Financing Graduate Medical Education — Mounting Pressure for Reform

John K. Iglehart

Disparate voices from the White House, a national fiscal commission, Congress, a Medicare advisory body, private foundations, and academic medical leaders are advocating changes to Medicare's investment in graduate medical education (GME), which currently totals $9.5 billion annually. They offer various prescriptions, including reducing federal support, developing new achievement measures for which GME programs should be held accountable, and seeking independent assessment of the governance and financing of training programs. The recommendations come at a time when, whatever the outcome of the November election, Congress and the White House will soon resume their close scrutiny of federal programs in an effort to reduce the massive federal deficit.

The influential GME community has withstood most past efforts to change Medicare's GME policies. But recognizing today's more challenging political environment, the Association of American Medical Colleges (AAMC) has begun discussing alternative methods of financing GME that could better align training with the future health care delivery system and address U.S. workforce needs. The association is also examining the influence of student debt on the enrollment of a diverse student body.

When Congress enacted Medicare in 1965, it assigned to the program functions that reached well beyond its mission of financing health care for the elderly. One function was supporting GME, at least until the society at large undertook "to bear such education costs in some other way." Almost 50 years later, Medicare remains the largest supporter of GME, providing both direct payments to hospitals that cover medical education expenses related to the care of Medicare patients (about $3 billion per year) and an indirect medical education (IME) adjustment to teaching hospitals for the added patient-care costs associated with training (about $6.5 billion).

Congress has rejected the attempts of most past administrations to reduce Medicare's GME support, although in the Balanced Budget Act of 1997, legislators did cap the program's support for training. In its 2013 budget, unveiled on February 13, 2012, the Obama administration proposed reducing Medicare's IME adjustment by $9.7 billion over 10 years, beginning in 2014, citing a report from the Medicare Payment Advisory Commission (MedPAC) indicating that Medicare's IME adjustments "significantly exceed the actual added patient care costs these hospitals incur."[1]

The administration also proposed that the secretary of health and human services be granted the authority to assess GME programs' performance in instilling in residents the necessary skills to promote high-quality health care. Similarly, MedPAC had recommended redirecting about half the IME adjustments ($3.5 billion) into "incentive payments" that GME programs could earn by meeting performance standards.[1] The Obama budget would also eliminate coverage of the IME expenses of free-standing children's hospitals with pediatric residency programs — which do not treat Medicare patients — reducing their federal support by 66% (to $88 million).

In recent years, Congress has revealed its uncertainty over how to change federal workforce policy.[2] In the Affordable Care Act (ACA), Congress emphasized the importance of expanding the primary care workforce. But legislators rejected the AAMC's call to expand the number of Medicare-funded GME positions by 15% in response to reported physician shortages in some specialties. And the National Commission on Fiscal Responsibility and Reform, which included 14 senior congressional leaders, recommended substantial reductions in Medicare's GME support but failed to muster the votes necessary to send its package to the House and Senate floor for consideration.

On December 21, seven senators — Democrats Michael Bennet (CO), Jeff Bingaman (NM), Mark Udall (CO), and Tom Udall (NM) and Republicans Mike Crapo (ID), Chuck Grassley (IA), and Jon Kyl (AZ) — sent a letter to the Institute of Medicine (IOM) encouraging it to "conduct an independent review of the governance and financing of our system of [GME]." They urged the IOM to explore subjects including accreditation; reimbursement policy; the use of GME to better predict and ensure adequate workforce supply in terms of type of provider, specialty, and demographic mix; GME's role in care of the underserved; and use of GME to ensure the creation of a workforce

with the skills necessary for addressing future health care needs. The senators emphasized their interest "in IOM's observations about the uneven distribution of GME funding across states based on need and capacity, and how to address this inequity." In an interview, Bingaman said he initiated the letter for the same reasons he had championed creation of a National Health Care Workforce Commission as part of the ACA: to strengthen the government's resolve to do "a more credible job of assessing workforce shortages" and because he believes Medicare's GME policies are "outmoded." Republicans have opposed appropriating the $3 million requested for launching the workforce commission because its authority derives from the ACA.

The priorities cited in the IOM letter parallel some of the recommendations of a group of academic medical leaders who gathered at two conferences underwritten by the Josiah Macy Jr. Foundation. At the first conference, in October 2010, the top recommendation was that "an independent external review of the goals, governance, and financing of the GME system should be undertaken by the Institute of Medicine, or a similar body."[3] George Thibault, president of the Macy Foundation, says the group concluded that "because GME is a public good and is significantly financed with public dollars, the GME system must be accountable to the needs of the public." Acknowledging that some people in academic medicine "favor a behind-the-scenes discussion of GME reform alternatives," Thibault noted, "I believe we should be upfront, providing examples of change that could influence the thinking of policymakers." The foundation awarded the IOM $750,000 — about half the support it needs for the GME study.

The AAMC has strongly opposed reductions in federal GME support, asserting that such reductions would destabilize programs. But the association and its teaching-hospital members recognize that training programs may face a more hostile environment as Congress grapples with deficit reduction. Among subjects under discussion are the collection of more data highlighting the importance of the safety-net functions and unique services of academic medical centers and the creation of a long-term vision for GME financing that is more closely aligned with emerging care delivery models, such as accountable care organizations. The association is also revisiting a potential financial model under which all health care payers would explicitly cover GME expenses. Private insurers maintain that they accomplish this implicitly by paying teaching hospitals more for clinical services than they pay most other hospitals. GME leaders think one possibility would be to include the costs of residency training when calculating premium amounts for products sold through health insurance exchanges. Similarly, a recent Carnegie Foundation report asserted that "GME redesign demands . . . a more broad-based, less politicized flow of funds."[4]

"We recognize that GME programs must accelerate their efforts to demonstrate accountability for the support Medicare provides for advanced training," said Dr. Darrell Kirch, chief executive officer of the AAMC, "and we are prepared to engage in that discussion with policymakers." Kirch added, "A significant step forward is the announcement by the ACGME [Accreditation Council for Graduate Medical Education] describing major changes in how the nation's residency programs will be accredited in the future, putting in place an outcomes-based evaluation system by which new physicians will be measured for their competency in performing the essential tasks necessary for clinical practice in the 21st century."[5]

Congress won't address Medicare's future until its 113th session convenes in January 2013, with the probable exception of eliminating the 27% reduction in Medicare's physician fees scheduled to take effect January 1. However, under the Budget Control Act crafted by the Joint Select Committee on Deficit Reduction (the super committee), all federal programs will be subject to a 2% budget cut over the period from 2013 through 2021 — cuts totaling $1.2 trillion. And that's likely to be only the first skirmish in a prolonged partisan battle over deficit reduction.

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Mr. Iglehart is a national correspondent for the *Journal*.

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