Graduate Medical Education Summary for
AADPRT, AACDP, AADMSEP
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Institute of Medicine Releases GME Report

On July 29th, the National Institute of Medicine released a long anticipated report on Graduate Medicine Education: "Graduate Medical Education That Meets the Nation's Health Needs"

This is my summary of the report after reading the entire 200-some pages. Surprisingly, it makes interesting reading. This is necessarily a big topic and doing this justice means a somewhat long discourse. I will first discuss some background to try to put this in context, and then I will summarize the report with some analysis. I am also going to skip some details in the interest of keeping everyone from falling asleep.

Context

Why is this an important report? Clearly there has been increasing dissatisfaction in Federal circles with how GME is administered and its outcomes. A number of reports over the last 10 years or so have outlined deficiencies in training, in specialty distribution, in geographical distribution and in costs. The Federal Government is the primary funder of GME and of course, Federal budgets are under a lot of pressure. Oh and incidentally, we are in the middle of the biggest health reform process since the institution of Medicare in 1964. So the IOM report was commissioned to examine GME and make recommendations to Congress and the Executive branch. Overall, the IOM is quite influential when they come out with reports of this kind and it is likely that their recommendations will be carefully considered by policy makers.

Background of Authors

The authors are Julie Eden, Gale Wilensky and Donald Berwick. This is important. Berwick is a pediatrician and former head of the Institute for Health Care Improvement, a very influential body and a proponent of continuous quality improvement in health care and a former head of CMS. He has spent a career talking about how dysfunctional the system is and making valiant efforts to influence change. Gale Wilensky is an economist and former head of HCFA, what CMS used to be called. In a nice piece of political balancing, he is a democrat and she is a republican. Jill Eden is a staffer in the IOM. Gale Wilensky is known to believe in an economic interpretation of GME. She appears to believe, quoting a MedPAC report, that "GME funding is given for increased value provided for the higher value of patient care services provided in teaching hospitals" (MedPAC report to Congress) Notice that this phrase contains absolutely nothing about education and there is thus no economic value attached to education provided to residents by hospitals. I believe some of what you will see in the report is a reflection of this idea.

The Report: Guiding Principles and Basic Assumptions

The committee agreed to some guiding principles that also seem to have informed their approach and final recommendations. They are:

- **a mismatch between the health needs of the population and specialty make-up of the physician workforce;**

- **persistent geographic maldistribution of physicians;**
- **insufficient diversity in the physician population;**
- **a gap between new physicians' knowledge and skills and the competencies required for current medical practice;**
- **a lack of fiscal transparency.**

Their basic and guiding question was:
To what extent is the current system producing an appropriately balanced physician workforce ready to provide high quality patient centered and affordable health care?

If you take the guiding principles above and then ask that question, the answer is clearly, "No way". So if you believe that residents are being paid more or less only to work, hospital costs cannot be accounted for by education, and you observe that GME is not providing appropriate return on investment, then it is no leap to indict the current system and a) propose a fix the involves financial incentives to push change, b) alters funding mechanisms and decreases funding.

The committee makes some other interesting assumptions that are controversial:

1) **There is no developing physician shortage**:
   The committee believes that PA's and NP's should have expanded roles and that "care delivery redesign" and telehealth and other technology is going to result in enough providers to go around.
2) **There will not be a shortage of residency training positions**:
   They point out that 3,500 new ACGME positions have been created since 2010 and that in the 2014 match, there were "7,000 more first year residency slots than U.S. applicants"

   And now, more economic analysis from the committee:
   The committee points out that there is not a lot of good data on the economic impact of GME on teaching hospitals. It is not clear what **"indirect costs and indirect benefits"** are to teaching institutions and so it is not known what the impact is on the bottom line for these institutions. Then, they draw some inferences from the behavior of teaching hospitals since the residency cap was put into place in 1997. They note that teaching hospitals added almost **"17,000 residency and fellowship positions between 1997 and 2012", presumably all without Medicare funding**. Then they say:
   "If it is assumed that hospitals would not add the direct and indirect expenses of trainees unless those expenses are offset by gains (which is debatable), such additions above the cap suggest that residents add value in excess of those costs—even with no subsidization (Chandra et al., 2014)." (parentheses are the committee's)

   They also report:

   > **"The committee also considered the economists perspective that residents, not teaching sites bear the cost of their training by accepting low salaries that reflect (on average) the difference between the value of services they provide and the cost of the training they receive (Beckier, 1964; Chandra et al., 2014 Newhouse and Wilensky, 2001)"**

Finally, they observe that by limiting teaching funds to hospitals, Medicare decreases flexibility in terms of program structure and who can develop programs and disadvantages children's hospitals and other organizations that might be interested in training programs. They also note that this likely limits outpatient training.

These sections lay out the economic analysis I mentioned earlier. Interestingly, you have to read most of the report since not all of this material is in the same place. A few observations:

1) Despite not knowing what the economic impact of GME is, they have their suspicions and since they ultimately recommend some decreases in funding, they must think hospitals are profiting from GME and from the **work** or added value to patient care that residents provide and that it is the residents, not the hospital that bears the added costs of training. They as much as say this in commenting that they considered the economists perspective **“that residents, not teaching sites, bear the cost....”** This is also in line with many economic analyses that demonstrate that the "real" IDME level should be about 1/2 of what it is now.
2) The comment about new positions all being created "presumably without Medicare funding" is not totally accurate. Some of this increase must be from “virgin hospitals” that became teaching hospitals and are thus supported by Medicare, and some from fellowships are funded on clinical dollars generated by the fellow which is a different animal from average residency slots. The statement is probably mostly true though.
3) The way Medicare funds are delivered (only to hospitals) does indeed limit flexibility and clearly limits outpatient training.

The Report: Recommendations and Analysis

With this as background, on to the main part of the report, which consists of recommendations. I will present the recommendations with more analysis:

RECOMMENDATION 1:

Maintain Medicare graduate medical education (GME) support at the current aggregate amount (i.e., the total of indirect medical education and direct graduate medical education expenditures in an agreed-on base year, adjusted annually for inflation) while taking essential steps to modernize GME payment methods based on performance, to ensure program oversight and accountability, and to incentivize innovation in the content and financing of GME. The current Medicare GME payment system should be phased out.

Doesn’t sound too radical? This is just the set-up. Read on to see what they want to do.

RECOMMENDATION 2:

Build a graduate medical education (GME) policy and financing infrastructure.

2a. Create a GME Policy Council in the Office of the Secretary of the U.S. Department of Health and Human Services. Council members should be appointed by the Secretary and provided with sufficient funding, staff, and technical resources to fulfill the responsibilities listed below:

- **Development and oversight of a strategic plan for Medicare GME financing;**

- **Research and policy development regarding the sufficiency, geographic distribution, and specialty configuration of the physician workforce;**
- **Development of future federal policies concerning the distribution and use of Medicare GME funds;**
- **Convening, coordinating, and promoting collaboration between and among federal agencies and private accreditation and certification organizations; and**
- **Provision of annual progress reports to Congress and the Executive Branch on the state of GME**

2b. Establish a GME Center within the Centers for Medicare & Medicaid Services with the following responsibilities in accordance with and fully responsive to the ongoing guidance of the GME Council:

- **Management of the operational aspects of GME Medicare funding;**
- **Management of the GME Transformation Fund (see Recommendation 3), including solicitation and oversight of demonstrations; and**
- **Data collection and detailed reporting to ensure transparency in the distribution and use of Medicare GME funds.**

The committee recommends allocating Medicare GME funds to two distinct subsidiary funds:

1. **A GME Operational Fund to distribute per-resident amount payments directly to GME sponsoring organizations for approved Medicare-eligible training slots. The fund would finance ongoing residency training activities sponsored by teaching hospitals, GME consortiums, medical schools and universities, freestanding children's hospitals, integrated health care delivery systems, community-based health centers, regional workforce consortiums, and other qualified entities that are accredited by the relevant organization. Under current rules, teaching hospitals sponsor nearly half (49.9 percent) of all residency programs and slightly more than half of all residents (52.1 percent) train in programs sponsored by teaching hospitals.**
2. **A GME Transformation Fund to finance new training slots (including pediatric residents currently supported by the Children's Hospitals Graduate Medical Education program and other priority slots identified by the GME Policy Council), to create and maintain the new infrastructure, to ensure adequate technical support for new and existing GME sponsoring organizations, to sponsor development of GME performance metrics, to solicit and fund large-scale GME payment demonstrations and innovation pilots, and to support other priorities identified by the GME Policy Council.**

There is a lot here. Let's deal with the organizational issues: What they have here is a two-headed organism. A policy head to do the thinking and an operational head to carry out the policy, both located in HHS. This is the Federal Government deciding to take control of what they pay for. Henceforth and forever more the Federal Government will make GME policy, influence workforce structure and geographic distribution and decide who gets what and how much….because they can. And, it might even be better than what we have now….maybe.

This by the way is, I am told, consistent with how the military runs their GME programs. Decisions on policy and numbers of trainees in various disciplines are made much more centrally and based on what the military think they will need over some period of time in the future. This means workforce policy will be set at a Federal level and managed through allocation of residency positions and financial incentives/disincentives. It also means there will be reliance on outcomes to determine if, at a program level or perhaps GME consortium level, organizations are doing what policy makers want done. The innovations fund will fund demonstration projects to examine how outcomes, among other things, can be used to determine quality. This is much more centralized control than we have ever had.

RECOMMENDATION 3: Create one Medicare graduate medical education (GME) fund with two subsidiary funds:
3a. A GME Operational Fund to distribute ongoing support for residency training positions that are currently approved and funded.

3b. A GME Transformation Fund to finance initiatives to develop and evaluate innovative GME programs, to determine and validate appropriate GME performance measures, to pilot alternative GME payment methods, and to award new Medicare-funded GME training positions in priority disciplines and geographic areas.

The committee expects that the GME Transformation Fund will provide the single most important dynamic force for change. All GME sponsor organizations should be eligible to compete for both innovation grants and additional funding for new training positions.

Modernize Medicare GME Payment Methodology
The purchasing power of Medicare GME funding provides a significant opportunity for strategic investment in the physician workforce. The separate IME and DGME funding streams, however, present a formidable obstacle to taking advantage of this opportunity. Maintaining separate IME and DGME funding streams would hamper efforts to collect and report standardized data, to link payments with program outcomes, to reduce geographic inequities in GME payments, and to minimize administrative burden. Separate funding streams create unnecessary complexity and there is no ongoing rationale for linking GME funding to Medicare patient volume because GME trainees and graduates care for all population groups. Finally, basing payment on historical allocations of DGME costs and training slots only prolongs the current inequities in the distribution of GME monies.

RECOMMENDATION 4: Modernize Medicare graduate medical education (GME) payment methodology.
4a. Replace the separate indirect medical education and direct GME funding streams with one payment to organizations sponsoring GME programs, based on a national per-resident amount (PRA) (with a geographic adjustment). 4b. Set the PRA to equal the total value of the GME Operational Fund divided by the current number of full-time equivalent Medicare-funded training slots. 4c. Redirect the funding stream so that

GME operational funds are distributed directly to GME sponsoring organizations. 4d. Implement performance-based payments using information from Transformation Fund pilot payments.

So, we know about the two funds. The operational fund continues to bankroll what we have, while the innovation fund looks at ways to do things differently. Ultimately, they want to restructure GME by using the big stick of money, using financial incentives to create what they think is best for the country. So, DME and IDME are rolled into one big chunk and can be given to GME consortiums, FQHC's and a variety of other sponsoring organizations so that there is maximum flexibility in who can be funded. No longer is funding only to hospitals. And, a large administrative structure will be created to administer all of this. How much will this cost? Not clear, but the money to run it comes out of the total GME funds in the new scheme again reducing GME payments.

So now, you have one payment going to whoever sponsors GME programs. This payment is set at a national per resident amount simply calculated by dividing the number of Medicare funded resident FTE's by the total funds available. But not so simple....First they already told us the Operational Fund is going to be the total minus the Innovation Fund, and you have to fund the administrative structure too. So the total Operational Fund is <u>not</u> the DME plus IME fund. It is significantly smaller. And, since you now go to a national per resident amount (PRA) (with geographic adjustments) some hospitals are going to get more and some less than currently.

You are, no doubt, interested in what the per resident amount is? The committee estimates that the national average per resident amount (PRA) will be about $80,000/resident. For residents after completion of the initial residency period (like PGY 5 child fellows) the PRA will be about $62,000. In fact, in line with what I previously noted about economist views of GME, their calculations do include a **"net 50% reduction"** in IDME.

Now for the other consequences, since there are always downstream second and third order consequences.

1) While understandably the committee only is dealing with GME, they make a very artificial distinction between GME funding and other hospital funding. Think about your department finances. Typically, funds flows go to support all kinds of department activities. GME is not just supported by GME funds coming to the department. Some clinical funds tend to go to GME and sometimes funds from other sources might fund GME until another funds flow comes in and you can essentially pay back that pot of funding and so on. This is always compared to a shell game that ends up (hopefully) balancing at the end of the fiscal year. Hospitals do this to the extreme. Remember that DME does go to GME programs, but IDME is used by hospitals for whatever they want. It really goes to the bottom line. Other funds flows like disproportionate share funding (DSH) and of course, patient revenues all support the bottom line, with maybe some charitable giving and whatever the hospital makes on its investments. All will determine profit or loss for the year. Now, under this set of recommendations, GME funds will decrease. At the same time, DSH funds are decreasing and patient revenues are decreasing. Somewhat balancing this is that in states that expanded Medicaid, beds that were filled with "no pay" patients are more often going to be filled with patients who pay something (if you are lucky enough to be in a state that actually bought into the ACA and expanded their Medicaid programs. However, overall, funds

especially for big urban teaching hospitals appear to be decreasing and certainly will in states where there was not a Medicaid expansion. Based on this, will hospitals still be willing to fund as many "over the cap" positions as they currently do? There is anecdotal evidence that hospitals are picking off fellowships to keep residency positions and are decreasing over the cap positions now. This is an example of the kinds of linkages the committee seems not to have considered that may result in behavior not anticipated by the committee.

2) With GME given in one big chunk as a per resident amount, this effectively freezes GME funding at some level without regard to any particular hospitals costs. Some hospitals may well have costs that are higher or lower for a variety of reasons. One would think that academic medical centers with multiple specialty services and a lot of residents might have an argument for larger costs. However, if you consider GME in isolation from expensive specialty services, this argument is not as persuasive. This is a pendulum swing from big differentials between hospitals in terms of GME to minimizing differences. Neither might actually be the most accurate reflection of reality, but remember, if you don't believe variation in hospital costs is accounted for by GME, then it doesn't matter. You will also note that the committee recommended no changes in the total Medicare GME funding amounts. This is recognizing reality. No one is interested in increasing GME funding. Thus, there was no prospect of the committee recommending taking the cap off or doing anything to increase GME funding.

3) The history of national workforce policy does not make for encouraging reading. At various times, various committees have projected various levels of physician surpluses or shortages. One can come up with any sort of estimate depending on your initial assumptions. Bottom line, these projections are notoriously unreliable. There is no reason to think that this committee has any more franchise on accuracy than any other, but they act as if they do. I think a more honest answer might be "we don't know" and go on to recommend some range rather than certainty. What seems to me most unlikely is that physician supply will be more or less what is needed as the committee seems to indicate. What are the chances of that?

4) A related issue is the certainty that comes through to me regarding their assumptions about hospital behavior and about the future. ("Prediction is risky, especially of the future"). If you believe the world behaves in a certain way and will continue to do so you can probably make policy recommendations with some level of confidence. History is replete however, with unanticipated behaviors, occurrence and so on, to say nothing of chance events. I think it is interesting that the committee chose to make one set of recommendations and not include ranges of estimates of the future or some range of recommendations from which policy makers could choose.

5) What might be good about these recommendations? Well, undeniably, the huge differences in what hospitals get in DME and IDME currently is unsupportable. Some rebalancing is a worthy thing to do, with some qualifications as noted above. Getting rid of DME/IDME as a funding mechanism does create more flexibility and allowing Medicare GME to go to other organizations does create more and needed flexibility. Teaching health centers, funded for GME through the Affordable Care Act may be a model that will work for the future and could be encouraged under this kind of new funding scheme.

Overall, I think we have an honest attempt at a new kind of GME system that as they seem to believe, "meets the nation's health needs".

Finally, where does this go from here? Policy makers are sure to consider these recommendations carefully. Much of what is in here would require Congressional action, but some could be implemented by CMS via rulemaking with a heavy dose of political input after. Recommendations that are too outrageous (too much change at any one time) are likely to be opposed by Congressional delegations from states with a lot of GME, like those in the northeast. Given Congressional behavior lately, and the midterm elections coming up, nothing is likely to happen too quickly and there should be plenty of time for discussion/politicking.

Questions/Comments? email me at magenj@msu.edu