HOD ACTION: Council on Medical Education Report 5 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-16

Subject: Accountability and Transparency in Graduate Medical Education Funding (Resolution 327-A-15, Resolution 329-A-15)

Presented by: Darlyne Menscer, MD, Chair

Referred to: Reference Committee C (Albert M. Kwan, MD, Chair)

Resolution 327-A-15, introduced by the Medical Student Section and referred by the American Medical Association (AMA) House of Delegates (HOD), asked: 1) that the AMA support combining Indirect Graduate Medical Education with Direct Graduate Medical Education payments into a single, transparent funding stream; 2) that Medicare's graduate medical education (GME) funding be a per-resident federal allocation, adjusted according to solely geographic measures (e.g., cost-of-living); and 3) that the payment of GME funding directed to the designated residency GME office, in lieu of the hospital system, be allocated across the department(s), sites and other specialties to provide comprehensive training.

Resolution 329-A-15, introduced by the Resident and Fellow Section and referred by the AMA HOD, asked the AMA to support: 1) that federal funding for GME be based on all costs to train and educate a resident/fellow (e.g., salary, benefits, and other institutional support for training and education) including yearly adjustments for geographic and inflation-based cost-of-living; 2) that the allocation of GME funds within an institution be transparent and accountable to all stakeholders; 3) that federal funding for GME strive to meet the health needs of the public including but not limited to size of the training program, geographic distribution, and specialty mix; 4) that federal funding for GME from the Centers for Medicare & Medicaid Services or any federal successors be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payer system; and 5) additional federal funding for GME that provides flexibility for innovation in training and education above and beyond current levels of funding.

These two resolutions, in general, support several recommendations of the 2014 report, Graduate Medical Education That Meets the Nation's Health Needs, prepared by the Institute of Medicine's (IOM) Committee on Governance and Financing of Graduate Medical Education.[1] The IOM's report, as well as other recent inquiries into Medicare's role in GME funding—i.e., a letter sent from the Health Subcommittee of the House Committee on Ways and Means to the Government Accountability Office (GAO) requesting a study,[2] and the House Committee on Energy and Commerce's letter to the medical education community requesting information on GME[3]—point to rising concerns with the abstruse and entrenched methods of current GME funding. Policymakers and the public want to ensure that tax dollars designated for financing the residency/fellowship training of tomorrow's physicians provide a good return on investment in terms of current and future health care workforce needs, particularly among underserved populations. Due to the complexity of these issues, both resolutions were referred for further study and a report back to the HOD.

This report will: 1) briefly summarize the current funding structure for GME; 2) describe recent proposals to encourage increased accountability and transparency in GME funding; 3) explain potential benefits of and barriers to increased accountability and transparency; and 4) describe different efforts to measure accountability and transparency.

CURRENT FEDERAL FUNDING FOR GRADUATE MEDICAL EDUCATION

Although the federal government is not the sole contributor to GME funding, it is by far the largest single source, mostly through Medicare funding. Medicare funding to support GME programs comes from direct GME funding and indirect GME funding. Direct GME (DGME) funding represents approximately one-third of all Medicare support for GME. It supports the direct costs of running a residency program and covers salaries for residents and faculty as well as educational support. Indirect GME payments (IME), which represent the majority of Medicare GME funding, are calculated based on the size of a hospital, the number of residents supported, and the number of Medicare inpatients treated. IME payments are in addition to payments an institution receives from Medicare reimbursement and are meant to offset the costs of maintaining an educational program that are not captured by Medicare reimbursement. Both IME and DGME payments are derived by complex formulas, and are not designed to account for differences in costs resulting from training residents of different specialties. There is little understanding of the costs and funding of GME, often described as a "black box."[1]

The Department of Veterans Affairs, Medicaid, and the Children's Health Insurance Program are other federal sources of GME funding, of varying levels. Additionally, the Army, Navy, and Air Force support their own in-house residencies and fellowships to provide for the future physician workforce needs of those services.

RECENT CALLS FOR INCREASED ACCOUNTABILITY AND TRANSPARENCY IN GME FUNDING

Most discussions of accountability and transparency in GME funding have included either carrots or sticks (or both) to effect change. The recent IOM report prominently called for increased transparency in GME funding, and includes both types of motivational techniques. Concerned that the current funding mechanism does not produce a workforce that meets national workforce needs, the IOM called for redirecting federal funding from DGME and IME into two new streams—an "operational" fund and a "transformational" fund. The operational fund allows for continued funding of the direct costs of GME. The transformational fund is intended to fund initiatives to: 1) develop and evaluate innovative GME programs; 2) develop and validate GME performance measures; 3) pilot alternative GME payment methods; and 4) award new GME funding to underserved disciplines and geographic areas. Although the IOM did not recommend any reductions in the current level of Medicare GME funding, funding for the proposed transformational fund would come from overall GME funding, thus reducing the total amount of funds available for the operational fund. The AMA, in its comment letter to the House Energy and Commerce Committee, asked that existing funds not be diverted from directly supporting training opportunities to create these new programs, and has suggested that existing entities, such as the Centers for Medicare & Medicaid Innovation, test new models.[4]

Following the release of the IOM's report, the House Energy and Commerce committee requested input from the GME community on issues raised by the report. In addition to the AMA,[4] many other organizations responded; a review of these responses reveals a significant amount of agreement among stakeholder organizations.[5] Areas of high-level agreement included the need for increased accountability and transparency in GME funding; expansion of teaching sites for GME,

specifically into teaching health centers and rural areas, as well as expansion of the National Health Service Corps; reform of GME funding to diversify clinical training experiences; and elimination of the current caps on Medicare-funded slots. Subsequently, in August 2015 a number of members of the House of Representatives authored a letter to the GAO requesting that the GAO investigate federal GME funding to determine: 1) how much money is being spent on GME; 2) how many residents and fellows are funded through these dollars; 3) the potential need for increased GME oversight through the Council on Graduate Medical Education or the Accreditation Council for Graduate Medical Education (ACGME), or others; 4) any "inefficiencies or duplications" in current GME programs (and suggestions for improving these); and 5) the level of geographic disparities by specialty and region, and possible recommendations to reduce these disparities.[2]

THE BENEFITS OF INCREASED ACCOUNTABLITY AND TRANSPARENCY

Sustainable funding for and governance of GME must include accountability and transparency both for current operations as well as for any proposed innovations in oversight, distribution of funds, or new funding sources. Implementing accountability in the context of GME first requires defining its scope—specifically, who should be accountable, for what, and to whom. Most importantly, accountability is owed to the general public as well as to individual patients. In addition, our GME system must be accountable to its trainees, not only for medical knowledge content and skills training, but for their learning experience, including sites of training, work conditions and fair compensation.[6,7] The scope of accountability goes beyond ensuring quality training in medical knowledge and skill sets to incorporating practical aspects of quality care and medical practice, including patient safety; equitable, timely, efficient and effective delivery of care; and appropriate stewardship of resources.[8] The system needs to be accountable for training an adequate and diverse workforce in terms of numbers, an appropriate balance between primary care and specialty practice, geographic distribution, and in providing service to the community and the public.[1,9] Refining the performance metrics to achieve accountability in this context requires a shift from structure and process measures to outcome and experience measures.[6] Responsibility for oversight depends upon the particular issue, resting with either the individual GME program, sponsoring organizations, training site, or national authority.[6]

POTENTIAL BARRIERS TO INCREASED ACCOUNTABLITY AND TRANSPARENCY

Currently, Medicare funding of GME is dependent upon program accreditation, a process through which professional standards for training within a given program are monitored, with respect to trainees' knowledge, experience and skills (rather than measuring outcomes). Although the ACGME is shifting toward outcomes and competency-based accreditation through its Next Accreditation System and Clinical Learning Environment Review program, the transition has been gradual. Furthermore, the accreditation process does not address the areas of specialty practice and/or geographic distribution of the physician workforce, due to antitrust and fair trade regulations.[1] A lack of accountability and transparency to taxpayers in states that provide a contribution to GME funding can, in part, be attributed to the difficulty in tracking non-salary-related residency costs, which is necessary to comply with reporting requirements.

Barriers to transparency also include the disincentive inherent in the ill-defined and uncertain extent to which GME funding contributes to hospitals maintaining positive margins at the local level[10,11] and the lack of oversight over public spending at the federal level. [1, 11]

Barriers to social accountability have also been identified, including training time constraints, financial limitations and institutional resistance. The complexity of current GME funding is likely a

barrier to meaningful change and presents significant difficulties in measuring certain desirable training outcomes, such as professionalism and cultural sensitivity.[9]

DIFFERING MEASURES OF ACCOUNTABILITY AND TRANSPARENCY

Proposed measures of transparency and accountability vary widely, and some are more accepted than others. Although a high level of concordance was seen for increased GME funding accountability and transparency among 27 organizations that publicly responded to the House Energy and Commerce committee request[3] for information on GME, how that actually could be achieved is apt to create dissension. For example, one-third of the organizations proposed ideas for GME funding reform to improve geographic distribution of residency programs,[5] which could be a measure of increased accountability to the U.S. public, as graduating residents often stay in the general location of their training. A similar number of organizations proposed linking residency funding to workforce projections, which theoretically would increase training of physicians in the specialties of greatest need. Many organizations, including the AMA, recommended that measures of residency program quality should be created and maintained by accrediting organizations (namely, the ACGME and the American Osteopathic Association), and that performance-based penalties are inappropriate in an educational setting.[4]

The authors of a recent GME stakeholder study on defining and measuring social accountability in GME identified several calls for GME accountability, including Canada's mandate that medical school education, research and activities address the priority concerns of the community, region and nation.[12] Another appeal, MedPAC's 2010 proposal of financial incentives to improve accountability for both the quality of care and training and the value of the health care delivery system, was subsequently echoed in budget recommendations for 2013.[13,14] In addition, the GME stakeholder study highlighted successful past efforts toward achieving accountability, such as the Health Resources and Services Administration (HRSA) Title VII program, which funded efforts to provide for increases in primary care, care in underserved areas, underrepresented minorities/ disadvantaged students entering health professions, and faculty development in health care education.[15,16] Evidence from HRSA's Title VII funding experience could be applicable in creating new models for accountable GME funding that meet the health care needs of the public.[17,18]

Defining transparency for GME funding may prove challenging. Some institutions may fear that a thorough exploration of the "black box" of GME costs could result in a reduction of IME payments, even though those savings could then be reallocated into the IOM's proposed transformational fund.[19] Further, such scrutiny within a particular institution may provide reason for an institution to review its "return on investment" value of maintaining particular programs.[20] A broad generalization could be made that the level of enthusiasm for suggested transparency reforms is lower among organizations that are direct recipients of funding, e.g., teaching hospitals and medical schools, and higher among organizations that include among their missions improved geographic and specialty distribution.[21,22,23]

EXISTING AMA POLICY

Current AMA policy relevant to this report includes the following:

D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
(22) Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide

data that support the value of GME to the nation; (23) Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

H-305.929, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs (8) Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

D-305.973, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs Our AMA will work with: (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes: . . . (c). make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions.

H-310.917, Securing Funding for Graduate Medical Education
Our American Medical Association will: (1) continue to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); and (2) continue to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.

D-305.969, Payment for Graduate Medical Education by the Centers for Medicare and Medicaid Services
Our AMA will work with the Association of American Medical Colleges and other interested groups to prevent reduction in Medicare graduate medical education payments by disallowing reimbursement for the time residents spend in didactic learning.

H-200.954, US Physician Shortage
Our AMA (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US; . . . (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need.

SUMMARY AND RECOMMENDATIONS

Achieving GME accountability and transparency entails partnering with and reporting to the public, defining specific aims and requirements, and establishing appropriate, feasible performance and outcome measures that can be agreed upon by a majority of GME stakeholders, if not a consensus. Transparent oversight of GME funding is critical, as is the optimal coordination of components, with built-in flexibility to address the changing health care needs of the public at local, regional and national levels. [1, 6]

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 327-A-15 and Resolution 329-A-15 and that the remainder of the report be filed.

1. That our American Medical Association (AMA) endorse the following principles of social accountability and promote their application to GME funding:

    a. Adequate and diverse workforce development;
    b. Primary care and specialty practice workforce distribution;
    c. Geographic workforce distribution; and
    d. Service to the local community and the public at large. (New HOD Policy)

2. That our AMA encourage transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees. (New HOD Policy)

3. That our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including:

    a. Resident salary and benefits;
    b. Administrative support for graduate medical education;
    c. Salary reimbursement for teaching staff;
    d. Direct educational costs for residents and fellows; and
    e. Institutional overhead. (New HOD Policy)

4. That our AMA reaffirm Policy D-305.967 (8), Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME. (22), Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation; and (23) Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-305.988 (12), Our AMA will advocate that resident and fellow trainees should not be financially responsible for their training. (Reaffirm HOD Policy)

6. That our AMA monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and that our AMA report back to the House of Delegates regularly on important changes in the landscape of GME funding. (Directive to Take Action).

Fiscal Note: $1,000.

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