

COUNCIL ON GRADUATE MEDICAL EDUCATION

*Proceedings of the
GME Financing
Stakeholders Meeting*

*April 11, 2001
Bethesda, Maryland*

**Public Response to COGME's
Fifteenth Report**

SEPTEMBER 2001

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Editor: P. Hannah Davis, M.S.

September 2001

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

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The Council on Graduate Medical Education

The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs. The legislation calls for COGME to advise and make recommendations to the Secretary of the Department of Health and Human Services (DHHS), the Senate Committee on Labor and Human Resources, and the House of Representatives Committee on Commerce. The Health Professions Education Partnerships Act of 1998 reauthorized the Council through September 30, 2002.

The legislation specifies 17 members for the Council. Appointed individuals are to include representatives of practicing primary care physicians, national and specialty physician organizations, international medical graduates, medical student and house staff associations, schools of medicine and osteopathy, public and private teaching hospitals, health insurers, business, and labor. Federal representation includes the Assistant Secretary for Health, DHHS; the Administrator of the Health Care Financing Administration, DHHS; and the Chief Medical Director of the Veterans Administration.

Charge to the Council

The charge to COGME is broader than the name would imply. Title VII of the Public Health Service Act, as amended, requires COGME to provide advice and recommendations to the Secretary and Congress on the following issues:

1. The supply and distribution of physicians in the United States.
2. Current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties.
3. Issues relating to international medical school graduates.
4. Appropriate federal policies with respect to the matters specified in items 1-3, including policies concerning changes in the financing of undergraduate and graduate medical education (GME) programs and changes in the types of medical education training in GME programs.
5. Appropriate efforts to be carried out by hospitals, schools of medicine, schools of osteopathy, and accrediting bodies with respect to the matters specified in items 1-3, including efforts for changes in undergraduate and GME programs.
6. Deficiencies and needs for improvements in data bases concerning the supply and distribution of, and postgraduate training programs for, physicians in the United States and steps that should be taken to eliminate those deficiencies.

In addition, the Council is to encourage entities providing graduate medical education to conduct activities to voluntarily achieve the recommendations of the Council specified in item 5.

COGME Reports

Since its establishment, COGME has submitted the following reports to the DHHS Secretary and Congress:

- First Report of the Council (1988)
- Second Report: The Financial Status of Teaching Hospitals and the Underrepresentation of Minorities in Medicine (1990)
- Scholar in Residence Report: Reform in Medical Education and Medical Education in the Ambulatory Setting (1991)
- Third Report: Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century (1992)
- Fourth Report: Recommendations to Improve Access to Health Care Through Physician Workforce Reform (1994)
- Fifth Report: Women and Medicine (1995)
- Sixth Report: Managed Health Care: Implications for the Physician Workforce and Medical Education (1995)
- Seventh Report: Physician Workforce Funding Recommendations for Department of Health and Human Services' Programs (1995)
- Eighth Report: Patient Care Physician Supply and Requirements: Testing COGME Recommendations (1996)

- Ninth Report: Graduate Medical Education Consortia: Changing the Governance of Graduate Medical Education to Achieve Physician Workforce Objectives (1997)
- Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas (1998)
- Eleventh Report: International Medical Graduates, The Physician Workforce and GME Payment Reform (1998)
- Twelfth Report: Minorities in Medicine (1998)
- Thirteenth Report: Physician Education for a Changing Health Care Environment (1999)
- Fourteenth Report: COGME Physician Workforce Policies: Recent Developments and Remaining Challenges in Meeting National Goals (1999)
- Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment (2000)
- Collaborative Education to Ensure Patient Safety: A COGME - NACNEP Joint Report (2000)

COGME Resource Papers

- Process by which International Medical Graduates are Licensed to Practice in the United States (1995)
- Preparing Learners for Practice in a Managed Care Environment (1997)
- International Medical Graduates: Immigration Law and Policy and the U.S. Physician Workforce (1998)
- The Effects of the Balanced Budget Act of 1997 on Graduate Medical Education (2000)
- Update on the Physician Workforce (2000)
- Evaluation of Specialty Physician Workforce Methodologies (2000)

Other COGME Publications

- Council on Graduate Medical Education: What is it? What has it done? Where is it going? (2000)

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Medicine
Chevy Chase, Maryland

Designee of the Assistant Secretary for Health

VACANT

Designee of the Health Care Financing Administration

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Director, Division of Acute Care
Center for Health Plans and Providers
Health Care Financing Administration
U.S. Department of Health and Human Services
Baltimore, Maryland

Designee of the Department of Veterans Affairs

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U.S. Department of Veterans Affairs
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Geographic Distribution Issues

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Program Analyst and Committee Management
Specialist

Velma Proctor
Secretary

Acknowledgements

The Council wishes to thank the panelists who participated in the Stakeholders Meeting and provided their insights for the discussion on financing graduate medical education. The Council also appreciates the excellent direction of Carl J. Getto in chairing the Stakeholders Meeting as it was incorporated in the April 11 -12, 2001 COGME meeting.

The Council also gratefully acknowledges P. Hannah Davis for her diligence and dedication in

planning and organizing the Stakeholders Meeting. The Council recognizes Jo Ivey Boufford who suggested the idea of a meeting of stakeholders, and the GME Financing Workgroup who agreed to it.

The Council also appreciates the commitment from Crystal L. Clark, COGME Acting Executive Secretary in bringing this report of the proceedings to completion.

Joint Statement

The Council on Graduate Medical Education published its Fifteenth Report, *Financing Graduate Medical Education in a Changing Health Care Environment* in December of 2000.

As an in-depth analysis of graduate medical education (GME) financing, the report stimulated much discussion among the institutions and organizations involved in graduate medical education.

COGME intended the document to be a working document and anticipated that comments and constructive criticism would be needed to effect the report's recommendations.

On April 11, COGME held a "stakeholders meeting" inviting comment from interested parties. This document is the transcript of that meeting. As you will note, panels representing academic medicine, organized medicine, residency accreditation, and specialty medical societies provided a spirited discussion and a wealth of constructive criticism of the Fifteenth Report.

In reviewing the comments, COGME members concluded that potential consensus seemed to be forming around four conclusions contained in the report:

1. Medical education is a public good.
2. Graduate medical education is an educational activity.
3. The funding of graduate medical education by all payers of medical care is a desirable goal.
4. It is appropriate to use GME funding to implement workforce goals.

We hope that the distribution of the proceedings of the stakeholders meeting will stimulate further discussion of the critical issues of GME funding. COGME welcomes your comments.

Carl Getto, M.D.
Chair, COGME

David N. Sundwall, M.D.
Former Chair, COGME

Stakeholders Meeting Goal, Objectives and Outcome

Meeting Goal

The Council's one-day "stakeholders meeting" enabled presenters to respond to the recommendations COGME put forth in its recently published Fifteenth Report, *Financing Graduate Medical Education in a Changing Health Care Environment*. COGME recognized that some of the recommendations might be provocative, and wanted to give affected parties the opportunity to publicly voice their concerns. Representative stakeholders were invited to present their perspectives in a series of panels. They were followed by other interested "stakeholders" who arranged in advance to comment during an open forum session. The meeting ended with public comment.

Meeting Objectives

To elucidate areas of agreement and disagreement in the COGME recommendations of the Fifteenth Report and to determine the next steps for COGME to take, if any, in making recommendations for reforming the funding of graduate medical education.

Meeting Outcome

To publicize the ideas expressed at the "stakeholders meeting", COGME decided to publish a lightly edited version of the transcript. This report, *Proceedings of the GME Financing Stakeholders Meeting: Public Response to COGME'S Fifteenth Report*, includes the stakeholders' presentations and COGME discussions from the stakeholders meeting, and relevant discussions among COGME members at the the following day's COGME meeting.

Transcript of COGME Meeting on April 11, 2001

The Council met at 8:30 a.m. in the Versailles I Room of the Bethesda Holiday Inn, 8120 Wisconsin Avenue, Bethesda, Maryland, Dr. Carl J. Getto, Chair, presiding.

Present:

- CARL J. GETTO, M.D., Chairman
- REGINA M. BENJAMIN, M.D., M.B.A., Member
- F. MARIAN BISHOP, Ph.D., M.S.P.H, Member
- WILLIAM CHING, Medical Student, Member
- ALLEN IRWIN HYMAN, M.D., FCCM, Member
- ROBERT L. JOHNSON, M.D., Member
- LUCY MONTALVO-HICKS, M.D., M.P.H., Member
- JERRY ALAN ROYER, M.D., M.B.A., Member
- SUSAN SCHOOLEY, M.D., Member
- DONALD C. THOMAS III, M.D., Member
- DOUGLAS L. WOOD, D.O. Ph.D., Member

Others Present:

- STAN BASTACKY, D.M.D., M.H.S.A., Acting Executive Secretary.
- ELIZABETH M. DUKE, Acting Administrator, HRSA
- JERILYN K. GLASS, M.D., Ph.D., Acting Deputy Executive Secretary
- GLORIA HOLLAND, Ph.D., Former Designee of the Department of Veterans' Affairs
- SAM SHEKAR, M.D., M.P.H., Associate Administrator for Health Professions

WELCOME

CHAIRPERSON GETTO: Welcome everyone. Welcome to the COGME meeting. I'm very pleased to see everyone at COGME as well as the guests that are arriving for today's meeting. This is clearly a meeting of transitions. The Council has just added new members as of December. The Chair and Vice-Chair are now filled, so we are all transitioning here and we'll hear of other transitions in a moment.

I think today is really an interesting day for COGME because it marks a change in the usual structure of our meetings. As you have all noted and as the visitors have noted,

the meeting today is a series of panels followed by an open panel, all of whom are stakeholders in aspects of the Fifteenth Report that we discussed at COGME at the last meeting.

And this is the direct result of the response that we received to the Fifteenth Report as well as marking the importance of the financing of GME, and as the report details, the consistency of financing GME in accordance with what the goals of COGME are, at least the goals COGME has espoused over the years.

So I think it will be a very interesting meeting. It will be an interesting day. I am very pleased at the response that we've had of people who are interested in coming. We have some additional written comments that we'll highlight.

In fact, in your packet, there's a statement from the International Longevity Center that I call your attention to. Doug Wood has just passed out a paper copy of his presentation.

I think the topic and our session today are particularly timely in view of President Bush and the Congress beginning their budget deliberations.

I think it is particularly timely in view of the activity among physician training groups, particularly specialty physician training groups, and what all of us I'm sure are hearing about shortages in specialties versus generalists and the practice of generalists in various parts of the country.

And it all comes back to the issue that we will discuss today, and that is, how do we train physicians and how do we support that training. Let me turn the meeting over to Dr. Shekar. Dr. Shekar.

DR. SHEKAR: I'm glad to be here again to share a little bit of time with you this morning. I'm pleased that COGME has continued to be and will continue to be a major advisory body to this Bureau of Health Professions, to this Agency of HRSA [Health Resources and Services Administration] and this administration. I salute and commend the new Chair, former Vice-Chair of COGME, and wish him very well over the next few months and years in terms of leadership of this Council, as well as the new Vice-Chair, Dr. Jo Ivey Boufford, who unfortunately could not be here today.

It's my pleasure at this point to introduce the new acting administrator for the Health Resources and Services Administration, Elizabeth James Duke, Betty James Duke. She was named acting administrator on March 23 and before coming to HRSA, she was the Deputy Assistant Secretary for administration in the Administration for Children and Families (ACF). And that role encompassed a number of activities.

Just to give you a sense of the number of activities she was involved in, she concomitantly in that role served as Chief Financial Officer, Management Control Officer, Chief Grants Officer, and Chief Information Officer for ACF, while holding down her day job.

She has more than 12 years of experience prior to ACF in the Management and Budget office of HHS [Department of Health and Human Services], where she was both acting and principal Deputy Assistant Secretary for the ASMB [Assistant Secretary for Management and Budget]. She has overseen major organizational changes within the Department over the last few years, including reinvention efforts to streamline HHS personnel, regional restructuring, and the transfer of functions according to the National Performance Review recommendations.

In addition to all this and thinking about her upcoming tasks, she is in the middle of a major effort which she is tackling with dedication and enthusiasm, which is the May 8 budget hearing for the Agency. And she literally will be going over the Agency's budget and issues before Congress on that May 8th date, and obviously, as you can tell, that's a major assignment. But again, she is working on it very hard and learning as much as she can about the Agency and doing quite well with that.

She has graciously agreed to take time out from those intense preparations to spend some time with us this morning and share with us her thoughts about COGME and its continued importance to the Agency. Ms. Duke.

MS. DUKE: Thanks Sam. I'm delighted to be here. I'm so honored to be part of the HRSA family and to be able to be with you this morning.

I came to know HRSA's mission and some of its issues in the dozen years I spent in Management and Budget and so it's sort of nice to be here to sort of have a chance to make some of those ideas happen.

I'm delighted to welcome Carl Getto as your new Chair. That is an exciting and challenging role and I'm sure this is a marvelous opportunity for you all to work together. I'm sorry that Dr. Jo Ivey Boufford can't be here this morning because of a family situation. I enjoyed working with Jo Ivey Boufford when she was the Acting Assistant Secretary for Health and the long term she had as Principal Deputy in Health. She's a good person and I look forward to working with her again. So congratulations to the both of you.

I actually have the joy of coming here this morning to commend you for all the commitment and energy that you put into the nation's work. You make such a contribution to HRSA's ability to carry its mission forward and I'm delighted to support and welcome you all to that task.

We're counting on you for guidance, the President, the Secretary, the Congress, to help us work with the critical issues that the nation faces regarding our physician workforce. Your studies will shape our debate and give us guidance that we desperately need.

The change is the fact of life. As I woke up on the morning of the 23rd, I said, well, here we go again. Change is a good thing. And I say that to myself every day because if I didn't, I would be insane.

The shifting environment is good for us all. It helps us stay on our toes and it also offers us challenges that help us to make the contribution that makes life worthwhile for each of us individually and collectively as a group.

I think that the policies and programs that we create will be nothing if we cannot guarantee that we have a first-class physician workforce and that's going to be a front-burner issue for a long time to come. So our need for an organization like this continues.

Your Fifteenth Report: *Financing Graduate Medical Education in a Changing Health Care Environment*, is a perfect example of why people wait anxiously for the release of your new studies.

I had a very pleasant visit with an old friend and colleague, Dr. David Sundwall, almost as I arrived at the Agency. It was a very pleasant welcome to have a note from David and get to spend an hour or two with him. He has put your report at the absolute top of my required reading list, I will have you know. So you have had a very nice introduction to me through his eyes.

And the issues you raise in that report are really right in the headlines today. Who pays for graduate medical education and how much are the issues we're going to have to all tackle together and resolve? Today's meeting will allow all of us to hear an open and honest dialog about these and other issues from lots of different perspectives from different stakeholders.

I enjoy a lively debate, I truly am a redhead, and I look forward to hearing your views and opinions and Sam will make sure that I am up to date on the results of your meeting.

And I look forward to the work you're going to be doing in the future this year as you evaluate issues related to the Hispanic physician workforce, to the public health workforce, and to efforts to improve physician workforce data sources.

I encourage you to continue to investigate, to evaluate and to make recommendations to us about these emerging needs. I look forward to your telling us what we do right and what we can do better.

In closing, let me emphasize that we are very much in step with your future direction. This is a strong partnership and I look forward to continuing to work together with you. We have a shared responsibility to build a better graduate medical education system, one which will recognize the needs of the underserved individuals and communities and prepare a workforce that will meet the demands of the 21st century.

Thank you for having me here and very good luck with your meeting. Thank you.

DR. GETTO: Thank you very much for those words of encouragement. I'm really pleased that you find the Fifteenth Report stimulating because one of the comments I received verbally was that the Fifteenth Report could be used as the placebo control in sedative hypnotic studies.

(laughter)

And I don't think it's quite that dense, but it is certainly a dense report as we've all found. Just a couple of words about today's meeting. It is a series of panels and the COGME members, hopefully, will have a chance at the end of each group of panels to ask a few questions. The major discussion is scheduled for the end of the afternoon after we've heard everyone. I think it will be a time for us on COGME to hear what people have to say about the report and about the issues that we've struggled with for a couple of years now, certainly around this report.

I also think, as Dr. Duke suggested, it's a chance for us to hear what kinds of things need to be improved and what sorts of sights we should set for ourselves in terms of our future projects, which we'll be discussing in more detail tomorrow.

As everyone knows, you have a white binder that has most of the materials in it. They are supplemented by some additional materials in the folder that is at your places. I would like to compliment Stan and Sam and the staff particularly for all of the work that went into setting up today. This is the result of a lot of, probably three months, four months of hard work on the part of the staff.

Hannah Davis did a yeoman's job of setting up these panels and making sure the people were filling the places and that we could accommodate everyone who wanted to speak. So I'm looking forward to a very exciting day.

INTRODUCTIONS

I'd like to go around the table and briefly introduce ourselves, some comments about what we're doing currently, and tomorrow morning we can spend a little more time updating each other on what major changes might be occurring with us on COGME. Will, would you like to start?

MR. CHING: Sure. Hi, I'm William Ching, M.D./Ph.D. candidate at the New York University School of Medicine. What's new?

Basically, dissertation work is going on right now, and the major issues that we're looking at are medical student debt, children's health, resident training and other issues such as that. I'll keep it short. Thank you.

DR. MONTALVO-HICKS: Lucy Montalvo. I'm a pediatrician from San Diego, and I represent the International Medical Graduates and right now my main concern is the Latino workforce and how we're going to deal with increasing the number of physicians of Latino background.

DR. HYMAN: Good morning, I'm Allen Hyman. I'm a Professor of Anesthesiology at Columbia Presbyterian Medical Center in New York and now New York Presbyterian Hospital. Formerly I was Chief of Staff of the hospital and now serve as Senior Advisor to the CEO as well as reporting to the new Dean of the medical school.

I've had long-standing interest in workforce issues, particularly with respect to residency, having managed a residency program for almost three decades, and continue to look forward to working with COGME. Thank you.

DR. JOHNSON: Good morning. My name is Bob Johnson. This is my first meeting, at least on this side of the table. I'm a Professor of Pediatrics and Psychiatry at the New Jersey Medical School. I am a pediatrician and Vice-Chair of the Department of Pediatrics. I run the Division of Adolescent Young Adult Medicine. In that role my work is primarily in mental health issues in adolescence with a large emphasis on HIV. We have one of the largest adolescent HIV programs in the country.

I'm an academic physician. I do a lot of research and so I'm frequently in this hotel for the NIH and some work for the National Academy of Sciences as well.

My background in workforce issues goes way back. I chaired the pediatric workforce committee of the American Academy of Pediatrics for a number of years. We produced

a number of reports on pediatric workforce and the critical shortages there and that was the reason I was here before, to testify as chair of that committee.

And I just recently finished as a member of the Pediatric RRC [Residency Review Committee] for the ACGME [Accreditation Council for Graduate Medical Education] and so I've had a great deal of knowledge about what's going on with training among pediatricians.

DR. WOOD: Good morning. I'm Doug Wood. I'm the President of the American Association of Colleges of Osteopathic Medicine. It seems like what we're doing Carl is pretty much the same. That we continue to feel that change and innovation in medical education is important and we continue to work in that particular area.

We're also concerned about quality in medical education and how can we continually enhance quality. The other thing that I'm very involved in with Dr. Bastacky and Dr. Shekar is the UME-21 project, Undergraduate Medical Education for the 21st Century, which is a five-year HRSA-sponsored project which is just about to complete its fourth year.

The importance of this project I think is that we have now seen some very definite innovation in 18 different medical schools around the country and the fact that we feel that much of what has happened is generalizable and now we're starting to see some of the things that happened in the demonstration schools happening in other schools now.

So we're very pleased about that project, and in one more year we'll be having a major presentation of all of the things that happened in the project next year and I'm sure that all of you will be invited because we're going to invite everybody to that thing.

DR. BISHOP: Good morning. Marian Bishop, University of Utah, Chair Emeritus, Department of Family and Preventive Medicine. I just consider it a triumph to be here one more time.

(laughter/applause)

But what I would say is that one of the things that I've had fun doing that we've never really talked about much, is working with the Utah Demonstration Project. You know, that's been on the books for four years and it's still not quite formally approved. But two of my colleagues are here from Utah, from the consortium, Gar Elison and David Squire, so there is a workforce report out from Utah.

Gar will have a couple of copies at noon, so you might want to talk to them and see what's going on. And then push HCFA to get that finally approved. That would be very nice.

DR. ROYER: My name's Jerry Royer, Medical Director for Mercy Health plans in St. Louis and our market is in Illinois and Missouri and Texas. As Medical Director of an HMO, my clinical colleagues back in California insist that I've gone over to the dark side.

My central concern as a Chief Medical Officer in the work I do is addressing the great variation that exists in clinical medicine and I'm back in the seat where I have a chance to observe that day in and day out and how do we deal with that variation, so that's much of my work.

DR. THOMAS: Good morning. I'm Don Thomas. I formerly was the Chief Medical Officer for the Los Angeles County Health Department for three years and currently the Principal in WellSpring Partners, which is a group that does hospital turnarounds. We're very interested in the entire dynamic of both staffing and financing academic centers and continue that work.

DR. BENJAMIN: Good morning. I'm Regina Benjamin. I'm a family physician in solo practice in Bayou La Batre, Alabama, in a rural health center, basically still trying to recruit a National Health Service Corps doc, if any of you know one.

The other hat that I wear is I'm Associate Dean for Rural Health at the University of South Alabama where I'm Administer and Program Director for our Alabama Telemedicine and AHEC [Area Health Education Center].

DR. GETTO: I'm Carl Getto. I'm the Dean and Provost at SIU [Southern Illinois University] School of Medicine in Springfield and Carbondale, Illinois, and in addition to running a medical school, I dabble in helping the state try to set agendas. We just completed a report to the governor on medical errors in the state of Illinois.

And I also discovered that Friday is an important anniversary date for Springfield, that they generally do not talk about. On April 14, 1846, the Donner party set out from Springfield, Illinois, and we all know what happened to that.

So I guess the question of political leadership needs to be taken in a little different sense. But I'm very happy to be the Chair of COGME and I am, as I said before, looking forward to a very exciting meeting today.

START OF STAKEHOLDERS MEETING

PANEL 1

I think we can move into the first panel and I'd like to arrange it so that the panelists can come up here and I'll do an introduction and we'll ask Doug [Wood] to go first because I know he has some time constraints, and then follow with Bob [Dickler] and Mike [Scotti] if that's okay.

Doug has introduced himself and just to mention that Doug had been Dean of the College of Osteopathic Medicine at Michigan State University from 1987 to 1991. He has been Director of Medical Education at Mount Clemens General Hospital in Michigan for 12 years. He has a long-standing interest in medical education and we're very pleased to have him on COGME as well as a member of today's panel. Doug.

DR. WOOD: Thank you very much Carl, and I certainly appreciate the opportunity to present some views on the Fifteenth Report. I have some obvious biases here because I was part of the workgroup, at least the tail end of the workgroup, that constructed the report. I also have the privilege of representing three separate organizations here.

I represent the American Osteopathic Association which I will refer to as the AOA, the American Osteopathic Health Care Association, which I will refer to as AOHA, and then the organization that I actually work for [American Association of Colleges of Osteopathic Medicine].

It also is important to point out that views of AOHA, which I will express to you, are shared by the Association of Osteopathic Directors and Medical Educators and this is a group which consists of hospital medical directors and those who are involved in medical education.

The three organizations certainly appreciate the efforts that have gone into the construction of the report. We think that the analysis of GME and GME funding was excellent and as opposed to what Carl has said, that I don't find this to be a very good sedative.

Carl, as a matter of fact, when I read it I get excited because I think there are a lot of interesting things that are a part of the report.

What I would like to do, as I mentioned, is offer for you the views of three separate organizations and the organizations do not always agree on certain things that are in the report. So I will be presenting three different views.

However, fundamentally, the three organizations do agree with many of the concepts that are part of the report and truly feel that the report does represent a challenge to the policy-making community to take a look at new ways of financing graduate medical education.

Those of you who are familiar with osteopathic medical education can imagine that we are very pleased by the discussion that is in the report on community-based medical education.

The reason for this is that community-based medical education has been a part of osteopathic medical education since its inception over 100 years ago. The goals upon which the report is based are those with which we agree. We were particularly pleased to see the goal which proposed the increase in the number of generalists and increase in the diversity of the workforce.

One of the things that osteopathic medical education and the osteopathic profession has been about literally for a long period of time, is to number one, increase the number of generalists, which I think we've done very well. And number two, to increase the diversity of the physician workforce.

What I'd like to do before I get to the specific recommendations is to make some comments on some of the sections and then make comments on the eight recommendations that are part of the report.

The section on current financing of graduate medical education we again feel was very well done and certainly presents a very thorough review of this topic.

One of the suggestions that is embedded within this section of the report, is that if the IME teaching adjustment should happen to be reduced—the report points out that MedPAC has suggested that this be reduced to 3.1 percent—that this would generate a significant amount of money.

We would support the recommendation of COGME that if this should happen, that an increase in community-based training capacity could be accomplished by using these funds.

We would support this increase because, as I said, osteopathic medical education has been about community education for a long period of time. However, we feel to do this through further IME reductions would be risky. And I think it's very evident that as hospital margins decrease, that further downward adjustments in the IME do have the potential to destabilize the GME education capacity. So we have concern over this particular issue.

We do appreciate the fact that COGME has raised concern about teaching physicians rules. Now, in the segment on residency training in community settings, you can imagine again that we're very supportive of this; however, we, as I'm sure all of us here who are involved in community medical education, have concern over the issue of community clinician educators becoming less willing to teach without compensation.

And I'm sure that many of us have faced this. As I visit our schools and talk to community educators, it seems the one thing I hear increasingly is that they can no longer afford to teach without compensation.

In the area of alternative models of GME funding, we concur with the six policy goals that form the basis of this part of the report and we totally support the concept of stabilizing the physician workforce. This is obviously not going to be easy, but we support the concept that we should do what we can to stabilize the physician workforce.

We were particularly pleased with the segment of this section where a suggestion was made that research needs to be conducted relative to whether IME adjustments are needed or not needed in non-hospital settings. We do think that such research should be done; however, there is caution here in that what might benefit non-hospital sites, could potentially negatively impact hospital sites. So we think it's important that there's some balance between these two, between the non-hospital sites and the hospital sites.

Let me now comment on the eight recommendations that are part of this report, and I'll not read all of the recommendations because they are out there. I will just refer to them as recommendation number one, two, et cetera.

Relative to recommendation number one, the three components of the osteopathic medical profession that I represent, are supportive and have been supportive for some period of time of an all-payer fund. We do feel that the establishment of five separate accounts would deserve further discussion; however, we do support a separate account which would be targeted to support specific workforce and educational objectives.

Concerning recommendation number two, and this is where we get some difference in opinion of the three groups that I represent, the AOA and AACOM support recommendation number two as a concept, as a concept for a revised and more encompassing approach to IME financial support of graduate medical education; however, we do suggest that the amount of payment and the formula for payment should be determined by research. And we feel that research is important in this area.

And we would encourage those who are going to do this research to consider the use of accepted business modeling in order to better identify the unintended as well as intended outcomes.

The American Osteopathic Health Care Association feels that the report's rationale for reducing IME payment is both incomplete and misleading.

We note in the report, and certainly this is evident in other reports, that the IME payment may be overstated; however, it also needs to be recognized that there are those who believe direct payments are understated, and actually in some instances fail to cover all of the direct medical education costs.

The AOHA realized all too well that there's substantial difference in payment from hospital to hospital. There are those at the low end of a range, and those that are at the high end of a range. And yet those that are at the low end have noted that often times the direct payment barely covers resident's salaries, let alone other direct components.

The AOHA again, this is their opinion, feels that as a result, reducing IME payments and then shifting direct payment to non-hospital sponsors or to consortia, will splinter these resources, will create another level of bureaucracy which could lead to destabilization of physician training.

They also feel that a reduction in IME payment could eliminate a critical source of funding for needed public goods such as research and uncompensated care.

Relative to recommendation number three, the AOA and AACOM support this recommendation, again as a concept to encourage new cooperation between GME-sponsoring institutions and community-based clinical training partners.

We feel that this approach gives a level of flexibility to the sponsor in directing payments to where the cost has occurred. And we furthermore feel that this level of flexibility simply is not currently present.

The AOHA feels that shifting payments to non-hospital entities such as program sponsors or consortia, would add a level of bureaucracy which is unnecessary and particularly, a level of bureaucracy between teaching hospitals and Medicare and other payers.

They furthermore feel that this shift would reduce accountability, would reduce efficiency, would add complexity to the system, and would fragment the payment system. And they feel strongly that both that responsibility and the resources for hospital's teaching programs should stay with the hospital.

The AOHA goes on to point out that often times residents' salaries are barely covered by the DME and that shifting would then be an inadequate payment system to outside entities that do not have infrastructure. This is in reference to outside entities such as consortia. They do not have the infrastructure in place to pay salaries, to pay benefits, to

receive these monies, and to literally account for these monies in a way that hospitals currently can.

Relative to recommendation number four, all three of the organizations I represent support this recommendation. And of course, as you can imagine, we feel that if costs of GME in community-based settings truly are higher than in other settings, then these settings should be reimbursed accordingly.

Concerning recommendation number five, the AOA and AACOM both support this recommendation. The AOHA disagrees particularly with recommendation 5.a in that they feel the shifting of resident caps from hospitals to non-hospital sponsors or consortia is both unwise and unnecessary.

They feel that where aggregation does serve legitimate educational purposes, that the current law already allows multiple hospitals to consolidate their resident caps through affiliation agreements when certain criteria are met. And they feel that there is no compelling reason to consolidate the caps and shift them to outside entities.

Concerning recommendation number six, all three organizations support this recommendation. We are especially interested in building high quality community-directed training capacity and/or achieving specific workforce goals.

Relative to recommendation number seven, again, we all support this recommendation. We accept the challenge posed by the current Medicare rules on teaching physician payment and that this challenge should be addressed.

It is obviously of particular concern to us and I mentioned this once before, that the willingness of community physicians to participate in teaching programs is diminishing and quite obviously this issue needs to be addressed.

Concerning recommendation number eight, we all support this recommendation and we agree that without additional support, graduate medical education is not sustainable in community-based training sites with a high volume of uncompensated care.

Now, we have also made some specific suggestions outside of those that we have already offered and I'd like to briefly run through these for you. We suggest, and feel strongly, that stable, all-payer financing is essential to provide support for high-quality physician training wherever it takes place. And that's an important concept, wherever it takes place.

Next, we feel that payment from all funding sources should be sufficient to support effective high-quality medical education for an appropriately sized physician workforce.

Thirdly, we feel that all teaching hospitals should receive at least the full national average per resident amount as a basis for Medicare direct DME payment.

Next, we feel that limits on FTE resident counts established by BBA '97 has hurt hospitals that at that time had residents training in community-based settings. The law should be changed to allow hospitals to include in their caps all residents who were in non-hospital settings during the 1996 base year.

Next, we feel that resident caps should be adjusted where training programs improve physician workforce distribution or patient access to care.

We also feel that increased funding must be made available for safety net providers. And lastly, we feel that Medicare rules for teaching physicians should be changed to more accurately reflect the roles of these physicians.

Again, we appreciate this opportunity. Thank you.

DR. GETTO: Thank you Doug. The next panelist is Bob Dickler who is Senior Vice-President of the Division of Health Care Affairs at the AAMC. I think probably everyone in the room is familiar with Bob. He is the person who is most active at the AAMC with the Council of Teaching Hospitals. That is one of his major jobs.

Prior to coming to the AAMC, Bob was the Director of the University of Colorado Hospital Medical Center and the University of Minnesota hospitals—not at the same time, sequentially. Bob, thank you for coming.

MR. DICKLER: Thank you Carl. It's a pleasure to be here. I certainly appreciate the opportunity to meet with COGME and discuss your Fifteenth Report. As always, as is true of every COGME report, it was a thoughtful and challenging document and we had a lot of fun reading it and discussing it, both with staff and internally and with some of our membership groups.

Because of the time constraints and for a variety of other reasons, I'm not going to walk through the report this morning in terms of where we come out on each specific recommendation. Rather, I thought what might be more helpful to you was to try to summarize some of our thoughts and comments as we discussed them both during some of the drafts of the report and when the final report came out.

In reality, I think that at times we're a little confused and a little puzzled by the exact nature of some of the recommendations and that it may be helpful to you as you continue these deliberations and move on to the Sixteenth Report, to have some of that background and information.

PANEL 1

We're obviously in agreement with many of the recommendations. We feel an urgent need to move to an all-payer funding mechanism. We're clearly concerned with and have been and are trying to deal with the teaching physician rules related to documentation. The ability of health-care providers to serve the underserved is being threatened in a variety of settings.

What I will focus on are four broad themes that at least we believe highlight some of the concerns that cut across multiple recommendations or various aspects of some of the more comprehensive recommendations.

The first of those is the report, we believe, would benefit from clarification and elaboration of the all-payer recommendation. As I read the report, it was unclear to me what the Council meant by all-payer.

Most of the time, I was convinced that all-payer was defined as a fund that would incorporate all existing funds and be supplemented by contributions from private insurance. However, in a number of places throughout the report, I also sensed that COGME envisioned a substantial reduction in the level of funding currently provided by Medicare as the report alluded to phase out and reductions.

The magnitude of those proposed reductions and/or refocusing of funds was not clear. And it was also not clear whether COGME was sensing an inevitability in reduction of funds or recommending a reduction of funds. So when we talk about your all-payer recommendation, there is some confusion, at least on our part.

I was also confused in reference to the all-payer fund by the recommendation to meld all existing federal funds into a single pool that would be part of the all-payer mechanism. While initially as I read this, this made some intuitive sense, by the end of the report, I had the feeling that we were combining funds and then segmenting funds, such as your proposal to dedicate ten percent of the fund to special projects and programs directed at building high-quality, community-based training capacity, or achieving specific workforce goals.

Thus, I was unsure whether the proposal was really intended to bring all funds together for purposes of funding GME and GME-related activities or it was to reallocate the current and future funds. If, in fact, reallocation is the primary intent, I think COGME should consider clarifying this and reassessing whether the effort required to bring about the recommended consolidation is really worthwhile if, in fact, what you are really seeking is reallocation and segmentation of the funds in different ways.

Finally, in reference to the all-payer fund, my biggest concern was whether you were making your recommendations contingent on the establishment of a all-payer fund prior to their implementation. I think this is a crucial point that COGME needs to clarify.

For instance, while I have a number of philosophic and organizational concerns related to your recommendation that funds should go to program sponsors or their designees, the practicality of this recommendation is significantly different if you're talking about redirecting Medicare funds or you're talking about directing all-payer funds.

And while in some recommendations there was a level of clarity on whether this recommendation needed all-payer funding, that was not true throughout the entire report, and again, we would urge you to potentially work on that in your future deliberations.

The second general concern I would like to share with you is what I feel is an inadequate distinction between direct and indirect medical education. And if I could impose on my colleague Sunny Yoder to help me with some overheads—

The first slide is the definition or the purpose of direct graduate medical education based on the 89th Congress House Report.

Clearly, direct, as we all know, is intended to deal with the direct costs of graduate medical education and there was an initial hope that, in fact, Medicare could get out of that business when there was some type of a community-wide mechanism or at least not bear a disproportionate share. In fact, the all-payer system goes some degree towards that.

Indirect was really quite different. Indirect, as I think you are all aware, really came out of a lot of uncertainty related to the ability of the DRG system to provide adequate compensation when there was differential severity and complexity in the care of the patient.

And, in fact, the solution to that problem of how you distinguish differences between hospitals within a specific DRG in the absence of a severity adjustment system, was to use a proxy measure and that proxy measure was the relative magnitude of the graduate medical education program within that institution.

And thus, we have these contorted formulas that you're all so familiar with, the intern and resident-to-bed ratio by a multiplier and so on, but, in fact, it was not fundamentally a payment for medical education. It was fundamentally a payment for severity, complexity and the whole array of differentiating costs that exists within teaching hospitals relative to other hospitals including some of the indirect costs of education.

Now on page four of your report, you essentially repeat this purpose, although it was interesting to me that you've somewhat reversed it. You said Medicare pays additional patient care costs attributable to teaching activity.

I'm not sure that's what the original intent was. It wasn't attributable to teaching activity, it was attributable fundamentally to severity and complexity that occurred within the teaching setting. But we could have a nice five-hour debate about that and probably come to no conclusion.

But by page ten of your report, I became totally confused. You state that researchers needed to refine the Medicare IME adjustment and to determine the appropriate IME teaching adjustment for non-Medicare hospital inpatients. You further state that Medicare's adjustment should be based on the higher costs attributable to teaching activities.

So, within your recommendations, you have really progressed from saying IME is for teaching and teaching alone, or if it isn't, it should be for teaching and for teaching alone.

If that, in fact, was your intent, to put a stake in the ground and say you think Congress is wrong, and you do not think IME should be fundamentally a severity adjustment mechanism for inadequacies in the DRG system, I think that requires a lot more elaboration and discussion than is contained within the Fifteenth Report of COGME.

If, in fact, it is not your intent to fundamentally redefine the purpose of the IME, then I think you need to clarify statements such as this in terms of what the purpose of IME is.

Now, this becomes important, and if we could put up the last slide, because as you redefine IME, you are going to interplay with something that Doug [Wood] has already mentioned, and that is the margins.

The red line is the total margin for major teaching hospitals. It has a nice downward slope. We see no reprieve from that given some of the things that are going on and I think we are also all aware that IME is fundamentally one of the things that keeps that above zero in the total equation for all patient care activity in a teaching hospital.

That may not be right, we can debate that, but to redefine and move and reallocate without recognition of the fact that it was a payment for patient care and it will interplay with this and cause serious problems, I think is a problem.

The other place that lack of distinction between IME and DGME interplays is when you refer to the GME fund. And that is when COGME is utilizing the term GME fund, you are really talking about all money with the GME label, whether it be Medicare or in the all-payer fund, or you are talking about specific components.

For instance, back to your recommendation that ten percent of the funding be used for a set of specific purposes. Is that ten percent of Medicare DGME funding, is it ten percent of all Medicare GME funding, is it ten percent of all-payer DGME funding, or is

it ten percent of all all-payer GME funding? Those are radically different numbers and that type of problem arises in many places throughout the report.

My third generic observation is that in reviewing the recommendations, it was unclear whether some of them are either practical or feasible and whether they've been evaluated in that context.

Let me illustrate that with two quick examples. The first relates to the suggestion in your recommendation 4.a that direct graduate medical education be based on the net costs of supporting an appropriately-sized workforce.

Now, in reality this seems contrary to 1), previous efforts to determine these net costs, all of which have been a unmitigated failure; 2), the desire articulated by this Council, our organization, and many other organizations to shift the emphasis of residency training from service to education and therefore make it an educational activity increasingly unrelated to the provision of care and the generation of service revenue; and 3), the lack of appropriate antecedents within the payment system that would at a minimum align the incentives between physician and hospital revenue.

It's often curious to me that while residents are talked about in terms of their daily functioning, often as a physician surrogate, we then assume the hospital should pay. If we're going to get into net benefits and net costs, then who are the net benefits to and who are the net costs to in terms of the total delivery equation.

The second example relates to the recommendation to move towards an average DGME payment. Now, it's unclear what the consequences of this recommendation would be over time. For instance, how would you, once you have moved everybody to the average, compute a average?

That is, would now the computation of the average take what everybody was paid last year, which was the average or higher, to recompute the average to arrive at the new average?

It's also of interest that you then propose, after recommending the average, a number of potentially differentiating calculations that would move us away from the average. And finally, at the end of that recommendation, you recommend research on this topic.

It strikes me and strikes many of the people that I've talked to, that you might want to consider reordering that and undertaking the research and then deciding whether in fact we should move to an average and what the construct of that average would be and how one would deal with the desire for differentiation in some of the costs.

Let me end with a final comment, the fourth area I wanted to comment on, and that is really an area of potential activity for COGME.

The Fifteenth Report acknowledges the need to look at the previous conclusions and recommendations regarding the size and composition of the workforce, and you've already mentioned that this morning. At the same time, many of the recommendations assume that the workforce is too large and the composition needs to be redirected more towards generalists.

I mean, as I read the report, clearly that is a substratus set of assumptions that comes out time and time again.

Now, personally, I need to tell you that I am more confused now than I have ever been regarding whether we have a surplus or a shortage or the right number, and whether the composition is right or wrong, and if it's wrong, whether that means we have too many or too few specialists or generalists.

Now, that is clearly an arena where COGME has expertise and the ability to bring together expertise that I think is almost unmatched within the federal government, if not within the nation.

And my recommendation, and our recommendation, is that we think this should be one of your major areas of concentration, if not your major area of concentration in the coming months. And that within that, we would hope you would also debate and try to determine whether prospective planning related to workforce is even feasible and how much we should base future mechanisms for dealing with the workforce and funding the workforce on planning versus market forces.

Depending on the answers to these questions, I think many of the recommendations that are contained within the Fifteenth Report of COGME may well be worth reconsidering and reevaluating in either your Sixteenth, or Seventeenth, or a special report. And we wish you luck and we look forward to working with you and we thank you for the opportunity.

DR. GETTO: Thank you Bob. As always, eloquent and an analysis that will probably keep us busy well into the next year. The third panelist is Dr. Michael Scotti, who is Vice-President for Medical Education of the American Medical Association.

Dr. Scotti is responsible to the AMA for all activities relating to undergraduate and graduate medical education and physician professional development. Prior to joining the AMA in 1996, Dr. Scotti served 30 years in the US Army retiring as a Major General. He was responsible for residency programs, family practice, and served as primary

care consultant. He is board certified in internal medicine and family practice. Dr. Scotti.

DR. SCOTTI: Well, I appreciate very, very much the kind invitation. And I appreciate even more reacquainting myself with Dr. [Marion] Bishop. Dr. Bishop was a mentor of mine when 25 years ago this year I assumed responsibility for my first family practice residency program and needed all the help I could get.

I'd like to talk today from a slightly different viewpoint. And the reason for this is that in going through the report with my staff and with the individuals that do advocacy work for the American Medical Association, I found us very much bogged down in detail, in percentages, in decimal places, and in a whole variety of minutiae so that I was losing track of exactly what it was we were all about.

My mentor at the AMA when I first arrived there was Dr. Harry Jonas. Dr. Jonas taught that when you have seen one academic medical center, you have seen one academic medical center. Trying to understand what is going on in that institution and what is going on in that community by looking at averages across the country is fraught with difficulty.

So I wanted to talk a little bit about what exactly is going on here, what a profound responsibility COGME has. I would make the point that although the number in graduate medical education, 100,000 residents, is only a very small fraction of one percent of the population of the United States, that graduate medical education is probably one of the most important activities that the nation performs. GME in the United States has an impact on communities and on citizens, not only in our country, but throughout the world. Graduate medical education is education and it provides education for our domestic market and it provides education for nations around the world.

The American Medical Association does many surveys of physicians and over the decades there are different concerns that rise to the top. Not once, in any survey since World War II, has there been a concern among practicing physicians that the new physicians coming out of training to practice with them in their offices and in their groups and in their communities are not well trained. The job that our graduate medical education has done is absolutely superb. And as we try to fund it and to shape it, it's very important that we don't lose what we have.

The other points that have been made many, many times, and I'll make them again, are the tremendous community resources that are provided by graduate medical education.

In U.S. graduate medical education programs just about 100,000 people are in training. And they are in training in a broad variety of settings, and these settings are in the

midst of change. Twenty years ago, a resident could get an adequate clinical education by being hospital-based with perhaps an afternoon or two afternoons a week in a latter year of residency downstairs in the clinic. This is no longer the case. The patient presents in the ambulatory setting, the patient is evaluated in the ambulatory setting, the patient has the preoperative evaluation or the prehospitalization evaluation in an ambulatory setting, comes into the hospital for it, whatever it is, and then goes back to the ambulatory setting for recovery, for rehabilitation, and for maintenance. And so the settings in which residents are educated are tremendously important and much of what has been said by my colleagues has to do with the community resources, the community teachers of medicine, that make graduate medical education possible.

The number of faculty in LCME schools has increased over the years as more and more faculty are hired because of the need to generate clinical income. In fact, many medical school faculty spend a minority of their time in teaching compared to their clinical work. At the same time, we're trying to encourage more and more community physicians to take not only resident physicians and medical students into their offices, but also clinical nurse students and physician assistant students. It is a tremendous burden and physicians do it willingly. There are over 170,000 physicians that do some clinical teaching over the course of a year.

Now whom do we educate? These are the backgrounds of the 100,000 residents, or at least ones I could identify. The data come from the JAMA, the Journal of the American Medical Association, educational issue, and the Journal of the American Osteopathic Association.

There's always a great deal of concern in the funding of graduate medical education that we're spending money on international medical graduates and somehow this is a bad thing. I would like to make the case that this is not a bad thing. Firstly, almost 20 percent of the international medical graduates are citizens and over 50 percent are either citizens or permanent residents. These are people that are part of our nation and we have responsibilities here that are very important. We have about 30 percent of international medical graduates that are here on an exchange program, the J-1 or J-2 programs. These are primarily designed to assist countries which require additional physician specialists by providing that specialty training here so they can return to serve their countrymen.

We know that a great number remain in the United States, and that is because of a variety of circumstances, almost always human circumstances. When young people live in the U.S. for one, two, three, four, five, six years, they frequently get married. They frequently have children. They frequently have a much more complicated home life than they did when they arrived in this country. So many wish to stay. At the same time, and to our shame, we have decided to care for populations, mostly in rural areas or inner cities, which don't generate large amounts of income, by sending international

medical graduates to provide care for a period of years in return for their green card and ultimately their citizenship. This is a substantial contribution.

Now on the other side of the argument, many of the physicians given specialty training do return to their native lands. The data are a little hard to get, but if you look through the American Board of Medical Specialties database, for physicians that are diplomates of American Boards and look at their addresses, for every board there's a section outside the United States. There are tens of thousands of physicians practicing all over the world that have received their training here, were recognized by an American board and have returned. Many relationships established while in training are maintained. International medicine is becoming American medicine.

There's also a small number of temporary workers where academic hospitals have made the point to the State Department that these are not students, these are workers and they can't fill these positions with Americans, so they must go outside.

Graduate medical education provides several resources to the community. Clearly academic medical centers disproportionately provide health care to the uninsured. But it is also an asset for every citizen of America. If a member of the wealthiest family were to have severe trauma, have a child born at less than two pounds, to have a 70 percent burn, care would not be available without academic health centers. Patients cannot pay enough money to make these kinds of specialized units profitable. The other asset is the actual facility in which academic medicine is practiced. Facilities in which graduate medical education occurs are generally high-volume intensive care facilities. And as we've seen time and time again in terms of low morbidity from procedures and diagnostic evaluations, these high-volume facilities are of high quality.

Academic medicine and academic medical centers with graduate medical education are economic engines for most communities. They are often the largest employers in their congressional districts. And let me tell you, that gets Congress' attention and that of individual congress people. Another advantage is that they have large numbers of entry-level positions: janitors, security, transporters, and kitchen workers. These are available to immigrants, people that are reentering the job market after a time on welfare, part time students, a whole variety of people. And these are entry-level jobs with fringe benefits: unemployment benefits, hospital insurance, dental insurance, retirement plans, et cetera. The loss of this option for a large segment of our communities would be disastrous. It's not only graduate medical education that goes on where residents are being trained. We're training nurses. We're training x-ray technicians. We're training physical therapists. There are over 50, by a poll of allied health disciplines, that are training concomitantly with residents.

Who pays for graduate medical education? Lots of people now pay. And lots of those that pay are in the midst of change. We immediately think of the Health Care Financing

Agency. They are a major payer, but not the sole payer. The Department of Veterans Affairs, which has had a tremendous relationship with academic medicine, is undergoing continuing demographic change that will extend over the next 20 years. NIH right now is up. DoD is stable, as it must continue to grow its physician specialists to avoid a physician draft. The Governor's Conference has outlined quite specifically that individual states put in over \$3.4 billion a year into graduate medical education.

Patients pay. I mean patients pay for their health care, patients with health insurance are spending their own money, earned by their labor. It is not the health insurance company's money. That's not the employer's money. Patients pay either directly or indirectly. And then there's some philanthropy. Every room with a door on it in academic medicine has a name over it.

Now who should pay? Some people have said that residents should pay. That is, this is education and residents should pay the equivalent of tuition. In fact, residents are generally out of money by the end of their long period of preparation: four years of college, four years of medical school, and average of four years of residency training. Many are repaying their school loans; you've seen those numbers, \$70,000, \$80,000, \$90,000.

Or they've said that residents actually do pay for it in terms of their work. That is, they're getting less cash than the value that they're generating for the teaching hospital. No one questions the fact that residents present great value to patient care.

But I want to make the point, and I think I have made the point, that GME is a public good and right now, it's surviving. And that the big danger we see at the AMA is that somebody will dismantle what we have now before something new is in place. Because for all of its randomness, what we have now is better, I think, than the unknown.

We need some accountability to contribute to workforce planning. Unfortunately trying to figure out whether we have the right number of what, can take a huge amount of time and is probably not completely resolvable to anybody's satisfaction. I remember the comments from the specialty societies to the GMENAC report twenty-odd years ago. Each specialty said this was a fine report and they concurred with it entirely except how it related to their specific specialty because GMENAC got it all wrong.

The fact is the young people vote with their feet in selecting a field of specialization. They obtain their information most influentially by word of mouth. And if you talk to a urologist in Chicago, we have far too few urologists. If you talk to a urologist in Cleveland, they're starving to get some partners. A few years ago one anesthesiology resident came back from job interviews and said, I can't find any jobs in anesthesiology, the nurses have them all and they're only going to pay me what they're going to pay the nurse. That went on the e-mail. The following year the application rate to anesthesiology

dropped 80 percent in that one year. Applications are again competitive in anesthesia. This last year, the word went out, as if from God: "they're working the family docs like crazy for decreasing income", so the fill rate for family medicine went down.

Evidence-based medicine will have a huge impact on graduate education. Much of what we do now we won't be doing in the future and much of what we don't do now we will. Output evaluation for graduate medical education is an important new task undertaken by the ACGME [Accreditation Council for Graduate Medical Education]. There are residency programs that have not turned out a resident that has been able to pass the boards in a decade. And that's wrong. The American Board of Internal Medicine has taken the lead, publishing on their web site, and it's also available on the ACGME web site, the three-year rolling average of the percentage of program graduates that have passed the boards. It ranges from 100 down to zero.

The AMA believes there needs to be workforce planning through a private-public partnership. Public because there's a lot of money that comes from public coffers and also because you don't want to be accused of antitrust, but also private.

The difficulty is that if you gather at the table to discuss physician workforce planning, all of the other disciplines that provide health care, e.g., podiatrists, optometrists, nurses, physician assistants, will want to be at that table. All educational endeavors in the health sciences are operating completely independently and generally planning on the basis of what the institution wants rather than patient need.

So our position at the AMA is that many of the options that you've laid out in the latest COGME report, and in previous COGME reports, are extremely good on the observation side. The reports demonstrate that you have ignorance in the same places as everybody else has ignorance, how to proceed. Much of this ignorance is not resolvable and we have to make people understand that. To get bogged down in the details of percentages is not near as important as ensuring the stability of the funding stream.

The AMA had some doubts a couple of years ago as to whether or not the annual appropriations process was a suitable alternative for a semi entitlement system now in place for HCFA funding. I think the President's budget with the sudden decrease as pertains to pediatric hospitals and pediatric residents has convinced us that you cannot run residency programs on annual appropriations.

Thank you.

DISCUSSION FOLLOWING PANEL 1

DR. GETTO: Thank you Mike. We have a couple of minutes for questions of the panelists. Yes, Don.

DR. THOMAS: I had a question for the AAMC presenter. There were three lines on the graph showing the kind of bottom line effects of our expenses. The non-teaching and the other teaching seem to be a little bit leveled off and the academics seem to be falling off.

I wonder if you thought that that might be some evidence that the emphasis needs to be more on the cost of teaching, than it does on the increase of the severity in the facilities.

MR. DICKLER: It's a terrific question and I wish I had a terrific answer to it because I don't think we fully understand the dynamics. What we have been able to determine is that the fall off that has been more precipitous within the major teaching hospitals is representative of some of the BBA impacts which did have a disproportionate impact on major teaching hospitals, even with some of the relief legislation, there was still that impact.

The second cause, is that historically these institutions have the highest charge structures. And as communities have moved more and more and as Medicaid has moved more and more to price competition, their ability to maintain historic margins has been more deeply reduced than other hospitals because they were relying on much higher payment structures. So they felt that impact more severely.

But the other thing we need to remember is that this group has always had the lowest total margins. The fact that they have low margins is something that has been true for 20 years and they have been consistently below every other group of hospitals. And so when we talk about the public goods they provide, public goods cost money, public goods are rarely paid for in full, and that increases your financial liability.

I've deliberately not gotten into the uninsured and uncompensated care because that care is another set of dynamics, but it's worth noting that our Council of Teaching Hospitals membership, which is about six percent of the hospitals in the country, provide 45 percent of all the charity care. And so we have that type of major safety net obligation inherent in the community.

DR. THOMAS: My comment that goes along with that is that it may be that we're disguising and masquerading a discussion that we need to have around that kind of care,

by not really having a precise idea of how much work versus learning the residents contribute to these hospitals. And it appears on gross examination that you have a cost of education, but in fact, what we may be looking at is other parts of the public good that the hospitals located in these areas do, and we need to define it more correctly.

MR. DICKLER: Well, again I would agree. I think you've pushed us into the joint product discussion. I think you'll hear the other end of that discussion, probably, I think I saw Craig [Lisk] come in, when Craig shares with you the MedPAC view of where these funds should be coming from and what the purpose of the funds is.

DR. GETTO: Robert.

DR. JOHNSON: I have a question and then a comment and then maybe a question following. First to Bob Dickler. I was really intrigued by your final comment, and that is, what effort should we make to predict the right size and composition for the physician workforce? There are so many different forces, whether it's medical science, payment systems or population changes that affect the workforce, and you suggested that maybe we need to understand the dynamics of the health care workforce, before we go about doing anything else.

And from your comments, it seems as if you've given a lot of thought to that and I wonder if you'd elaborate on that last comment and tell us what the answer is.

MR. DICKLER: I actually think there are a number of people in this room including some around the table, Mike [Scotti] and others, and COGME and HRSA who think a lot more about it than I do. I'm struck though by how inept we are. With all our best efforts and with all our best minds, we are just almost always wrong in terms of what it is we say is happening.

Which has led me to conclude that what we probably want to talk about is much more shaping the workforce on the margin, not overall. We need physicians, we need nurses. As Mike pointed out, the market forces are going to direct people in certain directions.

At the same time, we do have the ability to identify areas where we need to encourage people to try new things, we need to see if we can deal with some age-old problems. So this concept and actually the structure we have right now—we have some targeted programs such as those at HRSA and you have your fundamental program which resides in HCFA, or Medicare, or however you want to structure it—with an all-payer fund is probably not a bad approach.

And that we may not want to expend a lot of energy on dealing with the 90 percent, just assure that it's stable and monitor it and see what's happening, but really focus on the ten percent, and to the extent that reshapes the 90 percent. That I think will occur under natural forces. Mike, you may want to comment on that.

DR SCOTTI: I couldn't agree more. If I were doing health planning ten years ago, that's essentially what you do. From the time a person applies to medical school until they come out of their residency is eight or nine years. You would not know what work was out there today to be done. You would not know the invasive cardiology.

Last year, in the year 2000, the most commonly performed surgical procedure in the United States was liposuction. I mean, it's very difficult to predict what people will need, what's going to be out there.

Secondly, people remodel themselves. Dr. Frank Simon from my office pointed out that close to ten percent of the first program year in graduate medical education are people that have had a previous first program year and are retraining. Either they switched during their current residency or they're coming back from something else. And he made the valid point that if you're looking at PGY-1 positions and some sort of workforce planning, you need to take into account that this occurs.

But I agree completely with Bob. On the margin, you're in great shape. And the states do a nice job of this. The states target their money to what they think their citizens and their voters want. And so the state money is a lot more targeted than federal money.

But it's very difficult to predict what we're going to need ten years from now. The radiologists say we won't need any invasive cardiologists ten years from now because they're going to do it all with electron beams. Maybe we will.

DR. GETTO: A comment, and then Allen has a question.

DR. JOHNSON: Yes, the comment was about Mike's presentation. Mike, I think you did an excellent job of talking about the current justification for academic medical education. I think we also agree that we do an excellent job.

I get real worried, however, when we begin to justify academic medicine based upon service to the uninsured and the economic status of communities. Because academic medical education is not the best way to provide medical care for the uninsured and we saw it in pediatrics, for example, when we develop a national program to provide care for the uninsured children's health program, then suddenly pediatric programs don't have enough patients to fill their general pediatric clinics.

The same thing can be said for the economy of communities because when we go to close hospitals, one of the justifications for not closing hospitals is people lose jobs. That's not a good health care plan. So we agree that that clearly is what exists now, but we have to really move in our arguments to justify what we do based upon the fact that we train excellent health-care providers and we're going to continue to do that.

DR SCOTTI: Yes, I agree, absolutely. The point, and I know you understand it, the point I was making is let's not dismantle before the future is here. Let's not dismantle on the cuff. The fact is that I don't know the right number of academic medical centers.

I know we have seven academic medical centers in Chicago. There are 72 licensed hospitals in Cook County and the General Accounting Office made the observation on any given night there are 5,000 empty staff beds. Now that's not being accountable. Although when you go to the medical centers, their job is to turn out the best doctors. Their job is to turn out the best nephrologists. Their job is to turn out the physicians. I mean, they're not in the business of workforce planning.

DR. GETTO: Allen, last comment.

DR. HYMAN: Having worked in an academic medical center all of my career, now almost 45 years, I'm mindful of the complexity and the confusion of training and educating physicians.

I'm also mindful of the words of Winston Churchill when he was asked about his opinion of democracy and he said, "Democracy is the worst form of government except for all the others." And I don't know if anyone can really have imagined a different way we might have evolved through our system.

But no doubt, the system has evolved because of the way it has been financed and of the follow-the-money as it has been said. We are confused because of quality versus cost, because of training versus service, and because of our interest in planning versus market forces.

So I would ask you then, after listening to all this discussion, what do you see as the role of the payers, particularly the government, in determining the distribution and the payment and the allocation of the physicians in their training programs?

MR. DICKLER: There are a number of ways to try to answer that one. Clearly I feel that the payers should be part of the funding formula, as COGME has recommended, as have many others, and I won't spend any time on that.

PANEL 1

I think there's two kinds of accountability. One is the quality and the relevance of the product. And two, is it the right number at the right cost in the right place of the right kind? I think we do a pretty good job with the first. I think Mike pointed that out. I mean, we produce quality physicians in this country.

We have concern about whether they are well positioned to function in the delivery system of tomorrow. I have that concern. I do force myself to recall that if we took that to heart five years ago, or ten year ago, we would have trained all physicians to function within closed-panel HMOs because that's what everybody said would be the health system of tomorrow, and I'm not sure that would have been necessarily the best model. So I think we've got to be a little cautious with that.

Where I think we stumble is the right kind at the right costs and the right place and so on. And I think we do need to work on that accountability and I think that's going to be something that's in a constant state of flux.

I think payers should be part of that constant evaluation system as should all other components of the system, but if you go back to sort of the 90/10 equation, I think it should be the ten percent that we're constantly evolving up and using that input to redirect and then through the funding mechanism trying to assure that we do not spend money inefficiently.

But also don't assume everybody is going to have identical costs because there are real and important differences by setting and by specialty and by structure of the institution.

DR SCOTTI: I would echo that. I think the role of government is to point out what the needs of the citizens are. Not necessarily to design the system to get there.

One of the best examples of that in the United States is the acid rain. They set standards for the emissions of products that created acid rain. But you could get there by putting scrubbers in your chimney. You could get there by switching to a different kind of fuel. You could get there by trading off with somebody else, buying if you want, the pollution.

So this hospital turns out more cardiologists, and this one turns out more neurosurgeons. I mean, there are a whole variety of ways. I think the government's role is to indicate what they think the citizens need, but not to design the system of how to get there.

DR. GETTO: We are going to break now. I really want to thank Dr. Scotti and Mr. Dickler and our own member, Dr. Wood in absentia, for really starting off the day with a great panel. Thank you very much.

PANEL 2

DR. GETTO: I'm very pleased to get the next panel started, and given our start this morning, I think that we have a lot of excellent comments to look forward to. Before we get started, I want to acknowledge that Susan Schooley, Gloria Holland, and Don Thomas, COGME members, have joined us. Welcome the three of you. It's nice to have you here and I notice you joined in the questioning on the first panel.

The second panel continues comments that we've had on the Fifteenth Report and the first speaker is Patricia Wang, who is the Senior Vice-President for Finance and Managed Care at the Greater New York Hospital Association. She joined the staff in 1991 after practicing health law in New York City.

She is responsible for analysis and policy formulation with respect to Medicare and Medicaid payment policy, graduate medical education financing, uncompensated care financing, and managed care, Patricia. Thank you.

MS. WANG: Thanks very much. We very much welcome the opportunity to spend some time with you this morning and talk a little bit about some of our reactions to COGME's Fifteenth Report.

Just a word about the Greater New York Hospital Association. We're a membership organization. We have about 175 hospital, not-for-profit, private, and public hospital, and long-term care members in the metropolitan New York City area. Our hospitals are overwhelmingly teaching institutions. As you may know, New York state itself trains about 15 percent of the residents overall in the country and most of those happen to be downstate [New York]. So we follow COGME's recommendations and perspectives with keen interest.

My perspective today, after the excellent presentations this morning, is going to be more from the ground, to talk to you about some practical perspectives as to what the recommendations in the Fifteenth Report might mean to teaching hospitals, nationally, but with particular reference to my membership.

Bob Dickler's slide on the margins of teaching hospitals overall is more than mirrored in New York where teaching hospitals are really struggling financially as they never have before as the result of a confluence of factors, including Medicare cuts from the Balanced Budget Act, substantial changes in our Medicaid program, particularly the move to mandatory Medicaid-managed care, a growing number of uninsured, and the conversion of our marketplace from one in which rates were set by State government to one in which negotiated rates and price competition are paramount. This conversion to a market-driven environment occurred just as the BBA cuts were phasing in.

PANEL 2

According to MedPAC, the private payer payment-to-cost ratio in New York right now actually is below one, it's at 0.97, so our costs are not being covered on the private payer side, and that creates many difficulties in addition to those posed by the BBA cuts.

At the outset, we would express appreciation for COGME's recognition of graduate medical education as a public good that should be supported. We think that this is really critical.

A couple of general observations and then I want to spend just a few minutes updating you on a very interesting demonstration project that we had in New York that may offer some perspectives on some of the practical implications of some of your recommendations.

The one overall recommendation we would make regarding the theme that runs through COGME's report regards the many uncovered needs that the GME funding stream now covers. It's important to continue discussion of this effort to purify the financing streams, but I do think that we would do well to recognize that GME means many things to different people.

The nature of cross-subsidies, the need for cross-subsidies, and flexible financing streams is really evidenced in the fact that GME does pay for education training, research, sophisticated or more complex patient care, basic patient care, care to people who can't pay for their own care, who can pay in varying degrees, et cetera and it's something to be sensitive to and mindful of as we talk in a theoretical sense about purifying all of these financing streams.

The danger is that if you pull a thread someplace, the blanket starts to unravel and it uncovers many problems that are not otherwise adequately addressed by our payment systems. And I think we all want to avoid inflicting that kind of harm on teaching hospitals that are really at the edge right now.

This echoes the concern stated at the beginning, which is that given the dire financial condition of teaching hospitals everywhere, certainly seen in my membership as well, we would urge a special caution in any recommendations that would disrupt or change in any way the very delicate funding balance that exists right now, which as was pointed out this morning, is on a very clear downward slope.

I would like to spend a minute talking about something that's a little bit unique to New York regarding a demonstration project that we undertook back in 1996-1997 under the sponsorship of the Health Care Financing Administration.

The goal was to develop a program in which hospitals could voluntarily reduce their resident complements and I would like to give you an update on the status of that program.

Because as you consider and go forward with ideas about reducing the number of residents, we would like you to understand the practical implications of that goal and also of shifting funding streams and residents out of the hospital setting.

The GME demonstration project is a Medicare voluntary demonstration project that was undertaken in 1997. The requirements were that each participating hospital reduce its resident FTE complement by 20 to 25 percent over the course of five years. Actually, year five of the demonstration program starts next July.

The requirements were quite stringent. The primary care/OB-GYN ratio had to be maintained or increased during this five-year period, with no exceptions. Other features that predate the Balanced Budget Act included caps on FTE residents and caps on the intern and resident-to-bed ratio.

The concept in the demonstration at the time that we put it together was that if you stopped training residents, all Medicare GME payment sources associated with those residents would also stop. That inhibited many hospitals which might have wanted voluntarily to reduce their resident complements from doing so because the loss of revenue would be too intense and it would be difficult to replace those residents with patient caregivers because the money would be gone.

And so the concept of the demonstration was to more slowly phase out the reimbursement, but still eliminate it completely and permanently by the end.

However, the BBA put in a three-year rolling average for computation of changes in the numbers of residents being trained, which actually became a much softer way in the BBA to try to remove some of that disincentive to reducing the resident complement. As you know, the BBA capped the number of FTEs in a particular teaching hospital. At the end of the demonstration, the hospitals' caps will be lowered to the end of demo level. The base here was the 1996-97 academic year and by the end of the demo with a 20 to 25 percent FTE reduction, their caps will be lowered to that level.

Dental and podiatric residents are actually in the demonstration cap, unlike the BBA where they float outside of it, so that's another critical difference.

We started with 49 teaching hospitals in the demonstration project. Thirty-nine have dropped out, and ten remain. The remaining hospitals include nine in New York City and one in Westchester County which is just north of New York City. Six of them are municipal public hospitals, which is interesting. It wasn't necessarily the anticipated mix when we started out. And four are voluntary.

PANEL 2

Eight are participating as individual freestanding hospitals. Two are participating in a category in the demonstration of joint participants which try to collaborate in the reduction of their resident counts as they share residents from the same program sponsor.

The most recent dropouts from the demonstration were the Buffalo consortium, a very interesting consortium of teaching hospitals around the State University of New York at Buffalo, and most recently a freestanding hospital in New York City.

The ten hospitals that remain trained about 1600 residents in the 1996-97 base year and by the end of year five of the demonstration they will have eliminated 393 FTE positions. Medicare, as we know, measures residency trainees by FTEs. A single FTE could actually be three different people and not one person in a program. Moreover, Medicare reimbursement rules do not look at residents in programs, they look at residents training at a particular hospital.

From the perspective of the payment stream, most of the hospitals have actually not seen any transition payments yet. Unfortunately, 1998 would have been the first year for the beginning of the payment of some of those transition funds—this is just one of those practical realities that we all have to remember when we are talking about changes in the Medicare program and demonstration programs—they're hard to implement.

And this one turned out to be difficult to implement for our fiscal intermediary and we are living with the fact that the transition payments, will not actually get to the hospitals until their cost reports are settled, and the 1998 cost report will not be settled for at least a little while. And so, from a cash flow perspective, this has been a great disappointment in the demo.

Some of the reasons cited or observed for withdrawal of institutions from the demonstration project include the following: When the demonstration was first approved, it was anticipated that six or fewer hospitals would actually participate. Many institutions signed up, and then as the demonstration progressed, because of the difficulties of the program and many demo features, institutions starting dropping out. So there was a little bit of a "me too" effect, both in enrollment and in disenrollment from the demo.

Some of the changes that were in the Balanced Budget Act included differences in the way that the IRB cap is applied, and differences in the way the FTE cap is applied. Treatment of dentists and podiatrists was an issue; the BBA excluded all but allopathic and osteopathic residents from the FTE cap, giving more flexibility for dental and podiatric programs. For one of the upstate consortia, the straw that broke the camel's back was that the FTE cap after the end of the demonstration would still include dentists and podiatrists and they had new programs phasing in in these areas, and they would not be able to accommodate them without reducing programs elsewhere. So for that consortia, the BBA provisions were actually more flexible.

It turns out that making a 20 to 25 percent reduction in five years is really difficult. There are no exceptions. A participant has to hit those numbers and if they don't they don't get any transition money. That's the way the demonstration was set up. There's no flexibility. You don't get paid for what you did if you do only a partial reduction. It's a pass-fail demonstration.

And the five year time frame is also difficult. As I recall, when the demonstration was being put together, there were actually many teaching hospitals around the country that were talking about efforts to voluntarily reduce the size of their resident complement. I don't think it's quite happened the way that people had anticipated. It's very, very difficult. Twenty to 25 percent turns out to be a huge number and difficult to plan within that very tight five-year time frame.

Another issue has been that institutions that are important rotation sites for other teaching hospitals seeking specialized training found it very difficult to accommodate that role from a programmatic and quality perspective. For example, an academic medical center found it very difficult to serve as an academic resource in the community for training because this demonstration is measured by on-site FTEs under Medicare payment principles.

So, if the academic medical center accepted those rotations in, they were faced with having to make cuts in their own programs to accommodate the new FTEs. That was very, very difficult to do and was probably not appropriate.

Not surprisingly, I think another thing that the demonstration has underscored is just how critical residents are as clinical caregivers in the hospital setting. They are not just the best and the brightest, they are enthusiastic, energetic, hard-working, positive clinicians. They are very, very difficult to replace. They are expensive to replace even if you had the funds to do it, and many institutions that really were trying to come up with replacement patterns came to value tremendously the type of caregiver that is represented in a physician resident.

A further wrinkle that was not foreseen at the inception of the demo was the nursing shortage that faces hospitals nationally today. We do await the results and lessons that we learn at the end of the demonstration because some of the resident replacement strategies that would have relied on adding to nurses' responsibilities may turn out to have been unrealistic.

Another issue with the demonstration is that to the extent that you replace residents, the cost of their replacement continues past the demonstration and the funding disappears.

PANEL 2

There are, as I mentioned, still ten institutions in the demonstration. I think since we had anticipated that there would be five to six at the outset, it's still a very important demonstration. I think that there will be many lessons to learn.

With those perspectives in mind, just a couple of comments on some of COGME's recommendations, about which I think the comments this morning were excellent.

We support the creation of an all-payer trust fund. In New York state we have, pending a national solution, created our own private payer GME fund and we strongly support the movement to all-payers nationally contributing to a fund of that nature.

There is also a contemplation that Medicaid would contribute the federal share of its GME-related payments to this fund. On that I look forward to hearing Tim Henderson's presentation.

The one observation I would offer is that if you've seen one Medicaid program, you've seen one Medicaid program. I know that in the case of New York for example, the state reported that 15 percent of inpatient expenditures carry a GME label, but the way that they calculate that is unusual, such that, for example, if you were to isolate those funds and take them away, you would see the final, completely adjusted operating rates of academic medical centers in urban areas falling below those of 50-bed rural hospitals and upstate communities. It's not inappropriate, but it should be anticipated that there will be significant variation in the definition of GME from state to state.

What the state calls GME is not necessarily GME and certainly not what Medicare would label as GME and so they get there in different ways. I suggest that one area that is ripe for further research is exactly what different state Medicaid programs are calling GME.

With respect to some of the bells and whistles that COGME referred to, for example, concerning workforce numbers, training numbers, workforce composition, et cetera, there is a suggestion that there would be perhaps some method of enforcing tied to a trust fund. To the extent that there is contemplation that there be determinations made from the perspective of a trust fund as to how many physicians should be trained, perhaps where and in what specialty, we would sound a note of caution about regulatory apparatuses being set up at a national level to try to do that. We think that is a very difficult thing to do.

We clearly do not support the reduction of IME to the empirical level. I think that has been discussed sufficiently to this point. And again, just in terms of the practical impact of the loss of funding on teaching hospitals, I think that our lessons from the demo are pretty clear in that regard.

The report does in our view make an incorrect assumption that if the IME adjustment were reduced that somehow this would lower the incentive for hospitals to train residents. I think the BBA cap does that sufficiently now. If there's a recommendation by COGME that even fewer residents be trained, that should be stated more explicitly and addressed directly.

Reducing the payment level per unit of IME is simply going to create financial problems. I don't think it creates the disincentive so much as it perhaps makes it not viable to be a teaching hospital anymore. Maybe that's the biggest disincentive.

With respect to the recommendation that direct GME be paid directly to program sponsors, we read that as being within the context of a new all-payer fund, with funds being redirected. We were puzzled by the recommendation. There would seem to be many practical difficulties with implementing it and diverting what is reimbursement for hospital operating costs that include faculty salaries and resident stipends into institutions that really have never handled that kind of money before and do not incur those costs. The recommendation would pull the revenues out of a hospital's operating budget and put it in the budgets of entities that don't incur the costs.

But even the impetus behind the recommendation was confusing to us. As we read the report, it seemed that one of the major goals in that recommendation was to ensure that funding be sent to community-based ambulatory training settings. But again, just given that there is not even consensus among the accrediting bodies, for example, the ACGME [Accreditation Council for Graduate Medical Education], about how that should occur, it wasn't clear how shifting funding to the program sponsor would make that occur, again, unless it was accompanied by regulatory requirements, which raise their own set of concerns.

To the extent that there are problems with the current Medicare financing systems for payment of ambulatory care training in the community, we suggest that more attention be directed at that specific issue. It is a very complicated and major proposal to shift funding to program sponsors to try to achieve that goal without even knowing how that would happen, unless perhaps we misunderstood it.

With regard to a national average per-resident amount, we support raising hospitals to the national average. There are many historical reasons as to why per-resident amounts differ from institution to institution. People can talk about those and argue about them, but the fact is that there are also current practical considerations that affect the amount of support, for example, that a teaching institution has to provide to its attending physicians.

One of them concerns payer mix. If I have a very high complement of indigent patients, and there's no Part B billing opportunity for that physician, I am going to have

to support a teaching physician's income and cannot rely on his voluntary services. That's one practical current distinction I think that is really always going to affect the cost of DGME.

With regard to the concept within the trust fund of creating pools to create incentives, we have some experience in New York with that. We have an incentive pool. The one observation or recommendation that I would make based upon our experience concerns outcome measures, for example, making extra payments to programs or institutions whose graduates practiced in a certain medically underserved areas or practice primary care, et cetera.

It is very difficult in any kind of incentive program to hold a program responsible for the decisions of its graduates after graduation and we really have found in New York that it doesn't work. Programs can't respond to incentives that measure outcomes over which they have no control. So I would really recommend that to the extent that you are looking at incentive programs, that you focus on what happens during the training period, while the resident is training, and not beyond that.

Generally speaking, we do really appreciate COGME's overall orientation towards GME as something that is important to be supported, as well as its sensitivity to the many roles that GME plays in serving all of the patients that we take care of, including those without insurance. Thank you.

DR. GETTO: Thank you, Patricia. The next panelist is Dan Hawkins, who's Vice-President for Federal and State Affairs at the National Association of Community Health Centers [NACHC]. He has been there for nineteen years. He provides leadership in the analysis of federal and state health policies, policy development, policy research, information advocacy, technical assistance. Prior to joining NACHC, Dan was a VISTA volunteer, Executive Director of a Migrant and Community Health Center in south Texas, and an assistant to HHS Secretary Joseph Califano during the Carter Administration. Dan, thank you.

MR. HAWKINS: Thank you very much Mr. Chairman, and good morning. Good morning to all on the panel. It's a pleasure to be here and I appreciate very much the opportunity to join with you today in this important meeting and to speak with you briefly about the involvement of America's community health centers with health professions education, particularly graduate medical education, and to provide our views on the Council's report.

You mentioned in the introduction that I began my health career as Director of a Community and Migrant Health Center. I was privileged last week to be back in Texas to help celebrate the 30th anniversary of that health center, one that I was involved in helping to start and served as its first Director.

As it turned out, however, the celebration had a second dimension—in some ways even more significant than the completion of three decades of service. That was to announce a dual ground-breaking for both a new, state-of-the-art 60,000 square-foot health center facility, and what will, by next summer, be the nation's newest medical school branch—an extension of the University of Texas Health Sciences Center at San Antonio. My old health center—which already serves as a principal teaching health center for local hospital-based residency programs in all four primary care disciplines—will soon become the primary teaching facility for more than 60 third- and fourth-year students of the new medical school branch.

Were the events of last week unique? Of course they were, in many significant ways. But increasingly, events such as these are only the latest in a long and growing string of collaborations and partnerships with a whole panoply of health professions education and training programs. What brings these two vital sets of players in our country's health care system together is, I believe, a confluence of both shared values and complementary needs.

Many members of the Council are quite familiar with the origins and current work of health centers. You already know that, from their humble beginnings rooted in poor and minority communities 35 years ago, health centers have grown to serve some 12 million medically underserved Americans today in more than 3,000 communities across the nation, including:

- ◆ Almost 5 million uninsured persons, 1 of every 9 uninsured Americans;
- ◆ Nearly 5 million low income children, 1 of every 6 such children;
- ◆ 8 million people of color, 1 of every 9 minority Americans—including almost 3 million whose primary language is other than English;
- ◆ More than 5 million rural residents, 1 of every 10 rural Americans;
- ◆ And the 400,000 births to health center patients last year accounted for 1 of every 5 low-income births in the U.S.

Although the 6,000 health center physicians represent barely 1 percent of all practicing physicians, health centers provided nearly 20 percent of all uncompensated ambulatory care visits in the U.S. last year. The demographics of their patient population—90 percent low income, 80 percent either uninsured or on Medicaid—mean that health centers face some of the toughest, most complex primary health care problems of any ambulatory provider group. And I'm pleased to report that the work of health centers has received increasing recognition and support from a majority of the Congress—and now President Bush—who have called for doubling the number of people served by health centers over the next five years.

On a broader scale, these proportions closely parallel our country's public and teaching hospitals, which share with health centers the mission to be of service to their communities, especially to those most in need. But as that need has grown, practically unabated over the past decade, safety net providers like health centers and the public and teaching hospitals have felt ever more severe strains and financial pressures as a result. Here is where complementary needs enter the equation.

As today's teaching hospitals grapple with the need to move more training and more health care services out of their inpatient facilities and into community-based ambulatory care settings, health centers have also realized that they alone cannot hope to meet even a fraction of their patients' health care needs without viable partnerships. And so, like the proverbial "Strangers in the Night," they have proceeded from "exchanging glances" to "taking chances" on collaborative endeavors that can at once substantially improve the quality and continuity of care for those they serve and bring some, at least limited, relief from the financial strains they feel. A recent survey of health centers, conducted for the second time in three years by my organization, reveals the extent to which these partnerships are growing:

Last year, more than 87 percent of health centers answering the survey were involved in the training of health professionals, including medical students, medical residents, dentists, nurse practitioners, nurses, and physicians' assistants. This marks a continued growth from 1997, when 83 percent indicated that they were involved in such training activities.

Some 43 percent of health centers were engaged in medical residency training efforts, up from 36 percent in 1997. An average of more than 11 residents trained at each of those programs, nearly double the average of 6.4 recorded in 1997. In fact, ten percent of these teaching health centers reported training more than 30 residents each, and another 20 percent reported training between 10 and 30 residents each. At that rate, more than 3,500 medical residents spent some time in a health center as part of their residency last year.

Only four health centers reported providing the total residency training experience through full-time, full-year programs, but 122 other health centers indicated that they provide one-third or more of the training experience, involving at least 1,000 residents.

Almost two-thirds of all health centers—and the vast majority of those offering the medical residency training programs—also indicated that they were involved in the training of medical students, suggesting a strong link between undergraduate- and graduate-level training. And more than three-fifths of health centers reported participating in training programs for nurse practitioners, nurse midwives, or physicians' assistants.

More than 15 percent of health centers indicated that they participate in dentistry training, averaging six dental students per site. This would equate to hundreds of dentistry students—a significant portion of each year’s graduating dentists.

The one serious, continuing problem noted in the survey is that only 42 percent of health centers with residency programs indicated that the teaching hospital or training program paid any portion of the health center’s training costs—by comparison, more than half of health centers involved with other types of training programs reported receiving assistance in meeting their costs. Herein, I believe, lies the greatest barrier to any expansion—and potentially even to the continuation—of these vital partnerships.

In 1997, the Congress clearly demonstrated its recognition of this critical barrier, as it revamped the system of Medicare GME payments as part of the Balanced Budget Act of 1997—the BBA. For the first time it allowed GME payments to be made to “qualified non-hospital providers” including Federally Qualified Health Centers, the term used to define Community Health Centers in the Medicare and Medicaid laws, as long as that provider pays all or substantially all of those costs. Significantly, it also provided that hospitals entering into such agreements with these providers may receive their full IME payments for the residents who train in non-hospital provider settings. While these changes acted to remove some major roadblocks to the development of affiliated training relationships between health centers and teaching hospitals, the changes were all but swept away by the BBA’s much more profound cutbacks in Medicare support for both the direct and indirect costs of medical residency training. Now, almost four years after the BBA’s passage and enactment, we are unable to report to you even a single instance in which a health center is receiving direct Medicare GME payments for its teaching costs—although I was pleased to note in your report that your staff site visits uncovered limited evidence that this change may be working as intended in at least a few instances.

Another feature of the BBA was a new requirement that HCFA conduct a three-year demonstration to test the concept of making shared GME payments to consortia composed of teaching hospitals and affiliated organizations—again including health centers among others. HCFA finally published a notice early last year inviting applications from eligible consortia. Here, too, more than a year after the initial application deadline, we are unable to identify for you a single consortium applicant that includes one or more health centers.

Clearly, although we are approaching the fourth anniversary of the BBA’s enactment, information on the impact of these key BBA provisions is sketchy at best—suggesting that either more time or a dedicated effort—or perhaps a combination of both—will be needed to determine whether these provisions are likely to achieve the desired effect.

In the meantime, however, further changes are occurring that may have substantial effects on the future ability of health centers to even sustain, let alone expand, their involvement in health professions training. Most importantly for health centers, last year's Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) finally replaced the decade-old Medicaid reasonable cost reimbursement system—which the BBA had initially targeted for phase-out and repeal—with a new prospective payment system for health centers. While we strongly supported the newly-enacted PPS as a critical alternative to the total loss of cost-based payments, we also clearly understand that the PPS will begin to immediately constrain the growth in Medicaid health center payment levels, and that these constraints will be felt ever more profoundly with the passage of time.

This payment pinch alone might be tolerable for health centers if it were not occurring at the same time as the number of uninsured people seeking care at health centers is burgeoning as well. While the overall growth in the number of uninsured persons affects all providers, it is particularly harsh at health centers, due in no small part to the marked decline in charity care by other community providers as a result of the downward cost pressures brought on by commercial managed care. Uninsured patients today represent more than half of all new health center patients, compared to less than one-third of all new patients only eight years ago.

Health centers understand the importance and value of their involvement in health professions training—not only to the country's future health workforce but also to their own ability to successfully recruit and retain quality clinicians. But without some form of relief, it appears all but certain that for health centers, any costs not directly associated with patient care will come under increasing pressure to be reduced or eliminated—and that, despite their importance and value, these training programs will most likely be among those costs in question.

That is why we generally support the report's recommendation for the creation of a separate all-payer fund to support GME activities. We strongly believe that payments for education and training activities must somehow be separated from payments for patient care services, for the many reasons articulated in the report. We do, however, take issue with other specific points or recommendations, which I would like to elaborate on briefly:

With respect to the recommended recapture of supposedly "excess" IME amounts and their re-targeting to achieve certain workforce goals—especially expanding its diversity—and to support uncompensated care costs at safety net sites: while we strongly support the uses to which the funds would be put, we equally strongly urge you not to attempt to fund these most worthy efforts with recaptured funds. My 20 years of experience in this town tells me that the ambitious goal of redirecting funds in this manner

will most likely never be accomplished—so we urge you to identify new funding sources for these worthy endeavors.

With respect to restricting the overall residency positions to 110 percent of U.S. medical school graduates, I must tell you that—even as health centers have found themselves less and less able to rely on key programs like the National Health Service Corps to help them meet their clinical workforce needs over the past decade—they have come to increasingly rely on international medical graduates to meet their staffing needs. I trust you know that, today, the NHSC assists less than one of every four individuals who apply for scholarship or loan repayment assistance, and their field strength of 2,500 professionals is less than 20 percent of the number needed to meet all health professions shortages across the country. As a direct result, while we do not have any solid figures, we would estimate that one-fifth or more of the 6,000 physicians working at health centers today are IMGs. It's noteworthy that more than half of my old health center's 20-plus physicians are IMGs, a fact that doesn't seem to have affected one iota its relationships with the local teaching hospital, local medical community, or the medical school—not to mention its recent JCAHO re-accreditation for five years. I visited another nearby health center along the U.S.-Mexico border on the same trip, and more than 80 percent of its physicians are IMGs. I urge you—in the strongest terms—not to engage in such restrictive actions until and unless you clearly know what the effects will be. Put simply, any precipitous action on foreign-trained physicians could endanger the entire health care safety net for millions of uninsured and underserved Americans—perhaps tens of millions, if the teaching and public hospitals are also affected.

Thank you again for the opportunity to present our views. I would be happy to answer your questions.

DR. GETTO: Thank you, Dan. The last speaker in the panel is Tim Henderson, who has talked with COGME several times in the past. Tim is the Program Manager and Director of Primary Care Resource Center at the National Conference of State Legislatures here in Washington.

He works with states looking at initiatives, particularly those that have to do with underserved communities and in helping communities and states deal with the inadequate services that they may have in areas of their states.

Prior to heading the Center, Mr. Henderson was the Senior Policy Analyst for the National Governor's Association and he was the Director of the Primary Care Cooperative Agreement with the U.S. Public Health Service. Tim.

MR. HENDERSON: Thank you, Carl. I'm going to take a little different approach to my remarks. I would like to say that in general the references that were made to state

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initiatives and programs in the report are applauded. I intend to elaborate on some of the activities that were mentioned in the report that states are doing, offer some lessons learned that could be considered for national or federal policy activities from our prospective, and some thoughts personally as to what I think national policy might look like that would encourage more out of hospital training of residents.

Medicaid, in particular, is a major payer at the state level for GME, and has traditionally, like Medicare, been a long-standing source of support for residency training.

What's changed recently though is the advent of managed care which most of you know too well involves price controls, and more recently, new escalating cost pressures.

Coupled with these trends, across the board and with GME, has been a renewed, more explicit effort at accountability, more of what I think is the latter type of accountability that Bob Dickler mentioned earlier. That is trying to direct lower cost training of more appropriate professionals.

This has happened in several ways, beginning as early as the '90s with more of a top-down planning approach, which frankly did not prove to be very effective in many states. These laws require those states' public medical schools, primarily, to prepare plans to train more primary care physicians. Most of those requirements had no teeth, probably rightly so, and market forces ultimately determined many of those efforts in and of themselves.

However, cost controls more recently have been more of a significant initiative within states and within Medicaid alone, we know of at least nine states that put explicit limits on either the total costs that would be allocated to GME, either as a percent of their inpatient Medicaid hospital expenditures, or in the total number of residents that they will fund under those programs.

And in the area of practice location, clearly I think, as our colleague from New York would say, and others have perhaps said, you cannot regulate in the current environment where people ultimately will decide to go. However, there have been several states that have used, not so much their Medicaid dollars, but their general appropriations funds, to routinely evaluate and decide whether continued funds will be based on whether a certain proportion of their graduates, first of all, remain in state to practice—I'm talking for residency, post-residency training funds—and secondly whether they actually are going into some kind of HPSA [health professions shortage area] or other designated shortage area to practice in those states.

Again, as an update to what we saw in the report, some of these, as I said, were referenced, and many of these, as I think Bob [Dickler] had said earlier, are at the

margin in terms of their effectiveness because they are relatively small efforts in levels of appropriation and levels of attention. But I think they're worthwhile in the way they've approached them.

One of the things that we've seen, again through appropriations, the first point, is to really target these funds, particularly for family medicine residency training in underserved and ambulatory settings. What is particularly distinctive about those and per the point that Doug Wood made earlier about the declining interests that many preceptors have in serving on some voluntary basis as preceptors, is the fact that in many states there are funds, particularly in Texas, where those funds have been significant to support preceptors in their participation in these community-based residency training activities.

Medicaid has also tried to in a smaller way play some part. We know of at least four or five states that have explicitly decided to redirect some or all of their GME payments into out-of-hospital settings; however, they do this in quite different and varied ways. I won't elaborate, but some of this is in the report.

A couple of states actually do this by simply having the monies flow directly to the medical schools and not to the teaching hospitals, thereby circumventing any kind of requirement that say Medicare has had.

And Medicaid does not have, such as Medicare does, the statutory restriction of course to have those monies flow to only Part A or at the Medicare level Part A, or hospital-based providers. Typically though HCFA has wanted to weigh in on those decisions and give some kind of approval, either through a waiver or through a state plan amendment.

But for the most part, these activities have been allowed to move ahead where the monies will flow either to a medical school training site, such as in two states, or will flow through the hospital explicitly with the requirement that they go on to some kind of non-hospital-based community setting.

Also what I think is interesting in some of these same states is the effort to link the long-standing efforts that states have made to provide scholarship and loan repayment support of residents to the actual monies that flow to the institutions.

State loan repayment, as I think was mentioned earlier, has become a predominant form of support in the area of service obligations for particularly primary care residents in many states. And in a few states they've attempted to link those efforts to the support that the state provides directly to the resident training programs where those residents are actually receiving those payments, to provide further strength to the idea that these

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people will go on through additional stipend support to training in these areas and ultimately into practice in these areas.

Even a few states, Texas the first one, actually created a statute requiring the offering of rural rotations to all primary care residents for, and I say a genuine period of time because in many states either those that have rural training track resident programs and where the money flows, there is some attempt to actually have those rotations be for a significant period of time and under a significant set of circumstances.

And finally, we've seen a number of states actually improve their support for distance learning technologies through telemedicine activities and the like, that really have gone a long way to encouraging many residents in out-of-hospital training activities. This isn't just for physician training, but particularly for nursing education as well

This has manifested itself again at the margin largely in three or four states, and I'm just going to make reference to three or four of them. Kentucky years ago developed a large network when health reform was a major initiative across many states and health was a major issue.

A large family practice rural resident initiative where both the number of residency training programs in family medicine were increased and they were increased in a sort of geographically regional-oriented approach where different areas of the state were ensured to develop new training activities. The stipends were of a certain level and directed to a certain kind of speciality. And again the effort was to link residents that were also receiving state loan repayment programs.

Michigan, through their Medicaid program and their efforts to move out of hospital settings into managed care activities, has developed a separate innovations pool, and again this was mentioned in the report, to promote innovation. The only other state that we know that does that explicitly is New York, but it is not under their Medicaid program per se, it's under their all-payer initiatives.

Again, Tennessee is one of the two states where the monies flow for GME under Medicaid to the medical schools. I must say though that with the tremendous upheaval that's happening now in TennCare, which has perhaps been there from day one, the support for GME is once again being threatened as it was about five years ago when monies stopped altogether and then were restored under a completely different set of rules, mostly which favored the fact that these monies would flow to settings that would do a better job of training residents that would want to serve ultimately Medicaid patients, particularly in underserved areas.

Finally, Texas has developed I think a substantial set of workforce policies that really look at trying to develop a fairly statewide approach to getting residents trained in out-of-hospital settings and primary care activities.

Waco is an interesting program that I did a case study on a few years ago. It's a freestanding program, community-based residency, that does not favor any one particular school of medicine or hospital that negotiates for its best circumstances. It's garnered a lot of local funding to support its activities, in addition to state support for its programs.

One thing that we've seen this program do that we're seeing increasingly a number of residency programs do I think offers a word to the wise for many. Many of you know in several states there's been a strong move for the sale of nonprofit hospitals to for-profit hospitals and by legislative dictate in those states, there's been the creation of a lot of community foundations that have been charged with distributing these funds to programs that can document community benefits.

And I know that I was attending a conference as was Marian Bishop recently where the intent was to talk about ways that family practice residency programs could demonstrate more effectively what their community needs were.

And I've seen several instances where some programs with say some support from states at the same time, look to these local or these regional community foundations as valid new supports, new forms of revenue and support for these training programs.

I wanted to offer some advice to HCFA about where Medicaid policy for GME might proceed. These were some comments that were prepared in a report that I put out a couple of years ago for the PEW Health Professions Commission.

One of the things that we see Medicaid does through a lot of its efforts to look at special issues is to develop TAGs, or Technical Advisory Groups. I would suggest that efforts to support Medicaid GME might be useful in this climate.

One of the reasons I think this is important is to not only better understand the innovations that several states have done to support payment for GME, but it also provides some new monies for demonstration projects and GME payment.

We mentioned earlier here about the New York demonstration for Medicare. I think that there are several efforts, including in the audience today, members from the state of Utah that are in the midst of hoping to get some monies from HCFA in this regard, to encourage these efforts. Not to belie them, but to encourage statewide pooling for payment of non-hospital training programs in particular.

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And I think that there certainly could be some opportunities for HCFA to take a closer look at ways to have those monies better spent.

And finally, I just want to offer some views of my own that are not NCSL's, related to what I think at the national level GME policy might look like. I think, as opposed to reports that we've seen from MedPAC and otherwise, that workforce goals and policy realities are important to acknowledge in Medicare GME policy. And that we need to be more explicit about our needs to be accountable.

Clearly, there's some need to articulate what we think we can practically do in the way of more accountability, but I think some effort to be more accountable, which I would clearly endorse as part of the Fifteenth Report is important.

A couple of other questions that might be worth considering, and that is, if we're trying to really encourage more monies to flow out of hospitals into community-based training programs, should we, for Medicare purposes, think that Part A should be the only source of payment for these monies to flow for all GME activities?

In other words, could Congress or HCFA do a couple of other things? Should they in the era of demonstration projects create a demo that perhaps uses some Part B monies that would flow to not only private physician practices, but to FQHCs, managed care organizations and the like, so that they could benefit from these programs?

We know that they're on the books, these new BBA initiatives that Dan [Hawkins] mentioned, but that they have been largely viewed as not very effective because there's not been any new monies associated with them. And these demonstration projects that I'm suggesting might be put in place, the Part B or otherwise, or even through Part A, for nursing homes, could be new dollars.

And I mention nursing homes because I think we all realize that geriatric training and the need for more attention to having residents exposed to the value of training in these settings is critical. Yet, there's not been any significant attention that I'm aware of paid under Part A to having these monies flow to training outside of hospitals into some nursing home environments and I offer that as an option for consideration.

And finally, we all know that outpatient prospective payment is on the way here under Medicare and Medicaid and I offer this as sort of a heads up to say, are there some opportunities as well as constraints that might exist there in the way that it's formulated that might give opportunity for greater support for GME in those settings? Thank you.

DISCUSSION FOLLOWING PANEL 2

DR. GETTO: Thank you Tim. I think we have some time for questions. Yes, Regina.

DR. BENJAMIN: In the New York demonstration project, of the resident programs that were decreased, what specialties were they, do you know?

MS. WANG: Do we know Tim? Actually, I'd like to introduce Tim Johnson, my colleague from Greater New York who has worked very extensively with the demonstration hospitals.

MR. JOHNSON: For the ten hospitals that are still in it, I think some of them have closed some programs in the hospital-based specialties, the radiology, pathology programs, in part in response to what was mentioned earlier, some difficulty in recruiting folks a couple of years ago and not liking the quality, not feeling comfortable with the quality of the people they were recruiting, so they thought that there were opportunities there.

Frankly, there were some opportunities there to eliminate residents and close those programs without having the impact on the service component of an internal medicine program or a peds program or a surgery program. There have been some cuts in those programs, partly just in recognition of the fact that they are large programs and if you're going to make cuts, you have to dig a little bit into them.

But it's been pretty significant in those RAP programs, those radiology, anesthesiology, and pathology programs and smaller cuts I think in some of the others.

DR. GETTO: Other questions? Yes, Allen.

DR. HYMAN: Pat, you touched on a sensitive subject of the disparity of payment per resident across the country and New York may be somewhat of an outlier, or at least some of the hospitals in the metropolitan area.

How do you explain that and what would you propose going forward?

MS. WANG: One of the criticisms of the per-resident amount is that it is rooted in a 1984 base year. But the fact of the matter is that even if you look at the total costs of DGME per resident, the fact is that in 1984 as today, different entities, unlike other parts of the hospital complex, share in the cost of that DGME based on historical structure.

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For example, a state university medical school might have had all of the faculty's salaries on their books such that what was on the hospital's actual cost was really the resident component. That hospital's per-resident amount is going to be lower.

It doesn't mean that the total amount being spent on DGME is less, but it does mean that different entities are bearing the cost and Medicare has very specific rules for defining what could and could not be rolled into that per-resident amount.

The other factor that I mentioned in terms of faculty opportunities for billing, et cetera, also comes into play even today. And so we think that there are really legitimate differences in the differences in the per-resident amounts.

There is Senator Feinstein, who has introduced a bill this year and there were successive efforts in the past with the BBRA as well as the BIPA [Benefits Improvement and Protection Act] to raise the floor of lower per-resident amount hospitals. It's now at 85 percent. In the first year the higher per-resident amount hospitals did feel an impact from that.

The BIPA raised it further by adding new money and Senator Feinstein has again introduced legislation to raise that floor to 100 percent so that all hospitals at least receive that without taking away from those that might have per-resident amounts above the average.

And we certainly support that approach, but we certainly do not support an approach that would make it budget neutral and rob Peter to pay Paul so to speak.

DR. GETTO: Susan.

DR. SCHOOLEY: Allow me to struggle with this comment a little bit. I appreciate the juxtaposition of these three very different points of view because I think what it does is underscore the delicacy of the balancing act that is going on for graduate medical education. I trained in a community health center a couple of decades ago, and at that time, inside the community health center, and in its relationship with the medical center, Medicaid was the Robin Hood that in fact supported the indigent and uninsured care that was going on.

As I look at our struggles in Detroit at this point, trying to create collaborations, both for clinical work and for teaching, that is clearly not the case and in fact, both uninsured care and Medicaid are hot potatoes that everybody's kind of juggling to avoid impeding those relationships for teaching and/or clinical care.

And that the balance is in jeopardy not because those collaborative relationships can't work on a conceptual level, but because the basic undersupport for clinical care

through public programs jeopardizes both and allows neither to collaborate with one another.

And until we deal with that very fundamental problem and the problem of peer enrollment of the population in the public programs, which we're discovering is rampant in Detroit.

Just by illustration, I participate in a Kellogg-funded project where we're doing kind of a virtual demonstration of managed care with uninsured people as a multisystem collaboration. Seventy percent of the people we encounter in the emergency room who are uninsured are in fact, eligible. And the barriers to enrollment are significant and I don't need to tell you.

So this comment, I think, is just to underscore that the basic underfunding and underenrollment in the public programs impedes our ability to make any progress.

DR. GETTO: Yes, Robert.

DR. JOHNSON: Dan, one of the issues that frequently comes up with community-based training, both at the medical school level and the postgraduate level, is the relationship between the cultures of the academic departments and the community-based health center. Differences in faculty, credentialing the faculty, the administrative differences in health centers. And I've seen examples where it has worked and examples where it hasn't worked because of those cultural clashes.

Has that been your experience as well and could you talk about how it has worked and what needs to be done to make sure that it does work?

MR. HAWKINS: Sure. Two, I think, important points on that. One on the focus on the quality of the clinical staffs. You talked about credentialing, et cetera. More than 250 health centers of the roughly 750 across the country today, those are the organizations. There's 300 delivery sites.

More than 250 have gone through JCAHO accreditation thus far and as you know, in going through that there is a fairly strict and extensive credentialing requirement.

Secondly, remember what I said about half of all health centers being in rural communities where managed care is barely existent, if at all, and particularly for publically insured populations which is what health centers tend to see most.

Three-quarters of all health centers are involved in some form of managed care. And even if it's just for Medicaid—I might add 15 percent of health center patients nationally

are commercially insured. That number jumps to 25 percent when you look at just the rural health centers. They tend to be the only show in town. The family doctor for miles around.

When they get in these managed care agreements, they also have to go through a very strict credentialing process.

Finally, under the Federal Tort Claims Act, which was extended as a form of malpractice coverage substitute back in 1992, but only fully implemented about four years ago, and is saving about \$80 to \$100 million a year in unnecessary, essentially malpractice insurance company profits, has also imposed very strict credentialing requirements on health centers. They're much tougher on that.

As far as the teaching versus patient care culture, which is really at the core I think of your question, that I think, yes, it is there. As I said, I think health centers have more appreciation now than they did five years ago or ten years ago of the importance and value of teaching as an important component of their activities, but patient care will never ever be made second or step-cousin to anything else. That will be the most important factor always.

DR. JOHNSON: I want to press you further. The issue I'm concerned really about is academic appointments. Should the staff that teaches in a community health center have academic appointments? Is that necessary for them to be involved in teaching?

And if they do have academic appointments, what type of appointment should they have? And in some medical schools there's actually a two-tiered system where you have the clinical faculty and non-clinical faculty, the non-clinical faculty getting grants and working in laboratories and the clinical faculty working seeing patients.

The other thing that's happened, especially now with pressures on income for academic faculty is the academic faculty have been asked to go into community health centers and see patients. And I shudder at the idea of someone who's never seen a patient in 20 years, suddenly say, you're a professor of medicine, you have to see patients now. And I know of at least one example where the community health center said, no we don't want that person.

MR. HAWKINS: They haven't had a whole lot more success forming MFAs I might add. I mean financially.

DR. JOHNSON: So that's the issue I've seen as more of an issue, that some community health centers have said, well, one of the enticements to become involved with the medical school is that our staff can get faculty appointments and you can say on your

C.V., I'm a clinical professor of whatever. And I don't know what value that is, but that was one of the enticements. Well, what does that really mean?

MR. HAWKINS: Well, you're talking to one person who's always felt like, when you're talking to a health center clinician that's worked there for 15 years or 10 years and provided top-quality health care to thousands of people in the community, my attitude as far as the appointments are concerned is sort of classic Wizard of Oz. You don't need a brain, you need a diploma.

Fine, give them the paper, if that's what it really means. What's more important is the quality and the substance of their involvement in the teaching activity.

I do think there are clinicians, however, who work at health centers who do value that and there are health centers who value it because they can't offer a whole lot. They really can't compete with the market out there in terms of salary, in terms of benefits.

There are more physicians in private practice today and group practice getting private loan repayment from their employer than there are publically funded by federal and state government combined.

So loan repayment is not exclusively a public domain. That's being done by employers all the time as a perk, as a recruitment incentive. Health centers don't have the ability.

And then comes the population that health centers deal with and a difficulty often times, sociodemographic issues, patient compliance issues, when people are struggling just to put food on the table and keep a roof over their head every day, it's not often a priority to think about, is it time for me to take my next set of pills, or do the follow-up appointment when, in fact, I'm feeling at least a little bit better than when I went last week for the first visit.

So there's so much there that counters the needs that the ability to provide faculty appointments I think is an important issue in that context, to be able to offer that.

It's also something that's important for health centers who had never felt recognized, respected, or appreciated for the quality of care they provide. Even though they're the only set of providers in this country today, other than VA and DOD in a different kind of way, subject to a uniform consistent set of standards for quality assurance and quality of care. Everything is voluntary. This is government.

But it doesn't matter. They still feel like they get knocked on the quality of care. And believe me, just as JCAHO accreditation, and you may take it, you may have seen JCAHO, you know, what does it mean, you got process measures in place. It doesn't

necessarily mean the quality is top notch. But it is important to health centers precisely because of that. It's some form of recognition. I do think those appointments are important in a number of ways.

DR. GETTO: Marian.

DR. BISHOP: This question might be better asked at the end of the day, but so far on both panels I've heard general agreement on the all-payer system, and I wonder if there's any way to establish how do we take that next step and get the all-payer system started? Now, I'll defer to Dr. Dickler's statement that we're probably not sure what it is, but that's never stopped Congress or us even from getting started. So I just wanted to put on the table that—

(laughter)

MR. HAWKINS: I wanted to say, I noted that your earlier version of the program had Chip Kahn here on our panel and I guarantee you, if Chip had been here, there would not be unanimity, in terms of the respondent's view of that issue.

DR. GETTO: We tried very hard to have a representative, either Chip or Karen Ignani, one of those two.

MR. HAWKINS: You get private payers in here and I'm sure they're going to fight you like Hell, no matter how right it is.

DR. GETTO: Marian, I'm glad you put it on the table, because I think that is clearly one of the jobs for the workgroup tomorrow to talk about. How do we move that particular issue along with other issues that come up today? It has been pretty unanimous with that outstanding group not being here.

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DR. GETTO: The next panel will actually go in the order that they're listed on the agenda, for a change of pace anyway. And the first speaker is Craig Lisk. Craig also has come to COGME several times before and enlightened us on the activities of MedPAC.

Craig is the Senior Policy Analyst with the Medicare Payment Advisory Commission and he has been with the Commission since it was established. As certainly COGME, and I'm sure everyone in the room knows, graduate medical education has been an issue that MedPAC has concerned itself with and there are some articles under I think tab four or five in your agenda book that summarize some of recent thinking of MedPAC by Wilensky and Newhouse, that were taken from Health Affairs.

And we're very pleased that Craig has joined us today. Thanks Craig.

MR. LISK: Well, glad to be here. What I wanted to first of all say, is that I'm here for the Commission, but the views that are going to be expressed today are my own interpretation of how the Commission might view COGME's report recommendations, since the Commission hasn't directly examined COGME's report. But I want to discuss COGME's report in the context of the Commission's August 1999 report and subsequent recommendations that we have made since that time.

So I want to start off by reviewing MedPAC's views about education and training costs. Basically in the Commission's view, trainees bear the cost of general training by accepting lower wages or paying tuition.

And that what we see as graduate medical education expenses, or Medicare's education payments, therefore, should be treated as patient care costs. So we can't view these as education costs. The Commission views these as patient care costs.

The Commission also though believes that Medicare should recognize the higher cost of teaching settings if the added costs are commensurate with the added value of the patient care services received. And we basically have taken it so far as a given that when we've seen those higher costs, that we should reflect those in Medicare's patient care payment rates.

The Commission though also has recommended that workforce policies should be made through specific target programs rather than through Medicare payment policies or payment policies in general.

So that was kind of a summary of the Commission's August 1999 report. In June of last year, the Commission recommended that direct GME costs be folded into PPS rates

and a new teaching adjustment be calculated to reflect this change by incorporating those costs into base payment rates.

So essentially reflected in patient care rates, the uniform, the higher costs of teaching hospitals, including direct GME, and that requires a new IME adjustment essentially.

The Commission in doing so, also, and I'll get into the implications of this in a moment, recommended continuing what is the implicit subsidy, the long-run subsidy in the current IME payment at the 5.5 percent IME adjustment level or what we estimate is about a \$1.5 billion subsidy, once the phase-in of the IME adjustment is complete.

In March 2001 though, the Commission also in part of a BBRA mandated report on the residency weighting factors recommended that the weighting factors used to calculate direct GME payments be eliminated in a budget-neutral manner and that all residencies be counted equally through the first specialty and subspecialty. But then no payments would be given for residents who train beyond those periods.

So I want to now go and review COGME's report recommendations and how these mesh with what the Commission has recommended in the recent past. I also want to note though that we're going to be talking some again about these issues at our Commission meeting tomorrow afternoon. We have a mandated report also required by the Congress as part of BBRA to examine Medicare's education payments for nursing and allied health training programs. So I'll be giving that presentation tomorrow and the Commission will be making some potentially final recommendations for that report, which is due in the end of May.

So moving on, the first recommendation that COGME made was to create a GME fund that combines federal funding to support GME and patient care with all-payer funds.

First, in the Commission's view, residents pay for the cost of education and training, and hence, these costs should be reflected in patient care payment rates. A fund would not be doing that in our view.

Now another aspect of things is, we have not seen in hospitals—and I guess we'd say that this is maybe what Chip Kahn would have said if he were here—we have not seen negative payment-to-cost ratios in teaching hospitals for private payers.

And if we're not seeing negative payment-to-cost ratios, in effect, those private payers are paying the higher costs associated with teaching in those facilities. Although private payer payment-to-cost ratios are lower in teaching hospitals than some other facilities, they may not be making as much of a profit, but in essence, the payment-to-cost ratios for private payers in teaching hospitals we have generally seen are positive,

which is an indication that the private payers are paying for those higher costs. So I think that these findings have implications for an all-payer fund.

A second issue also relates though to funding the fund and there didn't appear to be a lot of discussion in the report concerning how the fund would specifically be funded from all-payer revenues. And I think there are some difficulties with that because in effect, you are creating a new tax and in this political environment, a new tax is something that Congress and others are not likely to do. So the reality of being able to do an all-payer fund I think is probably limited.

Now again, the Commission hasn't discussed this specific aspect of an all-payer fund, so that view would be my own in terms of the interpretation of what the Commission might believe.

I want to move on then to the second issue which is regarding the IME accounts and that they should pay hospitals and other clinical training sites as appropriate for indirect costs of education activities.

And I think the basic discussion in the COGME report does reflect the view that these are patient care payments and I think then that is appropriate. But we also then, as I had said before, would include the direct costs as part of this patient care expense as well.

Now the Council recommends that the IME adjustment be brought down to the empirical level but the Commission in its report didn't recommend bringing the adjustment down or removing the subsidy from the current IME level—or rather the long-run IME level of 5.5 percent.

The Commission recommended maintaining a subsidy of about \$1.5 billion and the rationale for this was the current financial state of teaching hospitals and their lower overall total margin. So the Commission didn't think it was appropriate to put more pressure on the teaching hospitals at this point in time. But this is an issue the Commission likely will revisit in the future.

Now COGME also, in your report, recommended some research on the level of the IME and there are two issues I think that are important to explore in the future. And that is, research is needed on alternative measures to the IME adjustment level in terms of the ratio of residents to bed which is currently used.

There's an implicit problem with the intern and resident-to-bed ratio, in that it potentially provides incentives for hospitals to have more residents because they're getting paid more for each resident they have.

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Now there is the cap that takes care of that, but in terms of having an efficient level of residents, you still have an incentive to have potentially as many residents as you have up to your cap and not reduce your number of residents, which otherwise may from an economic standpoint be desirable.

Research is also needed, not just on the relationship on the inpatient setting, but on the cost relationship between the amount of teaching that's going on and the supposed enhanced care that's maybe going on in other settings—in the outpatient setting, in community settings, SNFs [skilled nursing facilities] as well. Not just for residents, but also for nurses and allied health professions as well.

I think those are very important research areas that would take an extensive amount of research to really delve into appropriately.

In the third recommendation you recommended direct GME accounts should pay for program sponsors or their designees for the direct costs of GME. Now again, the Commission believes residents are paying for the costs of their training and therefore these are patient care costs, not education costs. So again, it's paying the provider for their higher costs is what the Commission would view as being appropriate. So we disagree with COGME's underlying premise that these are education costs.

The Council did recommend requiring a separate reporting of residents' time spent in different clinical settings and I believe this is probably appropriate. Again, for being able to get more information to tell whether in other settings we have higher patient care costs and we can adjust payments appropriately in those different settings, I think that could be important data for doing that.

Next is the fourth recommendation, establishing a national average per-resident payment amount, and essentially this is somewhere where our recommendations kind of mesh. Because our national recommendation for folding in GME costs into the base rate, in effect would be a national rate to some extent. It's going to be adjusted for case mix and local wage levels, but in a sense, it is a national rate to some extent.

And as you recommended, a transition though going to a national rate would be needed because it would redistribute costs fairly substantially for some providers.

Now the avenue of a national rate, from the Commission's perspective with the IME adjustment particularly, is we're recognizing the efficient costs of providing care reflecting what a hospital's involvement is in teaching. And so a national rate, adjusting for those factors, would be reflecting this.

If you have higher costs, you may be inefficient and it's not clear whether the Medicare program would want to recognize those inefficiencies.

The Council also recommended providing higher payments in community settings and providing provider incentive payments for meeting specific workforce and education objectives.

Now the Commission believes that such incentives should be made through specific targeted programs rather than through payment policies. You do later go on and I will comment on that in just a moment about providing a fund for special projects. I think that probably would be the appropriate place for those funds.

On the fifth recommendation, continuing the BBA limits on the number of residents, the caps do serve a potentially useful purpose. The Commission discussed this briefly. We didn't make any recommendations on this, but they do provide a disincentive for hospitals to expand the number of residents they train. And we don't believe it's appropriate to have the financial incentives for hospitals to increase the number of residents they are training. That a payment based on that is providing too much of an incentive for hospitals to potentially do that.

Now you also recommended including residents in non-hospital settings. Now again, you could do this, but if you did do that, you would need to adjust the IME adjustment so it reflects the current level of spending. Otherwise, you'd be introducing new funds and providing additional subsidies that may not be appropriate.

Now in the account for funding special projects, again, as I said, the Commission believes this type of thing should be done through specific targeted programs, but I'm not sure what the Commission would think of this as a fund.

Because all of a sudden we're creating potentially what might be an entitlement fund versus something where people and the government decide what might be the appropriate allocation of funds to these activities and these needs, balancing general education versus education for nurses and physicians and how those allocations should be made. So I think that's a concern to be made with that proposal.

Now in the teaching physician rules, the Commission really has not discussed this. I think the basic issue is quality of care and maintaining that beneficiaries have access to high-quality of care and that the care being provided is of high quality. Ensuring that physicians appropriately supervise trainees is what is important here. The extent to which the physician supervisory rules maintain and ensure high-quality care, that is what would be important.

Finally is the support for additional DSH [Disproportionate Share Hospital] monies. This is how I kind of interpret the last recommendation. The Commission does have a recommendation for improving Medicare's DSH payment policies, really looking at, instead of this messy ratio of Medicare, low-income Medicare and Medicaid, looking

at really low-income patient population. A combination of uncompensated care and Medicaid as the determinant of those DSH funds.

The main issue on DSH policies is Medicare's ability alone to handle those. Because Medicare should maybe pay its appropriate share of those costs, but in many of those hospitals they have the large uncompensated care burden and Medicare is not a large portion of their business. So Medicare's ability to do something is limited. So that may be something appropriate for a larger fund.

Now the Commission hasn't recommended that at this point, but that's where that stands. So I'll be happy to answer questions after we're through. Thank you.

DR. GETTO: Thank you Craig. The next speaker is Marvin Dunn, who is the Director of Residency Review Committee Activities for the ACGME [Accreditation Council for Graduate Medical Education]. Marvin is a frequent attendee and participant in COGME activities and a noted watcher of COGME.

Dr. Dunn has the distinction of having served as the Director of the Division of Graduate Medical Education at the AMA and he has been the Dean of the University of South Florida Medical School and the University of Texas Medical School at San Antonio. Marvin.

DR. DUNN: Thank you very much, and thank you for allowing me to come and speak.

I think the Fifteenth Report is a fascinating edifice coming out of COGME and I think holding this discussion is a real tribute to COGME to bring so many people together to hear different views. So I'm going to take the opportunity to introduce still another view that's been mentioned three times today.

I knew Craig would mention it, and he did. But Sunny [Yoder], thank Bob Dickler for mentioning it also. And then [Dan] Hawkins mentioned it as well. And it's the word "quality."

We've been dealing with quantity. Quantity of physicians, types of physicians, distribution of physicians, but who's looking at quality? And so I appreciate being invited because, as a matter of fact, the mission of ACGME has to do with quality. Not just the quality of the training program, but rather the mission is to improve the quality of health care in the United States by improving the quality of the graduate medical education experiences for physicians in training.

We're now measuring quality of the process going in and we all assume because it's very good quality going in, it must be good quality coming out. Maybe that's worth measuring. So we've engaged in a major outcomes project which will take at least five,

and some think longer, years to do, and assessing the six basic outcomes of competencies.

This will mean we'll look at their competence in patient care, in medical knowledge, in professionalism, in self-based practice analysis and improvement, interpersonal communications and skills, and systems based.

Now if you look at the last two IOM [Institute of Medicine] reports, they deal with quality. One is dealing with quality when it is not there and errors are made. And the second one is bridging the quality gap.

I think this is interesting that a few years ago IOM was putting out reports on numbers of physicians. Do we have enough of the right specialty? Are they located in the right place? Now they too are looking at the quality issue. And I'm pleased that MedPAC has looked at the quality issue and that's why I told Craig I was glad to be following him because I knew he would be bringing it up from that standpoint.

ACGME does not have as part of its mission to deal with workforce issues, so that's off the table for ACGME. But quality is and we will monitor that and hope you will join us and recognize that financing and quality are linked.

Now don't think I'm insulting you by saying that, but rather, it costs to measure these things. As we talk to the program directors about measuring basic competencies, they say this is a wonderful idea. Of course we try to set up a standard for professionalism and trust that our residents when they finish will emulate this and go forward.

But do you realize what it would cost for us to set up a system to actually monitor that? And those are real costs. And if we want to have quality, someone's going to have to pay for that. So I'll remind you of that.

The second thing about financing and quality is that it does require having a stable source of funding regardless of where that source is coming from. But if there's not a stable source of funding, any residency program is headed for a rocky road. And that's one of our requirements is, that they should have a stable source of funding in order to have an accredited residency.

This gets to be a catch-22 if the funding begins to dry up and then they lose their quality and then you say, well, if you don't have quality you can't be approved.

So this is again where COGME's report, calling for a stable source of funding in adequate amounts is so critically important as national policy. That's one that we can join with and support wholeheartedly.

Thank you.

DR. GETTO: The third speaker is Malathi Srinivasan, who is the immediate past President of the National Consortium of Residents and she is Chair of the Long-Range Planning Committee of the AMA Resident and Fellows section.

She is currently finishing a fellowship and a national research service award in general internal medicine at the University of Indiana. And she will be joining the faculty of one of our medical centers next year. Welcome.

DR. SRINIVASAN: Thank you very much. Well, first, Marvin Dunn may have been happy to follow Craig Lisk, I'm sort of scared to follow all of you. It's been truly a wonderful meeting and it was an honor to be asked to come and speak to you about the essential resident perspective on COGME's Fifteenth Report. So I thank you, and congratulate COGME on its forethought in having all the stakeholders come and really discuss these issues—prior to the Bush Administration actually coming out with a larger policy on GME.

To really talk about GME issues from the resident perspective, we must first ask, "What are the real goals of graduate medical education?" Second, we must ask "What are resident-physician concerns within the GME funding arena?" And third, we must ask "How do COGME's recommendations address these resident concerns?"

Discussing the first question will take about five minutes, the second will be a little bit longer, and the third will be reasonably short.

The first goal of medical education, that I think that Dr. Dunn touched on, is to provide excellence in patient care.

And the second goal is to meet societal needs and demands, in reasonable ways, that allow flexibility in the system so that learners have the ability to adapt to changing needs within the system, and can be systems-based problem solvers. Learners need to understand the complex business environment. Whatever system of medical education there is, it needs to recognize that not all physicians will contribute to society the same way. Some physicians may have the audacity to be involved in research or teaching administration, and some may even decide that they're advocacy or policy wonks, and some devote their lives to community service. Similarly, over the course of a physician's practice, you may see people move smoothly between these areas of practice. And in fact, the way people practice is very different now than it was say 10 to 15 years ago.

So within this current system of GME and GME financing, what can we do to optimize learning, to achieve the goals of GME? We need to really consider who these adult learners are.

Adult learners are people in apprenticeship model situations. [Hank] Slotnick, in a recent Academic Medicine article, had talked about the adult learner, a neglected species first described in the '70s, and talked about a couple of the characteristics of the adult learner.

One, adult learners want to be actively involved in their own education. Two, they want to be involved in problems that they had seen before. Three, they have very real time constraints, both within the system that they're operating and also extramural time constraints. One of the GME's goals is really to create excellent patient caregivers, but this paradigm of the adult learner also helps us promote the role of the physician citizen, the physician who involves himself in the community in ways that are meaningful and useful.

[Donald] Schon had also talked a little about a couple of the things that are necessary for good training: specifically "reflection-in-action" as well as "reflection-on-action." So think as you do and go back and think about it afterwards.

There's also a very big difference between training and education. Training is the ability to put out someone who's a technocrat and who has a technical understanding of what they're doing. Education is the larger understanding of the process in the system and the ability to be malleable. And in optimizing learning, you really want a process that's rigorous, but also that's humane.

One of the questions that people have asked me is, well, Malathi, is medical training really all that unique? We've got lots of people who independently practice after their professional degrees. For the most part dentists do this, although some of them also undergo internships, as do nurses, people with masters in information sciences or computer sciences. Clearly these are not models on which the medical model is patterned. Who pays for the rest of new professional post-graduate training?

We do see apprenticeship models in Ph.D. programs, M.B.A. programs, and J.D. programs. They're a little bit different. A Ph.D.'s salary is usually paid by a department and that payment is cost shifted when they are still junior faculty or trainee researchers. And usually they're done from direct grants from the federal government or from other departmental costs, or through state and government fellowships. So that period of training is subsidized by the government in other ways.

The second is the MBA. Typically the client bears the cost of the MBA's initial training, and there's really not a lot of catastrophic outcomes that occur in terms of the day-to-day practice of the MBA, although the long-term effects I won't comment on.

(laughter)

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When lawyers graduate from law school, they are either trained by the state on a county population—sometimes, but not always involving life and death decisions. Again, their post-graduate training is paid by the state, subsidizing their training at a lower wage. Or they go into a corporation, which then transfers those training costs to the client.

However, medicine is very different in the sense that it probably has the longest training time to independent practice. And because there's a very high-stakes outcome and quick turnaround times in terms of the decisions that need to be made, the supervision requirements, as well as the educational requirements, are considerably different.

Departments typically can't cost shift. They have low margins and they've got a charity mission. And finally, there's a service to all society with a future use for all people involved in it. I'm not going to talk about too much of the public good for GME. There are several people in this audience who've already written about it and Mike Scotti did a wonderful job this morning on talking about that mission.

So medicine as a profession then has obligations to both society and to itself. Samuel Thayer, who is a former President of the Institute of Medicine, had modified Supreme Court Justice Louis Brandeis' definition of a profession for medicine and had noted three essential characteristics.

One, that the profession had an exclusive body of knowledge of which it had some proprietary claim, although now in medicine that is changing. The profession was self-governing, setting standards for entrance into the profession, maintenance of that profession, professional certification or accreditation, and also standards for leading the profession as well. And that the service that was performed was of value to the society.

Along with that societal value came the covenant with society of acting in a professional manner. The American Board of Internal Medicine came up with this definition of professionalism. It is a series of six observable behaviors which you can read over here, and also some countervailing, individual problems that could get in the way of maintaining professional behaviors.

But as we know, medicine is big business. We're spending a quite a bit of our GNP on medicine, between 14 and 16 percent.

And the expenditure trends are also interesting. The out-of-pocket and private percentage of expenditures is decreasing, the federal percentage increasing, whereas state and local expenditures is reasonably flat.

We've heard a lot from different stakeholders in GME, but I wanted to touch on a couple other market/business issues that I wasn't sure people would cover today.

The first is market consolidation. As you know, the HMOs over the past ten years or so have consolidated significantly—with companies like Cigna and U.S. Health Care merging in 1997, generating revenues of \$18.7 billion and enrolling 13.5 million people. Booz Allen and Goldman Sachs noted that 50 percent of the total U.S. marketplace is concentrated in the top ten health plans. Hospitals similarly have also started to consolidate. From '94 to '98, the percentage of hospitals in networks increased from 56 percent to 71 percent and that's according to the American Hospital Association's data from 2000.

Second, in the meantime, profitability has also decreased. The after-tax profit margins for HMOs decreased from 2.4 percent in '94 to negative 3.5 percent in '98. The source is the Interstudy Competitive Edge HMO industry reports in January '99. Hospital profit margins have either been stable or have been somewhat decreasing from about 4.6 percent to a max of about 6 percent, down to 5.5 percent in '98—and decreasing again.

Third, during that same time period, hospital admission rates have been increasing similarly and there's been a downsizing of hospital beds from over 900,000 to about 840,000 a year or two ago. Length of stay, in the meantime, has stabilized.

Fourth, we know that about five percent of the population is consuming about 38 percent of medical services.

Next, non-profits have been increasingly becoming for-profit institutions. When non-profits shift to for-profits, there's a loss of the DSH mission.

Finally, there's concern that the safety net is eroding and we know that the number of uninsured and underinsured in the U.S. is increasing.

So with that as extensive background, we have to ask the question, what is the current physician training environment? How do the values of market-centered medicine based on cost effectiveness, reconcile themselves with the patient-centered medicine based on altruism, professionalism, and accountability?

In medicine, we have both explicit and hidden agendas and we see that in the conflict between service and education.

So the six resident concerns that I'm going to talk about now regarding funding changes in GME are:

1. quality of patient care,
2. resident training,
3. resident well-being,

4. medical debt,
5. practice choice,
6. and the need for faculty training, which is essential.

Some of this data are from a survey that we did in the AMA Resident Fellow Section at the intern meeting in Florida in December 2000. At the time we administered the survey, which was a Saturday morning, a couple of people were sleeping in, we had 95 resident leaders who were surveyed from 35 states.

Sixty-eight surveys were returned and 60 of those people gave consent to share data. And you can see, there is a split between resident and fellows, university, community, and military. And we had 22 specialties represented, so it's a pretty broad cross section. And these are motivated people who had taken the time and trouble to leave their residency programs and come to this meeting.

There needs to be caution in making statements that imply causation. So as you know, this was a convenient sample set and so take this data in a limited sense and be careful about the generalizations that we can make with it, but I still think it's reasonably suggestive.

The first item is quality of patient care. In assessing the medical environment, Dr. Dunn has already talked a little bit about patient safety and care improvement. I'm not going to quibble about the numbers in the IOM's "To Err is Human" report, although I don't necessarily agree with their generalizations. Some of the statements they've made in crossing the quality chasm are actually quite good. They all point to the fact that we need to have big improvements in the way we deliver health care. AHRQ's [Agency for Healthcare Research and Quality] recent concentration on translating research into practice, again highlights the fact that we know a lot about medical care and medical science, but we're not necessarily doing a lot to enact great patient care. And similarly, the competency measures used by the ACGME and the ABMS [American Board of Medical Specialties] are really pointing the way in letting us know that we need to be better, in documenting what we're doing, and also making sure that we're delivering the highest standards of patient care.

One of the questions that we asked on the AMA-RFS survey was, "Have changes in your health care system ever compromised patient care?", which we thought was an important question to ask when we talk about quality—since residents are frontline deliverers of patient care, and therefore are in a position to know about quality changes.

I'm going to read just about three or four of these statements with you. They don't take too long.

- ◆ “Every day, working at a public teaching hospital, our department is so overburdened that patient care is often not up to what it could be. Our private clinics are also in a similar situation because of poor reimbursement rates with our managed care contracts. Furthermore, California legislation mandated a 25 percent cut in the number of specialty residents and greatly exacerbated our inability to care for all our patients who are coming in to see us.”
- ◆ The second comment is, “In surgery at both places that I’ve been, I did my internship separately. I’ve seen patients die as a direct result of understaffing and lack of attending supervision. There’s quite a few things about people jumping on the bandwagon early and making incorrect decisions based on sort of the special cause variation. Such as a verbal order of wrong patient medication was given and now the result is that no verbal orders are being accepted by nursing staff.”

We have a bit about staffing.

- ◆ “On our ward there’s a very limited number of nurses available and with high turnover, their experience base is quite limited. This has resulted in multiple patient medication or order deliveries per month. It makes the resident’s job more difficult because we have to be significantly vigilant in making sure that medications are given and orders are completed in a timely fashion.”

A couple of these comments discuss the impact of over-work, such as tired residents are who not sharp-minded and forget crucial lab exams or doses of medications. The list of anecdotes is quite extensive. You will be surprised and interested, sometimes horrified and other times mollified, to see what these residents had written.

The next area we explored in the AMA-RFS survey was about the quality of resident training. The ACGME has set some wonderful standards for training in a variety of areas. We asked our residents to quantify the quality of that training on a scale of one to five—from terrible, inadequate, adequate, very good, and excellent.

The good news is that most residents felt that the quality of their training in medical knowledge was actually quite good. As was their overall ability to care for patients, and also their overall educational experience.

However, this is the bad news. When we looked at other paradigms and the ability to navigate within the current environment in medicine, we found that our residents rated as “terrible or inadequate” their training in health policy, practice management, research, interactions with system, staying current with medical knowledge, which is personally very scary, teaching, communication skills, and professionalism.

I thought that Dr. Dunn might mention a little bit about the work hours violations noted by the ACGME on their last cycle. About a third of internal medicine programs,

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which actually do have specific work hour limitations, had noted violations of the work hour limitations by programs as did about a third of surgery programs if I'm remembering the numbers correctly. When we talked to the AMA residents, they said that on average they were working about 85 hours per week on the ward, ranging anywhere between 64 to 130.

The quality of the work experience as well is important, not just sort of the quantity of the work experience. Forty percent felt that work load was too high to adequately care for patients or to learn well. Thirty-five percent had too much non-educational scut-work, inadequate rest and dining facilities, and a few mentioned that they were unsafe on call.

Thirty percent of residents reported that their ability to resolve problems within their system was either "terrible or inadequate", which is again a sign that our system is still really not where it should be. When we consider funding changes, these are important areas that we need to be thinking about. One of the questions that we had wanted to know was, when you have a problem within your training program, who do you actually go to? And how easy is it to resolve the problems? And 33 percent said that their ability to resolve problems within their program, once brought to attention, was either "terrible or inadequate."

On this slide, please notice the column of which entity addresses the problems raised. The majority of people who address problems that residents bring to their attention tend to be people within the program, such as chairs and program directors, or other residents. People who had housestaff associations actually used them.

But interestingly, when you look at the effectiveness column, the people within the program tend to be some of the most effective, along with the housestaff association. Government was perceived as being reasonably ineffective, making the problem, or not changing the outcome.

The next thing that I wanted to talk to you about was resident well-being. Resident physicians are a group of learners who have committed between three to seven years of their lives to learning a profession and to hopefully practicing it quite well.

And within that system and during training, we must make sure that the people who are providing service and who are going to be joining the workforce are well rested—and satisfy at least some of the Maslow's "hierarchy of needs," however you feel about the hierarchy itself.

One of the goals within programs should be to build good citizenship patterns. And residents rated "terrible or inadequate" their involvement in community service or ability to do so. And also terrible or inadequate as their ability to continue outside reading.

So why do we have these problems within the system? Clearly, we have an overburdened system dependent on trainees for local patient care and that's been brought up already today, with more patients of higher acuity.

Residents often cover planned leaves of absences, going from q3 or q4 systems to q1 or q2, so they're on almost every night with almost no break, and I can give you multiple examples of that if you're interested. And there's often inadequate staffing levels for ancillary support.

The next question is about medical debt. When we talk about medical debt, we really need to rephrase this as talking about educational access. This is an educational access issue—the same way that college funding support is an access issue.

If you want minorities and under-represented groups to be able to get into medicine, they need to be able to manage their debt in reasonable ways. And I'll share an anecdote about that after we finish this section.

The average debt per resident is about \$86,000, that's including both public and private schools, although for private it's somewhat more. The average resident income is about \$37,000. Length of post-doctoral training is between three to six years.

An example: Steve is a third-year emergency resident in Ohio, who some of you in this room actually may know. He's single, unmarried, and no dependents. His debt is \$93,000 per year and at a ten-year repayment at 8.25 percent, he owes about \$1200 per month. His income is \$35,000. But because he was getting married, he felt that it would be nice to be able to moonlight and save a little bit.

His gross income was about \$3600 per month, which sounds like a lot until you subtract loans and taxes. There are two criteria needed to qualify for deferment. He initially qualified for loan deferment because he could claim economic hardship—for the first three years of his residency as long as his loan repayment amount was greater than 20 percent of his adjusted gross income.

The second criteria is AGI [adjusted gross income] minus loans is less than 220 percent of the state poverty limit. However, when you took a look at Steve's numbers, his AGI, which was \$44,400, minus his loans, it really wasn't less than 220 percent of the poverty limit. In Ohio the poverty limit is \$10,400 for a family of two and he was above the limit.

So he had two options. He could either go into forbearance with capitalization of interest and debt burden increases, or he could enter repayment. He chose to enter repayment.

What does this really mean for a post-doctoral learner? Let's look at the slide. Steve's starting salary at the beginning of the month was \$3,600. After 25 percent in taxes it decreased as seen. After repayment, \$1200, again you can see it decreased. He has a very small apartment, \$500 a month in rent. And he has a car that he financed for \$400 a month. So his wage, really what he had to live on after normal living expenses, was \$573.

After paying for food, utilities, and gas, and putting a little bit in his IRA that didn't fill last year, he had \$20 a month, six percent of his total income. He's 31, he's single, and he has no kids. His friends with kids have to double their salary to save any money.

Similarly, John is a fifth-year neurosurgical resident with a similar profile. He again did not qualify for deferment because he was past the initial three years. After paying all his expenses, repayment, taxes, rent, and car, because he had to drive to get to the medical center, he had \$275 left to live on for food, utilities, gas, and savings, and not including perhaps taking a dinner out periodically.

This becomes an educational access issue.

The next issue of concern for residents is practice choice. We agree that workforce needs are very important and we must equitably address maldistribution of the medical workforce. But right now we have inaccurate predictors for the medical needs of the country. Before we tie educational funding to workforce, we really need better data on the relationship between the two. And of the determinants of practice choice.

Where one trains is not necessarily where one ends up working. That choice is influenced by a lot of different factors. Personal affinity and role modeling. Goals for patient care. Management. Research. Lifestyle. Geography. Familial responsibilities. Often the couples match is much harder than the single match. Although GME funding can be tied to practice choice, it is hard to dictate to adults what they should do with their lives. Plus, there is a seven to ten year lag between the determinants of a population's medical needs, and incentives to get learners to choose a profession, be trained, and move to a practice area. Such planning does not always account for innovations in medicine, or in population distribution changes.

Finally, faculty training and adequate supervision is very important. We must be one of the few professions in which our educators have no formal training aside from the role-modeling that they observed during their own training.

Our faculty have almost no training in teaching skills, communication skills, leadership style, assistance-based improvement, attitude, or behavioral modification methodologies.

Faculty are being asked to do increasing paper work. They anecdotally spend less time teaching directly and less time with patients. When I was attending on the wards last year, that's exactly what happened. I spent four hours a day documenting. I spent at least two to three hours making sure that I had direct resident contact and my patient contact fell off dramatically.

So why is this? We believe that teaching is undervalued in most institutions and it tends to be an unfunded mandate, which is interesting because our Medicare payment system is supposed to help compensate for that.

There's a hidden agenda versus explicit agenda. A hidden agenda being, you know, just go see more patients, generate revenue. The explicit agenda, we value education. And productivity measures are usually tied to patient revenues. And we see this in the sense that faculty volunteerism is decreasing.

So to contribute to the plethora of recommendations, we had a few recommendations from the resident and fellow perspective.

First, the all-payer system seems a rational and equitable way of financing health care. And while building a trust fund for GME, the actual amount of the fund should be based on good research about the actual costs of resident training. The concept of an all-payer tax on insurance premiums has been intriguing. I was very curious about what the insurance premiums actually were. Premiums are increasing almost every year. A small additional tax will not be too great an individual burden. Here you can see a few numbers from employer-based premiums from '95 to 2000, and you can see that these are significant increases each year.

The next item is accountability. No one knows where GME money goes. There's no paper trail. How much money does it actually take to train a resident? How much money makes it to the resident?

We need to quantify the academic health care missions in ways that are transparent. There's no reason not to do this. When I've been interviewing for faculty jobs and I've gone and asked people, so what's your per-resident payment?—most program directors have absolutely no idea. They've said, "I've gone to my hospital director and asked him, 'How much are you getting for all the residents that we're having in here, so we can try to figure out how we can adjust the system of care so that we're providing better teaching?'" And the administrator can't or won't tell the program directors. Again we need to allow educators or physician entities responsible for the education to have some control over this funding.

So the next big issue of course is, to do this, we need really good research to quantify true training costs. And the research will only give us a snapshot of where we are. It

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doesn't necessarily tell us where we need to go unless we can get really good predictive models. How much do residents actually cost to educate? How much does it cost to have faculty-supervised teaching learning new skills? How much is our current physician workforce actually practicing? And what are the real workforce projections?

We would strongly recommend that funding should not be tied to workforce objectives pending better data on current workforce and the true U.S. population needs.

The last two are quality control and debt relief. We need to build in mechanisms to remediate programs that don't meet key accreditation standards.

If a program isn't ensuring good quality, in some ways we need to make sure that the accreditation system is tied to the funding system. We'd like to strengthen the ACGME in some unknown, to be determined, way and maybe Marvin Dunn can actually solve everything for us. If not him, maybe David Leach. Funding should not be tied to workforce, and I mentioned that already.

And finally, debt relief. We need to make sure that DME/IME makes it to the resident to provide adequate debt relief and also importantly, a living wage. These are people who are dedicating their lives to their patients for several years within their training program and probably for the rest of their careers.

And so with that I wanted to finish with a small story. I was at the National Hispanic Medical Association meeting a couple weeks ago. Anita Moncrease had substituted for Sam Shekar as a closing speaker and had related a very interesting story.

A young boy who used to ask his father every night to tell him a story. His favorite story was a lion who would go adventuring through the jungle. The lion would run with kangaroos, play with monkeys and bears. In the end, the lion always fought and struggled with an alligator at a pond. In the end, the lion would always get eaten and die. But it was the child's favorite story. And so every day the father would tell the story, and at the end the lion would struggle with the alligator and get eaten up and die.

One day, the son said to the father, "Daddy, why does the lion always die?" And the father said to the son, "Well, as long as the lion doesn't write his own story, he'll always end up dead."

Thank you.

DISCUSSION FOLLOWING PANEL 3

DR. GETTO: That's the toughest act to follow. We have a few minutes for questions. Don.

DR. THOMAS: As one of the people who insisted that the issue about the accountability of attendings be addressed in the report, I'd like to address this question at the comment that was made that MedPAC was interested in quality and that's why the documentation rules were kind of structured the way they were. I thought maybe you should hear part of the discussion that lead to the comment that was in the book.

The attending physician is responsible for the care of the patient, just like they're responsible for the education of the resident. Writing a separate dialog in the chart is simply a time-wasting proxy for doing that activity. They're responsible for all the documentation in the chart in the first place.

If there's something in that chart that's in error and they have signed it, they're responsible for it like they wrote it, but it is subtracting from the things that they need to do to require them to write separate treatises in the chart. And furthermore, it encourages them not to read anything that anybody else has written, which they're also responsible for.

So unlike what seems to be presented, it is not, in my opinion, a quality issue to have folks write down what they see, and in fact, is a disincentive to quality medicine and supervision.

MR. LISK: As I indicated in my presentation, MedPAC has not looked at this issue. What is important, however, is that rules be in place that ensure quality patient care is being provided when residents and other trainees are providing patient care services to Medicare beneficiaries. A second point, though, which I failed to mention, is that these rules are also in place to ensure that Medicare is paying for services that are provided to beneficiaries and that the supervising physician plays a sufficient enough role to be reimbursed for the care provided to the patient. Since the Commission has not examined the current teaching physician rules I cannot say whether they help ensure that quality care is being provided by residents or that the requirements the supervising physician must meet to be reimbursed are appropriate. My only intent was to say that quality of care is important and that sufficient rules need to be in place to ensure that the care being provided by residents and other trainees is appropriately supervised.

DR. GETTO: Yes, Robert.

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DR. JOHNSON: It concerns me a bit that the quality of the nation's health care system has become equated with the quality of residency education/training. And clearly quality of education is a prerequisite for quality of medical practice. But after the resident leaves residency and then goes on to practice, there are so many other issues that are involved in that.

And the proportion of individuals who are juxtaposed to residency as opposed to the proportion who are years into their practice or individuals who didn't even complete a residency program is so great, that there are just so many, many other things in the equation.

And I think that Marvin, in addition to looking at ACGME competencies, and I absolutely agree that's important, we really need to also begin to look at the continuing education of individuals in practice to assure that they are practicing a quality of medicine.

Now maybe that's something for state boards and medical examiners of the federation. Each state differs on whether or not they require CME [continuing medical education]. Hospitals may differ on whether they require CME. And then the definition of what CME is, or even the regulation of CME differs all over the place.

So I think we have a problem that goes far beyond residency training to assure quality. I think the one place in medicine that we do have some good controls is in the residency program, but beyond that, we really have a huge problem.

DR. DUNN: I totally agree with you. Residency training is not the end-all, be-all, but it is a very basic beginning. And if roots and habits are not inculcated there, they sure are not going to get picked up later on.

And secondly, I'm sure you're aware of the fact that the boards are very much getting in line on this. ABIM [American Board of Internal Medicine] has a very sophisticated program for example, which includes how a person comes into the board and has a portfolio to demonstrate their professionalism.

Now it's been a long time since somebody said, Doctor, you come in and tell me how I know you are a professional. We just all assumed each other were professional. And we've learned that's not always the case.

So I agree with you and it's a lifetime of learning.

DR. GETTO: I can tell it when I see it, right? One more comment, Don.

DR. THOMAS: One indication of the devaluation of teaching as a specialty profession, at least in our medical area, is the ranking of the CME ratings that you give for teaching versus doing some direct education processes.

And the thought occurred to me that in order to teach, you really ought to have a quality learning experience and maybe certifying the learning experience and then making the teaching experience a higher level of CME might encourage a lot more people to do it better, and would still give credit for it in the licensing process which is monitored a lot more closely and a lot more often than some of the other things that we do.

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DR. GETTO: We're going to get the next panel started. To begin the discussion, I'd like to introduce Jan Towers, who's the Director of Health Policy for the American Academy of Nurse Practitioners. Jan has been on the graduate faculty at Penn State University in the nurse practitioner program. She has had positions in Maryland as well, and she has been very active in health policy at all levels and in advising on health policy as it pertains to nurses and nurse practitioners. Jan.

DR. TOWERS: Thank you.

So that you can relate to me better, I have served for eight years on the faculty of Penn State Medical School with the Department of Family and Community Medicine.

So in some of my speaking, in terms of understanding how residency programs work, I was very much involved in residency training, and perhaps am in a position to see how the kinds of things we do in nurse practitioner training relate very closely to the residents.

What we found in those settings was that the relationship of these two groups was actually much better than trying to combine things with nurse practitioners and medical students for instance. A lot of this had to do with the fact that nurse practitioners are a group of professionals who are going back to school for advanced clinical training just as the residents are. Thus the ability to relate to one another professionally at that level was much better than if we tried to do it at different levels within the framework.

Given that, I'm really here to speak to you about how we can try to pull nurse practitioners into the scenario of graduate medical education as it pertains to your report.

One of the things of which we are very aware is that there continues to be a tremendous need for the provision of primary care in the United States. We still have 44 million people that are uninsured. We still have 2500 sites, National Health Service Corps sites unfilled.

We now are talking about significantly increasing the number of community health centers and we're going to need providers in those particular areas.

One of the goals of the COGME report is to provide adequate support for training clinicians to provide care in community settings. This is another area where nurse practitioners, of course, are very much involved. Thus, the need for us to team up in relation to those things, that is, try to create things together, I think becomes particularly significant.

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So while the major focus of your talking today had been on residency education, I'd like to pull the nurse practitioner component into this for just a few moments and plant a few seeds.

There have been multiple studies and recommendations such as those of the PEW Foundation and The Institute of Medicine, that recognize the need for inclusion of nonphysician primary care providers such as nurse practitioners in the body of primary care and for the provision of support to the preparation of these providers.

One of the problems we have within our framework as nurse practitioners is that there is little funding for this from federal or state programs. In addition, we're not a part of the other piece of GME that deals with allied health, and have never been so because of the way that particular program is structured. So looking at the inclusion of nurse practitioners becomes more important.

The recognition of new practice designs, the need for increased cooperation and collaboration among clinicians and the need for interdisciplinary approaches to enhance the quality of primary care is clear. I think you spoke to some things related to interdisciplinary approaches this morning.

If we include nurse practitioners in the scenario, I think it can give a great deal of relief to some of the stresses that we are having within the health care system at this particular time.

Nurse practitioners have been studied extensively. We know that they give quality primary care, that they are safe, that they are cost effective, that the emphasis in terms of their educational preparation, from their basic nursing preparation through their advanced preparation, focuses on some things that are not as popular within the medical community.

And sometimes primary care, requires a lot of teaching and working with patients in the proactive mode and doesn't create some of the excitement that you have when you cure someone of a very serious illness.

On the other hand, we have an increasing body of people with chronic illness. One of the things that nurse practitioners have in their background is a lot of preparation in relation to dealing with maintaining the health and well-being of people with chronic illness, and the multi-problem frameworks with which they have to deal. These are the kinds of things that we want to try to emphasize.

As I mentioned, the conceptual model for advanced training in terms of nurse practitioners is very similar to the advanced training of residents in terms of having a professional who is already licensed, who moves forward to get additional training in relation to a specific specialty.

So some of the educational frameworks nurse practitioners can administratively work in are very similar to that of residency programs.

In looking at the report, there were two aspects under consideration. The first part were the alternatives, the different ways that this might in fact be done. The second part, of course, were the recommendations that you made based on what we have now and how you just can't just up and change it.

But if you looked at those first alternatives, it struck me how easily we really could fit nurse practitioner training programs into the same framework as the residency training programs.

The one that they talked about first, of course, was the Health Care Provider Model and that perhaps is the most limited for us because we'd be talking about a relatively small number of nurse practitioners within that venue.

But it would be an easy thing to incorporate and we actually did back in the early days of the Clinton Administration, have a proposal that was called a GNE proposal that was framed on an all-payer system, that was to pair up with GME at that particular time to subsidize clinical training of nurse practitioners in a way that would be very similar to that of residents. We actually composed formulas to show how the clinical training in terms of what we call preceptorships, similar to what you may call internships or residencies, actually could fit within the venue of our training programs.

The "education model" is even more positive from the stand point of incorporating educational programs because it would provide windows of opportunity for collaborative administration. Some of the same kinds of things that you would propose for residents could be proposed for nurse practitioners doing their internships or residencies or preceptorships in their clinical settings.

The "planning model" had the same thing. It allowed for the development of consortia, for looking at local workforce issues and needs, looking for what is needed in terms of health care in a community, much in the way we do with the National Health Service Corps, where a variety of providers might be used and trained within that framework. And so that too has some very positive aspects.

In the "performance model", where you're serving the medically underserved, we probably could enhance things for you a bit because nurse practitioners are very well-known for their activities in working with the underserved. A lot of this has to do with their strong preparation in community health and the fact that there is a certain Mother Teresa quality about nurses that makes them move into these areas and really find it a very rewarding experience where others might not find this quite so rewarding. So the need to provide incentives is not as great.

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When you look at the recommendations, I think there are a lot of possibilities, for there to be a way to join in some new endeavors that would allow the two groups to be able to work together and actually formulate ways that we could cooperatively work in these areas and help to shore up preparation for both groups.

In the area of recommendations, I think the thing that was most noteworthy, is the framework that talks about the all-payer system, because this would be a very good stepping off point for all of the groups in relation to the fact that you're now going to be looking at a scenario that brings in monies from more than just one pot, which is an ever-limiting pot. So there would not have to be any taking away of monies from one group to try to start providing support for others, and yet we still would be able to get a group of primary care providers out there that would be interdisciplinarian working together and perhaps deal with some of the cost issues as well as the quality issues of health care.

One of the statements is that you want to provide high-quality efficient training, and I think that speaks for itself. The more efficient we can be in the way we give care with the kinds of people that we pull together to give care, the better the care is going to be. And what we know from all the studies that have been done is that the team approach has certainly worked better than anybody working in isolation. That certainly is the framework under which we work and we would presume that you would want to do the same.

In terms of some of the other things related to your recommendations, there are a number of places where you're examining how to make appropriate payments and how to do research to explore alternatives. This again would be a good place to begin to open up and look at not just how you could do this with residency training, but to do it with people like us, nurse practitioners. Then you could begin to test out certain things to see how they might or might not work.

The issues of higher payments for community, are things that probably, as has been pointed out, need to really be examined. And some of the things that they've been considering, such as, whether it really costs to have students being trained in an area, and this includes all of our students, or is it really something that actually helps to save money and actually raise the quality of care within a setting, I think are questions that people are raising that we need to answer. But we need to have all of us in those examinations so that we are looking at those things together. The opportunity for special projects and demonstration projects, to try out some of these scenarios where you have some doubts about whether there should be an interdisciplinary approach, I think again, there are opportunities here to try to build some things into whatever is put forth in terms of legislation.

One of the other things that I would point out to you is that nurse practitioners, and another group of nurses that functions in this way as well, nurse midwives, have served on faculties of medical schools and in residency programs for many, many years. They run into the same problems that the attending physicians do in terms of the record keeping and what do you do with the person who is under your tutelage when you're responsible for the care of the patient that they are seeing.

And of course, we have the same problem with our nurse practitioner students. So that trying to figure out what is the best case scenario for this is something that we are as concerned about as you are and certainly want to work with you in relation to these particular issues.

So I guess the point that I'm here to make is that we would like to work together with you, that we try to find a way to fold nurse practitioner training in with the residency training, and do some things in tandem. We certainly don't want to take away from funds that would be utilized for residency training. On the other hand, I think we have an opportunity here to move things in such a way that we might be able to fold the groups together in some things or to do things cooperatively that might facilitate and enhance the development of both these groups so that we really have good primary care providers out there carrying the load in a way that they're able to share it, provide quality care, and have a cost-effective framework.

And of course, what we really want, all of us, is a healthier America. So I thank you for the opportunity to bring our views to you.

DR. GETTO: Thank you Dr. Towers. The next speaker is Dr. Olga Jonasson, who is the Director of Surgical Education and Research for the American College of Surgeons.

Dr. Jonasson has been on the faculty of the Department of Surgery at the University of Illinois, and was Chief of the Division of Transplantation. She was Chief of Surgery at Cook County Hospital in Chicago and later on the Robert Zollinger Professor and Chair of Surgery at Ohio State. She has been at the American College of Surgeons since 1993. Dr. Jonasson.

DR. JONASSON: Thank you very much for the opportunity to present some views on behalf of the American College of Surgeons on the Fifteenth Report.

First of all, the College would like to commend COGME on its work products, especially in studies of the physician workforce.

Early on you identified general surgery as a stress speciality, and likely to be inadequately populated to serve the growing population of the elderly. Your recent workforce

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analysis, the Fourteenth Report, calling into question the 110:50/50 assumptions, is particularly important in the context of this, the Fifteenth Report.

The College has had a long interest in the surgical workforce, beginning with its seminal analyses in the 1970s, the “Study on Surgical Services in the United States,” the SoSSUS report, and more recently, we have been engaged in testing Cooper’s Trend Analysis Model as described in your Fourteenth Report in the surgical specialties of neurosurgery and neurology. Thus we strongly support the establishment of specialty workforce goals that are data driven, and established on the basis of evidence. To our knowledge, the 50/50 goal was arbitrary and has not been supported by data such as Cooper has presented. Use of GME funding to accomplish workforce goals, we believe, would only be appropriate if data were available to support those goals.

Medical students make career choices based on a number of factors. Personality, interest, role models, perceptions of job availability, and other factors. Nowhere in their decision-making algorithm can be found the factor of how much GME funding a particular teaching hospital receives.

Each year since 1982, the College has conducted a thorough and comprehensive enumeration of residents enrolled in and graduating from surgical residency programs. We have shown that there has been no change in the number or specialty composition of surgical residents for at least the past 20 years. It is a flat line. Surgery positions in residency programs are tightly regulated by their residency review committees based on the program’s resources and patient population. And all surgical programs remain highly competitive.

In this light, we find that the .5 funding level for surgery residents beyond their PGY-5 year to be puzzling. It has had no effect whatever on the number of residents in these programs. In fact, the only measurable effect has been to further stress teaching hospitals and dramatically reduce the time that surgical faculty can spend on teaching and research.

There is a reason some surgery programs are so long. It takes years of exposure, progressive responsibility and caring for a broad variety and complexity of patients before a neurosurgeon for example, acquires the necessary skill and judgment to become an independent practitioner. The institutions and the faculty in neurosurgery supporting such a residency program should not be penalized for providing the nation with competent neurosurgeons, as they are today.

By nature, surgery residency programs must take place in large tertiary care hospitals. Most program graduates cannot and do not stay in that community to practice. We find the recommendations that the communities’ perceived physician workforce needs should play a role in GME funding to make no sense for surgery programs.

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We concur with your recommendations pertaining to the supervisory role of teaching physicians and believe that modification of the present rules along the lines you suggest will be more consistent with the principle of graded responsibility and gradual independence that has been critical to the American system of surgical graduate medical education. Parenthetically, the system, is admired and emulated worldwide.

There is vague reference in the report to various incentives to programs to achieve certain goals. We completely agree that one of those goals should be diversification of the workforce. The much desired goal to achieve better distribution of surgeons, for instance, to underserved areas has very complex implications for the entire health care system. An important incentive, however, to graduates of these long surgery residency programs to locate in underserved areas would be, as Dr. Srinivasan so well put it, educational debt relief in some form. And we urge that the Council take further consideration of such a program in management of debt for residents very seriously.

Thank you very much for the opportunity of presenting these comments and I will be happy to answer any questions.

DR. GETTO: Thank you. Thank you very much, Dr. Jonasson. The next speaker is Dr. Richard Pan who is a member of the American Academy of Pediatrics Committee on Pediatric Workforce. That document which Dr. Pan authored, or helped to author with the Committee, has been available to several of us before this meeting.

Dr. Pan is currently an Assistant Professor of Pediatrics and Associate Pediatric Residency Director at UC-Davis [University of California at Davis]. He's held several leadership positions in the American Academy of Pediatrics and the AMA and as I mentioned, he is a member of the AAP Committee on Pediatric Workforce and the lead author of the policy statement on GME financing.

Dr. Pan.

DR. PAN: Thank you very much. I'm pleased to come in from Sacramento, California, to speak to you today representing the Academy and the Academy certainly is very appreciative of this opportunity to contribute to the "stakeholders meeting" of COGME.

And I also want to state that I'm not only speaking as a member of the Committee on Pediatric Workforce, but also as someone who is really on the front lines as a program director and a clinical director and someone who's also hopefully not so long ago been a resident leader as well. So I hope to bring all these perspectives together.

So what I would like to do is actually discuss the recommendations of the American Academy of Pediatrics statement on graduate medical education financing and go through that and present that to you.

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I think that you'll find that many of the conclusions we've come to are similar to those of your own and certainly I won't go over much of the background information which you are probably more familiar with than anyone else.

So first of all, our first recommendation is one that has been supported by COGME, which is to create an all-payer trust fund and I think many other organizations have agreed and are also supporting that particular position as well.

I just also want to make a point that I think fundamentally our statement is basically based on two principles. One is that graduate medical education is a public good, and I know that many other speakers have previously said that, although I understand some other speakers have disagreed with that particular statement. But we really do strongly believe that graduate medical education is a public good.

And second of all, if you're looking at your report's discussion of different models of financing, that we really believe graduate medical education financing should address education. That we're really talking about how we finance a public good, namely graduate medical education.

So our second recommendation is that GME funding should be paid to the entities that incur the cost of residency education. I think as far as the particular mechanism, we're certainly open to the idea that the funding could go to a sponsoring institution which would then negotiate with individual sites as they determine what kind of experiences the residents will have.

But we do think it's particularly important that that financing does flow down into those particular sites and I think, as was previously mentioned, many community health centers and other sites currently do not receive any funding and that this could be a great inhibitor to training in the community, which is an important priority to the Academy.

Our third recommendation is that freestanding children's hospitals should receive GME funding at the equivalent level as other institutions. And I think that it's sort of I believe implicit in your report that basically all residents should be treated the same. That because we're looking at graduate medical education as a public good, that we shouldn't be treating some sets of residents differently than others.

And I think that also points to the difficulties of having a Medicare-based system instead of an all-payer system where all-payers, all people who benefit from graduate medical education should be helping to support that.

Our fourth recommendation deals with capitation, that GME funding should not be included in capitation payments for clinical services. I know this has been an issue

that's sort of come and gone, but we're afraid may come back again. So again, we hope that any sort of mechanism that is used to finance GME not be a patient service one that could be folded into a capitated rate, and without accountability for supporting graduate medical education.

Our next recommendation is that the distribution of Medicare indirect medical education funds should be uncoupled from the number of residents from the teaching hospital. This is in principle the same as what I think COGME has been thinking about as well and I know that many of the hospitals are particularly sensitive to this issue because IME funds are such a large proportion of medical education funds.

But I think that both the Academy and COGME understand that IME funds actually aren't really about medical education necessarily. Some of it may be, but that, in fact, much of it has to deal with other missions. And we do strongly believe that those missions need to be funded.

Our approach is a little different in where we're broadening our definition of DME to include all the educational costs and saying that IME still needs to flow to the hospitals, that we cannot just reduce those because they do represent critical missions that our teaching hospitals provide to society, but that they should not be linked to resident numbers, so they should not be driven by residents, they should be recognized for what they are.

Our next recommendation is that we would recommend a portable authorization system for use by graduates of accredited U.S. medical schools and other qualified recipients as a possible mechanism for distributing GME funding.

And this particular recommendation is based on the difficulty I think that all of us recognize. Everyone talks about how we need to get better data and do more studies. I think there are certain limitations to how much we can do studying one point in time to try to figure out what's going to happen in the future.

The Academy believes, at least at this point in time, we have not heard an alternative mechanism and are certainly open to hearing other proposals to distribute GME trust dollars to residents.

I think that if there was a centralized system where one body would make a decision about how much each specialty would get, it would become overly politicized. We do think that you're going to need a workforce body to sort of decide on an overall cap or number of positions you would fund as an overall way of looking at it.

But in terms of trying to decide how you would distribute things between specialties, that really the students themselves can be an excellent mechanism for making that sort

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of distribution. And I think that would also involve educating students more about what the market is and also the demand and the needs of society.

But I think that the students themselves, because they have a vested interest in both getting a good education—I believe most medical students really do look for good education—and also they have a vested interest in being able to practice in the future and looking for positions which are viable, that this would be an appropriate way of distributing these funds in a more responsive manner than trying to do a top-down mechanism.

Our next recommendation is that pediatric subspecialty physicians also get funding for graduate medical education and I think this speaks to some of the previous speaker's comments about the .5 funding level and the 50/50 distribution and so forth.

Not all subspecialties are in oversupply. I'm sure that everyone wants to say that their subspecialty is not in oversupply, but I think there is credible evidence that there are several subspecialties that are in undersupply and when we look at mechanisms, they also need to be funded by a GME financing system.

We feel that's the case particularly in pediatric subspecialties. I'm sure there are other specialties, but that needs to be looked into. You cannot treat all subspecialties the same in a blanket manner.

Finally, we do recommend that for children in underserved communities, there need to be mechanisms to ensure that there's an adequate supply to address geographic maldistribution. We do recognize that our proposed portable authorization system really addressed trying to be responsive to specialty demands. It does not really address the problem of geography.

And that is a particularly difficult and troubling issue for the Academy to try to wrestle with and I'm sure that it's been probably difficult for COGME as well. There are many different factors that go into how residents decide what they want to do after residency and they can include not only factors about pay or debt, but also about spouses and families and where they might locate to.

And also that in many subspecialties and specialties, there are both national and local markets, although many primary care residents may stay in the area in which they did their residency. I think for some of our subspecialty training and even a lot of our primary care residents, that they go all across the nation and that while I think there needs to be local input into training decisions and how many residency positions and so forth, we need to recognize this is also a national market as well as a local one.

So it's particularly important to create national level programs to provide incentives for people to participate in underserved communities such as the National Health Service Corps providing funding to community health centers for graduate medical education.

Finally I'd like to touch on COGME's recommendation about documentation. There is no official AAP policy on this. I'm going to speak more as an individual who has participated in many discussions with my fellow pediatric educators.

We too agree that this is an onerous burden—the current Medicare documentation rules. From my understanding, those documentation rules are really due to the fact that Medicare has taken the approach that GME financing is really about patient care and it's not about education. And I think we heard that reflected in some of the previous testimony. And certainly they would be justified in saying that if they're already paying for the resident, they shouldn't have to pay the attending unless they write a separate note. However most payers do not pay for the resident, but use the same Medicare rules and want to receive the resident's service for free.

I think that we really need to talk about graduate medical education as education and talk about GME financing as financing a public good. Thank you very much.

DR. GETTO: Thank you very much. The next speaker is Jack Ginsburg, who is the Director of Policy Analysis and Research, the American College of Physicians – American Society of Internal Medicine. Jack.

MR. GINSBURG: Good afternoon. The American College of Physicians – American Society of Internal Medicine, represents 115,000 doctors of internal medicine. About 16,000 of our members are medical students and 20,500 are physicians in residency training. About half of our remaining members are involved directly in graduate medical education.

The College has a long-standing involvement with public policy on graduate medical education and financing. We've had extensive policy papers, positions going over the past 20 years. But in light of the deliberations of COGME in developing this Fifteenth Report and of MedPAC developing their report, and other deliberations including proposals in Congress, we decided to take a look at all of our policy positions and identify our core values, our core principles regarding GME financing and physician workforce.

What I'd like to do today is to share with you those core principles and then briefly analyze the COGME recommendations against those principles. That's the framework we've decided to use in evaluating all proposals on GME financing.

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In brief, I've identified the core principles that were most relevant to the COGME report.

First, all health care payers should share in the cost of graduate medical education. Physicians should be educated and trained in proportion for a balanced mix of generalists and specialists.

The expanding roles and increasing numbers of nonphysicians must be considered and supply of these health professionals should also be adjusted to reflect national needs and requirements.

Workforce policy should improve the geographic distribution of physicians. Incentives should encourage all health care professionals to meet the health care needs of the underserved.

Funding for GME should be sufficient, predictable, and stable to support the academic, patient care and research missions of teaching hospitals and ambulatory training sites, including a disproportionate share of hospital costs for the indigent and underinsured.

Now regarding the specific COGME recommendations. ACP-ASIM supports the proposal to combine the various federal funding streams for GME into a single fund that would be supplemented by contributions by all-payers.

ACP-ASIM is concerned that reductions in the IME payments will be made before alternative funding is assured. This would be inconsistent with our core principle that funding should be sufficient to support the various missions of teaching hospitals and ambulatory training sites.

The College cannot support reductions in IME funding unless and until the additional costs of teaching hospitals that are now reflected in Medicare IME payments are replaced by alternative sources of funding.

Now, we are very pleased to see that in the COGME Fifteenth Report, you did recommend that a transitional implementation be used so that this would be accomplished.

ACP-ASIM favors allowing the program sponsors and training sites to determine the allocation of direct GME funds under an all-payer system. This recommendation, as well as the ones to require written agreements, availability of model agreements and information, and for accounting for residents time in various settings should be accomplished with as little administrative burden as possible for program directors and teaching faculty.

On recommendation four, the College favors development of a coherent and coordinated national health professions workforce policy to achieve optimal balance between supply and requirements for health care personnel.

However, the College emphasizes that further research is needed to better determine health workforce needs and to separately identify the costs involved in GME.

ACP-ASIM supports the recommendation to modify current Medicare provisions concerning training in community-based sites to benefit all such programs, not just those established after 1996.

The College also supports the COGME proposal to modify the caps to apply to the number of residents in all programs sponsored by an institution rather than only the hospital serving as training sites.

ACP-ASIM supports the proposal to allow adjustments in the balanced budget act limits so that caps would not apply to primary care residency programs whose graduates practice predominantly in areas with low physician-to-population ratios.

Recommendation six, ACP-ASIM supports the use of special project grants and programs to support high quality community-based training and for achieving national health workforce goals. The College strongly supports enhanced funding for Title VII grants for primary care residency training and faculty development.

ACP-ASIM applauds the recommendation for incentives for residents who agree to provide services for medically underserved populations and for transitional funding for replacement of residents in hospitals that incur high amounts of uncompensated care costs.

Recommendation number seven, ACP-ASIM strongly agrees with COGME that current Medicare supervision and documentation rules for teaching physicians must be revised.

The impact of the teaching physician rules should be evaluated and there should be clear and reasonable documentation requirements.

ACP-ASIM also supports revising the rules for residents who are beyond their initial residency training years to permit Medicare payment if the teaching physician is immediately available, reviews the patient's medical history and care with each resident during or immediately after the visit and documents his or her participation in the review and direction of services.

Finally, recommendation eight, specific legislative relief is necessary for safety net institutions that provide a disproportionate share of care to low-income and indigent

patients. ACP-ASIM strongly supports the COGME recommendation to provide additional financial support to these training programs.

In conclusion, the Fifteenth Report of COGME highlights key issues in financing graduate medical education and provides useful insight into how sufficient financing can be achieved under a system in which all health care payers share in the cost of graduate medical education.

The recommendations we found are generally consistent with ACP-ASIM core principles for financing graduate medical education, which also calls for a system in which all payers share in the financing of GME.

ACP-ASIM supports the recommendations for addressing current critical funding issues and alleviating burdensome supervision and documentation requirements for teaching physicians.

However, the College does not support recommendations for reducing federal financial support for GME until alternative sources of funding are assured.

I should also point out that the recommendations and analysis that I presented are being voted on by our Board of Regents as of today. So I'm sticking my neck out a little bit.

(laughter)

Our detailed analysis has been approved by our Health and Public Policy Committee and has been initially reviewed by our Board of Regents and there was no disagreement. The core principles, I had some handouts there on the table. I will be glad to answer questions later. Thank you.

DR. GETTO: Thank you, Jack. The next speaker is Dr. Perry Pugno, who is the Director of the Division of Medical Education, the American Academy of Family Physicians. Dr. Pugno has been a residency director for the last 20 years in programs from California to Connecticut and most recently he has chaired the ACGME Residency Review Committee for Family Medicine. And he has also been the Vice-President for GME and Medical Affairs at Mercy Healthcare System in Sacramento. Dr. Pugno.

DR. PUGNO: Thank you very much. I appreciate this opportunity to comment and I'm sensitive to the lateness of the day. I recognize that at this point in the day brevity is a virtue.

So let me simply say that I agree with about 85 percent with what's been said. Thank you very much.

(laughter)

DR. GETTO: That's the best offer we're going to get today, so thank you very much.

(laughter)

DR. PUGNO: Now that I have your attention, let me just say that the Fifteenth Report is indeed, in our opinion, a very positive report for several reasons. It includes a strategy for long-term support which I think is extremely important.

It is indeed consistent with the policies of the American Academy of Family Physicians, and it agrees with my personal value set of the way GME should be funded.

I'm gratified that the statement of GME as a public good is so clear in the report. I think that GME is a public good like air traffic control, where we have about 100,000 747's full of disenfranchised populations circling above us and our GME system is part of what keeps them aloft.

Let me just comment on a few of the specific recommendations. In recommendation 5.c there's a comment about graduates who practice in the low physician-to-patient ratio states. Although I agree with the need for data-driven workforce support, I think that we know a great deal about the holes in our current workforce system. I believe that's the low-hanging fruit that we can start moving on immediately.

However, instead of basing it on population, I think that it would be important to identify those places where residency graduates go, not so much the place that they practice, but the populations they serve. We know there are lots of practices that are located in medically underserved areas, but who serve only paying patients.

And so practices that serve rural, urban underserved, or programs that disproportionately provide graduates for the National Health Service Corps, Indian Health Service, and entities like that, I think would provide a better benchmark.

For recommendation six, the fund regarding special projects, my only comment is that the recommendation risks being misconstrued as not supportive of Title VII programs which have clearly demonstrated a positive impact on health care access in underserved areas.

Regarding recommendation 7.c, I think that reasonable documentation requirements are an exceptionally good idea and would recommend that the federal folks take a look at what some states have done for their Medicaid programs. I think North Carolina is a good example of a state that has identified teaching physician supervision guidelines that are very workable and a little bit less onerous with respect to documentation.

Finally let me mention, as Dr. Scotti mentioned this morning, that the shift of student interest away from primary care is very concerning and I think it bodes ill for our

objectives of 100 percent access with zero disparity. I think this is a workforce issue that we cannot ignore and must not set aside at this point.

Let me thank you again for the opportunity to comment and I'll stop there. Thanks.

DR. GETTO: Thank you very much. The final speaker is Dr. Dennis Zerega, who is Vice-President for the Office of Graduate Medical Education, University of Pittsburgh Health System.

Dr. Zerega has been involved in undergraduate and graduate medical education for 24 years. It includes service at Wayne State University School of Medicine, two community hospitals, and was currently with the University of Pittsburgh. He has been involved in just about every aspect of medical education and has focuses in teaching—is responsible for the teaching of 14 hospitals in the University of Pittsburgh system—and focuses on the improvement model.

Dr. Zerega.

DR. ZEREGA: It's good to meet all of you. It's always good to go last because you can win the audience's affection forever by being succinct and quick and I will attempt to do that.

I think all the points that I was going to make on the report have certainly been made. I think the Fifteenth Report, which has been released for about three months, when I first read it, I found it to be fresh, thought provoking, and a challenging proposal.

During this time, obviously, it was prepared by very bright, resourceful, and academically sophisticated group. It particularly appeals to those of us who have some background in economics. However, over the last year and a half I think all of us have seen our environment change in some accelerating ways and the good order postulated by economists has been replaced by the norm of the chaotic organization.

How many of you have heard that phrase? How many of you never heard it up until a couple years ago? About the same number of hands. And that seems to be the world that we're living in and that seems to be our norm.

Remember the good old days when our external financial reports really reported only our operational activities? All of our institutions now report operations and investments and that still only provides with us a very thin operating line.

In Pennsylvania, you'll see that that line for many of our facilities is between one and three percent. And as recent as a few years ago we were looking at four to eight percent. And we have several institutions that are very fragile as we move forward.

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As was mentioned, UPMC Health System is a very large undertaking with a clear mission dedicated to quality care, secondly research, and thirdly education.

We have 14 teaching facilities and for those of you in pediatrics, as of Friday, we added the fourteenth, which was CHOP, which is, I just learned that phrase the other day, Children's Hospital of Pittsburgh. And you can have a pediatrics hospital too, all you have to do is come up with a half a billion dollars and a lot of chutzpah to believe that you can come up with those kind of funds in this environment and going forward.

We have 1200 residents in our institution, residents and fellows, and we also have 19 unaccredited programs which account for us paying the complete costs related to somewhere close to about 100 other residents.

We do this because our mission is connected to the development of medicine and pushing the forefronts of medicine forward. As we do that, we find having fellows, having opportunities for training for people in highly tertiary areas necessary and part of our mission.

We have not adopted the concept of keeping our findings at home and marketing those at the expense of the care of our own people, our own region, and our own country and the world.

However, today I would caution that we move forward carefully because I believe there's a certain fragileness that continues in our arena, which most recently has been exacerbated by the 40 percent skid on the investment side, which we've all lived through as we've calculated our impending retirements.

This has obviously impacted cash and cash reserves and income, and I tell you, I believe it's dangerous. Because institutions fail catastrophically, they don't fail systematically and in an orderly way.

I would caution that no change would matter if the intention is positive in the long run. It may cause additional costs, the cost of complexity, duplication, that has the potential to destroy mentored teetering rural and urban facilities. And I can speak of that with some knowledge since we have several rural facilities and all of them report the same kinds of exposures and they do not have the opportunity to dance quickly as we engineer some of the payment structures. So it's a very risky situation for all of us who care about patient care.

Let me make one other point, which is as institutions teeter and collapse, what happens is, those patients are redistributed. However, if you don't have in the details of the sixty days notice to the HCFA intermediaries and you don't have a proposal out there, you then pick up the patients, but without the caring hands.

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You also damage your educational program, which I've heard several people speak eloquently about, because many of us have worked heroically to devise ratios of service to education with an emphasis on education that are very delicate balances. And the influx of additional patients is catastrophic and destroying that ratio. And so we cannot say that the cap is friendly towards education if it doesn't take into account that distribution over a regional area.

I'm trying to be friendly about these things, but it is a real problem and I will not sugarcoat because I think we have the lives of many good men and women at stake.

As a corollary to the academic model which several people have mentioned this morning, med schools are appropriately pleased with the existing firewalls between them and their clinical sites where the training occurs, particularly at the residency level, which is at the residency level where the liability and the risk resides.

In Pennsylvania, the cap fund makes the New York Times about every quarter and its expenditures have increased in scalars that are way beyond comprehension of all but a handful of medical schools. And I can assure you that med schools are not well served by having that on their back. They are, in fact, terrified of that.

We are opposed to the academic model. It chills the existing consortial and system relationships. It has potential to divide carefully cultivated loyalties, and potentially creates additional duplications, redundant bureaucracies and places schools at risk. Other than that, it's just terrific.

(laughter)

In closing, I'd mention two things. One, of course we support the all-payer system. I can't imagine anyone that would be opposed to that unless they'd be a payer. The other part is, we certainly support the idea or the concept of GME as a public good. I think that's just patently obvious; however, again, to everyone except those who don't see it.

(laughter)

And I have a major concern, which is in the area of the flexibility under the BBA '97 cap. The cap, I am not going to say we eliminate the cap because I actually believe personally that it has a tremendous benefit to the good order and services a real public benefit.

However, it is amazing for me in my twenty-some years in med ed, to turn to the ACGME and the RRCs and to point to them as a model of flexibility in relationship to caps. They have been the good guys in responding to the needs of the profession, needs of their housestaff and fellows, and also to the needs of a region and fairly dividing up spots based on where is the educational quality and how can we serve and broker

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arrangements that are in the interest of the residents, the patients, the facilities, and good academic training.

And I would strongly recommend that we look at the cap and how we might afford an appeal process or a way for legitimately recognizing different missions that are critical to the development of expertise and new pathways in the care in medicine.

And the second thing I would mention is, and is the most recent announcement, I believe it was yesterday, with the federal budget in which the children's hospitals had the opportunity to have their, and I understand that it's an annual appropriation; however, to take the children's hospitals and again summarily dismiss any funding for their training programs, to me makes no sense. If you look at what they are paid on the basis of the appropriations, they are at the lower levels of the payment scale in terms of housestaff nationally.

I think that has to be looked at because they are critical to health care. That's a problem in its own right, and on top of that, I just think it's bad public policy. I agree with the comment that someone made which was, residents are residents are residents and fellows are fellows are fellows, which is a different matter, but then there's different kinds of fellows to look at too. Some are more worthy for national consideration than others I believe.

In closing, in Pittsburgh, we have recently founded the Pittsburgh Regional Health Care Initiative which is an amazing consortium which has allowed institutions and medical professionals and specialties in six areas to cross competitive boundaries in the interest of two things, patient and provider safety, and seeking the elimination of medical error as a corollary to that.

We have all committed in our institution over the next couple of years to achieve zero adverse medical error and secondly to reduce towards zero nosocomial infection, which I think is a critical commitment.

I would say as we move forward, let me be kind of ornery, COGME, your future is in three areas. Quality. Quality. Quality. Costs will all be the same across the country. That's going to happen in several different ways. What we have to look at is doing the appropriate thing in the right order and achieving the correct outcomes with the amount of resources appropriately applied in the care of patients.

I certainly thank you for the chance to listen to me. I have to leave town and drive all the way from Pittsburgh to find a group that will do that. And I found the comments earlier today very fine. Thank you very much.

DISCUSSION FOLLOWING OPEN FORUM

DR. GETTO: Thank you very much for those provocative comments, we appreciate it. Comments from COGME.

Jerry.

DR. ROYER: I have a question of Dr. Pugno and Dr. Ginsburg and Dr. Pan, a two-part question. If I understand right, if I look at the graduates, our medical school graduates the last two or three years, it has been declining in those entering primary care. I put that in the context of Dr. Dickler's comment this morning questioning the feasibility of prospective planning in terms of workforce.

What observations do you have, or reasons do you see, for the decline in primary care residents and what do you see in terms of how we might address this going forward?

DR. PUGNO: I'll go ahead and start. In fact, the trend of decline in primary care is four years now in a row, there's been a decline. And I think that there are a number of factors that are playing a role, not the least of which I think is the perceptions of the market place and the hassle factor that primary care physicians are seeing in their practices.

I think that compensation for their services is one that the present student population simply does not ignore. I saw an interesting graphic the other day plotting match percentage versus projected first year income and it was a straight line. So I think that that's it.

I think that there are image issues. I think we have a student population right now that has priorities in life that are oriented around lifestyle and options and choice. For example, I think in the last several years we've seen a number of increases in things like transitional year residencies where the housestaff go into that because that then gives them the option to see where the workforce is going to go and to start moving in that direction.

I agree with you too that there are areas that need to be looked at. I think our surgical colleague mentioned about shortages of general surgeons and there are significant shortages of pediatric psychiatrists and folks like that. So I think that there's a great deal of study that needs to be done.

What are we going to do about it is a very good question. I think that the instability of the GME system, however, currently contributes adversely to it. Because I think many of the programs that are most vulnerable in this present system are those that, for

example, don't generate a great deal of clinical revenue to offset the educational costs of their program and I think that that's something that we need to be sensitive to.

DR. PAN: Well, actually, for the past couple of years, I understand in pediatrics it's actually gone up. So we're running a little counter to the trend. But I agree that we are very concerned about the overall decline and interest in primary care and I think for many of the reasons that have already been mentioned and I think it has to do a lot with practice environment.

It probably also has to do with encouragement by faculty and peers, sort of the milieu of the medical center. I know that occasionally what has happened is that especially as there has been more of an emphasis to do training in primary care, that sometimes some people have subspecialists in order to try to pull the students back, have sort of preyed on the insecurities of the students and residents about their knowledge to be able to practice everything, which our generalists are sort of asked to do. And they'd say, "well, wouldn't you be more comfortable practicing a small, you know, knowing more about a little bit instead of trying to be a master of all trades."

But I do think we do need to address the whole issue of compensation and how we finance medical services and I think that also, as far as sort of going back to our recommendations about a portable authorization system.

I think that's very difficult to try to contain the residents in a box and then try to get them to go into primary care that way, by trying to say, okay, we're only going to have a fixed number of residencies and you're not going to be able to go into a subspecialty if you want to because there isn't going to be anything available.

That we really need to create incentives and educate them about opportunities for practice, including primary care, and emphasizing what's different about primary care as well as provide opportunities for practice and through better reimbursement instead of trying to figure out ways to box them in.

MR. GINSBURG: The declines in internal medicine have not been as great as in family practice, but you're right, the general trend for primary care has been down. We remain confident that groups like COGME can serve a major purpose in looking toward the future, of what the future needs are going to be. Looking at demographics and service needs for the future.

We think there should be incentives provided as inducements to encourage physicians to go into primary care.

DR. GETTO: Allen.

DR. HYMAN: Yes, just to follow-up a very quick point. Following up Dr. Royer's very important question about the decline in primary care, we also have to be cognizant and recognize the significant decline in applications to medical schools over the last few years.

I'm not sure of the numbers, but it's something like 25 percent fewer college students are now applying the medical school. And we as Americans have been blessed by having the best and the brightest going into medicine in at least most of our lifetime and we aren't really sure, we thought there may be some obvious financial and maybe other opportunities and maybe until the decline in the NASDAQ a few will be looking to become investment bankers.

But it does represent a very substantial shift in the choice of young Americans as to what they want to do with their creative and skillful lives.

So we haven't really addressed this issue and we know that there are some very important problems that young people face and we did touch today on debt as being one, and why would anyone chose a profession in which the debt is so substantial that with the decline in incomes, there's just no way of ever getting out of debt. There's just no practical way. And I don't think that we have fully understood or addressed what the implications of that are.

So I would say as a question to every one of us in this room, how are we preparing for this change? Because again, this is like a wave. This decline will affect the character of the young people coming out of medical schools in two or three or four years, and that may have substantial change in what they choose to become in terms of their practice and what their value systems may be as well. So I'd be interested in your opinions on that.

DR. ZEREGA: I'd be kind of curious. There is what I think of as a factoid that appeared last week which described in California that 80 percent of the physician practices are losing money, and I'd like to hear about—

DR. ROYER: The other 20 percent are lying.

(laughter)

DR. ZEREGA: And then California is composed of bankrupt liars.

(laughter)

I'd like to hear what that happens to mean for the other panelists.

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DR. GETTO: Do we have any comments?

DR. PUGNO: Yeah, we need more money.

DR. PAN: What happens is that managed care is basically passing risk to medical groups and medical groups are having tremendous difficulty in trying to determine what risks they actually have. Accounting systems aren't all that great and many groups are going bankrupt. Even then the largest payer tells everybody, we're rejecting all your bids, come back to us again.

CALPERS [California Public Employees Retirement System], they just did that this year, basically told all the insurers, all the HMOs that, we're just rejecting all of your bids, come back to us with lower bids. This creates for a very tight market and that just gets passed down. And it's very hard and I think the challenge is how medical groups can manage risks.

DR. PUGNO: In those kinds of environments, primary care physicians are probably their own worst enemy too because as medical students do clerkships with them, they find a population of people who are hassled and unhappy and I think if there ever was a disincentive, that would be it.

I think the other thing, as I mentioned about the instability of our graduate medical education programs economically, I think it's very telling that in our environment we have 1998 legislation allowing DGME payments to community health centers, and yet we heard today that none of them have gotten any money yet.

And I don't know about you, but I don't know many businesses that can operate three years without income.

DR. GETTO: Jerry, you had a comment?

DR. ROYER: Yes, just another factoid and that is that the rumor going around that many physicians are leaving California. That's not actually borne out, I heard in a study that was published just last week.

DR. GETTO: Robert, comment?

DR. JOHNSON: Yes, I don't want to maybe bring a little ray of sunlight or a reflection on this issue of medical school applications and medical students. I've been on admissions committees for about 25 years and these trends have gone on over time. This isn't

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the first time there's been a downturn in high school or college students deciding for a career not in medicine.

A lot of it has to do with other popular careers and the big popular career that's come aboard is computers. We spend a lot of time working with the teenagers in our community and everyone is very interested in those types of careers and persons with a scientific bend tend to go in that direction.

We still have, every medical school in this country still is inundated with applicants. We have good applicant pools. We have MCAT scores that are higher, for each entering class, as well as the their grade point averages in college.

So I'm not so concerned about the quality of individuals going into medical school and I think we're going to see this historical trend go back and forth.

But I'd like to ask Richard a question about the portable authorization system. The first time I heard about this in 1993, I was, like most people, concerned that it might bring some instability to the current graduate medical education system. That is, that a residency program or a hospital couldn't project the money they were going to receive and they'd have a lot of difficulty in deciding how they'd afford the staff and all of that.

And I wondered whether or not the Committee on Pediatric Workforce had considered that issue and whether or not they thought that there would need to be a revolutionary change in graduate medical education to allow this type of system to work.

DR. PAN: Well actually, we did think very carefully about this particular issue. I know that a stable funding stream is certainly something that's come up and over again. And certainly we believe that it's important that there is stable funding for graduate medical education.

However, we also felt that in order to make the workforce more responsive to societal demands, that there needs to be some sensitivity in this system.

Now maybe there have been cases where residencies have gone from being full one year to being half empty the next year, but my guess is that usually they may be down one or two physicians out of several, and maybe someone can correct me. But the idea is that we did need to retain that sensitivity and that actually over time, and probably not even over a very long period of time, that basically you probably have a sort of stable core of residency programs that would be there.

And that really it wouldn't be impossible to try to predict about how much money you're getting. Pretty much most of the residency programs do fill. So we don't expect that there are going to be huge waves of people sort of shifting from one direction and

suddenly next year shifting to the other direction, and causing massive disruptions in the system.

But we do feel that there needs to be some sensitivity and that without having that sensitivity in the system, residencies will be filled to meet hospital and not societal needs. If you just have a fixed amount of money for a particular residency position, what happens if there's not really a demand for that particular specialty? You keep funding it and it just either stays open or they fill it with someone from outside.

DR. JOHNSON: Richard, does this respond to the demand for the speciality or does it respond to the desire of the specialty as a career for graduating medical students? It doesn't really respond to the market demand or the societal demand, does it?

DR. PAN: Well, I think it does. As I said, we have looked at and we have tried alternatives, we have tried to identify the most practical method, and we're certainly very open to other suggestions. We're looking at either a sort of command and control structure where a body of some sort tries to decide and micro manage exactly how many of each resident whether on the national level or regional levels or local levels. Or you can look at how you educate students, how students can take information to make wise career decisions.

And we felt that this type of a model would be most responsive to actual need. It is probably going to be more, in some senses, responsive to market demand, or at least perceptions in market demand, but at the same time I think that it's not exactly fair to the students to sort of say, okay, we're only going to have residencies for certain things because we think there's a need for this and we feel like there's a need for that, but there isn't a job or career available.

But the students are going to say, well, I don't really see a job market for that or I don't see a career coming out of that because I don't see people finding positions and so forth in that field.

Those would be factors that students would take in in trying to make their decisions about which programs and which specialties.

The other thing is that they believe that would allow the student to have a greater stake in trying to leverage the education, the quality of education, the nature of education they get in residency programs that they believe would best match their career needs.

DR. GETTO: Dennis, you had a comment?

DR. ZEREGA: It seems to me, in my involvement with medical students for 12 years at Wayne State when we had 1060, I was always amazed. No matter what the data were that was presented on career selection, it's like it's all ignored on the basis of mentoring. I've found someone who I can relate to who meets my ideal, there's a good chemistry there, and everything else goes out the window.

Now that having been said, over the last few years, we saw a radiology shift from not being particularly attractive to medical students to returning to strength in the last match. It's bounced back tremendously. And we've seen that medicine has been struggling fairly consistently over the years, but IM has some of the most carefully structured and strongest clinical programs across the country and offers a tremendous education.

And I still don't understand why we can't attract people into pathology. But if you look at all the numbers on pathology right now, if anyone wanted to be well positioned for the future, I mean, it certainly is pathology.

I think we've essentially failed in communicating to the medical students in a believable coherent fashion, and their faculty, as to what the manpower needs will be, going into the future.

And there are also other factors. We recently deployed a tremendous amount of resources over the last two years in our anesthesia program. And now we achieved the situation where our program, which was very marginally functioning over the years, all of a sudden we should have 45 people in that. But given where we were under the regulations, we'll have 45, but we're going to be paying for about 30 of them.

There are those kinds of disparities that exist. But I think it would be wonderful if we could do more with educating faculty and faculty mentors and residents about what the market looks like in our best guess. And then they make their decision at their risk.

DR. GETTO: Dr. Towers.

DR. TOWERS: I just wanted to comment on the whole issue of cost in relation to these things and I realize I'm a bit of an outlier here. I don't think anybody denies the fact that we need more money for all of these things and that things wax and wane in terms of what kind of speciality is popular, et cetera.

But I think this does provide us with an opportunity to try to team up and work on some of the issues that have to do with cost and also try to find ways to plug in interdisciplinary ways and cooperative ways things that can help with some of the costs in ways that use other kinds of health care providers as well.

OPEN FORUM

DR. GETTO: One more comment, Marian and then Don and then I'd like to open it up to public comments. Marian?

DR. BISHOP: Back to my question earlier this morning, can we move on something? And I've been listening and I'm sort of glad that Craig Lisk left because now I can speak without him correcting me.

(laughter)

I think virtually everybody but the MedPAC comments were in favor that GME is education rather than service and that was an outlier. And that we should influence manpower issues with the GME payment except MedPAC was an outlier, as was the representative in surgery, but she's gone too.

(laughter)

DR. GETTO: I like your style Marian. Policy by attrition.

(laughter)

DR. BISHOP: So given that those two outliers were kind of there, and those two issues might affect our ability to push an all-payer system, I wonder what kind of coalitions and networks we need to maybe get that all-payer system, despite the fact we don't have all the devils in the details, but get that moving and moved along.

DR. HOLLAND: Of course, the insurance industry decided not to come today.

DR. BISHOP: Yes.

DR. HOLLAND: And they're the main ones that are not paying.

DR. BISHOP: But they're not here either, so...

DR. GETTO: And that's a good point Gloria for the entire Council's knowledge, we did invite the insurance industry, Chip Kahn, and Karen Ignani. Hannah Davis talked to them regularly for a month or so, and they just couldn't quite find their way to come today. So they are an important group who aren't here.

DR. GETTO: Don, you had a comment.

OPEN FORUM

DR. THOMAS: I just wanted to point out that there is, in fact, a sociological, stereotypical factor that works on career selection for the way the folks select their residencies based on what they hear and what they see and what they think about what the specialty is going to be like. And that pretty much flies in the face of whatever might be the economic benefit or the work goals or rewards.

For instance, there are a good number of people that believe that if you go into family practice for instance, and you may end up in a setting where you're isolated socially from your peers and in smaller places. And that's not attractive to some people, regardless of how much they want to practice primary care.

There are other folks who believe that, for instance, pathology is going to be in the basement in a dungeon and that you're not going to be treated appropriately by your peers as the same as anesthesia was for a long time. And that has a lot more to do with people going into it and thinking where they'll be in the pecking order than it does the income that you might generate.

So along with some of the things that we're contemplating doing in terms of managing distributions, we have to also think about what we might do about these stereotypes so that folks can get a better glimpse of what the practices are actually like.

PUBLIC COMMENT

DR. GETTO: I would like to invite any public comment. I know people have been here all day and they've heard all of the speakers that the COGME folks have heard, and anyone who would like to make a comment, please feel free to step up to the microphone.

Prior to the meeting we did a lot of mailings and contacts of anyone that we thought might be interested in this and in an effort to try to have anyone who had some comments, make sure that they had an opportunity. We did receive some written ones that have been distributed. Yes.

MR. ELISON: If nobody else is, I'm going to take advantage of your invitation. Gar Elison, Director of the Medical Education Council in Utah, which is a newly created body to look at some of the same issues you're wrestling with and is also in the process of becoming a HCFA demonstration project to link the funding of GME to state workforce objectives.

I would start maybe with the last point that was raised a little bit here. If we're talking about caps and limits, I guess one of the things that we would like to see is more range in terms of, how much do we need, of what kind, so we can talk about mixes, and maybe not an absolute cap, which I think flies a little bit in the face of some of the federal policy makers.

I'd like to go back and comment in two or three areas about what I've heard today. I guess the very first issue is being one of the states in the Mountain States and having talked to my peers in all of the states, we just don't see the surplus.

We are absolutely in a difficult time recruiting and it doesn't matter whether we're recruiting at the primary care level or at the speciality or the subspecialty level.

I was glad to hear the three-pronged mission of this issue of training because one of the challenges we're facing is not just in primary care, but faculty, adequacy to keep the whole system intact and keep it going. And also the point of the research or the administrator.

And I guess in my opinion, being new and not having attended before, I would say that for me, the COGME report's a little deficient in the research, administrative, teaching areas. Rightly so, I think it's emphasized appropriately in terms of what's needed on the patient care side.

This discussion about an all-payer system, it's one that we're looking at and we find it very difficult and very challenging to try to figure out how you determine what's

PUBLIC COMMENT

equitable. How do you decide who ought to help pay. We're not even sure as we've looked at it, that we can justify, if you look at it in terms of percent, the reasonableness of what Medicare and Medicaid are now paying as part of that pool.

And as we've talked about, and you've talked about today, would we aggregate all of the various payment mechanisms into a single pool, and if so, how, and then how do you tie those to the various subjective areas for which each of those payment systems has more or less been tied.

It might be well to offer some encouragement just to get Medicaid and Medicare a little closer in terms of how they participate in the system and some language that would be encouraging to get a little closer to a seamless system just within HCFA.

Speaking strictly as a local person, and I haven't heard absolutely strong convincing evidence to the contrary, and let me say I agree with you, I think it's a public good. I'm finding the "public good" argument more difficult every year to sell. And I don't think we've articulated today very well the public good.

Recently talking with legislators, just to play Devil's advocate, he said, I'm going to tell you up front it's not a public good and I don't know what you can do to convince me. And I said, well, we've debated it well enough that we can argue either side.

I said, I want to take a used car salesman, with little or no education beyond high school. By the time they create a garage and get an inventory, they're a half a million in debt. Now who's got the better ten-year potential of paying back that debt, the used care salesman or an educated resident? And he said, that's exactly my point. What makes this different? What are they contributing that makes it so much more a public good?

And frankly I guess I would say, we'd welcome your help to articulate the public good more forcefully than it's articulated in the report.

I think those are the key points that I would add in terms of the discussion and points from a new participant. Thank you.

ADJOURNMENT OF STAKEHOLDERS MEETING

DR. GETTO: Thank you very much. Any additional comments? If not, we will stand adjourned until tomorrow and I would like each of the workgroups, and I'll remind you of this tomorrow morning, but I'd like each of the workgroups to address Marian's suggestion that there are four issues that appear to have at least some preliminary consensus, and I'll remind you of them tomorrow morning.

And I'd like each of the groups to take a look at those and see if we can't come back with at least some thoughts or a strategy of where we should to on those issues when we leave tomorrow.

Thank you for being very patient and attentive. Meeting adjourned.

Partial Transcript of COGME Meeting on April 12, 2001 Concerning the Stakeholders Meeting

(Beginning of discussion relevant to previous day's Stakeholders Meeting)

CHAIRPERSON GETTO: It is now time for work groups and before we go, let me just remind you of Marian's [Bishop] summary of yesterday's activities that I would like the work groups to at least consider for our discussion when we get back together around 11:00 a.m. Marian pointed out that there were four areas that seemed to have concordance in the discussions yesterday of the panelists.

And the four that I wrote down, correct me if I'm wrong, Marian, are 1), medical education as a public good; 2), an all-payer pool made up of public and private financing is a good idea; 3), GME is an educational activity not just a health care enhancement; and 4), funding should be used to drive workforce goals. Is that accurate?

DR. BISHOP: Those were the four with some minor discrepancies raised by those who left.

CHAIRPERSON GETTO: Yes, right. This was voting with the feet when they left. But let's at least talk about those areas of agreement so that we can discuss whether we want to do anything, take action around those areas of at least a perceived sort of consensus.

We will reconvene at 11:15 back here.

(Meeting reconvened at 11:14 a.m.)

(Resuming discussion relevant to "Stakeholders Meeting")

CHAIRPERSON GETTO: I'll do a very brief report on the Financing Workgroup. There were really two issues that we discussed, one was what do we do with COGME's Fifteenth Report from here on out in light of the panel yesterday and Marian's summary? And then where do we go next?

The discussion on the first really, I think, came to the conclusion that we should publish the proceedings from yesterday as a proceedings document with a COGME commentary, and perhaps not a detailed commentary but at least a response of COGME to what we heard yesterday, probably outlining areas, not trying to respond to it all but at least saying here's where there appeared to be agreement, here's where we could make some additional recommendations.

And that that response would be the joint product of an Internet-accessible sort of web site where COGME members could add their comments once an editor had put the proceedings together. And perhaps David Sundwall who's very much attached to that report and is very interested in maintaining contact, if we put that together I think we could certainly do a commentary that could go along with it.

That thought was supported by several of the members of the audience and people who have been around COGME almost as long as some of us, who suggested that having the proceedings available would allow them to go back to their organizations and use the proceedings in a better way.

And I think that's really where we want to go, to keep having materials out that will give people information that they can use in developing the recommendations to the next step.

That led into a discussion of where the Financing Workgroup should go, and I think there are two areas that we see for ourselves. The first is continuing to follow COGME's Fifteenth. That is, it is going to need additional refinement help, et cetera after the proceedings are out. Secondly, look at the whole area of quality.

Much of what we heard today and the idea that educating a workforce for quality, that is the quality education that AHRQ and IOM are talking about, should lead to improved quality of health care. And that those two, while they are somewhat separate, are linked, and that it's worth paying for the education if you get the product. Obviously, there are some huge leaps of faith here, and the data are not in, but that would be kind of the summary of the discussion.

Jerry, do you want to add to that?

DR. ROYER: One of the concerns that I raise and I also would like to report on what Dr. Dunn had suggested. One concern I have is the newcomers. To what extent we play a role as a change agent, and in that area I probably have some of the impatience, if not frustration, of Don Berwick and perhaps Marian Bishop as well, how do we move this thing along?

And I'm certainly convinced, both from my own experience and from the last 24 hours, that our approach will not be incremental, but what role should we play in bringing about major change?

Dr. Dunn, in speaking to that point, indicated that this change will not happen through Congress and pointed to the attendance yesterday—or lack of attendance—of staffers, and was suggesting that the link in fact might be tied to quality and through working with payers.

And my note also in trying to put the proceedings together is that it may be an atypical proceedings in that I think that we should have the payer organization represented, even if some of us need to go to Karen Ignani and interview her and say, "What's your thought on this? With what points do you agree and what points do you disagree?" Because I think that it's a very exciting prospect and perhaps at the next meeting I would certainly be willing to take some time to share with the group what we are doing as a payer to pay on the basis of outcomes. And that's clearly tied to quality.

CHAIRPERSON GETTO: Jerry has an interesting definition of exciting.

Allen and then Don.

DR. HYMAN: I just wanted to go forward with that idea. I was interested and concerned and somewhat disappointed that, besides Jerry, there were no payers yesterday. And there are two possibilities. One is that they didn't want confrontation, which I really doubt. I think they're accustomed to confrontation. And, second, which is of greater concern to me, and that is they didn't think that this organization was of any importance to them and to their future concerns. And that would be of great concern to all of us.

We need to find out what reasons they are not interested in entering into dialogue with COGME, because they are so crucial to the future of where this report is going to go.

I was also unsure, and maybe you can clarify for me, what MedPAC was doing. I wasn't sure whether we were hearing the personal opinions of Dr. Newhouse and Gail Wilensky as individuals when they wrote in *Health Affairs*, or did this represent MedPAC. And, if so, does MedPAC have parallel interests because this is the first time I've read anything about graduate medical education coming from MedPAC unless I've overlooked some previous reports.

So I was wondering why they were jumping in on graduate medical education at this time. Maybe Stan can enlighten me.

DR. BASTACKY: First of all, the gentleman who spoke yesterday [Craig Lisk] I think made it clear that he was speaking on behalf of himself and not MedPAC. And that it sounded to me like they were familiar with our report but yet MedPAC, as a group, is not going to or is not ready to comment on it. They're coming from this, not from the workforce standpoint, but from the financing standpoint.

So we felt good that Craig Lisk would agree to come and speak to us, and indeed we go to their meetings and as far as I know we haven't spoken at their meetings, but we go to them and listen and so forth.

DR. BENJAMIN: And Gail Wilensky has come and talked to us at this meeting several times.

DR. BASTACKY: Yes, she has.

CHAIRPERSON GETTO: I think GME is the area of overlap and for MedPAC it's sort of a small area that they see. For us it's obviously a much larger area. MedPAC is moving along at their own congressionally driven pace in terms of delivering reports to Congress on a regular basis, as well as attending to these issues as they come up.

It's interesting to follow their debate because they're looking at the entire Medicare Trust Fund and Medicare issues from a very different perspective. Education is a blip on the screen for them, I think, and this is a way around it that may allow them to move ahead.

They've also proposed a financing revision which basically keeps teaching hospitals whole by folding these GME costs in under patient care. Don't you?

DR. THOMAS: The one addition to our session I'd like to make is the suggestion was made that if we try to link financing to quality, that we might find ourselves being more in MedPAC's area and maybe getting overrun. That's kind of a segue into the issue of graduate medical education and our focus which needs to expand I think over the past sessions that we've had, to include the education, the continuing medical education of all the practicing physicians so that our universe is larger and the effect is larger.

And when you do that, then the practice and the education in the real world are two sides of the same coin, and trying to divide it into one thing or the other at any given minute, is something that we've always argued against. And I think that's the actual way to approach it.

Whether we come from the MedPAC side in looking at financing and how it affects quality, or whether we come from the graduate medical education that you use on a minute to minute basis and how that affects quality, the finance still has to be tied to it kind of as a triple or it won't work.

(End of COGME discussion relevant to Stakeholders Meeting)

Appendix A – Overheads Used During Presentations

OVERHEAD PRESENTATION OF ROBERT DICKLER *Association of American Colleges of Medicine*

Why 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.

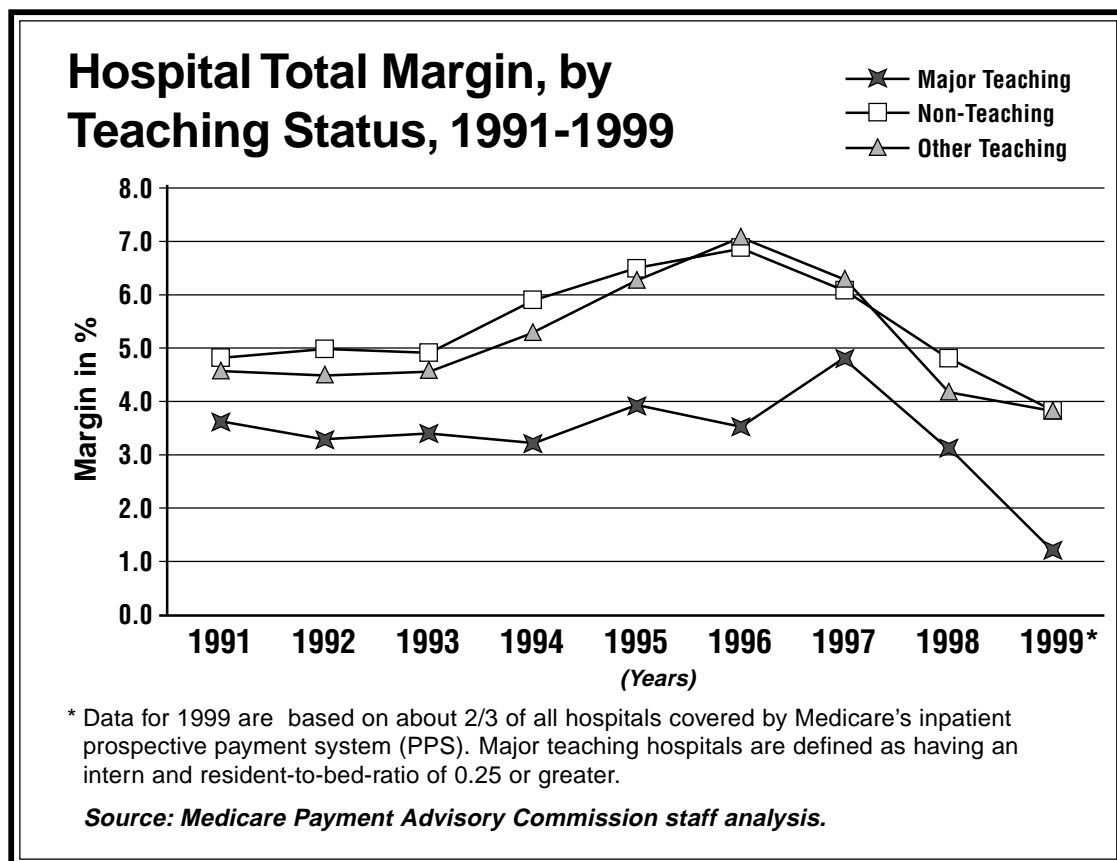
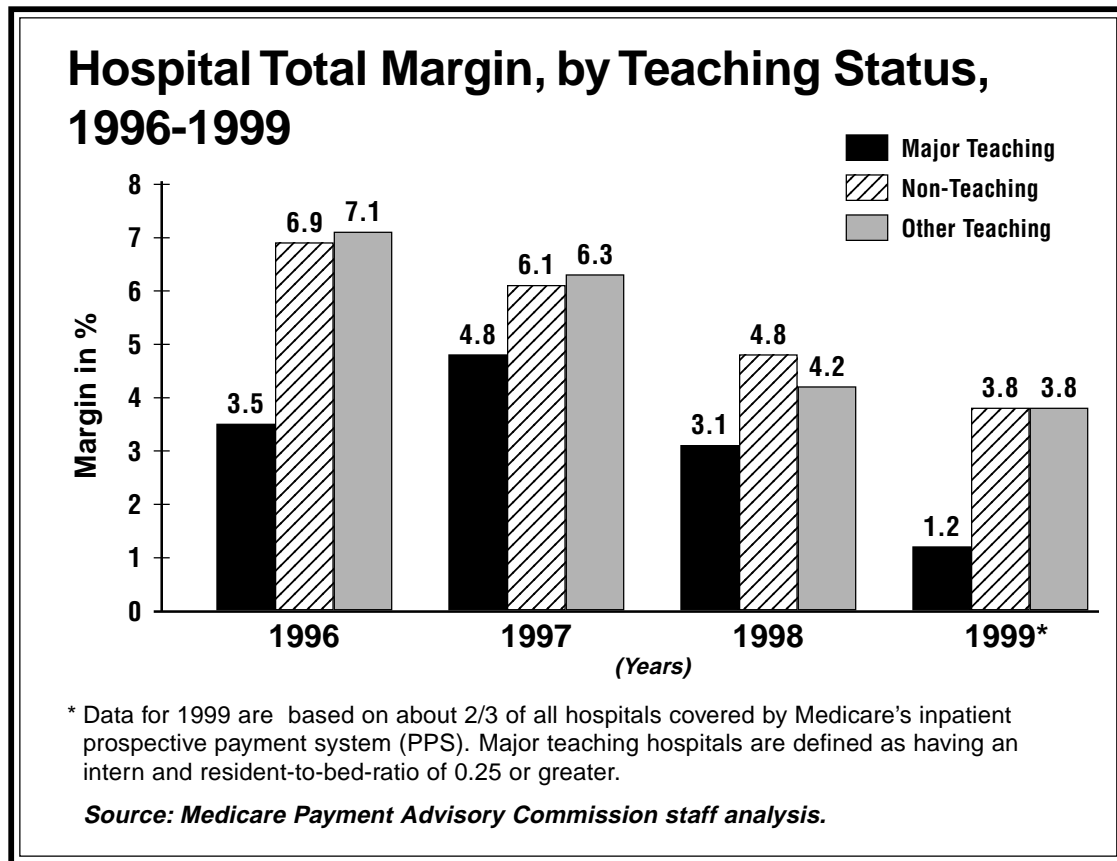
House Report, Number 213, 89th Congress. 1st Sess. (1965) and Senate Report, Number 404. Pt 1. 89th Congress. 1st Sess. 36 (1965)

The Purpose of the IME Adjustment

“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.

Overhead Presentation of Robert Dickler (Continued)



**OVERHEAD PRESENTATION OF
MICHAEL J. SCOTTI, JR., M.D.
*American Medical Association***

**FUNDING OF GRADUATE
MEDICAL EDUCATION**

COGME

Michael J. Scotti, Jr., MD
American Medical Association

April 11, 2001

michael_scotti@ama-assn.org

WHY GRADUATE MEDICAL EDUCATION

- **Education**
 - Domestic
 - Foreign
- **Community Resource**
- **Economic Engine**

Overhead Presentation of Michael J. Scotti, Jr., MD (Continued)

EDUCATION

- **How Many Do We Educate?**

– ACGME & Combined Specialty	97,989
– AOA Approved Residencies	2,928
– Total	100,917

EDUCATION

- **Who Do We Educate?**

– LCME US Medical School Graduates	67,316
– AOA Medical College Graduates	6,797
– International Medical Graduates	25,880
– Canadian LCME School Graduates	534
– Total	100,527

Overhead Presentation of Michael J. Scotti, Jr., MD (Continued)

EDUCATION

- **Who Are the 25,880 IMGS?**

– Native US Citizens	9.9%
– Naturalized US Citizens	9.1%
– Permanent Residents	35.5%
– Temporary Workers (H1,2,3)	7.7%
– J1, J2 Exchange visitors	30.2%
– Other & Unknown	7.6%

COMMUNITY RESOURCE

- **Specialized Units, e.g.,**
 - Emergency rooms
 - Trauma Centers
 - Neonatal Intensive Care
 - Burn
- **High Volume Invasive Care**
- **Uninsured**

Overhead Presentation of Michael J. Scotti, Jr., MD (Continued)

ECONOMIC ENGINES

- **Employment by Academic Health Centers**
 - largest employer in congressional district
 - entry level positions with fringe benefits
- **Education**
 - medical, nursing and over 50 “allied” health disciplines
- **Neighborhood Preservation**

WHO PAYS?

- **Governments**
 - Federal (HCFA, DVA, DOD, NIH)
 - States
- **Patients**
 - directly & indirectly as employee benefit
- **Philanthropy**

Overhead Presentation of Michael J. Scotti, Jr., MD *(Continued)*

WHO SHOULD PAY?

- **Residents**
- **All Payer System**
- **Tax Payers (Governments)**
- **Philanthropy**

ACCOUNTABILITY

- **Too Many? / Too Few?**
- **Evidence Based Medicine**
- **Output Evaluation**
- **Work Force Planning**

**OVERHEAD PRESENTATION OF
MARVIN R. DUNN, JR., M.D.
*Accreditation Council for Graduate Medical Education***

COGME

**Fifteenth Report: *Financing Graduate
Medical Education in a Changing Health
Care Environment***

(December 2000)

STAKEHOLDER'S MEETING: APRIL 11, 2001

Marvin R. Dunn, MD

Director of RRC Activities for the Accreditation
Council for Graduate Medical Education

COGME: 15TH REPORT

COGME is to be commended for developing a very thorough and detailed report on the issues surrounding the financing of GME.

We must also thank COGME for holding this meeting of Stakeholders to discuss the report, for as Karl Weick says . . .

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

***How can we know what we think . . .
. . . until we see what we say?***

Karl Weick

COGME: 15TH REPORT

First, this complex subject is one that has serious immediate ramifications for:

- 100,000 residents
 - 7,800 residency programs
 - 736 institutions that sponsor GME;
- ◆ **But overarching is the significance for the patients of today and tomorrow.**

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

COGME: 15TH REPORT

It is to this aspect of quality of health of the American people, that ACGME is committed and so states in its Mission Statement:

The ACGME Mission

To improve the quality of health care in the United States by ensuring and improving the quality of graduate medical educational experiences for physicians in training.

Overhead Presentation of Marvin R. Dunn, Jr., MD *(Continued)*

COGME: 15TH REPORT

It is noteworthy that the first recommendation in the recent Institute of Medicine Report, “Crossing the Quality Chasm”, parallels the ACGME Mission Statement:

**“CROSSING THE QUALITY CHASM”
(INSTITUTE OF MEDICINE 2001)**

“RECOMMENDATION 1: All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.”

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

To Repeat: The ACGME Mission

To improve the quality of health care in the United States by ensuring and improving the quality of graduate medical educational experiences for physicians in training.

COGME: 15TH REPORT

- ◆ **For the specific issues of funding GME, the ACGME has two narrow but critical concerns:**
 1. That funding is sufficient to conduct the GME program in compliance with the the requirements of the Residency Review Committees, and
 2. The funding is stable and reliable.

Overhead Presentation of Marvin R. Dunn, Jr., MD *(Continued)*

COGME: 15TH REPORT

Integrally related to adequate and stable funding is the ability for continual quality improvement.

But from a public policy perspective, how do we demonstrate the quality of GME for which funding is provided?

COGME 15TH REPORT

“Never confuse activity with productivity.

It’s what comes out the other end of the pipe that is important;

Not what you push into it.”

(Dee Hock)

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

The current mindset . . .

- ◆ Does the program comply with the Requirements?
- ◆ Does the program have established goals and objectives and an organized curriculum?
- ◆ Does the program evaluate its residents and itself?

. . . to a new way of thinking

- ◆ Do the residents achieve the learning objectives set by the program?
- ◆ What evidence can the program provide that they do so?
- ◆ How does the program demonstrate continuous improvement in its educational processes?

Overhead Presentation of Marvin R. Dunn, Jr., MD *(Continued)*

ACGME Outcome Project

- ◆ A long-term initiative
- ◆ To enhance residency education
- ◆ Through educational outcome assessment

Project Activities

- ◆ Identifying what to measure
- ◆ Developing measurement tools
- ◆ Collaborating to find the answers

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

Naming What to Measure

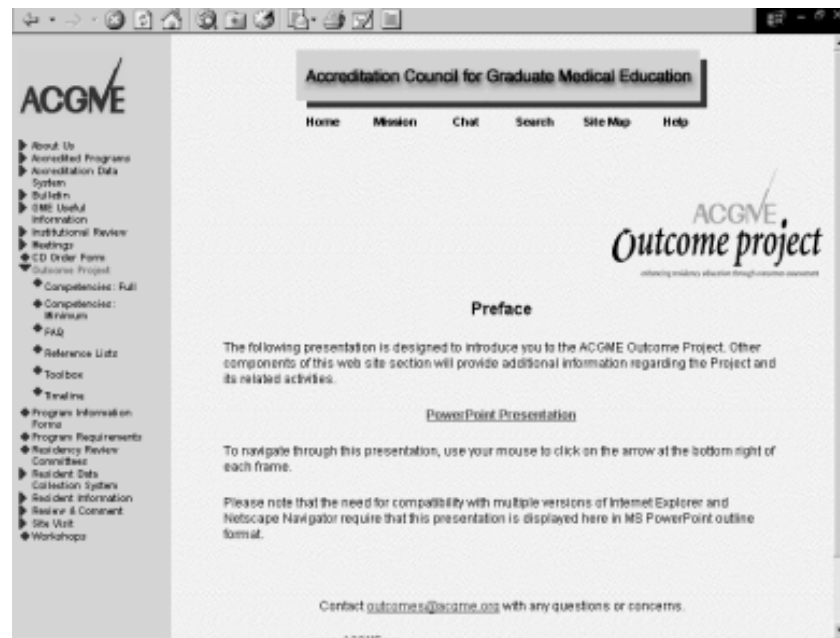
- ◆ Review of literature (2500 articles)
- ◆ Initial list of 84 competencies
- ◆ Advisory Committee
- ◆ Extensive vetting (RRC members, program directors, residents, corporate leaders, university presidents, public)
- ◆ RWJ support

Project Activities: Identifying what to measure The General Competencies

- | | |
|---|--|
| ◆ Patient care | ◆ Interpersonal and communication skills |
| ◆ Medical knowledge | ◆ Professionalism |
| ◆ Practice-based learning and improvement | ◆ Systems-based practice |

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

www.acgme.org/Outcome Project



Patient Care

- ◆ **Compassionate**
- ◆ **Appropriate**
- ◆ **Effective**
 - For treatment of health problems
 - For the promotion of health

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

Medical Knowledge

- ◆ **About established and evolving science**
 - Biomedical
 - Clinical
 - Cognate (epidemiological & social-behavioral)
- ◆ **About application of this knowledge to patient care**

Practice-based Learning and Improvement

- ◆ **Investigation and evaluation of their own patient care**
- ◆ **Appraisal and assimilation of scientific evidence**
- ◆ **Improvements in patient care**

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

Interpersonal and Communication Skills

- ◆ **Result in effective information exchange and teaming with**
 - Patients
 - Their families
 - Other health professionals

Professionalism

Manifested through

- ◆ **A commitment to carrying out professional responsibilities**
- ◆ **Adherence to ethical principles**
- ◆ **Sensitivity to diverse patient population**

Overhead Presentation of Marvin R. Dunn, Jr., MD (Continued)

Systems-Based Practice

Manifested by

- ◆ **Actions that demonstrate awareness of and responsiveness to larger context and system of health care**
- ◆ **Ability to effectively call on system resources to provide care that is of optimal value**

COGME: 15 TH REPORT

- ◆ **COGME is to be commended for developing such a comprehensive document describing GME financing in all its complexity.**
- ◆ **ACGME hopes that COGME will recognize the overarching value of adequate and stable funding and focus on that targeted goal to assure quality of GME and in turn improve the quality of health care for the American people.**

**OVERHEAD PRESENTATION OF
MALATHI SRINIVASAN, M.D.
*American Medical Association
Resident and Fellow Section***

**FUNDING GME:
ESSENTIAL CHARACTERISTICS
FROM THE RESIDENT PERSPECTIVE**

COGME April 11, 2001

Malathi Srinivasan, MD
National Consortium of Residents
AMA-RFS Comm on Long Range Planning

Goals of Medical Education

- ◆ Provide excellence in patient care
- ◆ Meet societal needs and demands
- ◆ Flexible learners, systems based problem solving
- ◆ Understand complex business environment
- ◆ Not all physicians will contribute to society the same way
 - Research, teaching, administration
 - Advocacy, policy, community service

Overhead Presentation of Malathi Srinivasan, MD (Continued)

Is medical training unique?

- ◆ **Independent practice after professional degree**
 - DDS, RN, MIS, MCS
- ◆ **Apprenticeships after professional degrees**
 - PhD, MBA, JD, MD
- ◆ **MD post-doctoral training characteristics**
 - Longer training time to independent practice
 - Overt High stakes outcomes, quick turn-around
 - Dept can't cost-shift: low margin, charity mission
 - Service to all society, future use for all

Six Resident Issues in GME

Resident Survey: AMA-RFS December 2000

- ◆ **95 residents leaders surveyed: 35 states**
- ◆ **68 surveys returned (70%)**
- ◆ **60 consented to share data**
 - Residents (47), Fellows (13)
 - University (42), Community (12), Military (6)
 - 22 Specialties

1. QUALITY OF PATIENT CARE

- ◆ **“Have changes in your health care system ever compromised patient care?”**
(3 quotes from AMA-RFS survey)

Overhead Presentation of Malathi Srinivasan, MD (Continued)**2. QUALITY OF RESIDENT TRAINING**

- ◆ **“Very good or excellent”**
 - 66% overall ability to care for patients
 - 60% overall educational experience
- ◆ **“Terrible or inadequate”**
 - 67% health policy
 - 60% practice management
 - 35% research
 - 33% interactions with systems
 - 32% staying current with medical knowledge
 - 23% teaching
 - 21% communication skills
 - 18% professionalism

3. RESIDENT WELL-BEING

- ◆ **Quantity of work (work-hours)**
 - ACGME: 1/4 of residencies in violation
 - AMA-RFS: 85 ±19 hrs/ward week (64-130)
- ◆ **Quality of work experience**
 - 40% workload too high
 - 35% too much non-educational scut-work
 - 33% inadequate rest
 - 23% inadequate dining facilities
 - 8% unsafe on call

Overhead Presentation of Malathi Srinivasan, MD (Continued)

3. RESIDENT WELL-BEING

◆ **Problem resolution (Terrible/inadequate: 33%)**

<i>Who addresses problems</i>	<i>Worse/ unchanged</i>	<i>Effective</i>	
Chair	98%	16%	84%
Prog director	93%	15%	85%
Chief resident	91%	18%	82%
Other residents	86%	33%	67%
ACGME	40%	38%	62%
Dean	37%	32%	68%
TV/Media	35%	43%	57%
Government	28%	59%	41%
Housestaff Assn	23%	21%	79%
Ombudsman	15%	33%	67%

- 3. RESIDENT WELL-BEING**
- ◆ **Building citizenship patterns**
- Terrible or inadequate . . .
 - 40% involvement in community service
 - 33% continue outside reading (medical)
- ◆ **Overburdened system, dependent on trainees for low-cost care**
- More patients, higher acuity
 - Residents cover planned leaves of absence
 - Inadequate staffing levels

Overhead Presentation of Malathi Srinivasan, MD (Continued)

4. MEDICAL DEBT = EDUCATIONAL ACCESS

- ◆ Average debt per resident: **\$86,000**
- ◆ Average income resident: **\$37,000**
- ◆ Length of training: **3-6 years**
- ◆ Example: **Steve ER resident in Ohio**
 - Debt: **\$93,000**
10 year repayment at 8.25%, about \$1200/month
 - Income: **\$35,000/year, moonlight \$11K**
About \$3600/month gross income

4. MEDICAL DEBT = EDUCATIONAL ACCESS

- | ◆ Repayment | <i>Starting</i> | <i>Net</i> |
|--|-----------------|--------------|
| Starting | \$3600/month | 100% |
| 25% Taxes (\$11,125) | \$ 927 | \$2673 (74%) |
| Repayment | \$1200 | \$1473 (41%) |
| Rent | \$ 500 | \$ 973 (27%) |
| Car | \$ 400 | \$ 573 (16%) |
| Food, utilities, gas, savings... | | \$ 20 (6%) |
- ◆ **Steve is 31, single, no kids**
 - ◆ **His friends with kids have to double their salary to save any money**

Overhead Presentation of Malathi Srinivasan, MD (Continued)

5. PRACTICE CHOICE**◆ Workforce needs important, however . . .**

- Inaccurate predictions
- New specialty formation
- Societal needs v expectations
- Population shifts
- 7-15 year lag time to implementation

◆ Place of training ≠ place of practice

- Personal affinity and role modeling
- Goals: patient care, management, research
- Lifestyle: hours, call schedule, income
- Geography: urban, suburban, rural
- Familial responsibilities

6. FACULTY TRAINING AND ADEQUATE SUPERVISION**◆ Faculty not trained**

- Teaching skills: feedback, remediation
- Communication skills
- Leadership, systems-improvement
- Behavior and attitude

◆ More paperwork means . . .

- Less time teaching directly
- Less time with patients

Overhead Presentation of Malathi Srinivasan, MD (Continued)

COGME: Resident Perspective

1. ALL PAYER SYSTEM/GME TRUST FUND

- ◆ Rationale and equitable
- ◆ Amount based on true cost of training
- ◆ Premium tax or for all-payers
- ◆ Insurance premiums increasing yearly (2—>8%)

2. ACCOUNTABILITY

- ◆ How much money makes it to the resident????
- ◆ Quantify academic health care missions
- ◆ Make the money trail transparent
- ◆ Educators responsible for education should control funding

COGME: Resident Perspective

3. RESEARCH QUESTIONS

- ◆ How much do residents costs to educate?
- ◆ How much does it cost to have faculty supervise, teach, and learn new skills?
- ◆ How is our current physician workforce practicing?
- ◆ What are real workforce projections?

Funding should not be tied workforce objectives pending better data on current workforce & true US population needs

Overhead Presentation of Malathi Srinivasan, MD (Continued)

COGME: resident perspective

4. QUALITY CONTROL

- ◆ Build in mechanisms to remediate programs that don't meet key accreditation standards
- ◆ Funding should not be tied workforce objectives until we have better data on the actual needs of the US population

5. DEBT RELIEF

- ◆ Make sure enough DME/IME makes it to the resident to provide adequate debt relief and living wage

Appendix B – Written Statement Submitted in Advance of Stakeholders Meeting

From International Longevity Center, New York

STATEMENT FOR THE COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)

April 11th 2001

Robert N. Butler, M.D.

President and CEO

International Longevity Center – USA



I would like to thank the council members of COGME for this opportunity to comment on the recent report “Financing Graduate Medical Education in a Changing Health Care Environment.” This report contains many important recommendations to enhance the ability of our graduate medical education system to adapt to a changing health care environment. I applaud COGME for this report and I am hopeful that its recommendations will be carefully considered by our nation’s policymakers.

There is one aspect of our nation’s graduate medical education system that I would like to focus on today, and is not discussed in this new report—which is the critical shortage of academic geriatricians. One of the underlying themes of the COGME report is that GME funds should help achieve specific workforce and educational objectives. I believe that the need for more individuals with the combination of medical, academic, and scientific training to be academic geriatricians is an important workforce objective that has been overlooked for too long.

Our nation is growing older, and our health care system needs to respond to this demographic imperative. The number of people over 65 is increasing every year. Currently there are about 35 million people over 65, and this will at least double over the next 50 years. Moreover, the number of people over 85, who generally use the most medical services, is currently about 4 million and will increase to roughly 19 million by 2050.

Older patients often have several chronic conditions, take multiple medications, and respond to treatments and medications differently than do younger persons. The clinician who has not received training in geriatric medicine to prepare him or her to deal with these and other complications may make incorrect diagnoses. It has been estimated that as many as 35 percent of people over 65 experience adverse drug reactions

each year, and another study estimates that 17 percent of hospitalizations of people over 65 are a result of an adverse drug reaction. Such hospitalizations can cost as much as \$20 billion a year, according to a government report.

As many of you are no doubt aware, most medical students and residents currently receive little if any training in geriatric medicine. Out of 145 US medical schools, only 14 require a separate course in geriatrics, and only 60 percent even offer an elective, which very few students take. One result of this inattention to geriatrics education is a severe shortage of physicians trained to provide effective health care to older people in the United States. This problem can be addressed, however, in a cost-effective manner within the current health services delivery system. We do not need to focus on the expansion of the specialty of geriatricians, which would further fragment the health care provider industry. Rather, we need to simply ensure that **all** physicians, primary care and specialists, receive basic education and training in the care of older people during their medical studies.

To accomplish this, the United States needs to increase the number of academic geriatricians, who can teach physicians in all fields about the appropriate care for older people. They will serve as role models and mentors to medical students, and their presence will ensure that geriatrics will become mainstreamed into the whole medical education and training process. The American Association of Medical Colleges (AAMC) has reported that fewer than 600 faculty members report geriatrics as their medical specialty in our nation's 125 allopathic medical schools. The ILC has estimated that it is necessary, and feasible, to increase this number to 2,400 academic geriatricians over the next 20 years – to be faculty members at both allopathic and osteopathic schools of medicine. This is a small number when we are talking about a total physician population of roughly 650,000, but it is enough to provide a foundation of knowledge and leadership to improve our health care system's capacity to care for an aging population.

A geriatrics faculty development initiative under GME would effectively address the need for academic geriatricians. It is ironic that our federal government spends billions of dollars to train health care providers through the Medicare program, yet hardly any of these funds go towards training individuals in geriatrics. Whatever reforms are made to GME, such as an all-payer model, the need for academic geriatricians should be included as a vital health care workforce goal. An academic geriatrician requires an additional four years of training after the initial residency. Medicare GME currently supports a one-year geriatrics fellowship. Various other programs, mainly supported by foundations, have supported additional years of training. Although these programs are well-intentioned, a targeted initiative to establish a four-year geriatrics faculty development program is needed and should be included in our nation's GME system.

Recommendation #6 of the COGME report presents a practical way to implement a geriatrics faculty development initiative. The recommendation calls for the establishment of an account “for funding special projects and programs directed at building high-quality community-based training capacity or achieving specific workforce goals.” One of the specific workforce goals should be a program to promote the career development of individuals as academic geriatricians. Given the aging of our baby boom generation, such a program should begin as soon as possible. We must think about the 21st century. We must develop a way to fund the education of those who will be the leaders and innovators in the field of geriatrics through an allocation of GME dollars. A faculty development initiative to create a cadre of academic geriatricians is the way to do this.

Again, I would like to thank the members of this Council for this opportunity. I applaud your interest in and dedication to improving our graduate medical education system to better provide health care to all Americans. If you would like a copy of the ILC report that further highlights the need for academic geriatricians and how this can be accomplished, please do not hesitate to contact me. Thank you very much.

Appendix C – Recommendations in COGME’s Fifteenth Report

Recommendations for GME Financing Reform

Graduate medical education (GME) should meet community needs and remain current as new technology and evolving health systems affect the way care is delivered. The funding policies should provide incentives to support high quality training in both traditional and community settings. It should encourage training innovation and improved ways to meet patient needs. Funds should be allocated to regional or local levels consistent with national workforce priorities. However, Federal support must be sufficiently flexible to allow some funding allocation decisions to be made at the local level. At the same time, recipients of those funds must be accountable for producing:

- an appropriate number and specialty mix of physicians distributed across geographic areas consistent with current and future national health care needs; and,
- educating physicians who are well-equipped to provide high quality, effective and efficient care.

The recommendations outlined below are based on these principles. The recommendations are made within the context of an all-payer GME fund. However, some recommendations could also have applicability to current GME funding policies under the Medicare program.

RECOMMENDATION 1

CREATE A GME FUND THAT COMBINES FEDERAL FUNDING TO SUPPORT GRADUATE MEDICAL EDUCATION WITH ALL-PAYER FUNDS.

To assure financing policies are consistent across Federal programs and reflect national workforce priorities, the various Federal funding streams for GME that is provided by non-Federal institutions (i.e., excluding DoD and DVA) should be combined into a single fund and supplemented with all-payer funds obtained through a modest surcharge of private insurance premiums. The GME fund would include amounts that would otherwise be paid under current

formulae for Medicare for direct GME and indirect payments to teaching hospitals, the Federal portion of Medicaid payments that are implicitly GME payments, and the Children’s Hospital GME fund. In addition, the HRSA Title VII grants for GME, e.g., primary care residency training grants, would be included in a set-aside fund for specific workforce goals.

Within the general GME fund, five separate accounts should be established for:

- Medicare direct GME payments;
- non-Medicare direct GME payments;
- Medicare IME payments;
- non-Medicare IME payments; and,
- targeted payments to support specific workforce and educational objectives.

The separate Medicare and non-Medicare accounts are needed as a transitional measure. They would assure full funding on behalf of Medicare patients if contributions from other payers are not sufficient. Also, since the Medicare funds are currently being paid, changes in the allocation of the Medicare funds should be phased-in or offset by additional funding from the non-Medicare accounts. A transition may not be needed for the non-Medicare funds. To the extent they represent new funding streams, funds in the non-Medicare accounts should be allocated consistent with preferred policies from the outset.

While the GME fund would not include funding for residency training in DoD and DVA-sponsored programs, the Federal budget for those programs should be consistent with the policy objectives for the GME fund. Residency training in these programs has significant impact on the size and specialty composition of the physician workforce.

a. GME should be broadly supported by all-payers.

Explicit funding for GME should be spread more broadly across all sectors of society. A permanent and stable funding source, such as premium contributions from all health insurance plans, should supplement current Federal funding for GME. In the long run, Medicare and Medicaid’s contribution

to the GME fund should be proportionate to the percentage of insured population represented by their enrollees.

b. Funding from all sources should be sufficient to support high-quality, efficient training of an appropriately sized physician workforce.

Total aggregate funding should be sufficient to support the efficient training of an appropriately sized physician workforce. Together with payments from other sources (primarily patient care revenues and State funds), GME funding should be adequate to train the number of physicians required to meet current and future national health care needs. Additional funding would not be in the public interest since it could contribute to a continuing surplus of physicians.

In the past, COGME has recommended that the total number of physicians entering first year residency should not exceed the number of U.S. medical school graduates in 1993 plus 10 percent (COGME, 1994). The Council's 14th Report found that a reduction of 3,386 first year positions in 1997-1998 was needed to meet the 110 goal. In view of recent changes in the health care delivery system since its initial recommendations were issued, COGME plans to review the 110 goal and its target of a 50/50 mix of primary care and other specialists.

Most of the increase in the total number of residents in recent years is attributable to an increase in the number of graduates from medical schools outside the United States. Support should be discontinued for new exchange visitors (J-1 visa) residents. As COGME has previously recommended (1997), exchange visitor residents should be funded by alternative sources, such as home country financing or foreign aid.

A conceptual framework should be used to establish an appropriate level of Federal support for funded residency positions. Because GME is a joint product with patient care services, patient care revenues cover some direct GME costs. Consideration also needs to be given to issues such as maintenance of effort for current State funding through the Medicaid program and grant programs and whether all resident activities required for accreditation in an approved program should be funded. Under Medicare, only resident time spent in patient care activities is supported.

RECOMMENDATION 2

IME ACCOUNTS SHOULD PAY HOSPITALS AND OTHER CLINICAL TRAINING SITES AS APPROPRIATE FOR THE INDIRECT COSTS OF EDUCATIONAL ACTIVITIES.

IME accounts should be created to subsidize higher patient care costs associated with residency training. The funds should be allocated to hospitals and, to the extent it is empirically supported, to other clinical training sites that incur indirect teaching costs, including hospital outpatient clinics and community-based settings. Initially there should be separate accounts for Medicare and non-Medicare patients in order to assure the indirect costs for Medicare patients are fully funded. In the long run, a single account would be appropriate.

a. IME payments should be set at no more than the analytically justified level for teaching activities

Paying more than the analytically justified amount would subsidize inefficient providers and give teaching institutions a competitive edge over non-teaching institutions. For Medicare inpatient services, MedPAC's (2000b) current estimate is a 3.1 percent adjustment for each 0.1 increment in the resident-to-bed ratio after other refinements are made to the Medicare prospective payment system. Based on this estimate, Medicare IME payments would be \$1.5 billion lower than the 5.5 percent adjustment provided by the BBA. The difference could be targeted toward achieving specific workforce and educational goals (see Recommendations 4 and 6) or toward supporting uncompensated care (see Recommendation 8). A transition would be needed to the extent reductions in Medicare IME payments are not offset by increases in non-Medicare IME funding.

b. Research is needed to determine the appropriate IME payment formulae.

Research is needed to refine the Medicare IME adjustment and to determine the appropriate IME teaching adjustment for non-Medicare hospital inpatients. Medicare's adjustment should be based on the higher costs attributable to teaching activities. For non-Medicare patients, the adjustment should be directed at "leveling the playing field" between teaching and non-teaching hospitals. It does not need to cover the full indirect teaching

costs if teaching hospitals are able to command a premium for quality or specialized services.

Ideally, the IME payment formula should not reflect higher costs indirectly attributable to other teaching hospital missions, e.g. specialized services, uncompensated care, and research. Subsidies for those public goods should be directed toward the hospitals producing them through separate funding streams. Reducing the adjustment to an analytically justified level for teaching would reduce incentives to train more physicians than necessary. It would also eliminate confusion between funding for the teaching mission and funding to support charity care. Higher costs attributable to serving low-income patients and uncompensated care costs should be recognized through a separate funding mechanism (which would also distribute payments to non-teaching institutions serving low-income patients. See Recommendation 8). Refinements in the IME payment methodology should not reduce the total level of support for hospitals with significant uncompensated care until specific funding for such services is provided. Reductions in the IME payment formula should be accompanied by refinements in the prospective payment system to incorporate better case-mix and severity measurements. An additional adjustment for research-intensive hospitals may also be appropriate.

Additional research is also needed to determine the extent to which there is an indirect teaching effect on costs when resident training takes place in hospital outpatient and non-hospital settings. If empirical research finds there is an indirect teaching effect on the costs of services provided in ambulatory/community settings, the IME account should pay for these services as well as inpatient hospital services.

RECOMMENDATION 3

DIRECT GME ACCOUNTS SHOULD PAY PROGRAM SPONSORS OR THEIR DESIGNEES FOR THE DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.

Direct GME costs are educational costs that should be supported through payments to the sponsoring institution ultimately responsible for the graduate medical education program. Payment allocation decisions should be made at the local level because the tremendous variety of existing arrangements cannot be accommodated at the national level. By making pay-

ments to either the sponsoring institution or its designees, the sponsor can determine the most appropriate recipient of the funds based on local circumstances for a particular program. For example, a sponsoring institution may decide to retain maximum control over the funds and receive them directly, elect to continue historical arrangements having the funds flow through the teaching hospital, or may choose to have a consortium distribute the funds. The same election would not need to apply to each program sponsored by the institution. Regardless of which entity received the funding, the sponsoring institution would be accountable for the funds being expended to support a high quality training program with the appropriate balance of hospital and community-based training experiences.

a. There should be written agreements between the program sponsor and training sites indicating the sponsor is assuming substantially all of the training costs and describing how GME payments will be allocated

The program sponsor or its designee must assume all or substantially all of the direct costs of operating the residency program as a condition of receiving direct GME payments. Written agreements should be required between the sponsoring institution and clinical training sites to formalize the negotiation process and to increase accountability for the funds. The agreements should detail how the direct GME funds will be allocated between the sponsor and the training site, identify which entity will pay resident salaries and fringe benefits, and specify teaching physician compensation arrangements for supervising residents. The goal is to strengthen the negotiating position of community-based sites without jeopardizing longstanding relationships between academic institutions and community training sites. A sponsoring hospital may have a disincentive to rotate residents to community-based training sites if all direct GME funds automatically follow the resident to a community-based training site through direct payments from the GME fund or a voucher system.

b. Model agreements and information on direct GME costs should be made available to facilitate equitable agreements between the sponsor and the sites

Local circumstances should determine how direct GME payments are allocated to teaching sites.

However, benchmarking information should be provided to facilitate the negotiation process, including:

- breakdown of GME payments into three components based on average direct GME costs: resident salaries and related costs, teaching physician compensation, and an administrative and overhead cost component.
- benchmarks for teaching physician compensation and the added time per teaching session when residents are present in community-based practices on short-term rotations and on an ongoing basis; and,
- model agreements between institutional sponsors and community-based sites.

c. *Require separate reporting of resident time spent in inpatient hospital, hospital outpatient and community settings*

At present, there is no formal accounting for the time residents spend in each type of training site. Standard definitions should be developed to distinguish hospital outpatient settings from community settings. Community settings should be broadly defined to include both hospital-operated and community-based sites that are representative of the environment in which residents will eventually practice. The determining characteristics are the processes of care rather than proximity to the hospital or provider ownership. Community settings address the care of the individual patient in the context of the population of which the patient is a member. They teach residents to deliver culturally effective care to an ethnically and racially diverse population.

RECOMMENDATION 4

ESTABLISH A NATIONAL AVERAGE PER RESIDENT PAYMENT FOR DIRECT GME COSTS.

The base payment for direct GME costs should vary only for differences in the cost of living across geographic areas. For Medicare payments, there should be a transition from the hospital-specific per resident amounts to the national per resident payment. The length of the transition will depend on additional payments for non-Medicare patients. These can help compensate for any reductions in Medicare payments. At the end of the transition, separate Medicare and non-Medicare accounts would no longer be necessary.

Higher payments may be appropriate for training in community-based settings. In addition, there should be an incentive payment for programs that meet specific workforce or educational objectives.

a. *Base total direct GME payments on the net costs of supporting an appropriately sized workforce.*

Ultimately, total direct GME funding should be based on the net costs of educating an appropriately sized physician workforce. Establishing a fixed payment per resident should provide incentives for efficiency in the educational process. However, the costs of efficiently delivering high quality GME and the extent to which these costs are offset by patient care revenues has not been determined. As an interim policy, either the average per resident amounts or average GME costs per resident could be assumed to represent the total costs of an efficient program. Total costs based on the FY1997 average per resident amount updated for inflation and the 110 percent target are estimated at \$6 billion for FY2000.²⁶ A lower funding amount would be appropriate since the per resident amounts do not take into account patient care revenues attributable to GME.

b. *Provide higher payments for training in community settings*

When training occurs in a community setting, the sponsoring institution continues to incur some supervisory physician and overhead costs. The community setting incurs some direct GME costs as well (for example, to compensate the community physician for teaching) even if the sponsoring institution continues to pay resident salaries and fringe benefits. As a result, total GME costs may be higher when residents rotate to community-based settings than when they remain in hospital-based settings. A higher payment for training in community-based settings would be appropriate if the net total costs (after taking any additional patient care revenue into account) are higher in the community-based settings. Research is needed to determine whether this is the case. To counter any disincentive that might currently exist for community-based rotations, a temporary policy might be to increase the component of the per resident amount attributable to teaching physician compensation by a fixed percentage, e.g. 25 percent. The higher payment could apply in all community settings even though the rationale for the payment is primarily applicable to settings off the hospital

premises. This would provide an incentive for hospitals to turn training in ambulatory clinics into experiences that are more representative of community physician practices.

c. *Provide incentive payment for meeting specific workforce and educational objectives.*

In addition to the base per resident payment, there should be an incentive payment for meeting specific workforce and educational objectives. Programs that meet one or more of the objectives would be eligible for a bonus on the national average base payment. The incentive payment should be established as a fixed payment rather than a pool so that the benefits do not erode as additional programs meet the objectives and qualify for payment. The bonus payment could be awarded based on:

- Participation in a broad-based consortia of the sponsoring institution(s) for residency programs in an area, hospitals and community providers participating in GME activities, and community representatives. The consortia would have to be designated by the sponsoring institutions to receive all direct GME funds. Bonus payments would be made if the consortia has a formal process to identify the health care needs of the community, engage in workforce planning, and promote community-based training opportunities;
- Number of graduates that provide significant amounts of care to medically underserved populations;
- Percentage of time residents spend providing care to medically underserved populations; and,
- Quality of the residency program.

d. *Research is needed to understand variation in direct GME costs by specialty and setting.*

Most research regarding residency training costs was conducted at a limited number of sites and before the growth of managed systems of care. A better understanding of differences in the net costs of training across residency programs and training sites is needed to refine the payment allocation methodology. A generic financial model should be used to examine systematically issues such as:

- Whether there are significant differences in the amount of teaching physician involvement between primary care and non-primary care resi-

dency programs and between initial residencies and fellowships;

- Whether there are significant differences in impact on clinical productivity and net physician practice revenue when teaching occurs in ambulatory settings relative to inpatient settings and between initial residencies and fellowships;
- How direct GME costs are affected by the presence of students in other health professions at the training site and by residents teaching medical students; and,
- Factors that affect the efficiency and quality of the educational process.

RECOMMENDATION 5

CONTINUE THE BALANCED BUDGET ACT OF 1997 LIMITS ON THE NUMBER OF RESIDENTS WITH MODIFICATIONS.

In concept, the Balanced Budget Act of 1997 limits on the residents that will be recognized by Medicare are consistent with the goal of reducing the future physician workforce and should be carried over to eligibility for payments under the GME fund. However, hospital-specific limits are not an appropriate long-term way to deal with physician supply issues. The limits hamper a program director's ability to move residents among hospital programs for educational reasons. In geographic areas with physician shortages, the limits preclude expansions in needed residency programs.

a. *Modify the caps to apply to sponsoring institutions rather than hospitals.*

The sponsoring institution is to be held accountable for educational outcomes and workforce objectives. Therefore, the limits should apply to the number of residents in the programs sponsored by the institution rather than the hospitals serving as training sites for the program. This will provide the flexibility to move residents between hospitals and other settings. Consortia that meet certain workforce planning objectives should be able to work under an aggregate limit for multiple sponsoring institutions.

Applying the limit to sponsoring institutions is consistent with making direct GME payments to sponsoring institutions. However, it complicates IME payments to individual hospitals. One option

would be to apply no limit for IME as long as the sponsoring institutions whose residents are training at the hospital are under their caps. An adjustment would be needed only if the total number of residents in programs at the sponsoring institution(s) exceeded an aggregate cap. The three-year rolling average and the one-year cap on the resident-to-bed ratio should continue to apply. The rolling average provides a form of transition payments to hospitals that reduce the number of residents and slows the recognition of new residents in the IME count.

b. *Include residents in non-hospital settings regardless of who paid the resident's salary in the 1996 base year count.*

Residents who were working in non-hospital settings were not included in a hospital's 1996 base year count for Medicare IME payments. They were included in the direct GME count only if the hospital incurred substantially all of the training costs. The limit applicable to a sponsoring institution should be adjusted to include all resident time in non-hospital settings regardless of who paid the resident's salary.

e. *Allow adjustments in the Balanced Budget Act of 1997 limits to improve the distribution of physician workforce.*

Further research is needed to understand the impact of the Balanced Budget Act of 1997 limits and to develop policies that will result in a better geographic balance in the physician workforce while encouraging an overall reduction in the number of physicians. Appropriate indicators of adequate distribution by specialty are needed. As an interim measure, the limits should not apply to rural residency training tracks if their graduates practice predominately in rural areas. In addition, the limits should not apply to primary care residency programs whose graduates practice predominately in those States with low physician-to-population ratios.

RECOMMENDATION 6

ESTABLISH AN ACCOUNT FOR FUNDING SPECIAL PROJECTS AND PROGRAMS DIRECTED AT BUILDING HIGH-QUALITY COMMUNITY-BASED TRAINING CAPACITY OR ACHIEVING SPECIFIC WORKFORCE GOALS.

At least 10 percent of the GME fund should be set aside to support specific projects and programs di-

rected at building high-quality community-based training or achieving specific workforce priorities. The types of projects and programs that should be funded include:

- Primary care residency program grants;
- Faculty development grants to support training of community clinician teachers;
- Information technology infrastructure development to link patient care records at teaching hospitals and community sites within organized systems of care;
- Incentive programs to reward residents that focus their practice on medically underserved populations;
- Transition funds to cover residency replacement costs in hospitals with high uncompensated care patient loads; and,
- Demonstration projects involving development of broad-based consortia.

RECOMMENDATION 7

MODIFY THE MEDICARE RULES RELATED TO TEACHING PHYSICIANS TO EMPHASIZE THE TEACHING PHYSICIAN'S OVERALL RESPONSIBILITY FOR THE MANAGEMENT OF THE PATIENT'S CARE AND TO REDUCE THE IMPORTANCE OF DOCUMENTATION.

The Medicare rules pose two challenges to graduate medical education: 1) the supervision rules make it more difficult for residents to become progressively independent, and 2) the documentation requirements detract from the amount of time available for teaching and resident supervision. There is some evidence that the rules may adversely affect the willingness of community physicians to participate in teaching programs. The rules should be revised to address these concerns.

a. *Establish different rules for residents in fellowship programs*

HCFA's rationale for its teaching physician rules rests on: 1) making payment only when there is an identifiable physician service to an individual patient and 2) avoiding duplicate payment for the physician's supervisory time. Duplicate payment should not be an issue with residents who are beyond their initial residency period. These residents

count as only .5 FTE and resident salaries and fringe benefits comprise only 43 percent of the per resident amount.

The rules on teaching physician supervision should be revised for residents who are beyond their initial residency program to permit Medicare billing if:

- the teaching physician is immediately available;
- reviews with each resident during or immediately after the visit the patient’s medical history and care; and,
- documents his or her participation in the review and direction of services.

Accreditation standards for the residency program should be relied upon to determine issues regarding supervision requirements for specific services and resident-to-preceptor ratios.

An alternative would be to allow residents beyond their initial residency period to bill for services furnished in the hospital if an election is made to forego a direct GME payment for the resident’s time.

b. Evaluate the impact of the teaching physician rules

The issue of when physician billing is appropriate for care provided by residents is not limited to the Medicare program. It will remain relevant under an all-payer fund. There is a need to evaluate formally the administrative and teaching burden associated with the current Medicare rules and their impact on the quality of clinical training and patient care. Particular attention should be paid to the effect in hospital ambulatory clinics and community-based settings where there is a low resident-to-preceptor ratio.

c. Develop clear and reasonable documentation requirements

There is need for additional guidance and common understanding of what constitutes adequate

documentation of a teaching physician’s participation in the care of patients involving residents. HCFA should work with the academic physician community and the Office of Inspector General to develop reasonable standards that do not compromise high quality clinical education. The standards should provide a reasonable means for documenting the teaching physician’s involvement in the care of the patient and assuring appropriate payments without imposing undue administrative burden. They should be tested in a variety of teaching settings and specialty programs before implementation.

RECOMMENDATION 8

PROVIDE ADDITIONAL SUPPORT FOR HOSPITALS AND COMMUNITY-BASED TRAINING SITES THAT SERVE A DISPROPORTIONATE SHARE OF LOW INCOME PATIENTS.

In the absence of national health insurance, “safety net” providers should be provided with additional funding to cover uncompensated care costs. Major teaching hospitals provide substantial uncompensated care. Faculty practice plans also furnish charity care. Uncompensated care is not an educational cost. However, it affects the training site’s ability to provide high quality educational experiences. More importantly, teaching institutions that furnish high amounts of uncompensated care rely on current GME funding to support their charity care. As changes are made in the IME payment methodology, the current level and distribution of DSH payments should be examined to assure the funds are well targeted to subsidize uncompensated care. The subsidies should apply to hospitals for both inpatient and outpatient services and to community-based providers. Without additional support, GME is not sustainable in community-based training sites with a high volume of uncompensated care. These sites cannot generate the patient care revenues needed to support their educational activities.



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