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GME Funding—Short and Longer Term Musings

Michigan Association for
Medical Education

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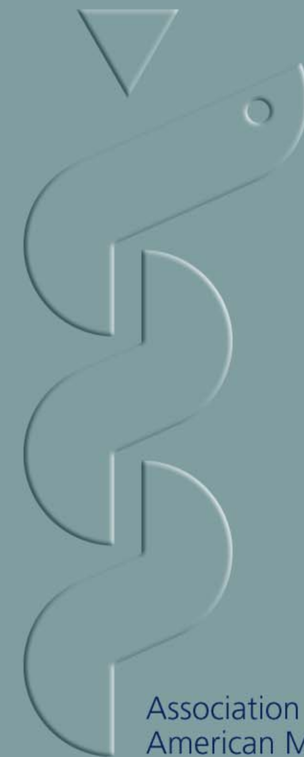
Karen Fisher, J.D.
Health Care Affairs
AAMC
202-862-6140
kfisher@aamc.org



Association of
American Medical Colleges

DGME and IME Funding—Short Term Concerns

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Capital IME Payments

FY 2009 IPPS final rule called for the elimination of capital IME payments:

FY 2009: 50% elimination

FY 2010: 100% elimination

Estimated annual aggregate cut to teaching hospitals would be about $360 million

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Federal Proposed Rule Eliminating FFP for Medicaid GME Payments

Published on May 23, 2007

Comments were due June 22, 2007

AAMC comments at http://www.aamc.org/advocacy/library/teachhosp/corres/2007/062207.pdf

Legislative moratorium in place until April 1, 2009

MedPAC 2008 March Report

IME Recommendation (No. 2A-2):

"The Congress should reduce the indirect medical education adjustment in 2009 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the indirect medical education adjustment should be used to fund a quality incentive program."

Other quote of note:

"These funds are provided to teaching hospitals with no accountability for how they are used, and a better use of the funds is desired."

MedPAC March 2008 Report, page 70

Increasing/Eliminating the Resident Caps

Medicare support for expansion of medical school graduates???

Cost issues

Physician Shortage Context

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GME Funding—Longer Term Musings

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Our Collective Goal

Dedicated, stable funding for the funding of physician training and the other valued contributions of teaching hospitals and their faculties.

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Upcoming Debate??

Rx needed for sick healthcare system

Still a chance to resuscitate health care for uninsured

A Battle Over Health Care

A Healthy Dose of Hillary

Health Care Tops voters' busy 2008

An Ailing Health System Feels Better

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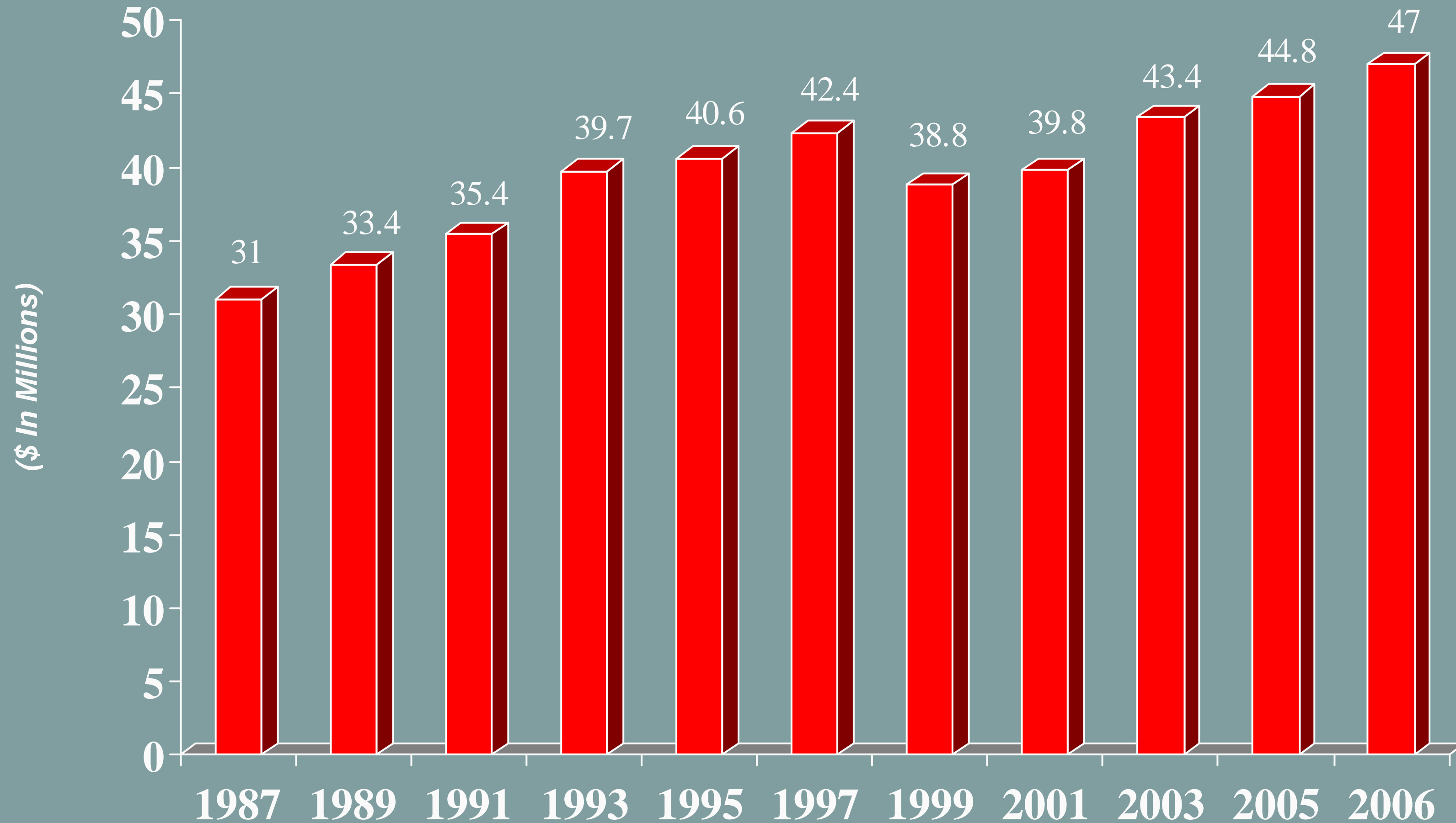
Number of People who lack Health Insurance Coverage 1987-2006



Source: US Census Bureau, Current Population Survey, 1988 to 2007 Annual Social and Economic Supplements.

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National Health Expenditures (NHE) as a percent of GDP, 1993-2017

•Projected

SOURCE: For 1993, data come from National Health Statistics Group, Centers for Medicare and Medicaid Services, Office of the Actuary *NHE Web tables*, Table 1 (http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf)
For 2002-2017, data come from Centers for Medicare and Medicaid Services, Office of the Actuary, *NHE Projections 2007-2017, Forecast summary and selected tables*, Table 1 (http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf)

What do we mean by “health care reform” ?

Universal access/coverage?

Health care cost containment?

Insurance coverage changes?

System delivery changes?

All of the above?

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Quality Takes Center Stage

Medicare quality reporting and potential “value-based purchasing” (VBP)

State public reporting web sites

Private sector initiatives

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System Delivery Changes

Is current system driven by a “toxic” fee-for-service system?

Hospital-physician alignment

“System-ness” versus retail clinics

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Academic Medicine and Health Care Reform

Educating physicians and other health care providers

Pushing the frontier of medical science

Providing disproportionate amount of care to the uninsured

Teaching hospitals are costly

Relationship between teaching hospitals and clinical faculties

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Health Care Reform

Incremental versus wholesale change

How intertwined is Medicare reform with overall health care reform?

Where does funding for special missions of teaching hospitals fit in?

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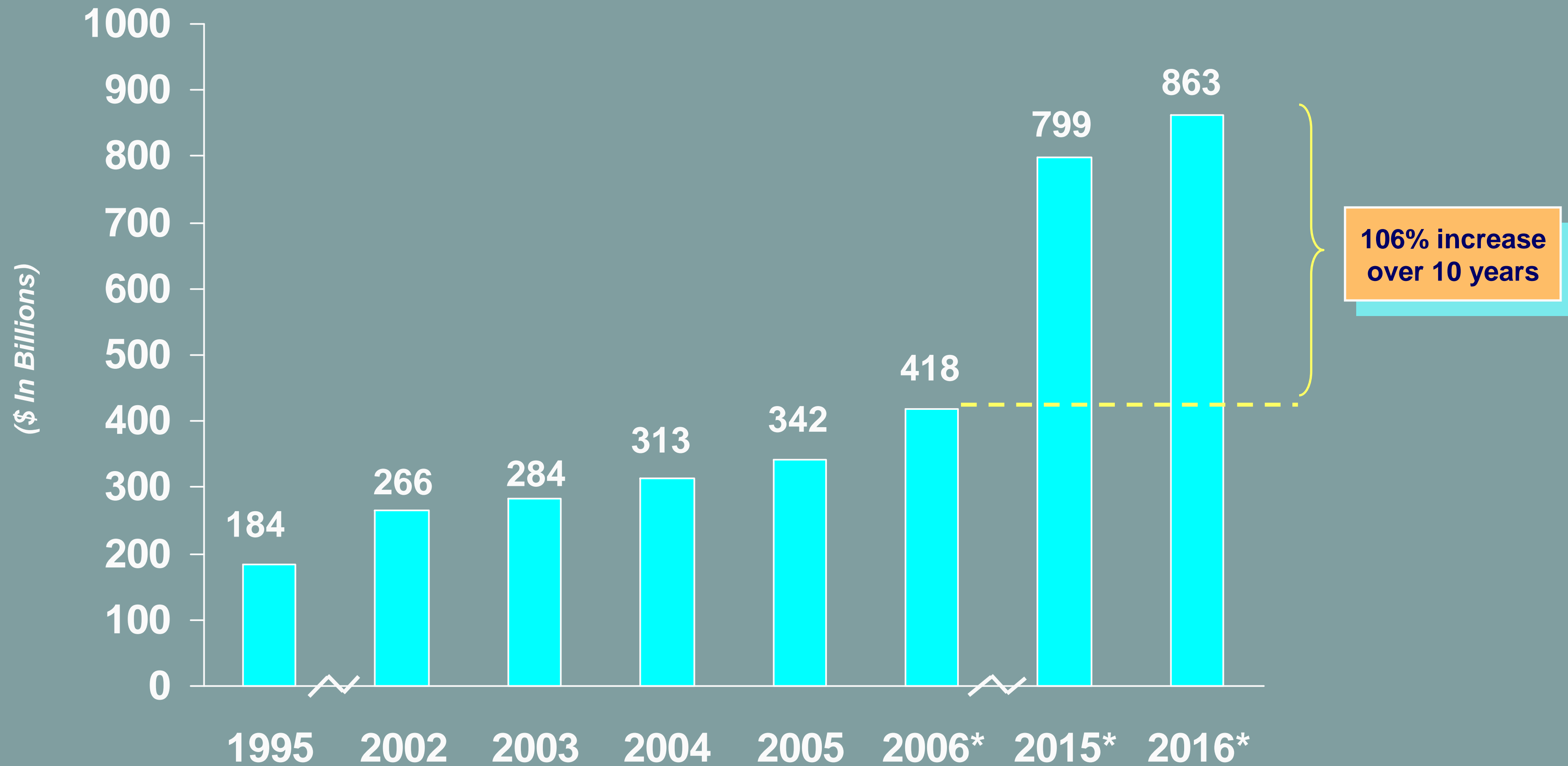
Medicare Spending, 1995-2016



*Projected

SOURCE: Data for 1995 come from the National Center for Health Statistics, **Table 137**: *Medicare enrollees and expenditures and percent distribution, by Medicare program and type of service: United States and other areas, selected years 1970-2005* (http://www.cdc.gov/nchs/products/pubs/pubd/hus/medicare.htm).
Data for 2002-2016 come from the Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group (*NHE Projections*, Table 3 (http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf)).

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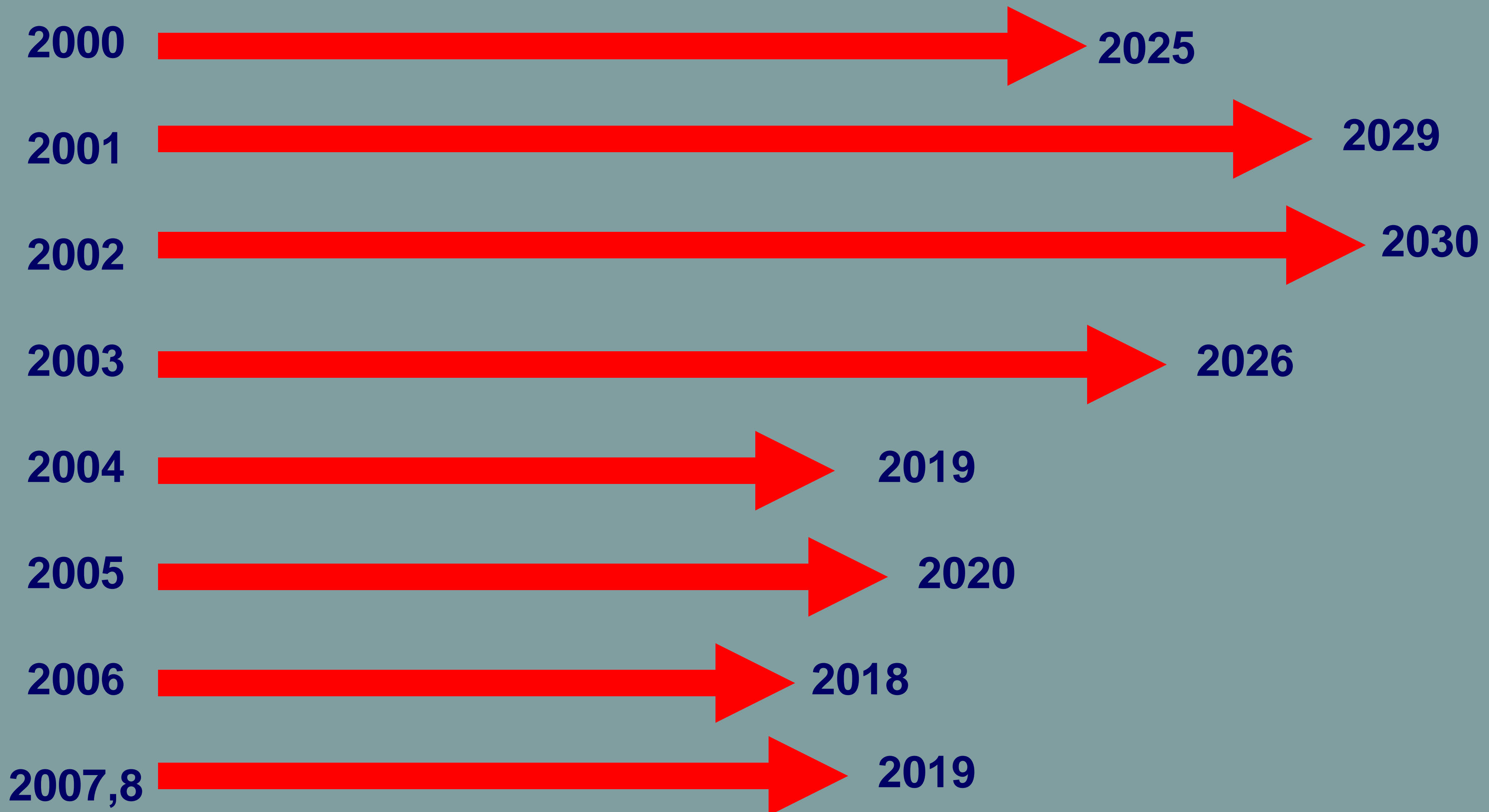
Projected Solvency of the Medicare Part A Trust Fund



Source: Health and Human Services Press Releases Announcing Release of Annual Medicare Medicare Trustees Reports, 1998 - 2005; The 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund.

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Future Health Care Spending--A Sobering Picture

"CBO projects that, without changes in law, total spending on health care will rise from 16 percent of GDP in 2007 to 25 percent in 2025 and 49 percent in 2082. Federal spending on Medicare (net of beneficiaries' premiums) and Medicaid would rise from 4 percent of GDP in 2007 to 7 percent in 2025 and 19 percent in 2082."

"The bulk of the projected increase in spending on Medicare and Medicaid is not due to demographic changes (such as increases in the number of beneficiaries) but rather to ongoing increases in costs per beneficiary."

Testimony of Peter Orszag, Director, CBO before the US Senate Budget Committee, 1-31-2008

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View of HHS Secretary Leavitt

“I believe the key to health care reform in our nation is Medicare reform. Successfully changing Medicare will trigger the rest of the health care sector to follow.”

From, an April 29, 2008 speech entitled
“Medicare: Drifting Toward Disaster”

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What Has Been said about GME and IME Funding Alternatives?

All Payer Trust Funds

Appropriations

Medicare "premium" support

Important Question: How intertwined are GME and overall Medicare Reform?

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GME Funding: Some Key Questions

Should there be public support of GME training?

What should be the source of funding?

What should be the level of funding?

What entities should receive the funding?

Should teaching institutions be held “accountable” for the GME $$ they receive (ala “pay for performance”)?

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Summary

Viability of Medicare and Medicaid: may be the primary driver of change

Status of overall economy (including bail out); status of war

Where is science and technology going? Do these activities portend big change in delivery?

Are we educating future physicians to lead change in quality, resource use, consumer self determination, etc.?

Can academic medicine lead in system delivery changes?

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