Why Graduate Medical Education Funding Matters

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To most radiologists, graduate medical education (GME) funding mechanisms seem abstract and of little relevance to their practice. However, GME and its funding status have the potential to have wide implications for radiologists throughout the country.

The sources of GME funding are complex. The history and sources of funding have been reviewed in past articles [1,2]. The modern-day GME funding program has its roots in the passage of the Medicare program in 1965 [1]. Although originally intended to be temporary, the program has survived, having been modified and amended with a series of legislative and regulatory efforts [1,2].

Since inception of the federal GME funding program, billions of dollars have been provided to train residents and fellows. For example, in 2010, the federal government contributed $9.5 billion in Medicare funds and approximately $2 billion in matched Medicaid dollars to help subsidize GME [3].

Medicare GME funding is distributed via two separate programs: direct medical education (DME) and indirect medical education (IME) [4]. DME payments support residents' and faculty members compensation, institutional costs associated with providing GME programs, and overhead [5]. IME payments compensate teaching hospitals for the increased costs associated with training residents, including higher case mix indices, decreased productivity of faculty members because of teaching responsibilities, and more diagnostic tests [6]. The IME supplement is included in the diagnosis-related group hospital payment [6]. IME is often twice as large as DME, although there is considerable variation across the country [6,7]. Of the 2010 Medicare funds, approximately $3 billion went for DME reimbursement, and $6.5 billion was spent on IME payments [7]. Other relatively minor sources of GME funding include the Department of Veterans Affairs, the Public Health Service, and the Department of Defense [7]. Some states also have programs to help fund GME [7].

We believe that stakeholders agree that the current system is flawed and needs to change. A recent Medicare Payment Advisory Commission analysis suggested that only 40% to 45% of current IME payments are justified and suggested cuts in payments of up to 60% [8].

The Institute of Medicine, (IOM), subsequently renamed the National Academy of Medicine, commissioned a study in 2014 to review GME funding [9]. The Committee on the Governance and Financing of Graduate Medical Education was established and co-chaired by Gail Wilensky, PhD, and Don Berwick, MD [9]. Their results were published in a report titled "Graduate Medical Education That Meets the Nation's Health Needs" [9].

This committee determined that the system had significant flaws and lacked transparency and accountability [9]. They contended that Medicare's dominance in the space provides substantial leverage to redesign the system and realign incentives [9]. Their report recommended significant GME funding reforms. Six goals were identified to improve the system [9]:

1. Train the future physician workforce to provide better individual care, better population health, and lower cost.
2. Encourage innovation.
3. Provide transparency and accountability.
4. Strengthen public policy planning and oversight.
5. Maximize the value of the funds invested in GME funding.
6. Mitigate unintended consequences during the transition period from the status quo.

Additionally, the committee recommended that a new program be created to include the following [9]:

1. Establish a 2-part governance infrastructure: a GME Policy Council in the Department of Health and Human Services for

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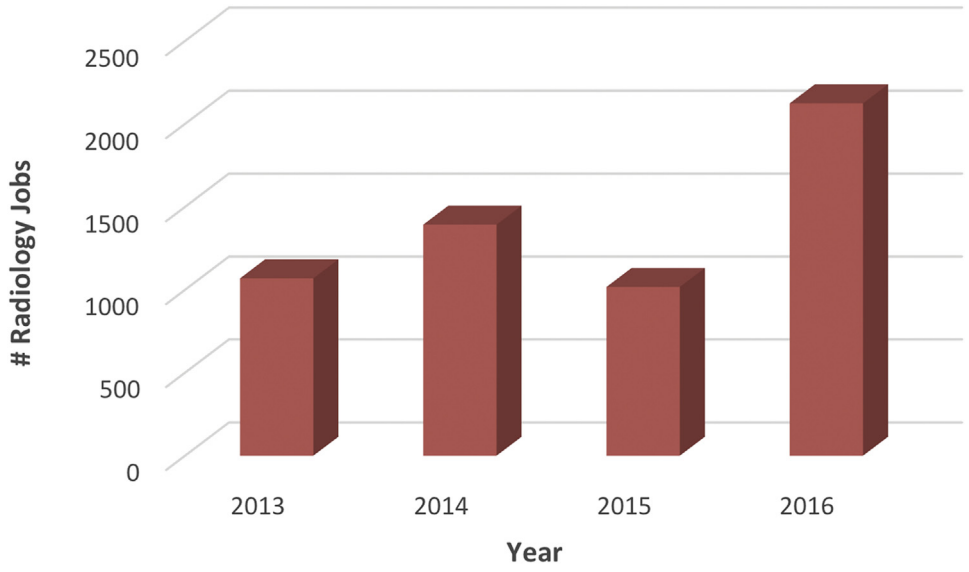

Fig 1. Number of jobs that have been filled over the past 4 years. Data acquired from the ACR Human Resources Survey since its inception (personal communication, July 24, 2017).

decision making and a GME Center with CMS as an operational unit to administer payment reforms and new payment models.
2. Current funding for DME and IME would be eliminated. Total funding for the program would continue at current levels for at least 10 years to provide stability.
3. Establish a 2-part Medicare GME fund: an operational fund would finance ongoing residency activities, and a transformation fund would finance development of new and innovative programs.
4. Base payments on a basic per-resident amount for each resident, with geographic adjustments.
5. Direct the per-resident funds to the institutions that are responsible for the actual educational content of GME.

The recommendations have been sharply criticized by groups whose members rely on the current GME funds flow [10]. These include the Association of American Medical Colleges (AAMC), the American Hospital Association, and the AMA [10]. The report did not recommend an increase in the number of Medicare-funded GME positions [10]. Critics warned that the proposed 35% reduction in Medicare GME payments would jeopardize services unique to teaching hospitals [11]. The Medicare funds would be siphoned off at a time when the solvency of the program was in jeopardy [12]. The IOM recommendations are another manifestation of "big government" controlling health care [12]. Medicare would determine the "winners" and "losers," including the incentives and benchmarks to decide who will have funding for training residents [11,12].

Supporters of the IOM report include organizations representing primary care [13-15]. Proponents argue that the current system inappropriately favors tertiary care centers over alternative providers such as community programs and outreach centers [13]. Future training systems need to equip physicians to provide integrated care outside the hospital to elicit better outcomes at lower costs [14]. Any additional training slots should be targeted to underserved areas and primary care [15].

A pivotal issue in the debate is the number of physician trainee slots to be funded. The position of the AAMC and the American Heart Association is that there will be a physician shortage of up to 130,000 physicians by 2025 [16]. They argue that current caps on Medicare-funded GME positions from the Balanced Budget Act of 1997 should be lifted so that additional slots can be created to address the projected shortage [16]. Others believe that health care reform and extending scopes of practice will cap, if not decrease, the required number of physicians [13,14].

Regarding radiology, estimates about future demands for trainees have been notoriously inaccurate [17]. Although data have only been recently compiled through surveys of the ACR Human Resource Department, they illustrate the unpredictability of the number of