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AAHC PERSPECTIVES ON HEALTH REFORM, PART 3: GRADUATE MEDICAL EDUCATION

The recently enacted Patient Protection and Affordable Care Act (PPACA, Pub L 111-148) embodies the most significant changes in federal health policy in 40 years. Provisions related to hospital reimbursement, reductions in disproportionate share hospital (DSH) payments (once reduction in uninsured thresholds are reached), fraud and abuse, quality improvement, research, manufacturers' payments to physicians and teaching hospitals, graduate medical education, student loans, and health workforce will affect academic health centers in ways both anticipated and unanticipated by the drafters.

PPACA Section 5503 amended Section 1886(h) of the Social Security Act regarding the reallocation of unused residency slots, but does not include a number of additional proposed amendments considered during the health reform debate. This third in a series of analyses by the Association of Academic Health Centers (AAHC) examines the new provision, as well as the ongoing debate over additional GME reforms, and assesses their strategic implications for AAHC member institutions.

OVERVIEW OF PPACA'S GRADUATE MEDICAL EDUCATION PROVISIONS

Legislative Background: 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 \$3 billion and IME payments totaled about \$6.5 billion in FY2009.¹ 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 most 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.

¹ MedPAC Report to Congress, June 2010. While the focus of this analysis is federal funding of graduate medical education, it should be noted that, according to AAMC, state funding of graduate medical education eroded by about \$0.6 billion from 2005 to 2009, as fewer states fund graduate medical education, at lower levels, than they have in the past.

Because increasing health care coverage resulting from health reform is expected to 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 2009 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 proposed legislation also would redistribute residency slots currently lost when the hospital that supports them closes, and removed barriers to resident training in non-hospital settings.

Summary of PPACA Provisions: PPACA includes some, but not all, of the provisions contained in the House and Senate bills. Beginning in July 2011, it redistributes unused residency slots, with seventy percent of the redistributed slots allocated to states with the lowest physician-to-resident populations. It does not include provisions to increase the total number of residency slots, however.

PPACA made several technical changes relating to GME reimbursement, including a provision allowing hospitals to count didactic time in outpatient settings for direct cost calculations, and to count didactic time in inpatient settings for indirect cost calculations, as well as a provision allowing hospitals to count resident time at non-hospital sites, so long as the hospital is incurring the costs of stipends and fringe benefits while the resident is in that setting. PPACA also includes reductions in Disproportionate Share Hospital (DSH) payments, the size of which will depend on the level of health insurance coverage expansion achieved. PPACA is estimated to cut Medicaid DSH payments by about \$14.0 billion and Medicare DSH payments by about \$22.1 billion over 10 years.

POST-PPACA GRADUATE MEDICAL EDUCATION REFORM DEBATE

Long History of Reform Debate: The debate over graduate medical education reforms, including proposals to redirect expenditures toward primary care, have been ongoing for decades. For example, in 1985 *Health Affairs* published a commentary by then-Indiana Senator Dan Quayle proposing that as much as 70 percent of available GME positions be allocated to primary care specialties.² Much more recently, COGME's 19th report (issued September 2007) stressed, among other priorities, the need to realign GME with future workforce needs, such as transforming primary care practice into more robust Medical Homes.³

² A copy of the Health Affairs Commentary, titled "Graduate Medicare Education: A Proposal for Reform," is available online at <http://content.healthaffairs.org/cgi/reprint/4/1/89.pdf>

³ COGME's 19th report is available for download at <http://www.cogme.gov/19thReport/default.htm>. In a May 5, 2009 letter to Secretary Sebelius and key Congressional Committees, COGME's Chair and Vice Chair summarized the recommendations contained in COGME's 19th report as follows:

"Recommendation 1 of the 19th COGME report 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.

Following the enactment of PPACA and its comparatively limited GME provisions, the focal point of the policy debate shifted to the proposal unanimously approved by MedPAC during its recent April 1-2, 2010 meeting. MedPAC recommended cutting \$3.5 billion of what it deems to be excess indirect medical education payments and using the savings to fund incentive payments based on new performance-based standards established by the Secretary.⁴ A more detailed discussion of the state-of-play in the congressional debate

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 of the 19th COGME report 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 of the 19th COGME report 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" 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 of the 19th COGME report 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."

⁴ See Chapter 4 of MedPAC's June 2010 report, which can be downloaded online at www.medpac.gov/documents/Jun10_EntireReport.pdf. Chapter 4 includes the following recommendations:

"4-1 The Congress should authorize the Secretary to change Medicare's funding of graduate medical education (GME) to support the workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality.

- The Secretary should establish the standards for distributing funds after consultation with representatives that include accrediting organizations, training programs, health care organizations, health care purchasers, patients, and consumers.
- The standards established by the Secretary should, in particular, specify ambitious goals for practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, including integration of community-based care with hospital care.
- Performance-based GME funding under the new system should be allocated to an institution sponsoring GME programs only if that institution met the new standards established by the Secretary, and the level of funding would be tied to the institution's performance on the standards.

surrounding the MedPAC proposal is included in a recent *New England Journal of Medicine* health policy report by John Iglehart.⁵

Four Broad Categories of Proposed Reforms: In the broadest terms, four categories of graduate medical education reforms have been discussed by various commentators, advisory groups, health professions organizations, health professions education organizations, and/or individual policy makers during the last decade. Numerous proposals, in addition to those already mentioned above, have addressed different combinations of some, but not necessarily all, of these four categories of GME reform.

1. **Broadening the pool of contributors to fund graduate medical education beyond Medicare and Medicaid.** -- 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.⁶
2. **Making the funding “follow 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

The indirect medical education (IME) payments above the empirically justified amount should be removed from the IME adjustment and that sum would be used to fund the new performance-based GME program. To allow time for the development of standards, the new performance-based GME program should begin in three years (October 2013).

4-2 The Secretary should annually publish a report that shows Medicare medical education payments received by each hospital and each hospital's associated costs. This report should be publicly accessible and clearly identify each hospital, the direct and indirect medical education payments received, the number of residents and other health professionals that Medicare supports, and Medicare's share of teaching costs incurred.

4-3 The Secretary should conduct workforce analysis to determine the number of residency positions needed in the United States in total and by specialty. In addition, analysis should examine and consider the optimal level and mix of other health professionals. This work should be based on the workforce requirements of health care delivery systems that provide high-quality, high-value, and affordable care.

4-4 The Secretary should report to the Congress on how residency programs affect the financial performance of sponsoring institutions and whether residency programs in all specialties should be supported equally.

4-5 The Secretary should study strategies for increasing the diversity of our health professional workforce (e.g., increasing the shares from underrepresented rural, lower income, and minority communities) and report on what strategies are most effective to achieve this pipeline goal.”

⁵ A copy of John Iglehart's NEJM health policy report, titled “Health Reform, Primary Care, and Graduate Medicare Education,” is available online at <http://healthcarereform.nejm.org/?p=3770>.

⁶ See Society of Teachers of Family Medicine, <http://stfm.org/advocacy/issues/gme.cfm>.

sites where care is delivered. They also argue that residency programs must meet accreditation standards, and are responsible for appropriate training, but do not in fact have control of funding to ensure appropriate training.

3. **Expanding and reallocating the currently capped number of 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 resulting from health reform and concurrent demographic trends. 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.
4. **Expanding graduate medical education 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. This is viewed as especially critical in light of health care reform, which will generate needs that can only be met both efficiently and cost-effectively by maximizing the contribution of all health professions.

Points of Contention: The strongest point of contention surrounding graduate medical education, as the discussion above regarding MedPAC's proposal suggests, is cost. Citing the continued growth of residency slots not funded by Medicare, critics have argued that federal funding of graduate medical education is neither necessary nor appropriate. Other critics, while acknowledging an appropriate federal funding role, argue that the public receives poor value for its multi-billion dollar investment due to ineffective targeting of GME expenditures toward public policy priorities. The concern is reflected in growing interest in, if not insistence on, incorporation of metrics and performance-based incentive payments as a quid pro quo for continued federal funding.

All four categories of proposed reforms discussed above have met with resistance from some stakeholders. For example, private payers have objected to all-payer funding of graduate medical education on the grounds that their contribution is 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 the need for 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 House and Senate legislation mentioned in the legislative

status section has been criticized by some within the health professions community as “primary care language camouflaging a clandestine specialty-driven agenda.”⁷

STRATEGIC IMPLICATIONS FOR ACADEMIC HEALTH CENTERS:

Because academic health centers include, by definition, multiple health professions schools, they would be directly impacted by all four categories of graduate medical education reform. How well an individual academic health center can balance the competing interests implicit in these categories of reform is likely to be strongly influenced by its prevailing cultural values and degree of alignment. In particular, academic health centers associated with teaching hospitals that rely heavily on GME funds will face significant challenges should the nature of GME funding be altered significantly for the first time in several decades.

Although strong arguments can be made for broadening the financing base for graduate medical education beyond Medicare as the nature of the health care system continues to evolve away from inpatient care, the current economic climate makes any expansion of GME funding a hard political sell. Federal budgetary pressure to increase the return on investment in graduate medical education, if not reduce GME expenditures outright, suggests that expansion of performance-based approaches may be inevitable if funding levels are to be preserved, and are likely to be prerequisite to any political consideration of broader reforms and expanded funding. Thus, academic health centers have an interest in and opportunity to influence the nature and extent of any performance standards and incentives.

Finally, the political constraints impacting the likelihood of achieving graduate medical education reform and expansion raise the question whether academic health centers should look to new partners to support graduate medical education. For example, health reform’s expansion of coverage creates opportunities for new players, such as major retailers, to enter or expand their presence in the health care marketplace, but only if there is an adequate supply of health professionals to support the expanded coverage. Stakeholders looking to establish or expand their market presence may find it in their own interest to partner with academic health centers to support innovative new approaches to funding graduate medical education.

CONCLUSIONS:

PPACA’s enactment left many of the most pressing graduate medical education reform issues unaddressed. The current economic and government budgetary environment may make contraction of federal GME funding more likely than expansion, and suggests that performance standards and incentives will become enduring features of federal GME funding from this point forward. The difficulty academic health centers will have navigating the

⁷ See blog post titled “Lost in Translation: Primary Care in the Perilous Game of GME Redistribution and Expansion,” at <http://medicaleducationfutures.org/blog/2009/12/lost-in-translation-primary-care-in-the-perilous-game-of-gme-redistribution-and-expansion/>.

political shoals of GME reform suggests it may be time to form or expand partnerships with non-governmental stakeholders to support graduate medical education in innovative ways.