

**COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)
INNOVATIONS IN GRADUATE MEDICAL EDUCATION FINANCING AND
ARCHITECTURE**

IN- PERSON MEETING MARCH 12-13, 2015

Council Members in Attendance:

H. David Reines, MD, FACS, Chair
Gamini Soori, MD, MBA, FACP, FRCP, CPE, Vice Chair
Kirk Calhoun, MD
Michael Core, MD
Erin Corriveau, MD, MPH
J. Nadine Gracia, MD, MSCE
Lois Margaret Nora, MD, JD, MBA
Mary Ellen Rimsza, MD, FAAP
Beth Roemer, MPH
Keya Sau, MD, PhD
Kenneth Shine, MD
David Squire, MPA
Karen Sanders, MD
D. Keith Watson, DO, FACOS, FAODME

Others Present:

Joan Weiss, PhD, RN, CRNP, FAAN Designated Federal Official, Health Resources and Services Administration (HRSA)
Kandi Barnes, Management Analyst, HRSA
Kimberly Kline, Director, Advisory Committee Operations, HRSA
Catherine Kuchinsky, Program Analyst, HRSA
Crystal Straughn, Technical Writer, HRSA

Presenters:

Mary Wakefield, PhD, RN, Acting Deputy Secretary, Department of Health and Human Services (HHS)
Debra Weinstein, MD, Vice-President for Graduate Medical Education, Partners Healthcare System, Member of the Committee on the Governance and Financing of Graduate Medical Education
Arpita Chattopadhyay, PhD, Chief, Workforce Analysis Branch Bureau of Health Workforce (BHW), HRSA
Hayden Kepley, PhD, Chief, Performance Measurement and Evaluation Branch, BHW, HRSA
Mark Miller, PhD, Executive Director, Medicare Payment Advisory Commission
Candice Chen, MD, MPH, Director, Division of Medicine and Dentistry, BHW, HRSA
Karen Sanders, MD, Deputy Chief, Office of Academic Affiliations, Veterans Health Administration
David Squire, MPA, Assistant Dean, Finance, University of Utah School of Dentistry
Paul Rockey, MD, Scholar-in-Residence, Accreditation Council for Graduate Medical Education
Kenneth I. Shine, MD, Special Advisor to the Chancellor, The University of Texas System
Kirk Aquilla Calhoun, MD, President and Chief Administrative Officer The University of Texas Health Science Center, Tyler

Thursday, March 12, 2015

The Council on Graduate Medical Education (COGME) convened its meeting at 8:30 AM at the Health Resources and Services Administration's headquarters in the Parklawn Building, 5600 Fishers Lane, Room 18-67, Rockville, MD 20857. Dr. Joan Weiss, Designated Federal Official, greeted COGME members, took roll, reviewed the agenda, and noted the focus of the meeting was Innovations in Graduate Medical Education (GME) Financing and Architecture. She then introduced Dr. Mary Wakefield, Acting Deputy Secretary, HHS. Dr. Wakefield welcomed COGME members and briefly introduced the new Bureau of Health Workforce (BHW) Deputy Associate Administrator Luis Padilla, M.D. She discussed how HRSA's activities have been influenced by COGME's most recent report recommendations and the future of COGME and GME. She also provided updates on the following HRSA programs: Primary Care Training and Enhancement Program; Geriatric Workforce Development Program; Children Hospital GME; Teaching Health Center GME Programs; and Targeted Support for GME Program.

COGME members engaged in a dialogue with Dr. Wakefield about the role of COGME in GME and HRSA's Mental Health Workforce activities. She assured them that COGME is a leader in providing GME advice to the Federal Government. COGME has two decades of history in providing expert judgment, expertise, and evidence on GME. She also stressed that mental health is a high priority for HRSA. HRSA is working to produce more behavioral healthcare providers, including psychologists. HRSA is also working very closely with the Substance Abuse and Mental Health Services Administration to ensure assets to strengthen our healthcare workforce in behavioral health.

Dr. Debra Weinstein, Vice President for GME, Partners Healthcare System, Member of the Committee on the Governance and Financing of Graduate Medical Education, Institute of Medicine (IOM) discussed the recent GME IOM recommendations in their recent report *Graduate Medical Education that Meets the Nation's Health Needs*. Dr. Weinstein also discussed the importance of accountability in healthcare and higher learning. She began her presentation by discussing the "stimulus" for the IOM, the Macy Foundation 2011 recommendations on GME (*Ensuring an Effective Physician Workforce for the United States, Recommendations for Graduate Medical Education to Meet the Needs of the Public*). Dr. Weinstein then discussed the IOM recommendations and proposed plan:

- Maintain public funding that is secure and predictable (at least for the next decade)
- Improve on a distribution methodology that is inequitable, inflexible, inscrutable and illogical
- Move from cost-based to outcome/value-based funding
- Leverage federal funding to incentivize, facilitate and support innovation
- Minimize problems from funding shifts via gradual implementation

Dr. Weinstein explained that if the IOM proposed plan was implemented there would be 2 phases. Phase one would be to create one Medicare GME fund that would involve two funds (operational fund and transformation fund) that would arise from Indirect Medical Education (IME) and Direct Medical Education merging. The operational fund would distribute a single payment to individual institutions. It would be based on a per-resident amount determined nationally that would be adjusted geographically and adjusted annually on a cost of living basis. The funding would be distributed to the sites or hospitals where residents are rotating. It would also be distributed to the sponsoring organization. The transformation fund would incorporate children's hospitals and teaching health centers (THC) into the same funding pool on the same basis as the other positions. It would provide an opportunity to award new GME positions in priority areas both in terms of priority specialties and in geographic areas that do not exist now under the cap. It would also allow research

to be done, which is necessary as a foundation for phase two. Phase two would pilot alternative GME payment methods and determine and validate performance measures needed for an outcomes-based payment system.

The proposed structure for governance includes a GME policy council in the Office of the HHS Secretary and a GME Center in Centers for Medicare & Medicaid Services (CMS). The GME Policy Council would develop a strategic plan for GME funding; sponsor research and pilots; provide regulatory authority to oversee payment policies; coordinate between federal agencies and accrediting/certifying organizations; and provide membership based on expertise. The GME Center in CMS would manage and distribute funds consistent with policy council decisions; have the capacity to run demonstration projects; and provide expert staff and sufficient resources.

The Council members expressed their concerns about the amount of money going to the transformation fund, the proposed governance structure, and COGME's future role in GME. Dr. Weinstein explained that the amount of money going to the transformation fund was a projection and would need to be refined based on a number of factors. There are 2 components to the proposed governance structure because they have different charges and therefore would need different personnel to fulfill those activities. She explained that the number of the people and the processes that COGME has utilized would be appropriate for a new group, but other important structure elements are missing. Regulatory authority was another important element that IOM would like added. For example, COGME doesn't have the ability to change the payment rule.

Dr. Arpita Chattopadhyay, Chief, Workforce Analysis Branch, BHW, HRSA and Dr. Hayden Kepley, Chief, Performance Measurement and Evaluation Branch, BHW, HRSA discussed the National Center for Health Workforce Analysis (NCHWA), NCHWA core activities, the Workforce Analysis Branch, major developments and trends impacting the health workforce, and performance measurement and THCs. The NCHWA goals are to:

- Support more informed public and private sector decision making related to the health workforce through expanded and improved health workforce data, projections and information.
- Promote the supply and distribution of well-prepared health workers to ensure access to high quality, efficient care for the nation.
- Conduct performance evaluation of HRSA programs

The NCHWA core activities include:

- Health workforce data collection, analysis, and dissemination
- Improved projections of supply and demand
- New Health Workforce Research Centers
- Update of the Standard Occupational Classification
- Conduct research and analysis for the National Practitioner Data Bank
- Conduct program performance measurement: Data Collection, Analysis, Evaluation and Reporting of BHW Programs

COGME discussed IOM's belief that there will not be a shortage of physicians in the future and their concerns about the availability of numbers and metrics. Dr. Chattopadhyay and Dr. Kepley explained there is currently a shortage of about 7500 primary physicians but they do not yet have the numbers for a future primary physician shortage.

Dr. Mark Miller, Executive Director, Medicare Payment Advisory Commission (MedPAC) discussed Medicare and GME. Dr. Miller commented that the GME process and residency process produces physicians of superior clinical training. He explained that Medicare is a critical component of GME and the Commission should play a role in its reform. The healthcare system needs to be oriented towards continuance of care, care coordination, continuous improvement and quality, and containing cost. GME and residency training have a role in producing physicians that would lead change, and bring about system reform.

Dr. Miller commented that residency programs are largely acute care, hospital-based. Most of the training is spent in the in-patient environment. There are many Medicare financial incentives in place that discourage training outside of the hospital. MedPAC's view is that care has been and will continue to change, and will have much less of an in-patient hospital focus over time. There needs to be greater coordination and training in non-hospital settings.

Dr. Miller discussed a recent MedPAC study conducted with RAND to learn about how selected curricula are presented in residency training programs. The curricula focused on practice-based learning, system-based practice, interpersonal communication, health information technology, and non-hospital care settings. The RAND study found that although most programs provided some training in selected topics essential for delivery reform, overall, curricula falls far short from that recommended by the IOM and other experts. There were concerns about lack of formal training and experience in outpatient care coordination, multidisciplinary teamwork, awareness of healthcare costs, comprehensive health information technology, and patient care in non-hospital settings. Programs more consistently include instruction on evidence-based medicine and communication about end-of-life care. MedPac recommended the following:

- Establishing performance-based payments for GME. Congress should authorize the Secretary to establish a performance-based incentive program with payments to institutions contingent on reaching desired educational outcomes and standards.
- A panel of individuals and stakeholders with expertise and relevant perspectives should advise the Secretary. There should be eligible institutions to include teaching hospitals, medical schools, and other entities sponsoring residency programs. Funding should come from reducing IME payments to eliminate the amount paid above empirical IME costs.
- Increase the transparency of Medicare's GME subsidies. The Secretary should annually publish a report that shows, by hospital, the amount of funding received in Medicare GME payments and associated costs.

Dr. Miller emphasized the goal is to foster greater accountability for Medicare's GME dollars and reward education and training that will improve the value of the healthcare delivery system. It is also important to encourage collaboration between educators and institutions on residency program funding decisions and recognize Medicare's significant investment in residency (and some nursing) training and education.

Dr. Miller concluded his presentation discussing the workforce needs and increasing diversity of health professionals. He noted resident subsidies should support workforce needs of high-value delivery systems. Before considering changes in the numbers of residents Medicare subsidizes:

- Analysis must be conducted to determine workforce needs of improved—high quality, affordable—delivery systems.
- The number of residents subsidized (in total and by specialty) should not exceed reformed delivery system needs.

- Analysis should incorporate optimal contribution from other health professionals, including nurse practitioners and physician assistants.

In addition, multiple studies find access and quality improvements associated with greater diversity in physician workforce. There is underrepresentation of physicians who come from minority, lower income, and rural communities. The impacts of current federal programs to improve healthcare workforce diversity are not rigorously studied.

COGME engaged in a discussion on the MedPAC RAND study, IME, hospital costs, and residents understanding the costs of care. Dr. Miller explained that the RAND study was conducted using contract funding. The IME analysis is a cost function analysis where you take the cost per admission, and then adjust for a range of things. He also discussed how hospitals charge 100 percent more for office visits and other services than a physician's office charges. He emphasized it is important to explore why services cost more in hospitals and if they need to be provided in hospitals. Dr. Miller also assured the Council that MedPAC does not expect residents or providers to know costs for all services or provide insurance advice.

Dr. Candice Chen, Director, Division of Medicine and Dentistry, BHW, HRSA gave the members of COGME an update on HRSA programs including the Children's Hospital GME (CHGME), THCs, Targeted Support for the GME Program (TSGME), Medicine, Geriatrics, and additional Fiscal Year (FY) 2016 proposed new programs.

Dr. Chen explained that the CHGME supports children's hospitals and GME. The current annual appropriation is \$265 million. This year, there are 57 children hospitals receiving GME payments through the CHGME program. For the first time, there were newly eligible entities. The reauthorization allowed some newly eligible hospitals to receive funding including a pediatric psychiatry hospital.

The THCGME Program expands residency training in community-based settings. The program was funded at \$230 million for five years and will finish at the end of September 2015. It increases access to healthcare services for people who are geographically isolated, economically or medically vulnerable. There is \$83.4 million in Affordable Care Act (ACA) funding for the 2014-2015 academic year. There has been training for more than 550 residents in 60 Teaching Health Centers. It expands states with THCs from 21 to 24.

The TSGME is a new program that has requested \$400 million in new mandatory funding in FY 2016 and a total of \$5.25 billion is requested over FY 2016-2025. It supports over 13,000 residents over 10 years in community-based ambulatory care. It focuses on key workforce goals including: training residents in primary care and other high need specialties; aligning training with more efficient and effective care delivery models; and encouraging physicians to practice in rural and other underserved areas.

In FY 2015, the Primary Care Training and Enhancement Program (PCTE) was streamlined to support projects across the training continuum. The total funding is \$39 million annually and the request is the same for FY 2016. The PCTE supports primary care training, which largely means supporting community-based ambulatory training. The most recent funding opportunity announcement focused on transforming clinical training environments to align with the transforming healthcare delivery system. This announcement is similar to the CMS State Innovation models. The

models define transforming healthcare delivery systems, coordination of care across different providers, settings, and the care continuum. They discuss using providers at the top of their license and scope of practice. In addition, the models stress the importance of better utilizing health information technology, integrating population health and public health into care, and using data to drive health system changes.

The 4 Geriatrics Programs were combined into the Geriatrics Workforce Enhancement Program. The funding request is \$34.3 million. The new FY 2015 focus provides greater flexibility to develop programs that are responsive to specific interprofessional geriatrics education and community training needs. The combined approach allows for higher funding levels that will support programs with greater impact and have larger geographical reach. This past year, HRSA received about 150 applications for this program. The program is focused on interprofessional care, integrated primary care, and geriatrics. In order to encourage more community-based training the program requires collaborations between academic medical centers collaborating sites and community-based organizations.

The Clinical Training in Interprofessional Practice (\$10 million) is a new program proposed for FY 2016 that increases the capacity of primary healthcare teams to deliver care and inform academic institutions about team-based training needs. The Rural Physician Training Grants Program is also a new FY 2016 proposed program (\$4 million) that recruits and trains physician students in rural settings to increase the number of medical school graduates who practice in rural communities.

Dr. Chen concluded her presentation by proposing the following questions to the Council:

- What quality measures and metrics should HRSA review for GME and undergraduate medical education (UME)? How do you start measuring the quality of the care being provided in THCs?
- Where is the evidence? COGME is charged with looking at the overall physician workforce. But the physician workforce is imbedded within the larger health workforce. COGME can help by guiding and making recommendations as to what COGME and HRSA should be prioritizing for analysis.

COGME asked Dr. Chen clarifying questions on the budget, amount requested for programs and number of slots.

Dr. Karen Sanders, Deputy Chief, Office of Academic Affiliations, Veterans Health Administration spoke to the Council about Veterans Affairs (VA) GME activities. The VA is the largest single provider of health professions education in the Nation. More than 120,000 trainees in 40 different health professions receive clinical training in VA each year. Only 25 percent of these trainees are paid. The VA provides \$850 Million a year in trainee stipend support. There is an IME component of equal amount that supports trainee education infrastructure in the field. The Office of Academic Affiliations in the VA oversees this training enterprise.

Dr. Sanders explained that in FY 2014, of the 160 VA medical centers, independent outpatient clinics and other facilities, 134 facilities are affiliated with 135 of 141 allopathic medical schools and 35 of 40 osteopathic medical school sites. In addition, more than 40 other health professions are represented by affiliations with over 1,800 unique colleges and universities. Over 7200 individual program agreements are in effect. Over 41,000 medical residents and nearly 23,000 medical students receive clinical training in the VA each year (30 percent of all U.S. residents at any time) in

conjunction with 2,000 individual programs in over 80 different specialties and subspecialties. Academic affiliates sponsor 99 percent of GME programs. VA is a participating site and 80 percent of total Office of Academic Affiliations stipend support goes to GME.

Dr. Sanders also discussed the Veterans Access, Choice, and Accountability Act (VACAA). A section of this law is a provision to expand VA GME funding by up to 1,500 positions over five years, beginning one year after signing. Phase one for VACAA starts on July 15. The requirements are: Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association accredited programs only; rigorous adherence to priorities defined in the legislation: primary care, mental health, rural, new and expanding sites, and critical needs; category “Critical Needs VACAA” required extensive justification; and follow-up reporting on fill rate/vacancy rate for positions required by Congress.

Dr. Sanders discussed with COGME rural hospitals and the shortage of doctors in the VA. She reminded COGME that the VA has 1,000 community-based outpatient clinics in rural environments. However, the VA is not the institutional sponsor. The VA is a participating site and it can be an inpatient facility or an outpatient experience. The VA will pay for either and it depends on the geography. There are 50 VAs that are in rural and remote sites, including the upper peninsula of Michigan and Grand Junction, Colorado. The VA is addressing the physician shortage through the Same Choice Act. The Act adds 10,000 extra healthcare provider positions of which many are physicians and nurse practitioners. The Choice Act also increases the maximum reimbursement ceiling for the Education Debt Reduction Program from \$60,000 to \$120,000.

Dr. David Squire spoke to COGME about the history of COGME and GME and what led to the creation of the Utah Medical Education Council (UMEC) and their activities and accomplishments. UMEC was established in 1997. It is a governor appointed, eight-member board charged to bridge the gap between public/private healthcare workforce and educational interests. UMEC’s mission is to conduct healthcare workforce research, provide advice on Utah's healthcare training needs, and influence GME financing policies. UMEC’s core responsibilities include: assess supply and demand of the healthcare workforce; advise/develop policy; seek and disburse GME funds; facilitate training in rural locations; manage Utah’s GME demonstration project awarded by CMS.

In 1997, UMEC applied for CMS waiver. The waiver would allow Utah to merge IME and GME funds and rationalize the payment system. The goals of the CMS waiver were to allocate resources based on workforce needs; track workforce needs to determine GME funding priorities; establish an independent body to coordinate workforce and educational objectives; manage residency positions on a statewide basis; direct funds to the individual programs with the greatest impact on the workforce needs; and hold each program accountable. The waiver promoted collaboration and collected workforce data at a local level. It established statewide goals and aligned state needs with the program sizes. The number of residents in training were expanded and new positions were allocated based on needs.

Today, UMEC has been able to react quickly to program changes, reallocate funds if contract terms are not met, redirect unfilled positions, target certain specialties for expansion, and minimize impact on Federal payment policies. Training programs and teaching hospitals are now accountable for the use of the GME funds. Medicaid funds are used to reimburse GME training costs and GME funds are linked to workforce objectives.

Dr. Squire discussed with COGME the ability to duplicate a program like UMEC in other states and funding support for UMEC. He explained that it is possible to replicate portions of it in some states, but not all states. In addition, UMEC received community and non-federal support. UMEC identified twelve critical areas (OB/GYN, anesthesiology, surgery, emergency medicine etc.) where workforce was needed. He noted that Intermountain Healthcare and the University of Utah provided millions of dollars to increase those residency programs with the understanding that the money would be distributed to UMEC. UMEC would then distribute the funds and ensure residents were being trained as designated in the agreement.

Dr. Paul Rockey, Scholar-in-Residence, Accreditation Council for Graduate Medical Education discussed GME, Medicaid, and the healthcare workforce. He began his presentation highlighting the cost of healthcare in the United States. The United States spends \$3 trillion a year on healthcare. The average cost per person per year is \$8,400. The median household income is only \$51,000. Dr. Rockey noted there is enough money for the healthcare workforce, including physicians. The explicit payments for GME are about \$15 billion a year. About \$10 billion of that is from Medicare. It is a little over half of 1 percent of the \$2.8 trillion that is spent on healthcare. He commented that there is a long-term debate and a dichotomy between whether or not training the next generation of physicians is fulfilling a useful public good or whether it is a subsidy to the profession.

Dr. Rockey explained that most data on GME are national. But it is important to look at the states because state governments in the United States control the delivery of healthcare. States determine who can deliver healthcare through professional licensing boards and scope of practice legislation; what services are paid for by Medicaid and private insurers through insurance regulations and legislated benefits; and how care is provided through regulations of healthcare facilities. States roles are expanding. States fund public medical schools and several are funding new medical schools. The ACA strengthens States' roles by vesting in them the authority to expand Medicaid and/or to create state-based insurance exchanges. There is a high degree of variability among the States.

States can expand GME by Medicaid to address workforce needs. There are Medicaid funds to support GME in 42 states. State and federal Medicaid GME funds total \$4 billion per year. Medicaid allows states flexibility in GME funding. States could redirect Medicaid GME payments strategically. Only 10 states direct Medicaid GME to specific needs. States could also seek additional Medicaid GME funds and states not supporting GME with Medicaid could start. Several states have submitted 1115 waivers and are submitting (or "planning" to submit) 1115 waivers to CMS. Approval by CMS is likely to depend on a state's commitment to expand Medicaid. The Ohio State budget would redirect \$100 million per year of state Medicaid GME funds to expand needed specialties.

Dr. Rockey believes state Medicaid programs should expand THCs. More than 40 percent of community health centers' (CHC) patients are insured by Medicaid. Medicaid is more appropriate than Medicare for support of care for pediatric patients and pediatric training programs. Support of THCs increases accountability for Medicaid GME funding. THCs increase CHC capacity, thereby alleviating community limitations in access to primary care for Medicaid patients. THCs also enhance cost effectiveness of CHCs and their capacity to serve the needs of low-income, uninsured patients.

Dr. Rockey and Dr. Squire answered questions from the Council. The following ideas and themes emerged from the discussion:

- Politics may have a role in states not providing Medicaid funding to GME. Medicaid payments slide behind Medicare payments. Oftentimes, states are balancing their cash flow by delaying Medicaid payments. The hospitals and doctors are unhappy and GME is not a priority.
- Legislatures see Medicaid as the fastest growing portion of their budget and they have convinced political leaders in about 20 states not to pursue Medicaid expansion because they believe they will expand Medicaid and then after the 90 percent period, they'll drop to 50 percent and it will affect their Medicaid expenditures.
- The Council should develop a per-resident amount (PRA) for distribution. The distribution would be contingent on a state process for determining need. The states would participate if they expected to favorably affect the distribution. The assessment of the workforce needs could be a powerful tool in terms of the redistribution if it is part of revamping Medicaid distribution which included the way in which PRA's were distributed.

The meeting was then opened to public comment and questions. COGME received comments from Dr. Ross Martin, VP of Policy and Development American Medical Informatics Association and Dr. Jeffrey Gold, Chancellor of the University of Nebraska Medical Center. Dr. Ross Martin, VP of Policy and Development American Medical Informatics Association requested that COGME advocate that CMS issue clarifying guidance that would allow accredited ACGME institutions to bill for clinical services delivered by fellows within their primary specialty but outside the designated educational time in their fellowship program.

Dr. Rockey explained the ability to adapt to technologies moves rapidly and there will be a need for collaboration between the training programs and the boards to recognize the added qualifications. There may be a new category of accreditation that works towards board recognition rather than board certification. The ACGME strategic plan is to facilitate innovation and the ability of physicians to continuously retool.

Dr. Jeffrey Gold commented on the concept of an all payer system in which the current UME and GME systems financially would be merged and medical school graduation debt would be eliminated. The indirect and direct medical educate payment would be converged with a four year service commitment by the graduates for 0.5-0.6 percent of the total spent by the federal and state government on GME. Dr. Gold explained that the system would allow all positions and facilities that are involved in educating physicians to use a billing code modifier. Initially, on the hospital side, the modifier would equal to the current total IME payments. On the physician side, it would produce a 7-15 percent increment in the charge capture for that teaching. It would reduce federal and state cost of GME by more than 50 percent. There would also be a different modifier for institutions that do not teach and that would trigger the 0.5 percent taxation that would fund a large portion of the system.

The meeting was adjourned at 5:00 PM.

Friday March 13, 2015

COGME convened its meeting at 8:30 AM at HRSA's headquarters in the Parklawn building, 5600 Fishers Lane, Room 18-67, Rockville, MD 20857. Dr. David Reines, Chair, opened the meeting by praising the Council for a productive meeting on the previous day. Dr. Reines then introduced Dr. Kenneth Shine, Special Advisor to the Chancellor, University of Texas and Dr. Kirk Calhoun, President and Chief Administrative Officer, University of Texas Health Science Center, Tyler. Dr.

Reines noted that Dr. Shine and Dr. Calhoun would begin the meeting discussing the innovations in GME and programs in Texas.

Dr. Shine gave an overview of GME funding and programs in Texas. He opened the presentation with a history of GME in Texas. Dr. Shine explained that Texas has a shortage of physicians and is well below the average in some care areas. Texas was capped at a relatively lower number and as a consequence, approximately 35 percent of resident physicians are funded by hospitals, medical schools, and others. A little over 60 percent are funded through Medicare. Until recently most of the growth has taken place in the hospitals and much of the hospital group is in specialties and subspecialties. Texas went through a period in which a number of family medicine programs closed. He emphasized that in most states, the majority of residency positions are supported by a small number of large public hospitals and there is very little support by for-profit hospitals. He explained that until 2003, with the exception of a small amount of funding for family medicine programs, most of the funding for GME came from Medicaid. It amounted to over \$125 million a year. The 2003 economic downturn had a profound effect on existing programs and the opportunities for additional programs. Dr. Shine also illustrated the formula for medical student education in Texas. Funds are divided by the number of medical students which is about \$50,000 per medical student. Texas started at approximately \$5800 per resident and rose to \$6500. The funds were principally to help underwrite the cost of the education of the resident and the faculty time associated with the resident. The last session appropriation was \$66 million, which is divided over a large number of residents in the medical schools.

Medicaid 1115 Waiver

Dr. Shine discussed Texas obtaining a Medicaid 1115 Waiver. The waiver allowed the state to reorganize the way Medicaid is provided for 5 years. Texas wanted a waiver that would enhance patient care. He noted that Texas negotiated for the waiver to be used to support GME. The waiver provided \$29 billion and it was used for uncompensated care, disparate programs, and delivery reform programs to improve policy and access.

Medical School in Austin, Texas

Dr. Shine provided an overview of how Texas funded a medical school in Austin, Texas. Taxpayers were told 35 million dollars a year was needed to fund the medical school. They agreed to a tax increase and it raised \$50 million in local taxes and \$75 million in Medicaid funds through the waiver. The Medicaid funds were used to develop a collaborative care model which would be a model of ambulatory care and inpatient care with continuity of care for all patients. It would also strengthen mental health, focus on team-based healthcare, and use that as both a classroom and laboratory for healthcare education and research. Dr. Shine emphasized that taxpayers' money only helped to build the medical school, not Medicaid. Funding was received from regions to fund the remaining costs of the medical school.

Texas Higher Education Coordinating Board

Dr. Shine then gave an overview of the programs the Texas Higher Education Coordinating Board oversees:

- Family Practice Residency Program was established in 1977 to increase the number of physicians selecting family practice as their medical specialty, especially in rural and underserved communities.
- Emergency and Trauma Education Partnership Program supports partnerships between hospitals and GME programs to increase emergency medicine and trauma care physician

residents and fellows. Eligible GME programs include: Emergency Medicine, Pediatric Emergency Medicine, and Surgical Critical Care. The program also supports partnerships between hospitals and graduate nursing programs to increase the education and training experiences in emergency and trauma care for Registered Nurses.

Dr. Shine concluded his presentation discussing GME expansion. GME planning grants were designed to allow entities that do not currently operate a GME program to investigate the feasibility of establishing a program. There are a maximum of 12 awards of \$150,000. The Coordinating Board developed rules, published Request for Applications and announced awards in December 2013. A total of 10 grants were awarded. The GME Resident Physician Expansion program increased the number of residency positions in GME programs and provided awards on a competitive basis to encourage the creation of new GME positions through community collaboration and innovative funding. In FY 2014-2015, \$5million was provided to support the program. Rules were established through the negotiated rulemaking process to establish the program. The program has received eight applications, currently under review. The Grants for Additional Residency Years were established to fund residents who have completed at least three years of residency training and whose residency program is in a field in which the state has less than 80 percent of the national average of physicians per 100,000.

Dr. Kirk Calhoun discussed efforts in residency expansion in Texas. He began by providing an overview of healthcare issues in Texas. In Northeast Texas, there are many older, poor residents with minimal education and poor health outcomes. There are 65,000 people with serious mental illness. About 130,000 have serious drug abuse problems and nowhere to go for treatment. The suicide rate in rural Northeast Texas is 65 percent higher than the state average.

Good Shepherd Medical Center

Dr. Calhoun explained the journey in receiving funding for a community hospital in Texas. Good Shepherd Medical Center is a 425 bed regional medical Center in Longview, Texas. It has 18,000 annual inpatient admissions and 85,000 emergency room visits each year. The new Center Administrator was interested in involving the center in GME and improving the quality of care. The University President and the hospital CEO were working together without boards, political leadership, community support, or medical staff support. In addition, a consultant was hired to help the start up. Dr. Calhoun commented that the most challenging part of the expansion was receiving acceptance from the medical and nursing staff. There was fear that the demands of training would overwhelm the institution. A large number of the medical staff were concerned about how they would interact with the trainees and nurses. The University held one-on-one visits with individual faculty to discuss the merits of GME. The physicians were concerned about their lack of ability to become volunteer faculty and teach and train residents. They feared they didn't have enough clinical knowledge, experience, or time to be involved in teaching.

Dr. Calhoun noted there were issues surrounding quality and how community faculty would be paid. The quality issues were handled by engaging the residents in quality improvement initiatives at the hospital. This had a dramatic impact on improving patient satisfaction and quality of care at the hospital. After receiving accreditation from the ACGME, constructing a call room and an ambulatory clinic, and handling administration changes, a successful Center was created.

Council Discussion Questions

Dr. Gamini Soori, Vice-Chair, COGME Medical Director, Alegant Creighton Bergan Mercy Cancer Center Clinical Professor of Medicine, Creighton University. School of Medicine Nebraska Cancer

Specialists opened the discussion asking the Council members to discuss the following questions: *What are examples of innovations in streamlining the GME architecture to increase the throughput and cost efficiencies of GME, in order to reduce the overall length and cost of training? How can medical education technology be leveraged in the transformation and innovation in GME? What are the potential regulatory and licensing challenges from such changes, and how can they be mitigated?*

The Council discussion generated the following ideas and comments:

- The number of years a student must be trained to become a physician has serious implications to society and to the student, personally and financially. Past streamlined models of training should be revisited. For example, many years ago a cardiologist needed 2 years of internal medicine. Today it is 3 years. Cost savings would occur if leaders thought about whether a third year is needed.
- Kaiser Permanente is involved in an American Medical Association (AMA) innovation grant with University of California Davis. It is a three-year medical school, primary care focused track and then a 3 year primary care residency at Kaiser Permanente. Part of the three-year medical school track involves clinical exposure and care that is traditionally done in the fourth year of medical school. This approach could reduce the GME residency time with increased specialization. There must be a robust evaluation of these new models.
- The basic science content can be moved to an earlier phase of education. The first two years of medical school can be eliminated and replaced by study on-your-own time. Then there would be a two-year clinical education period for students that know basic science. Medical schools are best for delivering clinical and experiential education, and not efficient at delivering basic science content. Undergraduate education should be drastically revised. There should be a focus on completing step one and getting individuals into the clinical environment as fast as possible.
- At the Hofstra North Shore-LIJ School of Medicine, the students spend the first 12 weeks being certified emergency medical technicians. This is easier because the school owns an ambulance company. It is not possible for anyone to put students in a direct clinical environment. This will have an enormous impact on maintaining the altruism that students have when they enter medical school. It is important for students to have contact with patients in medical school. This would increase their enthusiasm and commitment to patient care.
- It is difficult to predict what the healthcare delivery system or society needs will be in 30 years. Narrowing the knowledge base of the physicians may affect their ability to be relevant 30 years from now.
- Kathleen Macy wrote an article in the New England Journal of Medicine, about the New Medical School and how new technologies can revolutionize UME.
- The AMA Innovation Grant has been focused on new technologies and they are expanding that model. They have virtual classrooms.
- The University of New Jersey has a trauma program based on simulations.

After much discussion the Council decided that there should not be a 23rd report developed at this time. Instead, a comprehensive National Strategic Plan should be developed for GME. COGME should lead this effort with sufficient staff resources and funding allocated to develop the plan – estimated to be in the amount of \$2 to \$2.5 million. The Council also selected a subcommittee to draft a letter to the Secretary and Congress requesting the resources needed to develop the Plan. The subcommittee members include: Erin Corriveau, Lois Margaret Nora, David Reines, Kenneth Shine, Gamini Soori, David Squire, and Keith Watson.

HRSA's Ethics office then spoke to the Council members about ethics training, waivers and financial disclosure reports. The meeting was then opened for public comments. The Council members heard comments from Paul Rockey, ACGME, Hope Wittenberg, MA, Director, Government Relations Society of Teachers of Family Medicine and Janice Orlowski, Chief Health Care Officer, Association of Medical American Colleges.

Dr. Paul Rockey commented that in receiving the help needed to develop the GME strategic plan, COGME must engage peers outside of public payers and engage patients.

Hope Wittenberg commented that there are technical issues and barriers for rural hospitals to obtain Medicare GME payments. Ms. Wittenberg noted she would send the list of technical issues to Dr. Weiss.

Dr. Janis Orlowski commented on a recent plan AAMC launched on GME. The AAMC and its member institutions are working on a comprehensive approach to optimizing GME in three broad strategic areas: investing in future physicians, optimizing the environment for learning, care, and discovery, and preparing the physician and physician scientist for the 21st century. The goal is to ensure the medical student is prepared for practice and there is a lifelong learning strategy.

Dr. Shine then commented on the issue of accountability in attempting to get members to identify how much IME receives and how it was used. The Council members then discussed AAMC's recent workforce numbers. The AAMC predicts that by the year 2025 the United States will face a shortage of 46,000-90,000 physicians, a shortage of 12,500-31,100 primary care physicians, and a shortage of 28,200-63,700 surgeons and specialists. Dr. Orlowski commented that COGME can assist AAMC with pinpointing shortage locations, geographic variations, and where there should be additional support for training programs.

There were no additional comments made by the public or speakers. Kimberly Klein provided additional information on travel for the Council members. The meeting was adjourned at 2:00 PM.