Opinion

Tied Up in Traffic? So Is Funding for Resident Education

My favorite route to work used to involve a quick trip up a sparsely traveled road, and a U-turn for a half-mile, to a freeway entrance that was seldom busy. When congestion was present, I had a couple of alternate routes to employ. Life was good until the State Transportation wizards decided to improve traffic on the chronically congested routes I consistently avoided. Doing so involved destruction (literally) of my precious bypass route. What to do?

Ophthalmology residencies are facing an analogous dilemma, as Congress threatens to simplify the complex system of subsidies for graduate medical education (GME). Of course, the government would like to pay less and gain more control in the process. If you are like me, when we were residents we had no clue where the hospital got the money to pay our salaries. (Back then, they truly were starvation wages, so the hospital cooks left sandwich makings in the cafeteria refrigerator for us to raid while on call.) Since the advent of Medicare in 1965, teaching hospitals have been reimbursed for costs directly related to training. When the prospective payment system (PPS) was introduced to Medicare in 1983, two separate funding streams were established: the direct, reimbursing costs as before; and the indirect, adjusting the PPS payment to reflect the added costs of sponsoring residencies. In 2012, roughly 30 percent of the $9.6 billion Medicare subsidy was direct, and 70 percent was indirect. Other major contributors were Medicaid, at $3.9 billion, and Veterans Affairs, at $1.4 billion. Notably absent are private health insurers, who do not participate—mostly because they haven't been forced to, but also because they need the money to pay their executives' salaries (a cheap shot, I'll admit). One final historical factoid: Resident counts at all hospitals are capped at 1996 levels; no matter how many residents have been added since then, Medicare only pays for the 1996 number.

So this GME subsidy system is as complicated as the way I used to get to work. And Congress is listening hard to those who point out that other professions that are also important to society, and whose workforce also falls short of demand, don't receive government subsidies. But those professions do not carry the huge student loan burdens that medical graduates do, nor do they generally require schooling until middle age.

Recognizing the looming debate, the Institute of Medicine (IOM) convened a Committee on the Governance and Financing of GME and issued a report on July 29. For ophthalmology residencies, there's some good news and some bad news. The good news: The committee felt it would be too disruptive to change the GME financing system abruptly, so it suggested a phased implementation over 10 years. The bad news: The new system will be "performance based" (heard that before?), meaning that resident production will be in areas where need is greatest (primary care and rural areas). The report recommended channeling an increasing part of the GME subsidy into a "transformation fund" to finance new training slots identified as priorities by Medicare (including pediatrics, a true anatopism!).

All of this, of course, is subject to Congress' buying in to the IOM committee recommendations and then drafting and modifying legislation. Lobbying is likely to be intense, with a lot of horn honking and road rage. It's a traffic jam worth monitoring closely.

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