AAHPM ADVOCACY PLAN
FOR
ENHANCED GRADUATE MEDICAL EDUCATION FOR PALLIATIVE CARE

Issue Overview

AAHPM has a strong desire to promote efforts that will result in increases in the number of faculty and residency opportunities in palliative medicine. AAHPM has expressed interest in promoting two approaches that would accomplish these goals.

The first approach of interest to AAHPM to stimulate expanded palliative medicine residency programs relates to the Medicare Graduate Medical Education (GME) program. Medicare pays for direct graduate medical education (DGME) costs and indirect graduate medical education (IME) costs for approved ACGME programs. Different formulas apply to both payments, but one factor in each formula is the count of residents on rotation at a hospital during the cost year (or at non-provider sites for which the hospital pays the training costs). Medicare will also pay the costs of resident salaries for non-approved programs, but payments for "approved" programs are generally higher.

An approved medical residency program is defined as one that:

1) is approved by the ACGME, the Osteopathic Association, the American Dental Association or the American Podiatric Medical Association; <u>or</u>

2) may count towards certification of the participant in a specialty or subspecialty listed in the current edition of either the AMA Directory of GME programs or the Annual Report and Reference Handbook published by the American Board of Medical Specialties; <u>or</u>

3) is approved by the ACGME as a fellowship in geriatric medicine.

There are caps imposed on the number of residents that a hospital may include in its FTE count for DGME and IME payment purposes. One of these caps is generally known as the "fiscal year 1996" cap and limits an urban hospital's DGME resident count to the DGME and IME resident count during the hospital's fiscal year that ended in 1996. Rural hospitals are limited to 130% of the 1996 resident count. The cap applies to allopathic and osteopathic residents only and does not apply to dental or podiatric residents.

For DGME purposes only, resident time is weighted at 50% for a resident who is beyond his or her initial residency period (up to 5 years), although there are some exceptions. For geriatric residency programs of two or more years duration, an additional two years is considered part of the resident's initial residency period and that time is weighted at 100%. For child neurology residents, the initial residency period is considered the period needed for a specialty in pediatrics plus two years. For residents and fellows in preventative medicine, there is a two-year add-on to the initial residency period. For combined programs in which all of the individual programs are for training primary care residents or obstetrics and gynecology residents, the

initial residency period is the time required for individual certification in the longer program, plus one year.

Hospitals may add to their FY1996 caps for new residency programs, but generally only if the hospital did not train residents during FY1996 or is located in a rural area. There are also some opportunities for an add-on for residency programs with a "rural track" or "integrated rural track."

The second approach would be modeled after the Geriatric Academic Career Award Program (GACA). GACA was established by Congress in the 1998 Health Professions Partnership Act to support the career development of geriatricians in junior faculty positions who are committed to an academic career of teaching clinical geriatrics. GACA provides awards of $50,000 directly to individuals who must establish a relationship with an institution that supports the recipient's career development plan and efforts to provide leadership as a teacher of geriatric care. The awards are made for a five-year period and recipients are required to provide training in clinical geriatrics, including training interdisciplinary teams of health care professionals. The first GACA award was made in 2001, when fourteen individuals received funding. In 2002, twenty awards were made; in 2003, forty new awards; in 2004, thirty-four new awards and in 2005, twelve new awards were provided.

AAHPM believes that GACA would serve as a good model to stimulate interest in palliative medicine careers. To that end, Senator Ron Wyden (D-Oregon) introduced S.1000 the Palliative Care Training Act (PCTA) on May 11, 2005. This legislation amends the Public Health Service Act to create a Hospice and Palliative Care Academic Career Awards program based on the GACA model. The AAHPM expended significant efforts to move forward the PCTA and to date, there are no co-sponsors to this legislation.

AAHPM Advocacy

- AAHPM has chosen 100% Medicare payment for palliative medicine fellowship programs as its top educational advocacy priority.
- AAHPM should highlight data to support the argument that palliative medicine is of great concern to the providers and patient community and that presently there are unmet needs in this area of medicine. The need to train palliative medicine specialists needs to be emphasized. These arguments should be made by not only AAHPM but other organizations with an interest in hospice and palliative care.
- AAHPM should retain services of highly regarded research organizations such as the Lewin Group or university based researcher to document care for unmet palliative care needs. Data should focus on potential cost savings for health care programs.

- Efforts to convince Congress to amend Medicare to allow for 100% payment of post residency fellowship for palliative medicine would focus on members serving on the Senate Finance and House Ways and Means Committees.

- AAHPM must find Congressional members willing to introduce and push legislation that would amend Medicare. The preference would be for a law maker serving on Finance or Ways and Means Committees.

- AAHPM must be prepared to respond to objections to a Medicare Amendment based on cost and need from other medical specialty groups who will demand similar treatment. AAHPM should anticipate objections from AMA and AAMC in any effort to obtain a Medicare fix for one specialty group alone.

- AAHPM should be aware of the change in policy at AMA and AAMC regarding physician supply and be prepared to work with these groups on the subject of physician shortages.

- AAHPM should conduct a "call to action" if and when legislation is introduced seeking a Medicare change to benefit palliative medicine.

- AAHPM should arrange meetings with all members of Senate Finance and House Ways and Means Committees to discuss palliative care needs. Similar meetings should be arranged with MedPAC, CMS, AHRQ and HRSA.

- AAHPM should seek partners, both Congressional and other organizations, to make the argument that palliative care needs are not being met in the health care system.

- S.1000 was referred to the Senate HELP Committee. Advocacy efforts would be focused on members of this Committee;

- S.1000 advocacy efforts would need to be coordinated with Senator Wyden. It would be necessary to arrange meetings with the Senator's Senior Health Care Policy Advisor Stephanie Kennan to review the history of the legislation and current level of Senator Wyden's interest in pushing this bill.

- Success in passage of S.1000 would depend on securing Republican co-sponsors, in particular Senators serving on the HELP Committee and support from "ranking" Democrat Senator Ted Kennedy.

- AAHPM would need to identify AAHPM members from the states that match with key members of the HELP Committee. AAHPM members would need to be trained and provided with a script and information about this Bill before being asked to contact HELP committee members. The goal would be to gather as many HELP Committee co-sponsors as possible to indicate support for S.1000.

- Senator Wyden should be asked if he would consider placing directive language, known as a "soft earmark" in the HRSA section of the FY2008 HHS appropriations bill in support of expanding the GACA program to address palliative care.

- AAHPM would work with Senator Wyden's office to determine if he would be willing to distribute a "Dear Colleague" letter to all Senators seeking support for S.1000. This letter would be best sent if also signed by a Republican Senator preferably one serving in the HELP Committee.

- Efforts should be made by AAHPM working with Senator Wyden to identify a member of the House of Representatives who would be willing to introduce "companion" legislation to S.1000 in the House of Representatives. It would be best if this House sponsor sat in the House Energy and Commerce Health Subcommittee which would have jurisdiction over legislation of this nature.

- AAHPM should consider issuing a "call to action" to all AAHPM members asking that they contact their Senators to get them to agree to co-sponsor S.1000. AAHPM members would be provided with background information, talking points, and a sample letter to assist in the call to action. AAHPM members would be provided with a list of their Senators with phone numbers and e-mail addresses for the health staff, who they should contact to ask for support for this bill.

- AAHPM should askfor support to pass this legislation from other organizations, as it will be very difficult to pass this bill working alone.

- AAHPM should consider retaining the services of a public relations firm to conduct messaging on unmet palliative care needs. P.R. would be coordinated with Congressional advocacy schedule and activities. AAHPM leaders should approach health press to raise these issues and "drive the issue" to gather support.