

**Memorandum for the Policy Assembly:
GRADUATE MEDICAL EDUCATION REFORM**

QUESTIONS FOR THE POLICY ASSEMBLY:

This memorandum provides a brief overview of graduate medical education reform legislative status, primary reform issues, and points of contention. The current state of graduate medical education policy raises several questions:

- *How is the AAHC's perspective on graduate medical education policy reform different from other major stakeholders?*
- *What are the fundamental principles that should form the basis for our national graduate medical education policy?*
- *What new paradigms for graduate medical education – and more broadly, health professions education -- provide the most compelling basis for a shift in the reform debate?*
- *What are the most persuasive arguments for shifting the locus of graduate medical education from teaching hospitals to training programs?*
- *Is the AAHC prepared to adopt policy positions that may be objectionable to teaching hospitals or divisive within the health professions community? What steps can the AAHC take to engage these objections constructively?*

LEGISLATIVE STATUS:

The Medicare program covers a portion of costs associated with graduate medical education through two payments: direct graduate medical education (DGME) payments, which help fund resident stipends and benefits, as well as other costs directly related to residency training; and indirect medical education (IME) payments, which help cover the higher patient care costs incurred by teaching hospitals. Medicare DGME payments totaled about \$2.7 billion and IME payments totals about \$5.7 billion in FY2008. Medicare's share of direct GME costs are based on each hospital's ratio of Medicare inpatient days to total days, with teaching hospitals largely bearing the remaining costs of training and other missions. The Medicaid program also provides some support for GME in 47 states and the District of Columbia.

In 1997 the Balanced Budget Act capped the number of residency slots supported by Medicare at the then-current level. Hospitals may choose to create additional slots above the hospital-specific cap, but Medicare does not fund them. The Balanced Budget Act also capped the number of residents used in the IME payment formula.

Because increasing health care coverage through health reform would likely increase demand for physician services, the health reform debate renewed discussion among policymakers about raising the cap, which many see as an impediment to educating more physicians. In May House and Senate bills were introduced to increase the number of

residency training slots by 15 percent (or approximately 15,000 slots) and distribute the new slots in a way that gives preference to teaching hospitals that commit to expanding or creating more primary care and general surgery residencies, emphasize community-based training, or are in areas with rapidly growing populations. The legislation also redistributes residency slots currently lost when the hospital that supports them closes, and removes barriers to resident training in non-hospital settings. Although pending House and Senate health reform bills include provisions to redistribute unused GME training slots, they do not yet reflect this proposed 15 percent increase or specific reallocation scheme.

The Medicare Payment Advisory Committee (MedPAC), which advises Congress on Medicare issues, voted last January to recommend reducing indirect medical education (IME) payments by 18 percent. However, provisions in pending House and Senate health reform bills maintain current IME levels.

PRIMARY REFORM ISSUES:

In the broadest terms, four types of graduate medical education reforms have been under discussion by various commentators, advisory groups, health professions organizations, health professions education organizations, and/or policy makers for more than a decade: (1) broadening the pool of contributors to fund graduate medical education beyond Medicare and Medicaid; (2) making the funding “follow the student”; (3) expanding and reallocating the currently capped number of residency slots; and (4) expanding graduate medical education to a broader spectrum of health professionals. Numerous reform proposals have addressed different combinations of some but not necessarily all of these issues.¹

¹ As on illustrative example, COGME's 19th report include the following recommendations:

- *Recommendation 1* calls for aligning GME with future healthcare needs. This is entirely in keeping with MedPAC's recommendation and the current interests of the Senate Finance and HELP committees. The future of healthcare is moving more care, particularly complex care, into the community and even patients' homes. Our current training infrastructure and funding will not prepare physicians for this future. There is a concerted effort to transform primary care practice into more robust, more complex Medical Homes. We must train the next generation of physicians in this model and GME funding could facilitate this. Medicare's investment in graduate medical education training should be accountable for the health of the public, particularly Medicare beneficiaries, and should move training into new places and models.
- *Recommendation 2* calls for a broadening of the definition of "training venue". There is currently an imbalance in the locus of training that is not adequately preparing a physician workforce for outpatient care, where most of health care takes place, nor in exposing young physicians to rural and underserved settings. Medicare and Medicaid beneficiaries would benefit from physician training moving out of the hospital into rural and community health centers and physician offices, both directly, in terms of service, but later as physicians exposed to working in these settings decide it is a career option. Training in community, rural and underserved settings has been shown to increase physician choice of working in such settings. [11] The Government Accountability Office has emphasized the intractable problem of physician distribution twice in the last decade. [12], [13] GME funding has become a barrier rather than a facilitator of improving physician distribution and access to care.
- *Recommendation 3* is to remove regulatory and statutory barriers limiting flexible GME training programs and training venues. Recent regulatory efforts to pay for community-based GME by private practice physicians had the unintended consequence of retrenching training back in hospitals. CMS had the good goal with the “Community Preceptor”

Broadening the Pool of Contributors. As noted above, graduate medical education is currently funded by Medicare with some supplemental state-level funding. Various organizations (including the AAHC in the mid-1990s) have called for all payers to contribute to funding graduate medical education on the grounds that all payers benefit from graduate medical education. For example, one organization has called for an annual contribution from private insurers of \$20 per beneficiary, which would generate approximately \$4 billion.

Funding “Following the Student”. Currently Medicare DGME and IME payments are made to teaching hospitals rather than directly to training programs. A number of organizations have argued that funding should “follow the student” rather than be made to teaching hospitals. Advocates of this approach argue that payment for training should be made directly to the training program to allow programs to offer the kind of training necessary to meet community needs and to be accountable for the training, believing that the current system does not support primary care training in all sites where care is delivered. They also argue that the residency program must meet accreditation standards and is responsible for the product, but doesn’t have control of funding to ensure appropriate training.

Expanding and Reallocating Residency Slots. As noted above, expanding the number of residency slots is often argued as crucial to creating a supply of physicians necessary to meet expected increased demand for services. In terms of reallocation of the slots, several objectives have been identified, including geographic redistribution, redistribution toward non-hospital settings, and significantly increased targeting toward the training of generalists and specialists willing to practice in underserved communities.

Expanding GME to a Broader Spectrum of Health Professionals. DGME and IME are currently directed toward the training of physicians. Other health professions have argued the lack of comparable funding is contributing to critical shortages in their health professions.

POINTS OF CONTENTION:

All four of these types of reform have met resistance from some stakeholders. For example, private payers have objected to all payer funding on the grounds that their contribution is

regulation of paying for community physician education of trainees. Unfortunately the required payment, or reporting required to avoid it, had the reverse effect of pulling those positions back into hospitals. This new regulation and Medicare’s 40 year old model of paying for physician training stand in the way of progress. If Medicare GME funding is retooled, the regulatory process must also be directed by statute, not just report language, to create incentives to accommodate these changes.

- *Recommendation 4* calls for making accountability for the public’s health the driving force for graduate medical education. The nearly \$10 billion spent annually on GME can no longer afford to be bent to the needs of hospitals. We appreciate the need to help teaching hospitals with the problems of workforce and financial solvency that GME currently serves, but we cannot afford the byproduct of an overly-specialized and expensive physician workforce. With modification the byproduct of GME funding could be a reshaping of the role of teaching hospitals in meeting the needs of the public. Clearly, 25% growth in subspecialty training when there is no societal imperative for this makes this dependence even more explicit and at odds with societal needs.

implicit in the higher rates they pay compared to public payers. Because DGME and IME payments are now well established, they have become an entrenched element of teaching hospitals' budgeted revenue streams, making any alterations objectionable. Similarly, the entrenched allocation of residency slots also gives rise to resistance to change; as a result many reallocation proposals are limited to reallocating new or unused slots. Not surprisingly, proposals to reallocate a portion of graduate medical education payments to health professionals other than physicians have also raised objections from recipients of current payments.

Although there is a broad consensus within the health professions community that reform is needed, including a greater emphasis on primary care, there are significant divisions within the health professions community regarding how best to accomplish those objectives. For example, the legislation mentioned in the legislative status section, which is generally viewed as based on a well known organization's reform proposal, has been criticized by others within the health professions community as "pro-primary care language camouflaging a clandestine specialty-driven agenda."