Attaining a balanced physician workforce—the appropriate numbers and mix of specialties—is regarded as a critical prerequisite to ensuring sufficient access to care and achieving delivery reform that promotes greater quality and efficiency. Central to achieving this goal is graduate medical education (GME) or residency, the three or more years of training following medical school that physicians must complete to obtain board certification and practice.

GME is a large and complex undertaking. In the 2013-2014 academic year, 120,108 residents were being trained in 9,527 programs approved by the Accreditation Council for Graduate Medical Education (ACGME). An additional 8,210 residents were enrolled in 1,152 training programs certified by the American Osteopathic Association. Medicare is the principal public funder of this training. In 2012, it contributed $9.7 billion, and Medicaid provided an additional $3.9 billion. The Veterans Health Administration and U.S. Department of Defense contributed somewhat smaller amounts. Hospitals and health systems funded the remainder from their own revenues.

Hosting residency programs may have a range of benefits for hospitals and health systems, for example leverage in negotiating private insurer prices or lower-cost interns and residents substituting for other workers. However, there has been longstanding discussion and debate on how well the GME system produces a physician supply suited to the nation’s needs, and how the system’s shortcomings might be ameliorated. A particular focus of these discussions has been Medicare’s role in financing GME.
Medicare contributes funds for direct GME (DGME)—resident stipends or salaries, faculty salaries, and other educational costs—and for indirect medical education costs (IME), the potentially higher treatment costs for patients admitted to teaching hospitals. Multiple analyses conducted by the Prospective Payment Assessment Commission (ProPAC) and its successor, the Medicare Payment Advisory Commission (MedPAC), have found that IME payments exceed the estimated higher costs of caring for patients in teaching hospitals. Both commissions have recommended reductions in IME payments. In 2010, however, MedPAC modified its recommendation. It suggested that, rather than a simple reduction, the estimated excess payments should fund incentives for GME programs to produce “workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality.”

An Institute of Medicine committee completed an extensive review in 2014 of the purpose of public financing of GME and the effectiveness of that investment. Its report recommended a new, performance-based system of Medicare financing to produce a more optimal physician workforce. Recognizing that substantive change to the current system of GME financing, which has been in place for the past 30 years, could be disruptive and that fully specifying the desired objectives for GME and the mechanisms to achieve them would require both research and discussion, the committee recommended a transition period. Initially, Medicare DGME and IME funds would be combined with payments provided to program sponsors on a per-resident basis, adjusted geographically. Over time, as performance goals and measures were defined, performance-based payments would be introduced.

The Ways and Means Committee of the U.S. House of Representatives is currently considering a bill (H.R. 3292) that would replace the current method for determining hospitals’ IME payments. At present, Medicare provides an additional payment for each inpatient admission, with an adjustment for a hospital’s teaching intensity (ratio of residents to hospital beds). Medicare inpatient admissions have been declining since 2008 as more care is moved to outpatient and other ambulatory settings. This decline reduces the level of IME payments to teaching hospitals. The current payment structure also creates an incentive to provide inpatient care. Under the bill, payments would be based on the number of residents training in a hospital, eliminating IME reductions associated with the overall decline in admissions. Tying payments to residents would also reduce the incentive for additional admissions.
SESSION

This Forum session provided an overview of the fundamentals of GME, reviewed recommendations for change advanced by MedPAC and the IOM, and offered perspectives on what those changes might mean for residency programs and teaching hospitals. Speakers included Mark Miller, PhD, executive director of the Medicare Payment Advisory Commission; Gail R. Wilensky, PhD, senior fellow, Center for Health Affairs, Project HOPE and co-chair, IOM Committee on Governance and Financing of Graduate Medical Education; Debra F. Weinstein, MD, vice president for Graduate Medical Education, Partners Healthcare System (Boston); and Atul Grover, MD, PhD, chief public policy officer, Association of American Medical Colleges.

ENDNOTES


4. IOM, Graduate Medical Education That Meets the Nation’s Health Needs.


