AAFP should strongly support the 2014 IOM (now NAM) Report.

Statement #3: Require all sponsoring institutions and teaching hospitals seeking new Medicare and Medicaid-financed GME positions to meet primary care training thresholds as a condition of expansion.

Current View – Overall Theme	Suggestion – Overall Theme
Confusing to implement and track. Likely too blunt given the current cap language.	Potentially add language calling for increasing GME cap and making GME a national priority.

Related Comments:

"Nobody can expand with the current rules. We can talk around existing distribution of slots but the fact that CMS has frozen/capped the slots are an enormous impediment to change."

"GME should be a national priority. GME programs train more than residents and it should be noted that training other health professions such as nurses, pharmacists, social workers would be harder without federal and state investments in GME.

"I don't think the AAFP will be successful in increasing family physician workforce without getting the Medicare GME caps increased."

"We prefer the IOM language that calls for a deliberate oversight of workforce policy."

Statement #4: Align financial resources with population health care needs through a reduction in IME payments and allocation of those resources to support innovation in GME.

Current View – Overall Theme	Suggestion – Overall Theme
Too vague to be useful.	Avoid "reduction" messaging in current political climate. Be more specific. Reference language in the 2014 IOM/NAM report on combining IME/DME into a flat rate.

Comments:

"There needs to be a transformation fund that can reward and expand primary care training.

"Think creatively about using GME dollars to support and expand team based teaching and care delivery."

"Address workforce maldistribution by leveraging GME funding for innovation"

"It will be hard for AAFP to talk about training physicians for the future without having a clear feel for what the job will look like in 10 or 20 years." That information should be incorporating into the purpose of the policy.

"The Teaching Health Center Model won't live up to its potential until they are comfortably funded like other GME programs."

Statement 5: Fund the National Health Care Workforce Commission.

Current View – Overall Theme	Suggestion – Overall Theme
Good idea with no traction. Might be time to let it go.	Mixed feedback. Let it go vs Double down on this notion.
Related Comments: "We agree with funding a national health care workforce commission, but it needs to be responsive to state and local needs." "Forget the National Health Care Workforce Commission – it's not going anywhere."	

Other quotable quotes:

"Start with defining the desired outcomes and then work backwards. The goals are not clear when reading the current document and related policy statements."

"If you want to have impact, (the policy) should be driven by a focus on the end goal of improving access, quality, cost efficiency and provider wellbeing."

Maldistribution and geography is one of the biggest problems we have in the country. If you really are interested in the health of the nation and how GME impacts health, we need to address levers that account for reducing maldistribution.

"There may be other things that we would want to include in the policy that are not financial such as length of training time, innovation, transparency."

"One of the things - you need to convince yourself that this is worth fighting for – we need to be a little bit militant.

"Policy that is too vague causes people within our own community to argue but we don't really get anywhere."

"Adequate PRA and making sure the CAP opens - and for every accredited residency position there is an appropriate amount of funding - is really important."

"In the current environment, it is unlikely that reducing IME will mean reallocation to DME – most likely those IME payment reductions will go back to the Medicare Trust. It's risky talking about reductions in this environment."

"Are there other non-governmental grant programs that should be addressed in a remade policy?"

In Summary: An updated GME funding policy needs to be simplified, specific and have a clear call to action – locally and nationally.