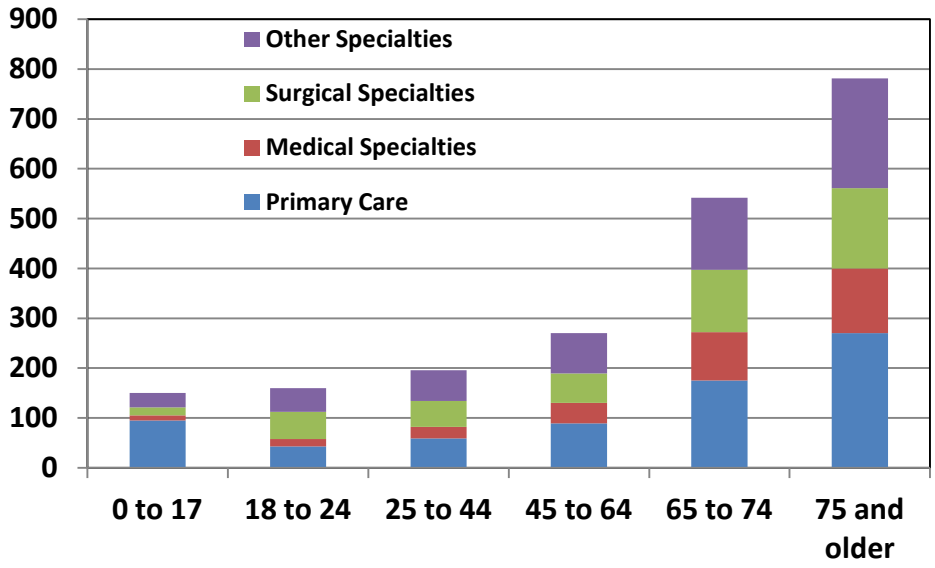
TALKING POINTS: MEDICARE GME

- **THE NATION FACES A GROWING PHYSICIAN SHORTAGE**
  - ✓ Record numbers of seniors enter the Medicare system;
  - ✓ One-third of currently practicing physicians approach retirement; and
  - ✓ 32 million Americans gain health care coverage under ACA; one-half will gain coverage under Medicaid.

- **THE NATION FACES A SHORTAGE OF 91,500 PHYSICIANS BY 2020**
  - ✓ 46,100 primary care physicians; and
  - ✓ 45,400 surgeons and other specialists.

- **MEDICARE BENEFICIARIES REQUIRE A BROAD RANGE OF SERVICES:**

Physician Requirements Per 100,000 Population by Age Group



- **THE UNIQUE ROLE OF TEACHING HOSPITALS**
  - ✓ Teaching hospitals maintain an environment in which clinical research can flourish alongside physician training and the highest level of patient care
  - ✓ Their education and research missions enable teaching hospitals to offer the most advanced expertise, services and technology.
  - ✓ The physicians that staff teaching hospitals provide a diverse range of specialty services around the clock and are prepared to care for the nation's most critically ill or injured patients.
  - ✓ They provide **$8.4 billion in charity care (including care for poor seniors and dual-eligibles)**

- ✓ Teaching hospitals fully fund (**receive <u>no</u> Medicare support**) 10,000 training positions.
- ✓ ***All patients in a community benefit from these services*** when they become severely ill, regardless of whether or not they are Medicare beneficiaries.

- **NEW MEXICO PROGRAMS PRODUCE NEW MEXICO PHYSICIANS**
  - ✓ About two-thirds (64%) of physicians who graduate from the University of New Mexico School of Medicine and also complete their GME training in New Mexico remain in New Mexico to practice medicine.

- **PURPOSE: MEDICARE INDIRECT MEDICAL EDUCATION (IME) PAYMENTS**
  - ✓ Since the creation of IME payments, Congress has consistently clarified they are patient care payments that recognize the **<u>unique expertise, resources, and other costs associated with caring for the disproportionately high level of complex and acute patients treated at teaching hospitals</u>**.
  - ✓ **House Ways and Means and Senate Finance Committee Reports 1983** (upon creation of the IME payment): *"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."*
  - ✓ **Health Affairs 2003 (Koenig et al):** The mission-related costs of teaching hospitals **exceed $27 billion a year**, and they have only increased over time
  - ✓ Medicare supports only $6.5 billion of those costs; the level has been effectively capped since 1997

- **PURPOSE: MEDICARE DIRECT GRADUATE MEDICAL EDUCATION (DGME) PAYMENTS**
  - ✓ DGME payments offset a portion of the direct costs associated with training physicians (eg, resident stipend and benefits, supervising physician stipend and benefits, GME office overhead costs).
  - ✓ Teaching hospitals incur (on average) a per resident annual training cost of over $100,000
  - ✓ Medicare's share of that cost (*see section below*) averages $40,000 annually
    - ➢ Teaching hospitals incur about **<u>$13 billion</u>** in direct training costs each year (assume 110,000 residents), while **<u>Medicare supports about $3 billion of that total</u>**.

- **MEDICARE PAYS THE "MEDICARE SHARE"**
  - ✓ Medicare supports only a portion (the "Medicare share") of the costs associated with training a resident. The share is a hospital-specific amount that reflects each hospital's Medicare volume.
  - ✓ Teaching hospitals themselves must offset the balance of each resident's training costs (a declining number of states provide a declining level of support through the Medicaid program).

- **OTHER FEDERAL PROGRAMS SUCCESSFULLY SUPPORT WORKFORCE GOALS**
  - ✓ **MedPAC June 2010 Report to Congress**: "*Several HRSA programs are designed to attract individuals—particularly from minority, rural and low-income communities—to health careers through a variety of incentives, ranging from early education (grade school) programs to loan repayment programs. HRSA programs are also focused on promoting primary care access, particularly in underserved areas, and enhancing the cultural competence of this workforce by funding opportunities for medical students and residents to train in diverse settings and locations. These programs have the potential to improve the mix of health professionals*."

- **PHYSICIAN REIMBURSEMENT INFLUENCES WORKFORCE SUPPLY**
  - ✓ **MedPAC June 2010 Report to Congress**: "*the single most important way Medicare can influence the mix of physicians … is to reform how it pays for services*."
  - ✓ **MedPAC June 2010 Report to Congress**: "[Medical school graduates] *reasonably look at future earnings prospects when choosing a specialty…payment rates can influence that choice*."
  - ✓ **House Ways and Means Committee Report 2009** (on ACA bonus payments for payments for primary care providers and physicians who practice in underserved rural and urban communities): *"[they are] intended to encourage primary care providers who are currently practicing to remain in practice and incentivize additional physicians to choose a career in primary care."*
  - ✓ **House Ways and Means Committee Report 2009** (on ACA bonus payments for payments for primary care providers and physicians who practice in underserved rural and urban communities): "[*the special payments recognize] "the challenges that certain areas of the country face in attracting a sufficient primary care workforce by providing an additional incentive to physicians who practice in health professional shortage areas "*

REQUIREMENTS FOR DESIGNATION
AS A LEVEL I (HIGHEST LEVEL) TRAUMA CENTER:
AN EXAMPLE OF THE UNIQUE PATIENT CARE COSTS
INCURRED BY TEACHING HOSPITALS

REQUIRED MINIMUM Clinical Services

- *Minimum* 1200 trauma admissions annually
- 24 hours/7 days a week in-hospital trauma surgeon and anesthesiologist
- 24 hours/7 days a week immediate access to complete operating room team (team cannot be dedicated to other functions in the hospital)
- 24 hours/7 days a week in-hospital surgical ICU physician
- 24 hours/7 days a week in-hospital radiology staff
- 24 hours/7 days a week in-hospital clinical lab services
- 24 hours/7 days a week access within 15 minutes to a board certified:
    - ✓ Critical Care Physician
    - ✓ Radiologist
    - ✓ Cardiac Surgeon
    - ✓ Hand Surgeon
    - ✓ Neurosurgeon
    - ✓ Orthopedic Surgeon
    - ✓ Microvascular/Replant Surgeon
    - ✓ OB/GYN Surgeon
    - ✓ Eye Surgeon
    - ✓ Oral/Maxilllofacial Surgeon
    - ✓ Plastic Surgeon
    - ✓ Thoracic Surgeon

REQUIRED MINIMUM Education and Research Programs

- Maintain a trauma fellowship and/or trauma-focused residency training programs in related specialties
- Offer educational programs for providers not affiliated with the trauma center (eg, other area hospitals, EMS network)
- Maintain a trauma registry
- Conduct research that investigates issues related to trauma, trauma care, and trauma prevention

THE IMPORTANCE OF SUPPORTING AND MAINTAINING LEVEL I TRAUMA CENTERS FOR NEW MEXICO

★ = LEVEL I TRAUMA CENTER