

Proposed Federal Budget Cuts GME, Freezes NIH Funding

AAMC Reporter: March 2012

—By Sarah Mann

After several months of national conversations about the need to reduce the federal deficit, President Obama released his fiscal year (FY) 2013 budget that proposes to lower the national debt by \$3.2 trillion over 10 years. But for medical schools and teaching hospitals, there is bad news: About 9 percent of that reduction, or \$358 billion over 10 years, will come from Medicare and Medicaid programs, including graduate medical education (GME).

With such drastic cuts, leaders at medical schools and teaching hospitals are considering how they will continue to fund GME and other special services that teaching hospitals provide.

The administration's budget blueprint assumes a 10 percent cut (\$9.7 billion over 10 years) in Medicare indirect medical education (IME) payments, which teaching hospitals receive in recognition of the unique services associated with physician training programs. In addition, the budget assumes a 67 percent (\$177 million) reduction in the Children's Hospital Graduate Medical Education program, which helps fund GME training at pediatric hospitals. A teaching hospital's GME funding is closely tied to the number of doctors it can train, and GME cuts could further deepen the current physician shortage. The AAMC's Center for Workforce Studies has projected a shortage of 90,000 doctors within 10 years.

In addition, the budget would freeze funding for the National Institutes of Health (NIH) at FY 2012 levels.

"The cuts to teaching hospitals through the plan's drastic reductions to Medicare will hurt beneficiaries and exacerbate the already critical shortage of doctors in the United States," said AAMC President and CEO Darrell G. Kirch, M.D. "The significant cuts to Medicare IME payments proposed in the president's budget would reduce the ability of teaching hospitals and their physicians to care for the most vulnerable in our communities—seniors and the underserved."

Although GME funding concerns are not new—there has been a cap on federally funded GME positions, as well as a steady reduction in support since 1997—these cuts come while many institutions already are facing rising operational costs, lower insurance reimbursements, and in some states, reduced Medicaid funding.

"My view is that this is the wrong time to be putting a bigger burden on teaching hospitals in terms of their GME mission," said Sheldon Retchin, M.D., M.S.P.H., CEO of Virginia Commonwealth University Health System. "GME funding has been flat already. I think the reaction is going to have to be, one way or another, some reduction in the number of training spots."

Historically, many teaching hospitals have funded GME positions by redirecting a portion of their clinical revenues to residency training programs. But clinical revenues also are dropping, forcing many teaching hospital leaders to find new ways to fill the funding gaps.

"Declining government funding has caused a flurry of activities to look at how funds flow between the departments and missions of teaching hospitals," said Joanne M. Conroy, M.D., AAMC chief health care officer. "Teaching hospitals need to know how well integrated and how efficient their operations are, in specific and explicit terms."

At the University of California San Diego Health System, efficiency is the top priority to stretch its hospital and medical education dollars.

"Every year we look at efficiencies," said Tom Jackiewicz, CEO at San Diego. "I'm not sure how much more efficiency we can squeeze out, but I feel obligated to make sure we maintain that focus."

Health care "extenders," such as nurse practitioners and physician assistants, play an increasingly important role in efficiency improvement, said Jackiewicz, who served as national chair of the AAMC Group on Business Affairs. Quality control, safety measures, silo integration, information technology, and staff wellness programs are important efficiency components. To address these issues, many teaching hospitals are hiring "chief transformation officers"

who help cut costs, improve efficiencies, discourage retrenchment, and stretch medical education dollars that come from hospital revenues.

Regardless of how they trim their budgets, many hospitals will need to rethink how they fund GME.

“There’s a limit. I think it’s getting closer and closer to the point where the price is so sensitive that we have to constrain the growth of the residency programs just because we can’t afford it,” Retchin said. “I think that the days of relying on clinical revenue to support missions that are important to the communities in terms of research and education are going to have to be constrained.”

The NIH budget freeze also could place a further strain on medical schools and teaching hospitals that conduct medical research.

“I think we’ve probably grown very resilient to being hit from multiple directions, but I just don’t remember the pressures from virtually every side,” Retchin said.

John Erwin, M.B.A., executive director of the Conference of Boston Teaching Hospitals, said the NIH budget freeze could have significant implications in the Boston area, reaching beyond medical schools and teaching hospitals.

“We have one of the largest life sciences clusters in terms of biotech and medical device manufacturers,” Erwin said. “All of these companies say that they locate in Massachusetts because of the concentration of federal research dollars that are here. If these funding cuts are coming off the bottom line, the research suffers and I think the larger life sciences industry could also suffer.”

Obama’s budget proposes to cut several other programs important to academic medicine, including Title VII health professions programs, the National Health Service Corps, and the Centers for Disease Control and Prevention. The budget would increase funding for the Agency for Healthcare Research and Quality, the National Science Foundation, and the Food and Drug Administration.

Mike Martin contributed to this article.