Consensus on Graduate Medical Education Financing: An Analysis of Stakeholder Responses to the House Energy and Commerce Committee's Open Letter

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ABSTRACT

Background In December 2014, the Energy and Commerce Committee of the US House of Representatives sent an open letter requesting interested parties to respond to 7 questions on graduate medical education (GME). More than 100 organizations and individuals responded.

Methods An online search for responses yielded 27 organizations that had published their responses to the committee's open letter. Responses included answers to the 7 questions and additional recommendations. The 27 respondents proposed a total of 80 unique interventions. Each intervention was screened for concordance with those from other organizations, and then categorized as supportive, in opposition, or making no mention. Data were entered into a spreadsheet and rank ordered on the frequency of support.

Results At the top of the rankings were several interventions with significant support from many respondents.

Conclusions Given the broader GME constituency represented by the 27 stakeholders in this analysis, the 80 proposed interventions represent a comprehensive inventory of the extant ideas regarding the financing, governance, and oversight of GME. This objective analysis could help both spur productive discussions and form the foundation for a larger public policy deliberation of GME financing.

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Introduction

The $16 billion spent on public support of graduate medical education (GME)[1] pales in comparison to the more than $3.2 trillion consumed by health care delivery in the United States.[2] At the same time, federal government funds that support GME have been targeted for reductions by several panels.[3] In December 2014, the Energy and Commerce Committee of the US House of Representatives invited stakeholders to respond to 7 questions about GME. A diverse group of stakeholders with expertise in GME took this opportunity to formally state their positions.

This article aggregates information from 27 published responses to the House Energy and Commerce Committee questions. Responses represent most major GME stakeholders (BOX 1), offering insight into stakeholder recommendations regarding the future of GME.

Interventions were entered into a spreadsheet that sorted them into functional categories and tracked the support for the given intervention by other responding stakeholders. The most notable interventions are shown in BOX 2.

Discussion

The Institute of Medicine report entitled "Graduate Medical Education That Meets the Nation's Health Needs,"[1] released in July 2014, stimulated a national discussion on GME. Building on this momentum, the questions posed by the House Energy and Commerce Committee engendered a wide range of proposals about how GME should be funded, how those funds should be distributed, and how stewardship and oversight of federal GME support should be organized. Among major GME stakeholders that published their responses, there was broad-based support for expanding GME funding and increasing residency positions. Many respondents also noted that the current approach to GME funding through the Medicare and Medicaid programs does not

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Editor's Note: The online version of this article includes the letter from the Energy and Commerce Committee of the US House of Representatives and a linked table of all responses.

BOX 1 Respondents to the Open Letter on Graduate Medical Education From the US House of Representatives Energy and Commerce Committee

- Accreditation Council for Graduate Medical Education (ACGME)
- Alliance for Academic Internal Medicine (AAIM)
- Alliance of Specialty Medicine (ASM)
- American Academy of Dermatology (AAD)
- American Academy of Family Physicians (AAFP)
- American Academy of Otolaryngology–Head and Neck Surgery (AAO)
- American Academy of Pediatrics (AAP)
- American Association of Colleges of Osteopathic Medicine (AACOM)
- American Association of Orthopaedic Surgeons (AAOS)
- American Board of Family Medicine (ABFM)
- American Board of Medical Specialties (ABMS)
- American College of Emergency Physicians (ACEP)
- American College of Physicians (ACP)
- American College of Surgeons (ACS)
- American Hospital Association (AHA)
- American Medical Association (AMA)
- American Osteopathic Association (AOA)
- American Psychiatric Association (APA)
- American Society of Anesthesiologists (ASA)
- American Society of Plastic Surgeons (ASPS)
- Association of American Medical Colleges (AAMC)
- Children's Hospital Association (CHA)
- Council on Graduate Medical Education (COGME)
- Council of Medical Specialty Societies (CMSS)
- Midwest Family Medicine Coalition (MWFMC)
- National Association of Urban Hospitals (NAUH)
- Trinity Health (Trinity)

completely meet the public's need, and that diversification of GME funding would be beneficial. In this regard, many stakeholders favored a larger role for the states in the regionalization of physician training and its support.[4] There also was broad support for the Accreditation Council for Graduate Medical Education to continue its role in assuring the quality of GME programs.

The most supported intervention, "to increase accountability and transparency of GME funding," was included in the recommendations from 18 of 27 respondents, and another broadly supported intervention, "reform GME funding to diversify the clinical training experience," was mentioned by 16 stakeholders. Among the possible approaches to develop a national GME strategy, "increase the support and influence of COGME" appeared most frequently. There also was some support for "fund the National Health Care Workforce Commission."[5] Although this commission was established by the Affordable Care Act, it has not been funded by Congress. Conversely, the creation of a new "National GME Council," to reside in the Center for Medicare and Medicaid Services, as had been proposed in the IOM report, was not supported by most stakeholders, nor was the establishment of "performance-based penalties."

The inventory of interventions proposed by this diverse group of GME stakeholders can be viewed as a good start toward resolving the issue of how to finance physician clinical education. Several innovative interventions were suggested by single stakeholders. These ideas, including, for example, "insurance exchanges to fund GME," may deserve more attention as a potentially viable strategy for moving toward "all-payer" support of GME.

Limitations to this analysis include that less than 25% of the organizations that responded to the House Energy and Commerce Committee's letter are represented in the sample. In addition, the responses to the Committee's request do not offer a complete picture of the advocacy agenda of any respondent. Responses were submitted independently from one another, and innovative ideas from 1 respondent could neither garner support nor provoke opposition from others. In addition, with the grouping of interventions, the attribution of support is based solely on 1 individual's reading of the responses, and there were several instances for which the degree of stakeholder support of a given intervention was not clear. Finally, the data include the thoughts and ideas of stakeholders who would benefit from the expansion of GME and its funding and should be balanced with the input of those with different priorities, such as the fiscal viability of any proposal and its compatibility with society's needs.

Conclusion

This study represents the first synthesis of the responses to the House Energy and Commerce Committee's open letter. Additionally, the interventions proposed by a substantial core of GME stakeholders could form a foundation on which to build future policies for the governance and structure of GME. The questions posed by the House Energy and Commerce Committee engendered a wide range of proposals by subject matter experts with regard to GME. This analysis suggests that it is not accurate to say that there is no consensus among major GME stakeholders. To the contrary, many interventions have broad support from a substantial core of GME stakeholders, and could form a foundation for a broader deliberation of policies for public governance and oversight of GME financing and structure. Solutions to GME financing that begin in consensus have a greater likelihood of ultimate success.

BOX 2 Interventions With Broad Support From the Graduate Medical Education (GME) Stakeholder Community

General GME Funding Principles

- Reform GME funding to diversify the clinical training experience (supported by AAD, AAFP, AAO, AAOS, AAP, ABMS, ACEP, ACGME, ACS, AHA, AMA, AOA, APA, ASM, MWFMC, and Trinity)
- Eliminate Balanced Budget Amendment residency caps (supported by AAD, AAMC, ABMS, ACEP, ACGME, AMA, AOA, APA, ASA, ASM, CHA, NAUH, and Trinity)
- Maintain Medicare indirect medical education funding at least at its current levels (supported by AAFP, AAOS, ACEP, ACGME, ACP, AHA, APA, ASPS, CHA, and COGME)
- Increase overall funding for GME (supported by AAD, AAOS, AAP, ACGME, ACS, AMA, ASPS, CHA, COGME, and NAUH)
- Reform GME funding to improve geographic distribution of residencies (supported by AAFP, AAOS, ABFM, ACGME, ACS, AMA, AOA, and MWFMC)
- Affirm Medicare as a funding source for GME (supported by AAD, AAOS, ACGME, ASM, and ASPS)

National GME Funding Proposals

- 113th Congress Bills (HR 1201, HR 5458, HR 1180, S 577, HR 2037; supported by AAD, AAMC, AAO, AAOS, ACEP, ACP, ACS, AMA, AOA, APA, NAUH, and Trinity)
- All-payer funding of GME (supported by AAIM, AAOS, ACP, ACS, AHA, AMA, AOA, APA, ASM, and ASPS)
- Increase the number of GME slots (supported by AAFP, AAMC, ACP, AHA, AMA, AOA, and NAUH)
- Funding follows residents to training site (supported by AAFP, AAO, ABFM, ABMS, ACGME, AOA, and ASPS)
- Funding should augment, not cut, current funds (supported by AAFP, ABMS, ACGME, ASPS, and Trinity)
- Federal grants for new GME slots (HR 4282; supported by AMA, AOA, and ASPS)
- Increase the number of primary care GME slots (supported by AAP)

Funding Proposals to Expand and Diversify GME and the Workforce

- Expand National Health Service corps; teaching health centers; rural training tracks; area health education centers (supported by AACOM, AAFP, AAIM, AAMC, AAO, ABFM, ABMS, ACP, ACS, AMA, AOA, ASPS, MWFMC, and Trinity)
- Expand loan forgiveness and repayment programs (supported by AAD, AAO, ABMS, AMA, AOA, APA, ASPS, and NAUH)
- Link resident slot funding to workforce projections (supported by AAFP, AAIM, ACS, AOA, ASM, COGME, MWFMC, and Trinity)
- Stabilize funding of community health center GME programs and teaching health centers (not subject to annual appropriations; supported by AAOS, AAP, AHA, AMA, AOA, APA, CHA, MWFMC, and Trinity)

Oversight and Governance of GME Funding (Well-Supported)

- Increase accountability and transparency of GME funding (supported by AAD, AAFP, AAIM, AAMC, AAO, AAOS, AAP, ABFM, ABMS, ACGME, ACP, ACS, AMA, AOA, ASA, ASM, ASPS, and MWFMC)
- Develop a nationwide GME strategy (supported by AACOM, AAFP, AAIM, ABFM, ABMS, ACP, AMA, COGME, and MWFMC)
- Increase the support and influence of the federal Council for Graduate Medical Education (supported by AACOM, AAFP, ABFM, ABMS, ACEP, AMA, ASA, and COGME)
- Conduct workforce studies (supported by AAFP, AAO, AAOS, AAP, ABMS, ACEP, ASM, and COGME)

A Greater Role for States and Medicaid

- Support state-funded initiatives (eg, Centers for Medicare & Medicaid Services waivers; supported by AACOM, AAD, AAFP, ABFM, ACP, ACS, AHA, AOA, ASM, and ASPS)
- Regionalize GME allocation and funding (supported by AAO, ACS, and AOA)
- States collaborate with programs to address workforce needs (supported by AAIM, AAP, and AOA)

Support for GME to Expand in Rural and Critical Access Sites

- Incentivize rural and underserved training/practice (supported by AAFP, AAOS, AAP, AHA, and AOA)
- Share sponsoring institution's indirect medical education with rural sites (supported by AAFP, AAP, and ASPS)
- Allow rural hospitals to make affiliation agreements (supported by AAMC, AAO, and AAP)

Additional GME Funding Ideas Proposed by Individual Stakeholders

- Require institutions to have > 33% of full-time equivalents in primary care (PC) to expand GME (proposed by AAFP)
- Distribute new slots 50/50 between PC/specialties (proposed by AAFP)
- Fund only first-certificate (pipeline) programs (proposed by AAFP)
- Require institutions to maintain > 33% PC production (proposed by AAFP)
- Insurance exchanges to fund GME (proposed by AOA)
- Rebalance per-resident amount to reflect costs of community-based GME (proposed by AOA)
- Reward high-performing programs (proposed by AAO)
- Count all residency time to reduce administrative costs (proposed by AAO)
- Require the Affordable Care Act to fund registries' infrastructures (proposed by AAO)
- Establish a uniform data analysis process (proposed by AAP)
- National effort to engage minority students in health care professions (proposed by AAOS)
- Funding split between sponsoring institution (for infrastructure) and rural site (to fund training; proposed by AAP)
- Funding should be preferentially provided to programs that are training residents in primary care (proposed by AAP)
- Establish national residency curriculums (proposed by AAOS)
- Specialty-specific slot allocation based on objective shortages (proposed by AAP)

Potential Roles for GME Accreditation

- Rely on ACGME/AOA accreditation to ensure GME quality (supported by AAD, AAP, ABMS, AMA, AOA, and MWFMC)
- Use performance and quality metrics (supported by AAFP, AAIM, ACS, AOA, and MWFMC)
- Link financing of slots to accreditation performance (supported by AOA, ASM, and ASPS)
- Accelerate undergraduate medical education/GME training pipeline and competency-based curricula (supported by AAO and AOA)

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