

## HEALTH POLICY REPORT

Mary Beth Hamel, M.D., M.P.H., *Editor***Institute of Medicine Report on GME — A Call for Reform**

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For more than three decades, administrations from that of Republican Ronald Reagan (1981–1989) to Democrat Barack Obama have proposed sharp reductions in the robust support by Medicare of graduate medical education (GME) programs. Teaching hospitals, the major recipients of an annual federal GME investment of more than \$15 billion in 2012, have withstood most of these incursions because senior Democrats who chaired the congressional committees that oversaw Medicare and represented areas with heavy concentrations of training programs, such as New York, Massachusetts, and Illinois, strongly opposed these cuts. Their advocacy was reinforced by academic medical centers that house GME programs, conduct clinical research, provide complex care, and treat uninsured patients.<sup>1</sup> But the continued growth of large entitlement programs, including Medicare (and its GME program), remain a target of budget cutters. Indeed, shortly after Republicans secured strong majorities in the House and Senate in an election-day romp on November 4, 2014, GOP leaders pledged to use the congressional budget process, which sets top-line spending limits with advisory policy details, to reduce spending and cut tax rates.<sup>2</sup> In this scenario, maintaining current GME funding levels may become a tall order.

The academic medical community had become unsettled even before the November election because of a controversial new GME report<sup>3</sup> issued by the Institute of Medicine (IOM). The 21-member IOM Committee on the Governance and Financing of Graduate Medical Education, two thirds of whose members are or previously were academic medical and nursing leaders, asserted that GME programs that are supported by Medicare do not train adequate numbers of physicians who are prepared to work in needed specialties or underserved geographic areas. The report recommends the creation of a new GME financing system “with greater transparency,

accountability, strategic direction, and capacity to innovate.” Earlier proposals that also favored larger investments in GME innovation were included in the Obama administration’s 2015 budget<sup>4</sup> and in a Medicare Payment Advisory Commission (MedPAC) report<sup>5,6</sup> and were outlined by the past two chairs of the federal Council on Graduate Medical Education — Drs. David Goodman and Russell Robertson.<sup>7</sup>

This article will cover the key recommendations of the IOM committee, strong objections to them voiced by recipients of Medicare GME payments, and disagreements over whether there is a shortage of physicians. Within hours of the release of the report on July 29, 2014, the Association of American Medical Colleges (AAMC), the American Hospital Association (AHA), and the American Medical Association (AMA) issued sharply critical statements opposing its recommendations. They were dismayed by the failure of the report to recommend an increase in the number of Medicare-funded GME positions and by the fact that it rejected estimates of a growing national shortage of physicians. The report focused on Medicare because its annual GME payout of \$9.7 billion in 2012 makes it, by far, the largest public supporter of residency training. The report notes, “This funding is essentially guaranteed, regardless of whether its recipients address local, regional, or national health care priorities.”

The funding formulas — established by Congress — do not reflect the financial consequences of operating different types of residency programs. MedPAC sought to determine these differences by means of a study conducted by RAND, but its researchers were unable to provide a definitive answer because of the lack of available data.<sup>8</sup> Other public funders of GME are state-based Medicaid programs (\$3.9 billion), the Department of Veterans Affairs (\$1.4 billion), and the Health Resources and Services Admin-

istration (\$464 million). Almost half of the state-based Medicaid funding is spent by New York, dwarfing the GME expenditures of every other state. The GME expenditures of the Department of Defense were not publicly available, but the agency sponsors approximately 200 GME programs that train an estimated 3200 residents per year.

The IOM committee acknowledged that the American approach to GME training is a model emulated by many nations — particularly because of the technical skills that residents acquire (Wilensky G: personal communication). But the panel also noted that “in recent decades, the need for improvements to the GME system has been highlighted by blue ribbon panels, public and private-sector commissions, provider groups, and Institute of Medicine committees.” Among calls that prompted the new review by the IOM were reports published by the Josiah Macy Jr. Foundation calling for GME reforms<sup>9,10</sup> and two letters sent to the IOM by senators of both parties.<sup>11,12</sup> Two former administrators of the Centers for Medicare and Medicaid Services (CMS) and the agency that preceded it, the Health Care Financing Administration, cochaired the IOM committee — Dr. Donald Berwick, who headed CMS under Democratic President Obama, and Dr. Gail Wilensky, an economist appointed by Republican President George H.W. Bush. Berwick and Wilensky wrote a Perspective article in the *Journal* summarizing the recommendations of the IOM report.<sup>13</sup>

The report stated the “overarching question”

that the panel would address: “To what extent is the current GME system producing an appropriately balanced physician workforce ready to provide high-quality, patient-centered, and affordable health care?” The committee conceded that strengthening GME programs alone would not produce a better performing health care system. “Other factors, such as the way in which we pay for health care services, are surely more significant determinants of how physicians select specialties and geographic areas. . . . Nevertheless, the GME system is a powerful influence on the makeup, skills, and knowledge of the physician workforce.”

The first of the report’s major recommendations (Table 1) derived from a fundamental question that the panel debated at “great length”<sup>3</sup>: Was there a rationale for Medicare to continue its support of GME? The panel considered a range of other GME funding options, including an all-payer approach favored by the academic community that would tap the resources of public and private payers. This model was proposed by the IOM in a 1997 study<sup>14</sup> but strongly opposed by commercial carriers that maintained that they support GME programs implicitly through the higher payments they negotiate with teaching hospitals on behalf of the inpatients they cover. The committee concluded that leveraging the public’s GME investment “through an entitlement program (Medicare) provides a level of stability that enables sponsoring institutions to make the commitments to the trainees, faculty, and facilities that GME needs.” But, to

**Table 1. Recommendations of the Institute of Medicine Report on Graduate Medical Education (GME).\***

Maintain Medicare GME funding at its current amount, adjusted for inflation, while modernizing payment methods on the basis of performance and encouraging innovation in the content and financing of GME
Build an overarching GME policy-development unit in the office of the secretary of Health and Human Services and a separate GME office of operations with the Centers for Medicare and Medicaid Services to disburse GME payments and manage demonstrations of new GME payment models
Phase out the current GME payment system and create a new Medicare GME fund with two subsidiary payment streams — an operational fund to disburse Medicare GME payments and a transformation fund that would support innovative new GME programs — and, through the GME policy office, award new training slots in priority disciplines and geographic areas
Replace the direct and indirect GME funding streams with one payment to GME programs that is based on a national per-resident amount, with a geographic adjustment; and expand eligible recipients to include GME programs operated by children’s hospitals and teaching health centers
Keep Medicaid GME funding at the discretion of the state but permit recipients to be subjected to the same transparency and accountability standards that are required of Medicare-supported programs

\* In an abbreviated form, these are the five recommendations contained in the report prepared by the Committee on the Governance and Financing of Graduate Medical Education of the Institute of Medicine.<sup>3</sup>

remain supportive of its recommendation, “essential steps” must be taken to replace the current Medicare GME payment formulas and phase in a performance-based model of payments over a decade. The American College of Physicians (ACP)<sup>15</sup> and others have urged CMS to introduce performance metrics and outcomes-based GME payments in Medicare, and a recent study showed their feasibility.<sup>16</sup>

The committee found that, “remarkably little is known about the individual, institutional, and societal costs of residency training. . . . This dearth of information exists, in part, because CMS requires only minimal reporting from teaching hospitals. . . . Federal GME regulations are nearly silent regarding transparency and accountability for use of Medicare GME funds.” Medicare supported training through direct GME payments of \$2.8 billion in 2012 that cover the stipends of residents and supervising physicians, plus related expenses, and an indirect medical education (IME) adjustment (\$6.8 billion in 2012). The adjustment is added to the inpatient payment rate to account for the extra costs incurred by training programs. The IOM report recommends the replacement of this payment model and the “current rationale for linking GME funding to Medicare patient volume because the care delivered by GME trainees and graduates extends across the (patient) population,” not just to Medicare-covered patients.

Two new payment streams would be created — an operational fund and a transformation fund. The operational fund would provide a single payment to currently accredited GME programs on the basis of a national, geographically adjusted, per-resident amount and, in the future, would also support residents currently covered by the Children’s Hospitals GME Payment Program and the Teaching Health Centers program. (The report offered no details on what the geographic adjustment would be.) The transformation fund — “the most important single dynamic force for change” — would award new Medicare GME-funded training positions in priority specialties and geographic areas, develop GME program performance measures, and support other innovative projects. Resources to pay for its activities would be drawn from the operational fund (the total payments to accredited GME programs) at a rate of 10% in the first year (approximately \$1 billion), increasing to 30% by the fifth year (approximately \$3 billion), with even-

tual restoration of the monies to GME operations once successful innovative models had been established.

The report underscored the absence of an “overarching system to guide GME funding in the interests of the nation’s health or local or regional health care workforce needs. CMS simply acts as a passive conduit for GME funds distribution to teaching hospitals.” To address this matter, the committee recommended creation of a GME policy council — modeled after MedPAC — that was composed of a dozen members appointed by the secretary of Health and Human Services, a majority of whom would not be stakeholders who derive support from the Medicare GME program. The council would be lodged in the quarters of the Office of the Secretary and, over the long term, would prioritize the allocation of GME funds “across identified domains, such as specialty or subspecialty, geographic location, training site, or types of sponsoring organizations.” A GME center within CMS would distribute the training funds.

The recommendations of the committee came under heavy fire from the AHA, AMA, and AAMC, many of whose members rely on Medicare GME support. In a statement, the AHA said, “We are especially disappointed that the report proposes phasing out the current Medicare GME funding provided to hospitals and offering it to other entities that do not treat Medicare patients.”<sup>17</sup> Dr. Darrell Kirch, chief executive officer of the AAMC, said that the proposed 35% reduction in Medicare GME payments (the AAMC estimate of the percentage of monies that would be redirected to the transformation fund) would “slash funding for vital care and services available almost exclusively at teaching hospitals. . . . Moreover, the IOM has suggested that Medicare trust fund dollars be siphoned off to care for non-Medicare patients and create new government bureaucracies at a time when there is increasing concern about the (Medicare) trust fund’s solvency. . . . The nation faces an estimated shortage of 130,000 physicians by 2025, split nearly evenly between primary care and many other specialties. . . . By drastically cutting support to teaching hospitals, the IOM recommendations will worsen these projected shortages.”<sup>18</sup> Kirch pointed out that 120 members of Congress are cosponsoring a bill that would authorize a modest expansion of Medicare-funded GME positions and create ac-

countability and transparency measures for GME funding received by teaching hospitals. However, the measure puts very little money at financial risk for hospitals that fail to measure up.

Emphasizing the projected shortage, the AMA said “the report provides no clear solution to increasing the overall number of GME positions . . . to meet actual workforce needs.”<sup>19</sup> The AAMC, AHA, and ACP share that view, and over time they have joined other medical interests in urging the lifting of a cap on Medicare-funded GME positions that Congress enacted in the Balanced Budget Act of 1997 so that additional training slots could be created. Anticipating these views, the report asserted that “the available evidence suggests that increasing the production of physicians is not dependent on additional federal funding. . . . In 2012, a total of 117,717 physicians were in residency training — 17.5% more than 10 years earlier.” A separate analysis of residency data, as noted in the report, shows that “the number of first-year residency positions has grown steadily since 2003 — at a rate of increase similar to the period before the caps.”<sup>20</sup>

Primary care interests were more supportive of the IOM report but took exception to its dismissal of the strong opinion of organized medicine of a growing physician shortage. (Anticipating this opinion, the report asserts that shortage estimates “often assume historic provider–patient ratios with limited relevance to . . . contemporary health care delivery. . . . The evidence instead suggests that while the capacity of the GME system has grown in recent years, it is not producing an increasing proportion of physicians who choose to practice primary care, to provide care to underserved populations, or to locate in rural or other underserved areas.”) In an interview, Edward Salsberg, who previously directed the workforce centers at the AAMC (2004 through 2010) and the federal Health Resources and Services Administration (2010 through 2013), agreed with the view in the IOM report that any increase in the number of physicians should be targeted to underserved areas and particular specialties rather than simply expand the overall supply. Salsberg said, “Assuring an adequate supply of physicians in underserved geographic areas or certain specialties would be best addressed by policies and programs targeted to eliminate these shortages.”

The American Academy of Family Physicians

avored the closer alignment in the report of the GME investment by Medicare with “the health care needs of our (total) population. We are most pleased to see recommendations . . . that will decouple payments from Medicare patient care loads and shift funding away from the legacy hospital-based system to more community-based training.”<sup>21</sup> (As the report described it, “By distributing funds directly to teaching hospitals, the Medicare payment system discourages physician training outside the hospital, in clinical settings where most health care is delivered.”) The American Academy of Pediatrics said, “Providing support . . . from secure entitlement funds, such as Medicare, would offer stability to the institutions that train” pediatricians.<sup>22</sup> The American Association of Colleges of Osteopathic Medicine voiced a similar view as it applied to all primary care physicians.<sup>23,24</sup>

Another issue that could become divisive in a congressional debate concerns variances in the number of Medicare-funded GME positions and per-resident payments that teaching hospitals in different states receive from the program. Most of these training positions are concentrated in the large urban centers of the northeastern United States. In New York, for example, teaching hospitals receive an average payment per resident of \$131,000, whereas Texas hospitals receive only \$65,000 per resident.<sup>25</sup> These imbalances are locked in by Medicare payment formulas that Congress established, and they are not amenable to recalibration, absent new legislation. The IOM report said, “Transitioning to a uniform, single PRA [per resident amount] payment (geographically adjusted) . . . enables a more equitable distribution of GME funds because, unlike the current system, the PRA will be equivalent across institutions except for the geographic adjustment.”

Another potentially explosive issue is how teaching hospitals spend their IME payments that total approximately two thirds of the Medicare annual GME amounts. In studies conducted by the Department of Health and Human Services and MedPAC, policy analysts have estimated that these adjustments are almost twice as large as could be justified to cover the higher patient care costs of Medicare inpatients, as compared with Medicare patients who are treated at nonteaching hospitals.<sup>5,26</sup> In addition, there are questions about the use that teaching hospitals make of their IME payments. At a National

Press Club briefing on September 10, 2014, MedPAC chair Glenn Hackbarth said, “IME funding is really medical education funding in name only. The money goes into the general funds of teaching institutions,” and their executives allocate those monies for a variety of purposes — “mergers, buying other institutions, buying physician practices, advertising. The money just flows to the general fund without any accountability. It is not GME funding.”<sup>27</sup>

Bruce Vladeck, a hospital consultant who directed the Health Care Finance Administration under President Bill Clinton, expressed a different view at the briefing, asserting that Medicare’s IME adjustment is not “a pot to be raided for other purposes however valid” but rather “an entitlement” to eligible beneficiaries for a specific set of health care services. Vladeck said that he “absolutely agreed” with the IOM recommendation to promote GME innovation but strongly objected to its redirection of Medicare monies as the best way to pay for it. Their exchange surfaced an issue that has not been discussed by Congress: Should Medicare revenues, which derive from a payroll tax on employers and employees, general tax revenues, and patient cost sharing, be allocated to defray the costs of Medicare inpatient services or, as the IOM report asserts, also be used for broader public purposes that reflect other national, regional, and community workforce priorities?

With its strong emphasis on funding innovative new approaches to GME, the IOM recommendations reflected proposals previously incorporated in the Obama administration’s 2015 budget,<sup>4</sup> in a 2010 MedPAC report,<sup>5,6</sup> and in an article by Goodman and Robertson.<sup>7</sup> The administration’s budget proposed to target “\$5.23 billion in mandatory (Medicare) funds to an innovative competitive grant program to create new residency slots with a focus on community-based ambulatory care.” The funds would be redirected from the Medicare GME payments. The MedPAC, an advisory body to Congress that is respected by both parties, proposed that \$3.5 billion of the Medicare IME payments be reallocated to support the development of performance measures on which Medicare payments would be partially based and other innovations. Goodman and Robertson proposed that a new GME funding mechanism be coupled with a competitive peer-review process resembling that of the National Institutes of Health.

Over a period of many years, during which estimates of physician shortages and surpluses were calculated at different times, Congress showed a reluctance to tackle issues surrounding the capacity and composition of the health care workforce in the United States. One recent sign of its reticence came when House Republicans declined to appropriate \$3 million to launch a National Health Care Workforce Commission as authorized by the Affordable Care Act.<sup>28</sup> Nevertheless, the IOM report has provoked stirrings among congressional staff members who were briefed on its recommendations. On December 6, 2014, eight House members, including Rep. Joseph Pitts (R-PA), who chairs the House Energy and Commerce Subcommittee on Health, wrote an open letter requesting information on GME from interested parties. The signators explained, “Given the importance of graduate medical education, we would like your thoughts on GME financing, federal program governance and structure, and how it might be improved or restructured to better meet the country’s health professional needs.”<sup>29</sup> Physicians who are members of Congress also have requested a briefing on the IOM report.

The new Republican majorities in the House (246 Republicans, 188 Democrats, and 1 vacancy — the largest GOP majority in the House since 1928) and the Senate (54 Republicans, 44 Democrats, and 2 independents who have historically caucused with Democrats) will increase the number of Republicans who sit on the key Medicare-related committees, at the expense of Democrats. The chairs of the three panels that oversee Medicare are more conservative than their Democratic predecessors. The House chairs are Rep. Fred Upton (R-MI) of the House Energy and Commerce Committee and Rep. Paul Ryan (R-WI) of the House Ways and Means Committee, who was Mitt Romney’s vice presidential running mate in 2012. Senator Orrin Hatch (R-UT), who will be the chair of the Senate Finance Committee, often collaborated with the late Senator Edward Kennedy (D-MA) on striking compromises that shaped many health-related issues.

Meanwhile, the AAMC and its allies realize that they may have a tall challenge to maintain the current level of Medicare support of GME, although interests that favor the status quo, regardless of the subject, almost always have a leg up on others that foster reforms. After Kirch

objected to the IOM recommendations, he declared that GME policy is at a “critical juncture.” In October 2014, the association announced plans to form an “army” of advocates — including medical students, residents, and others in the community — to do battle over maintaining the Medicare GME program, if not expanding it.

Beyond the Washington Beltway, leading academic medical centers are taking action to prepare for a tumultuous era of change that may transform the GME enterprise. In a recent report published by the AAMC, academic medical leaders from 13 exemplary systems identified common principles to assist academic medical centers in creating sustainable models for the future. In its executive summary, the authors warned, “Changing economics, market consolidation, fiscal pressures, and payers’ new focus on higher quality and lower costs require a new operating model for academic medicine. Every aspect of academic medical centers will undergo transformation in the decades ahead: how care is delivered, how students and residents are educated and integrated into clinical care, how the research enterprise is organized and funded, and how the missions come together in a new and meaningful way.”<sup>30</sup>

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://NEJM.org).

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DOI: 10.1056/NEJMp1413236

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