Graduate Medical Education Reform Act of 2012 (S. 3201)

Policy Position

- The AAMC supports the "Graduate Medical Education Reform Act of 2012" as an integral component of a larger legislative approach to graduate medical education (GME) reform that addresses short- and long-term workforce demands by increasing the number of Medicare-supported residency positions, such as S. 1627, The Resident Physician Shortage Act of 2011.
- The legislation is a thoughtful approach to achieving transparency and accountability within Medicare's support for GME, and a positive first step that directly aligns with AAMC members' ongoing commitment to advancing medical education in accordance with the country's anticipated workforce needs.

General

- Introduced May 17, 2012 by Senators Jack Reed (D-RI) and Jon Kyl (R-AZ).
- Applies to any hospital that receives Medicare Indirect Medical Education (IME) payments.
- Directs the Health and Human Services (HHS) Secretary to implement a budget neutral Medicare IME Performance Adjustment Program.
- Requires HHS Secretary to submit to Congress and the National Health Care Workforce Commission an annual report on Medicare GME payments.
- Does not expand the current cap on Medicare GME support.

Medicare IME Performance Adjustment Program

I. Measure Development

- HHS Secretary will establish measures of "patient care priorities" in GME that demonstrate the extent of training provided in:
  - The delivery of evaluation and management (E/M) or other cognitive services;
  - A variety of settings and systems;
  - The coordination of patient care across various settings;
  - The relevant cost and value of various diagnostic and treatment options;
  - Inter-professional and multidisciplinary care teams;
  - Methods for identifying system errors and implementing system solutions; and
  - The use of health information technology (HIT).
- The patient care priorities measures must:
  - Be adopted or endorsed by an accrediting organization such as the Accreditation Council for Graduate Medical Education (ACGME); and
  - Be developed through a consensus-based process, and may include measures submitted by teaching hospitals, medical schools, and other stakeholders.

- The Secretary shall propose an initial set of measures for public comment by July 1, 2014.
- The Secretary shall publish a final set of initial measures by January 1, 2015.
- The Secretary may periodically update the measures through notice and comment rulemaking.
- By 2017, the Secretary must report to Congress a report on the measure development process (including possible barriers), program compliance (including possible barriers); and recommendations for addressing possible barriers.

Performance Standards and Reporting of Measures

- The Secretary will establish performance standards for the measures discussed above.
- Beginning in FY 2017, each hospital that does not report patient care measures will have its IME payments reduced by 0.5 percent.
- Starting in FY 2018, hospitals that fail to achieve the new performance standards established by the Secretary will have their IME payments reduced by up to three percent (to be determined by the Secretary).
- The budget neutral section implies that hospitals that successfully exhibit the new performance standards may receive IME bonus payments; however, it's unclear how that will be calculated.
- The IME performance adjustment applies only to payments made in the current year and has no impact on payments in subsequent years.

Increasing Graduate Medical Education Transparency

- Within two years of enactment, the Secretary must begin to issue an annual report on Medicare GME payments, which shall include the:
    - DGME and IME payments made to each hospital;
    - DGME costs of each hospital, as reported on the annual Medicare Cost Reports;
    - Number of full-time-equivalent residents (FTEs) at each hospital that are counted for DGME and IME purposes;
    - Number of FTEs at each hospital that are not counted for DGME and IME purposes; and
    - Factors contributing to higher patient care costs at each hospital, including the:
        - Costs of trauma, burn, other stand-by services;
        - Provision of translation services for disabled or non-English speaking patients;
        - Costs of uncompensated care;
        - Financial losses with respect to Medicaid patients; and
        - Uncompensated costs associated with clinical research.

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