Cap Flexibility:

Providing New Teaching Hospitals in Areas of Need with Additional Time to Establish Medicare Funded GME Caps

Medicare Should Exercise Existing Authority to Target GME Support to Areas of Greatest Need

Download the full white paper at: www.CapFlex.org

The Centers for Medicare & Medicaid Services (CMS) has both the opportunity and the obligation to leverage its existing authority to establish GME caps in order to strategically target additional support to areas with the greatest need across the country.

Specifically, CMS should allow new GME teaching hospitals[1] located in areas of need, to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years). This would include GME programs currently in their cap-building window.

Injecting flexibility into the cap-building process provides CMS with the ability to supplement the current broad-based cap-building window with a tailored policy designed to target federal funding (while keeping control over incremental costs) to the areas of highest need.

A cap-flexibility policy benefits our national GME system in many ways, including, but not limited to:

- Providing lifesaving opportunities for new teaching hospitals to further develop residency programs and secure the resources necessary to launch and/or scale-up training capabilities. Additional time is vital to ensuring that teaching hospitals in under-resourced areas will be able to build-up to a level necessary to meet regional needs.

- Alleviating regional physician shortages by providing time for institutions to add primary care and/or specialty and sub-specialty residencies in shortage.

- Boosting the return on investment for Medicare, local communities, states, medical schools, and the hosting teaching hospital. By expanding training opportunities, the likelihood of physicians remaining in the underserved area to practice increases.

- Helping address the maldistribution of physicians and GME resources across the country. Cap flexibility incentivizes the establishment of GME programs in areas of high need, without taking away resources away from other areas. As residents tend to practice where they train, adding, developing, and incentivizing the establishment of programs at teaching hospitals

[1] As conceptualized in this proposal, "New" GME hospitals should include those yet to begin the base year of cap-building period as well as those currently in their cap-building window.

located in underserved, under-resourced, and rural areas will help address the current mal-distribution of physicians across the country. Over time, a well-tailored cap-flexibility policy will better align the supply of physicians with demand by creating a more diverse and equal distribution of GME training resources and programs, as well as physicians across the U.S.

Medicare's Critical Role in GME

As the single-largest financer of Graduate Medical Education (GME) in the United States (U.S.), Medicare plays a critical role in shaping the size, makeup, and geographic distribution of the national GME system and physician workforce. Despite this crucial role, however, Medicare funding for GME has evolved without strategic direction or a targeted approach in relation to the nation's physician workforce needs.

Moreover, in 1997, Congress enacted caps on Medicare funded GME slots. These caps have resulted in a national GME system that is not easily and readily able to respond to growing demands, and which does not strategically supply or effectively locate physicians according to demand. Although CMS has adopted regulations that provide rural hospitals with the ability to adjust their GME caps for additional new programs, the current allowance does not go far enough in providing the flexibility new teaching hospitals need to meet workforce needs.

Physician Workforce Issues

The U.S. suffers from a maldistribution of physicians and training programs across the country and is projected to face a **shortage of between 40,800 to 104,900 physicians** by the year 2030. These physician shortages vary widely by both specialty and geography, with no area of the U.S. left unaffected. While some areas of the country have an adequate supply or face minor shortages of primary care and/or specialty physicians and GME programs, other areas face significant shortages.

Particularly, rural, under-resourced communities, and underserved areas are dealing with a dearth of both the physicians and GME programs needed to supply the current and next generation of physicians.

Resource and Time Challenges in Areas of Need

The cap has all but crippled the development of GME program in under-resourced areas with the greatest need. The significant amount of resources, investment, and time required to establish new GME programs is a major barrier to their creation. Accomplishing the requisite groundwork for residency programs is all the more challenging for new teaching hospitals, especially those in medically and economically underserved and/or rural areas where available resources are scarcer and the referral area and community need larger.

Accreditation Requirements

Building residencies to the level of complexity and volume expected for accreditation requires a significant amount of time. Criteria by the Accreditation Council for Graduate Medical Education (ACGME) for example, require new programs to operate under a two or three-year "initial" period before they can be granted "continued" accreditation. These requirements limit a teaching hospital's ability to add additional residency slots or to expand into new specialty or sub-specialty training program(s). Moreover, at the foundation of specialty programs are core primary care residencies that must be established and accredited first. Thus, specialty residencies in many cases take more than the five years provided by the cap to establish which means that a hospital must build these programs without Medicare funding. For rural and under-resourced communities, this is all but impossible.

Location of GME Programs

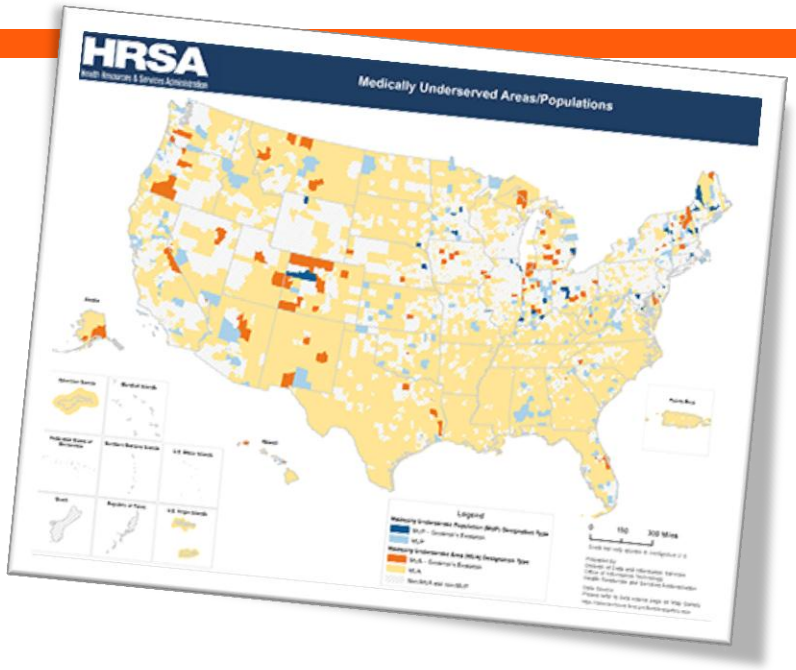
The location of GME programs significantly influences the geographic makeup of the nation's physician workforce. Roughly two-thirds of physicians practice in the same state in which they complete their training. Thus, targeting federal support to underserved areas facing physician shortages is critical in order to build the infrastructure that will supply the next generation of physicians and alleviate local and regional shortages.

Organizations Supporting Cap Flexibility

GME Cap Flexibility Coalition

- Jefferson, Thomas Jefferson University
- NASMHPD
- Texas Hospital Association
- AMA, American Medical Association
- DHR Health
- Augusta University Medical Partnership, University of Georgia
- Baptist Medical Group
- Teaching Hospitals of Texas
- AAFP
- Halifax Health
- Magnolia Regional Health Center, One Patient at a Time.
- Texas Medical Association
- Mississippi Physician Workforce
- The University of Texas Rio Grande Valley School of Medicine
- Applied Policy®

www.CapFlex.org



Strategically Targeting Support to Areas of Need

By design, cap-flexibility is intended to target support to those areas of the country with the greatest need for physicians and GME programs. The areas with the greatest need are more often than not rural, underserved, and under-resourced communities that also face the steepest obstacles to securing the necessary resources to address these issues. Consequently, in designing eligibility for cap-flexibility, CMS should prioritize undeserved and under-resourced communities.

Areas of Need for the purposes of determining eligibility for cap-flexibility should be defined so as to incentivize the establishment or expansion of GME programs in areas of the country that are currently:

- under-resourced and/or neglected;
- experiencing primary care and/or specialty physician shortages;
- struggling to expand or keep GME programs operational;
- lacking existing medical training infrastructure; or
- in the midst of building up such infrastructure.

Defining ***Areas of Need*** in this way provides Medicare with a tailored and targeted approach to direct additional GME support to areas of the country with the most need for such support.

Various criteria and measures could be used to define *Areas of Need*, including, but not limited to:

- Rural areas (as designated by HRSA);
- Medically Underserved Areas (MUAs) as designated by HRSA;
- Areas with shortages in primary-care or specialty for which the GME program is applying;
- Areas that lack access to an established medical school or GME program;
- Areas that lack existing medical training infrastructure, or are in the midst of establishing said infrastructure and would benefit from additional time;
- Hospitals located in states with the lowest resident-to-population ratios, residency slots, or Medicare GME funding;
- Hospitals located in states with the lowest physician to population ratios who demonstrate a shortage in their area;
- Hospitals that emphasize training in community-based settings or in hospital outpatient departments.
- Additional eligibility criteria should be considered for programs partnering with the VHA

A Dynamic, Flexible, and Targeted Policy with Built-In Cost Controls

Through an application and evaluation process, CMS can tailor policy objectives and outcomes to specific hospitals and increase both transparency and accountability. Cap-flexibility represents a dynamic policy solution that can be scaled to the nation's physician workforce needs.

Beyond allowing the Agency to respond to increasing demands, it also allows the CMS to adjust to future financial constraints through the ability to scale policy development according to timing and size of the teaching program needs as well as national physician workforce needs (through the evaluation and approval/denial of applications[2]). Cap-flexibility provides CMS with the ability determine and control incremental costs in a way that the current cap-building window does not.

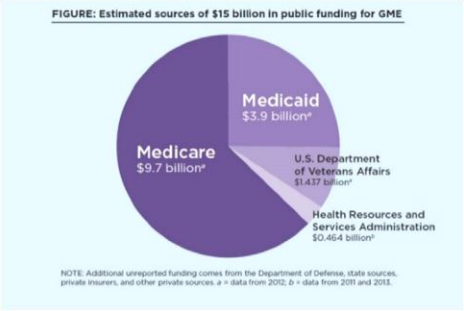
Cap-flexibility may be structured in various ways designed to target the cap-extension more narrowly or broadly, as CMS experiments with the needs of particular programs or regions of the country. CMS can build controlled amounts of elasticity into the program and provide itself with sufficient discretion to:

- Define eligibility requirements to directly address particular disparities in the physician workforce in a specific region;
- Approve applications for an hospital's whole program *or* just specific needs within a program, whether it be primary care or a specialty;
- Approve applications while limiting the number of residency positions programs could add within a set time period or phase them in at a disclosed rate; and/or
- Limit years that can be added within the cap extension.

Furthermore, the application and evaluation process provides CMS an excellent opportunity to examine the challenges and operational capabilities of GME programs across the country. Based on an institution's particular challenges, CMS can tie cap-flexibility approvals to specific metrics.

[2] As proposed in this paper, the cap-building window would function just as it does today, with the exception that new teaching hospitals would have the added opportunity to apply for a cap-extension based on clearly prescribed criteria set by CMS and/or Congress in order to target additional support to under-resourced communities, alleviate physician shortages, and better distribute GME programs and physicians across the nation.

GME FINANCING SNAPSHOT



Medicare Provides Lion's Share of Federal GME Funding

GME programs are financed through a mixture of private and public funding sources. However, the federal government is by far the largest financer. Of the over $15 billion in total federal spending on GME annually, Medicare contributes approximately $10 billion. This qualifies Medicare GME funding as the single largest public investment in the U.S. health care workforce.

FAST FACTS

99%

of residents in GME programs trained in urban areas from 2005 through 2015.

99%

of Medicare GME funding in 2010 went to just 21 states, with one state alone receiving 20% of that funding, while the remaining 29 states received less than 1%.

What is the Cap?

In 1997, Congress enacted caps on Medicare funded GME slots for existing teaching hospitals. For new teaching hospitals, however, CMS has the authority to define the timeframe by which new teaching hospitals can establish these caps.

CMS currently allows for a five-year window to establish caps. During the five-year cap-building window, new teaching hospitals are allowed to add as many residents as their program accreditations allow. However, once the cap-building window is reached, Medicare funding to that particular hospital for all future years is limited by the number of slots the hospital is able to fill during the cap-building window.

While the cap-building window provides new teaching hospitals time to get established, it represents a generalized, inflexible policy that lacks the ability to tailor policy or target areas of the country with the greatest need. CMS does provide narrow flexibility to rural hospitals, however, the flexibility is limited to new programs and does not allow rural, medically, and economically underserved areas to obtain cap-extensions as does cap-flexibility.

CMS Authority

Congress delegated significant - indeed, nearly unlimited - authority to CMS to establish GME caps for new programs, and explicitly provided CMS with flexibility in determining the proper time frame by which new programs can establish permanent caps.[3]

CMS has exercised its authority to establish first a three year window, and subsequently a five year window, and also to grant one particular, if narrow, type of cap relief to rural hospitals.

Although the Secretary has not yet exercised the authority to tailor cap windows to the particular needs of individual teaching hospitals, the statutory framework setting caps at the facility levels and Congressional intent supports the Secretary's ability to do so.

[3] Section 1886(h)(4)(H)(i) of the Social Security Act outlines the requirements. https://www.ssa.gov/OP_Home/ssact/title18/1886.htm

National Physician Workforce Faces Many Challenges

Physician Demand Outpacing Supply

According to the most up-to-date assessment by the Association of American Medical Colleges (AAMC), the U.S. is predicted to face a **shortage of between 40,800 to 104,900 physicians** by the year 2030. The report notes that shortages are projected in almost all categories of physician practices from primary care (8,700 to 43,100 shortfall projected), to medical and surgical subspecialties (projected shortfall of between 33,500 and 61,800), as well as emergency medicine, anesthesiology, radiology, neurology, and psychiatry (shortfall between 18,600 to 31,800).

Despite the growing number of residents year-over-year, physician demand outpaced the supply provided by current resident positions and is projected to continue to do so. According to the AAMC, the primary factors driving demand are population growth and an increase in the number of older Americans. The total U.S. population is expected to grow by about 12% by 2030. Also by 2030, the number of U.S. residents aged 65 and older is expected to increase by 55%.

Geographic Maldistribution of Physicians and Resources Exist

It is important to note that not all things are equal when it comes to physician workforce needs across the U.S. There is a maldistribution of physicians and training programs across the country. In fact, there are significant variances between physician supply and demand amongst the nation's regions, states, and even localities. While some areas of the country have an adequate supply or face minor shortages of primary care and/or specialty physicians and GME programs, many areas, particularly rural and underserved areas, are dealing with a dearth of both the physicians and GME programs needed to supply the current and next generation of physicians.

Location of Training Programs Linked to Workforce Shortages

One important determinant of where physicians end up practicing is where they train. The location of a physician's residency and/or fellowship program is predictive of their ultimate practice location. Despite the growth of GME programs from 2005 through 2015, residents are still overwhelmingly concentrated in urban areas and the resident ratio to the population continues to vary significantly by region of the country, as shown in Figure 3. The concentration of physicians in urban areas or in certain regions of the country can be largely attributed to a concentration of GME programs in those areas.

As residents tend to practice where they train, adding, developing, and incentivizing the establishment of programs at teaching hospitals located in underserved, under-resourced, and rural areas will help address the current mal-distribution of physicians across the country.

PHYSICIAN and RESIDENT LOCATIONS NATIONWIDE

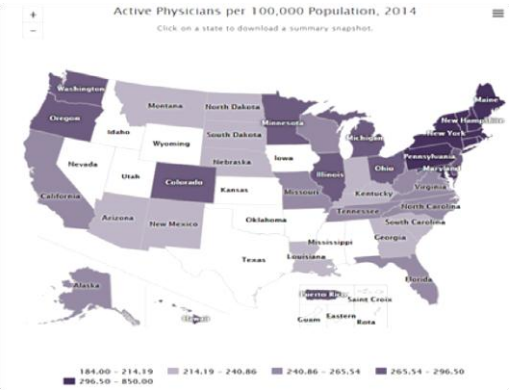


Figure 2 - Active Physicians per 100,000 Population by State

Comparing Figure 2 and Figure 3 illustrates the relationship between GME program locations and where physicians practice after completing training. These figures reveal the number of practicing physicians and the number of residents in each state per 100,000 residents, respectively. Tellingly, the maps present a strikingly similar picture of the concentration of physicians and residents by state.

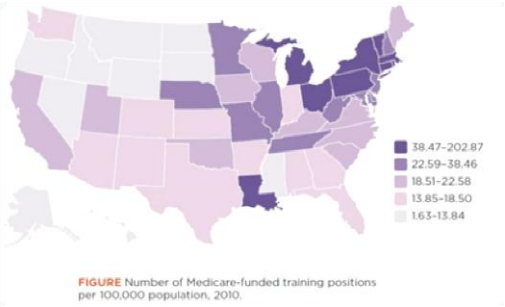


Figure 3 – Number of Medicare-funded Training Positions per 100,000 population (2010)

CMS can and should add flexibility into how new GME programs are allowed to set their resident caps through a strategic and targeted approach, providing incentives and additional assistance for GME programs to develop in areas of need across the country.