AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

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Graduate Medical Education

RECOMMENDATIONS

- Any reductions in Medicare's Graduate Medical Education (GME) payments should be structured to preserve primary care training programs.

- This is an opportunity to change Medicare GME to encourage innovations in primary care training to help build a physician workforce that implements needed changes in health care delivery.

Medicare GME was created at a time when hospital-based training for acute health care delivery was the norm. It encourages academic hospitals to focus their training programs on specialized physicians who provide health care for specific conditions or trauma in the hospital setting. Over the years, health care delivery has moved out of the hospital to the doctor's office and other non-hospital settings.

Medicare GME has not kept pace. It is still directed to the teaching hospital and does not encourage the hospital to support training in community settings. Additionally, there is no accountability for the use of GME funding once it is provided to the hospital.

Drastic, untargeted reductions in Medicare GME will prevent the health system from having the primary care physician workforce it needs, but restructuring GME to support primary care can solve the aforementioned problems.

BACKGROUND

There are three major sources of federal funding for graduate medical education (GME): Medicare and Medicaid GME, Children's Hospital GME, and Teaching Health Center GME.

Medicare GME

When Congress created the Medicare program in 1965, it established a Medicare GME funding stream to support the training of our nation's medical residents to provide and care to Medicare beneficiaries. Medicare remains the single largest payer of graduate medical education (GME)—$9.5 billion in 2009. Approximately $3 billion of Medicare's payments are intended to support Medicare's share of the direct costs of running GME programs, known as DME. The other $6.5 billion, intended to support Medicare's share of the indirect clinical costs associated with the presence of GME, is known as IME. Medicare Payment Advisory Commission (MedPAC) analysis has shown that this IME amount is $3.5 billion higher than the empirically calculated indirect clinical costs associated with teaching.

According to MedPAC, the Medicare GME program "requires minimal accountability from its recipients for achieving education and training goals" (MedPAC Report, June 2010). MedPAC has recommended the reform of Medicare GME to support the workforce skills needed in a delivery system that reduces cost

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growth while maintaining or improving quality. The recommendations are meant to decouple Medicare GME payments from the fee-for-service payment systems and to ensure that resources for GME are devoted to meeting educational standards and outcomes that can improve the value of our health care delivery system.

Medicaid GME
Medicaid is the second-largest explicit payer of GME. Teaching hospitals receive GME payments from both the federal government and the states through the Medicaid program. The Congressional Budget Office (CBO) estimates that total mandatory federal spending for hospital-based GME in 2010 was about $500 million through Medicaid. In 2009, Medicaid GME payments were estimated to be $3.78 billion, a significant increase over the amount of such payments in 2005. However, the number of states making Medicaid DGME and/or IME payments in 2009 had declined significantly since the 2005 survey.

Children's Hospital GME
Children's hospitals treat very few Medicare beneficiaries and so receive very limited Medicare GME. The Children's Hospital GME program is authorized to receive annual appropriations to support the training of general pediatricians and pediatric specialists. The Children's Hospital GME program received $316.8 million in FY 2010 and $317.5 in FY 2011.

Teaching Health Center GME
The Teaching Health Center GME program supports primary care residency training in community health centers and other ambulatory primary care settings, consistent with recommendations by the MedPAC and other advisory bodies to promote opportunities for community-based training. The THC program was authorized in the *Affordable Care Act* and provided with a mandatory five-year appropriation of $230 million.

Proposals to Cut or Eliminate GME Funding

- The December 1, 2010 document, "The Moment of Truth: Report of the National Commission on Fiscal Responsibility and Reform," called for a reduction in excess payments to hospitals for medical education estimated to save $6 billion in 2015, $60 billion through 2020. The fiscal commission recommended bringing GME payments in line with the costs of medical education by limiting hospitals' direct GME payments to 120 percent of the national average salary paid to residents in 2010 and updated annually thereafter by chained CPI and by reducing the IME adjustment from 5.5 percent to 2.2 percent, which the Medicare Payment Advisory Commission has estimated would more accurately reflect indirect costs.

- MedPAC's June 2010 report recommended that the Congress authorize HHS to change Medicare's funding of graduate medical education (GME) establishing standards for distributing funds. Specifically, they called for IME payments above the empirically justified amount to be removed from the IME adjustment and that sum would be used to fund the new performance-based GME program.

- The CBO published a budget option to consolidate all mandatory federal spending for GME into a grant program for teaching hospitals which would save approximately $25 billion over the 2012–2016 period and roughly $69 billion over the 2012–2021 period. By 2021, the annual savings would represent about 60 percent of federal spending for GME projected under current law.

- President Obama's budget for FY 2012 made no request for Children's Hospital GME effectively calling for a cut of $317.5 million for that program.