**Training Tomorrow’s Doctors Today Act (H.R. 1201)**

**Policy Position**

The AAMC supports the “Training Tomorrow’s Doctors Today Act” (H.R. 1201) that both addresses short- and long-term workforce demands by increasing the number of Medicare-supported residency positions, and is a thoughtful approach to achieving transparency and accountability within Medicare’s support for graduate medical education (GME). This legislation directly aligns with AAMC members’ ongoing commitment to advancing medical education in accordance with the country’s anticipated workforce needs.

**Summary**

- Introduced by Representatives Aaron Schock (R-IL) and Allyson Schwartz (D-PA);
- Increases, by 15,000, the number of Medicare direct graduate medical education (DGME) and indirect medical education (IME) slots;
- 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 an annual report on Medicare GME payments;
- Requires Government Accountability Office (GAO) study and report identifying physician shortage specialties;
- Requires GAO study on strategies for increasing health professional workforce diversity;
- Requires the Comptroller General to conduct a study addressing the competency of the physician workforce to care for older adults upon completion of residency training and submit a report to Congress along with recommendations for any legislation and administrative action necessary; and
- Includes a series of technical and administrative changes:
  - Eliminates the three-year rolling average;
  - Improves how hospitals record medical resident time spent on didactic activities/scholarly time and research;
  - Prevents unintentionally triggering a non-teaching hospital’s per resident amount (PRA) when resident(s) rotate through that non-teaching hospital;
  - Permits new urban teaching hospitals to participate in affiliation agreements after five years; and
  - Resolves issues with the Initial Residency Period (IRP) when a resident switches residency programs.

**Distribution Methodology for Additional Slots**

- Increases the number of residency slots nationally by 3,000 each year between 2014-18 (total 15,000).
- One-third of new residency slots are available only to teaching hospitals training over their cap.
- At least half of the available new slots each year must be used for a shortage specialty residency program as identified in the GAO physician shortage specialty report.
- Prior to report, directs the HHS Secretary to define shortage specialties as identified by the December 2008 Health Resources and Services Administration (HRSA) report on the physician workforce.
- A hospital may not receive more than 75 slots in any fiscal year.
- In determining which hospitals will receive slots, CMS is required to consider the likelihood of a teaching hospital filling the positions and would prioritize teaching hospitals in the following manner:
  - Hospitals with approved medical residency training programs affiliated with medical schools that have at least 40 percent of graduates matched in primary care residency program in the 5 years prior;
  - Hospitals in states with new medical schools or new branch campuses;
  - Hospitals eligible for electronic health record (EHR) incentive payments;
  - All other hospitals.

**Requirements Associated with Additional Slots**

- Hospitals receiving additional slots must ensure that:
  - At least 50% of the additional slots are used for a shortage specialty residency program;
  - The total number of slots is not reduced prior to the increase; and
  - The ratio of residents in a shortage specialty program is not decreased prior to the increase.
Reimbursement Level for Additional Slots

- Under H.R. 1201, new slots would be reimbursed at the hospital’s otherwise applicable PRA for DGME purposes, and using the usual adjustment factor for IME reimbursement purposes.

Medicare IME Performance Adjustment Program

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) or the American Osteopathic Association (AOA); and
  - Be developed through a consensus-based process, and may include measures submitted by teaching hospitals and medical schools.
- The Secretary shall propose an initial set of measures for public comment by July 1, 2015.
- The Secretary shall publish a final set of initial measures by January 1, 2016.
- The Secretary may periodically update the measures through notice and comment rulemaking.
- By 2018, 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 2018, each hospital that does not report patient care measures will have its IME payments reduced by 0.5 percent.
- Starting in FY 2019, hospitals that fail to achieve the new performance standards established by the Secretary will have their IME payments reduced by up to 2 percent (to be determined by the Secretary).
- The budget-neutral section implies that hospitals that exhibit successfully the new performance standards may receive IME bonus payments; however, it’s unclear how that will be calculated.
- The IME performance adjustment only applies 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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