SHARE SGIM Forum
MARCH 2019 V42, NO.3

HEALTH POLICY: PART I

CONSIDERING INNOVATIVE FUNDING FOR GRADUATE MEDICAL EDUCATION: WHAT WE HAVE TO GAIN

Sarah G. Candler, MD, MPH

Dr. Candler (candler@bcm.edu) is assistant professor of medicine, Baylor College of Medicine, Michael E. DeBakey VA Medical Center

Washington is interested in accountability for federal funds. Physicians and academic institutions need funding sources that allow trainees to meet patients where they are—both geographically and by specialty distribution. Hospitals could benefit from diversification of payers and transparency of Graduate Medical Education (GME) funding to ensure sufficient resources are available when and where they are needed, particularly as hospital systems are expanding into the community and outpatient settings. Patients deserve a system that supports health systems, educators, and trainees focused not on hospital throughput, but longitudinal, quality-based, comprehensive care. We get what we pay for, and right now, we all have something to gain from GME funding reform.

If we have learned anything in recent discussions about the Affordable Care Act, it is that policies that *take away* benefits are much more difficult to move forward than those offering new opportunities or rights. The latest example has been the coverage of people with pre-existing conditions. However, this same concept has been at the root of discussions about GME funding for decades, an issue that is reemerging as the models of care delivery and trainee education continue to shift away from hospital-based, fee-for-service care.

Since its creation in 1965, the Centers for Medicare and Medicaid Services (CMS) has been a primary funder of GME in the United States. Though initially intended to be a temporary investment, the complex mechanisms of their GME support have now been in place for 52 years. As described recently in SGIM *Forum* (December 2018 issue), this system now accounts for $9.6 billion of our nation's estimated $15 billion GME budget.[1]

Understandably, discussions about changing the way CMS and others determine GME funding are anxiety-producing, opening doors to cuts in seemingly secure sources of income for hospitals and training programs. However, the current allocation of these resources, like the funding, is still based on decades-old algorithms, which may not be as applicable to today's health care landscape. The status quo may not be as rosy as it seems.

CMS funds are distributed to organizations (usually hospitals) that serve Medicare (and, in some states, Medicaid) patients. These algorithms and the resultant payments are based on data from 1996, which identified how many trainees were present and in what geographical locations. Even then, these calculations did not fully calculate how much training did or should cost. The current system assumes that the utilization of resources, the geographical distribution, and specialty distribution are unchanged since the original calculations were made. However, the increasing focus on outpatient care as well as urban growth and population redistribution have led many to worry that many populations are underserved due to lack of training in certain specialties or regions based on these outdated funding mechanisms. Additionally, the bookkeeping processes of these funding mechanisms is less than transparent, so much so that a national Institutes of Medicine (now National Academy of Sciences) committee on the subject relied on subjective survey data rather than hard numbers to calculate costs and accountability of services.[2]

Physician and health policy organizations, such as the Society of General Internal Medicine (SGIM), have identified many concerns with the current GME payment structure. The following are common threads in the positions of multiple specialties and stakeholder organizations:

continued on page 2

HEALTH POLICY: PART I *(continued from page 1)*

- **Diversify Funders:** Including all payers in contributing to GME funding would help un-couple training from care of only Medicare patients and would (appropriately) revisit the question of whether residency training is a public good that even should be paid for by federal funds.[3,4]

- **Improve Transparency of the Payment Process:** Many suggest combining IME and DGME or creating a new measure like a National Per Resident Payment (NPRP).[3,4]

- **The Focus on Inpatient Care Does Not Address Need for Primary Care Workforce:** A growing body of evidence suggests that we are in need of more primary care physicians in the United States, some estimating that "demand for primary care physicians is projected to reach 263,100 FTEs in 2025".[5]

- **Create Performance-Based GME Metrics:** Standardized and timely metrics would assist with allocation of funds in a way that addresses the needs of the American people and the medical profession.[4,6]

- **Lift Caps on GME Residency Slots:** the current number of residents and fellows is based on an algorithm that uses data from 1996.

The administration also recognizes these needs. As a result of discussions about shifting resources to meet locations of health care, and calls for transparency of these processes, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) performed an audit of the GME system and found significant variability in hospital reporting of GME funding allocations. In a review of 8 prior audits, OIG discovered that systems to assure accurate counting of residents (for purposes of reimbursement) were lacking. In fact, its review revealed that it was common for multiple hospitals to be reporting (and collecting funds for) the same residents. In response to the report, CMS concurred with the recommendations that their database be updated and better overseen—a positive step towards more effective models for transparent and accountable reimbursement for GME.[6]

Through the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, CMS has started exploring alternative models of payment and delivery for the country's older and poorer populations, so this would seem to be an opportune time to address other items on the federal agency's mandatory budget. In June 2018, Senator Cory Gardner (R-CxO) introduced the Rural Physician Workforce Production Act of 2018 in hopes of unifying DGME and IME payments into a single per resident payment to facilitate the training of residents in sites beyond urban inpatient settings (S. 3014). This fall, Senator Mazie Hirono (D-Hawaii) introduced the Health Equity and Accountability Act (HEAA, S. 3660) that aimed to improve care to underserved populations, promote health equity, and eliminate the cap on Medicare GME funding. Both bills were read twice and referred to the Committee on Finance, but never voted on in the Senate. Now that the new Congress has convened, versions of these bills will need to be resubmitted for further action, presenting opportunities for individual and organizational advocacy.

It is hard to turn a ship that has been moving in the same direction for half a century, but with continued support from the educational community, improved oversight and diversification of major funders, restructuring of reimbursement models, and a call for increased government transparency, we may look forward to a different view.

Acknowledgements: this commentary is a summary of discussions among the Society of General Internal Medicine's (SGIM) Health Policy Committee's (HPC) subcommittee on Education. Thanks are due to that committee as well as to our chair, Meredith Niess, MD, as well as member, Susan Lane, MD, Jeffrey Jaeger, MD, and policy partner representative, Erika Miller, who were all instrumental in assisting with this summary.

References

1. Liebow M. How does Medicare pay for graduate medical eucation? SGIM *Forum*. 41 (12):4;2018.
2. Butkus R, Lane S, Steinmann AF, et al. Financing U.S. graduate medical education: A policy position paper of the Alliance for Academic Internal Medicine and the American College of Physicians. *Ann Intern Med*. 165:134–137.doi: 10.7326/M15-2917.
3. Jackson A, Baron RB, Jaeger J, et al. Addressing the nation's physician workforce needs: The Society of General Internal Medicine (SGIM) recommendations on graduate medical education reform. *J Gen Intern Med*. 2014 Nov;29(11):1546-51. doi: 10.1007/s11606-014-2847-4. Epub 2014 Apr 15.
4. U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2016. National and regional projections of supply and demand for primary care practitioners: 2013-2025. Rockville, Maryland. https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/

continued on page 3

HEALTH POLICY: PART I *(continued from page 2)*

primary-care-national-projections2013-2025.pdf. Published November 2016. Accessed February 1, 2019.

5. Caverzagie J, Lane SW, Donnelly S, et al. Proposed performance-based metrics for the future funding of graduate medical education: Starting the conversation. *Acad Med*. 2018 Jul;93(7):1002-1013. doi: 10.1097/ACM.0000000000002096.
6. Jarmon G. CMS did not always ensure hospitals complied with Medicare reimbursement requirements for graduate medical education. Report from the Department of Health and Human Services Office of Inspector General, November 2018 A-02-17-01017. https://oig.hhs.gov/oas/reports/region2/21701017.pdf. Published November 2018. Accessed February 1, 2019.

SGIM